ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

TO BE HELD IN THE TOWN AND COUNTY HALL, FORFAR ON WEDNESDAY 28 JUNE 2017 AT 2.00PM

AGENDA

PAGE NO.

1. MEMBERSHIP OF THE INTEGRATION JOINT BOARD

Submit Report IJB 25/17 by the Chief Officer. (1 - 4)

2. APOLOGIES

3. DECLARATIONS OF INTEREST

Members are reminded that, in terms of the Code of Conduct of Members of Devolved Public Bodies, it is their responsibility to make decisions whether to declare an interest in any item on this agenda and whether to take part in consideration of that matter.

4. MENTAL HEALTH SERVICES REDESIGN TRANSFORMATION PROGRAMME – OPTION REVIEW AND CONSULTATION PLAN REPORTS

Presentation to be provided by Dr Neil Prentice, Associate Medical Director and Keith Russell, Associate Nurse Director, Mental Health and Learning Disability; and Lynne Hamilton, Mental Health Programme Director and Finance Manager.

Submit Report IJB 26/17 by the Chief Officer. (5 - 756)

5. MINUTES INCLUDING ACTION LOG

(a) Previous Meeting

Submit, for approval, as a correct record, the minute of meeting of the Angus Health and Social Care Integration Joint Board of 19 April 2017. (757 - 762)

(b) Action Log

Submit Action Log of 19 April 2017. (763 - 764)

(c) Audit Committee

Submit, for noting, the minute of meeting of the Audit Committee of 19 April 2017. (765 - 768)

6. REVIEW OF STANDING ORDERS

Submit Report IJB 27/17 by the Chief Officer. (769 - 782)

7. IJB REPRESENTATION AND AUDIT COMMITTEE MEMBERSHIP

(a) IJB REPRESENTATION ON ACPP BOARD

The Board is requested to nominate one representative to the Angus Community Planning Partnership Board.

(b) AUDIT COMMITTEE MEMBERSHIP

The Board is requested to nominate six members to the Angus Health and Social Care Integration Joint Board Audit Committee.

8. FINANCE MONITORING REPORT

Submit Report IJB 28/17 by the Chief Finance Officer. (783 - 794)

9. PARTNERSHIP FUNDS

Submit Report IJB 29/17 by the Chief Finance Officer. (795 - 800)

10. BUDGET SETTLEMENTS FOR 2017/18 UPDATE

Submit Report IJB 30/17 by the Chief Finance Officer. (801 - 806)

11. IMPROVEMENT AND CHANGE PROGRAMME

Submit Report IJB 31/17 by the Chief Officer. (807 - 810)

12. ANNUAL STRATEGIC PROGRESS AND PERFORMANCE REPORT

Submit Report IJB 32/17 by the Chief Officer. (811 - 866)

13. HELP TO LIVE AT HOME UPDATE

Submit Report IJB 33/17 by the Chief Officer. (to follow)

14. REVIEW OF INPATIENT CARE IN ANGUS

Submit Report IJB 34/17 by the Chief Officer. (867 - 870)

15. PRIMARY CARE UPDATE

Submit Report IJB 35/17 by the Chief Officer. (871 - 874)

16. ADULT SUPPORT AND PROTECTION IN ANGUS

Submit Report IJB 36/17 by the Chief Officer. (875 - 876)

17. THE CARERS (SCOTLAND) ACT 2016 IMPLEMENTATION

Submit Report IJB 37/17 by the Chief Officer. (877 - 880)

18. COMPLAINTS HANDLING IN RELATION TO INTEGRATED SERVICES

Submit Report IJB 38/17 by the Chief Officer. (881 - 902)

19. DATE OF NEXT MEETING

The next meeting of the Angus Health and Social Care Integration Joint Board will be held on Wednesday 30 August 2017 at 2.00pm in the Town and County Hall, Forfar.

AGENDA ITEM NO 1

REPORT NO. IJB 25/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

MEMBERSHIP OF THE INTEGRATION JOINT BOARD

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to note the voting membership of the Integration Joint Board, the non voting membership of the Integration Joint Board appointed by NHS Tayside and Angus Council; and to consider appointing non voting members of the Integration Joint Board in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

(i) note the legal obligations incumbent upon it in respect of its membership,

(ii) note the note the appointment by NHS Tayside and Angus Council of the following members:-

NHS Tayside	Angus Council
Hugh Robertson	Councillor David Fairweather
Judith Golden	Councillor Julie Bell
Alison Rogers	Councillor Lois Speed

(iii) to note the appointment of Hugh Robertson and Councillor David Fairweather as chairperson and vice chairperson respectively until 2 October 2017 when the roles will alternate for a period of one year.

(iv) Note the appointment to the Board of the following postholders:-

(a) The Chief Officer of the Board – Vicky Irons

(b) The Chief Finance Officer of the Board – Alexander Berry

(c) The Chief Social Work Officer of Angus Council – Kathryn Lindsay

(d) A registered medical practitioner whose name is included in the list of primary medical services performers (G.P.s) (to be appointed by NHS Tayside) – Vacant

(e) A registered nurse employed by the Health Board (to be appointed by the Health Board) – Jim Foulis

(f) A registered medical practitioner employed by the health board and not providing primary medical services (to be appointed by NHS Tayside – Dr Douglas Lowdon

(v) agree to appoint the following persons to be members of the Board in respect of the following groups:-

(a) staff of the constituent authorities engaged in the provision of services provided under integration functions – Barbara Tucker (NHS Tayside) and [Vacant] (Angus Council)

(b) third sector bodies carrying out activities related to health or social care in the area of the local authority – Bill Muir

(c) service users residing in the area of the local authority – David Barrowman

(d) persons providing unpaid care in the area of the local authority – Peter Burke

(e) a representative from commercial providers of social care – Ivan Cornford

2. REPORT

2.1 Angus Integration Joint Board was established on 3 October 2015 by the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment (No. 3) Order 2015 and is subject to the provisions of the Public Bodies (Joint Working) (Scotland) Act 2015 and the Integration Scheme between NHS Tayside and Angus Council.

2.2 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") contains detailed provisions about the membership of Integration Joint Boards. The Order requires that an Integration Joint Board must include a number of Councillors nominated by the local authority and a number of persons nominated by the Health Board. The Board is asked to note that the members nominated by the Health Board must be non executive directors of that Health Board but can in certain circumstances be other members of the Health Board. NHS Tayside and Angus Council have agreed, in the Integration Scheme, that there shall be three members each of NHS Tayside and Angus Council on the Angus Integration Board. The Board is asked to note that NHS Tayside and Angus Council have appointed the following under this category of membership:-

NHS Tayside	Angus Council
Hugh Robertson	Councillor David Fairweather
Judith Golden	Councillor Julie Bell
Alison Rogers	Councillor Lois Speed

The Board is asked to note that only the members of the Board above are entitled to vote on questions put to a meeting of the Board.

