Clyde Modernising Mental Health Strategy

Adult and older people's mental health services for Inverclyde, Renfrewshire, West Dunbartonshire and East Renfrewshire

Clyde Mental Health Strategy

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Clyde Mental Health Strategy

1. SUMMARY AND OVERVIEW

1.1 NHS Greater Glasgow & Clyde took responsibility for delivering health services across Clyde in April 2006. Since then, local joint health and local authority planning groups, involving service user representatives, have been working with frontline staff to review the way existing services are organised with a view to developing plans that will achieve service improvement and modernisation.

1.2 In particular, this work has looked at how best we can redesign current services to shift the balance of care more towards enhanced community services, which better meet individual's needs.

1.3 The strategy provides the outcome of that joint work and sets out:

- What a modern mental health service looks like.
- Where we are now compared to such a service
- How we would put in place the core elements of a modern mental health service through redesign of services and reinvestment of savings to fund service developments.

1.4 The strategy has six core building blocks:

1. Development of community services.
2. Closure and re-provision of long stay continuing care beds: shifting the balance from hospital based care to long stay care in the community.
3. Reconfiguration of inpatient services.
4. Specialist services development.
5. Investment of resources released from the redesign of acute and continuing care inpatient services to fund:
    - Service developments.
    - Achieving £2m savings as mental health's contribution to the GG&C NHS Board's corporate savings targets to contribute to addressing the inherited NHS Argyll and Clyde financial deficits.
6. Bridging funding to support the transition and service redesign to enable:
    - Development of robust community services in advance of inpatient bed reductions.
    - Bridging funding to support service redesign pending full release of site based savings.

1.5 A further summary of proposals in relation to each of these areas is provided overleaf:

Development of comprehensive community services.

1.6 To ensure consistent access to core service elements of comprehensive services for all geographic areas of north and South Clyde through £3.7m investment to develop:

- Primary care mental health supports.
- Community Crisis resolution responses accessible on extended day and weekend basis.
- Expansion of community mental health teams.

Closure and re-provision of long stay continuing care beds: the shift from hospital based care to care in the community.

1.7 Throughout the UK there has been a major shift away from providing long stay continuing care in hospital settings, towards providing the majority of long stay care in a range of community placements, supplemented by retention of a much smaller number of inpatient continuing care beds.

1.8 In the last 30 years this shift has seen a UK reduction of hospital based long stay provision of 65-80%, matched by a corresponding increase in the provision of community based long stay placements. However it appears that the Clyde services are at a much earlier stage in their development, and have made only limited progress to date in shifting the balance of long stay care provision from hospital to community settings.

1.9 Long stay care in community rather than hospital settings generally reflects the aspirations of users and carers, and can provide higher quality care in less institutional settings. There is also a good evidence base that such community based care is both effective and enhances the quality of life for service users.

1.10 Continuing care beds in N&S Clyde are currently provided at about 2.4 times the level of Greater Glasgow and other UK provision. This high level of provision reflects the use of continuing care beds as a default residential provision in the absence of a wider range of services not yet in place. Significant numbers of people currently cared for in continuing care beds would benefit from having their care safely provided in a community setting, from a range of care home or supported accommodation placements. For these individuals discharge from inpatient care would significantly enhance their quality of life and functioning.

1.11 The remaining continuing care provision would then be more appropriately focused on those with more complex medical care needs, and would require a lower overall number of beds. The current inpatient environment of continuing care is of variable and often low quality. Our proposal builds on the experience of Greater Glasgow arrangements, by re-providing older peoples mental health continuing care beds in community settings based on Partnership models of provision which secure new provision with higher quality environments of care, including single room accommodation.

1.12 The strategy proposes investment of £3.5m to develop a range of accommodation with supports for those who would benefit from discharge from inpatient care including:

- Supported accommodation places
- Intensive community care support packages

- Group homes
- Care home places

1.13 Additionally the strategy proposes reducing the overall number of continuing care beds and re-providing older peoples continuing care beds in higher quality community based Partnership provision, normally located in each local authority area.

Reconfiguration of inpatient beds

1.14 99% of people with mental health needs receive their care from community based supports in primary or secondary care.

1.15 Less than 1% of people with mental health needs require admission to inpatient beds.

1.16 Current provision of acute admission beds in Clyde is about 1.4 times higher than that in Greater Glasgow. With comprehensive community services in place the bed numbers in N&S Clyde can then be reduced to levels comparable to those in Greater Glasgow.

1.17 In terms of location of beds the strategy has sought to retain local access to beds where this is consistent with principles of clinical safety, cost effective service delivery, and feasibility and capacity to deliver good quality inpatient services on particular hospital sites. The detailed site proposals for acute admission beds were developed through the disciplines of an option appraisal process involving clinicians and practitioners, service user representation and managers.

1.18 Based on the outcomes of that option appraisal process, and wider work relating to non acute services, the preferred options for inpatient service configuration are summarised below:

Inverclyde

- Retention of Inverclyde adult and older people's acute admission services on the IRH site.
- Closure of older peoples continuing care beds currently on the Ravenscraig site, and re-provision of 33 older people's mental health continuing care beds in a community based Partnership arrangement within Inverclyde.
- Closure of adult continuing care beds currently on the Ravenscraig site, and re-provision of 9 adult mental health continuing care beds within Inverclyde.

Renfrewshire

- Retention of 40 older peoples mental health acute admission beds on the RAH site as now.
- Closure of older people's mental health continuing care beds on the Dykebar site and re-provision of 59 continuing care beds in a community based Partnership arrangement within Renfrewshire.
- Consolidating all adult acute admission mental health beds in the good quality accommodation on the Dykebar site (currently split between the Dykebar and RAH sites) within Renfrewshire.

- Reducing the overall number of adult continuing care beds and re-providing 12 beds within the Dykebar site:

East Renfrewshire: Levern Valley

- Consolidate provision of adult mental health beds for all of East Renfrewshire from the Leverndale site already used by the majority population of East Renfrewshire covered by the former GG NHS Board (implemented during 2007).

- Explore proposals to consolidate the small number of Older peoples mental health acute admission beds for all of East Renfrewshire on a single hospital site - either at the Leverndale Hospital or at the RAH.

- Closure of older people's mental health continuing care beds on the Dykebar site and re-provision of continuing care beds in a community based Partnership arrangement – East Renfrewshire to access either Renfrewshire provision or Greater Glasgow provision based on whichever arrangement achieves the best fit between user need, local access and service availability.

West Dunbartonshire: Dumbarton and Alexandria

The West Dunbartonshire population currently receives its acute admission inpatient services from 3 hospital sites:

- Vale of Leven for the Dumbarton and Alexandria catchments

- Gartnavel Royal for the Clydebank catchments

- Lochgilphead for Intensive Psychiatric Care beds

Our proposals are to:

- Consolidate provision of all acute admission beds for WDC on the Gartnavel site and transfer the adult and elderly acute admission beds currently located on the Vale of Leven hospital site to the Gartnavel Royal.

  - Transfer 34 acute admission beds (16 adult and 18 older peoples beds) for Dumbarton and Alexandria/Helensburgh and Lochside catchments to Gartnavel, in addition to the 24 beds (10 adult and 14 older people) already provided at Gartnavel for the Clydebank catchments population.

- Relocate IPCU beds from Lochgilphead Hospital to 2 beds in Gartnavel Royal.

- Re-provide 12 continuing care older peoples bed within WDC area using Partnership model (to serve the population of West Dunbartonshire and Helensburgh / Lochside).

The benefits of the consolidation of all West Dunbartonshire inpatient services (i.e. acute admission, IPCU and intensive rehabilitation beds) on the Gartnavel site include:

- Achieving preferred resident junior psychiatric medical cover arrangements.

- Achieving the benefits of consolidation on a site with enhanced hospital infrastructure of specialist management of inpatient service, practice development resources and bed management resources.

- Retaining the planned high quality inpatient single room accommodation benefits of the new Gartnavel hospital accommodation for the Clydebank catchments.

- Providing access to high quality single room accommodation benefits of the new Gartnavel Royal hospital accommodation to the population of Dumbarton, Alexandria, Helensburgh and Lochside.

- Providing ground floor accommodation and safe access to garden space for inpatient ward accommodation.

- Enabling the provision of separate acute admission wards for organic and functional illness.

- Achieving continuity of care between users of both acute admission and specialist mental health services on the same hospital site.

Helensburgh / Lochside

Services to this population are funded and commissioned by the Highland NHS Board and provided through a service agreement with the GG&C NHS Board. The Highland NHS Board's recognises the desirability of the Helenburgh /Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

Specialist services for the South Clyde catchments (Inverclyde/Renfrewshire/East Renfrewshire Levern Valley)

1.19 The following specialist inpatient services are already provided to a South Clyde catchments:

- Specialist addictions beds

- IPCU Beds

1.20 Specialist addictions beds for South Clyde are currently provided from the 11 bedded Gryffe Unit at the Ravenscraig Hospital. It is proposed that specialist addictions beds for South Clyde are re-provided as part of a consolidated South Clyde and South & West Greater Glasgow service to be developed at the Leverndale Hospital. The consolidation of 7 South Clyde beds with the 15 South & West Glasgow beds enables the service quality benefits of critical mass to be achieved in a small highly specialist service.

1.21 The IPCU is currently located at Dykebar and it is proposed this retains its South Clyde catchments, but is relocated to the IRH.

1.22 Intensive rehabilitation beds are not currently provided in Clyde services, but their development would enable specialist management of a challenging behaviour group of patients generally requiring such support for 1-4 years, best provided in separate accommodation from the acute admission environment of care. It is proposed to develop 8 such beds for South Clyde on the Dykebar site.

1.23 Early onset psychosis services are currently provided from a specialist service for the South Glasgow population. The funding of this service will be increased to enable an expansion of the catchments to include the South Clyde population.

1.24 East Renfrewshire currently uses specialist services in both South Clyde and in Greater Glasgow. It is proposed to consolidate the specialist services patient flows for the whole East Renfrewshire population (IPCU and Intensive Rehabilitation beds) with the services already used by the Eastwood population, which are located on the Leverndale site.

Specialist services for the North Clyde catchments (Dumbarton and Alexandria)

1.25 Historically the Dumbarton and Alexandria population has had limited access to specialist services, which have been provided either from Lochgilphead or from services South of the Clyde.

1.26 It is proposed to improve local access to such services by extending the access already available to the Clydebank population to the whole of the West Dunbartonshire (WDC) population, including the Dumbarton and Alexandria population and the Helensburgh / Lochside population:

- Transferring IPCU beds from Lochgilphead to 2 beds for WDC in the Gartnavel Royal IPCU.
- Access to the intensive rehabilitation beds at Gartnavel Royal.
- WDC wide access to specialist co-morbidity beds currently provided only to the Clydebank population, at the Stobhill site.

1.27 Early onset psychosis services are currently provided from a specialist service for the North Glasgow population. The funding of this service will be increased to enable an expansion of the catchments to include the Dumbarton and Alexandria population.

Development of Highly Specialist services: GG&C or Regional services

1.28 Prior to the establishment of NHS Greater Glasgow and Clyde Health Board, plans for Regional Medium secure specialist forensic services were based on separate development of specialist services on the Dykebar site for the West of Scotland catchments, and on the Stobhill site for the Greater Glasgow catchments.

1.29 It is proposed to consolidate medium secure services formerly planned (but not yet provided) on the Dykebar site, within the new 74 bed Rowanbank Unit (opening in July 2007) at the Stobhill Hospital in North Glasgow. This will include provision of 7 new medium secure beds for Clyde services.

1.30 The retention of low secure beds on the Leverndale site enables the absorption of additional medium secure activity at the Stobhill Rowanbank unit within existing bed capacity at the Rowanbank unit, without compromising previously agreed bed provision for the Greater Glasgow population.

1.31 Low secure adult mental health services for both Clyde (previously no planned provision) and Greater Glasgow will be consolidated as a single service based on the Leverndale site, providing 8 new beds for North and South Clyde.

1.32 Low secure services for learning disabilities are currently provided in separate services in the Dykebar 8 bed unit for the West of Scotland catchments (5 beds for Clyde, 3 beds for NHS Lanarkshire, NHS Ayrshire & Arran and NHS Fife), and Leverndale for the Greater Glasgow catchments. The proposal is to consolidate both services on the Leverndale site.

1.33 In general terms the consolidation of small highly specialist services, typically provided on a regional basis, achieves significant service quality and financial benefits since:

- Larger specialist services can sustain dedicated access to scarce specialist multi disciplinary supports.
- Larger services prove more attractive in terms of recruitment and retention of scarce and highly specialist staff who see larger services as offering enhanced opportunities for professional and career development.
- Larger specialist services provide significant economies of scale and prove more cost effective to provide.

1.34 To secure provision of these additional 15 medium and low secure specialist forensic beds to the Clyde population is a prerequisite legal obligation under the Mental Health Act, and requires new investment of £1.7m.

Reinvestment of funding to support the planned service developments

1.35 The planned service developments summarized above would cost £8.9m. However it is recognised by NHS GG&C that a specific allocation of £1.7m funds is required to meet the costs of the forensic services, leaving £7.2m to be released from service redesign for reinvestment.

1.36 Additionally mental health services in Clyde are required to deliver £2m savings to the GG&C Board as part of addressing the inherited Clyde deficit.

1.37 Therefore a total of £9.2m needs to be released from service redesign.

This will be achieved by:

- Releasing the site infrastructure costs of Ravenscraig through the previously agreed closure and disposal of the site.
- Maximising the use of good quality accommodation on the Dykebar hospital site, vacation of all other accommodation and disposing of a large part of the site.
- Taken together the reduced expenditure on site infrastructure releases £3.0m.

1.38 Reducing expenditure on continuing care and acute admission beds, following development of comprehensive community services and reduced provision of beds at equivalent levels to Greater Glasgow, releases £6.2m (net of capital charge commitments).

1.39 Together these changes generate the £9.2m required to fund the rebalancing of services including the development of comprehensive community services; re-provision of Partnership continuing care beds in higher quality accommodation, and contribute £2m to the overall NHS GG&C Clyde Financial Recovery Plan.

Bridging funding to support the transition and service redesign

1.40 It is widely accepted that the process of rebalancing services requires robust community services to be in place in advance of changes to inpatient services.

1.41 In order to cover the double running costs of development of community services and wider service redesign in advance of releasing the full ward and site based costs, the GG&C Board will provide non recurrent transitional funding of up to £3m per year for the period until March 2010.

Developing Clyde Services with no detriment to Greater Glasgow services

1.42 The GG&C NHS Board has previously committed itself to the principle that the development of Clyde services should be achieved without detriment to existing planned and agreed levels of provision for the Greater Glasgow population. The service and financial framework for the Clyde strategy has therefore ensured this principle is reflected in the detailed arrangements for service development and reconfiguration.

2. INTRODUCTION

2.1 In April 2006 the Greater Glasgow and Clyde NHS Health Board was created following the dissolution of the Argyll and Clyde Health Board.

2.2 The Greater Glasgow and Clyde Health Board committed to build on the strengths of the previous NHS Argyll and Clyde plans, whilst reviewing them in the context of experience of developing comprehensive mental health services, both within the Greater Glasgow and Clyde area, and also throughout the UK.

2.3 This Strategy summarises the outcome of that joint work with our partner agencies and services users, and in particular sets out:

- What a modern comprehensive mental health service "looks like".
- "Where we are now" within Inverclyde, Renfrewshire, East Renfrewshire, and West Dumbarton.
- Proposals to develop services to achieve the functions required of modern comprehensive services.

2.4 The scope of the Strategy includes:

- Adult mental health services
- Older peoples mental health services
- Addictions inpatient services
- Forensic services

2.5 A Clyde Mental Health Strategy Group was commissioned to progress the overall development of the strategy.

2.6 The group works on a partnership basis with membership drawn from the NHS GG&C Mental Health Partnership, NHS staff side representation, Acumen representing user interests, the four local authorities of Inverclyde, Renfrewshire, East Renfrewshire and West Dunbartonshire, and local Community Health Partnerships covering the same areas.

2.7 The strategy is based on a framework and principles applicable across the whole of the Greater Glasgow and Clyde area.

2.8 However the approach has deliberately ensured that local planning groups are responsible for the application of those principles, in ways which are rooted in the local context and reflect the varied stage of service development for each of the four local authority areas.

2.9 In this way the service specification is the same for each area, but the detailed service models have been designed and adapted to the varying contexts and needs of each of the four local authority geographies.

2.10 This approach is reflected in this strategy document which sets out the overarching framework applicable to North and South Clyde, and then subsequent appendices set out the application of those principles for each of the four local areas.

2.11 The Strategy was originally completed in June 2007. Subsequently the Scottish Government set up an Independent Scrutiny Panel to review the robustness of proposals prior to public consultation. This final Strategy document has subsequently been further refined to reflect the further work undertaken to more fully explore issues which the Scrutiny Panel advised should be addressed and set out in the documentation.

3. VISION

3.1 Our vision is that service users should:

- Receive supports which anticipate and prevent the development of illness.
- Receive the care and treatment supports they require.
- Receive care in local community settings where possible.
- Receive care which maximises recovery and minimises the disabling impact of their illness.
- Receive care on a timely basis in good quality services which are acceptable to service users and their carers.
- Be supported to live well in the presence or absence of illness.

3.2 Beyond care and treatment supports our vision is that social attitudes evolve to become more socially inclusive, tolerant and supportive by:

- Reducing stigma
- Improving the recovery and "life chances" of people with mental distress through access to:
  - Somewhere to live
  - Income
  - Work or meaningful occupation
  - Things to do/leisure activities
  - Support networks

3.3 Whilst the vision for service and treatment supports is primarily addressed to providers of specialist mental health services, the vision for wider social inclusion is one which can only be influenced through specialist mental health services working with the wider range of public, voluntary sector and private agencies.

4. MODERN COMPREHENSIVE MENTAL HEALTH SERVICES

4.1 Modern comprehensive Community Mental Health services need to be organised to deliver the following service functions which were set out in The Scottish Framework for Mental Health (1999):

- Access and information
- Needs for individual planning
- Meeting needs in crisis
- Needs for treatment and support with mental distress
- Needs for ordinary living and long term support
- Services to promote personal growth and development

4.2 There is now widespread consensus within the UK, informed by international experience, that comprehensive services should comprise a range of core service building blocks as summarised overleaf (albeit the detailed organisation and service models may vary between areas).

5. WHAT A MODERN MENTAL HEALTH SERVICE LOOKS LIKE

Services provided in local community settings or in peoples own homes • **Primary care supports for people with more common and less complex mental health needs used by c25% of the general population.** • **Secondary care supports for people with complex and enduring needs and used by c5% of the general population.**	
Primary care supports	Identification and access to effective treatments for common mental health problems.
Integrated Community Mental Health Team	Community teams based in local Resource Centres providing treatment and care for those with more complex and enduring needs.
Crisis resolution and access to treatment out of hours (extended day or 24/7)	Rapid and urgent community response providing intensive treatment support to people experiencing a mental health crisis who might otherwise require inpatient admission.
Assertive outreach supports	Structured intensive "sticky" flexible wrap around assertive support to maintain contact and support a small group of service users whose chaotic life styles might otherwise lead to disengagement from services and relapse.
Personal growth and recovery supports for ordinary living	Range of supports including: • accommodation with supports • meaningful daytime activities • support to get and keep a job • access to a range of social care supports for practical daily living • access to support networks to reduce isolation • advocacy supports
Early Intervention first onset psychosis	Rapid assessment and age related treatment at an early stage of someone's first development of psychosis: • 14-30 age group • Early intervention is crucial to support users and carers coping capacity at the early stage of illness.
Continuing care beds	For people with complex medical needs who require long term or life long support in an inpatient setting. Older peoples continuing care services may best be provided in community settings whereas adult continuing care services may best be provided on hospital sites.

Services provided in hospitals • **Inpatient services used by less than 1% of the population**	
Acute admission beds	Assessment and Treatment of acute mental illness.
Intensive psychiatric care beds	Assessment and Treatment of acute mental illness in a more secure setting to manage high risks of self harm or risk to others during the acute episode of illness.

Specialist services provided on a North or South Clyde/GG&C or regional basis

- **Highly specialist community services managing very complex needs and providing liaison consultation support to general services**
- **Highly specialist inpatient services provided on a North or South Clyde/GG&C or West of Scotland basis**
- **Services used by 0.02% of the population**

Intensive rehabilitation beds	For a small number of people who need a sustained period of inpatient care for up to 5 years to ensure rehabilitation to a level of functioning consistent with discharge to community supports. Often a small inpatient group with high levels of challenging behaviours requiring a highly structured inpatient environment.
Inpatient specialist addictions beds	The majority of detoxification is managed in residential or community settings. Where inpatient admission is required for people who have a primary mental health problem coupled with a secondary addiction problem this is normally managed in psychiatric beds (c40% of inpatient admissions). However a very small number of people with major addictions problems and other secondary physical health or mental health needs require care in more specialist settings with staff groups skilled in addictions problems which may coexist with secondary physical health or mental health problems. Community addiction services are normally provided to local authority populations as part of local services, albeit where these are small populations they may be provided to a larger population base.
Community eating disorders service and access to specialist beds	Specialist community services assess and treat the most complex presentations of eating disorders and assist generic community mental health teams in the care and treatment of less complex presentations. The specialist community eating disorders service is actively involved in pre-admission and post-discharge care for people accessing specialist inpatient provision.
Perinatal community service and inpatient beds for mothers and babies	Perinatal inpatient provision enables a safe and specialist environment for a baby to remain with its mother during her inpatient assessment and treatment episode. Care in mainstream inpatient beds is an unacceptable and unsafe environment for mothers and babies. Specialist community services assess and treat mothers with complex mental health needs in their home setting. For some people, this support will mean that admission to inpatient beds can be avoided. For people who require admission, the community service provides pre-admission and post-discharge support.
Forensic community service and inpatient services at varying levels of security	A very small proportion of people with a mental health problem may be at significant risk of committing a criminal offence whilst their judgment is impaired due to their illness. Care of these individuals takes place in environments of additional security by virtue of both physical security of the inpatient environment and specialist staff skilled in the management of forensic patients. Inpatient services are provided at varying levels of security from the state hospital providing a national high secure service, to regional medium secure inpatient services, and local services providing low secure inpatient services and specialist community services for those presenting lower degrees of risk.

5.1 In a modern service such as that summarised above each CHP/local authority area would have:

- A range of primary care supports and psychological interventions available through GP practices for people with the more common mental health problems.

- Resource Centres from which community mental health teams co-ordinate and provide a range of care and treatment supports including:

    - Ordinary living and long term supports

    - Management of complex care needs

    - Assertive outreach supports

    - Access to extended hours crisis resolution

5.2 About 95% of all care, treatment and support services are provided through the primary care supports and the community based Mental Health Resource Centres.

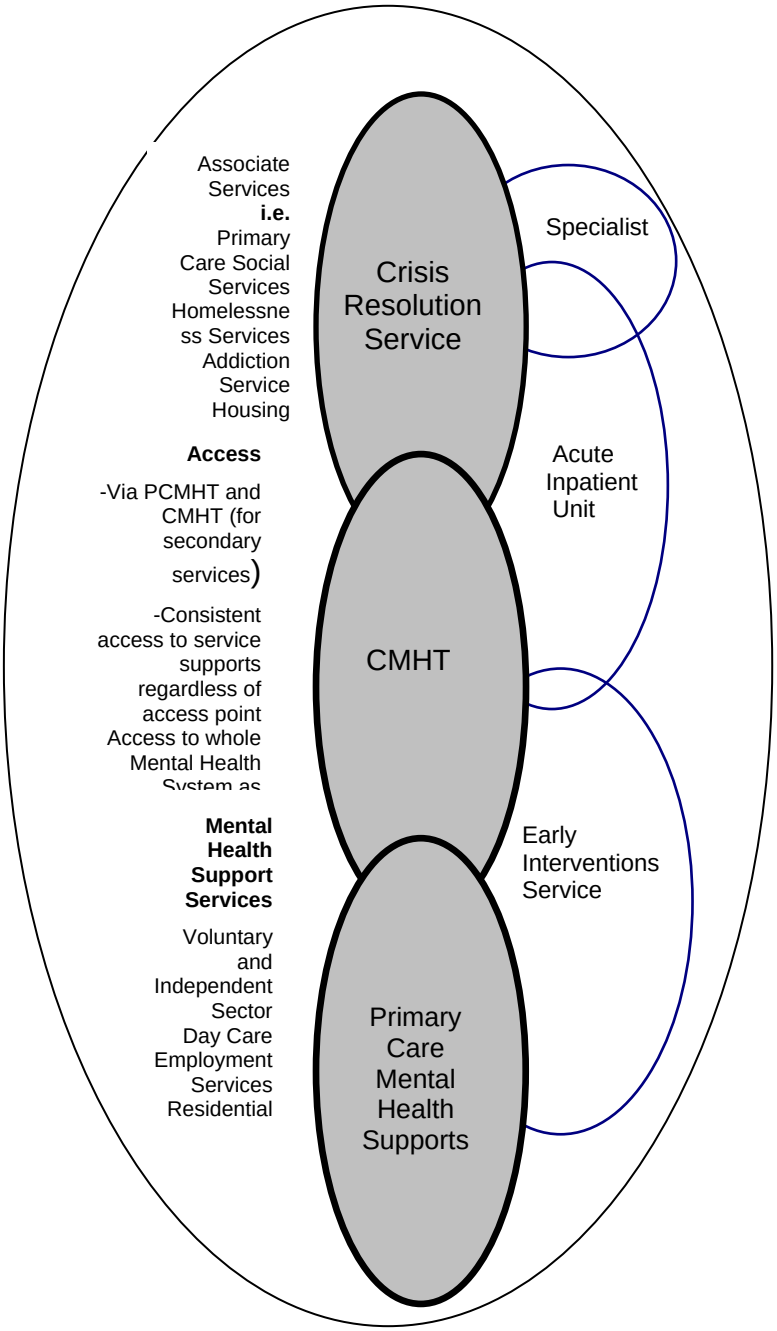
5.3 The community services are the core of the local mental health network and provide support for as short or as long is required, including long term ongoing support lasting months or years.

5.4 Such community services are underpinned by access to inpatient services for the small proportion of service users whose care is best provided in an inpatient environment.

5.5 Typically only c5% of mental health needs are cared for by secondary care services (including inpatient services); and less than 1% of mental health needs require service users to be admitted to inpatient beds, usually for a time limited period normally lasting no longer than 4-6 weeks.

5.6 This modern service is summarised in the diagram overleaf:

A CHP VIEW OF A MODERN MENTAL HEALTH SERVICE



Services directly provided within a CHP

Services generally provided to larger populations on a South Clyde basis, GG&C or WoS basis (albeit exceptionally acute inpatient units may be provided for CHP populations)

Broadly for CHP shaded service bubbles the ordering of the service bubbles reflects complexity of need with most complex needs at top of diagram,

Primary Care Mental Health Supports

- Identification/management of common MH problems
- Community bridge building/social supports
- Develop knowledge and facilitate access to full range of local resources
- Counselling and Brief therapeutic interventions
- Shared care of more complex needs with CMHT
- Health improvement and health promotion

Community Mental Health Teams

- CMHTs are the core of the Mental Health System, acts as gateway to full range of Specialist Mental Health System Services
- Providing treatment and care:
- specialist interventions with discharge back to Primary Care
- Substantial minority, ongoing treatment and care for people with complex and enduring needs
- Assessment and case/care management and access to specialist treatment
- 'Care Management' function re purchase of care packages
- Advice, guidance and direct support to primary care
- Develop knowledge and facilitate access of a full range of local resources
- Provide assertive outreach function

Crisis Resolution Supports

- Extended day or 24/7 service, access via CHP teams or specialist crisis service providing intensive care at home
- To help prevent admissions to hospital and speed discharge
- Expert support to CMHT's re management of acute relapse in hospital or community settings
- Short term case management during period of acute relapse
- Remain involved until crisis resolved and user linked to ongoing care of CMHT

Acute Inpatient Care

- Assessment and Treatment of acute mental illness
- Focused admissions with emphasis on planning appropriate discharge
- Emphasis on active use of time, maximising access to talking therapies
- Active engagement with meaningful day time activity
- Dedicated beds for each CMHT

Early Interventions First Onset of Psychosis

- Early diagnosis and treatment for severe mental illness
- 14 to 30 age group
- Early detection through links with youth services etc
- Rapid assessment and responsive age related treatment
- Bridge into Primary Care and Child and Adolescent services

Specialist Services inc.

- Forensic Services
- Eating Disorder Services
- Perinatal Services
- Liaison Psychiatry Service

6. NATIONAL POLICY CONTEXT

6.1 Any local strategy needs to ensure it takes account of the National legislative and policy framework.

6.2 The two main areas of significance are:

"The Scottish Mental Health Care and Treatment Act (2003)" which:

- Requires services to be provided at the least level of restriction consistent with meeting service user needs.
- Requires provision of age appropriate services.
- Requires Health Boards to ensure access to specialist/tertiary services.
- Requires the NHS and local authorities to provide trained Mental Health Officers and Approved Medical Practitioners to implement the act, and in particular powers of compulsory treatment.
- Provides a balance of rights and responsibilities for service users, including the right to appeal to a mental health tribunal against care in excessive levels of security.

"The Scottish Mental Health Delivery Plan" whose focus is:

- Improving patient and carer experience of mental health services
- Responding better to depression, anxiety and stress
- Improving the physical health of people with mental illness
- Better management of long-term mental health conditions
- Early detection and intervention in self-harm and suicide prevention
- Manage better admission to, and discharge from, hospital
- Child and adolescent mental health services
- Enhancing specialist services

6.3 The Mental Health Delivery Plan has four immediate performance targets to:

1. Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.

   - relates to appropriate prescribing of anti depressant drugs

2. Reduce Suicides in Scotland by 20% by 2013%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.

3. Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009.

    - relates to ensuring effective post discharge community support reduces vulnerability to rapid relapse and inpatient readmission

4. Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.

7. LOCAL CONTEXT

7.1 NHS GG&C became responsible for Clyde Mental Health services in April 2006.

Challenges

7.2 THE GG&C NHS Board faces the following challenges:

- Achieving recurrent financial balance by April 2010 – effectively requiring savings of £2m from mental health services.

- Limited access to capital expenditure.

- developing a *service driven* strategy which delivers:

  - A shift in the balance of care from hospital based care to community based care supported by access to inpatient admission when necessary.

  - Substantial development of comprehensive community services to support and sustain such a rebalanced service.

  - A retraction and re-provision programme which provides high quality long stay care in community settings, for those people who have traditionally received care in inpatient NHS continuing care wards, but whose quality of life would be improved by discharge to community settings.

  - Improvement of the therapeutic environment of inpatient care.

  - Ensuring the ongoing sustainability of medical cover arrangements in the more challenging context of the National introduction of the Modernising Medical Careers arrangements for medical training and medical cover arrangements.

  - Local delivery of the high priority targets of the Mental Health Delivery plan.

  - Achieving sustainable financial balance, whilst minimising overall reductions to effective spending on direct services.

Opportunities

7.3 Notwithstanding the challenges summarised above the GG&C Board also has a number of opportunities and in particular:

- High degree of shared vision and values between the Partner NHS and Social Care agencies, and flexibility of joint approaches to enable practical and tangible progress.

- Substantial experience of delivering rebalanced mental health services to achieve the radical service rebalancing required.

- Substantial experience of operating such rebalanced services on a sustainable basis providing confidence in the practical sustainability, as well as the logic, of such service redesign.

- Experience that comprehensive community services can ensure sound care whilst requiring bed use at c60% of inherited Argyll and Clyde provision.

- Access to a range of financial and service benchmarking tools to enable the design and costing of such a rebalanced service.

- Opportunities for shared use of Greater Glasgow service capacity to support the Clyde developments both locally, and for GG&C wide developments.

- Access to transitional funding to provide the necessary time limited investment to underpin the service redesign during the transitional period to 2010.

8. WHERE ARE WE NOW?

8.1 The table below repeats the earlier table summarising the service building blocks of comprehensive community centred mental health services, and compares this to the current position in N&S Clyde.

Services provided in local community settings or in peoples own homes • **Primary care supports to c25% of the general population** • **Secondary care supports for people with complex and enduring needs and c5% of the general population**	
Primary care supports	Some areas have no specialist support/some areas have limited access; requires rolling out across N&S Clyde
Integrated Community Mental Health Team	Some areas have minimal or no CMHT staffing; no area has full geographic coverage at sufficient staffing capacity
Crisis resolution and access to treatment out of hours (extended day or 24/7)	No service provision for extended day/24/7 access to treatment support for mental health crisis in community settings; some areas have access to social care supports for those in life crisis and with a mental health problem.
Assertive outreach supports	No service provision consistent with full implementation of assertive outreach programme responses.
Personal growth and recovery supports for ordinary living	Wide range of practical supports, including creative partnerships with voluntary providers. Further work is required to assess the balance and degree of comprehensiveness of such supports.
Continuing care beds	Substantial numbers of patients who would benefit from community placements currently cared for in lower quality environment of life long or long stay NHS continuing care beds. Continuing Care bed use at about 240% of Greater Glasgow level. Underdeveloped progress in shifting the focus of long stay care from hospital to community settings.

Services provided in hospitals • **Inpatient services used by less than 1% of the population**	
Acute admission beds	Overall acute bed provision at c140% of Greater Glasgow levels; varying ward sizes with a number of wards operating at greater than good practice norm of 20 beds ward size.
Intensive psychiatric care beds	In place though throughput appears low suggesting sub optimal use of such beds.

Specialist services provided on a North or South Clyde/GG&C or regional basis • **Highly specialist community services managing very complex needs and providing liaison consultation support to general services** • **Highly specialist inpatient services provided on a West of Scotland basis** • **Used by less than c0.02% of the population**	
Intensive rehabilitation beds	No specialist provision, sub group managed in general inpatient settings with consequential disruption to general inpatient therapeutic environment; small numbers mean specialist provision is only viable on a South Clyde basis.
Early Intervention first onset psychosis	No access to such services in North or South Clyde
Specialist co-morbidity addictions beds	Currently provided in Ravenscraig and requires relocation. Community addictions services underdeveloped
Community eating disorders service and access to specialist beds	No access to community eating disorder services and historic high use of inpatient extra contractual referrals
Perinatal community service and inpatient beds for mothers and babies	No access to community service; access to beds as part of WoS agreement
Forensic inpatient services at varying levels of security	Low secure learning disability services provided separately at both Dykebar (for West of Scotland) and Leverndale for Greater Glasgow services Planned development of Dykebar secure unit but no current provision for medium and low secure services; interim provision of Stobhill secure unit providing medium secure beds for West of Scotland including Greater Glasgow and Clyde; Leverndale providing low secure services to GG&C

8.2 When compared with the service building blocks of a comprehensive mental health service the table above suggests a picture of an incomplete and unbalanced service characterised by:

- Under developed community services.
  - Postcode variations in access and response.
  - Comparatively low spend per head on community services.
  - Under developed primary care services.
  - Under developed community services.
  - Very limited urgent access to community treatment supports out of hours and weekends.
- Disproportionate reliance on hospital based responses.
  - Comparatively high levels of bed provision and use.
  - Variable quality of environment of hospital estate.
  - High spend on hospital estate.

- Poor qualities long stay care in inpatient settings.
    - High numbers of patients inappropriately cared for in inpatient rather than community settings.
    - Underdeveloped progress in shifting the focus of long stay care from hospital to community settings.
    - Variable quality of inpatient environment.
- Limited access to specialist services.

9. THEMES FROM FEEDBACK

Stakeholder Involvement in the Strategy Development

9.1 There was service user involvement throughout the development of the Strategy. This was co-ordinated through the involvement and participation of ACUMEN's senior officer as a member of the Clyde Strategy Group. In addition, joint planning groups in each of the Clyde localities involved service user representatives in considering and developing service plans within an overall framework agreed by the Strategy Group.

9.2 Clinical leads for mental health services in each of the Clyde localities were also members of the Clyde Strategy Group and in local joint planning groups. In addition, the Medical Director and Director of Nursing for the Mental Health Partnership were members of the Clyde Strategy Group, providing robust clinical leadership to the process.

Pre-consultation engagement events

9.3 Pre-engagement events were held during the strategy development process to enable early sharing of the emerging direction of travel and provide an opportunity to shape the subsequent development of the strategy. The main themes from the pre-engagement events included:

- The importance of retaining local service provision.
- The need to focus on recovery and rehabilitation.
- The welcomed investment in primary and community services (though concerned the deficit position doesn't deflect this).
- Concerned to ensure quality of care standards for continuing care and concerns as to how this is achieved in the proposed Partnership bed models.
- The need to develop and formalise the networks of collaborative partnership between not for profit organisations and NHS and social care.
- The need to strengthen primary care supports beyond postcode variation.
- The need for a focus on good quality admission and discharge arrangements.
- The need to take transport links into account to ensure good access to inpatient care locations.
- Concerns over potential relocation of some services from their current locality and in particular that consolidation of adult acute services for Renfrewshire, at RAH, would reduce the standard of accommodation compared with the Dykebar admission wards.
- The needs to bring a stronger service user focus to the formal consultation process, with a suggestion of targeted events for specific client groups.

9.4 The first round of community engagement events gave a strong indication of the general support for the rebalancing of services in favour of more developed community services. This was therefore consistent with the Clyde Mental Health Strategy Group's thinking, as set out in the significant community service development proposals in this consultation document.

9.5 The priority that local service users and community groups placed on good local access to inpatient services was also a key theme. The Clyde strategy group therefore applied a guiding principle to support local inpatient provision, except where this compromised the quality, cost effectiveness or clinical robustness of inpatient services.

9.6 This principle was reflected in the follow-up engagement events that focused on emerging options for inpatient provision, which advocated the retention of local acute admission services for older people and adults in each of the localities (except West Dunbartonshire where the challenges of retaining more local provision were outweighed by the advantages of consolidation of all WDC activity on the Gartnavel Royal site), as well as suggesting NHS commissioned 'partnership' beds may offer the best way of securing good, modern and local accommodation for older people's continuing care services.

9.7 As with current practice, there are smaller specialist inpatient services (for Addictions, Intensive Psychiatric Care, and Forensics) where critical mass and sustainability suggest they should continue to offer a service across locality boundaries.

9.8 The feedback received at the follow-up events, in the main reaffirmed the Clyde Strategy Group's thinking around its work on options for the future location of inpatient services.

9.9 However, the option to consolidate Renfrewshire adult acute admission beds at RAH saw opinion divided. Some saw the logic and clinical benefits of collocation and consolidation on the RAH site as a high priority; whilst other stakeholder feedback expressed concern that location at the RAH was unlikely to achieve the high standard of current purpose built accommodation at the Dykebar site, which had been hard fought to secure and was now highly valued.

9.10 Concurrently further work has explored the capital costs of providing single-room accommodation at refurbished RAH wards for this client group, to try and attain a standard of internal accommodation similar to that offered at Dykebar. Having further explored these issues it is clear that the costs of bringing the RAH wards to a similar environment and standard to those at Dykebar appear to be substantial, and difficult to justify at this point in time, given the good quality accommodation available at Dykebar.

9.11 We have therefore revised the original proposal to locate adult beds at the RAH, to a proposal to consolidate all adult mental health admission beds for Renfrewshire in the existing good quality Acute Assessment Unit accommodation at the Dykebar Hospital.

9.12 The proposals to consolidate all WDC admission activity at the Gartnavel site saw opinion more divided with concern at the potential loss of this local service to the Dumbarton and Alexandria population. The strategy proposes that the challenges of retaining the service at the Vale of Leven are outweighed by the benefits of consolidation of all WDC inpatient activity at the Gartnavel Royal site. The detail of this rational is further considered in paragraph 13.22 onwards.

Independent Scrutiny Panel Feedback

9.13 An Independent Scrutiny Panel was established by the Scottish Government to review the key service changes arising from the Strategy, following its presentation to the NHS GG&C Board and the approval by the Board to the significant service change proposals for public consultation.

9.14 In terms of stakeholder engagement, the ISP commented:-

- The need to better describe the extent to which front-line clinical staff had been involved.
- The need to report on clinical views that were contrary to the Health Board's preferred options.
- The need to describe in more detail how the views of service users, their parents or carers, and community representatives had influenced proposals.
- The concerns expressed at public meetings over proposals to transfer mental health inpatient services from Vale of Leven Hospital to Gartnavel Royal Hospital, particularly with regard to potential travel and access difficulties.
- Concerns expressed at public meetings regarding 'ambitious bed reductions'.
- Concerns expressed at public meetings regarding the contribution to the financial recovery plan associated with Clyde Services (following the deficit inherited from NHS Argyll & Clyde).
- Concerns expressed at public meetings regarding the uncertainty surrounding NHS Partnership bed proposals.
- The need to undertake a formal option appraisal process to determine preferred options, particularly for the proposals relating to Vale of Leven Hospital given the concerns expressed by the community.

Option Appraisal

9.15 In light of the ISP's recommendations, the Health Board agreed to undertake formal option appraisals to help determine preferred option(s) for consultation. It was considered that doing so would also address the aforementioned concerns expressed by the ISP, by providing a robust and structured process enabling a range of partners (clinicians and practitioners, users, community representatives and managers) to influence and challenge the developing proposals and a structured process for recording the outcome of that dialogue.

9.16 Option appraisal events were held between November 2007 and January 2008, led by an independent facilitator. The full option appraisal report is attached as an appendix to this report. However, it was clear that participants were able to contribute and influence proceedings, for example:-

- The range of options considered in respect of West Dunbartonshire services were expanded to reflect the community aspirations to explore options which retained inpatient services on the Vale of Leven site.
- The high benefits criteria scoring of options to retain services at Vale of Leven Hospital.

- In particular, the identification of an option to potentially sustain resident medical out-of-hours services at Vale of Leven in the short term.

- The reflection of the range of divergent views and concerns expressed by West Dunbartonshire Mental Health Forum participants in reports to the Clyde Strategy group and in the consultation material.

- The commitment by the Board to explore further, during the consultation period and beyond, ways to minimise the difficulties some visitors will have in travelling to Gartnavel Royal Hospital.

- While the outcome of the option appraisal processes for South Clyde mental health services broadly confirmed the Strategies previous recommendations, the appraisal process provided an evidenced based process to support this. It also provided an opportunity to further explore and take account of a range of diverse and challenging views.

- The major areas of difference in the South Clyde option appraisal process being reflected in relation to the proposed relocation of the IPCU in South Clyde from Dykebar to the IRH and whether this best served the needs for access and integration between IPCU and other inpatient services. Throughout the option appraisal process there was a need to look at the combined impact of proposals across a wide range of factors to ensure that single issue considerations were considered and then weighted as part of a more rounded set of considerations. In the case of the IPCU discussion other factors such as supporting the critical mass and clinical sustainability of the IRH service were also factors which were considered. While the proposed transfer of IPCU services to Inverclyde remains the preferred option, there is now a commitment to also explore the potential for eastern areas of Renfrewshire (along with East Renfrewshire) catchments to access Leverndale Hospital's IPCU, thereby mitigating the concerns about access for the population of the eastern areas of Renfrewshire.

9.17 In response to the ISP's recommendation that further clarity is needed for the public in terms of NHS Partnership beds and also the evidence to support changes in bed numbers, work has taken place under the direction of the Clyde Strategy Group to help address these issues. Further clarification on these issues is set out within this Strategy and is summarised within the consultation document. Full copies of the Independent Scrutiny Panels report and the Boards initial response can be accessed from

http://library.nhsggc.org.uk/mediaAssets/library/nhsggc_consultation_clyde_mental_health_full_2008_04.pdf

9.18 In addition to the engagement issues raised by the Independent Scrutiny Panel the Panel also raised issues relating to the need for proposed bed levels to be more fully explored in terms of both local needs assessments, location within benchmarking beyond Greater Glasgow, and further articulation of the evidence base which underpins both the bed modelling and the wider strategic direction. These issues have now been reflected in the relevant sections throughout this report and addressed in detail in Appendix 5 of this Strategy

Public Consultation Process

9.19 The Public Consultation Process during April, May and June 2008 will provide a further opportunity to engage with the public, service users and other key stakeholders on the service change proposals arising from this Strategy. The Board is keen to ensure people have the opportunity to participate and has organised a number of events to inform and engage people in our plans to modernise and improve services.

10. ACHIEVING A MODERN COMPREHENSIVE MENTAL HEALTH SERVICE:

HOW WILL WE GET THERE?

10.1 The strategy has 6 main components:

1. Substantial development of comprehensive community services to support a rebalanced comprehensive community based mental health service.

2. Closure and re-provision of continuing care beds and development of long stay care in higher quality environments in community settings.

3. Reconfiguration and development of inpatient services to lower benchmark levels of provision consistent with a sustainable rebalanced service.

4. Development of access to specialist services for the Clyde population.

5. Investment of resources released from the redesign of inpatient and continuing care services to:

    - Fund the service developments set out above.

    - Achieve financial balance whilst minimising impact on direct service delivery.

6. Bridging funding to support the transition and service redesign to enable.

    - Development of robust community services in advance of inpatient bed reductions.

    - Bridging funding to support service redesign pending full release of site based savings.

10.2 A brief explanation of the rationale informing each of these components is summarised in the following sections 11-16.

10.3 A summary of the service and financial changes associated with these 6 components is provided in the following sections 11 – 16.

11. THE PROPOSED LEVELS OF COMMUNITY AND INPATIENT SERVICES

Context

11.1 Over recent decades there has been a progressive trend (both UK and internationally) to shift the balance of care from reliance on hospital dominated services, to a mental health network of highly developed community services, supported by access to inpatient support when required.

11.2 This shift in the balance of care has been marked by:

1. Reduced provision of NHS long stay continuing care in hospital based inpatient settings, and re-provision of long stay care in a range of community settings comprising a smaller number of NHS inpatient continuing care beds, often in community locations, and a wider range of placements in care homes, supported accommodation, and intensive community care packages.

2. The development of community mental health teams and community services, and their subsequent further development to provide primary care, early intervention, assertive outreach and crisis resolution supports.

3. More focussed and effective use of inpatient beds characterised by shorter lengths of stay in inpatient episodes and reducing readmission from post discharge relapse, through the more effective community management of long term conditions in community services by provision of more flexible, responsive, intensive, and where appropriate, 24/7 community service supports.

4. Shifting the balance of care for the management of acute mental health crisis, between care in inpatient settings and care in community settings.

Changes in the provision of inpatient care and the shift of provision from hospital based long stay care to care in the community

11.3 In a UK context the process of “deinstitutionalisation” of long stay care and development of “care in the community”, has been the dominant factor in shifting the balance of care between inpatient beds and care in a wider range of community settings.

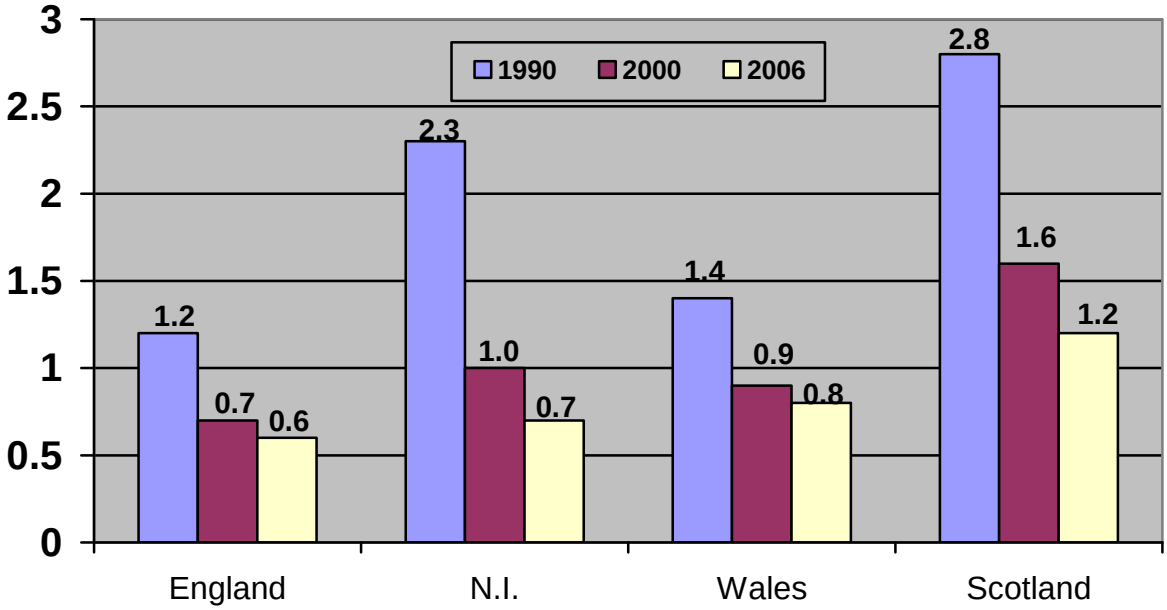
11.4 In Scotland in the period 1980 to 2006, hospital based provision reduced by some 65% from 17,200 to 6020 beds. (Acute and long stay adult and elderly beds).

11.5 In Greater Glasgow over the last 20 years in patient bed provision has reduced by about 70% from around 3000 beds to 920 beds – again reflecting the trend to provision of long stay care in community settings through the development of a range of community placements which offset the bed reductions.

11.6 In a broader UK context, the English position over the 30 year period from 1970 to 2006 saw levels of bed provision reduced by some 80% from 123,000 to 24,400 beds, offset by a substantial increase in provision of placements in community settings.

11.7 The graph below shows the comparative position for UK countries in terms of levels of beds provided per 1000 population, over the period 1990 to 2006. The figures relate to both acute and continuing care beds – however the levels of acute beds are likely to have remained fairly stable over the period with the major factor being the shift of long stay beds from hospital based care to care in the community.

UK bed rates per 1000 population: 1990 to 2006

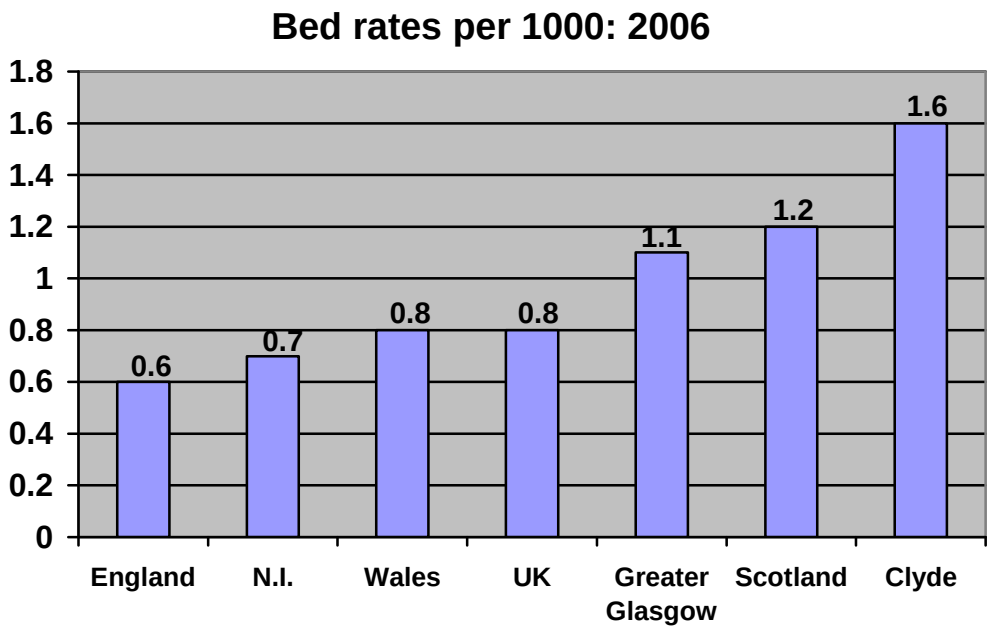


The graph shows:

- All countries within the UK have had a substantial reduction in bed levels over the period with UK average bed levels at 40% of the 1990 levels.
- Substantial variation between the countries within the UK on current bed rates in 2006.

11.8 It is likely the major factor reflected in these differences will be that Scotland and Clyde services are at an earlier stage in their shift from “hospital based long stay care” to “care in the community”. Current bed rates in Scotland appear closer to those in place for the rest of the UK around 10 -15 years ago and about 50% higher than the other UK countries.

11.9 The graph below shows the comparative levels of beds per 1000 population for 2006 for both Greater Glasgow and Clyde, and for each of the UK countries.



The graph shows:

- Scottish bed levels are 50% above UK average levels.
- Clyde bed levels are substantially higher than Scottish levels or Greater Glasgow levels.
- Glasgow levels are lower than the Scottish average but higher than the UK average.

11.10 In Clyde it appears that this process of re-provision of long stay beds is at an earlier stage, as Clyde bed provision is around:

- 35% higher than the Scottish average (acute and continuing care beds).
- 55% higher than the Greater Glasgow rates (acute and continuing care beds).
- 225% higher than Greater Glasgow rates for long stay continuing care beds.
- 45% higher than Greater Glasgow rates for acute assessment beds.

11.11 Whilst the figures quoted above reflect both acute and continuing care provision the overwhelming majority of UK bed reductions have been in long stay continuing care beds with acute bed reductions seeing only more modest reductions.

Proposed Bed Levels: Overall

11.12 There is no definitive evidence base for a particular level of beds for a given population or for the health outcomes of a given balance of care between inpatient and community services. There are no persuasive arguments to support a hospital only approach. Nor is there any scientific evidence to suggest that community services alone can provide comprehensive care. There is however a general consensus that comprehensively developed community services are required to sustain lower levels of hospital provision.

11.13 In overall terms the weight of opinion and results from available studies support balanced care consisting of both inpatient and community practice.

11.14 Contemporary practice in modern mental health services in both the UK and the developed world has seen:

- A substantial shift in the location of provision of long stay care from hospital to community settings, for which there is a good evidence base of positive outcomes for service users
- An associated reduction of hospital based long stay care provision of 65-80% across the various UK countries
- The development of comprehensive community services approaching the benchmark levels of community services provision described in paragraph 11.26-11.30 below
- More modest reductions in the provision of acute admission beds associated with more focussed and effective use of the remaining inpatient beds underpinned by more comprehensively developed community services
- A further shift in the balance of care for the management of acute mental health crisis with c20% of admissions now managed by community crisis teams without recourse to hospital admissions

11.15 Determining bed levels requires judgements taking account of epidemiological norms (where these exist), benchmarking against other services, and local needs assessments of the pattern of actual usage of beds.

11.16 In the case of long stay patients the requirements are particularly influenced by the outcomes of the individual needs assessments of the current patient cohort. These needs assessments are based on a combination of more general clinical assessments, and detailed individual needs assessments. It should be noted that the needs of some patients change over time and there will always require a degree of flexibility around planning assumptions to reflect this.

11.17 Additionally UK experience suggests that the most deprived areas require bed levels of 2 to 2.5 times those of the least deprived areas. Whilst social class influences deprivation it also has a significant impact on needs for mental health services because of its effect on the course of the illness. Deprivation is associated with longer duration of episode, greater risk of relapse, poorer treatment response and clinical outcome, disproportionate use of psychiatric services and differing perceptions of psychiatric illness.

11.18 The Greater Glasgow bed levels were themselves determined by the process described above through a cross referencing process of:

- Use of epidemiological norms.

- Benchmarking with other comparable demography's.
- Local needs assessment of the pattern of bed use.
- Local judgement on positioning Greater Glasgow levels taking account of the above 3 factors.

11.19 The initial development of bed levels for Clyde therefore extrapolated from Greater Glasgow bed levels per 1000 relevant population (i.e. adult or elderly), and applied a weighted deprivation factor to that extrapolation to reflect differences between the demography of Greater Glasgow and the various areas within Clyde.

11.20 This benchmarking has then been refined by exception, based on the outcomes of local needs assessment and local judgement, and final bed levels adjusted to reflect the modest adjustments required to take account of actual ward sizes.

11.21 The subsequent sections (13 & 14) have provided tables which have used the benchmarking methodology to compare:

- Current levels of provision in North and South Clyde.
- Benchmarked required levels of provision.
- Comparative levels of provision between Clyde services and Glasgow services.
- Proposed levels of provision to benchmarks.

11.22 This approach has been applied to:

- Continuing care beds.
- Acute admission beds.
- N&S Clyde Specialist beds.
- Highly specialist beds provided on a GG&C or Regional basis.

11.23 The Independent Scrutiny Panel were concerned that the bed modelling should be more transparently located within a wider context than Greater Glasgow, further informed by local needs assessments within Clyde and should provide further background information on the evidence base informing the proposals set out in the Clyde strategy.

11.24 Appendix 5 to this strategy has therefore set out a substantial and more detailed basis for the bed modelling used for projecting the basis for bed requirements and the evidence underpinning the strategic approach. The appendix has done so with reference to:

- The evidence base for the provision of long stay care in community rather than hospital settings.
- The evidence base for management of crisis care in community crisis teams.
- Location of proposed bed requirements in the context of local needs assessments in Clyde, and cross referencing to benchmarked levels of service provision in Greater Glasgow, Scotland and the UK, epidemiological norms and professional guidance.

11.25 This further work has confirmed that the proposed benchmark levels are consistent with both local needs assessments and within the range of bed levels consistent with benchmarking to other demography's and professional norms etc.

Benchmarking the levels of community services

11.26 The weight of professional opinion supports a balanced care approach consisting of both inpatient and community services. Additionally there is a general consensus that comprehensively developed community services are required to sustain lower levels of provision.

11.27 The Sainsbury Centre for Mental Health / Department of Health (England) has produced guidance on the scale of staffing for the main adult community service teams:

- Community Mental Health Teams (CMHT's).
- Crisis Resolution and assertive outreach supports.
- Early Intervention first onset psychosis services.

11.28 This guidance has been applied into the context of the varying deprivation levels of GG&C areas, to model the outstanding required scale of additional staffing net of existing community staffing resources.

11.29 There is no similar clarity of required levels of primary care mental health supports, and the benchmark has therefore extrapolated from existing Greater Glasgow levels of provision.

11.30 No similarly developed benchmarking tools are available for use to model the required scale of older people's community mental health services, and the approach has therefore been more reliant on local judgement.

12. DEVELOPMENT OF COMMUNITY SERVICES

12.1 We have used service benchmarking tools to assess the scale of the services required to provide comprehensive CMHT's, Crisis and assertive outreach supports, and primary care supports. This has then enabled us to assess the deficit levels and funding required responding to such deficits.

12.2 Provision of robust community services is a prerequisite of service rebalancing in which higher levels of more intensive community services sees a lowering of the required levels of inpatient services required. This has been the experience of services within both Greater Glasgow and throughout the UK. Services within Greater Glasgow have been operating on this basis for some years and demonstrated the practical sustainability of such a rebalanced service.

12.3 The proposed expansion of community services will provide consistent access to community services supports throughout the North and South Clyde area as set out in the service specification for community services.

12.4 The strategy has proposed investments of £3.7m to:

- Develop primary care services to ensure all GP practices have ready access to staff skilled in the care and treatment of patients with mild to moderate mental health needs.

- Enhance community based mental health teams to increase their capacity to support people with more severe and enduring mental illness in the community.

- Develop crisis services to provide community responses to people in an acute mental health crisis and to provide more intensive input to patients who may otherwise be admitted to hospital, and support the discharge of patients.

- Provide assertive outreach supports to sustain contact and maintain the functioning of a small group of chaotic service users prone to relapse following disengagement from services.

13. CLOSURE AND RE-PROVISION OF CONTINUING CARE BEDS: DEVELOPING LONG STAY CARE IN COMMUNITY SETTINGS

13.1 The NHS Management executive letter MEL 1996(22) sets out that NHS Continuing In Patient Care should be provided where someone requires ongoing and regular specialist clinical supervision on account of :

- The Complexity of their medical, nursing or other clinical needs taken together *or*
- The Need for frequent not easily predictable clinical interventions *or*
- The Need for, or routine use of, specialist healthcare or treatments requiring specialist NHS staff supervision.
- A rapid degenerating or unstable condition which requires support from specialist medical or nursing supervision.

13.2 It is clear that the current use of continuing care beds is far wider than the more focussed use summarised above and has often defaulted to become the long stay residence for a wide range of needs for which more appropriate services are not yet in place.

13.3 It is also clear that current arrangements for provision of continuing care take place in hospital environments of:

- variable and often poor quality
- few wards with single room accommodation
- an absence of space for visitors
- limited space for therapeutic activities

13.4 The provision of continuing care within the Clyde area is about 2.4 times higher than provision within Glasgow, and substantially higher than other areas of both Scotland and the UK. (See appendix 5 for the detailed work on bed modelling, benchmarking and the evidence base for long stay care in the community).

13.5 Throughout the UK the provision of long stay care in community settings has increased substantially and has been reflected in a reduction in the provision of hospital based long stay care of 65-80%, offset by an expansion of community based placements.

13.6 It appears that the Clyde services are at an earlier stage of development, reflecting an un-modernised service in which inpatient continuing care beds are used as default long stay accommodation, for a wide range of needs which do not require long term care in an inpatient setting.

13.7 This means that a number of people are currently cared for in inpatient continuing care beds, whose quality of life would be substantially enhanced by placement in community based accommodation with a range of supports. This has been our experience in Greater Glasgow where we have already implemented substantial closure and re-provision programmes, reprovided alternative care in community rather than inpatient continuing care settings, and experienced marked improvements in the quality of life and functioning of individuals. There is also a clear evidence base which indicates that long stay care in community settings provides an effective and good quality alternative to long stay care in more institutionalised inpatient settings.

13.8 With continuing care inpatient beds used for more focussed requirements, the level of continuing care beds required will reduce substantially. Based on experience of such closure and re-provision programmes within Greater Glasgow, and elsewhere in the UK, we have benchmarked the requirements for continuing care within N&S Clyde.

13.9 These benchmarks have been further tested through the detailed work on bed modelling in appendix 5, and local needs assessments of the needs of the current cohort of continuing care patients. The local needs assessments have broadly confirmed that the majority of patients currently cared for in hospital based continuing care would more appropriately be cared for in a range of placements in community settings. Additionally the local needs assessments have broadly confirmed that the benchmark proposed levels of provision are consistent with the needs identified with the local needs assessments.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Continuing Care beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total Clyde South	WDC (Clyde pop)	Total Clyde N&S	Helensburgh / Lochside (provided from GG&C hospital sites)
Current bed levels N&S Clyde							
Continuing care							
Adult	31	108	15	154	3	157	1
Elderly	80	59	7	146	8	154	4
total	**111**	**167**	**22**	**300**	**11**	**311**	**5**
Benchmark extrapolated from Greater Glasgow							
Continuing care							
Adult	9	15	2	26	3	29	1
Elderly	33	52	7	92	8	100	4
total	**42**	**67**	**9**	**118**	**11**	**129**	**5**
Comparative % current N&S Clyde to Greater Glasgow levels	%	%	%	%	%	%	%
Continuing care							
Adult	344	720	750	592	100	541	100
Elderly	242	113	100	159	100	154	100
total	**264**	**249**	**244**	**254**	**100**	**241**	**100**
Proposed bed levels (benchmark adjusted to reflect local judgement and best fit to ward sizes)							
Continuing care							
Adult	9	12	2	23	3	26	1
Elderly	33	52	7	92	8	100	4
total	**42**	**64**	**9**	**115**	**11**	**126**	**5**

13.10 There are currently 300 continuing care beds in South Clyde with 261 people using these beds. We propose to re-provide 115 inpatient continuing care beds for South Clyde supplemented by a range of community placements in:

- supported accommodation
- group homes
- extra care housing
- registered care homes

13.11 This represents an overall reduction in the level of inpatient continuing care beds of 60% offset by the expansion of provision of long stay placements in community settings.

13.12 Whilst a 60% reduction in provision of inpatient continuing care beds appears to be a dramatic reduction there is a need to put this in context. The rest of Scotland and the UK have already reduced such beds by 65-80%, whereas the Clyde services are at a much earlier stage in their development of long stay care in community settings, and in reality are now developing such services on a more extensive basis.

13.13 In terms of adult continuing care the reductions appear to be particularly dramatic. However the local needs assessments of the current patient cohort are confirming that the needs of this patient cohort are primarily for long stay community placements rather than inpatient care. Indeed the Renfrewshire needs assessment process is currently indicating that the balance of care may yet need to be more weighted towards a higher level of community placements and lower levels of inpatient continuing care. This Renfrewshire experience highlights the need for planned levels of provision to retain some flexibility for review if they are to be closely aligned to the needs of current service users. Compared to levels of provision in other areas of the UK provision at the proposed benchmark levels is still higher than the average UK levels of provision.

13.14 In terms of elderly continuing care the major reductions are for Inverclyde where levels of provision are at 3 times the rate of current provision for Renfrewshire. The Renfrewshire levels of provision are already close to those proposed by the benchmarking model with a more modest reduction of 7 further beds proposed. The benchmark levels for Inverclyde simply bring Inverclyde provision more in line with that already in place in Renfrewshire.

13.15 The local needs assessment work in Inverclyde is broadly confirming this assessment.

13.16 In Dumbarton and Alexandria there are 12 older peoples' beds providing a service to the Dumbarton and Alexandria and Helensburgh/Lochside populations? It is proposed to re-provide these beds within WDC through Partnership arrangements. Four adult continuing care beds are provided at Lochgilphead hospital and as the current cohort of user's changes we would transfer these beds to more local provision in Gartnavel Royal.

Arrangements for provision of continuing care beds: NHS Partnership Beds

13.17 NHS inpatient continuing care provides inpatient healthcare arranged and fully funded by the NHS. It is for patients requiring a high level of ongoing healthcare, usually for prolonged periods, but not necessarily for life. Care of this nature can be provided in a hospital ward, or in a contracted inpatient bed with the independent sector (referred to as NHS Partnership beds), or occasionally in a hospice. Traditionally in Clyde, the majority of NHS continuing care beds has been provided in a hospital ward, offering only a limited number of single rooms and often within buildings that are no longer consistent with modern expectations of higher quality environments of care.

13.18 NHS Partnership beds are proposed for the re-provision of NHS continuing care beds for older people with a mental illness. Such services are commissioned from purpose-built facilities offering modern, single room accommodation within a 'homely' environment that enables the principles of dignity, respect and privacy to be achieved.

13.19 Patients within Partnership beds continue to receive their healthcare free under the overall responsibility of the NHS, and under the clinical responsibility of an NHS consultant psychiatrist. Patients will continue to have access as necessary to other healthcare professionals, such as physiotherapists and speech therapists.

13.20 Qualified and suitably trained nursing staff, within agreed staffing levels, will provide care for all patients within the Partnership facility. Nursing staff can either be employed directly by the independent sector provider or directly by the NHS. Both models have operated for some years within Greater Glasgow. Where NHS Partnership beds are commissioned within Clyde for older people with a mental illness, it is probable that a combination of these nurse staffing arrangements would be adopted, with NHS nursing staff caring for the patients with the greater complexity of need. However, time will be taken during the consultation period to hear views from carers and our staff to contribute to developing our thinking on the detail of the preferred nursing model in preparation for formal discussions with potential providers.

13.21 Typically, NHS Partnership beds are provided in community settings in accommodation visually similar to a new nursing home. The exact location of the Partnership beds can only be determined once a process commences to identify a preferred provider but there is a clear commitment for these services to be provided locally. Potentially, Partnership beds could be located alongside other related services, such as care home services.

13.22 Partnership beds will be commissioned through a formal procurement process, supported by a detailed specification setting out the standard of service to be achieved and against which the service will be monitored. The commissioning and tendering process for these beds will not be completed in advance of any necessary approvals following the public consultation process.

Adult continuing care

13.23 It is proposed that adult continuing care is provided from either an NHS facility based on an existing psychiatric hospital site or a Partnership model of care, located in a community setting.

13.24 The detailed arrangements will depend on the combination of needs in the current long stay cohort. Where the balance of needs is associated with very high levels of intractable and significant challenging behaviours it is likely such provision would be provided in specialist beds located on an NHS hospital site, as this can provide access to wider back up and support. Where the balance of need is less complex, albeit still requiring inpatient care, our experience is such that needs can be met in Partnership bed arrangements located out with acute hospital sites.

13.25 The detailed service model arrangements will be further developed based on the detailed outcomes of individual needs assessments. Pending that detail the strategy has proposed provision of adult continuing care beds in NHS provision on the Dykebar Hospital site.

Older peoples continuing care

13.26 For older peoples mental health continuing care it is proposed that:

- Provision should enable separate spaces for functional and organic patients.
- Single room accommodation is generally preferable, albeit a mix of accommodation should be provided to allow reflection of individual choice of accommodation, as a small number of people may prefer shared accommodation.
- Location in community settings out with inpatient sites, with access to the range of community networks and facilities.
- Provision based on Partnership models of care.

Arrangements for developing a range of community placements beyond continuing care

13.27 The table below summarises the current provision of continuing care beds for both older people and adults and the proposed arrangements for provision of long stay care in a reduced number of inpatient beds and an expanded level of long stay placements in community settings. The proposed arrangements are based on the outcome of both the benchmarking work and the local needs assessments of the needs of the current patient cohort.

Current arrangements

Form of Care	Number of Beds
NHS inpatient continuing care on hospital sites – adults	157
NHS inpatient continuing care on hospital sites – elderly	154
Total	311

Proposed arrangements

Form of Care	Number of Beds/ Placements
NHS inpatient continuing care for adults on hospital sites	26
Inpatient continuing care for older people located on community sites	100
Care home placements	60
Supported accommodation placements	51
Intensive community supports	7
Total inpatient beds and placement requirements	244
Vacant beds: no placement required	67
Total	311

14. RECONFIGURATION AND DEVELOPMENT OF INPATIENT BEDS

The number of inpatient beds

14.1 Throughout the UK Mental Health services have strengthened their community services and found this has enabled a rebalancing of services from an inpatient dominated service, to a community based service supported by access to briefer periods of inpatient care when required.

14.2 In considering issues of number and location of inpatient beds there is a tendency to emphasise the significance of local access to the provision of inpatient services, whilst underplaying the need for local access to comprehensive community services delivered in local areas. In terms of care and support for people with mental health problems:

- 95% of mental health problems are managed in primary care.
- 5% of mental health problems are managed in secondary care community and inpatient services.
- Less than 1% of mental health problems are managed in inpatient settings where a hospital admission is required.

14.3 In the above context the overwhelming priority is the development of locally accessible community resources, for the 99% of mental health problems managed in primary and community settings.

14.4 The current provision of acute admission beds for the Clyde area is about 1.4 times per head higher than that of the Greater Glasgow levels.

14.5 Greater Glasgow's experience has demonstrated the long term sustainability of operating at lower levels of inpatient bed use where this is underpinned by provision of comprehensive community services.

14.6 Our proposal is therefore to provide inpatient bed levels consistent with those of Greater Glasgow. The tables below summarise the current and future bed proposals for acute admission and specialist beds based on:

- The application of the benchmarking methodology.
- Further refinements to reflect local judgements.
- Achieving a "best fit" between benchmarking requirements and individual ward capacity.