The Order also requires a chairperson to be appointed by either NHS Tayside or Angus Council for a term of office not to exceed three years and that NHS Tayside and Angus Council must alternate which of them is to appoint the chairperson in respect of each successive appointing period. In addition, the organisation which is not entitled to appoint the chairperson in respect of an appointing period must appoint the vice-chairperson of the Board in respect of that appointing period. NHS Tayside and Angus Council have agreed, in the Integration Scheme, that the term of office for the chairperson and vice-chairperson shall be one year. The Board is asked to note that NHS Tayside have appointed Hugh Robertson to be the chairperson of the Board and his term of office ends on 2 October 2017. Angus Council have nominated Councillor David Fairweather to be the vice-chairperson of the Board who will assume the role of chairperson with effect from 3 October 2017.

The Board is specifically asked to note that the chairperson of the Board does not have a second or casting vote. The Board's Standing Orders provide a procedure to deal with situations where a consensus cannot be reached.

2.3 The Order provides that certain postholders must be members of the Board. The posts and the persons holding the posts are:-

(a) The Chief Officer of the Board – Vicky Irons

(b) The Chief Finance Officer of the Board – Alexander Berry

(c) The Chief Social Work Officer of Angus Council – Kathryn Lindsay

(d) A registered medical practitioner whose name is included in the list of primary medical services performers (G.P.s) (to be appointed by NHS Tayside) – Vacant

(e) A registered nurse employed by the Health Board (to be appointed by the Health Board) – Jim Foulis

(f) A registered medical practitioner employed by the health board and not providing primary medical services (to be appointed by NHS Tayside) – Dr Douglas Lowdon

2.4 The Order specifies that the Board must appoint at least one member in respect of each of the following groups:-

(a) staff of the constituent authorities engaged in the provision of services provided under integration functions;

(b) third sector bodies carrying out activities related to health or social care in the area of the local authority;

(c) service users residing in the area of the local authority; and

(d) persons providing unpaid care in the area of the local authority.

2.5 The Board has previously agreed that there should be two members in respect of staff of the constituent authorities engaged in the provision of services provided under integration functions (one each from NHS Tayside and Angus Council).

2.6 The Order permits the Board to appoint such additional members as it sees fit. The Board has previously determined to appoint:-

(a) the clinical director of the Board – Alison Clements; and
(b) a representative from commercial providers of social care.

2.7 Given the above, it is recommended that the Board appoint the following persons to be members of the Board in respect of the following groups:-

(a) staff of the constituent authorities engaged in the provision of services provided under integration functions – Barbara Tucker (NHS Tayside) and [Vacant] (Angus Council)

(b) third sector bodies carrying out activities related to health or social care in the area of the local authority – Bill Muir

(c) service users residing in the area of the local authority – David Barrowman

(d) persons providing unpaid care in the area of the local authority – Peter Burke

(e) a representative from commercial providers of social care – Ivan Cornford

All of the persons referred to above have previously served as members of the Board.

3. CONCLUSIONS

The Integration Joint Board is legally obliged to appoint members in respect of each of a number of distinct groups and is permitted to appoint additional non voting members as it sees fit. The recommendations contained in this report will enable the Integration Joint Board to discharge the legal obligations incumbent upon it in terms of its membership.

REPORT AUTHOR: David Thompson
EMAIL DETAILS: ThompsonD@angus.gov.uk

June 2017

AGENDA ITEM NO 4

REPORT NO IJB 26/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION (MHSRT) PROGRAMME – OPTION REVIEW AND CONSULTATION PLAN REPORTS

REPORT BY VICKY IRONS, CHIEF OFFICER

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board:-

(i) Note the content of the Option Review Report and supporting Appendices.

(ii) Note the process followed in undertaking the review and the level of engagement involved in the preparation and consideration of options for future General Adult Psychiatry and Learning Disability services.

(iii) Note the methodology used to identify the preferred option and justification for its choice over other options considered.

(iv) Note and comment on the Consultation Plan content and note the requirement to proceed to a three month period of formal consultation in line with Scottish Government guidance on major service change.

2. BACKGROUND

2.1 Purpose of the report

The purpose of this report is to present the preferred option from the review of Mental Health and Learning Disability services undertaken by the Mental Health Service Redesign Transformation Programme and share the proposed consultation plan. The report will be presented to NHS Tayside Board and the Angus and Dundee Integration Joint Boards to note and comment before seeking approval from the Perth and Kinross Integration Joint Board to progress to a period of formal consultation from 3 July 2017 to 3 October 2017

Mental Health Services in Tayside have undergone significant change following the Mental Health Review in 2005-06 which allowed for a shift in the balance of care and substantial reinvestment in community services through a reduction in General Adult Psychiatry inpatient bed numbers. However the decision to retain inpatient services within each locality of Tayside has meant the majority of mental health resources remain within Inpatient Services and the level of inpatient spend in Tayside is still substantially higher than the Scottish average when benchmarked against other Board areas.

In line with the optimum delivery of Mental Health service provision across Scotland, the balance of care must shift to community-based services. To achieve that we must ensure that people who need in-patient care have access to specialist, high quality care environments that support recovery. In particular, in conjunction with the three local Health and Social Care Partnerships with their focus on community-based services, we must re-model adult in-patient mental health services in a way that makes the best use of our skilled workforce to provide patients with the right care in the right place at the right time.

The Option Review Report attached presents and appraises the top four options identified in the August 2016 NHS Tayside Board report from the early Option Appraisal scoring exercises and

recommends a preferred way forward, together with initial indicative costs, for further detailed analysis within subsequent Initial Agreement and Outline Business Case reports that will be presented for approval following a period of formal consultation in keeping with statutory requirements.

The initial plan outlining the approach to the period of formal consultation is included within the Option Review Report at section 14 and in the separate Consultation Plan Report attached. The consultation plan report describes the proposed methods of engagement and approach to be taken. The supporting consultation materials are currently being prepared and developed in partnership with key stakeholders and will be available for the consultation period starting on 3rd July 2017 following approval of this paper by Boards and Committees in June 2017.

It is only through the involvement of service users, carers, communities and those who work within the Mental Health and Learning Disability services that NHS Tayside and the three IJBs can ensure that services and the way in which they are delivered, have the best chance of being both fit for purpose and sustainable to meet the needs of the population of Tayside.

NHS Tayside and the three Integration Joint Boards must be assured that people with a mental disorder that require treatment can access this promptly and that the quality of care and treatment received is of a high standard.

Most people receive such treatment in a primary care setting and treatment occurs while living at home or in residential care and is supported by a General Practitioner or community based services, examples include community mental health teams, psychological services and substance misuse services. Third Sector, voluntary and self help organisations have an important role to play in this as well as social housing and supported accommodation.

Admission to hospital however is required for a small number of people when the nature and severity of the mental disorder cannot be managed safely or appropriately in the community. In these situations specialist care in an acute inpatient unit is necessary. In order to provide high quality care and treatment in these inpatient units it is fundamental that these are safe and therapeutic environments.