14.7 The further work on bed modelling in appendix 5 has confirmed that the benchmark bed levels based on the above methodology are consistent with the application of wider cross referencing to actual provision in a range of UK settings, and professional norms. Based on that wider work the proposed benchmark levels of provision are within the expected levels of provision albeit at the upper end of such ranges of provision.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Acute admission beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total Clyde South	WDC (Clyde pop)	Total Clyde N&S	Helensburgh/ Lochside (provided from GG&C hospital sites)
Current bed levels N&S Clyde							
Acute admission							
Acute Adult	45	66	9	120	18	138	6
Acute Elderly	20	35	5	60	8	68	4
sub total	**65**	**101**	**14**	**180**	**26**	**206**	**10**
Benchmark extrapolated from Greater Glasgow							
Acute admission							
Acute Adult	25	42	6	73	12	85	6
Acute Elderly	17	26	3	46	12	58	4
total	**42**	**68**	**9**	**119**	**24**	**143**	**10**
Comparative % current N&S Clyde to Greater Glasgow levels							
	%	%	%	%	%	%	%
Acute admission							
Acute Adult	180	157	150	164	150	162	100
Acute Elderly	118	135	167	130	67	117	100
total	**155**	**149**	**156**	**151**	**108**	**144**	**100**
Proposed bed levels (benchmark adjusted to reflect local judgement and best fit to ward sizes)							
Acute admission							
Acute Adult	20	42	6	68	12	80	4
Acute Elderly	20	35	5	60	12	72	6
total	**40**	**77**	**11**	**128**	**24**	**152**	**10**

Notes to the table:

1. The figures for ERC and WDC relate to the catchments populations served by the previous Argyll and Clyde Health Board and don't include the full local authority catchments

2. The provision of beds for older peoples mental health acute admission beds in Renfrewshire is being led by the Renfrewshire Elderly Strategy process. The application of the standard benchmarking methodology would see proposed bed provision at 26 beds. The Renfrewshire Elderly strategy process will further review the proposed level of provision at between 26 beds per the benchmark and 40 beds (the current level of provision) to determine the balance of care between inpatient and community services.

3. Helensburgh and Lochside services are commissioned by the Highland Health Board. The table above reflects the services to that population provided from the Vale of Leven site, which would be affected by the proposals in this report. The figures for Helensburgh / Lochside in the proposed bed requirements are based on the standard Benchmarking for services with developed community services, supplemented by local judgement. The Highland Health Board has indicated it would wish to ensure the Helensburgh / Lochside population continued to access the services also accessed by the Dumbarton and Alexandria population.

Proposed location of inpatient beds

14.8 The following *service and clinical safety principles* have informed proposals on the location of acute admission and related specialist beds:

- Provision of inpatient mental health services can be provided on either a stand alone psychiatric hospital site or collocated with physical health beds on an acute medical admissions hospital site (a District General Hospital). Both forms of provision currently exist within the GG&C area and throughout the UK.
- the preferred location for inpatient mental health beds is collocation on an acute admission site as this has the benefits of:
  - Access to physical and diagnostic investigations.
  - Opportunity to integrate both physical and mental health care, particularly for older people.
  - Proximity and support to Accident and Emergency units where significant numbers of people with mental health problems may present, particularly out of hours.
- Acute admission beds should be located on a site with medical cover arrangements which ensure acceptable levels of clinical safety (see further detail below).
- Specialist addictions beds to be collocated:
  - At a minimum with a site with acute mental health admissions to ensure access to similar expertise and back up from medical and nursing support.
  - Preferably on a site with both acute mental health and physical health admissions – i.e. a DGH with Mental Health beds on site.
- IPCU to be collocated with:
  - Adult acute mental health admissions to ensure access to psychiatric medical expertise and nursing support.
- Forensic medium and low secure beds should be:
  - Located on a site with acute adult admission beds to ensure access to wider specialist medical and nursing expertise and support.
- Ward spaces should enable:
  - Beds for patients with organic and functional needs to be located in discrete areas to enable separate management of these distinct patient groups.
  - Provision of age appropriate services.

Medical cover issues

14.9 The national process of Modernising Medical Careers will see changes to the arrangements for training and provision of medical cover, particularly by junior doctors. The cumulative impact of these changes is likely to see:

- c20% reduction in allocation of junior doctor training posts between now and 2013 full implementation date, albeit local variations linked to nationally determine junior doctor training allocations.

- Reduced direct patient contact time as part of junior doctor training.

14.10 The cumulative effect of these changes is likely to make the long term sustainability of current models of medical cover significantly more challenging, particularly for sites covering smaller catchments populations.

14.11 In terms of medical cover arrangements for acute admission units the following principles are applicable to ensure clinically safe levels of medical cover:

14.12 Preferred arrangements:

- Resident junior psychiatric medical cover on site supported by access to on call Consultant Psychiatrist support.

14.13 Where this preferred arrangement is not feasible the minimum acceptable arrangement would be:

- Integration of arrangements for Mental Health junior doctor cover with resident site based general medical cover arrangements for the hospital site.

- Resident junior medical cover on site, involving both non psychiatric and psychiatric junior medical cover, with access to on call Consultant Psychiatrist support.

14.14 In the longer term there may be merit in more radical solutions linked to emerging models of “hospital at night” and the use of “advanced nurse practitioners”. However these models of service are unlikely to be applicable to single site solutions except on large sites. This is because it is only on larger sites that there would be sufficient out of hour’s activity levels to ensure the range of experience and specialist provision required to sustain and develop advance nurse practitioners. These issues are more fully explored in the detail of the option appraisal process for WDC set out in appendix 6.

Guiding principles on the location and configuration of beds: cost effectiveness and feasibility issues

14.15 In addition to the *service and clinical robustness* principles summarised above a number of further principles were considered to inform the detail of proposed location of beds. These *cost effectiveness and feasibility* principles are summarised below:

- The need to maximise site infrastructure savings to fund community service developments.

- The need to ensure the feasibility of specific site options in terms of:

  - Ward and space capacity available for mental health use.

  - Achievement of acceptable quality therapeutic environments for inpatient and continuing care.

- Compliance with the service and clinical robustness principles summarised above.
- Capacity to provide sustainable provision of medical cover consistent with the preferred or minimum cover principles.
- Capacity to provide cost effective provision taking account of size/critical mass issues (i.e. local / South Clyde / GG&C or Regional provision varies with bed numbers and degree of specialist provision).

- Capacity to achieve the site configuration within the capital allocations available.

14.16 In general terms c85% of all mental health hospital site infrastructure costs are associated with the Dykebar and Ravenscraig psychiatric hospital sites. The site infrastructure costs of mental health provision on the RAH, IRH and Vale of Leven sites amount to only c15% of total infrastructure costs as the majority of such site costs relate to acute DGH use of these sites.

14.17 Maximising release of site costs on the Dykebar and Ravenscraig sites is therefore critical to funding the range of service developments set out in this strategy.

14.18 Location on DGH/ACAD sites rather than “stand alone” psychiatric sites is normally the clinically preferred option.

14.19 Broadly speaking this sees congruence between the clinically preferred service location imperatives and the maximisation of financial savings. In general terms the approach has therefore been to:

- Release the site infrastructure costs of the Ravenscraig Hospital closure and disposal of the site.
- Maximise the use of good quality accommodation on the Dykebar Hospital site, vacation of all other accommodation and disposing of a large part of the site.
- Maximise the use of DGH sites where this is consistent with cost effectiveness, service quality, clinical robustness and feasibility.
- Use of Partnership models of provision for older people’s mental health continuing care to achieve both environmental improvements and maximise release of hospital site infrastructure savings.

14.20 Finally we have sought to reflect the strong local desire for local provision of inpatient services wherever this can be achieved without compromising:

- The service and clinical robustness principles.
- The cost effectiveness and feasibility principles.

14.21 Applying the above service, clinical safety, economic, and feasibility principles, and the benchmarked capacity requirements referenced earlier in the paper, the proposed provision of beds would see:

- Acute admission and continuing care beds provided at a more local level.
- Specialist beds provided on a South or North Clyde basis.

- Highly specialist beds provided on a GG&C wide or Regional basis.

14.22 The above principles were further developed and applied through the disciplines of the process of option appraisal. A copy of the outcome of that process is attached as an appendix 6 to this strategy. Based on the outcomes of the option appraisal process the proposals below set out the preferred options for inpatient site configuration.

Inverclyde

- Retention of Inverclyde adult and older peoples acute admission services on the IRH site :

  - 20 adult and 20 older people's beds.

- Closure of older peoples continuing care beds currently on the Ravenscraig site, and re-provision of 33 older people's mental health continuing care beds in a community based Partnership arrangement.

- Closure of adult continuing care beds currently on the Ravenscraig site, and re-provision of 9 adult continuing care beds with local flexibility about the detailed arrangements to reflect the need to balance the advantages between accesses to specialist provision located for a South Clyde catchments at Dykebar and more local location of less specialist provision.

Renfrewshire

- Retention of 40 older peoples mental health admission beds on the RAH site as now.

- closure of older peoples mental health continuing care beds on the Dykebar site and re-provision of 59 continuing care beds in a community based Partnership arrangement

- consolidation of 42 adult acute admission beds in the good quality accommodation on the Dykebar site (currently split between the Dykebar and RAH sites)

- re-provision of 12 adult continuing care beds in higher quality accommodation on the Dykebar site

14.23 Our preferred proposal would have seen adult mental health beds located on the RAH site, however this would involve substantial capital and revenue costs which could not be prioritised given the alternative option of location of adult acute admission beds within the existing high quality accommodation on the Dykebar site.

East Renfrewshire: Levern Valley

- Consolidate provision of adult mental health beds for all of East Renfrewshire on the Leverndale site already used by the majority population of ERC covered by the former GG NHS Board (6 beds already transferred during 2007).

- Consider consolidation of the small number of Older peoples mental health acute admission beds for all of ERC on a single hospital site - either at the Leverndale Hospital or at the RAH.

  - 5 Clyde beds currently at RAH.

  - 12 beds currently provided at Leverndale Hospital.

- Closure of older people's mental health continuing care beds on the Dykebar site and re-provision of continuing care beds in a community based Partnership arrangement – ERC to access either Renfrewshire provision or Greater Glasgow provision based on whichever arrangement achieves the best fit between user need, local access and service availability.

West Dunbartonshire: Dumbarton and Alexandria

- Consolidate provision of all acute admission beds for WDC on the Gartnavel Royal site and transfer the adult and elderly acute admission beds currently located on the Vale of Leven hospital site to the Gartnavel Royal.

    - Transfers 36 acute admission beds (16 adult and 18 older peoples beds) for Dumbarton and Alexandria and Helensburgh/Lochside catchments to Gartnavel, in addition to the 24 beds (10 adult and 14 older people) already provided at Gartnavel for the Clydebank catchments population.

- IPCU beds relocated from Lochgilphead to 2 beds in Gartnavel Royal.

- 12 Continuing care older peoples beds redeveloped within WDC area using Partnership model.

14.24 The detailed rationale for the proposed transfer of acute and older people's mental health admissions beds to the Gartnavel site is set out in the full option appraisal report (Appendix 6).

Helensburgh / Lochside

14.25 Services to this population are funded and commissioned by the Highland NHS Board and provided through a service agreement with the GG&C NHS Board.

14.26 The Highland NHS Board recognises the desirability of the Helenburgh /Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

15. SPECIALIST SERVICE DEVELOPMENT

Specialist services covering a South Clyde catchments (Renfrewshire and Inverclyde)

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Specialist beds N&S Clyde

	Total South Clyde	WDC (Clyde pop)	Total N&S Clyde
Current bed levels N&S Clyde			
Specialist beds N&S Clyde			
Intensive Rehab	0	0	0
IPCU	8	3	11
Addictions	11		11
ARBD	0		0
total	**19**	**3**	**22**

Benchmark extrapolated from Greater Glasgow			
Specialist beds N&S Clyde			
Intensive Rehab	8	2	10
IPCU	10	2	12
Addictions	7	1	8
ARBD	2	0	2
total	**27**	**5**	**32**

Comparative % current N&S Clyde to Greater Glasgow levels	**%**	**%**
Specialist beds N&S Clyde		
Intensive Rehab	0	0
IPCU	80	92
Addictions	157	138
ARBD	0	0
total	**70**	**229**

Proposed bed levels **(benchmark adjusted to reflect local judgement and best fit to ward sizes)**			
Specialist beds N&S Clyde			
Intensive Rehab	9	2	11
IPCU	11	2	13
Addictions	7	1	8
ARBD			1
total	**38**		**33**

15.1 For a range of more specialist services the numbers of beds are so low that it is only feasible to provide such services to either a South Clyde, GG&C wide or Regional population.

15.2 The following specialist inpatient services are already provided to a South Clyde catchments:

- IPCU beds.
- Specialist addictions beds.

IPCU

15.3 8 IPCU beds are currently provided on a South Clyde basis and the proposal is that this continues albeit with a change of location from Dykebar to a 10 bedded unit at the IRH.

15.4 The rationale for the change of location of beds is to optimise the use of inpatient capacity between the Dykebar and IRH sites whilst ensuring compliance with the service clinical robustness principles set out in paragraph 13.7.

15.5 IPCU services are generally provided to catchments populations of 200,000 to 300,000 and therefore will always entail access issues beyond purely local service provision. It is recognised however that whereas the current location at Dykebar provided better access to the Renfrewshire population and more problematic access to the Inverclyde population, the strategy proposals would reverse this in favour of the smaller Inverclyde population.

15.6 There is however the potential to consider a hybrid option of the above proposal, whereby a unit at the IRH provides IPCU beds to the catchments of Inverclyde and the western areas of Renfrewshire, whilst the eastern areas of Renfrewshire might be supported by access to IPCU beds at Leverndale (in relatively close proximity to the previous location of Dykebar).

Addictions

15.7 Eleven specialist addictions beds are currently provided at the Gryffe unit on the Ravenscraig site serving the South Clyde catchments population. No provision has historically been available for the North Clyde population. The specialist addiction beds provide an inpatient service for people whose primary problem is a complex addiction problem – albeit individuals who may also have other secondary physical or mental health problems in addition to their addiction needs.

15.8 Within the Greater Glasgow area one unit at Stobhill provides 15 beds to the population of the North and East Greater Glasgow catchments, and a second unit is planned to provide 15 beds to the South and West of the Greater Glasgow catchments. The beds are provided to meet the needs of people with a major addiction whose management is particularly complex by virtue of coexisting mental health or physical health needs.

15.9 In addition people whose primary problem are an acute mental health problem, and additionally have an addiction problem, are cared for within general psychiatry beds and may typically constitute c40% of the inpatient population.

15.10 The specialist addiction beds in the Gryffe Unit will need to be relocated to facilitate the closure of the Ravenscraig site. Therefore these beds require relocation to another inpatient site. In considering the re-provision of these beds we considered either re-providing them as a smaller 7 -11 bedded South Clyde service, or as a larger unit providing a service to the South Clyde and South Glasgow area.

15.11 Our proposal is to consolidate the provision of 7 South Clyde and 15 South and West Glasgow beds as part of a larger 22 bed unit serving the South Clyde and South and West Glasgow population. The rationale for this consolidation proposal is:

- Quality services require access to a range of specialist disciplines to provide multi disciplinary supports required for the delivery of tier 4 services to the most complex range of addictions problems.

- Units of less than 15 beds cannot sustain dedicated or economic access to such specialist supports (e.g. OT and psychology).

- A larger 22 bed unit is likely to prove more attractive in terms of recruitment and retention of specialist staff that would see a larger unit as providing greater opportunity for their professional development, supervision and support.

- A larger 22 bed unit is likely to provide more cost effective provision at lower unit costs.

15.12 The proposed location for a consolidated specialist addictions inpatient service is on the Leverndale hospital site. There had been previous consideration of location on the Southern General site as part of the site redevelopment. However the phasing of the developments on that site provides no possibility of developing an operational addictions unit on that site for at least 7 years. The Leverndale location enables compliance with the minimum clinical location principles set out in paragraph 14.8, whilst providing reasonable centrality to enable access for the South and West Glasgow and South Clyde catchments.

15.13 At this stage it is acknowledged that the Clyde Mental Health Strategy has necessarily dealt with the development of the addictions beds in the absence of a clear community and inpatient service addictions services strategy, or funding sources with which to generate the development of community services.

15.14 In particular the movement of the addictions inpatient beds will have implications for the viability of existing community and day services collocated with the Gryffe unit. The issues of broader service strategy and the implications for the community and day services will need to be more fully developed in advance of any move of the inpatient services – given the pace of redevelopment of the Ravenscraig site it is likely this move will occur over the next 2 years.

15.15 We will therefore establish a Clyde wide addictions planning process to resolve these outstanding issues and also to confirm the transitional location of the specialist addictions beds, in advance of the final location on the Southern General site.

15.16 The proposed reduction from an 11 bed to a 7 bed provision for South Clyde reflects:

- Comparable levels of provision to Greater Glasgow.

- The bed provision of 9 beds comprising of 7 beds for South Clyde, 1 bed for North Clyde and 1 ARBD bed.

Intensive rehabilitation

15.17 Intensive rehabilitation beds are not currently provided in Clyde services, but their development would enable specialist management of a challenging behaviour group of patients generally requiring such support for 1-4 years beyond their acute admission, best provided in separate accommodation from the acute admission environment of care. It is proposed to develop 8 such beds for South Clyde on the Dykebar site.

Early onset psychosis

15.18 Early onset psychosis services are currently provided from a specialist service for the South Glasgow population. The funding of this service will be increased to enable an expansion of the catchments to include the South Clyde population.

Specialist services for the North Clyde catchments (Dumbarton and Alexandria)

15.19 Historically the Dumbarton and Alexandria population has had limited access to specialist services, provided either from Lochgilphead or from services South of the Clyde.

15.20 It is proposed to improve local access to such services by extending the access already available to the Clydebank population to the whole of the WDC population including the Dumbarton and Alexandria population:

- Transferring IPCU beds from Lochgilphead to 2 beds for WDC in the Gartnavel Royal IPCU.
- Access to intensive rehabilitation beds at Gartnavel Royal.
- WDC wide access to specialist co-morbidity beds currently provided only to the Clydebank population at the Stobhill site.

15.21 Early onset psychosis services are currently provided from a specialist service for the North Glasgow population. The funding of this service will be increased to enable an expansion of the catchments to include the Dumbarton and Alexandria population.

Highly Specialist services for a GG&C or Regional Catchments

15.22 The table below summarises the current and proposed provision for highly specialist services provided to a GG&C or Regional catchments.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Highly Specialist beds GG&C/Regional Services	Total N&S Clyde
Current bed levels N&S Clyde	
GG&C /Regional provision for Clyde population	
Low secure adult mental health	0
Low secure adult learning disabilities	5
Medium secure adult mental health	0
Total	**5**

Benchmark extrapolated from Greater Glasgow	
GG&C /Regional provision for Clyde population	
Low secure adult mental health	8
Low secure adult learning disabilities	3
Medium secure adult mental health	7
Total	**18**

Comparative % current N&S Clyde to Greater Glasgow levels	%
GG&C /Regional provision	
Low secure adult mental health	0
Low secure adult learning disabilities	167
Medium secure adult mental health	0
Total	**28**

Proposed bed levels **(benchmark adjusted to reflect local judgement and best fit to ward sizes)**	
GG&C /Regional provision	
Low secure adult mental health	8
Low secure adult learning disabilities	5
Medium secure adult mental health	7
Total	**20**

Forensic medium and low secure services

15.23 The Argyll and Clyde plans had proposed development of a 30 bed medium secure unit to be located on the Dykebar site to service a West of Scotland catchments excluding Greater Glasgow. Greater Glasgow has developed a 74 place medium and low secure unit on the Stobhill site in North Glasgow originally developed to serve a Greater Glasgow catchments population. The Stobhill site is a new purpose built unit which opened in July 2007.

Consolidation of medium secure services

15.24 It is clear that consolidation of medium secure services on a single site has a number of advantages compared to a 2 site option in terms of:

- Lower capital and associated revenue costs.
- Reduced duplication of provision of infrastructure supports (e.g. recreational and other communal facilities).
- Improved access to specialist dedicated multi disciplinary supports which are difficult to sustain in smaller 30 place units.
- Increased ability to recruit and retain specialist staff as larger units provide more opportunity for professional and career development.
- Lower revenue costs associated with reduced duplication of infrastructure supports and economies of scale.
- Higher quality of service provision linked to opportunity to recruit and retain dedicated specialist multi disciplinary supports.
- Improved flexibility in the matching of clinical space use to changing needs and changing patient populations through a pooled use of a higher number of ward spaces not available to the previously planned 2 ward 30 bed Dykebar unit.

15.25 Pending the development of the Dykebar forensic unit the Stobhill unit is already the interim provider of medium secure beds to the West of Scotland, including the GG&C catchments.

15.26 It is therefore proposed to make this interim proposal permanent by consolidating medium secure services on the Stobhill site for GG&C and the West of Scotland and withdrawing the previous proposal to develop medium secure beds on the Dykebar site.

15.27 This proposal would provide 7 new medium secure beds requiring investment of £900k.

Consolidation of adult low secure services

15.28 The Argyll and Clyde Board had made no provision for adult low secure services for its catchments. However the Mental Health Act requires that service users are cared for in the least restrictive environment consistent with their needs. It is therefore proposed to invest £800k to develop 8 low secure beds for the N&S Clyde catchments to be located on the Leverndale site.

Consolidation of low secure learning disability services

15.29 Additionally 8 specialist low secure beds for people with learning disabilities are located at the Dykebar site serving West of Scotland catchments, and 8 similar beds for the Greater Glasgow catchments are provided on the Leverndale hospital site.

15.30 The logic of consolidation of small highly specialist services into a larger single service applies to the consolidation of the two separate low secure learning disability services into a single service on the Leverndale site. Broadly the rationale would echo that summarised above for the medium secure service.

Perinatal and Eating Disorder Services

15.31 The North and South Clyde catchments already have access to the 2 Regional perinatal beds located at the Southern General Hospital and this will continue.

15.32 Specialist Eating Disorder beds are currently provided through the Priory hospital located on the Southside of Glasgow and there are no current plans for GG&C to change these arrangements, as they already provide local access to a highly specialist regional service.

15.33 Within Greater Glasgow specialist community teams have been developed for both eating disorder services and for perinatal services. These specialist community teams provide a liaison and consultation service to support mainstream services to develop their capacity in the management of such specialist needs.

15.34 The specialist teams also provide direct case management of the most complex patient needs including pre and post admission arrangements.

15.35 In the long term an extension of the geographic coverage of the Greater Glasgow specialist community teams to cover the N&S Clyde catchments is required to provide appropriate service responses and ensure a community oriented service rather than an inpatient dominated service. However this catchments extension can only be achieved when the Clyde services can fund such developments which are beyond the scope of the current financial constraints.

15.36 In the interim the role of the teams will be more modestly extended to provide a liaison and consultation advice resource to mainstream services in the N&S Clyde area.

16. FINANCING THE CLYDE STRATEGY

16.1 Contrary to popular belief there does not appear to be a major inequity of spend per head on mental health services between the Greater Glasgow area and the Clyde area.

16.2 Rather the pattern and outputs of such expenditure are differently balanced with Clyde services spending:

- 1.5 times as much per head on inpatient services compared to Greater Glasgow.
- Halve the expenditure per head on community services compared to Greater Glasgow.
- High levels of spend on site infrastructure costs of services located on multiple hospital sites deflecting from spend on direct services.

16.3 This pattern of expenditure is a function of:

- Comparatively high levels of inpatient provision.
- Comparatively high levels of expenditure on inpatient hospital estate and the revenue costs of sustaining such a multiple site infrastructure.
- Comparatively low levels of expenditure on underdeveloped community services.

16.4 The Clyde strategy is required to:

- bring existing deficit budgets into recurrent balance = £0.2m
- fund the development of comprehensive community services = £3.7m
- fund the retraction and re-provision programme = £3.5m
- fund the development of specialist services = £1.7m
- contribute to the GGC&C corporate recovery plan to contribute to the overall deficit reduction inherited from the Argyll and Clyde Health Board = £2.0m

16.5 Achieving the expenditure requirements summarised above requires achieving savings through:

- releasing site infrastructure costs by rationalisation of the number of hospital sites from which services are provided by:
  - releasing the site infrastructure costs of the Ravenscraig site through closure of the hospital and disposal of the site
  - maximising the use of good quality accommodation on the Dykebar hospital site, vacation of all other accommodation and disposing of a large part of the site
- Reducing expenditure on inpatient services resultant from providing fewer beds, consistent with the reduced requirements associated with more comprehensively developed community services.

- Unit cost savings from provision of a range of community based accommodation with supports in place of more expensive continuing care bed provision.

16.6 The table overleaf summarises these major financial changes to underpin the implementation of the Clyde Strategy.

Table of service change and financial investment (2008 / 09 price base)

SERVICE CHANGE : Expenditure commitments on service developments	**FINANCIAL COMMITMENT £'m**
Development of community services	
a. Primary care supports/psychological interventions	0.8
b. Community mental health team expansion adults / Crisis services development/ Early intervention first onset psychosis	2.4
c. Community mental health team expansion older people	0.5
Total development of community services	**£3.7m**
Closure and re-provision of continuing care beds and development of range of community placements	
• Develop a range of community placements • supported accommodation placements • residential and nursing home placements • Enhanced community care packages	
Total retraction and re-provision of continuing care beds	**£3.5m**
Specialist services development	
• 8 forensic medium secure places and 7 low secure places • access to specialist liaison consultation advice	
Total specialist service developments	**£1.7m**
Contribution to GG&C Corporate recovery plan	**£2.0m**
Revenue consequences of capital commitments	**£0.7m**
Sustainable baseline budget adjustments	**£0.2m**
TOTAL ALL SERVICE DEVELOPMENTS	**£11.8m**

SERVICE CHANGE: Efficiency savings to underpin expenditure commitments	**FINANCIAL COMMITMENT £'m**
Reduction in acute and continuing care beds to benchmark levels – reduction of 54 acute admission beds and 185 continuing care beds	**£7.1m**
Reduction in site infrastructure costs	**£3.0m**
Investment in forensic service developments	**£1.7m**
TOTAL ALL SOURCES OF FUNDS TO INVEST IN SERVICE DEVELOPMENTS	**£11.8m**

Bridging funding to support the transition and service redesign

16.7 It is widely accepted that the process of rebalancing services requires robust community services to be in place in advance of inpatient bed closures.

16.8 In order to cover the double running costs of development of community services and wider service redesign, in advance of releasing the full ward and site based costs, the GG&C Board will provide non recurrent transitional funding of up to £3m per year for the period until March 2010.

Developing Clyde Services with no detriment to Greater Glasgow services

16.9 The GG&C NHS Board has previously committed itself to the principle that the development of Clyde services should be achieved without detriment to existing planned and agreed levels of provision for the Greater Glasgow population. The service and financial framework for the Clyde strategy has therefore ensured this principle is reflected in the detailed arrangements for service development and reconfiguration.

17. ACCESS

17.1 The strategy proposes the substantial development of community services thereby improving access to these supports for the 99% of mental health service users whose needs are managed in community settings.

17.2 The strategy also proposes a range of changes to the location of inpatient services used by 1% of mental health service users whose needs are managed in inpatient settings. The access implications of the inpatient service changes are summarised below.

Acute admission and continuing care beds

17.3 Wherever practical and feasible, we have sought to retain non-specialist inpatient services within each of the Clyde localities. This has been achieved in respect of the proposals for adult and older peoples' acute admission services for Inverclyde and Renfrewshire. The proposed arrangements for the re-provision of continuing care beds have also sought to enable the retention of NHS continuing care services in each of the Clyde localities.

17.4 The proposed transfer of adult and older people's acute admission services from Vale of Leven Hospital to Gartnavel Royal Hospital will mean some residents of West Dunbartonshire travelling further to receive inpatient care. In terms of patient access to Gartnavel any necessary transport will be directly provided for patient admissions. For visitors without mobility problems there is comparatively good transport access by rail and bus. However it is accepted that transport access for visitors with mobility problems will be more problematic and we will further explore options for mitigating such problems during the consultation period. For the reasons outlined in appendix 6, the outcome of the option appraisal process concluded that, taking account of both non financial and financial benefits, the benefits of consolidating these services for all of West Dunbartonshire on a single site at Gartnavel, outweigh the additional travelling issues for visitors.

Addictions

17.5 Inpatient specialist provision for addictions is currently provided on a pan-locality basis. In the case of addictions, the Gryffe unit at Ravenscraig Hospital currently offers a service to the Clyde localities of Inverclyde, Renfrewshire, and East Renfrewshire and no current service provision to West Dunbartonshire. The consolidation of addictions services across Greater Glasgow & Clyde offers significant benefits, in terms of access to a wider pool of multi-disciplinary supports for patients (South Glasgow & Clyde inpatient services proposed for Leverndale Hospital and North Glasgow & Clyde inpatient services provided from Stobhill Hospital).

17.6 In overall terms the proposals will improve access to such services for the various populations within the North and South Clyde area. However it is acknowledged that access issues impact differently for the different sub geographies. For Renfrewshire, East Renfrewshire and West Dunbartonshire localities the proposals will improve accessibility to addictions inpatient care. For Inverclyde, the proposals have a detrimental impact on accessibility. Again, we will work with local bus operators to explore whether the existing transport provision is adequate and if not, explore the scope to improve the frequency or availability of buses. By car, the distance between Ravenscraig Hospital and Southern General is approximately 23 miles, one way, with an estimated travelling time of 30 minutes.

17.7 Inpatient specialist provision for Intensive Psychiatric Inpatient Care (IPCU) is currently provided from Lochgilphead for West Dunbartonshire residents and at Dykebar Hospital for Renfrewshire, East Renfrewshire and Inverclyde. The proposed transfer of IPCU services from Lochgilphead to Gartnavel Royal will significantly improve local access. The close proximity of Dykebar and Leverndale Hospital (under 3 miles) is not anticipated to offer difficulties in the transfer of East Renfrewshire's Levern Valley IPCU provision to Leverndale.

IPCU

17.8 The proposed transfer of the 10 bed remaining South Clyde IPCU provision from Dykebar to Inverclyde Royal Hospital will have positive access implications for Inverclyde and negative access implications for Renfrewshire. Any patient requiring travelling to an IPCU for admission will do so under the supervision and responsibility of the NHS. The period of time that a patient is expected to be cared for within IPCU should be relatively short and therefore any inconvenience for visitors should only be for a relatively short period of time. In terms of transport links, IRH is well served by a train connection that can be accessed from the Paisley Gilmour Street station. By car, the journey time is approximately 20 miles one-way, with an estimated travel time of 30 minutes.

Forensic services

17.9 Again, the close proximity of Dykebar and Leverndale Hospital is not anticipated to cause any notable difficulties for the proposal to transfer low secure learning disability beds from Dykebar to Leverndale.

Intensive Rehabilitation

17.10 The proposal to develop specialist adult intensive rehabilitation beds, adult low secure forensic beds and forensic medium secure beds are effectively all new services. From that perspective, they neither have a positive or negative impact for existing patients. Escorting patients for admission to these services will be under the supervision and responsibility of the NHS.

18. WORKFORCE ISSUES

18.1 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.

18.2 Once staff directly affected by the changes proposed is identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual’s skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

18.3 Only following this process of redeployment will voluntary redundancy or early retirement be considered, but only as a last resort.

18.4 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

18.5 Regular briefing sessions will be held with staff throughout the period of implementation.

19. SUMMARY OF BENEFITS AND LIMITATIONS OF THE CLYDE STRATEGY

19.1 The pre-engagement and local planning groups have signalled a range of issues. The summary below has both reflected these issues and also the way in which the strategy has responded to such issues.

- The need to develop primary and community services and end post code variations in access to support.
  - Reflected in strategy proposals for development of comprehensive community services on extended day/24/7 basis.
- The need to strengthen service responses to people in a mental health crisis.
  - Reflected in strategy proposals to develop crisis services.
- The desire to keep inpatient and continuing care beds locally provided.
  - Reflected in proposals to retain local inpatient and continuing care beds for Inverclyde and Renfrewshire, whilst acknowledging the wider benefits of consolidating West Dunbartonshire adult and older peoples' acute admission beds on one hospital campus at Gartnavel Royal Hospital.
- The need to improve the quality of the inpatient environment and ensure the changes has no adverse effect on this.
  - Reflected in proposals to develop continuing care beds through Partnership bed arrangements to achieve substantial improvements to quality of care environment.
  - Reflected in retention of use of adult acute admission beds at Dykebar given higher quality of inpatient environment:
  - Reflected in capital investment to improve the safety and therapeutic environment of wards at the Inverclyde royal hospital.
- The need to develop more formalised partnership networks of collaboration and care between the not for profit providers and the NHS and social care services.
  - The development of more formalised collaborative networks between partner agencies will be given increased emphasis and mainstreamed as part of the implementation of the strategy.
- The need to improve the management of admission and discharge to inpatient care.
  - Admission to in-patient care will be an extension of secondary care specialist community mental health services, including being seen for crisis resolution services. Community health and social work staff will work closely through joint assessment and care planning processes to identify the needs of the individual and to ensure the appropriate services are in place to support the person's discharge at the earliest opportunity.
- The need to ensure any Partnership models of care has robust quality assurance arrangements to maintain standards of care.

- The detailed implementation of Partnership models of care will ensure such robust arrangements are reflected in the service specification and detailed Partnership arrangements.

- The need to ensure financial deficits doesn't deflect from expenditure on community services.

  - The financial framework for the strategy has retained planned levels of investment in community services.

19.2 The Strategy has sought to turn a "financial crisis" into an opportunity for substantial service development, whilst delivering the financial savings necessary to provide a balanced budget and sustainable financial basis for ongoing provision of services.

19.3 The Strategy has addressed the most pressing needs to:

- Rebalance services and establish a sustainable comprehensive community service with the major service building blocks in place.

- Provide a sustainable financial framework to underpin service development.

- Deliver £2m net savings to meet the mental health contribution of £2m to the GG&C Clyde financial recovery plan.

19.4 However the strategy has identified other areas of shortfall which we have not been able to address at this stage given the financial constraints including:

- Achievement of full benchmark staffing levels for community services albeit current proposals achieve the majority of this ambition.

- Development of specialist community services for eating disorders, perinatal services – pending such developments we will nevertheless provide some support to local services by providing access to liaison advice and support functions (but not case management or treatment) from the equivalent Greater Glasgow services.

- More radical development and improvements to the quality of the inpatient environments of care.

- Further developments of the range of personal growth and recovery supports for ordinary living.

- Release of funds to support the development of community addictions services.

19.5 In this context the strategy should be seen as a major and ambitious further phase of service development, rather than a complete response to all service deficits identified through the strategy process.

19.6 It should also be recognised that the experience of mental health services as they go through this development cycle, is that once they have operated such a rebalanced service there will doubtless be further flexing and refinements of views about bed numbers and models of care – all the more so as services become more flexible in working with new cohorts of service users and less dominated by the needs of the historic long stay cohorts.

19.7 In this sense the strategy should be seen as a 3-5 year “route map” rather than an inflexible and unchangeable pattern of provision for a period beyond 3-5 years.

20. PUBLIC CONSULTATION, WIDER ENGAGEMENT AND NEXT STEPS

20.1 This Strategy sets out a wide range of proposals to modernise mental health services.

20.2 This includes proposals which constitute significant service change and therefore the subject of a statutory NHS Public Consultation process as summarised below:

The significant service change proposals that represent the Health Board have preferred options are:-

- Replacing a significant number of adult mental health continuing care beds at Dykebar Hospital with alternative forms of care accommodation and supports in the community.

- Transferring adult acute mental health admission beds from the Royal Alexandra Hospital to more modern, purpose built, single room accommodation at Dykebar Hospital.

- Re-providing older people's mental health continuing care beds from Dykebar Hospital to higher quality accommodation within an NHS Partnership bed model with the independent sector.

- Transferring adult and elderly acute mental health admission beds from Vale of Leven Hospital to modern, purpose built, single room accommodation at the new Gartnavel Royal Hospital, supplemented by the use of some upgraded ward accommodation at Gartnavel Royal Hospital to be used as "step down" accommodation for approximately a third of the elderly acute mental health beds.

- Transferring low secure learning disability forensic services from Dykebar Hospital to Leverndale Hospital.

20.3 The public consultation period will run for 12 weeks from the 9th April 2008 to the 2nd July 2008. Consultation events are being provided in each area during this period. These events will also be used to receive any wider feedback on service proposals which are not the subject of the statutory consultation process. All feedback received during public consultation will be considered by the Board of NHS Greater Glasgow & Clyde. Thereafter, a recommendation will be made to the Cabinet Secretary for Health and Wellbeing, who will make the final decision in relation to those areas of service change which is the subject of the statutory public consultation process.

20.4 In relation to these proposals a separate briefer consultation document is available which forms the basis for the public consultation process and consultation events. A copy of the public consultation document and related supporting documents can be downloaded from

http://library.nhsggc.org.uk/mediaAssets/library/nhsggc_consultation_clyde_mental_health_full_2008_04.pdf

20.5 The Strategy has proposed a wider range of service modernisation beyond those areas subject to the statutory NHS process. For these wider proposals the local planning groups are responsible for undertaking local engagement processes to further refine the detail of the local proposals to ensure the service models, and detailed local implementation, has taken account of user, practitioner and partner interests. All of the proposals in the strategy will be phased for implementation by April 2010.

20.6 In practice the development of the Strategy has been an iterative process where it is now a summation of work previously undertaken and developed through the local planning groups, and previous local engagement processes. For those areas of service change which are not the subject of the public consultation process, we have therefore sought to facilitate early progress to:

- Develop community services in advance of reductions to inpatient services.
- Make early progress on the development of crisis services.
- To provide long stay placements in community settings which facilitate patients discharge from long stay care in hospital settings where such community placements are consistent the most appropriate matching of service supports to individual needs.

APPENDICES

APPENDIX 1

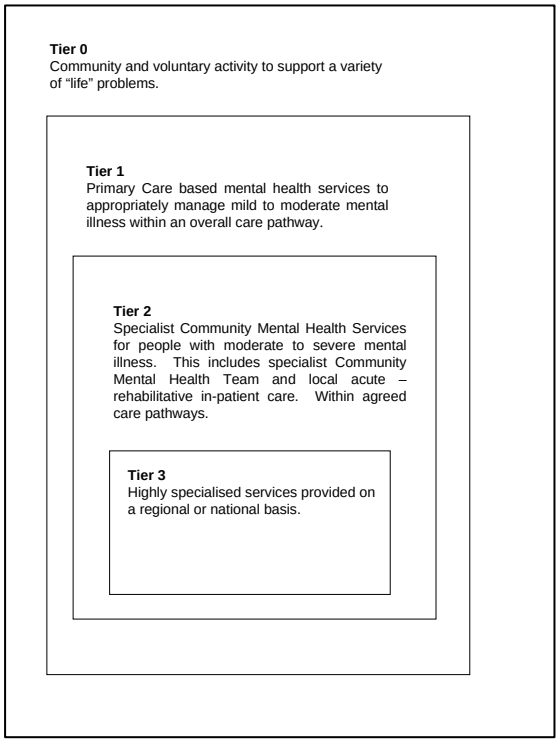
INVERCLYDE MENTAL HEALTH SERVICES

1. LOCAL CONTEXT

The Journey so far

1.1 Community service developments to date have supported the local vision of an integrated health and social care service that sees service functions delivered across organisational boundaries to meet the needs of individuals in a fully tiered mental health system. The tiered system aims to offer the appropriate level of input, in the most appropriate setting, at the most appropriate time. This recognises that a range of other services and resources are available in the community generally and provide support to the whole community. These include employment services, education, leisure and recreation all of which support in-directly and directly a community's mental wellbeing.

1.2 The majority of mental health problems can be responded to within primary care. Services for people with more severe mental health needs will require a more specialist service. It is anticipated that there will be a reduced requirement for in-patient care in the context of further development of integrated Community Mental Health services. Opportunistic enhancement of these initial services has taken place but there has not been a wholesale review of mental health services.



1.3 The development of community mental health teams and the wide range of supports from the voluntary sector have been successful in enabling many people to remain in the community. This has resulted in in-patient areas working with fewer people overall but a higher proportion of people with a greater severity of need. The advent of new treatments has also benefited a number of people and enabled community based mental health services to help people live in their own home for longer and to return to their own home earlier after they had to come to hospital for treatment.

1.4 There is still a relative over provision of beds that has limited even more substantial development of comprehensive community based mental health services.

Local Policy Context

1.5 Over the last 10 years there have been significant changes in the organisation of services and care of patients with mental health problems in Inverclyde. Inverclyde Council and the local NHS Board have invested in the development of community mental health services since 1997. This resulted in the development of community mental health services for adults, and subsequently the establishment of the community older person's mental health team.

1.6 In Inverclyde there is a well developed local joint Mental Health Development Group which leads on work to develop local services. This includes representatives from all the local mental health services, including the voluntary partners in the service, and active participation from service users and carers. Joint planning work to date has sought to deliver an integrated approach to addressing the needs of adults and older people experiencing a mental heath difficulty.

Inverclyde Population

1.7 The estimate of the total population, as 2006, was 81,257, with approximately 53% being male and 47% female. The projected population anticipates a fall to 76, 466 by 2015, but within that there will be increases in the older population 65 year and above. In general terms this means an ageing population with a decrease in the numbers of carers.

1.8 The estimate for the size of the working population is 51,100, (26,000 males and 25,000 females). There were 32,000 people in employment in Inverclyde in 2004, with 53% being female and 47% male. Approximately 76% of those worked full-time. The claimant count unemployment rate was 4.8% in Inverclyde in June 2005. Over four times as many men were unemployed as women; 1,968 men and 463 women, with male unemployment being more of a problem for Inverclyde than Scotland as a whole. Inverclyde is recognised as an area of relatively high deprivation comparable to other areas across Scotland.

2. FEEDBACK FROM PRE-CONSULTATION ENGAGEMENT EVENTS

2.1 Pre-consultation engagement events were held on 15th March and 22nd May 2007 with community interest groups and service users to look at mental health services. The purpose of these meetings was to give local mental health user and carer groups the opportunity to say what they think of current mental health services and what type of services they would like to see developed in the future and also gave the chance to discuss in more detail some of the key issues and challenges facing mental health services. The key themes from the pre-consultation engagement were:-

- Desire to see services provided locally
- Building on good joint working arrangements
- Need for better respite services
- Importance of advocacy services
- Lack of crisis services and limited responses to needs out of hours
- Desire to see service modernisation

2.2 The general theme running through each of the development proposals is one of recognising the importance of local services, integration, shifting the balance towards extended community and primary care based services, and greater emphasis on recovery. The development proposals also give priority to improving assessment prior to admission (where necessary), and facilitating early discharge and better design of in-patient environments.

CURRENT SERVICES AND PROPOSED DEVELOPMENTS

ADULT SERVICES

Service	Where we are now	What we propose to do
Primary care supports	**Deficit: Deficit: 50% GP Practices have no dedicated mental health support** Primary Care mental health service currently provided in 50% of GP practices in Inverclyde, for people with mild to moderate mental health problems, aged less than 65 years.	**Proposal: invest additional £192k to provide cover to all GP Practices** Significant additional investment to extend the Primary Care mental health service to all GP practices in Inverclyde, for people with mild to moderate mental health problems, irrespective of age. Plan to implement care pathways for a number of illnesses, linking where required with specialist secondary psychiatric care.
Integrated Community Mental Health Team (extended day Mon to Fri)	**Deficit: Adult CMHT well developed, but unable to extend service into evening and weekends. Older Person's Team established but under-developed** Inverclyde has an integrated community adult mental health team [CMHT] providing services to people with more complex needs arising from their mental health. The Older Persons Mental Health Team [OPMHT] meets the needs of people over 65.	**Proposal: invest additional £560k to employ extra 17wte specialist staff across both Teams*, with adult CMHT able to extend working hours into evenings and weekends.** **£236k and £324k for the CMHT and OPCMHT respectively.* Significant additional investment to increase the size of teams and extend the hours of the CMHT into the evenings Mon –Friday; and increasing access to services at weekends. Further development of the Older Persons Mental Health Team with increased staffing, Significant additional investment for further development of the Older Persons Mental Health Team, and integration of services within the wider provision for older people in Inverclyde.
Crisis resolution and access to treatment 24/7	**Deficit: Additional capacity needed within CMHTS to develop crisis service, providing access to treatment in community settings out of hours.** The CMHT and OPMHT currently provide a response to existing service users experiencing crisis during working hours. Additional care out with these hours is provided in partnership with other mental health providers in the community. Access to assessment and urgent treatment is provided by the Short Stay Psychiatric Unit for people under 65. NHS 24 also provides advice and on-ward referral.	**Proposal: invest additional £61k to support an increase in overnight staffing levels in SSPU. This will enable existing staff to further develop out of hours crisis response provided from inpatient acute unit.** •Additional investment is proposed to enhance and formalise the existing response function providing an overnight point of contact via telephone, out of hour's point of assessment and meet the requirement for home visits when necessary. Additional investment* for development of responses to the needs of older people will be undertaken in conjunction with the Early Intervention Team; and in redeveloping the existing day hospital service based at the Argyll Unit with the Larkfield Unit. This will be aimed at supporting people at home and in supporting people to return home where admission to hospital is required. **incorporated within £324k referred to under older persons' CMHT development*

Service	Where we are now	What we propose to do
Rehabilitation and recovery supports	**Deficit: no dedicated intensive inpatient beds to provide intensive rehabilitation to promote recovery and discharge** There are a limited number of rehabilitation beds based in Ravenscraig Hospital for people under 65. For all service users within the community the NHS and Inverclyde Council commission a range of services. This includes direct support to people within their own home; support to access day facilities and group based supports; and training and employment. Within the CMHT service the use of Staying Well and Relapse Prevention plans enable service users to identify supports to facilitate their recovery. For older people support is provided directly by the OPMHT both on an individual and group basis.	**Proposal: invest additional £180k to open 3 beds within Clyde-wide service at Dykebar Hospital.** Investment* in and access to Clyde wide rehabilitation beds for those requiring this within an inpatient setting, for people under 65 is proposed. Commissioning of alternative intensive home based supports, and residential based provision within Inverclyde, in partnership with Inverclyde Council and the voluntary and independent sector to maximise people potential for independent living. Continued development of services supporting recovery including day support, training and employment opportunities in partnership with Inverclyde Council and the voluntary and independent sector. This will include services for older people. **The section below details the level of additional investment proposed to support patient discharges, which will include the commissioning of community rehabilitation services.*
Continuing care beds	**Deficit: many people currently within mental health NHS continuing care wards could benefit from a range of community accommodation supports and care that could enable them to achieve a better quality of life and recovery.** **Those requiring NHS continuing care should have access to specialist medical care to meet their needs and good quality accommodation.** Currently all NHS continuing care beds are provided from the Ravenscraig campus (31 adult mental health beds and 80 older peoples' mental health beds)	**Proposal: invest additional £1.5m in approximately 14 supported accommodation places, 1 sheltered housing place, 39 care home places and 2 homecare packages. Invest £383k and £1003k in remaining 9 adult and 33 older peoples' NHS continuing care beds.** Significant additional investment to commission alternative intensive home based supports and residential based care within Inverclyde, in partnership with Inverclyde Council and the voluntary and independent sector. This will result in a reduction in the number of NHS continuing care beds for people under 65. Commissioning alternative NHS beds for older people in conjunction with the voluntary and private sector within Inverclyde again will result in a reduction of NHS continuing care beds and improved environments for people.

Services	What we do now	What we propose to do
Acute admission beds	**Deficit: Standard of accommodation for adult admission beds in need of upgrading.** For under 65: Currently there are 45 acute inpatient beds, based within the Short Stay Psychiatric Unit at the IRH. For older people there are 20 acute inpatient beds provided within the purpose-built Larkfield Unit at the IRH. For older people who require more intensive care this is provided within the Short Stay Psychiatric Unit.	**Proposal: Retain local admission ward at SSPU and Larkfield for adults and older people respectively. Adult ward will be upgraded to improve quality of patient accommodation.** The significant development proposed in the range of community based services will enable a planned reduction in adult mental health in-patient provision to a level of circa 20 beds for Inverclyde. This level of beds would be comparable to investment elsewhere pro-rata to the population. The benefits of such beds being located on a DGH site are acknowledged in terms of proximity to A&E, physical diagnostic and liaison services. The benchmark for adult acute beds is 25. However, optimum ward size constraints have resulted in a proposed re-provision of 20 beds, with the difference being compensated for through additional community services. It is proposed to retain the current 20 bed older persons' acute provision within Larkfield.
Intensive psychiatric care beds	Currently this South Clyde service is provided from Dykebar Hospital.	**Proposal: relocate South Clyde service from Dykebar to Inverclyde Royal Hospital campus in upgraded accommodation** Locating the service at IRH has the benefit of locating these beds on a general hospital site along with adult mental health admission beds. It also will maintain a critical mass of adult service provision for Inverclyde.

The additional primary and community infrastructure developments summarised above for Inverclyde amount to an investment of circa £ 2.3m.

3. SUMMARY OF INPATIENT SERVICE CHANGES

INVERCLYDE INPATIENT SUMMARY	**current**	**proposed**	**Comments**
Acute admission			
Acute adult	45	20	Retained at IRH (SSPU)
Acute elderly	20	20	Retained at IRH (Larkfield)
Sub total	**65**	**40**	
Continuing care			
Adult	31	9	Reprovided locally from Ravenscraig
Elderly	80	33	Reprovided locally from Ravenscraig in Partnership beds
Sub total	**111**	**42**	
Specialist beds N&S Clyde			
Intensive rehab	0	3	South Clyde development at Dykebar Hospital
IPCU	2	4	Transfer South Clyde beds from Dykebar to IRH (SSPU)
Addictions	3	2	South Glasgow & Clyde consolidation - Leverndale
ARBD	-	-	
Sub total	**5**	**9**	
Clyde element of GG&C/Regional Provision			
Low secure adult mental health	0	-	Clyde provision to be developed at Leverndale
Low secure adult learning disabilities	-	-	Transfer of Clyde provision from Dykebar to Leverndale
Medium secure adult mental health	-	-	Consolidation of provision at Rowanbank, Stobhill
Sub total		**-**	
Total	**181**	**91**	

APPENDIX 2

RENFREWSHIRE MENTAL HEALTH SERVICES

1. THE LOCAL CONTEXT

The Journey So Far

1.1 The proposals set out in this consultation paper build upon the progress made by local NHS and local authority partners to achieve service modernisation. Such joint working has brought about notable service improvements in recent years within Renfrewshire. These improvements include:-

- The commencement of specialist community mental health teams within Paisley and West Renfrewshire /Renfrew.
- The nationally acclaimed Doing Well Service to further improve the care of people suffering from depression, within Primary and Community Care.
- The development of new-build single room accommodation at Dykebar Hospital, currently accommodating adult mental health assessment patients.
- The development of 'First Crisis' social care crisis service in partnership with Renfrewshire Association of Mental Health.
- An integrated older persons' community mental health team.
- Residential respite services for older people with dementia.
- Specialist day care and home care services for people with dementia.
- Specialist dementia residential unit.

1.2 In addition to the above, work is at an advanced stage to introduce a new community based crisis response team service for adults with a mental health problem that will provide specialist intervention and treatment.

1.3 Despite the aforementioned developments, Renfrewshire still has relatively high numbers of beds and a relatively less comprehensively developed range of community mental health services. This is more so for adult mental health services. Older peoples' services have been the subject of successive balance of care reviews that have led to a rebalancing of inpatient and community provision. However, there is still a need for further work to achieve a more equitable balance in line with the current and future needs of the local population.

1.4 Since 2001 significant work has been undertaken to reduce delayed discharges and meet the national targets. The 2007/8 target of zero delayed discharges over 6 weeks is challenging. In order to minimize delayed discharges as far as possible further investment is required to increase the quality, capacity and access arrangements to community based health, care and housing support services. These community developments will be progressed through a separate CHP/Renfrewshire Council strategy process for older people (including older people's mental health).

Local Policy Context

1.5 Mental health community and inpatient services have traditionally served the population of Renfrewshire and Levern Valley in East Renfrewshire. The establishment of NHS Greater Glasgow & Clyde Health Board has facilitated discussion on the benefits of consolidating services for the total Greater Glasgow & Clyde East Renfrewshire catchments. For adult mental health acute in patient services, such a consolidation has already been achieved, with East Renfrewshire beds transferring to Leverndale Hospital. Further consideration will be given to the potential for East Renfrewshire older peoples' inpatient services to be consolidated on a single hospital site.

1.6 Renfrewshire CHP and Renfrewshire Council have established a joint planning structure to lead the planning and development of services for community care clients. The joint planning group for older people (JPPIG), which comprises representatives from Renfrewshire CHP, Clyde acute division, Renfrewshire Council and the voluntary sector has worked closely with. NHS GG & C's Mental Health Partnership to ensure the proposals being developed are consistent with both board-wide mental health strategies and local older peoples' strategies (inclusive of older people's mental health)..

1.7 Key policy drivers include the Mental Health Care & Treatment (Scotland) Act, All Our Futures. Better Outcomes for Older People, and Delivering for Health.

Renfrewshire CHP Resident Population

1.8 Renfrewshire has seen an increase in the actual number and proportion of the population aged over 65 years. This is more marked in the over 75 age group. The average life expectancy in Renfrewshire is lower than the national average and is currently 71 years for men and 77 years for women. Using the current population projections it is expected that the number of people aged over 75 is due to increase by 23% by 2013. From these demographics it is clear that the care needs of the population are set to increase significantly over the next 5 - 10 years.

1.9 By 2013 it is anticipated that at least 230 additional older people (from 2005 level) will require the level of care that a care home provides. Based on the current profile of the present care home population it is estimated that around 70% of these people will require support with mental health needs and 30% will have complex physical care needs.

1.10 Although work is underway to rebalance care provision in line with anticipated dependency levels, it appears that a number of older people could, with appropriate community health, social care and voluntary services, be living independently in their own homes. This is evidenced by ISD studies conducted in Renfrewshire since 2001 have shown that the dependency levels of NHS continuing care patients, care home residents and tenants of sheltered / very sheltered housing are lower than they should be for these types of specialist provision.

2. FEEDBACK FROM PRE-CONSULTATION ENGAGEMENT EVENTS

2.1 Pre-consultation engagement events were held on 12th March and 21st May 2007 with community interest groups and service users to look at local mental health services. The purpose of these meetings was to give local mental health user and carer groups the opportunity to express what they thought of current mental health services and what type of services they would like to see developed in the future. They also provided a forum to discuss in more detail some of the key issues and challenges facing mental health services. Key themes that emerged from these events were:-

- Good examples of joint working with voluntary sector.
- Need for greater emphasis on patient recovery from mental illness.
- Better support needed in primary care.
- Room for improvement around admission / discharge planning.
- Need for rehabilitation and respite services.
- Importance of having local services, particularly acute services.
- Concern at potential option of consolidating adult acute beds at RAH – would result in poorer standard of accommodation for Dykebar patients.
- Potential transfer of IPCU beds from Dykebar to IRH undesirable (but recognition that these beds should serve South Clyde catchments because of small critical mass).
- Desire to see integrated health and social care crisis services, preferable 24/7.
- The need for any Partnership continuing care bed model to be monitored robustly to ensure quality standards are achieved and maintained.
- Need for development of more formalised collaborative network of care between NHS, local authority and voluntary sector.

2.2 In line with the general feedback received, the development proposals recognise the importance of enhancing local services, integration, shifting the balance towards community and primary care based services and a greater emphasis on recovery. The development proposals also give priority to improving assessment prior to admission (where necessary) and facilitating early discharge.

3. CURRENT SERVICES AND PROPOSED DEVELOPMENTS

ADULT SERVICES

Services	What we do now	What we propose to do
Primary care supports	**Deficit: 50% GP Practices have no dedicated mental health support** Primary care support provided to circa 50% GP practices through Doing Well By People with Depression initiative, which offers an integrated care pathway to help care for people with depression. In addition, part of the CMHTs' function is currently to provide short term interventions within primary care.	**Proposal: invest additional £370k to provide cover to all GP Practices** Significant additional investment to extend the primary care mental health service to all GP practices in Renfrewshire for people with mild to moderate mental health problems. This will help to deliver a more co-ordinated and consistent approach across organisations and care teams.
Integrated Community Mental Health Team	**Deficit: CMHTs only partially developed and work Mon-Fri, 9am-5pm** Currently 2 teams in place (1 for Paisley catchments and the other covering West Renfrewshire /Renfrew).	**Proposal: invest additional £1.1m to employ extra 25wte CMHT specialist staff.** Significant additional investment to increase capacity to deliver appropriate care to meet peoples' needs in community settings.
Crisis resolution and access to treatment 24/7	**Deficit: no dedicated crisis resolution team in Renfrewshire. No access to community response to mental health crisis out of hours.** Access to crisis treatment is currently through duty doctor at acute inpatient unit. Social crisis support is available through 'First Crisis' (14 hours per day, 7 days a week). Access to advice and onward referral also available via NHS 24.	**Proposal: invest additional £500k to employ 15wte specialist staff to form community crisis team, with Team's working hours extended into evenings and weekend.** Significant additional investment to develop a crisis resolution team. The team will be able to provide an alternative to admission to hospital for people whose acute mental health needs can be met safely at home. Ultimately the fully functioning team will provide home treatment and assessment, a gateway to admission when required and a means to facilitate early discharge. Initially this team will operate an extended hours service into the evening and weekends. The need to move to a 24/7 service will be reviewed at a later date.
Rehabilitation and recovery supports	**Deficit: no dedicated intensive inpatient beds to provide intensive rehabilitation to promote recovery and discharge** Day service and community based rehabilitation service in place to support access to day facilities and group based supports, and training and employment support. This limited resource is accessed by inpatients and people in the community. Mental health development workers within the CMHTs also provide intensive support to link people into community services.	**Proposal: invest additional £300k to open 5 Renfrewshire beds at Dykebar.** Significant additional investment to establish inpatient beds specifically dedicated to intensive rehabilitation to maximise people's potential for independent living.

Continuing care beds	**Deficit: many people currently within mental health NHS continuing care wards could benefit from a range of community accommodation supports and care that could enable them to achieve a better quality of life and recovery.** **Those requiring NHS continuing care should have access to specialist medical care to meet their needs and good quality accommodation.** Currently 123 adult continuing care beds for Renfrewshire/East Renfrewshire. These beds are based at Dykebar Hospital in traditional style, older ward accommodation.	**Proposal: invest additional £1.6m in circa 18 supported accommodation places, 12 group home places, 5 sheltered housing places, 17 care home places and 3 homecare packages. Remaining 12 adult continuing care beds based at Dykebar in better standard of accommodation.** Significant additional investment to re-provide alternative community services and accommodation for people inappropriately residing in NHS continuing care wards. The range of community services will be commissioned within Renfrewshire, based on individual needs assessment in partnership with Renfrewshire Council and the independent sector.
Acute admission beds	**Deficit: adult admission beds for Renfrewshire provided from 2 hospital sites in mixed standard of accommodation.** Currently adult acute admission beds are located at RAH and Dykebar Hospital (66 Renfrewshire/East Renfrewshire beds in total). The impact of modernizing medical careers necessitates making the most efficient use of our medical workforce to ensure sustainable working rotas are in place.	**Proposal: consolidate remaining 42 adult acute admission beds in existing purpose-built accommodation at Dykebar, at cost of £2.6m.** The development of crisis resolution and other community based services will enable a planned reduction in acute adult mental health inpatient provision. It is proposed to consolidate these services at Dykebar in recognition of the high standard of accommodation there and the constraints in trying to replicate this at RAH. Consolidation of all adult services on a single site achieves improved integration of community and inpatient services and simplifies medical cover.
Intensive psychiatric care beds	Currently 8 beds serving South Clyde based at Dykebar Hospital.	**Proposal: relocate South Clyde service from Dykebar to Inverclyde Royal Hospital campus in upgraded accommodation** Locating the service at IRH has the benefit of locating these beds on a general hospital site along with adult mental health admission beds.

The additional primary and community infrastructure developments summarised for Renfrewshire amount to an investment of circa £3.7m.

4. OLDER PEOPLES' MENTAL HEALTH SERVICES

4.1 Renfrewshire CHP's and Renfrewshire Council's Joint Planning, Performance and Implementation Group (JPPIG) for Older People has the lead role for improving the health and care of older people in Renfrewshire (including older people's mental health), and has already implemented a number of service developments. A comprehensive work plan and joint financial framework are in place. Some of the key service issues within the work plan include:-

Services Provided in Local Community Settings or in Peoples Homes	
Social Day Care	Model currently under review to incorporate support to those with significant dementia and or frailty.
Integrated Older Adults Community Mental Health Team	The team's role is to assess, treat and support older adults with complex and/or long-term mental health problems and their carers in the community.
Residential Respite	Around £500,000 is invested by the local authority in approximately 9000 nights of respite per annum for older people, including those with dementia. A review is underway, involving carers, to improve access to these services.
Assistive Technology	Development of the community alarm service will lead to creation of Renfrewshire Care 24 comprising extended provision with evening, weekend and overnight mobile care teams and extensive range of assistive technology to support more people with dementia and complex health and care needs to remain at home.
Extra Care Housing with 24 Hour Integrated Team	Provision of dedicated teams providing integrated care, health and housing support 24/7. Indicatively 25 % occupancy by older people with mental illness. 3 ECH facilities planned on phased basis in 2007-09.
Gerontology Nurse Specialists	These staff (2) take a lead role in supporting the care pathway for frail older patients across primary, secondary and community care services, with the aim of reducing emergency admissions, providing care advice and support on gerontology issues and referral to specialist teams/services as required.
Interface Pharmacist	Provides an Important bridge between hospital and community pharmacists to minimise medication issues and reduce inappropriate hospital admissions.
Alzheimer's Liaison Nurse RAH	Liaison between primary and secondary care to support patients pathway. Also has role in raising awareness about Alzheimer's disease with staff.
Alzheimer's day care service	Specialist day care provision to those patients with high level of dependency.
Alzheimer's home care and carer support service	Support service providing support to people in their own homes and respite/support for carers.
Specialist dementia residential unit (independent sector)	Specialist unit providing registered residential care for people with advanced dementia and high dependency levels.
EMI units within independent and local authority homes	Dedicated EMI units within registered care homes providing higher staff: client ratio and expertise.

OLDER PEOPLES SERVICES

Services Provided in Hospitals for Older People with a mental illness	
Day Hospital & Memory Clinic	Assessment, treatment for time limited period up to 8 weeks then onward referral. A review of both EMI and Frail Elderly Day Hospitals has commenced as part of the work plan of the Older People's JPPIG. The aim of the review is to improve referral criteria, introduce rapid access and deliver fit for purpose services which meet the needs of older people and ensure best use of resources.
Acute Admission Beds	Assessment, treatment and appropriate return home or placement beds currently on RAH site serving Renfrewshire/East Renfrewshire • ward 37: 20 beds organic illness • ward 39: 20 beds functional illness It is proposed to retain acute admission beds for older peoples mental illness on the RAH site. A review will take place of future bed capacity requirements, including the potential to further strengthen community services. Further work will be undertaken with East Renfrewshire Community Health & Care Partnership to explore the potential to consolidate acute admission beds for that locality on one hospital site. (Glasgow East Renfrewshire catchments beds currently located at Leverndale Hospital).
Continuing Care Beds	Care of mainly severe, enduring dementia patients with challenging behaviour. 66 beds on Dykebar site serving Renfrewshire/ East Renfrewshire (59 and 7 respectively) • wards 1 and 4 female 2 x 22 beds • ward 5 male 1 x 22 beds It is proposed that future NHS continuing care provision will be provided through a partnership model with appropriate medical, nursing and AHP input. This should ensure services are reprovided locally within an improved standard of accommodation. For Renfrewshire, this will be a re-provision of 52 NHS continuing care beds.

5. SUMMARY OF INPATIENT SERVICE CHANGES

RENFREWSHIRE INPATIENT SUMMARY	current	proposed	Comments
Acute admission			
Acute adult	66	42	Consolidated at Dykebar (no provision at RAH)
Acute elderly	35	35	Retained at RAH
Sub total	**101**	**77**	
Continuing care			
Adult	108	12	Retained at Dykebar in better accommodation
Elderly	59	52	Re-provided locally from Dykebar in Partnership beds
Sub total	**167**	**64**	
Specialist beds N&S Clyde			
Intensive rehab	0	5	South Clyde development at Dykebar Hospital
IPCU	5	6	Transfer South Clyde beds from Dykebar to IRH (SSPU)
Addictions	7	4	South Glasgow & Clyde consolidation - Leverndale
ARBD	-	-	
Sub total	**12**	**15**	
Clyde element of GG&C/Regional Provision			
Low secure adult mental health	0	-	Clyde provision to be developed at Leverndale
Low secure adult learning disabilities	-	-	Transfer of Clyde provision from Dykebar to Leverndale
Medium secure adult mental health	-	-	Consolidation of provision at Rowanbank, Stobhill
Sub total			
Total	**280**	**156**	

APPENDIX 3

EAST RENFREWSHIRE MENTAL HEALTH SERVICES

1. THE LOCAL CONTEXT

The Journey So Far

1.1 The need for service change in Levern Valley mental health services (i.e. the Clyde catchments within East Renfrewshire) has been recognised at a local level for some time. The current model of service evolved over time with limited investment in community capacity and a reliance on hospital-based services at Dykebar hospital. Gaps in community-based provision have been filled by a range of information, support and advocacy services provided by the voluntary sector and specific projects from short-term funding sources. In terms of outcomes for service users, when benchmarked against national and locality rates of admission, the existing model of care in Levern Valley shows an elevated level of hospital admission for people with mental health problems.

1.2 The following table compares the different stage of mental health service development between the Glasgow and Levern Valley catchments of East Renfrewshire

Mental Health Services	**East Renfrewshire's Glasgow catchments**	**East Renfrewshire's Clyde Levern Valley catchments**
Primary care	Dedicated Primary Care Mental Health Team in place.	No Primary Care Mental Health Team.
Community Mental Health Team	Community Mental Health Team in place.	No Community Mental Health Team.
Crisis Resolution	Greater Glasgow & Clyde NHS Crisis Service.	Social care crisis service provided through Renfrewshire Association for Mental Health First Crisis.
Assertive Outreach	Existing public and voluntary sector services provide intensive support to individuals who find it difficult to engage with services for a range of reasons. Links with homelessness services and local volunteer programme is in place. Carers and service users stress the importance of assertive outreach. Formal assertive outreach support is identified as a gap in the local assessment of current service responses.	Existing public and voluntary sector services provide intensive support to individuals who find it difficult to engage with services for a range of reasons. Links with homelessness services and local volunteer programme is in place. Carers and service users stress the importance of assertive outreach. Formal assertive outreach support is identified as a gap in the local assessment of current service responses.
Psychology & Psychotherapy	Access to psychological services through Community Mental Health Team.	Lack of access to psychology services identified as issue by service users and carers.
Rehabilitation & Recovery	Employment and training support is available from Renfrewshire Association for Mental Health. A range of supports are available from the voluntary sector. There are 5 community-based supported accommodation places in Eastwood. Supporting People also provides a range of wider support with tenancies for people with mental health problems. Reduction in Supporting People funding has been identified as an issue by staff, service users and carers at a local level.	Employment and training support is available from Renfrewshire Association for Mental Health. A range of supports are available from the voluntary sector. Supporting People also provides a range of wider support with tenancies for people with mental health problems. Gaps have been identified by staff, service users and carers in housing with intensive support. Reduction in Supporting People funding has been identified as an issue by staff, service users and carers at a local level.

Local Policy Context

1.3 Partners in East Renfrewshire have a long-standing commitment to delivering on national policy at a local level. Partners have invested significantly in mental health services in developing a Community Mental Health Team covering the Eastwood area and in commissioning a range of services from the voluntary sector. However, this has proven difficult in the context of a model of care in Levern Valley, which has concentrated on in-patient provision over prevention of admission and community-based services.

1.4 The establishment of NHS Greater Glasgow & Clyde Health Board has facilitated discussion on the benefits of consolidating services for the total Greater Glasgow & Clyde East Renfrewshire catchments. For adult mental health acute in patient services, such a consolidation has already been achieved, with East Renfrewshire beds transferring from Dykebar Hospital to Leverndale Hospital. Further consideration will be given to the potential for East Renfrewshire older peoples' inpatient services to be consolidated on a single hospital site.

1.5 Developing mental health services is a priority for the NHS and the local authority, with the Corporate Strategy for 2003-07 ('Making a Difference for East Renfrewshire') giving a commitment "to secure the provision of adequate mental health services across the whole of East Renfrewshire". This is echoed in the 'Regeneration Plan for 2005-08' produced by East Renfrewshire Community Planning Partnership. The CHCP Development Plan for 2006/07 identified service integration and re-designs in mental health as a primary priority and specifically highlights the implementation of "single service" models across East Renfrewshire and the levelling-up of services as key actions for service change and improvement.

East Renfrewshire CHCP population

1.6 East Renfrewshire CHCP serves population of 89,610 residents (GRO(S), 2004 Mid Year Estimate) and covers an area of 174 square kilometres. The population of East Renfrewshire CHCP shows a number of trends over time with a rapidly increasing population relative to the rest of Scotland, a rising proportion of people living alone and increasing diversity in terms of ethnicity. Patterns of deprivation show distinct concentrations of multiple deprivations in a number of East Renfrewshire communities, specifically, Barrhead, Neilston, Thornliebank, and Mearns. These communities have been identified as priority areas within East Renfrewshire's Regeneration Outcome Agreement. In relation to the adult population aged 18 to 64, East Renfrewshire CHCP covers a population of 53,678 of which 38,682 live in Eastwood and 14,996 in Levern Valley.

2. FEEDBACK FROM PRE-CONSULTATION ENGAGEMENT EVENTS

2.1 As part of the commitment by NHS Greater Glasgow & Clyde to listening to the views of mental health service users, carers, local support groups and voluntary organisations a pre-engagement event was held on 15th March 2007 in the Dalmeny Park Hotel, Barrhead. This event was facilitated by East Renfrewshire Community Health and Care Partnership and East Renfrewshire Public Partnership Forum. The purpose of the event was to give local mental health user and carer groups the opportunity to say what they think of current mental health services and what type of services they would like to see developed in the future. The event also provided the opportunity to discuss in more detail some of the key issues and challenges facing mental health services.

2.2 A total of 43 people attended the event. Workshops examined what works well, what works less well, identifying gaps in provision, and setting priorities. Key themes were as follows:

What works well?

- Existing community nursing staff
- Services provided by Renfrewshire Association for Mental Health
- Links across services
- Services where prevention and promotion are the focus
- Telephone crisis support
- Information from support worker to service user

What works less well?

- 24 hour crisis service covering East Renfrewshire
- The need to have a diagnosis to access crisis services
- Transport to hospital
- Links with NHS 24
- Communication between acute and primary care services

Priorities

- Bring all of the different support/information services within easy access
- Provide services through local clinics
- Developing psychology services
- Good clear communication linking with Public Partnership Forum
- Crisis cover should have a single point of entry
- Crisis intervention for people with no history of mental health

- Transport links
- Respite and short-break opportunities
- Make sure outpatient facilities appropriate and secure
- Management of transitions – people coming to terms with transition e.g., adult to older
- Services for people with early onset dementia.

2.3 A combined Renfrewshire/East Renfrewshire follow up engagement event was held on 21st May 2007 in Paisley Town Hall. The primary focus of this was to share and discuss emerging options for service configuration, including the potential location of inpatient services. Key themes from this were as follows:-

- Potential transfer of IPCU beds from Dykebar to IRH undesirable (but recognition that these beds should serve South Clyde catchments because of small critical mass)
- Desire to see integrated health and social care crisis services, preferable 24/7
- The need for any Partnership continuing care bed model to be monitored robustly to ensure quality standards are achieved and maintained.