The options being considered for future inpatient services must address two key issues:

- Concern about the ability to safely maintain three General Psychiatry acute admission inpatient units in Tayside and two Learning Disability inpatient sites.

- Concern that the hospital environment at Strathmartine Centre does not meet the needs for patients who are in hospital for often years at a time.

As will be highlighted in the report the main driver for the first of these issues is current and future availability of staff to safely manage the services across multiple sites.

For the second issue the main driver is the need to urgently upgrade the physical environment for Learning Disability patients which cannot be achieved in the current accommodation on the Strathmartine site. It is recognised however that the inpatient services provided on this site could be located in the existing hospital estate with the potential to improve patient experience and make more efficient use of current resources.

In addition, the document outlines the process by which options for change have been identified and evaluated, allowing recommendations to be made that can now be submitted for full public consultation. As services develop in conjunction with the community focus of Integration Joint Boards, we would seek to shift the balance of care to community based services and make best use of our workforce for the benefit of patients.

Describing development of options for appraisal and the method by which the preferred option was defined, NHS Tayside, Angus, Dundee, Perth and Kinross Integration Joint Boards must now progress this plan to ensure delivery of safe, sustainable and patient centred services. The process reflects NHS Tayside Board's instruction to the Programme team to strengthen public engagement and to consider one and two site options for General Adult Psychiatry and Learning Disability inpatient services

3. CURRENT POSITION

3.1 EXECUTIVE SUMMARY

This paper seeks to provide an overview of the detailed information contained in the attached

Mental Health Service Redesign Programme Option Review Report and supporting Appendix documents which provide Board members with a preferred way forward for Mental Health and Learning Disability inpatient services.

The attached Option Review Report outlines the current issues facing provision of Mental Health Inpatient services for both General Adult Psychiatry and Learning Disability services and examines in detail four potential options that seek to ensure provision of safe, sustainable and person centred services for the future which meet the needs of all our stakeholders across Tayside.

It is no longer possible to deliver safely the most specialist services for General Adult Psychiatry Acute inpatient admissions over three sites – overnight cover, weekends & public holidays are a particular challenge with the diverse geography and current spread of specialist Mental Health Services. NHS Tayside is experiencing the impact of a national shortage of Mental Health specialist clinical staff. Shortages of both Medical and Nursing workforce are particularly acute in Tayside though there are similar issues experienced across Scotland, particularly in more remote and rural areas. The workforce profile is ageing with early retirement opportunities for Mental Health employees affecting a large proportion of more experienced staff. The fixed single out-turn of Newly Qualified Practitioners every year is insufficient to match the numbers of people leaving the service. Tayside is competing with other Health Boards/Countries for a finite pool of staff. Like many areas in Scotland, National and Local Shortages of Junior and Senior Medical staff and Registered Mental Health Nurses are driving redesign. It is projected from staffing age profiles that within the next 5 years Mental Health and Learning Disability services will see retirements in current Nursing workforce of circa 35% and 24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years. Ten locums are currently employed out of a total of 64 consultants across Tayside Mental Health and Learning Disability services.

In order to provide a safe service within current resource limits the option appraisal considered the deployment of these resources across the optimum number of sites. This assessment was done on the basis of safe staffing levels for the patient care needed for each option.

3.2 REPORT DETAIL

Drivers for Change

In addition to the workforce challenges noted above a number of policy drivers and specialist opinion demonstrate that a strategic shift is required. Services in all settings must be safe and effective; however national strategy and clinical evidence propose enhanced community based care and development of specialist centres for those people with the most complex needs. We need to redress the remaining imbalance of in-patient and community-based services across Tayside. The changing population profile means more people survive into older age with learning disabilities. While people with mental illness often suffer from inequality and are likely to live 10-20 years less than their more affluent, relatively more healthy counterparts, we anticipate the increasing requirements for services from a greater number of older people to conflict with static numbers of working people, low unemployment in the more rural areas of Tayside and therefore challenging circumstances in sustaining the current profile of the workforce.

Health and Social Care Integration brings with it the delegation of the greater part of Mental Health Services. Hosting arrangements in Tayside have delegated responsibility for the majority of inpatient services to Perth and Kinross and Psychology to Dundee. Integration Joint Boards are obliged to include a wide contribution to Mental Health Service provision. Fig 1 attached at Appendix Eleven of the Option Review Report highlights the range of Mental Health and Learning Disability services provided in Tayside and where responsibility for their delivery now sits.

Realistic Medicine (2016, is driving a conversation across the clinical professions about the redesign of services through reductions in variation and in considering how the most effective care can be delivered in future. Families, Carers, Service-Users, Health and Social Care Integration, Localities, Communities and the Third Sector all have a contribution

Tayside General Adult Psychiatry In-Patient Mental Health services are accommodated in three modern Not For Profit Distributing (NPD)/ Private Finance Initiative (PFI) buildings. The ageing property on the Strathmartine site requires significant refurbishment and the even with major refurbishment would not lend itself to provision of modern healthcare facilities with single bedroom en-suite accommodation.

Contingency Plan

The predicted workforce shortages have triggered development and implementation of a contingency plan which was approved by the NHS Tayside Board on the 27th October 2016 and by the Perth and Kinross Integration Joint Board on 4th November 2016. This contingency plan is providing temporary solutions for some of the drivers for change ahead of the conclusion of the MHSRT programme which will move services to a more structure approach to transformational change.

Option Appraisal

A series of Option Appraisal and Option Modelling workshops involving an equal number of service users and carers, third sector organisations and multi agency staff have been undertaken to support the production and consideration of the options being considered. Of the options developed, four were carried forward for clinical, technical, workforce and financial appraisal.

As the paper describes, the two options that scored highest from the two workshops held to facilitate the process, still have services for adult mental health being provided from three sites across Tayside, albeit the acute admissions wards are either on a single site or two sites; in addition the difference in scoring between the top four options was marginal; therefore the top four scored options have been presented in the Report to ensure the scope requested for a single site or two sites for adult inpatient services are presented. Board members are directed to the attached paper for the detailed description, content and outcome of the Option Review and the associated appendices.

It should be noted that it is the professional opinion that only options 3A and 5A described below would meet requirements for safety, sustainability and clinical continuity of services.

In summary the top four options which have been considered are:

Option 3A

Single site option for General Adult Psychiatry (GAP) acute admission beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth to be provided from four refurbished wards in the Carseview Centre in Dundee and provide 84 beds for Tayside as per Table Two in section 9.3 below. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a single site option for Learning Disability services which would relocate current inpatient beds from Strathmartine and Carseview sites to a refurbished combined ward in Murray Royal. This ward will provide inpatient beds for Learning Disability assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area.. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 4A

Two site option for GAP acute admission inpatient beds with relocation of current inpatient beds provided in the Moredun Ward in Murray Royal in Perth to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Mulberry ward, Susan Carnegie Unit, Stracathro, Angus and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee and provide 87 beds for Tayside.. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open

forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Moredun ward within the Murray Royal hospital site would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 5A

Two site option for GAP acute admission inpatient beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro, Angus, to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Moredun Ward on Murray Royal site in Perth and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 8

This option was a new option generated at the Option Appraisal events.