3. CURRENT LEVERN VALLEY SERVICES AND PROPOSED IMPROVEMENTS

Services	What we do now	What we propose to do
Primary care supports	**Deficit: no dedicated mental health support within primary care**	**Proposal: invest additional £35k to provide specialist support within primary care setting**
Integrated Community Mental Health Team	**Deficit: no CMHT within Levern Valley**	**Proposal: invest additional £260k to employ extra 4wte specialist staff to align with existing community staff to form CMHT. (Accommodation costs also included in aforementioned funding)**
Crisis resolution and access to treatment 24/7	**Deficit: No local community health led crisis service in place** Access to social care crisis services is available through Renfrewshire Association for Mental Health's First Crisis service. Out of Hours health support available NHS 24 or assessment by duty doctor at inpatient acute mental heath admission ward.	**Proposal: extension of existing crisis service (covering non-Clyde catchments) to all of East Renfrewshire.**
Rehabilitation and recovery supports	**Deficit: no dedicated intensive inpatient beds to provide intensive rehabilitation to promote recovery and discharge**	**Proposal: invest additional £55k to give East Renfrewshire access intensive rehabilitation beds, to be located at Leverndale Hospital**
Continuing care beds	**Deficit: some people within adult NHS continuing care wards could be discharged if the range of community accommodation supports is developed. Those requiring NHS continuing care should have access to good quality accommodation.** Currently 123 adult continuing care beds for Renfrewshire /East Renfrewshire. These beds are based at Dykebar Hospital in traditional style, older ward accommodation, generally of a poor physical standard. Nominally, 15 beds available for Levern Valley catchments. **Deficit: Older people's mental health continuing care services are provided from traditional older style wards, with limited access to single rooms.** Greater Renfrewshire provision currently exists (66 beds) at Dykebar Hospital. Nominally, 10 beds available for Levern Valley catchments.	**Proposal: invest additional £150k supported accommodation and care home places to facilitate discharges from Dykebar Hospital. Remaining NHS adult continuing care beds for Levern Valley (2 beds) are proposed to be consolidated at Leverndale with other East Renfrewshire provision and £85k will be made available to fund this provision.** **Proposal: Invest £220k in remaining continuing care beds* through the commissioning of a Partnership bed model with the independent sector aimed at significantly improving the standard of accommodation.** *7 beds for Levern Valley

Acute admission beds	**Adult acute admission beds recently transferred from Dykebar Hospital to Leverndale Hospital, to allow East Renfrewshire's services to be consolidated on one hospital site. This was subject to local engagement with service users and community interest groups.** 40 beds currently provided across 2 wards (by functional and organic mental illness) at RAH for Renfrewshire /East Renfrewshire	**No change to this position is recommended.** **Future service configuration (including day hospital provision) will be considered as part of older persons' strategy development.** Consideration to be given to potential consolidation of all East Renfrewshire inpatient services on a single hospital site.
Intensive psychiatric care beds	Currently 8 beds serving South Clyde based at Dykebar Hospital.	**It is recognised that, for East Renfrewshire, there are advantages from the consolidation of 'Glasgow' and Levern Valley IPCU services, alongside the consolidated adult acute services. East Renfrewshire IPCU services are therefore proposed to transfer from Dykebar to Leverndale Hospital.**

The additional primary and community infrastructure developments for East Renfrewshire amount to an investment of £400k.

4. SUMMARY OF INPATIENT SERVICE CHANGES

East Renfrewshire Inpatient Summary	**current**	**proposed**	**Comments**
Acute admission			
Acute adult	9	6	Consolidated at Leverndale (currently Dykebar)
Acute elderly	5	5	Consider consolidation (currently RAH & Leverndale)
Sub total	**14**	**11**	
Continuing care			
Adult	15	2	Consolidated at Leverndale (currently Dykebar)
Elderly	7	7	Reprovided locally from Dykebar in Partnership beds
Sub total	**22**	**9**	
Specialist beds N&S Clyde			
Intensive rehab	0	1	Consolidated at Leverndale (currently Dykebar)
IPCU	1	1	Consolidated at Leverndale (currently Dykebar)
Addictions	1	1	South Glasgow & Clyde consolidation -Leverndale
ARBD	-	-	
Sub total	**2**	**3**	
Clyde element of GG&C/Regional Provision			
Low secure adult mental health	0	-	Clyde provision to be developed at Leverndale
Low secure adult learning disabilities	-	-	Transfer of Clyde provision from Dykebar to Leverndale
Medium secure adult mental health	-	-	Consolidation of provision at Rowanbank, Stobhill
Sub total			
Total	**38**	**23**	

APPENDIX 4

WEST DUNBARTONSHIRE MENTAL HEALTH SERVICES

1. LOCAL CONTEXT

The Journey So Far

1.1 The establishment of NHS Greater Glasgow and Clyde in April 2006 has given West Dunbartonshire the opportunity to benefit from a single NHS strategic planning process. The outcome of previous NHS mental health planning and investment processes for West Dunbartonshire has led to an inequity of NHS Mental Health Service provision for the Dumbarton and Alexandria localities (45 800 population) that were the previous responsibility of NHS Argyll & Clyde, in comparison to Clydebank (45 000 population) which was previously the responsibility of NHS Greater Glasgow. This is demonstrated in the table, below:-

RANGE OF EXISTING NHS MENTAL HEALTH SERVICES	
CLYDEBANK	**NORTH CLYDE (Dumbarton/Alexandria Localities)**
Primary Care Mental Health Team	None
Psychotherapy	None
Integrated Adult Community Mental Health Team	Community Mental Health Team
Older People Community Mental Health Team	Community Dementia Team
Intermediate Service(Crisis Function)	None
Out if Hours CPN Service	None
Rehabilitation (Gartnavel)	Rehabilitation (Lochgilphead)
Early Intervention Service for Psychosis	None
Adults and Older Peoples' acute Admission Wards (Gartnavel)	Admission Wards (Vale of Leven Hospital)
IPCU (Gartnavel)	IPCU (Lochgilphead)

1.2 There is an urgent need to provide the range of NHS Mental Health services to Dumbarton/Alexandria localities that are available to the Clydebank locality.

1.3 Historical pathways of care from Dumbarton/Alexandria to Lochgilphead Hospital (Argyll and Bute CHP) for Rehabilitation and Intensive Psychiatric Care Unit (IPCU) continue to exist. These pathways of care necessitate round trips of up to130 miles for Service users, Carers and in-reaching staff from West Dunbartonshire CHP and Council to visit Lochgilphead Hospital and return to their area.

Local Policy Context

1.4 West Dunbartonshire Adult Mental Health Strategy group has been very active involving key stakeholders to redesign and develop Community Mental Health services within our area. West Dunbartonshire CHP and Council established a single Strategic Planning Forum involving all key stakeholders from June 2006.

1.5 Significant work has been undertaken by West Dunbartonshire CHP and Council to further develop an integration of systems and processes that allow for integrated joint working within Mental Health to benefit Service Users.

1.6 Community Mental Health services must be developed to provide a service response 7 days per week and 24 hours per day as per the Organisations obligations to the Mental Health and Treatment Act (Scotland 2003) and in line with the Scottish Executives Delivery Plan for Mental Health services.

Helensburgh & Lochside Catchments

1.7 Acute Adult and Elderly Mental Health Admission Wards at the Vale of Leven Hospital also serve the communities of Helensburgh and Lochside (Population of 28 000). This population is part of Argyll and Bute CHP (under the responsibility of NHS Highland) and is served by Community Mental Health Staff based within Helensburgh Victoria Infirmary. West Dunbartonshire CHP has the responsibility for providing Adult and Dementia Community Mental Health services to the population of Helensburgh and Lochside, through Service Level Agreements between NHS Greater Glasgow & Clyde and NHS Highland.

2. FEEDBACK FROM PRE-CONSULTATION ENGAGEMENT EVENTS

2.1 Pre – consultation Community events were held on 20 March 2007 and 22 May 2007. The purpose of these events was to give local Mental Health service user and Carer groups the opportunity to say what they think of current Mental Health services including what type of services they would like to see identified for development within the Clyde Mental Health Strategy. The events also gave people the opportunity to discuss in more detail the challenges facing Mental Health Services within and beyond the Clyde area.

2.2 These events were facilitated by West Dunbartonshire CHP and Greater Glasgow and Clyde Mental Health Partnership.

Key Themes

- Need for Comprehensive Community Mental Health services providing a range of service options
- 7 Day Access to Community Mental Health service including Out of Hours
- Need for local services
- Improved Joint Working between Health and Social Work
- Public Transport links to Hospital sites is an important consideration

2.3 The potential to move Adult and elderly Acute Admission Beds from Vale of Leven Hospital to Gartnavel Royal Hospital raised anxieties regarding accessibility for the Dumbarton, Alexandria and Helensburgh localities. Reassurance was sought regarding the public transport links to Gartnavel Royal Hospital.

3. CURRENT NORTH CLYDE SERVICES AND PROPOSED IMPROVEMENTS

Services	What we do now	What we propose to do
Primary care supports	**Deficit: no dedicated mental health support within primary care**	**Proposal: invest funding to provide specialist support within primary care setting to support and treat people with a mild to moderate mental illness**
Integrated Community Mental Health Team	**Deficit: no provision into evening and weekends. Fragmented service in poor standard of accommodation.** All Community Mental Health services operate Mon – Fri (9am – 5pm). Community Mental Health staff operate from a number of sites which are of poor environmental quality and offer very limited space for consulting rooms and therapeutic activity. A Community Mental Health Team base has been identified at Dumbarton Joint Hospital. This new facility will provide an appropriate base for a comprehensive and integrated Adult Community Mental Health Team which will serve the Dumbarton and Alexandria Localities. **Deficit: no older persons CMHT exists.**	**Proposal: Significant investment to create a suitable base for the delivery of a modern, comprehensive and integrated Adult Community Mental Health Team service at the Dumbarton Joint Hospital site.** This will be the base for Occupational Therapy, Clinical Psychology, Social Work, Psychiatry, Community Psychiatric Nursing and Administration staff. The development of crisis resolution and primary care mental health services will allow existing CMHTs to provide targeted and intensive support to people with complex needs who are vulnerable to disengagement with services. **Proposal: significant investment to enable an Old Age Community Mental Health Team to be developed.** This development will embrace the current services delivered by the established Dementia Specific Community Team.
Crisis resolution and access to treatment 24/7	**Deficit: there is no access to Community Mental Health services after 5 pm on Week days and also at Weekends and Public Holidays.** **There is no access to CPN Out of Hours Service.**	**Significant additional investment is allowing the development of a crisis resolution team. This team will operate at Weekends and Public Holidays (9am – 5pm) including an extended hours service into the evening until 8 pm on Week days.** The team will be able to provide an alternative to admission to hospital for people whose acute mental health needs can be met safely at home. Ultimately the fully functioning team will provide home treatment and assessment, a gateway to admission when required and a means to facilitate early discharge from Hospital. **Significant additional investment will allow access to Out of Hours CPN service for Dumbarton and Alexandria localities.**

Rehabilitation and recovery supports	**Deficit: poor geographical access to 4 beds for rehabilitation services in Lochgilphead Hospital.** Community Rehabilitation is provided by the CMHT.	**Proposal: North Clyde Rehabilitation investment within Lochgilphead Hospital to be transferred to Gartnavel Hospital to provide this important service locally.**
Continuing care beds	**Deficit: mental health continuing care services are provided from traditional older style wards, with limited access to single rooms.** Currently 12 Continuing care elderly mental health beds (4 of which serve the Helensburgh / Lochside catchments) (at Dumbarton Joint Hospital (Glenarn Ward) and Vale of Leven Hospital (Campsie Ward for Challenging Behaviour Dementia)	**Proposal: Dumbarton Joint Hospital to be re-provided within a Partnership model (12 beds) to improve standard of accommodation and serve the Dumbarton and Alexandria and Helensburgh / Lochside populations** There is an opportunity to work closely with West Dunbartonshire Council with their proposal of a new-build development within the grounds of Vale of Leven Hospital for Older People.
Acute admission beds	**Deficit: sustainability risks around existing medical cover on-call arrangements. Lack of consolidated provision for West Dunbartonshire. Inappropriate age mix of adult and older people functional illness patients.** ***(please see section 4 for more detailed information on medical cover issues)*** There are 36 Acute Admission beds within Vale of Leven Hospital. Christie Ward – 18 Beds (Adult Admission) Fruin Ward - 8 Beds (Dementia Admission) In addition, 6 adult and 4 elderly mental health acute beds service the Helensburgh / Lochside catchments within the aforementioned wards.	**Proposal: consolidate all West Dunbartonshire adult and older peoples' acute admission beds for mental health patients at Gartnavel Royal Hospital.** This transfer of services will ensure the sustainability of effective and efficient medical cover. The opportunity will be taken to provide age appropriate provision by the separation of adult and elderly functional patients into separate ward accommodation. The following bed numbers would serve Dumbarton & Alexandria Adult Acute Admission : 12 Elderly Acute Admission : 4 Dementia Admission : 8 Additionally the following beds could be provided at Gartnavel Royal for the Helensburgh / Lochside population: Adult Acute Admission : 4 Elderly Acute/dementia Admission : 6
Intensive psychiatric care beds	**Deficit: poor geographical access to beds in Lochgilphead Hospital.**	**Proposal: North Clyde IPCU beds within Lochgilphead Hospital to be transferred to Gartnavel Hospital to provide this important service locally.** A significant amount of preparation and ground work has already been completed to enable this important development to take place. This development work has identified the requirement of 2 IPCU beds for Dumbarton and Alexandria and 1 IPCU bed for the Helensburgh / Lochside populations.

3.1 An additional investment of approximately £465k will be made to achieve the aforementioned community developments for the Dumbarton and Alexandria population**.**

4. GUIDING PRINCIPLES, MEDICAL COVER ISSUES AND RATIONALE FOR CONSOLIDATION OF ACUTE MENTAL HEALTH BEDS AT GARTNAVEL ROYAL HOSPITAL

4.1 The following service and clinical safety principles have informed proposals on the location of acute admission and related specialist beds:

- Provision of inpatient mental health services can be provided on either a stand alone psychiatric hospital site or collocated with physical health beds on an acute medical admissions hospital site (a District General Hospital). Both forms of provision currently exist within the GG&C area and throughout the UK.

- The preferred location for inpatient mental health beds is collocation on an acute admission site as this has the benefits of:

  - Access to physical and diagnostic investigations.

  - Opportunity to integrate both physical and mental health care, particularly for older people.

  - Proximity and support to Accident and Emergency units where significant numbers of people with mental health problems may present, particularly out of hours.

- Acute admission beds should be located on a site with medical cover arrangements which ensure acceptable levels of clinical safety (see further detail below)

- Specialist addictions beds to be collocated :

  - At a minimum with a site with acute mental health admissions to ensure access to similar expertise and back up from medical and nursing support.

  - Preferably on a site with both acute mental health and physical health admissions – i.e. a DGH with Mental Health beds on site.

- IPCU to be collocated with:

  - Adult acute mental health admissions to ensure access to psychiatric medical expertise and nursing support.

- Forensic medium and low secure beds should be:

  - Located on a site with acute adult admission beds to ensure access to wider specialist medical and nursing expertise and support.

- Ward spaces should enable:

  - Beds for patients with organic and functional needs to be located in discrete areas to enable separate management of these distinct patient groups.

  - Provision of age appropriate service.

Medical cover issues

4.2 The national process of Modernising Medical Careers will see changes to the arrangements for training and provision of medical cover, particularly by junior doctors. The cumulative impact of these changes is likely to see:

- c20% reduction in allocation of junior doctor training posts between now and 2013 full implementation date, albeit local variations linked to nationally determined junior doctor training allocations.

- Reduced direct patient contact time as part of junior doctor training.

4.3 The cumulative effect of these changes is likely to make the long term sustainability of current models of medical cover significantly more challenging, particularly for sites covering smaller catchments populations.

4.4 In terms of medical cover arrangements for acute admission units the following principles are applicable to ensure clinically safe levels of medical cover:

4.5 Preferred arrangements:

- Resident junior psychiatric medical cover on site supported by access to on call Consultant Psychiatrist support.

4.6 Where this preferred arrangement is not feasible the minimum acceptable arrangement would be:

- Integration of arrangements for Mental Health junior doctor cover with resident site based general medical cover arrangements for the hospital site.

- Resident junior medical cover on site, involving both non psychiatric and psychiatric junior medical cover, with access to on call Consultant Psychiatrist support.

4.7 In the longer term there may be merit in more radical solutions linked to emerging models of “hospital at night” and the use of “advanced nurse practitioners”. However these models of service are unlikely to be applicable to single site solutions except on large sites. This is because it is only on larger sites that there would be sufficient out of hour’s activity levels to ensure the range of experience and specialist provision required to sustain and develop advance nurse practitioners. These issues are more fully explored in the detail of the option appraisal process for WDC set out in appendix 6.

Guiding principles on the location and configuration of beds: cost effectiveness and feasibility issues.

4.8 In addition to the *service and clinical robustness* principles summarised above a number of further principles were considered to inform the detail of proposed location of beds. These *cost effectiveness and feasibility* principles are summarised below:

- The need to maximise site infrastructure savings to fund community service developments.

- The need to ensure the feasibility of specific site options in terms of:

    - Ward and space capacity available for mental health use.

- Achievement of acceptable quality therapeutic environments for inpatient and continuing care.

- Compliance with the service and clinical robustness principles summarised above.

- Capacity to provide sustainable provision of medical cover consistent with the preferred or minimum cover principles.

- Capacity to provide cost effective provision taking account of size/critical mass issues (i.e. local / South Clyde / GG&C or Regional provision varies with bed numbers and degree of specialist provision).

- Capacity to achieve the site configuration within the capital allocations available.

4.9 Location on DGH/ACAD sites rather than "stand alone" psychiatric sites is normally the clinically preferred option.

4.10 Finally we have sought to reflect the strong local desire for local provision of inpatient services wherever this can be achieved without compromising:

- The service and clinical robustness principles.

- The cost effectiveness and feasibility principles.

4.11 Applying the above service, clinical safety, economic, and feasibility principles, and the benchmarked capacity requirements referenced earlier in the paper, the proposed provision of beds would see:

- Acute admission and continuing care beds provided at a more local level.

- Specialist beds provided on a South or North Clyde basis.

- Highly specialist beds provided on a GG&C wide or Regional basis.

4.12 The above principles were further developed and applied through the disciplines of the process of option appraisal. A copy of the outcome of that process is attached as an appendix 6 to this strategy. Based on the outcomes of the option appraisal process the proposals below set out the preferred options for inpatient site configuration.

Transfer of adult and elderly acute mental health admission beds from Vale of Leven Hospital to Gartnavel Royal Hospital.

Current Service Profile

4.13 Thirty six Adult and Elderly acute mental health inpatient beds are currently located at Vale of Leven Hospital. These beds serve the Clyde catchments of West Dunbartonshire, as well as the Helensburgh and Lochside localities of NHS Highland The wards do not meet clinical or service user expectations of a quality environment due to an inappropriate mix of elderly and adult mental health patients in the same ward, together with the wards' upper floor location which offers poor access for patients to hospital grounds. These environmental concerns should not be seen as detracting from the high quality of care delivered by dedicated clinical staff.

4.14 In addition, there is no resident out-of-hours medical cover for the mental health wards at Vale of Leven Hospital, which raises significant clinical safety concerns for NHS Greater Glasgow and Clyde.

4.15 The Clydebank catchments in West Dunbartonshire already access inpatient mental health services from the new Gartnavel Royal Hospital.

Proposed Service Profile

4.16 It is proposed to transfer all adult and elderly acute inpatient mental health services from Vale of Leven Hospital to the purpose built and upgraded accommodation at Gartnavel Royal Hospital, thereby consolidating mental health inpatient services for all of West Dunbartonshire on a single hospital site, and addressing the service issues highlighted in the preceding paragraph. Patients from Helensburgh and Lochside localities would also access Gartnavel Royal Hospital for these mental health services.

4.17 Under this proposal a unified model of inpatient care would be implemented such that all users received a similar high quality of inpatient care regardless of whether they were from Glasgow, West Dunbartonshire or Helensburgh and Lochside. Additionally wards would be associated with specific catchment populations to ensure continuity of care between the inpatient service and local community services.

4.18 Therefore, all adult acute mental health admission beds, and the majority of elderly acute mental health admission beds, would transfer into the new purpose built wards at Gartnavel Royal Hospital which offers single room accommodation throughout.

4.19 The model of care for elderly people would see the wards in the new Gartnavel hospital providing acute admission care and offering separate ward environments for people with functional illness from those with dementia. These wards would be supplemented by the retention of an upgraded “step down ward” for people requiring further care prior to discharge. This would mean around 70% of elderly beds would be in the new single bedded accommodation in the new hospital, and up to a third of the elderly beds in the upgraded ward accommodation.

4.20 The local needs assessment has proposed retention of 34 beds, but with a shift in the balance of beds from the current position of 24 adult beds and 12 elderly beds to 16 adult beds and 18 elderly beds. Following the further development of crisis and community services it is possible that the required level of beds may reduce further, particularly adult beds.

4.21 The 16 adult beds can be accommodated at the new Gartnavel Royal Hospital because:

- Our experience of development of Greater Glasgow community services is seeing a further shift in the balance of care in favour of management of care in community settings following the further development of crisis services – thereby reducing Greater Glasgow bed requirements
- 6 beds currently temporarily used as specialist addictions beds will become available for adult mental health use following the move of addictions beds to the planned unit in South Glasgow.

Options Considered

4.22 The Independent Scrutiny Panel advised of the need for a formal option appraisal process to be undertaken to help determine preferred option(s) for consultation. In particular the Panel were concerned that such an appraisal process should explore options to provide out of hours clinical cover which was not reliant on junior doctor cover. An independent facilitator was appointed to undertake these events, which were undertaken with service user, community groups, management and clinical representatives.

4.23 The options considered were as follows:-

Option 1: Status Quo

This option would see adult and elderly acute mental health beds remaining at Vale of Leven Hospital in their current ward locations and with no resident medical staff out-of-hours.

It was the clear consensus from the option appraisal process that the status quo is unacceptable due to concerns over the lack of resident medical on-call staff, combined with the weaknesses of the current ward accommodation which provided neither ground floor accommodation, good access to external space, or age appropriate ward spaces (i.e. adult and elderly patients sharing the same ward environment).

It was also clear there was a strong community aspiration to resolve the problems associated with retention of services on the Vale of Leven site by exploring options which resolved both the difficulties of the ward accommodation, and also provided alternative options to deal with out of hours medical cover problems without reliance on junior doctor medical cover.

Options 2 to 7 below all represent variants on a range of options which have sought to explore such issues with a view to achieving retention of inpatient services at the Vale of Leven Hospital.

Option 2: Services remaining at Vale of Leven Hospital (in improved accommodation) with resident medical out-of-hours cover through integrating Mental Health and Acute rotas

This option was explored as a possible means to addressing the lack of resident out-of-hours medical cover for mental health patients at Vale of Leven Hospital. This arrangement exists elsewhere in the Health Board, where mental health medical staff participates in an integrated rota with general medicine medical staff. However, this option did not progress to full option appraisal scoring due to fact that the medical rota for Acute Services in the Vale of Leven Hospital is already stretched, relying partly on General Practitioner cover out-of-hours.

In addition, the appraisal group considered that the uncertainty surrounding the future configuration of Acute Services at Vale of Leven Hospital placed a high risk on the viability of an integrated rota with mental health services.

Option 3: Services remaining at Vale of Leven Hospital (in improved accommodation) with resident clinical out-of-hours cover through Advanced Nurse Practitioners

The Independent Scrutiny Panel suggested further exploration of the potential use of advanced nurse practitioners to resolve the concern of non-resident medical out-of-hours cover. However, this option did not progress to full option appraisal scoring due to concerns that such an approach could not be straightforwardly applied to the Vale of Leven in the foreseeable future.

The use of advanced nurse practitioners for out of hours cover is generally undertaken as part of “Hospital at Night” developments within larger hospitals which provide a large enough activity base to ensure the development and maintenance of the advanced nurse practitioners knowledge, skills and competency base. However in the context of only 34 mental health beds at the Vale of Leven, it was concluded that a major challenge to the introduction of advanced nurse practitioners would be the relatively low and limited out-of-hours activity, which would compromise the maintenance and development of previously acquired knowledge, skills and competence. This potential erosion of staff’s skills was considered to present a high service risk.

Option 4: Services remaining at Vale of Leven Hospital (in improved accommodation) with resident clinical out-of-hours cover through Advanced Nurse Practitioners and Junior Medical Staff

Integrating advanced nurse practitioners with junior medical staff would reduce the risks identified in Option 3, above, by reducing the reliance on the number of advanced nurse practitioner posts required and by developing this role as part of a team involving junior medical staff. However, the option appraisal group were not satisfied that the risks (as identified in option 3) could be reduced to a level that would make this option viable in the foreseeable future. Accordingly, this option did not progress to full option appraisal scoring.

Option 5: Services remaining at Vale of Leven Hospital (in improved accommodation) with resident clinical out-of-hours cover through combined Junior Medical Staff and Staff Grade (or non-career grade) Medical Posts

The Independent Scrutiny Panel suggested the potential use of additional staff grade medical posts to resolve the concern of non-resident medical out-of-hours cover. However this option did not progress to full option appraisal scoring due to the consensus that these arrangements were unlikely to attract candidates due to the unattractive terms and conditions inherent in such an arrangement.

Option 6: Services remaining at Vale of Leven Hospital (in improved accommodation) with resident medical out-of-hours cover through integrating mental health medical rotas across Vale of Leven and Gartnavel Royal Hospitals

It was considered that a minimum of 8 to 9 full time junior medical posts is necessary to sustain a rota that includes resident out-of-hours cover. Seventeen such posts currently exist across Vale of Leven and Gartnavel Royal Hospitals.

The option appraisal group considered that integrating the total number of junior medical staff across both hospitals is feasible, in terms of its ability to potentially address the resident medical on-call concerns in the short term. However medical advice indicated that such arrangements carried a high risk of not being sustainable beyond 2 years. After 2 years the national implementation of Modernising Medical Careers will see a reduction in the allocation of junior doctor trainees, at which point the integrated medical rota is likely to become unsustainable.

Nevertheless, the option appraisal group considered that the potential feasibility of this option in the short term enabled full option appraisal scoring to proceed on 4 sub-options for retaining mental health services at Vale of Leven Hospital. The sub-options, below, set out a variety of ways in which accommodation and ward environments could be improved to help to address previously stated concerns:-

Option 6a; 3 new build wards at Vale of Leven (one for adult mental health, one for elderly mental health, and one for elderly mental health with dementia).

Option 6b: 2 new build wards at Vale of Leven (one for adult and elderly mental health, and one for elderly mental health with dementia).

Option 6c: I new build ward for adults and elderly mental health and I refurbished ward for elderly mental health with dementia, at Vale of Leven.

Option 6d: 3 refurbished wards at Vale of Leven (one for adult mental health, one for elderly mental health, and one for elderly mental health with dementia).

Option 7: Admit out-of-hours mental health admissions (that currently go to Vale of Leven Hospital) to Gartnavel Royal Hospital, with patients transferred to Vale of Leven Hospital the following day

This option originally emerged as a possible way of minimising the impact of having no resident out-of-hours medical cover for mental health wards at Vale of Leven Hospital. However this option did not progress to full option appraisal scoring due to the consensus that these arrangements still presented a significant risk by not resolving resident out-of-hours medical cover for patients at Vale of Leven Hospital.

Option 8: Transfer of adult and elderly acute mental health admission beds from Vale of Leven Hospital to Gartnavel Royal Hospital.

Adult acute mental health admission beds and the majority of elderly acute mental health admission beds would transfer from Vale of Leven Hospital to the new purpose built unit at Gartnavel Royal Hospital which offers single room accommodation throughout. The remaining elderly admission beds would be located in an adjacent, upgraded step-down ward for elderly functional and dementia patients requiring a slightly longer stay in hospital before discharge.

The new unit at Gartnavel Royal Hospital currently provides access to the Clydebank catchments of West Dunbartonshire. It is expected that the impact of further developments in specialist community mental health services in Glasgow will reduce Greater Glasgow requirements freeing up 10 beds. A further 6 beds are currently being used as specialist addictions beds pending the development of the specialist addictions beds in South Glasgow, at which point these beds will also be available for other uses. It is expected that these arrangements could be implemented within a year of any final decisions following the consultation process. If necessary there is potential to provide interim accommodation in one of the upgraded wards on the site currently retained as a contingency for transitional use, pending the move to the long term arrangements within a year.

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Rationale for Proposal

4.24 From the option appraisal scoring process, the following 3 leading options were identified:-

Option 6a
Retain services at Vale of Leven Hospital in 3 new build wards to address ward environment and patient mix concerns, integration of medical cover rotas at Gartnavel Royal Hospital and the Vale of Leven Hospital.

Option 6b
As above but with 2 new build wards, with partial solution to issues of ward environment and patient mix.

Option 8
All adult and elderly admissions provided at Gartnavel Royal Hospital with the benefit of access to high quality ward accommodation currently accessed by the Clydebank population of West Dunbartonshire; but with the disbenefit of challenges around access.

4.25 Concern was expressed during the option appraisal process, (particularly from Mental Health Forum members, although not exclusively) over option 8, above, in terms of the difficulties and perceived risks this could present for people requiring to access inpatient services further away from the current location. Public transport difficulties were considered by Forum members to compound this concern, particularly for people with mobility problems.

4.26 Concerns were also expressed over option 8 in terms of patients being in an unfamiliar environment and potential difficulties that may arise in the interface between hospital and the community services.

4.27 However there is a need to distinguish between the needs of patients and the needs of visitors. Any patient admissions would be made through transport specifically arranged for that purpose. The access issues therefore apply to visitors only.

4.28 Concern was also expressed that on some occasions when Gartnavel Royal Hospital beds were full, admission may not be to Gartnavel but might actually be to another NHS GG&C hospital further away. However on further exploration it was clarified that, based on current patterns of "boarding out", this was only likely to occur for one admission in every 2 months for a maximum of 4 days prior to return to Gartnavel Royal Hospital. Additionally the protocol for boarding out within Glasgow hospitals would be implemented to reflect the priority of a principle of minimum distance in the very rare instance of cases of admission conflicts. The statistics on which this assessment is based are provided in an appendix to the Strategy. (Please see section 8 for information on how to access this.)

4.29 There were also concerns expressed that the transfer of inpatient services and staff from the Vale of Leven Hospital to Gartnavel Royal Hospital presented a higher level of challenge and risk than those options in which inpatient services were retained on the Vale of Leven Hospital site. This contributed to option 8 having the highest risk score of all options. However, whilst it is clear this option presents a higher level of challenges, the Health Board has substantial experience of safely dealing with the challenges associated with the relocation of services and staff, and therefore takes the view that the level of risk associated with option 8 is manageable. Additionally the further enhancement and development of community and specialist crisis services enables clear in-reach and continuity of care between community and inpatient services and improved support to people in the community.

4.30 The proposal to transfer 34 mental health beds from Vale of Leven Hospital to Gartnavel Royal Hospital is estimated to amount to approximately 400 patient admissions each year. The NHS will arrange the transport for patients being admitted to mental health acute inpatient care. For visitors to Gartnavel Royal Hospital, there is relatively good access by train and bus. However, similar to many other locations, it is recognised that there are challenges for people with mobility problems. NHS Greater Glasgow & Clyde is keen to explore ways in which such difficulties can be addressed.

4.31 In drawing conclusions from the option appraisal process, it was recognised that on the benefits criteria *alone,* (i.e. the non-financial criteria), the options involving new-build wards at Vale of Leven Hospital scored more highly than others in the option appraisal process. For that reason, those options are the preferred options of the West Dunbartonshire Mental Health Forum. However the option appraisal process seeks to achieve a best fit across *both* non-financial and financial criteria. From that combined perspective, the option that scored best in the process was the transfer of mental health services from Vale of Leven Hospital to Gartnavel Royal Hospital.

4.32 In addition to the option appraisal findings, the Health Board requires to take into account the wider issues of Affordability, Sustainability, and Future Flexibility.

Affordability

4.33 Significant capital funding (circa £6m) would have to be found to achieve the options requiring new-build accommodation at Vale of Leven Hospital, at a time when there is projected scope to accommodate the beds within existing high quality accommodation at Gartnavel Royal Hospital, thereby making efficient and effective use of the Health Board's estate.

4.34 Additionally, accessing the required capital is likely to be problematic because:

- The Board has prioritised the development of the Southern General Hospital as its highest priority for capital and there is very limited capital available beyond that commitment which is subject to a range of competing priorities.

- Accessing capital requires the need to comply with the capital business case disciplines including those of long term sustainability. In the absence of resolution of out of hour's medical cover beyond the next 2 years, it is unlikely such tests of long term sustainability could be met.

(The revenue comparisons associated with the new-build Vale of Leven Hospital options versus transferring services to Gartnavel Royal Hospital are set out in the full option appraisal report – please see section 8 for information on how to access this.)

Sustainability

4.35 Whilst an integrated Vale of Leven and Gartnavel Hospitals medical rota is sustainable in the short term, an integrated rota carries a high risk which is not sustainable beyond a 2-year period. This is because the current number of junior medical staff available is anticipated to reduce following the further national implementation of Modernising Medical Careers.

Future Flexibility

4.36 A minimum number of mental health beds are required at Vale of Leven Hospital in order to sustain the viability of mental health wards and services on that site. However with changing population needs it may be necessary to consider reducing the current planned number of adult acute mental health beds, in favour of further community service developments. Any decision to introduce new-build mental health inpatient accommodation at Vale of Leven Hospital therefore reduces the ability to flexibly manage any further shifts in the balance of between inpatient and community provision in an efficient way.

Conclusion

4.37 The concerns expressed by West Dunbartonshire's Mental Health Forum regarding the additional challenges that some visitors will have in accessing inpatient services at Gartnavel Royal Hospital is acknowledged. It is clear that the Forum do not support the proposed transfer of services. However, it is necessary for the Health Board to take into account a wider set of influencing factors, as described in the previous paragraphs. During the consultation period the Health Board will further explore the feasibility of transport options which mitigate the access issues to Gartnavel Royal Hospital for visitors with mobility problems.

4.38 The Health Board is confident that the quality of services and accommodation at Gartnavel Royal Hospital will be well received by service users. The Independent Scrutiny Panel also commented very favourably on the quality of the environment at Gartnavel Royal Hospital, describing it as possibly 'world class'. Whilst it is important to consider the issues of access in relation to inpatient services, it is also necessary to recognise that 95% of care and support takes place within community settings and the developments in community mental health services, including specialist crisis services, within West Dunbartonshire will improve overall access to services for the majority of occasions when people require care and treatment from mental health services.

4.39 The benefits of the consolidation of all West Dunbartonshire inpatient services (i.e. acute admission, IPCU and intensive rehabilitation beds) on the Gartnavel site include:

- Achieving preferred resident junior psychiatric medical cover arrangements.
- Achieving the benefits of consolidation on a site with enhanced hospital infrastructure of specialist management of inpatient service, practice development resources and bed management resources.
- Retaining the planned high quality inpatient single room accommodation benefits of the new Gartnavel hospital accommodation for the Clydebank catchments.
- Providing access to high quality single room accommodation benefits of the new Gartnavel Royal hospital accommodation to the population of Dumbarton, Alexandria, Helensburgh and Lochside.
- Providing ground floor accommodation and safe access to garden space for inpatient ward accommodation.
- Enabling the provision of separate acute admission wards for organic and functional illness.
- Achieving continuity of care between users of both acute admission and specialist mental health services on the same hospital site.

Helensburgh / Lochside

4.40 Services to this population are funded and commissioned by the Highland NHS Board and provided through a service agreement with the GG&C NHS Board.

4.41 The Highland NHS Board's recognises the desirability of the Helenburgh / Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

Helensburgh / Lochside

4.42 The services for Helensburgh / Lochside are funded and commissioned by the Highland NHS Health Board and provided by the GG&C Health Board through a service agreement.

4.43 The current access to the services at the Vale would be destabilised by the GG&C proposed transfer of mental health acute admission beds from the Vale of Leven to Gartnavel. The GG&C Board has indicated its preparedness to transfer inpatient services for the Helensburgh / Lochside population to Gartnavel Royal alongside the transfer of inpatient services to the Dumbarton and Alexandria population.