Single site option for General Adult Psychiatry (GAP) acute admission beds from a single inpatient ward for Tayside for acute assessment on the Carseview centre in Dundee. The inpatient beds provided from the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth and in the Carseview Centre in Dundee would then change function to provide step down/treatment inpatient beds for each locality and provide a total of 89 beds (18/22 Acute Admission). This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability inpatient services which would relocate from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds in one ward and 8 open forensic inpatient beds in a second refurbished ward on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

Appendix Twelve of the full Option Appraisal Report (attached at Appendix Four) provides further descriptor of other NHS bed provision currently provided around each of these options.

Option Appraisal

A number of factors have been used to determine the preferred option. Key to any decision regarding the selection of the future inpatient models has to be the sustainability of the clinical and workforce models. Financial and Technical appraisals and initial costings have been undertaken and will continue to be refined though the process of approvals outlined in the Programme timetable in Section 17 below.

The detailed appraisal of each of the top four options is provided in the attached Option Review Report.

STRATEGIC AIMS

The Mental Health Clinical Services Strategy which is a component part of NHS Tayside Clinical Strategy was approved by NHS Tayside Board in December 2015. The proposed changes to the service delivery model are in keeping with the strategic aims nationally and locally, to continue to shift the balance of care to provide optimum care and treatment in community settings, promoting a model of recovery and enablement.

HEALTH EQUITY

One in four people will experience mental health problems and it's important to access the right support in the right place when it is needed. It is also important to remember that the majority of people recover or learn to manage their mental health issue, lead meaningful lives and contribute positively to society.

94% of people who access secondary care mental health services each year do so in the community

The Mental Health Service Redesign Transformation Programme seeks to further promote health equity by ensuring a shift in the balance of care to meet the demands placed on both current and predicted population needs, whilst ensuring service users are cared for in as near to or in their own home as is possible. This will support equity of service provision across Tayside for the majority of the population accessing services.

4. PROPOSALS

Preferred Option

Option 3A provides the safest most sustainable service for the future, ensuring sufficient medical cover, nursing, AHP and Psychology workforce who can share learning and experiences across speciality services. This option will allow maximum resource release for any potential reinvestment in community workforce to provide services to the majority of the population and prevent unnecessary admissions for both GAP and LD services. By shifting the balance of care and providing centralised specialist services this option reduces variation and provides ease of acute care pathway.

Option 3A would therefore be the recommended preferred option for NHST Board and the three Integration Joint Boards to progress to seek views on during the formal three month consultation phase.

A move from the status quo inevitably involves change. Almost the most controversial aspects of the Programme and strategic review is the possible centralisation of acute admission beds for both GAP and Learning Disability services. Each option outlined above and in the body of the Option Review report brings its own benefits and problems.

However the creation of a centralised service provides the opportunity for synergistic learning through close contact with professionals, service users and carers who would otherwise have been in separate services with different goals and potentially different quality standards.

Option 3A will allow for the above and creation of a “Centre of Excellence” for both GAP and Learning Disability services and the only future model of care which is both sustainable from a nursing and medical workforce availability, whilst improving patient environments and ensuring financial affordability.

By contrast travelling time for professionals, service users and carers will be significantly increased in some cases and the problems this can bring re escorts etc. Further exploration of the impacts on service users and their families need to be considered throughout the consultation period and planning for any option implementation. Through the use of the EQIA report and quantification of the potential impacts on the population the programme will continue to monitor and evaluate and take actions necessary to support access wherever possible.

While it is not ideal to be working under contingency plans in the short to medium term, it is essential to demonstrate the rigour of this planning process and the careful examination of all the options before agreeing a preferred option for presentation and public consultation. Although the arrangements for major service change under Health and Social Care Partnerships may vary from the processes used by NHS Boards in the past, this process is underway at a time when the policy landscape is still in development. The principles applied to

implementation of the contingency plan will continue. Careful partnership working with patients, carers, staff and staff organisations will be ongoing and include communities, third sector organisations, independent contractors and care providers.

5. FINANCIAL IMPLICATIONS

The financial implications associated with the options being considered are captured in summary in Section 10 of the Option Review Report and detailed further in Appendices Six.

An appraisal of the financial benefits associated with each option has been reviewed by the management accounting team dealing with Mental Health and Capital resources to support the ranking of options. The detail of this is included in Appendix Seven.

Although the financial appraisal of the options is part of the identification of a preferred option, the primary focus of the programme is to ensure patient and staff safety through sustainable service models and high quality care as the priority. The Board can be assured that the preferred option at this stage does not place NHS Tayside in a position of any additional financial risk and will allow resource release and an associated reduction in current cost pressures in respect of supplementary staffing and premium locum agency costs.

Current high level estimates demonstrate that Option 3A allows for the greatest release of resources from current inpatient services to allow for any requirement for reinvestment in community and home treatment services, whilst maximising use of the current estate portfolio and allowing disposal of surplus assets which have significant backlog maintenance costs. Work will progress throughout the consultation period to identify any levels of reinvestment in community settings which may be required to support the preferred option. This work will review current activity data in line with the benchmarking data to ensure current community services are remodelled to make most effective and efficient use of resources available.

Workforce

The detailed workforce implications associated with each of the options are included in section 9 of the Option Review Report.

Option 3A is the only option which will provide sufficient safe inpatient staffing levels to provide services for the immediate future and next 5 years. This option also makes the most efficient use of the projected available workforce.

There are workforce implications associated with all options being considered and any proposed changes will be subject to NHS Tayside Organisational Change policies and procedures and implemented with full staff side and Human Resources support.

6. OTHER IMPLICATIONS

MEASURES FOR IMPROVEMENT

In keeping with the Keogh domains around patient improvement, we will measure the following:

- Continued quality improvement, evidenced through the outcome measures from the Institute for Healthcare Improvement pilot project on Safer Care
- Recruitment and retention of appropriately qualified and experienced staff
- Improved compliance with junior doctor rotas
- Improved medical trainee experience evidenced through a reduced incidence of ‘red flags’ in trainee placement evaluations
- Reduced use of supplementary staffing for nursing and medical staff
- Reduced cost pressures from junior doctor locums ; locum consultant agency costs; nursing agency costs totalling £1m in 2016/17

IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The Programme's Equality Impact Assessment is attached within Appendix One of the Option Review Report. Impact assessments have been undertaken to assess the potential impact of the options being considered in relation to both General Adult Psychiatry and Learning Disability proposals. Appendix Three details the programme of communications and engagement associated with the programme and work undertaken to date. The programme of engagement undertaken has sought to expand on initial involvement of key stakeholders in reviewing the options identified by that original group through a further Option Appraisal exercise and series of workshops, events, presentations etc. Staff side representatives have been members of the programme team and participated in associated work streams and workshops since inception of the programme. The contribution and support of staff side representatives throughout the process and at all events has ensured the implications for the workforce have been noted to date. The continued involvement of staff side representatives following the decision of the Board will ensure the impact of the programme on individual staff will be considered in detail.

The consultation plan report is attached and outlines the proposed approach to be undertaken during the three month period identified, as noted in the report this has been reviewed with colleagues from the Scottish Health Council.

PATIENT EXPERIENCE

The recommendations and preferred option being presented reflects an ambition to ensure patient experience is not adversely affected by the increasing challenges of further improving and sustaining the provision of high quality, safe, effective and efficient services. The transformation of the service includes a requirement to review and improve clinical pathways, revise service delivery models, and ensure most beneficial utilisation of hospital accommodation, aimed at improving patient experience, improving patient safety and providing sustainable, safe and effective, recovery focused services.

RISK ASSESSMENT

The current risk log for the programme captures all associated risks from the various work streams and work being undertaken and is reviewed at monthly Programme Team meetings. In addition to the risk assessment for the programme specifically, Mental Health service delivery is recorded as a strategic risk for NHS Tayside. The risk description presented here is specific to the risks of the sustainability of the current inpatient service delivery models that the programme is aimed at mitigating. Risk Description The current service configuration of the provision of General Adult Psychiatry inpatient services from three separate geographic localities across Tayside is not a sustainable service model for the current time and medium term future, due to the inability to provide optimal multidisciplinary staffing across all three sites. The consequences of lower than required medical and nursing staffing is a risk to patient and staff safety; risks to the quality of care and treatment provided; and continued risks of increasing financial imbalance.

Current Rating of Likelihood = 5
Current Rating of consequences = 4

- Crisis Resolution and Home Treatment services for Angus locality have been delivered from Dundee locality in the Out of Hours period since August 2015 as an emergency measure to address the continued vacancies on the junior doctor rotas.
- Business Continuity plans have now been evoked by the AMD, Lead Clinicians and Heads of Service to temporarily relocate Mulberry Ward and Perth locality Out of Hours assessments to Carseview Centre as a result of current Junior Doctor workforce shortages to ensure continued provision of safe services across Tayside.
- In times of nursing workforce shortages vs. clinical acuity on the inpatient wards, operational decisions are taken to temporarily divert admissions to other wards / localities in the interests of staff and patient safety. Target control level = 3
- The Mental Health Service Redesign Transformation Programme attached Option review Report recommended preferred option will reduce General Adult Psychiatry inpatient services from a three site to single site delivery model for Tayside.

LEGAL IMPLICATION

No legal implications identified. Any contractual issues associated with changes to existing PFI/NPD buildings will be reviewed with colleagues from the Central Legal Office (CLO)

INFORMATION TECHNOLOGY IMPLICATIONS

No information technology implications have been identified at this stage and will be examined as part of the further review of community services and any investment requirements to support outreach working practices.

HEALTH & SAFETY IMPLICATIONS

The programme is aimed at reducing current Health and Safety risks in respect of adequate, safe staffing levels and medical rota compliance. Any refurbishment works required will take cognisance of current work being undertaken across all Mental Health sites to review ligature risks.

HEALTHCARE ASSOCIATED INFECTION (HAI)

No HAI implications identified

DELEGATION LEVEL

Executive Sponsor - Dr Neil Prentice, Associate Medical Director
Operational Lead – Mr Robert Packham, Chief Officer, Perth & Kinross Integration Joint Board
Programme Lead - Lynne Hamilton, Director Mental Health Programme Director and Finance Manager

TIMETABLE FOR IMPLEMENTATION

Business Case Stages and Programme Timeline for Approval

Option Review Report Update and Consultation plan approval	June 2017 Committees/Boards
Consultation Period	3rd July 2017 to 3rdOctober 2017
Initial Agreement Report	December/January 2017/8 Committees/Boards then CIG in January/Feb 2018
OBC report	May/June 2018 Committees/Boards then CIG in May
Financial Close	November 2018
FBC report	December 2018
Refurbishment timeline	January 2019 to December 2019

REPORT AUTHOR:

Miss Lynne Hamilton
Mental Health Programme Director & Finance Manager

Ms L McLay
Chief Executive

Mr Robert Packham
Chief Officer
Perth & Kinross IJB

Mr Neil Prentice
Associate Medical Director for MH

EMAIL DETAILS: lynne.hamilton2@nhs.net

List of Appendices:
Attached - Mental Health Service Redesign Transformation Programme Option Review Report, Consultation Plan Report and Supporting Appendix Documents 1 – 12.

Mental Health Service Redesign Transformation Programme

Option Review

June 2017

Document Control Information	
Control Status	MHSRT Programme Board –Scheduled 08/06/2017 Clinical Care Governance Committee – Scheduled 12/06/2017 Area Clinical Forum – Scheduled 15/06/2017 Area Partnership Forum – Scheduled 27/06/2017 P&K IJB Transformation Board – Scheduled 19/06/2017 Angus Integration Joint Board – Scheduled 28/06/2017 Dundee Integration Joint Board – Scheduled 27/06/2017 NHS Tayside Transformation Board – Scheduled 28/06/2017 Tayside NHS Board – Scheduled 29/06/2017 P&K Integration Joint Board – Scheduled 30/06/2017
Date Last Printed	15/06/2017
Version Number	1.28
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager, NHS Tayside

List of Contributors – Programme Board, Programme Team & Supporting Information

Full list of all stakeholders who contributed to Programme listed in Option appraisal report (Appendix Four)