4.44 The Highland NHS Board's recognises the desirability of the Helensburgh /Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

West Dunbartonshire Inpatient Summary ***(excluding Helensburgh/Lochside)***	**current**	**proposed**	**Comments**
Acute admission			
Acute adult	1 8	1 2	Consolidated at Gartnavel Royal (currently Vale of Leven)
Acute elderly	8	1 2	Consolidated at Gartnavel Royal (currently Vale of Leven)
Sub total	**2** **6**	**2** **4**	
Continuing care			
Adult	3	3	Re-provided locally in Partnership bed model
Elderly	8	8	Re-provided locally in Partnership bed model
Sub total	**1** **1**	**1** **1**	
Specialist beds N&S Clyde			
Intensive rehab	0	2	Developed at Gartnavel Royal
IPCU	3	2	Consolidated at Gartnavel Royal (currently Lochgilphead)
Addictions	-	1	North Glasgow & Clyde consolidation - Southern General
ARBD	-	-	
Sub total	**3**	**5**	
Clyde element of GG&C/Regional Provision			
Low secure adult mental health	0		Clyde provision to be developed at Leverndale
Low secure adult learning disabilities	-		Transfer of Clyde provision from Dykebar to Leverndale
Medium secure adult mental health	-		Consolidation of provision at Rowanbank, Stobhill
Sub total			
Total	**40**	**40**	

APPENDIX 5

BED MODELLING: THE BASIS FOR PROJECTING BED REQUIREMENTS AND THE EVIDENCE BASE UNDERPINNING THE STRATEGIC APPROACH

EXECUTIVE SUMMARY

This paper sets out the basis for projecting the bed requirements for Clyde and the evidence base underpinning the strategic approach.

1. Context

References the trend since the 1950's from deinstitutionalisation to care in the community as characterised by:

1. The shift from "hospital based long stay care" to "Care in the Community".
2. Development of comprehensive community services.
3. More focussed and effective use of remaining inpatient beds.
4. Shifting the balance of care for the management of acute mental health crisis.

2. Long Stay continuing care beds: the shift from hospital based care to care in the community

Notes a reduction of 65-80% in the provision of hospital based long stay care over the last 20-30 years throughout each of the UK countries as they have implemented care in the community.

Notes, that in 2006 Scotland has the highest levels of bed provision in the UK at about 50% above the UK average. Current Scottish levels are comparable bed levels to those in place elsewhere in the UK 10 to 15 years ago; suggesting Scotland is at a somewhat earlier stage of its implementation of care in the community.

Notes, that Clyde levels are about 50% higher than Scotland levels suggesting an even earlier stage of development for Clyde services; whereas Greater Glasgow services are lower than the Scottish average reflecting a more advanced stage of implementation of care in the community.

3. Care in the Community – outcomes for service users

Rehearses the clear evidence base that care in the community has good outcomes for patients and that there is no evidence that deinstitutionalisation and community care have contributed to higher rates of offending amongst the mentally ill.

4. Acute Inpatient Care and the management of acute crisis in community settings

Notes:

- The weight of professional opinion supports balanced care between inpatient and community services.
- There is no definitive evidence base for the balance of care between inpatient and community care for a given population.

- That the pressures on beds are best resolved by a whole systems approach to the development of more robust community services than the requirement for more beds per se, and that such conclusions were reached in the context of English services operating at bed rates 60% lower than Scotland and 70% lower than Clyde services.

- That crisis services were developed to provide an alternative to admission for a proportion of individuals, albeit a minority of the total admissions.

5. Evidence on the outcomes of crisis resolution services

- Notes a number of suggestive findings in favour of the impact and user acceptability of crisis services as an alternative to hospital admission.

- Reflects that on the gold standards of the Cochrane Collaboration the position is deemed to be equivocal in terms of rigorous evidence from randomised control trials, whilst acknowledging the service model is more acceptable to service users and their carers and may be effective.

- Reflects the local judgement to recognise and develop the role of crisis services in the not uncommon scenario where the evidence is suggestive rather than definitive.

- Reflects that the assumptions around crisis services have a very modest impact on the benchmarked projections of acute bed requirements.

6. Proposed bed levels overall

Notes that:

- There is no definitive evidence base for the balance of care between inpatient and community care for a given population.

- Determining bed levels requires a cross referencing process to position bed levels taking account of use of epidemiological norms, benchmarking with other comparable demography's and local needs assessment.

- Highlights the impact of deprivation on bed requirements and the observed UK and local findings that this constitutes a 2 fold variation in bed requirements between high and low deprivation areas.

- Notes the concern of the Independent Scrutiny Panel that proposed bed levels for Clyde should be located in a more transparent and broader context than extrapolation from Greater Glasgow.

7. Locating Clyde, Glasgow, and Scottish bed levels in a UK context

Shows that:

- Clyde bed levels are the highest in Scotland substantially above the Scottish average and double the UK average.

- Greater Glasgow bed levels are close to average in a Scottish context but above average in a UK context.

- When the impact of deprivation is factored in Greater Glasgow bed levels are somewhat below the Scottish average but remain above though close to the UK average.

8. Comparing local admission rates in a GG&C and Scottish context

Notes that the major population of Clyde is located in Inverclyde and Renfrewshire. In terms of admission rates to hospital beds:

- Both areas have very high admission rates in a Scottish context.
- Even higher admission rates when compared to the much lower admission rates for Greater Glasgow areas with higher deprivation levels.
- This reflects a more hospital-dominated balance of care in Clyde than is the norm elsewhere in Scotland.
- The more even balance of hospital and community services of Greater Glasgow services is showing close to average admission rates for a deprivation level in which admission rates might be expected to be 33% higher than average.
- Service users and local authority partners have expressed a clear preference for the more evenly balanced care model of Greater Glasgow.

9. Balance of care, inpatient bed levels and service outcomes

Recognises that the Independent Scrutiny Panel were concerned to understand whether higher or lower bed levels could be demonstrated to have better or worse impact on health outcomes of the local population.

Reflects that:

- No definitive evidence base exists to answer that issue.
- Comparative analysis extending the work of the Scottish benchmarking project demonstrates that on a range of service efficiency and effectiveness measures, and the health outcome measure of suicides, the balance of care in the Greater Glasgow service evidences demonstrably better performance than the more hospital dominated services of Clyde, and elsewhere in Scotland.
- The shift from hospital based long stay care, to implementation of long stay care in the community, constitutes 80% of the proposed bed changes and this policy and service model has demonstrably good evidenced based outcomes as rehearsed in section 3.

10. Proposed bed levels: Acute beds:

Sets out Benchmark levels for Clyde beds and then reviews the benchmark levels in the context of wider service benchmarking, available epidemiological norms, and relevant local needs assessment.

Concludes:

- Adult acute bed benchmark levels are positioned at the upper end of the service norms and service benchmarks and therefore robust in this wider context.

- Elderly acute beds are left unchanged and for consideration as part of the Renfrewshire Frail elderly strategy review process albeit the benchmark levels would seem to suggest a reduction in acute bed levels.

11. Proposed bed levels: Continuing Care beds

Sets out benchmark levels and the consideration of the benchmark levels in the context of wider service benchmarking and available epidemiological norms and relevant local needs assessment.

Sets out the total re-provision placement requirements for the current long stay cohort based on local needs assessments for both inpatient beds and a range of community placements.

Concludes:

- The benchmark proposals are at the upper end of the service benchmark range albeit no direct epidemiological norms are available.
- The local needs assessments of the requirements of the actual patient cohort are largely confirming the benchmark projections.

BED MODELLING: THE BASIS FOR PROJECTING BED REQUIREMENTS AND THE EVIDENCE BASE UNDERPINNING THE STRATEGIC APPROACH

1. CONTEXT

1.1 Over recent decades there has been a progressive trend (both UK and internationally) to shift the balance of care from reliance on hospital dominated services, to a mental health network of highly developed community services, supported by access to inpatient support when required [1].

1.2 This shift in the balance of care has been marked by:

1. Reduced provision of NHS long stay continuing care in hospital based inpatient settings, and re-provision of care in a range of community settings comprising a smaller number of NHS inpatient continuing care beds, often in community locations, and a wider range of placements in care homes, supported accommodation, and intensive community care packages.

2. The development of community mental health teams and community services, and their subsequent further development to provide primary care, early intervention, assertive outreach and crisis resolution supports.

3. More focussed and effective use of inpatient beds characterised by shorter lengths of stay in inpatient episodes and reducing readmission from post discharge relapse, through the more effective community management of long term conditions in community services by provision of more flexible, responsive, intensive, and where appropriate, 24/7 community service supports.

4. Shifting the balance of care for the management of acute mental health crisis, between care in inpatient settings and care in community settings.

2. LONG STAY CONTINUING CARE BEDS: THE SHIFT FROM "HOSPITAL BASED CARE" TO "CARE IN THE COMMUNITY"

2.1 In a UK context the process of "deinstitutionalisation" of long stay care and development of "care in the community" has been the dominant factor in shifting the balance of care between inpatient beds and care in a wider range of community settings [2].

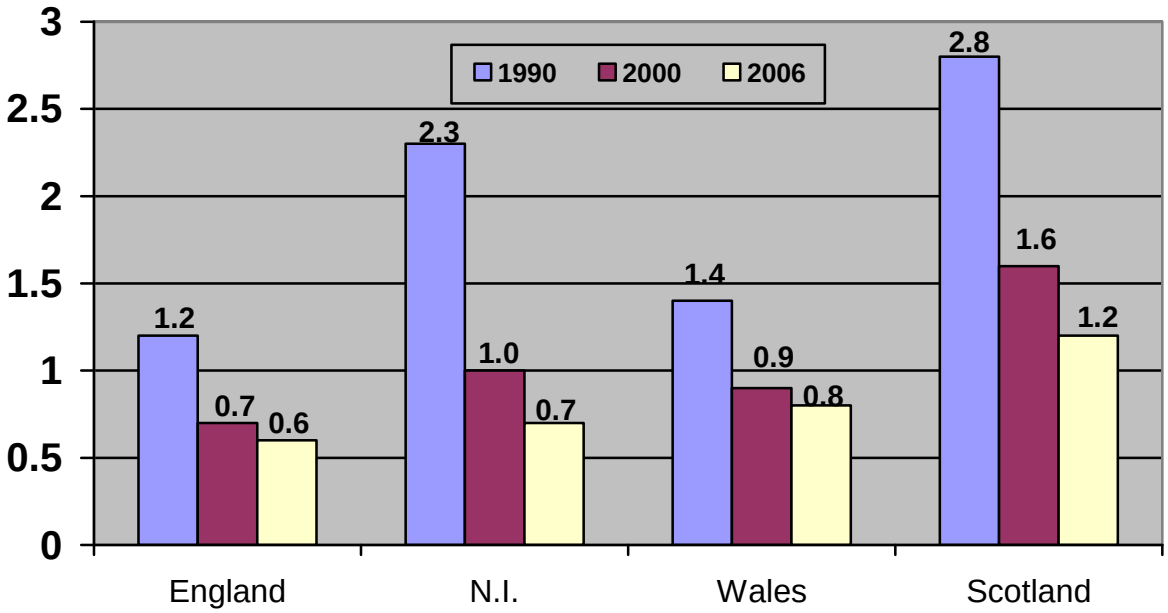
2.2 In Scotland in the period 1980 to 2006, hospital based provision reduced by some 65% from 17,200 to 6020 beds [3]. (Acute and long stay adult and elderly beds).

2.3 In Greater Glasgow over the last 20 years in patient bed provision has reduced by about 70% from around 3000 beds to 920 beds – again reflecting the trend to provision of care in community settings through the development of a range of community placements which offset the bed reductions.

2.4 In a broader UK context, the English position over the 30 year period from 1970 to 2006 saw levels of bed provision reduced by some 80% from 123,000 to 24,400 beds, offset by a substantial increase in provision of placements in community settings [4].

2.5 The graph below shows the comparative position for UK countries in terms of levels of beds provided per 1000 population, over the period 1990 to 2006. The figures relate to both acute and continuing care beds – however the levels of acute beds are likely to have remained fairly stable over the period with the major factor being the shift of long stay beds from hospital based care to care in the community [5].

UK bed rates per 1000 population: 1990 to 2006

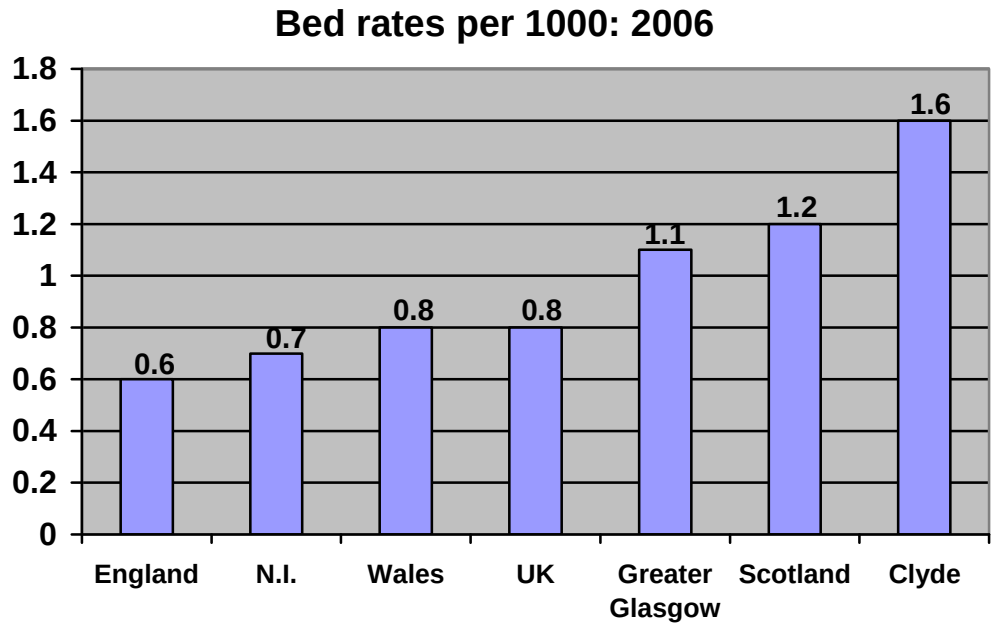


The graph shows:

- All countries within the UK have had a substantial reduction in bed levels over the period with UK average bed levels at 40% of the 1990 levels.
- Substantial variation between the countries within the UK on current bed rates in 2006.

2.6 It is likely the major factor reflected in these differences will be that Scotland and Clyde services are at an earlier stage in their shift from "hospital based long stay care" to "care in the community". Current bed rates in Scotland appear closer to those in place for the rest of the UK around 10 -15 years ago and about 50% higher than rest of UK current rates.

2.7 The graph below shows the comparative levels of beds per 1000 population for 2006 for both Greater Glasgow and Clyde, and for each of the UK countries [6].



The graph shows:

- o Scottish bed levels are 50% above UK average levels.
- o Clyde bed levels are substantially higher than Scottish levels or Greater Glasgow levels.
- o Glasgow levels are lower than the Scottish average but higher than the UK average.

2.8 In Clyde it appears that this process of re-provision of long stay beds is at an earlier stage, as Clyde bed provision is around:

- 35% higher than the Scottish average (acute and continuing care beds).
- 55% higher than the Greater Glasgow rates (acute and continuing care beds).
- 225% higher than Greater Glasgow rates for long stay continuing care beds.
- 45% higher than Greater Glasgow rates for acute assessment beds [7].

2.9 Whilst the figures quoted above reflect both acute and continuing care provision the overwhelming majority of bed reductions have been in long stay continuing care beds with acute bed reductions seeing only more modest reductions [8].

3. CARE IN THE COMMUNITY – OUTCOMES FOR SERVICE USERS

3.1 There is good evidence that this process of "de-institutionalisation" of care, through the move from "hospital based care" to "care in the community", has positive rather than adverse outcomes for service users [9].

- Over-reliance on the provision of long stay continuing care in NHS hospital sites is associated with the negative and detrimental effects of institutionalisation – e.g. progressive loss of life skills, repeated cases of ill treatment to patients linked to geographical or professional isolation of hospitals, and a range of inappropriate practices associated with institutionalisation of both patient and staff groups.

- Transfer to long term community based care shows better outcomes for most patients who had previously received long term inpatient care, when deinstitutionalisation is done carefully. Thus the TAPs study [10] found:

    - Overall patient's quality of life was significantly improved by the move to the community, albeit disabilities remained due to the nature of severe psychotic illness.

    - Very few patients became homeless and none lost to services.

    - No increase in death rate or suicide rates.

3.2 A range of studies have demonstrated that there is no evidence that "deinstitutionalisation" and community care have contributed to higher rates of offending amongst the mentally ill [11].

3.3 More local Greater Glasgow based research provides what appears to be the only Scottish based outcome research [12].

3.4 The study undertook a 10 year follow up of a group of older patients discharged from Gartnavel hospital as part of the extensive programme of care in the community within Greater Glasgow implemented since 1984. This research provides a balanced account of the experiences of this group who had previously been cared for in an inpatient setting for an average of 33 years. This follow up study found:

- Discharge from hospital had been successful with no significant change in mental state or symptomatic presentation post discharge – whilst for a younger cohort of patients an improvement of mental state has been found in other studies, the finding in the Glasgow study is probably consistent with the older age group and course of their illness which had reached the plateau.

- Supported accommodation placements were of high quality both in terms of the physical environment of care and in terms of proactive support to retain or develop independent living skills – good links with community secondary care services were in place for this group.

- Nursing home placements were of more variable quality, albeit the physical environments of care were generally of higher quality than the old long stay wards.

3.5 In Greater Glasgow, we have re-provided care in community settings to over 2000 patients formerly cared for in long stay beds. Our local experience has persuasively demonstrated such arrangements have frequently improved the quality of life for service users – albeit the process requires careful preparation and ongoing support, working closely with both patients and their carers.

4. ACUTE INPATIENT CARE AND THE MANAGEMENT OF ACUTE CRISIS IN COMMUNITY SETTINGS

4.1 There are no persuasive arguments or data to support a hospital only approach. Nor is there any scientific evidence that community services alone can provide comprehensive care. The weight of professional opinion and results from available studies support balanced care [13].

4.2 This paper has already noted the long term trend, to reduce the dominance of inpatient care and increase the comprehensiveness of community care. However it has also noted that the majority of bed reductions relate to the re-provision of long stay continuing care beds, rather than short stay acute assessment beds which have remained more stable.

In a Scottish context:

- Average spends on community services is around 32% of all expenditure.
- Greater Glasgow services have the highest proportion of spend on community services at 45%.
- The Clyde service has the second lowest proportion of spend on community services at 23% of spends [14].

4.4 There is no definitive guidance or evidence base concerning the balance of care between inpatient and community care for a given population. There is however a general consensus that comprehensively developed community services are required to sustain lower levels of hospital provision [15].

4.5 It is however clear that there is substantial sub optimal use of inpatient beds. Thus the National Bed Inquiry 1999 [16] (England – no Scottish equivalent available) found:

- 29% of admissions to acute mental health beds would not have been necessary had resources been available to provide care at home or in another community setting.
- 24-58% of patients in acute assessment beds stay longer than needed due to shortfalls in:
    - Ordinary housing.
    - Home based community support such as group homes or rehabilitation services.
    - Shortfalls in secure provision and an over reliance on high secure beds in the absence of more developed secure beds at a range of lower levels of security.
- Peak need for inpatient services for adults is the 25-44 age groups for whom the GG&C population is expected to fall by up to 8%.

4.6 Similar observations were found by Quirk & Lelliot [17] who describes the English position as being characterised by high levels of bed occupancy which compromise care, bed blocking due to lack of suitable community based accommodation, ward environments characterised by violence, and community care being compromised by lack of easy access to inpatient beds in crisis situations. It should also be noted that the English position has also been characterised by use of boarding out to private hospitals, which may be understated in the English acute bed use rates by a factor of circa 5-10%.

4.7 No comparable Scottish figures are available – however experience suggests the majority of findings are directly applicable into a Scottish context, with the exception of high occupancy levels and resort to use of private hospital placements, both of which appear less characteristic of Scottish mental health services.

4.8 In considering the projections for future need, the National Beds Inquiry (1999) and its consultation outcomes concluded (in an English context) that:

- Within each local community the requirement for acute mental health beds needs to be assessed in the context of the whole mental health system.

- Requirements were dependant on demography, a range of socioeconomic indicators, and the positive effect of community services such as crisis intervention and assertive outreach.

- There was no shortfall of beds per se, albeit there was a sub optimal use of beds and an imbalance of specialist beds which needed to be addressed by:

    - Rebalancing of beds between specialised functions.

    - Development of more robust community service options.

4.9 Notwithstanding the clear shortfalls experienced in the operation of inpatient wards, summarised by Quirk and Lelliot above, the National Beds Inquiry consultation concluded such issues were best addressed by optimising the functioning of the whole service system rather than an expansion of beds per se.

4.10 Our own experience within Greater Glasgow would echo the above view as being applicable within both a Glasgow and Scottish context.

4.11 It is salutary to note that these conclusions about required bed levels were in a service system currently operating at bed levels:

- 30% lower than Greater Glasgow for adult acute beds.

- 50% lower than Greater Glasgow for elderly acute beds.

- 70% lower than Clyde levels of provision (all acute assessment and long stay beds) [18].

4.12 Scottish figures are not available which distinguish between acute assessment and long stay beds - however in overall terms English levels of bed provision are 60% lower than those for Scotland and 70% lower than current Clyde bed levels [19]. Greater Glasgow is likely to be at the lower end of acute assessment bed provision for Scotland, but higher than then the English position.

4.13 In the context of the Clyde strategy the use of benchmark tools for the development of community services has sought to ensure high levels of community services are funded and developed. Higher levels of community supports are required to sustain the rebalancing of care proposed, and the associated bed reductions in the Clyde Strategy.

4.14 Other studies have noted the development of the "new long stay" cohort of patients, perhaps with treatment resistant illness, who would benefit from a more prolonged period of rehabilitation than that provided by short term acute assessment beds, or from access to a greater range and availability of highly supported community settings [20].

4.15 The Clyde Strategy proposals for provision of Intensive rehabilitation beds, and adult long stay continuing care beds managed as NHS inpatient beds has reflected a recognition of the needs of the "new long stay" group who would benefit from a more prolonged period of rehabilitation.

Crisis Resolution Services

4.16 A major problem with the earlier stages of implementation of community care was that although it could care for people during their relatively stable periods, it was unable to cope with patients during relapses.

4.17 This led to a cyclical pattern where people were hospitalised for short periods during a crisis, then discharged into the community until a further crisis arose.

4.18 Crisis intervention aims to treat psychiatric crisis in the community and avoid or reduce the need for time spent in hospital. People with severe psychiatric illnesses may have fragile coping mechanisms. If exposed to excessive stress, these coping mechanisms can breakdown leading to an exacerbation of their acute symptoms for which crisis intervention and resolution techniques can be used.

4.19 The aim of crisis intervention is to prevent or reduce reliance on admission to hospital, further deterioration of symptoms and stress experienced by relatives and others involved in the crisis situation [21]. Crisis resolution services are acknowledged as providing an alternative to admission in some circumstances, but the UK experience to date suggests this is likely to apply to the minority rather than majority of admissions [22.]

5. EVIDENCE ON THE OUTCOMES OF CRISIS RESOLUTION INTERVENTIONS

5.1 As with many mental health interventions, the evidence concerning the effectiveness of crisis resolution services is not at this stage definitive.

5.2 Our local experience within Greater Glasgow has found:

- Reduced pressure on acute bed use following introducing crisis services.
- Patient's use of hospital bed days in the year following the support of crisis/assertive outreach services is lower when compared to prior levels of bed days used for the year preceding these service inputs.
- High levels of user and carer satisfaction.
- Good health outcomes on exit from support reflected in clinical outcomes scales (HoNos/HADS/BPRS), where these were in place and records kept.
- Bed reductions of 10% of acute assessment beds were sustained following the introduction of crisis services, and further bed reductions are expected to follow following the further development of 24/7 supports.

5.3 Elsewhere within a Scottish context, Forth Valley have experienced reduced pressure on inpatient beds following the development of their crisis service, which led to the subsequent closure of acute admission beds reflecting a shift in the balance of care from inpatient to community services of about 17%.

5.4 There is indicative evidence [23] that where services have comprehensive community services in place, including crisis services, this is associated with reductions of acute admissions of around 20% and reductions in use of acute beds by 10%. These results were found in services covering 50% of England, and so represent extensive real world experience in a UK context, for an unusually large population and range of services.

5.5 The Royal College of Psychiatrists has identified that Crisis Resolution Services should provide the following additional advantages over standard community care or hospital based care:-

- Short term intensive treatment for people with severe and enduring mental health problems who are at risk of hospitalisation.
- 24 hour access to multidisciplinary assessment, care and treatment.
- Maximise existing support networks including family and friends and thus minimise disruption to users and carers.
- Good interface between primary care, social work department, police and accident and emergency services.
- Assist with issues in relation to accommodation, occupation, leisure activities, social inclusion and the health and wellbeing of children. (Community mental health care Council report. Royal College of Psychiatrists).

5.6 Similarly Assertive Outreach Teams have also developed a specialised role in supporting a specific population of hard to engage high need users, who would not be adequately supported by standard community services. These teams deliver intensive psychosocial and practical support, and treatment and rehabilitation to a core group of vulnerable patients. They are multi-disciplinary and interagency, and provide a highly co-ordinated and intensive service (some provide 24 hour care 7 days a week, monitoring and managing symptoms including crises. This approach enables patients who would otherwise require inpatient care to remain well enough to live in the community without recourse to hospital admission for a longer period of time. (Community mental health care Council report, Royal College of Psychiatrists).

5.7 More relevantly it has been applied in a service context directly comparable to the stepped care model [24] which underpins the Clyde Strategy, and in services which have used similar benchmarking tools to approach the development of their community services.

5.8 Few randomised control trials of crisis services have been undertaken. The Islington study on the functioning of crisis resolution services compared to standard treatment in inpatient settings found [25]:

- Patients receiving care from crisis resolution teams are less likely to be readmitted to hospital in the eight weeks following a crisis than is the case for inpatient care, albeit more so for voluntary than compulsory patients;
- There were no significant differences over a six-month period in rates of attempted suicide and violence or of participants losing their jobs or becoming homeless;
- High levels of user acceptability and preference compared to inpatient services, albeit the research findings are variable on this issue.

5.9 However whilst suggestive, this evidence does not yet definitively demonstrate improved health outcomes per se in terms of the “gold standard” of the Cochrane Collaboration evaluation of randomised control trials. In terms of the Cochrane “gold standard” the findings to date are more equivocal, with very few research studies of sufficient rigour to meet the Cochrane criteria. In the more cautious and measured language of the Cochrane standards the Cochrane findings indicate that comparing crisis intervention responses to inpatient care [26]:

- No significant differences in death rates or mental state between both forms of care.
- Half of those supported by crisis intervention were eventually admitted to inpatient services.
- Crisis interventions and associated home care supports may help reduce readmissions.
- Crisis interventions are more effective at retaining user engagement with services and reducing family burden.
- Crisis interventions are found to be a more satisfactory form of care to both service users and carers.

5.10 The need for evidence based interventions is supported, and this section has sought to explore these issues thoroughly.

5.11 However there are many mental health interventions for which the evidence is suggestive rather than definitive (e.g. inpatient care which also has a weak evidence base in terms of randomised control trials) however lack of rigorous evidence should not be mistakenly assumed to be evidence of ineffectiveness. In the "pragmatic realities" of local service redesign it is often the case that judgements are required in the absence of definitive evidence.

5.12 Our local judgement, based on wider experience than any other service in Scotland, is that crisis resolution services are highly valued by service users and carers as often being preferable to inpatient admissions, are effective, and are likely to substitute for between 10 - 20% of inpatient acute assessment beds. We have therefore reflected this in the benchmarking model which has assumed bed levels for adult acute assessment beds at 10% below current Greater Glasgow rates. These judgements are broadly consistent with experience elsewhere in the UK [27], but it is accepted that these are nevertheless judgements.

5.13 These assumptions make a difference of about 8 beds overall and about 4 beds in practice, given that bed levels are provided above benchmarks where ward sizes require this.

5.14 Whilst the debate about the efficacy and impact of crisis service will doubtless continue there is a need to keep this debate in context by recognising that in the context of the Clyde strategy the assumptions concerning crisis services have a marginal impact. The major proposals in the Clyde strategy relate to the implementation of the shift from "hospital based long stay care" to "care in the community" - for which there is a good evidence base of positive outcomes for service users, and where it can be demonstrated that Clyde services are at a radically earlier stage of implementation than the rest of Scotland or the UK.

6. PROPOSED BED LEVELS: OVERALL

6.1 There is no definitive evidence base for a particular level of beds for a given population or for the health outcomes of a given balance of care between inpatient and community services.

6.2 Determining bed levels requires judgements taking account of epidemiological norms (where these exist), benchmarking against other services, and local needs assessments of the pattern of actual usage of beds.

6.3 In the case of long stay patients the requirements are particularly influenced by the outcomes of the individual needs assessments of the current patient cohort. These needs assessments are based on a combination of more general clinical assessments, and detailed individual needs assessments. It should be noted that the needs of some patients change over time and there will always require being a degree of flexibility around planning assumptions to reflect this.

6.4 Additionally UK experience suggests that the most deprived areas require bed levels of 2 to 2.5 times those of the least deprived areas. Whilst social class influences deprivation it also has a significant impact on needs for mental health services because of its effect on the course of the illness. Deprivation is associated with longer duration of episode, greater risk of relapse, poorer treatment response and clinical outcome, disproportionate use of psychiatric services and differing perceptions of psychiatric illness [28].

6.5 In a Greater Glasgow context the local variance sees difference in admission rates between the highest and lowest deprived local authority areas of 1.9 times, and is therefore consistent with a 2 fold variation in provision between high and low deprivation areas described above.

6.6 The Greater Glasgow bed levels were themselves determined by the process described above through a cross referencing process of:

- Use of epidemiological norms.
- Benchmarking with other comparable demography's.
- Local needs assessment of the pattern of bed use.
- Local judgement on positioning Greater Glasgow levels taking account of the above 3 factors [29].

6.7 The initial development of bed levels for Clyde therefore extrapolated from Greater Glasgow bed levels per 1000 relevant population (i.e. adult or elderly), and applied a weighted deprivation factor to that extrapolation to reflect differences between the demography of Greater Glasgow and the various areas within Clyde.

6.8 The Independent Scrutiny Panel were concerned that the bed modelling should be more transparently located within a wider context than Greater Glasgow [30].

6.9 Sections 7- 10 below have therefore sought to provide that context by:

1 Locating Clyde, Glasgow and Scottish bed levels in a comparative and UK context.

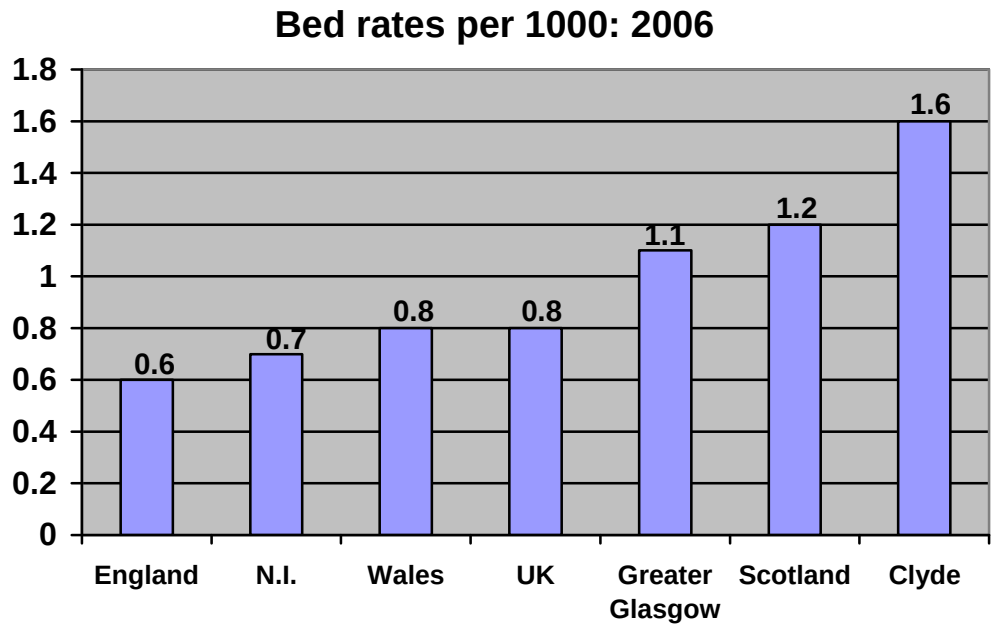
2 Setting out the proposed bed levels based on the Greater Glasgow benchmarking extrapolation process described above.

3 Reviewing the proposed bed requirements by benchmarking each type of bed in a GG & C, Scottish and UK context supplementing this analysis with epidemiological norms and local needs assessments where these are available.

7. LOCATING CLYDE, GLASGOW, AND SCOTTISH BED LEVELS IN A UK CONTEXT

7.1 The table below sets out the bed levels per 1000 population for each of the UK countries and locates the Greater Glasgow and the Clyde levels of provision within that context.

Comparing local bed rates to those elsewhere within the UK



Source: ISD and DH Statistical returns supplemented by local analysis: adult and elderly acute and continuing care beds [31].

7.2 The table shows:

- Substantial variation in current bed levels between the countries within the UK.
- Bed levels for Scotland are the highest in the UK and about 50% above UK average levels and double the English levels.
- Clyde bed levels are 35-40% higher than Scottish levels or Greater Glasgow levels.
- Glasgow levels are lower than the Scottish average but higher than the UK average.

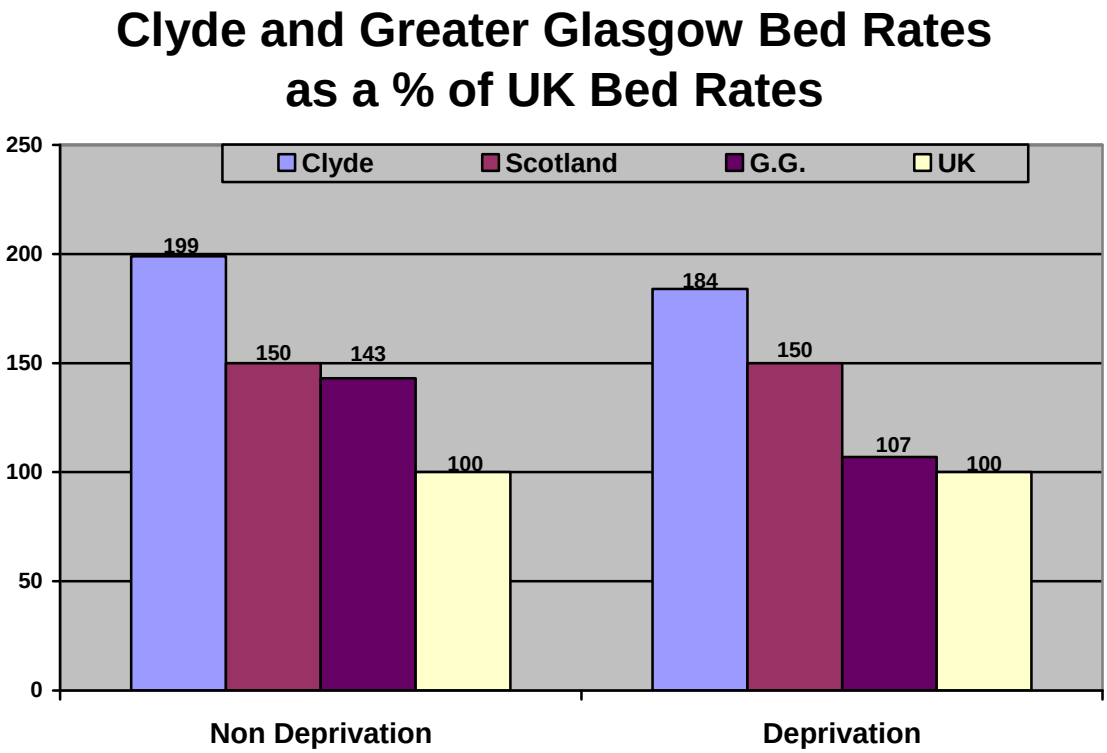
7.3 It is likely the major factor reflected in these differences will be that Scotland and Clyde services are at an earlier stage in their re-provision of long stay care from “hospital based care” to “care in the community”.