Name	Designation
Mark Anderson	Head of Property
Allyson Angus	Public Involvement Manager
Karen Anderson	Director of Allied Health Professions
Robert Bain	Clinical Team Manager – Learning Disabilities
Lindsay Bedford	Director of Finance
Dave Bennett	Engineering Systems Lead – Property Department
Dave Berry	Chief Finance Officer – Dundee Health & Social Care Partnership
Sandy Berry	Chief Finance Officer – Angus Health & Social Care Partnership
Roger Blake	Consultant Psychiatrist – Angus
Jane Bray	Public Health Consultant
Eleanor Brewster	Consultant Psychiatrist – Learning Disabilities
Bernie Brophy-Arnott	LD Speech and Language Therapy Manager
Lesley Burnett	Learning Disability Health Team Leader – Dundee Health & Social Care Partnership
Elizabeth Caesar	Consultant Psychiatrist - Rehabilitation
Santosh Chima	Diversity & Inclusion Manager
David Cook	Senior Management Accountant
Andrew Cowie	General Practitioner
Shelagh Creeghan	Associate AHP Director for Mental Health & Learning Disabilities
Stuart Doig	Consultant Forensic Psychiatrist
Jane Duncan	Head of Corporate Communication
Margaret Dunning	Board Secretary
Diane Fraser	Perth & Kinross Health & Social Care Partnership
Alan Gall	Interim Performance Director
Judith Golden	Employee Director
Linda Graham	Consultant Clinical Psychologist – Deputy Head of service
Lynne Hamilton	Mental Health Programme Director & Finance Manager
Jodi Hassall	Management Accountant
Fabian Haut	Consultant Psychiatrist – Learning Disabilities
Val Johnson	Head of Inpatient Services Mental Health & Learning Disabilities
Peter Kingston	Gauldie Wright & Partners - Architects
Linda Kennedy	Service Manager - Learning Disability
Julie Kermack	Team Manager - Learning Disabilities
Diane McCulloch	Head of Service, Health and Community Care, Dundee Health & Social Care Partnership
Kate McDermott,	Staff Side Representative
Iain Mceachan	HR Business Lead
Angie McManus	Learning Disability Service Manager
Wilma Mason	Capital Accountant
Arlene Mitchell	Locality Manager – Dundee Health & Social Care Partnership
Andy Moir	Team Leader, Perth & Kinross Health & Social Care Partnership
Ross Muir	Contract manager - Bellrock
Gillian Munro	Head of Spiritual Care
Bill Nicoll	Director of Strategic Change
Neil Prentice	Associate Medical Director for Mental Health

Robert Packham	Chief Officer – Perth & Kinross Health & Social Care Partnership
Alan Pattinson	NHS Tayside Transformation Programme Lead
Kevin Power	Head of Psychology Service
Rowan Reffold	Consultant Clinical Psychologist – Lead Learning Disabilities
Keith Russell	Associate Nurse Director – Mental Health & Learning Disabilities
Irene Sharkie	Lead Principle Pharmacist – Mental Health
Aidan Shorrock	Contract manager - Robertsons FM
Christopher Smith	Associate Director of Human Resources - HR & OD
Jane Smith	Chief Finance Officer – Perth & Kinross Health & Social Care Partnership
Muriel Steven	MHSRT Programme Support Officer
Carole Sutherland	Speech & Language Therapy Manager
Lynne Swankie	Management Accountant
Bill Troup	Head of Mental Health Services – Angus Health & Social Care Partnership
Barbara Tucker	Staff Side Representative
Tracey Williams	Associate Director Improvement
Barbara Wilson	Head of Service – Forensic Services
Louise Wilson	Communication Manager
Sally Wilson	Locality Integration Improvement Manager

Title

The title of the programme described in this document is ""Mental Health Service Redesign Transformation Programme". This title will be used in all subsequent documentation.

Purpose of this Report

This Report sets out why NHS Tayside in partnership with the three locality Integration Joint Boards seeks to redesign its General Adult Psychiatry and Learning Disability inpatient service models and review the accommodation from where these services are provided.

The Option Review Report attached presents and appraises the top four options identified in the August 2016 NHS Tayside Board report from the early Option Appraisal scoring exercises and recommends a preferred way forward, together with initial indicative costs, for further detailed analysis within subsequent Initial Agreement and Outline Business Case reports that will be presented for approval following a period of formal consultation in keeping with statutory requirements..

The initial plan outlining the approach to the period of formal consultation is also included within the Option Review Report at section 14. A detailed consultation plan and supporting materials are being further developed and prepared in partnership with key stakeholders and will be available following approval of this paper in June 2017.

Mental Health Services in Tayside have undergone significant change following the Mental Health Review in 2005-06 which allowed for a shift in the balance of care and substantial investment in community based services through a reduction in inpatient bed numbers. However with the decision to retain inpatient services within each locality of Tayside has meant the majority of mental health resources remain within inpatient Services and the level of inpatient spend in Tayside is still substantially higher than the Scottish average when benchmarked against other Board areas.

In keeping with the optimum delivery of Mental Health provision across Scotland, the balance of care needs to move to predominately community-based services. In achieving this we must ensure that people who need in-patient care do so in environments where they can be provided with the specialist, high quality care that they need to support their recovery. In particular, in conjunction with the three local Health and Social Care Partnerships, with their focus on community-based services, we seek to re-model adult in-patient mental health and learning disability services in a way that makes the best use of our skilled workforce to provide patients with the right care in the right place at the right time. This document seeks to outline the process by which options for change have been indentified and evaluated; allowing recommendations to be made that can now be submitted for full public consultation.

Table of Contents –

SEPARATE APPENDIX DOCUMENT -

1. INTRODUCTION

NHS Tayside in partnership with the Integration Joint Boards (IJBs) of the Angus, Dundee and Perth and Kinross Health and Social Care Partnerships is carrying out a strategic review of General Adult Psychiatry and Learning Disability inpatient services which is likely to lead to changes that will affect service users, their families, carers, voluntary organisations and staff. The extent of all of the changes required will not be fully known until the end of the review. The proposed changes (options) outlined in this paper have been developed by a group of key stakeholders who participated in an Options Appraisal process. The Option Appraisal is one part of the ongoing wider process of NHS Tayside's review of General Adult Psychiatry and Learning Disability Inpatient Services being undertaken by the Mental Health Service Redesign Transformation (MHSRT) Programme.

This paper seeks to outline:

- the mains reasons for the review
- the scope of the review
- the involvement process that has and continues to be followed during the review.
- the options that have been identified and considered
- the identification of a preferred option
- an initial plan outlining our approach to the consultation period

2. WHY IS A REVIEW BEING CARRIED OUT?

NHS Tayside and the three Integration Joint Boards must be assured that people with a mental disorder that require treatment can access this promptly and that the quality of care and treatment received is of a high standard.

Most people receive such treatment in a primary care setting and treatment occurs while living at home or in residential care and is supported by a General Practitioner.

Community services help people recover from the effects of their mental disorder and maintain their role in society as far as is possible. Examples include community mental health teams, psychological services and substance misuse services. Third Sector, voluntary and self help organisations have an important role to play in this as well as social housing and supported accommodation.

Admission to hospital however is required for a small number of people when the nature and severity of the mental disorder cannot be managed safely or appropriately in the community. In these situations specialist care in an acute inpatient unit is necessary.

Certain groups of patients also require specialist inpatient services such as eating disorder services, learning disability and forensic services.

In order to provide high quality care and treatment in these inpatient units it is fundamental that these are safe and therapeutic environments.

The reason this review is being carried out is to address two issues:

- Concern about the ability to safely maintain three General Psychiatry acute admission inpatient units in Tayside and two Learning Disability inpatient sites.

- Concern that the hospital environment at Strathmartine Centre does not meet the needs for patients who are in hospital for often years at a time.

As will be highlighted later in this report the main driver for the first of these issues is current and future availability of staff to safely manage the services across multiple sites.

For the second issue the main driver is the need to urgently upgrade the physical environment for Learning Disability patients which cannot be achieved in the current accommodation on the Strathmartine site. It is recognised however that the inpatient services provided on this site could be located in the existing hospital estate with the potential to improve patient experience and make more efficient use of current resources.

2.1 Strategic context

NHS Tayside's Mental Health Strategy (2015) supported the need to shift the balance of care from hospital based care to services that provide care and treatment in the community as near to home as possible. A review of Adult Mental Health services was undertaken in 2003/04. The earlier Adult Mental Health Review allowed for a shift in the balance of care through significant investment in community services to allow bed reductions at that time but agreed that general adult psychiatry acute admission inpatient beds would continue to be provided from three locations in Tayside.

When benchmarked against all other Scottish Health Boards, NHS Tayside continues to invest significantly more resources and whole time equivalent staffing in Mental Health inpatient services than all but one other Health Board area in Scotland. The cost per inpatient week for General Adult Psychiatry is
£3,984 compared to Scottish average £3,283, approx £82 per head of population in comparison with the Scottish average of £57 per head of population. The cost per inpatient week for Learning Disabilities is £4,311 (2nd highest to NHS Fife) compared to Scottish average of £3,968, approx £18 per head of population in comparison with a Scottish average of almost half at £9 per head of population.

2015/16 figures for average GAP wte staffing levels demonstrate that NHS Tayside provides 1 wte nurse per 1181 members of population in comparison to Scottish average of 1 wte nurse per 1403 members of population. For Medical staffing the figures are 1 wte per 9,805 compared with 1 wte per 11,679 Scottish average so again this reflects a higher level of spend than other Boards. This position is also reflected in LD services where figures are 1 wte per 4,241 against

Scottish average of 1 wte per 5,993 in nursing, and 1 wte per 142,625 against Scottish average of 1 wte per 224,159 in medical staffing.

However on comparison, spend on community services, NHS Tayside is consistent with other Boards across Scotland and therefore there would appear to be an imbalance in how Tayside resources are currently being invested per head of population on its inpatient Mental Health services. Cost Book latest published figures for 2015/16 shows NHS Tayside spend £39 per head of population on Community Psychiatric Teams which is in line with the Scottish average of £39. Learning Disability community services are also on a par at £6 per head of population with the Scottish average spend of £7 per head of population. Detailed extracts from the cost book are attached in Appendix Nine – Supporting Information

As a result of this information, NHS Tayside requested a further review of the existing models of care to create proposals for redesign across Mental Health and Learning Disability services to prepare for the future needs of the population and look at the potential to further shift the balance of care in line with the strategic intentions of Health and Social Care Integration across Angus, Dundee, Perth and Kinross.

The MHSRT programme is also aligned with the work being progressed through the NHS Tayside Transformation Programme which has also given a commitment to review the Boards large Property portfolio and aging estate.

This section explains how the scope of the Programme fits with the national drivers for change.

These drivers for change include:

- Realistic Medicine – Chief Medical Officers Annual report (2014 -2015)
- A National Clinical Strategy for Scotland- Scottish Government (Feb 2016)
- Better Health, Better Care Action Plan (2007)
- Scottish Governments 2020 Vision (2011)
- NHS Scotland Quality Ambitions
- Delivering for Mental Health – Scottish Government 2006.
- Mental Health (Care and Treatment) (Scotland) Act 2003.
- National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) – DoH 2002.
- Safety Privacy and Dignity in Mental Health Units – DoH 2000.
- Royal College of Psychiatrists Guidance on Facilities for Junior Doctors Interviewing Patients.
- Mental Health Tribunal Standards.
- Admissions to Adult Mental Health Inpatient Services – Best Practice Statement NHSQIS April 2004.
- NHS QIS ICPs – Standards for Integrated Care Pathways for Mental Health (December 2007).

- NHS QIS Admissions to Adult Mental Health In-patient Services – April 2004.
- Delivering for Mental Health: National Standards for Crisis Services (2006).
- Same as you? (2000)
- Health and Social Work and Related services for Mentally Disordered Offenders in Scotland Mel 5 (1999)
- National Mental Health Strategy 2017-27
- The Keys to Life - Improving Quality of Life for People with Learning Disabilities (June 2013)
- Public Bodies (Joint Working) (Scotland) Act. 2014
- Angus Integration Joint Board Strategic Plan 2016
- Dundee Integration Joint Board Strategic Plan 2016
- Perth and Kinross Integration Joint Board Strategic Plan 2016

2.1.1 Organisational Overview

In 2014 the Chief Medical Officer of NHS Scotland produced the annual report entitled "Realistic Medicine". This document challenges Medical Professionals and all NHS Boards to reduce unwarranted variation in clinical practice and services to achieve optimal outcomes for patients. NHS Tayside's vision in line with this report requires us to ensure that by 2020 we will have established Mental Health and Learning Disability services that are able to not only respond to the changing population demographics described below, but deliver high quality, high value person-centred models of care, balancing capacity with demand, ensuring safety and sustainability while demonstrating the principles of best value for the public pound.

NHS Tayside and the three local Integration Joint Boards are responsible for meeting the health care needs of just under 500,000 people living in Tayside. Tayside covers 3000 square miles of Urban, Accessible Rural and Rural populations within catchment from four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife. The Scottish Index of Multiple Deprivation (SIMD) identifies that three of the four local authority areas covered by NHS Tayside have areas within the 15% most deprived populations in Scotland, with the majority of these areas being in Dundee City.

The greatest proportion of Tayside's population lie within the 50-54 (7.5%) and 20-24 (7.2%) age groups. This is consistent with the Scottish average creating future planning implications for Mental Health and Learning Disability service provision for 16 – 65 year olds.

Tayside's population is also estimated to increase overall in the next 25 years with the greatest increase in Perth & Kinross (24.2% by 2037). Angus figures predict a decrease of 0.8% in growth, whilst Perth & Kinross under 16s population is set to increase by 26% and Dundee's by 25% during the same period.

Locally Perth & Kinross is also projected to see a 27% increase in housing developments by 2037 and is set to be one of the fastest growing regions in Scotland.

These conditions co-exist with data that demonstrates the need to plan for the needs of an ageing population, Perth and Kinross for example is predicting a 70% increase in the older age bandings across the next 15 years

These changes in population also signify the need for changes in the way future Mental Health and Learning Disability services are provided and reflected in the options put forward in the strategic case. NHS Tayside must create service resilience to manage the growing demands for Mental Health and Learning Disability services. We must plan for a shift in the balance of care that will see the majority of the service provision taking place within local communities and within the service users own home and a far greater interdependency with communities, third sector organisations, a wider range of care providers as well as families and carers themselves.

Since the Programme started there have been significant changes in the management structures for mental health services. Initially the inpatient and community services were largely locality based as part of Community Health Partnerships.