Table 2: Clyde and Greater Glasgow bed levels as a % of bed levels in each UK country

Comparison of Clyde and Greater Glasgow to other UK bed rates

	non deprivation adjusted			deprivation adjusted	
	Clyde %	GG %		Clyde %	GG %
England	292	194		250	146
N. Ireland	229	153		197	115
Wales	201	134		172	101
Scotland	136	91		117	68
UK average	199	143		184	107

7.4 The table above compares the bed levels for Clyde to those of England, N. Ireland, Wales and Scotland. For simplicity the graph below has compared Clyde, Greater Glasgow and Scotland to the UK. The graph below therefore shows Clyde, Scotland, and Greater Glasgow bed rates as a % of UK wide bed rates. Both the tables and the graphs present these without a deprivation adjustment and with a deprivation adjustment.



Source: ISD and DH Statistical returns supplemented by local analysis: adult and elderly acute and continuing care beds [32].

7.5 The left hand columns of the table and graph compare the bed levels for Clyde, Greater Glasgow and Scotland with the UK. The table shows that without deprivation adjustments:

- Current Clyde levels of beds are substantially higher than Scottish levels, and double the UK levels.
- Greater Glasgow beds are a little lower than Scottish levels and 43% above UK average levels.

7.6 The right hand columns attempt to illustrate the impact of deprivation on these comparisons to reflect a two-fold variation of bed use between high and low deprivation areas (as set out in Para 7.2). This means that highest deprivation areas can be expected to require bed levels 33% higher than average deprivation areas, whilst lowest deprivation areas can be expected to require bed levels 33% lower than average deprivation areas.

7.7 The Greater Glasgow deprivation adjusted column weights the figures at the highest deprivation level.

7.8 The deprivation adjusted to Clyde column in effect provides half the weighting applied to Greater Glasgow to reflect that Clyde services are above average deprivation for Scotland but at about half the rate for Glasgow. This is an inexact methodology but attempts to reflect some recognition of deprivation consistent with national and local experience of the impact of deprivation on bed use.

7.9 The table shows that factoring in the deprivation adjustments:

- Current Clyde levels of beds are substantially above Scottish levels, and 84% higher than the UK levels – the deprivation figures do however reflect a modest reduction in the degree to which Clyde bed levels exceed the rates in other areas (i.e. 84% above UK average rather than 99%).
- Greater Glasgow beds are now seen to be more substantially below Scottish levels and only 7% above UK average levels.

Summary

7.10 The analysis above has shown that:

- Clyde bed levels are the highest in Scotland substantially above the Scottish average and double the UK average.
- Greater Glasgow bed levels are close to average in a Scottish context but above average in a UK context.
- When the impact of deprivation is factored in Greater Glasgow bed levels are somewhat below the Scottish average but remain above though close to the UK average.

8. COMPARING LOCAL ADMISSION RATES IN A GG & C AND SCOTTISH CONTEXT

8.1 The table below compares hospital admission rates for the various local authority areas in the GG & C area.

Comparative admission rates : Clyde, Greater Glasgow and Scotland

	Administration	Population	% average Scotland	% of average Greater Glasgow
East Renfrewshire	280	90 000	58	60
East Dunbartonshire	337	106 000	60	61
West Dunbartonshire	466	91 000	96	99
Glasgow City	3 463	579 000	112	115
Renfrewshire	1 026	170 000	113	116
Inverclyde	713	82 000	163	168
A&C	**2 507**	**414 022**	**114**	**117**
GG	**4 496**	**867 787**	**2762**	**100**
GG&C	**6 285**	**1118 000**	**105**	**105**
Scotland	**27 136**	**5090 550**	**100**	**100**

Source ISD Scotland 2004/05 Admission Statistics supplemented by local analysis [33].

8.2 The table shows:

- Admission rates for Inverclyde were overwhelmingly higher than the Scotland average and all local areas - whilst deprivation levels are close to the Greater Glasgow average.
- Admission rates for Renfrewshire were:
    - At the same level as the most deprived area of GCC for demography closer to the least deprived areas of ERC or EDC whose admission rates were 40% below Greater Glasgow averages.
    - Higher than Scottish rates for a population of below average deprivation.
- Argyll and Clyde admission rates were 17% higher than Greater Glasgow rates for demography of substantially lower deprivation levels, albeit these admission levels appear closer to Scottish average levels [34].

8.3 The table highlights that the Clyde services are substantially more reliant on hospital admission than the Greater Glasgow services. The table illustrates that the Clyde services with a balance of care with lower levels of community services appear more reliant on the use of higher levels of inpatient services. By contrast the Greater Glasgow services have a more even balance of care between inpatient and community services and appear to be less reliant on inpatient admissions.

8.4 It is clear from the local engagement events and a wealth of literature on user preferences [35], that service users generally prefer care in community rather than inpatient settings, albeit they are concerned to have good access to inpatient services when necessary.

8.5 It is also clear that user organisations and local authorities which spanned both the A&C Board area and the Greater Glasgow Board area showed a very clear preference for the more even balance of inpatient and community services reflected in the Greater Glasgow balance of care, compared to the more hospital dominated balance of care reflected in the Clyde services.

Summary

8.6 The major population of Clyde is located in Inverclyde and Renfrewshire. In terms of admission rates to hospital beds:

- Both areas have very high admission rates in a Scottish context.
- Even higher admission rates when compared to the much lower admission rates for Greater Glasgow areas with higher deprivation levels.
- This reflects a more hospital-dominated balance of care in Clyde than is the norm elsewhere in Scotland.
- The more even balance of hospital and community services of Greater Glasgow services is showing close to average admission rates for a deprivation level in which admission rates might be expected to be 33% higher than average.
- Service users and local authority partners have expressed a clear preference for the more evenly balanced care model of Greater Glasgow.

9. THE BALANCE OF CARE, INPATIENT BED LEVELS, AND SERVICE OUTCOMES

9.1 The Independent Scrutiny Panel were concerned to understand whether higher or lower bed levels could be demonstrated to have a better or worse impact on health outcomes for a local population. [36]

9.2 This is an important issue - however there is no clear evidence base which can be used to provide a definitive answer. In the absence of such an evidence base the paragraphs below have set out a comparative analysis of the respective Greater Glasgow and Clyde services in terms of a range of service efficiency and effectiveness outcomes supplemented by some very limited available information on population health outcomes. The comparison has used the recently published information from the Scottish Benchmarking Project (Nov 2007) [37] as the basis for the core of this analysis, supplemented by local information and analysis to more accurately reflect the Greater and Clyde detail and provide deprivation adjusted comparative performance assessments.

9.3 The Greater Glasgow services have sustained lower bed levels and lower reliance on hospital admission for a number of years and there is a broad clinical consensus that the current balance of care does not lead to non admission to hospital supports when required. Additionally Glasgow hospitals operate with low levels of boarding of patients to other hospital catchments. National figures do not enable a comparison of this position across services in Scotland. However the local experience is that Greater Glasgow provides more bed days to other Boards than it uses such bed day's resultant from its own boarding out [38].

9.4 In a Scottish context Greater Glasgow services:

- Have close to average spend for Scotland
- Below average bed levels
- The highest levels of community provision in Scotland
- Average readmission rates
- Below average lengths of stay
- Amongst best in Scotland for delayed discharges
- High proportion of Community to inpatient use of compulsory treatment orders
- Average levels of suicide

9.5 The above assessment shows Greater Glasgow services to be performing at or better than the Scottish average before taking account of deprivation. If the impact of deprivation is factored in to the above performance measures Glasgow has best or second best in Scotland performance on this "basket" of measures - notwithstanding other services having higher bed levels, lower levels of community care and higher or equivalent spending levels.

9.6 By contrast Clyde services, with higher spending and higher bed levels, perform consistently poorer than Glasgow and at or poorer than the Scottish average on all the above measures except suicide (N.B. Clyde data unavailable for 2 of the 8 measures). When differential deprivation is factored in the comparative position between the Greater Glasgow and the Clyde services position becomes starker still, and the suicide differential disappears.

9.7 In terms of the transfer of long stay beds from “hospital based care” to “care in the Community” the issues have been rehearsed in sections 2 and 3 of this report, which show that the outcomes of this model of care are both beneficial and evidence based, subject to careful implementation. The provision of substantial levels of hospital based long stay continuing care beds on the Dykebar and Ravenscraig sites reflects the current position to be substantially reliant on “hospital based care” for long stay beds. The proposals in the Strategy reflect a move to “care in the community” models of service provision in which the long stay beds are re-provided at a substantially lower level as part of a wider range of placements and community supports.

9.8 Some 80% of the proposed bed reductions relate to the implementation of care in the community for long stay care, for which there is a clear evidence base and which simply catches up with the prevailing practice of UK services which have seen this policy progressively implemented since the 1950’s, and in particular implemented over the last 30-40 years and reflected in a 60-80% reduction in inpatient bed levels in all countries within the UK. On this issue the proposals for Clyde services are long overdue and simply “catching up” with the prevailing practice of the last 30-40 years.

9.9 Taking the service system performance measures above, together with the good outcomes evidence for the re-provision of long stay beds, suggests that the balanced care model of Glasgow is both effective and evidence based, and operating more effectively than Clyde services and a range of other Scottish services operating with higher bed levels and lower levels of community services.

9.10 In this context it is suggested that bed norms closer to Greater Glasgow levels are more appropriate than bed norms closer to the Scottish average, which seem to reflect an earlier stage in the re-provision of long stay beds. The detailed issues of the determination of actual bed requirements are rehearsed more fully in section 10.

9.11 Using the weighted benchmarking methodology for Clyde bed levels results in overall proposed bed provision levels at about 10% below Glasgow levels based on application of Greater Glasgow bed rates to the Clyde population, with some level of deprivation adjustment.

10. PROPOSED BED LEVELS FOR CLYDE: ACUTE CARE SHORT STAY ASSESSMENT BEDS: ADULT AND ELDERLY BEDS

Proposed bed levels based on the application of the Greater Glasgow rates and benchmarking methodology

10.1 The table below has summarised the proposed acute admission bed levels for Clyde based on the application of the Greater Glasgow benchmarking methodology. The table sets out the current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Acute admission beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total South Clyde	WDC (Clyde pop)	Total North & South Clyde	Helensburgh / Lochside (provided from GG&C hospital sites)
Current bed levels North & South Clyde							
Acute admission							
Acute Adult	45	66	9	120	18	138	6
Acute Elderly	20	35	5	60	8	68	4
Sub total	**65**	**101**	**14**	**180**	**26**	**206**	**10**
Benchmark extrapolated from Greater Glasgow							
Acute admission							
Acute Adult	25	42	6	73	14	87	4
Acute Elderly	17	26	3	46	8	54	2
Total	**42**	**68**	**9**	**119**	**22**	**141**	**6**
Current North & South Clyde to Greater Glasgow levels							%
Acute admission							
Acute Adult	180	157	150	164	129	159	150
Acute Elderly	118	135	167	130	100	126	200
Total	**155**	**149**	**156**	**151**	**108**	**146**	**167**
Proposed bed numbers (Benchmark adjusted to reflect local judgement and best fit to ward sizes)							
Acute admission							
Acute Adult	20	42	6	68	12	80	4
Acute Elderly	20	35	5	60	12	72	6
Total	**40**	**77**	**11**	**128**	**24**	**152**	**10**

Notes to the table:

1. The figures for East Renfrewshire Council and West Dunbartonshire Council relate to the catchments populations served by the previous Argyll and Clyde Health Board and don't include the full local authority catchments

2. The provision of beds for older peoples mental health acute admission beds in Renfrewshire is being led by the Renfrewshire Older Peoples Planning, Performance and Implementation Group. The application of the standard benchmarking methodology would see proposed bed provision at 26 beds. The Renfrewshire Older Peoples Planning, Performance and Implementation Group will further review the proposed level of provision at between 26 beds per the benchmark and 40 beds (the current level of provision) to determine the balance of care between inpatient and community services.

3. Helensburgh and Lochside services are commissioned by the Highland Health Board. The table above reflects the services to that population provided from the Vale of Leven site, which would be affected by the proposals in this report. The figures for Helensburgh / Lochside in the proposed bed requirements are based on the standard Benchmarking for services with developed community services, supplemented by local judgement. The Highland Health Board has indicated it would wish to ensure the Helensburgh / Lochside population continued to access the services also accessed by the Dumbarton and Alexandria population.

Locating the proposed bed levels within a wider range of service benchmarks and epidemiological service norms

10.2 The table below summarises a range of epidemiological norms and benchmarks for provision of adult and elderly acute assessment beds, and shows the level of beds proposed by application of the Greater Glasgow benchmarks.

10.3 Judgements about bed levels are necessarily an imprecise art in which proposals are cross referenced against benchmarks of actual practice in other areas, and a range of service norms where these exist. There are no single norms which have universal support, and the approach tries to position bed levels within the range of the various norms and benchmarks. It should be noted that the epidemiological norms are themselves partially derived from observation of actual service levels for a population and given the substantial shifts in bed rates over the last 25 years the older norms are likely to be less useful.

10.4 The national information on Scottish beds is weak in that it fails to distinguish between acute assessment and long stay beds. It is therefore not possible to provide UK benchmarks at the level of bed type. However more accurate information is available for both local and English services and therefore available English benchmarks are used. In general the English levels are likely to be around 10-20% lower than UK average levels.

Source	summary	rate per 1000	GG current/ planned	Clyde current	norm	proposed Clyde
adult acute						
RCP with higher development of community services [39]	0.29 per 1000 adult popn	0.29	316	138	61	80
England adult actual : 11761 beds [40]	0.36 per 1000 total popn	0.36	316	138	76	80
Greater Glasgow adult and crisis adjusted		**0.38**	**316**	**138**	**80**	**80**
Wing - adult acute [41]	360 per 900k adult popn	0.40	316	138	84	80
MINI [42]	41 per 100k adult popn	0.41	316	139	86	80
RCP with lower levels of community services [43]	0.5 per 1000 adult popn	0.5	316	138	105	80
elderly acute						
England elderly actual : 6945 beds [44]		0.6	165	68	32	72
RCP 1-2 beds per 1000 elderly popn [45]		1.5			78	
Greater Glasgow elderly MMH planned deprivation adjusted			165		54	72
Greater Glasgow elderly MMH planned no deprivation adjustment		1.2	165	68	64	72

10.5 For adult acute admission beds the table shows a range of service norms indicating bed levels of between 61 and 86 beds for services with developed community services. The weighted benchmark has proposed provision at the upper end of that range of 80 beds, subject to the planned investments in community services proposed in the strategy. This is a higher level than that proposed by the RCP (Royal College of Psychiatrists) for bed levels for services with higher levels of community services.

10.6 Whilst practitioners have expressed a variety of views on the proposed bed levels, including the fear they may be too low, none of the views expressed has provided grounds for evidencing particular local circumstances which suggest a departure from provision at the upper end of the benchmarked range, subject to the investment in community services, without which lower bed levels could not be sustained.

10.7 For elderly acute admission beds there are no direct epidemiological service norms against which the analysis can be cross referenced. The table shows the service benchmark requirements in the range of 32 to 78 beds compared to the current bed levels of 68 beds. However whilst the strategy has noted the benchmark norms, it has left the status quo bed levels in place with the exception of a small shift in the balance of adult and elderly bed levels based on the local assessment in WDC.

10.8 The rationale for this approach is:

- The major reductions would apply to Renfrewshire where the Renfrewshire Older Peoples Planning Group leads on the planning for all older peoples services including older people's mental health and elderly acute bed levels will be further reviewed through that process.
- Reductions in Inverclyde would take ward size below 20 beds and beds are therefore retained at that size rather than reduced to the benchmark figure of 17.

Summary acute beds

10.9 The Greater Glasgow benchmarking methodology has proposed: a reduction of adult acute admission beds from 130 beds to 80 beds. This level of 80 beds is at the upper end of the service benchmarks and epidemiological norms and higher than the level proposed by the Royal College of Psychiatrists for highly developed community services (as proposed by the Clyde Strategy). The proposed benchmark level of 80 beds is therefore within the range indicated by both epidemiological norms and service benchmarks, albeit at the upper end of that range.

10.10 There are no direct epidemiological norms for the provision of acute elderly beds. The strategy has simply left the current levels of provision for Inverclyde and Renfrewshire in place at 68 beds, and increased WDC levels by 4 reflecting the outcome of local assessments. The above analysis has noted these levels of provision are higher than would be suggested by the service benchmarks and left that issue to be considered and reviewed by the Renfrewshire Frail Elderly Strategy process.

11. PROPOSED BED LEVELS: LONG STAY CONTINUING CARE BEDS

Proposed bed levels based on the application of the Greater Glasgow rates and benchmarking methodology

11.1 The table below has summarised the proposed continuing care bed levels for Clyde based on the application of the Greater Glasgow benchmarking methodology. The table sets out the current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Continuing Care beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total South Clyde	WDC (Clyde pop)	Total North & South Clyde	Helensburgh / Lochside (provided from GG&C hospital sites)
Current bed levels North &South Clyde							
Continuing care							
Adult	31	108	15	154	3	157	1
Elderly	80	59	7	146	8	154	4
Total	**111**	**167**	**22**	**300**	**11**	**311**	**5**
Benchmark extrapolated from Greater Glasgow							
Continuing care							
Adult	9	15	2	26	5	31	1
Elderly	33	52	7	92	16	108	5
Total	**42**	**67**	**9**	**118**	**21**	**139**	**6**
Comparative % current North &South Clyde to Greater Glasgow levels							
	%	%	%	%	%	%	%
Continuing care							
Adult	344	720	750	592	60	506	100
Elderly	242	113	100	159	50	143	80
Total	**264**	**249**	**244**	**254**	**100**	**224**	**83**
Proposed bed levels (benchmark adjusted to reflect local judgement and best fit to ward sizes)							
Continuing care							
Adult	9	12	2	23	3	26	1
Elderly	33	52	7	92	8	100	4
Total	**42**	**64**	**9**	**115**	**11**	**126**	**5**

Locating the proposed bed levels within a wider range of service benchmarks and epidemiological service norms

11.2 The table below summarises a range of epidemiological norms and benchmarks for provision of adult and elderly acute assessment beds, and shows the level of beds proposed by application of the Greater Glasgow benchmarks.

	Rate Per 1000 popn	GG current/ Planned	Clyde Current/	Rate applied to Clyde popn	Clyde proposed
adult continuing care					
England average actual : 2887 beds [46]	0.09	90	157	19	26
GG adult cont care deprivation adjusted	**0.12**	**90**	**157**	**26**	**26**
GG adult cont care no deprivation weighting	0.15	90	157	32	26
Local needs assessment of patient cohort					26 max
Elderly continuing care					
England average actual : 2832 beds [47]	0.25	350	154	13	100
GG elderly cont care per benchmark	**1.23**	**350**	**154**	**64**	**100**
Meltzer elderly cont care [48]	0.38	350	154	20	123

Adult continuing care beds

11.3 The table has summarised the projected benchmark bed requirement of 26 beds. There are no direct epidemiological norms for this service to cross reference the benchmark proposals against. The benchmark proposals do show a substantial reduction in inpatient continuing care provision from current levels of 157 beds. However it is likely this simply reflects that the process of transferring long stay care from “hospital based care” to “long stay care in the community” is at an early stage in Clyde, with high levels of NHS inpatient long stay provision on both the Ravenscraig and Dykebar sites. This mirrors the earlier position in Greater Glasgow and the rest of the UK of 10 -25 years ago, but which has seen overall reductions in inpatient bed provision of c70% offset by development of a range of community placements.

11.4 Local clinicians have undertaken a range of both desktop and detailed individual needs assessment processes to clarify the requirements of the current patient cohort. These assessments have confirmed that the majority of this patient cohort would be more appropriately cared for in a range of community placements as set out in the table below. In essence the local needs assessments appear to confirm that 26 beds represents an upper level of inpatient long stay beds required. Given that individual needs change over time the planning and re-provision process will need to be flexible about revising the exact numbers as the needs of individual become clearer. Based on the current outcome of local needs assessments the table in Para 11.1 below sets out the current assessment of the total placement and bed requirements of the existing group of patients currently care for in Dykebar and Ravenscraig. An upper limit of 26 beds remains somewhat higher than UK or English rates albeit it is likely that current Scottish rates of provision are rather higher – however the Scottish information is not collected in a way which would enable that comparison.

Elderly continuing care beds

11.5 The table above summarises the projected bed requirements for elderly continuing care beds using both benchmark and epidemiological projections

11.6 The benchmark proposes a reduction of continuing care beds from 154 to 100. This figure is at the lower end of the epidemiology norms per Meltzer. However the Meltzer norms require to be interpreted with caution as the norms are themselves based on trends in actual provision in the early 1990's and there will have been substantial further reductions in trends in provision of continuing care beds since these norms were developed. So the norms are likely to be somewhat higher than would be the case from a direct extrapolation from current, rather than historic benchmark levels. However the norm has been reflected given the paucity of such norms.

11.7 Renfrewshire has already implemented a substantial shift in the balance of long stay care for older people from "hospital based care" to "community care" and is already operating at levels close to the benchmark proposals (59 now compared to 52 on the benchmark, excluding ERC). Inverclyde bed provision is currently 80 beds for half the population size of Renfrewshire which is currently operating with only 59 beds. The benchmark proposes 33 beds for Inverclyde which would be broadly consistent with coming closer to those levels already operating in Renfrewshire.

11.8 Local clinicians have undertaken a range of both desktop and detailed individual needs assessment processes to clarify the requirements of the current patient cohort and have confirmed that a significant proportion of this patient cohort would be more appropriately cared for in a range of community placements as set out in the table in Para 11.10 below.

Placement requirements of existing cohort based on outcomes of local needs assessments

11.9 The tables below summarise the outcome of local clinically based needs assessments of the current cohort of patients cared for in long stay beds on the Dykebar and Ravenscraig sites.

Current arrangements

Form of Care	Number of Beds
NHS inpatient continuing care on hospital sites – adults	157
NHS inpatient continuing care on hospital sites – elderly	154
Total	**311**

Proposed arrangements

Form of Care	Number of Beds / Placements
NHS inpatient continuing care for adults on hospital sites	26
Inpatient continuing care for older people located on community sites	100
Care home placements	60
Supported accommodation placements	51
Intensive community supports	7
Total inpatient beds and placement requirements	244
Vacant beds : no placement required	67
Total	**311**

Summary

11.10 The proposals see:

- Acute assessment beds reduce by 54 beds from the current level of 206 beds to a proposed level of 152 beds – a 26% reduction – the proposals are at the upper end of the ranges suggested by the epidemiology/service norms for adults and unchanged for elderly acute beds.
- Continuing care beds reduce by 185 beds from the current level of 311 beds to 126 beds – a 60% reduction in actual beds and a 50% reduction compared to currently occupied beds.
- These continuing care bed reductions will be offset by a range of community placements as set out in the table above. These placement plans are based on the outcome of local clinical needs assessments which have confirmed that local needs assessments and benchmark projections are broadly consistent with each other:

11.11 This move of long stay continuing care beds, from hospital based care to care in community settings, is consistent with the evidence base, which demonstrates good outcomes for service users. The scale of the shift is consistent with the long term trend throughout the UK, Scotland and Glasgow and reflects that Clyde services appear to have a higher proportion of its patients still cared for in hospital settings than any other area of Scotland.

Doug Adams
Head of Planning and Performance GG&C
January 2008

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APPENDIX 6

MODERNISING MENTAL HEALTH SERVICES FOR CLYDE

ADULT AND OLDER PEOPLES MENTAL HEALTH SERVICES FOR INVERCLYDE, RENFREWSHIRE, WEST DUNBARTONSHIRE AND EAST RENFREWSHIRE

Report on an Option Appraisal Exercise of Strategic Options

Final Report V1
24 February 2008

Contents

Introduction

This report describes the results from an option appraisal exercise that was undertaken at a series of workshops in November and December 2007 and January 2008. The workshops were attended by a wide range of clinicians, NHS managers and staff, stakeholders and patient/service user representatives. The objective of the option appraisal exercise was to use a systematic and structured process to identify preferred strategic options for modernising Mental Health Services in Clyde. The exercise covered the following services:

- Adult Mental Health Admissions & Elderly Psychiatry Admissions for South Clyde
- Intensive Mental Health Rehabilitation Service
- Intensive Psychiatric Care Unit (IPCU)
- Addiction Services
- Elderly Psychiatry (East Renfrewshire activity)
- Adult Mental Health Admissions & Elderly Psychiatry Admissions for West Dunbartonshire

The report has been prepared by Roger Tanner, an independent management consultant and Visiting Professor at Glasgow Caledonian University, who also facilitated the option appraisal workshops and provided expertise to ensure that the process adopted was compatible with the Scottish Government's current guidance on option appraisal in the NHS.

The Option Appraisal Process

Guidance on option appraisal in the NHS is provided in three main documents:

- HM Treasury's "The Green Book – Appraisal and Evaluation in Central Government"
- The Scottish Government's " NHS Capital Investment Manual"
- NHS HDL(2002)87 Revised Interim Capital Guidance and HDL(2003)13.

The option appraisal described in this report sought to comply with this guidance as well as providing evidence of a robust decision making process that led to the identification of the preferred strategic options for modernising Mental Health Services for Clyde

The option appraisal process had three key stages:

- An appraisal of the non-financial benefits, risks and costs of the options
- Sensitivity analysis – making changes in key assumptions and variables and examining the impact of these changes on the results from the appraisal of options
- Using the results from the first two stages to identify preferred strategic options for each service - one that maximises the benefits to patients and staff, provides good value for money, is affordable and has a manageable level of risk associated its implementation.

In accordance with the guidance, the process developed a number measures to enable options to be compared:

- **Weighted Benefit Score (WBS)** – a measure of how good the workshop participants considered the options to be at delivering the desirable benefits from the investment in the services. Options with high WBS are preferable. The options were scored against a set of weighted benefit criteria:
    - Safe & effective care

- Access to services
- Quality of environment
- Service interfaces/co-locations
- Strategic fit

- **Risk Score** – a measure of how risky the workshop participants considered the options to be taking into account the probability and impact of a range of risks associated with implementing the options. Options with low risk scores are preferable.

- **Net Present Cost (NPC)** – a composite measure of the estimated capital, revenue and lifecycle costs of the options over 60 years. Options with low NPC are preferable. Again, in accordance with the guidance, this measure excludes VAT & Capital Charges (interest & depreciation on asset value). This is known as an economic appraisal and is different from a financial or affordability appraisal which does take into account real costs to the Board such as capital charges and VAT. Neither does it make any assumptions regarding the availability of either capital or increased revenue costs associated with an option. Hence, the appraisal may identify an option as having the lowest Net Present Cost but it still may not be affordable in terms of the availability of new capital or revenue monies.

- **Cost per Benefit Point** – Combining the benefit scores and the Net Present Cost of options demonstrates which options are dominated by others i.e. cost more and provide less benefit. Options with low cost per benefit point are preferable. Where a "Do nothing" option exists it also enables the cost per benefit point of this option to be compared with the marginal cost per benefit point of moving to the preferred option which should favourable i.e. the marginal cost of moving to the preferred option should be less than the cost per benefit point of the "Do Nothing" option.

The ranking of options by these measures should help in the choice of a preferred option. Ideally, a preferred option will achieve the most favourable ranking on all four of the measures.

Sensitivity analysis was performed on the results from the option appraisal by:

- Substituting the consensus scores with more optimistic and pessimistic scores. These were provided by workshop participants to reflect (a) the group's uncertainty around the consensus score or (b) an individual's more optimistic or pessimistic view of the score for a particular option in relation to a benefit criterion.

- Using different sets of weightings on the benefit criteria to reflect different perspective on the relative importance of the individual criterion. Five weighting scenarios were examined:

    - All criteria equally important and weighted the same
    - Criteria weighted from a patient/frequent service user's perspective
    - Criteria weighted from the perspective of the general public
    - Criteria weighted from an NHS Manager's perspective
    - Criteria weighted from a clinical practitioner's perspective

  The weights given for each of these scenarios is shown in the table that follows.

	Weight (Importance)				
	Weighting Scenario				
Criteria	**Equal**	**Patient/Service user**	**General Public**	**NHS Manager**	**Clinical Practitioner**
Safe & Effective Care	**20**	**45**	**31**	**44**	**50**
Access to Services	**20**	**20**	**29**	**11**	**10**
Quality of environment	**20**	**20**	**15**	**15**	**18**
Service interfaces/co-locations	**20**	**10**	**20**	**15**	**17**
Strategic Fit	**20**	**5**	**5**	**15**	**5**
Total:	**100**	**100**	**100**	**100**	**100**

- Changing the estimated outturn costs of options within a plausible range taking into account the uncertainty associated with the estimates of future capital and revenue costs.

Ideally, the choice of a preferred option will not change as a result of changing the scoring, weighting of criteria and costs of options within plausible and realistic ranges i.e. it will remain the options which maximises the desirable benefits and provide good value for money.

Results

The following provides a summary of the results from the option appraisal for each service. More detail on the scoring and weighting and analysis of options from which the summarised results are derived is shown in Appendix A.

Adult Mental Health Admissions & Elderly Psychiatry Admissions for South Clyde

Three options were evaluated for this service and the results are summarised in the table that follows.

		Rank (Based on Patient/Service User weighting scenario)			
Option No	**Option Description**	**Weighted Benefit Score (Consensus)**	**Lifecycle Costs**	**Risk Score**	**Cost per Benefit Point**
1	**Co-locate Adult & Elderly services at RAH**	**2**	**1**	**3**	**2**
2	**"Hot" at RAH; "Cold" at Dykebar**	**3**	**3**	**2**	**3**
3	**Adult Admissions at Dykebar; Eld Admissions at RAH**	**1**	**2**	**1**	**1**

The table shows that Option No 3 has the most favourable ranking in three out of the four measures (Weighted Benefit Score, Risk Score & Cost per Benefit Point) and is ranked second in the remaining measure, Lifecycle costs.

Sensitivity analysis showed that Option No 3 retained its highest ranking when the changes were made in the scores (pessimistic and optimistic), criteria weights were changed to reflect different perspectives and costs were changed within a reasonable range. Therefore, the identification of this option as the preferred one is robust.

Intensive Mental Health Rehabilitation Service

Two options were appraised for this service and the results are summarised in the table that follows.

		Rank (Based on Patient/Service User weighting scenario)			
Option No	Option Description	Weighted Benefit Score (Consensus)	Lifecycle Costs	Risk Score	Cost per Benefit Point
1	Dykebar - Bute Ward	1	1	1	1
2	Inverclyde	2	2	2	2

The table shows that Option No 1 has the most favourable ranking in all four measures.

Sensitivity analysis showed that Option No 1 retained its highest ranking when the changes were made in the scores (pessimistic and optimistic), criteria weights were changed to reflect different perspectives and costs were changed within a reasonable range. Therefore, the identification of this option as the preferred one is robust.

Intensive Psychiatric Care Unit (IPCU)

Four options were appraised for this service and the results are summarised in the table that follows:

		Rank (Based on Patient/Service User Weighting Scenario)			
Option No	**Option Description**	**Weighted Benefit Score (Consensus)**	**Lifecycle Costs**	**Risk Score**	**Cost per Benefit Point**
1	**Status Quo (Dykebar)**	**4**	**1**	**4**	**4**
2	**IPCU Dykebar - New build**	**1**	**4**	**3**	**2**
3	**Inverclyde**	**2**	**2**	**2**	**1**
4	**Partial Inverclyde/Glasgow**	**3**	**3**	**1**	**3**

The table shows that there is no single option that achieves the highest ranking across all of the measures. However, it can be seen that Option No 3 has the overall best ranking across the four measures and in particular, achieves the highest ranking on the important measure of "Cost per Benefit Point". Sensitivity analysis showed that the results are sensitive to changes in weighting and scoring in relation to Option Nos 2 & 3 and that there is little to choose between these options in terms of the economic appraisal. However, Option No 2 requires significantly more capital because of its requirement for a new building and this may lead to selection of Option 2 on the basis of capital availability/affordability.

Addiction Services

Initially, three models of service delivery were appraised:

- Single site model
- Two site model
- Three site model

This initial appraisal clearly showed that the two site model of service delivery was superior in terms of non-financial benefits under all scoring and weighting scenarios. Consequently, a second appraisal was carried out on four options for delivering the two site model. Since all four of these options have the same capital and revenue costs, the decision on a preferred option can be taken by examining the Weighted Benefits Scores and the Risk Score which are shown in the table that follows.

		Weighted Benefit Score (Consensus)					
		Weighting Scenario					
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner	Risk Score
1	Stobhill Hospital & Inverclyde Royal Hospital	560	640	566	644	686	210
2	Stobhill Hospital & Royal Alexandra Hospital	560	635	551	644	674	224
3	Stobhill Hospital & Dykebar Hospital	580	655	580	655	684	213
4	Stobhill Hospital & Leverndale Hospital	600	660	585	670	689	161

Sensitivity analysis showed that there was a high level of consensus reaching on the scoring and that under all five weighting scenarios Option No 4 has the highest weighted benefit score. However, it should be recognised that there is very little difference between the Weighted Benefit Scores of the options which indicates that there is little to choose between them. The lower risk score of Option No 4 supports its selection as the preferred option.

Elderly Psychiatry (East Renfrewshire activity)

Three options were appraised for this service, each deemed to have the same capital and revenue costs. The Weighted Benefits Scores and the Risk Score are shown in the table that follows.

		Weighted Benefit Score (Consensus)					
		Weighting Scenario					
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner	Risk Score
1	Status Quo	740	780	770	755	773	33
2	East Renfrewshire activity at RAH	720	770	733	777	790	153
3	East Renfrewshire activity at Leverndale	740	725	706	734	731	127

Sensitivity analysis showed a high level of consensus reached on the scoring and the table shows that the Weighted Benefit Scores of the options are similar which indicates that there is little to choose between the options. It was therefore concluded that a further CHCP led process be undertaken to further examine the merits of each option in greater detail in order to arrive at a clear preference.

Adult Mental Health Admissions & Elderly Psychiatry Admissions for West Dunbartonshire

At the first workshop held for these services, a number of workshop participants expressed considerable concern in relation to:

- The option appraisal process – too complicated and time consuming
- The options – insufficient information was available and options that they considered feasible were not initially included in the short list for appraisal
- The non-financial benefit criteria – proposed weightings were not accepted as being representative of patients/service users. At an initial workshop participants were provided with an opportunity to re-weight the criteria for the weighting scenario that represented the perspective of the patient/service users but declined to do so.

Having identified these issues at the first workshop, considerable time and effort went into addressing them and eventually a long list of options was developed which included those put forward specifically by the patient/service user representatives. This long-list included the option to integrate junior psychiatric medical cover rotas at Vale of Leven and Gartnavel Royal Hospitals. Whilst such integration of rotas was considered, by medical staff, to carry a relatively high risk of sustainability, it was nonetheless considered as a 'feasibile' option for addressing concerns regarding out-of-hours on-call arrangements for mental health services at Vale of Leven Hospital. This long list was examined in an open workshop session for feasibility, informed by a range of professional inputs and supporting papers. This led to the workshop participants agreeing that a number of options were not feasible and therefore not suitable for taking forward in to a short list which would be subjected to a comprehensive appraisal. The options considered not feasible and therefore excluded from the short list were:

- Options based on resolving the "on-call" difficulties at Vale of Leven Hospital by the development of nurse practitioner posts or by recruiting additional staff grades
- An option to integrate mental health and general acute medical rotas
- Options to transfer out-of-hours admissions from Vale of Leven to Gartnavel Royal Hospital.

These options were all deemed to carry a very high risk in terms of achievability and offer a poorer alternative to the option of addressing "on-call" medical cover difficulties through the integration of Vale of Leven and Gartnavel Royal Hospitals' mental health junior doctor rotas.

The agreed short list of options that was subjected to full option appraisal process is shown in the table that follows.

Option No	Option Description
1	**Status Quo @ Vale of Leven Hospital (non resident "on-call" medical cover)**
6a	**Integrated Vale of Leven/Gartnavel Royal Hospital on-call (3 new build wards)**
6b	**Integrated Vol/GRH on-call (2 new build wards)**
6c	**Integrated Vol/GRH on-call (1 new build and 1 refurbished ward)**
6d	**Integrated Vol/GRH on-call (3 refurbished wards)**
8	**All Adult & Elderly Psychiatry @ GRH**

The agreed short-list included options for improving the quality of accommodation at Vale of Leven Hospital as well as providing additional space to enable 'age-appropriateness' services to be provided. This was in recognition of the deficiencies of the status quo in that regard and also to allow more comparable appraisal with the high quality of ward accommodation within the option to transfer services to Gartnavel Royal Hospital.

The agreed short list of options was scored by the whole workshop group.
Despite considerable discussion and debate during the workshop sessions, the group found it very difficult to reach consensus scores. In order to progress with the appraisal, optimistic and pessimistic scores were recorded to reflect the considerable difference of opinion between some workshop participants. Hence, in the results that follow it should be recognised that the consensus score has largely been produced by computing the mid-point or average between the optimistic and pessimistic scores. The principal difficulty for the group was that of "access" and a number of participants made frequent reference to the lack of disabled access at the train station for Gartnavel Royal Hospital, and also to the difficulties of travelling by bus to Gartnavel Royal Hospital from parts of west Dunbartonshire. Similarly, some participants highlighted the access problems likely to be experienced by the population in the Highlands area if services were to be provided in Gartnavel Hospital.

This issue of “access” led to some participants scoring the option that involved providing services from Gartnavel Hospital poorly on all the criteria whereas other workshop participants did not. As part of the sensitivity analysis, and to try to help provide some assistance with the problem of “access” issue, an additional weighting scenario was introduced by the facilitator and is referred to as “other” in the results that follow. This scenario had the criterion “Access” weighted equally with “Safe & effective service” and together these two criteria account for 80% of the overall weighting i.e. the other criteria are hardly significant in this scenario.

The results were further complicated by the complexity of the differences in capital and revenue costs associated with the options which also leads to affordability issues that will need to be considered by the Board in addition to the results of the economic appraisal.

The financial appraisal carried out within the overall option appraisal process included consideration of staffing and accommodation costs that related directly to the services concerned. Some participants raised the issue of the additional travel costs and travel time likely to be incurred by patients, their families and carers if services are provided at Gartnavel Hospital. Whilst acknowledging that there would be additional costs associated with the extended journey necessary for some people, it was considered unlikely that these costs would be of such a nature as to effect the outcome of the financial appraisal and furthermore, may be offset by other medical cost efficiencies associated with consolidating services at Gartnavel Royal Hospital (i.e. the reduced frequency which each junior medical staff member would be “on-call” in comparison with an integrated Vale/Gartnavel rota, thereby reducing the number of days off they would need to take to compensate for this).

A number of workshop participants raised the issue of the “human” cost of providing services from Gartnavel Hospital which would include the significant psychological/social impact on service users, their families and carers likely to result from longer, more complex journeys a greater distance from their natural communities. Whilst acknowledging this point other participants considered that this was reflected in the scoring of options against the “access to services” criterion. Again, this led to significant differences in delegate’s scores and this can be seen in the in differences between optimistic and pessimistic scores, particularly in relation to the option involving providing services from Gartnavel Hospital.

The three tables that follow show the ranking of options by weighted benefits scores, lifecycle costs, costs per benefit point and risk for all six different weighting scenarios. A separate table is provided for each of the three scoring scenarios i.e. consensus/average, optimistic and pessimistic.

		Rank (based on consensus/average scoring)													
		Weighted Benefit Score for each weighting scenario						Lifecycle Costs	Lifecycle Cost per Benefit Point for each weighting scenario						Risk Score
Option No	Option Description	Equal	Patient	Public	Manager	Clinician	Other		Equal	Patient	Public	Manager	Clinician	Other	
1	Status Quo @ VoL (No res on-call)	6	6	6	6	6	6	2	4	5	3	5	5	2	6
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	1	1	1	1	1	1	6	5	4	5	4	4	5	1
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	2	2	2	2	2	2	4	2	2	2	2	2	4	2
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	3	3	3	4	3	3	3	3	3	4	3	3	3	2
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	3	5	4	5	5	4	5	6	6	6	6	6	6	2
8	All Adult & Elderly Psychiatry @ GRH	5	4	5	3	4	5	1	1	1	1	1	1	1	5

		Rank (based on optimistic scoring)													
		Weighted Benefit Score for each weighting scenario						Lifecycle Costs	Lifecycle Cost per Benefit Point for each weighting scenario						Risk Score
Option No	Option Description	Equal	Patient	Public	Manager	Clinician	Other		Equal	Patient	Public	Manager	Clinician	Other	
1	Status Quo @ VoL (No res on-call)	5	6	6	6	6	6	2	2	2	2	2	2	2	6
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	1	1	1	2	1	1	6	5	5	5	5	5	5	1
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	3	3	2	3	3	3	4	3	3	4	3	4	4	2
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	4	4	4	4	4	4	3	4	4	3	4	3	3	2
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	5	5	5	5	5	5	5	6	6	6	6	6	6	2
8	All Adult & Elderly Psychiatry @ GRH	1	2	3	1	2	2	1	1	1	1	1	1	1	5

		Rank (based on pessimistic scoring)													
		Weighted Benefit Score for each weighting scenario						Lifecycle Costs	Lifecycle Cost per Benefit Point for each weighting scenario						Risk Score
Option No	Option Description	Equal	Patient	Public	Manager	Clinician	Other		Equal	Patient	Public	Manager	Clinician	Other	
1	Status Quo @ VoL (No res on-call)	6	6	5	6	6	5	2	6	6	4	6	6	5	6
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	1	1	1	1	1	1	6	2	2	3	2	2	3	1
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	2	2	2	2	2	2	4	1	1	1	1	1	1	2
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	3	3	3	3	3	3	3	3	3	2	4	3	2	2
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	4	4	4	4	4	4	5	5	5	5	5	5	4	2
8	All Adult & Elderly Psychiatry @ GRH	5	5	6	5	5	6	1	4	4	6	3	4	6	5

The preceding three tables show that:

- Option No 6a has the highest Weighted Benefit Score in all weighting and scoring scenarios except in the optimistic scoring scenario where Option No 8 has the highest Weighted Benefit Score in the “equal” and “manager” weighting scenarios. Therefore, if non-financial benefit criteria were the only criteria used to make the decision then Option No 6 would be the preferred option since it is the one most likely to result in the highest level of non-financial benefits. This option also has the lowest Risk Score and is therefore, considered by the workshop participants to be the least risky option. However, Option 6a has the highest lifecycle cost and this accounts for it being ranked less favourably in terms of the value for money as measured by the Lifecycle Cost per Benefit Point where it is ranked fourth/fifth in the consensus/average and the optimistic scoring scenarios and ranked between second and fourth in the pessimistic scoring scenario.

- Option 6b also performs well in terms of Weighted Benefit Score being consistently ranked second or third across the weighting and scoring scenarios. This option also has a relatively low Risk Score (ranked second). Its lower lifecycle cost (relative to Option 6a) means that it performs well in terms of value for money as measured by the Lifecycle Cost per Benefit Point where it is consistently ranked second for the consensus/average scoring scenario and ranked first for the pessimistic scoring scenario.

- Option 8 has the lowest lifecycle cost arising principally from the economies of scale achieved by co-location with services for Glasgow patients on the Gartnavel Hospital site. This option has a relatively high Risk Score compared to the other options (ranked fifth). In terms of non-financial benefits it performs reasonably well on the optimistic scoring scenario where it's Weighted Benefit Score is ranked between second and third across the weighting scenarios but it is poorly ranked in terms of the consensus/average and pessimistic scoring scenarios where it is consistently ranked fourth or fifth. However, its lower lifecycle cost compared to all other options accounts for it being ranked first across all weighting scenarios in two out of the three scoring scenarios (consensus/average and optimistic).

The table that follows shows the highest ranked option in each of the different weighting and scoring scenarios in terms of value for money as measured by the Lifecycle Cost per Benefit Point.

		Highest Ranking Options based on Lifecycle Cost per Benefit Point					
		Weighting Scenario					
		Equal	**Patient**	**Public**	**Manager**	**Practitioner**	**Other**
Scoring Scenarios	**Optimistic**	**Option 8**	**Option 8**	**Option 8**	**Option 8**	**Option 8**	**Option 8**
	Consensus/Average	**Option 8**	**Option 8**	**Option 8**	**Option 8**	**Option 8**	**Option 8**
	Pessimistic	**Option 6b**	**Option 6b**	**Option 6b**	**Option 6b**	**Option 6b**	**Option 6b**

This table shows that the two options most frequently ranked as highest across all the weighting and scoring scenarios are Option No 6b and Option No 8. The table shows that Option No 8 is ranked highest in 12 of the 18 scenarios. Furthermore, Option No 8 is more consistently ranked highest in optimistic and consensus/average scoring scenarios whereas Option No 6 b relies primarily on pessimistic scoring scenarios to achieve its highest rankings.

The sensitivity to changes in the lifecycle costs of options of the results from this value for money analysis is shown in the tables that follow where the results from four different costing scenarios are presented:

- Lifecycle costs of Options 6a, 6b, 6c and 6d reduced by 10% with the lifecycle cost of Option No 1 & No 8 remaining the same.
- Lifecycle costs of Options 6a, 6b, 6c and 6d reduced by 20% with the lifecycle cost of Option No 1 & No 8 remaining the same.
- Lifecycle costs of Option 8 reduced by 10% with the lifecycle costs of all other options remaining the same.
- Lifecycle costs of Option 8 reduced by 20% with the lifecycle costs of all other options remaining the same.

		Highest Ranking Options based on Lifecycle Cost per Benefit Point (Lifecycle cost of Option 6a,6b,6c,6d reduced by 10% with Options 1 & 8 remaining the same)					
		Weighting Scenario					
		Equal	Patient	Public	Manager	Practitioner	Other
Scoring Scenarios	Optimistic	Option 8	Option 8	Option 8	Option 8	Option 8	Option 8
	Consensus/Average	Option 8	Option 8	Option 6b	Option 8	Option 8	Option 6c
	Pessimistic	Option 6b	Option 6b	Option 6b	Option 6b	Option 6b	Option 6b

		Highest Ranking Options based on Lifecycle Cost per Benefit Point (Lifecycle cost of Option 6a,6b,6c,6d reduced by 20% with Options 1 & 8 remaining the same)					
		Weighting Scenario					
		Equal	Patient	Public	Manager	Practitioner	Other
Scoring Scenarios	Optimistic	Option 8	Option 8	Option 6c	Option 8	Option 8	Option 8
	Consensus/Average	Option 6b	Option 6b	Option 6b	Option 6b	Option 6b	Option 6c
	Pessimistic	Option 6b	Option 6b	Option 6b	Option 6b	Option 6b	Option 6b

These two tables show that when the lifecycle costs of options 6a to 6d reduce by between 10 % with Options 1 & 8 remaining the same, then Option 8 continues to be the option the most frequently ranked highest but if the lifecycle cost reduction is increased to 20% then Option 6b becomes the option most frequently ranked highest.

		Highest Ranking Options based on Lifecycle Cost per Benefit Point (Lifecycle cost of Option 8 reduced by 10% with all other options remaining the same)					
		Weighting Scenario					
		Equal	Patient	Public	Manager	Practitioner	Other
Scoring Scenarios	Optimistic	Option 8	Option 8	Option 8	Option 8	Option 8	Option 8
	Consensus/Average	Option 8	Option 8	Option 8	Option 8	Option 8	Option 8
	Pessimistic	Option 6b	Option 6b	Option 6b	Option 8	Option 8	Option 6b

		Highest Ranking Options based on Lifecycle Cost per Benefit Point (Lifecycle cost of Option 8 reduced by 20% with all other options remaining the same)					
		Weighting Scenario					
		Equal	Patient	Public	Manager	Practitioner	Other
Scoring Scenarios	Optimistic	Option 8	Option 8	Option 8	Option 8	Option 8	Option 8
	Consensus/Average	Option 8	Option 8	Option 8	Option 8	Option 8	Option 8
	Pessimistic	Option 8	Option 8	Option 8	Option 8	Option 8	Option 6b

These two tables show that reducing the lifecycle cost of Option 8 when all other options remain the same improves the dominance of Option No 8 as the highest ranked option across all the weighting and scoring scenarios.

A financial comparison of these two options is shown in the table that follows.

Option No	Option Description	Lifecycle Costs £NPC	Capital Cost £	Revenue Costs (excl Capital Charges) £	Capital Charges/PFI Unitary Charge £	Total Revenue £
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	69,067,402	6,010,020	2,394,000	420,000	2,814,000
8	All Adult & Elderly Psychiatry @ GRH	55,147,975	1,502,505	2,083,000	682,000	2,765,000

The table shows:

- Over the 60 year lifecycle, Option No 8 has a lower Net Present Cost.
- Option No 8 has a significantly lower initial capital cost and revenue costs.
- Option No 8 has a lower annual revenue cost (excluding capital charges).
- The PFI unitary charge associated with Option No 8 is significantly higher than the capital charges associated with Option No 6b (but is a cost that would continue to be incurred by NHS GG&C since the facility at Gartnavel is already in place).
- Option No 8 has the lowest total annual revenue cost.

Appendix A: Details of scoring & sensitivity analysis

1.0 Adult Mental Health Admissions & Elderly Psychiatry Admissions for South Clyde

Three options were appraised for Adult Mental Health & Elderly Psychiatry Admissions for South Clyde:

- Option 1: Co-locate all Adult MH & Elderly Psychiatry admission beds at Royal Alexandria Hospital (RAH).
- Option 2: Adult MH "hot" admission beds at RAH & Adult MH "cold" admission beds at Dykebar Hospital. Elderly Psychiatry admission beds at RAH.
- Option 3: Adult MH admission beds at Dykebar & Elderly Psychiatry admission beds at RAH

Non-financial benefits appraisal

The results from the appraisal of options in terms of non-financial benefits is presented in the table that follows and shows that Option No 3 has the highest Weighted Benefits Score under all the five criteria weighting scenarios. Hence, it is the option that the workshop participants considered most likely to maximise the desirable non-financial benefits from the modernisation of these services.

		Weighted Benefit Score (Consensus)				
		Criteria Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Co-locate all services at RAH	580	600	624	581	599
2	Adult MH "Hot" admissions at RAH, "Cold" at Dykebar; Elderly Psch. Admissions at RAH	480	510	505	485	508
3	Adult MH admissions at Dykebar; Elderly Psychiatric admissions at RAH	720	755	712	748	759

It can also be seen that this option has a significantly higher Weighted Benefit Score than the other two options which indicates that there would need to be substantially different scores to those at the workshop to bring about a different conclusion. Hence, in terms of non-financial benefits it is a robust choice of a preferred option.

The scoring that underpins the Weighted Benefits Scores is presented in the table that follows.

	Option 1			Option 2			Option 3		
Scoring of Options	**Co-location at RAH**			**Adult "hot" at RAH & "Cold" at Dyk'b**			**AA at Dyk'b; EA at RAH**		
Benefit Criteria	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**
Safe & effective care	**6**	**6**	**6**	**5**	**5**	**5**	**8**	**8**	**8**
Access to services	**7**	**7**	**7**	**5**	**5**	**5**	**6**	**6**	**6**
Quality of environment	**5**	**5**	**5**	**6**	**6**	**6**	**9**	**9**	**9**
Service interfaces/co-locations	**7**	**7**	**7**	**5**	**5**	**5**	**6**	**6**	**6**
Strategic Fit	**4**	**4**	**4**	**3**	**3**	**3**	**7**	**8**	**7**

The table shows that the scores for all three scoring scenarios (consensus, optimistic, pessimistic) are generally the same which indicates high levels of consensus reaching by the workshop group. It also shows that the superiority of Option No 3 arises from its high scores on “Safe & effective care”, “Quality of environment” and “Strategic fit”. The scoring is primarily associated with the Adult Admissions Service since this is what differentiates option – Elderly Psychiatric Admissions are retained on the RAH site in all options.

Non-financial Risks Appraisal

The table that follows shows the results from the non-financial risk appraisal carried out at the workshop and shows clearly that Option No 3 was considered by workshop participants to be the least risky of the three options. This was primarily as a result of the capacity of Dykebar to cope with change and the acceptability of the option to public and politicians because it builds on the already well established reputation of Dykebar in relation to this service group.

	Likelihood (0 - 10)			Impact (0 - 10)			Risk Score		
	Option			Option			Option		
Risk	1	2	3	1	2	3	1	2	3
Over/under estimating capacity to meet demand	3	3	3	4	1	2	12	3	6
Operational problems, staffing, H&S, HAI	2	5	2	3	7	3	6	35	6
Lack of flexibility to cope with change	5	3	2	5	4	3	25	12	6
Public acceptability	7	2	4	3	2	1	21	4	4
Political acceptability	7	2	4	3	2	1	21	4	4
							85	58	26

Economic Appraisal

The table below combines the lifecycle costs of the options with the Weighted Benefits Scores and compares options in terms of value for money by examining the lifecycle cost per benefit point. The results show that Option No 3 has the lowest lifecycle cost per benefit point and therefore provides best value for money.

					Weighting Scenarios									
					Equal Weight		Patient		Public		Manager		Clinical Practitioner	
Option No	Option Description	Capital Cost £	Revenue Cost £	Lifecycle Costs £NPC	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point
1	Co-locate at RAH	6,010,020	5,950,000	159,808,579	580	275,532	600	266,348	624	256,103	581	275,058	599	266,792
2	Hot at RAH, Cold at Dykebar	3,405,678	6,678,000	174,928,436	480	364,434	510	342,997	505	346,393	485	360,677	508	344,347
3	AA at Dyk'b; EA at RAH	2,003,340	6,678,000	173,066,933	720	240,371	755	229,228	712	243,072	748	231,373	759	228,020

2.0 Intensive Rehabilitation Service

Two options were appraised for the Intensive Rehabilitation service:

- Option 1: Dykebar Hospital – Bute Ward
- Option 2: Inverclyde Hospital

Non-financial benefits appraisal

The results from the appraisal of these two options is presented in the table below and shows that Option No 1 has the highest Weighted Benefits Score under all the five criteria weighting scenarios. Hence, it is the option that the workshop participants consider most likely to maximise the non-financial benefits required from the modernisation of these services. The relatively high Weighted Benefit Scores of Option No 1 compared to Option No 2 indicates that it is a clearly superior option in terms of non-financial benefits and this outcome is unlikely to change as a result of reasonable changes in scoring.

		Weighted Benefit Score (Consensus)				
		Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Dykebar - Bute Ward	760	770	751	774	755
2	Inverclyde	540	525	520	530	505

Scoring of options

The workshop group's scoring that underpins the Weighted Benefits Scores is presented in the table below and shows that the superiority of Option No 1 arises from its consistently higher scores across all of the benefit criteria:

	Option 1			Option 2		
Scoring of Options	**Dykebar (Bute Ward)**			**Inverclyde**		
Benefit Criteria	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**
Safe & effective care	**8**	**8**	**8**	**5**	**5**	**5**
Access to services	**7**	**7**	**7**	**5**	**5**	**5**
Quality of environment	**8**	**8**	**7**	**6**	**6**	**5**
Service interfaces/co-locations	**7**	**7**	**7**	**5**	**5**	**5**
Strategic Fit	**8**	**8**	**8**	**6**	**6**	**6**

Non-financial Risks Appraisal

The table below shows the results from the non-financial risk appraisal carried out at the workshop and shows clearly that Option No 1 was considered by workshop participants to be considerably less risky than Option 2.

	Likelihood (0 - 10)		Impact (0 - 10)		Risk Score	
	Option		Option		Option	
Risk	1	2	1	2	1	2
Sustainability of related services	5	3	4	5	20	15
Over/under estimating capacity to meet demand	2	2	3	4	6	8
Operational problems, staffing, H&S, HAI	3	5	3	5	9	25
Lack of flexibility to cope with change	3	5	3	4	9	20
Public acceptability	2	3	2	2	4	6
Political acceptability	3	5	3	5	9	25
					57	99

Economic appraisal

The table below combines the lifecycle costs of the options with the Weighted Benefits Scores and compares options in terms of value for money by examining the lifecycle cost per benefit point. The results from this show that Option No 1 consistently has a lower Lifecycle cost per benefit point and therefore provides best value for money.

					Weighting Scenarios									
					Equal Weight		Patient		Public		Manager		Clinical Practitioner	
Option No	Option Description	Capital Cost £	Revenue Cost £	Lifecycle Costs £NPC	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point
1	Dykebar - Bute Ward	450,752	692,000	18,256,634	760	24,022	770	23,710	751	24,310	774	23,587	755	24,181
2	Inverclyde	3,005,010	692,000	21,647,229	540	40,087	525	41,233	520	41,629	530	40,844	505	42,866

3.0 Intensive Psychiatric Care Unit (IPCU)

Four options were appraised for the IPCU:

- Option 1: Status Quo (Dykebar)
- Option 2: New build unit at Dykebar
- Option 3: Inverclyde
- Option 4: Partial Inverclyde/Partial Glasgow

Non-financial benefits appraisal

The results from the appraisal of these two options in terms of non-financial benefits is presented in the table below and shows that Option No 2 has the highest Weighted Benefits Score under four of the five criteria weighting scenarios. Hence, it is the option that the workshop participants consider most likely to maximise the non-financial benefits required from the modernisation of these services. However, the Weighted Benefits Scores for Option No.s 2, 3 & 4 are very similar indicating that there is little to choose between these options in terms of non-financial benefits.

		Weighted Benefit Score (Consensus)				
		Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Status Quo (Dykebar)	480	470	490	485	481
2	Dykebar - New build IPCU	680	705	676	689	704
3	Inverclyde	680	675	642	693	686
4	Partial Inverclyde/Glasgow	640	660	631	659	656

Scoring of options

The scoring that underpins the Weighted Benefits Scores is presented in the table that follows and shows the high levels of consensus reaching on scoring as well as the similarity of scores across many of the criteria.

	Option 1			Option 2			Option 3			Option 4		
Scoring of Options	**Status Quo (Dykebar)**			**Dykebar New Build**			**Inverclyde**			**Partial Inverclyde/Glasgow**		
Benefit Criteria	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**
Safe & effective care	5	5	5	7	7	6	7	7	7	7	7	7
Access to services	5	5	5	6	6	5	5	5	5	6	7	6
Quality of environment	3	4	3	9	9	9	8	8	8	7	7	7
Service interfaces/co-locations	6	6	6	6	6	6	6	6	5	5	5	5
Strategic Fit	5	5	5	6	6	6	8	8	8	7	7	7

Non-financial Risks Appraisal

The table below shows the results from the non-financial risk appraisal carried out at the workshop and show clearly that Option No.s 3 & 4 were considered by workshop participants to be considerably less risky than Option No.s 1 & 2.

	Likelihood (0 - 10)				Impact (0 - 10)				Risk Score			
	Option				Option				Option			
Risk	1	2	3	4	1	2	3	4	1	2	3	4
Sustainability of related services	5	5	2	2	4	4	2	2	20	20	4	4
Over/under estimating capacity to meet demand	5	3	3	3	4	2	2	2	20	6	6	6
Operational problems, staffing, H&S, HAI	2	2	2	2	5	5	6	4	10	10	12	8
Lack of flexibility to cope with change	5	3	3	2	3	3	3	2	15	9	9	4
Public acceptability	2	2	5	4	3	3	3	3	6	6	15	12
Political acceptability	5	5	3	3	5	5	3	3	25	25	9	9
									96	76	55	43

Economic Appraisal

The table below combines the lifecycle costs of the options with the Weighted Benefits Scores and compares options in terms of value for money by examining the lifecycle cost per benefit point.

					Weighting Scenarios									
					Equal Weight		Patient		Public		Manager		Clinical Practitioner	
Option No	Option Description	Capital Cost £	Revenue Cost £	Lifecycle Costs £NPC	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point	WBS	LC Cost per Ben Point
1	Status Quo (Dykebar)	1,502,505	1,120,000	30,574,366	480	3,130	470	65,052	490	62,397	485	63,040	481	63,564
2	IPCU Dykebar - New build	3,005,010	1,120,000	32,568,833	680	4,419	705	46,197	676	4,445	689	4,361	704	4,268
3	Inverclyde	1,803,006	1,120,000	30,973,259	680	2,651	675	45,886	642	2,808	693	2,602	686	2,628
4	Partial Inverclyde/Glasgow	2,103,507	1,120,000	31,372,153	640	3,287	660	47,534	631	3,334	659	3,192	656	3,207

4.0 Addiction Services

Initially, three models of service delivery were appraised:

- Single site model
- Two site model
- Three site model

The table below presents the results from this initial appraisal and clearly show that the "Two site" option was considered by workshop participants to be significantly superior in terms of non-financial benefits.

		Weighted Benefit Score (Consensus)				
		Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Triple sites	560	500	538	512	500
2	Two sites	700	722	691	729	722
3	Single site	460	480	465	470	480

Scoring of options

The scoring that underpins the Weighted Benefits Scores is presented in the table below and shows that the superiority of Option No 2 arises from its consistently higher scores on most of the benefit criteria with the exception of "Service interfaces/co-locations":

	Option 1			Option 2			Option 3		
Scoring of Options	**Triple site**			**Two sites**			**Single site**		
Benefit Criteria	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**
Safe & effective care	4	6	2	8	8	8	5	6	4
Access to services	6	6	6	7	7	7	5	5	5
Quality of environment	6	6	6	8	8	8	7	7	7
Service interfaces/co-locations	6	6	6	4	4	4	2	2	2
Strategic Fit	6	6	6	8	8	8	4	4	4

Having established that the "Two site" service model was most likely to maximise the desirable benefits from the project, a number of site options for delivering this model were identified and appraised:

- Stobhill Hospital & Inverclyde Royal Hospital
- Stobhill Hospital & Royal Alexandra Hospital
- Stobhill Hospital & Dykebar Hospital
- Stobhill Hospital & Leverndale Hospital
- Stobhill Hospital & Southern General Hospital
- Stobhill Hospital & Gartnavel Royal Hospital

Non-financial benefits appraisal

The results from the appraisal of these “Two site” options in terms of non-financial benefits are presented in the table that follows.

		Weighted Benefit Score (Consensus)				
		Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Stobhill Hospital & Inverclyde Royal Hospital	560	640	566	644	686
2	Stobhill Hospital & Royal Alexandra Hospital	560	635	551	644	674
3	Stobhill Hospital & Dykebar Hospital	580	655	580	655	684
4	Stobhill Hospital & Leverndale Hospital	600	660	585	670	689

Scoring of options

The scoring that underpins the Weighted Benefits Scores is presented in the table that follows.

	Option 1			Option 2			Option 3			Option 4		
Scoring of Options	Stobhill & IRH (New Build)			Stobhill & RAH			Stobhill & Dykebar			Stobhill & Leverndale		
Benefit Criteria	con	optim	pess	con	optim	pess	con	optim	pess	con	optim	pess
Safe & effective care	8	8	8	8	8	8	8	8	8	8	8	8
Access to services	2	2	2	2	2	2	3	3	3	3	3	3
Quality of environment	8	8	8	8	8	8	8	8	8	8	8	8
Service interfaces/co-locations	6	6	2	5	5	5	5	5	5	5	5	5
Strategic Fit	4	4	2	5	5	2	5	5	2	6	6	2

Non-financial Risks Appraisal

The table below shows the results from the non-financial risk appraisal carried out at the workshop and show clearly that Option No.s 3 & 4 were considered by workshop participants to be considerably less risky than Option No.s 1 & 2.

	Likelihood (0 - 10)				Impact (0 - 10)				Risk Score			
	Option				Option				Option			
Risk	1	2	3	4	1	2	3	4	1	2	3	4
Incompatible with existing national & local strategies	6	6	6	2	4	4	4	2	24	24	24	4
Over/under estimating capacity to meet demand	6	6	6	6	6	8	4	4	36	48	24	24
Deliverability - availability & priority for sites; within timescales	7	6	3	2	7	7	7	7	49	42	21	14
Operational problems, staffing, H&S, HAI	4	5	3	2	4	4	4	4	16	20	12	8
Lack of flexibility to cope with change	7	7	7	7	5	5	7	7	35	35	49	49
Change in public transport arrangements	2	2	6	5	6	6	6	6	12	12	36	30
Public acceptability	2	2	3	3	4	4	4	4	8	8	12	12
Political acceptability	6	7	7	4	5	5	5	5	30	35	35	20
									210	224	213	161

5.0 Elderly Psychiatry (East Renfrewshire activity)

Three options were appraised for the East Renfrewshire Elderly Psychiatry activity:

- Option 1: Status Quo (RAH & Leverndale)
- Option 2: All of East Renfrewshire Elderly Psychiatry activity at RAH
- Option 3: All of East Renfrewshire Elderly Psychiatry activity at Leverndale

Non-financial benefits appraisal

The results from the appraisal of options in terms of non-financial benefits are presented in the table that follows.

		Weighted Benefit Score (Consensus)				
		Weighting Scenario				
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner
1	Status Quo	740	780	770	755	773
2	East Renfrewshire activity at RAH	720	770	733	777	790
3	East Renfrewshire activity at Leverndale	740	725	706	734	731

The table shows that there is little to choose between the options in terms of the expected non-financial benefits since the options have similar Weighted Benefit Scores. Consequently, the results are sensitive to changes in weighting i.e. the option with the highest Weighted Benefit Score changes depending on the weighting scenario adopted.

Scoring of options

The scoring that underpins the Weighted Benefits Scores is presented in the table that follows. The table shows that the scores for all three scoring scenarios are generally the same which indicates high levels of consensus reaching by the workshop group. Furthermore, the difference between the scores allocated to options only varies by one to two points on each criterion which reflects the workshop group's view that there was little difference between the options in relation to the criteria.

	Option 1			Option 2			Option 3		
Scoring of Options	**Status Quo**			**East Renfrewshire activity at RAH**			**East Renfrewshire activity at Leverndale**		
Benefit Criteria	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**	**consensus**	**optimistic**	**pessimistic**
Safe & effective care	**8**	**8**	**8**	**9**	**9**	**9**	**7**	**7**	**7**
Access to services	**8**	**8**	**8**	**6**	**6**	**5**	**6**	**6**	**6**
Quality of environment	**8**	**8**	**8**	**7**	**7**	**7**	**9**	**9**	**9**
Service interfaces/co-locations	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
Strategic Fit	**6**	**6**	**6**	**7**	**7**	**7**	**8**	**8**	**8**

Non-financial Risks Appraisal

The table below shows the results from the non-financial risk appraisal carried out at the workshop and not surprisingly, shows clearly that Option No 1: Status Quo was considered by workshop participants to be the least risky of the three options. This reflects the fact that options involving change (Nos 2 & 3) are usually involve more risk taking than the "status quo" option.

	Likelihood (0 - 10)			Impact (0 - 10)			Risk Score		
	Option			Option			Option		
Risk	1	2	3	1	2	3	1	2	3
Over/under estimating capacity to meet demand	7	7	7	3	3	3	21	21	21
Closes off East Renfrew options	2	8	8	2	9	7	4	72	56
Public acceptability	2	5	5	2	6	5	4	30	25
Political acceptability	2	5	5	2	6	5	4	30	25
							33	153	127

6.0 Adult Mental Health Admissions & Elderly Psychiatry Admissions for West Dunbartonshire

Non-financial benefits appraisal

The results from the appraisal of options in terms of non-financial benefits are shown in the table that follows.

		Weighted Benefit Score (Consensus/average scoring)					
		Weighting Scenario					
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner	Other
1	Status Quo	540	545	587	518	524	610
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	740	805	789	751	779	825
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	680	735	724	681	714	740
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	640	695	694	651	678	720
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	640	655	682	618	625	715
8	All Adult & Elderly Psychiatry @ GRH	630	658	615	656	662	618

		Weighted Benefit Score (Optimistic scoring)					
		Weighting Scenario					
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner	Other
1	Status Quo	700	680	727	663	664	730
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	820	875	865	840	868	880
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	760	805	800	770	803	795
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	720	780	780	740	780	780
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	700	720	753	692	709	765
8	All Adult & Elderly Psychiatry @ GRH	820	850	797	848	847	815

		Weighted Benefit Score (Pessimistic Scoring)					
		Weighting Scenario					
Option No	Description	Equal	Service User	Public	Manager	Clinical Practitioner	Other
1	Status Quo	400	395	465	355	361	495
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	660	740	728	662	702	770
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	620	675	668	607	642	690
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	560	615	623	562	588	660
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	540	570	606	514	530	650
8	All Adult & Elderly Psychiatry @ GRH	440	465	432	463	476	420

The scoring that underpins the Weighted Benefits Scores is shown in the table that follows and clearly shows that wide differences between optimistic and pessimistic in relation to a number of criteria, particularly on Option No 8.

	Option 1			Option 6a			Option 6b			Option 6c			Option 6d			Option 8		
Scoring of Options	Status Quo			Integrated VoL/GRH on-call (3 NB wards)			Integrated VoL/GRH on-call (2 NB wards)			Integrated Vol/GRH on-call (1NB + 1Ref ward)			Integrated Vol/GRH on-call (3 Refurb Wards)			All Adult Admiss & Eld Admiss beds @ GRH		
Benefit Criteria	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Safe & effective care	5	6	3	8	9	7	7	8	6	7	8	6	6	7	5	7	9	5
Access to services	8	9	8	9	9	9	8	8	8	8	8	8	9	9	9	5	7	3
Quality of environment	4	6	2	9	9	9	9	9	9	7	8	6	6	6	5	8	10	6
Service interfaces/ co-locations	6	8	5	6	8	5	6	8	5	6	8	5	6	8	5	5	6	4
Strategic Fit	4	6	2	5	6	3	4	5	3	4	4	3	5	5	3	6.5	9	4

Non-financial risk appraisal

The table below shows the results from the non-financial risk appraisal

	Likelihood (0 - 10)						Impact (0 - 10)						Risk Score					
	Option						Option						Option					
Risk	**1**	**6a**	**6b**	**6c**	**6d**	**8**	**1**	**6a**	**6b**	**6c**	**6d**	**8**	**1**	**6a**	**6b**	**6c**	**6d**	**8**
Over/underestimating benefits	1	1	1	1	1	1	7	7	7	7	7	7	7	7	7	7	7	7
Operational problems, non-staffing, etc	5	4	5	5	5	7	4	4	4	4	4	7	20	16	20	20	20	49
Operational problems, staffing, etc	9	6	7	7	7	4	8	7	7	7	7	4	72	42	49	49	49	16
Lack of flexibility to cope with change	7	7	7	7	7	7	8	4	5	5	5	4	56	28	35	35	35	28
Public acceptability	4	1	2	2	2	9	3	3	3	3	3	6	12	3	6	6	6	54
Political acceptability													0	0	0	0	0	0
													167	**96**	**117**	**117**	**117**	**154**

Cost Analysis

Option No	Option Description	Capital Cost £	Revenue Cost excluding Cap Charges £	Capital Charges/Unitary Charge £	Revenue Cost including Capital Charges £	Lifecycle Costs £NPC
1	Status Quo @ VoL (No res on-call)	-	2,223,000	150,000	2,373,000	56,725,994
6a	Integrated Vol/GRH on-call (3 New Bld Wards)	7,011,690	2,707,000	490,000	3,197,000	78,384,108
6b	Integrated Vol/GRH on-call (2 New Bld Wards)	6,010,020	2,394,000	420,000	2,814,000	69,067,402
6c	Integrated Vol/GRH on-call (1 NB + 1 Refurb Ward)	4,507,515	2,394,000	390,000	2,784,000	67,072,935
6d	Integrated Vol/GRH on-call (3 Refurb Wards)	3,756,263	2,707,000	415,000	3,122,000	74,062,762
8	All Adult & Elderly Psychiatry @ GRH	1,502,505	2,083,000	837,000	2,920,000	55,147,975