In 2012 it was agreed to develop the Directorate model to create a more unified approach to delivery of mental health services in Tayside. Whilst the majority of psychiatric subspecialties were under a Directorate of Mental Health and Learning Disabilities, other services such as Psychiatry of Old Age were managed separately to enable closer links with Medicine for the Elderly services and Child & Adolescent Mental Health Services were included as part of the Medicine Directorate.

In response to the integrating of health and social care as set out in The Public Bodies (Joint Working) Act 2014 the structure again changed in April 2016.

In keeping with most other part of Scotland Tayside adopted an integrated joint board model and the mental health services are organised as detailed in Figures 1 and 2 in Appendix Eleven attached.

2.1.2 Health Inequalities

Health inequalities arise from variations in a range of factors including access to services, quality of care provision and extrinsic factors such as lifestyle, economic, educational, genetic and environmental factors.

The MHSRT Programme will impact on all the protected characteristics ranging from individual patient to locality populations although there is no immediate reason to think the service changes (reconfiguration or changes to pathway) would have an adverse impact. The Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected under the Act, examples of these are Age, Race, Disability, Sex, religion or belief, etc.

Minority Ethnic - There is little evidence to demonstrate any link between racial background and prevalence of mental health or LD conditions however from the supporting data gathered from ISD submission it can be noted that few people from ethnic minority groups access mental health 2.4% and learning disability 1% support and services

Women and Men – ISD information from inpatient admissions for GAP show more males are admitted to services than females (52% males 47% females), however in LD services this split shows admissions are predominately male dominated (66% male 33% females)

Perth & Kinross strategy for gypsies/travellers outlines a higher % of population in Perth & Kinross than elsewhere in Scotland – it highlights that the Scottish Census figures for 2011 included "Gypsy/Traveller" as a classification for the first time and the results were released in September 2013. Nationally 4,212 people were recorded as such with the highest individual local authority population being 415 in Perth and Kinross.

Current ISD information recorded 0.1% inpatient admissions in GAP were gypsy/travellers and none recorded in LD services

The MHSRT Programme team require to ensure the cultural and religious needs of service users are met. There is no link between religious belief and prevalence of Mental Health or Learning Disability

The options being considered will impact on people who have a learning disability and those with a learning disability and a major mental illness. In addition will also affect those who have a learning disability and are at a risk of offending behaviour (Forensic)

Evidence suggests that particular populations, for example those in areas of deprivation and remote rural communities have more difficulties gaining access to NHS Services. They often suffer multiple disadvantages (Appleby & Deeming 2001). NHS Tayside and the three Integration Joint Boards (IJBs) seek to understand the local reasons for inequalities and ensure the preferred option provides the best conditions to address these factors whilst building safe, effective and sustainable clinical and care services for the future.

There are fewer people living in poverty in rural areas. However their experience of deprivation may be different. It is important when planning future service provision to consider factors such as the infrequency and cost of public transport as a barrier for people seeking to access hospital sites. Such disadvantages are exacerbated if the person is disabled and/or requires to be accompanied by a carer when travelling, particularly if these challenges are encountered when a person is in a state of distress. These challenges already exist for patients in rural populations within Tayside. Consideration of transport issues will be reviewed following the feedback received during the consultation period; an initial evaluation of likely cost implications for volunteer drivers has been included within the draft financial framework.

A full Equality Impact Assessment (EQIA) has been undertaken as part of this process and as a "live" document will continue to be updated, monitored and evaluated throughout the duration of the programme to ensure full understanding of the impact of any changes approved. The draft EQIA is attached at Appendix One.

2.1.3 Mental Health Strategy

The Mental Health Services Clinical Services Strategic Framework, approved and endorsed by NHS Tayside Board in December 2015, reflects the strategic intent of both the NHS Tayside Clinical Services Strategy (NHS Tayside 2015 Reshaping Clinical Services for the Future) and the National Clinical Services Strategy. The Framework builds on a 12 year narrative and vision for adult mental health services across Tayside and further chimes with the Scottish Government's 2020 Vision.

The guiding ambition within the recently published Mental Health Strategy 2017 – 2027 is to prevent and treat mental health problems with the same commitment, passion and drive as physical health problems.

Parity of esteem is central to the Strategy which sets out three key areas of improvement:

- Prevention, early intervention and physical wellbeing
- Access to treatment and joined up accessible services
- Rights information use and planning.

There is the intention to measure the following for mental health compared to physical health over the ten years of the policy -

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- Allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes.

The Strategy sets out 40 actions which are underpinned by a human rights-based approach to the improvements needed by using the PANEL principles of Participation, Accountability, Non-Discrimination, Empowerment and Legality.

2.1.4 Learning Disability Strategy

Scotland's first national Learning Disability Strategy "The same as you?" published in 2000 formed the original 10 year programme to meet the needs of people with learning disabilities. The strategy provided a range of recommendations to improve the lives of people with learning disabilities in terms of where and how they live and how they become more involved and included in

their communities as neighbours, colleagues and social contacts. It was highly successful in shifting the balance of care to support more people to live in the community. It also led to the closure of over 1000 long-stay beds, improved day opportunities, created employment and meaningful day activity and better protection from harm.

In 2010, a two-year evaluation involving detailed participation from people with learning disabilities and their carers began to assess what progress had been made and what needed to be achieved. From these findings, key themes were decided and debated by a national Learning Disability Strategy group who discussed key themes and agreed broader responses which have formed "The Keys to Life".

The first Scottish Strategy for Autism was published by the Scottish Government in late 2011. The strategy set out a "vision that individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives".

The six values that underpin the strategy are:

- Dignity
- Privacy
- Choice
- Safety
- Realising potential
- Equality and Diversity.

The expectation is that the strategy will achieve meaningful partnership between central and local government and the independent sector. Creative and collaborative use of service budgets is expected to meet individual need. Access to appropriate assessment of needs throughout life and access to consistent levels of appropriate support should be available across the lifespan into older age.

"The Keys to Life" - Improving Quality of Life for People with Learning Disabilities, was published in June 2013. This new ten year learning disability strategy acknowledges that progress in implementing 'The Same as You?' has resulted in people with learning disabilities reporting they are generally more accepted and valued in their communities. The Ministerial Foreword highlights the need for people with learning disabilities to be treated equally and fairly and having a health service which "recognises and addresses the stark fact that people with learning disabilities still die twenty years earlier than the general population".

'The Keys to Life' contains 52 recommendations for local authorities, NHS Boards and the independent sector to progress in order to continue the promotion of equality of inclusion and access for people with learning disabilities across a range of community structures and systems.

The recommendations are grouped under 9 distinctive headings as follows:

(i) Human Rights – requiring public bodies to ensure equality impact assessments are completed where services are accessed by people with learning disabilities and including people with learning disabilities in service developments while ensuring accessible information is provided about their rights.

(ii) Commissioning of Public Services – community planning partners are required to develop joint commissioning plans by April 2015. In line with the implementation of the Social Care (Self-Directed Support) (Scotland) Act 2013 all stakeholders are advised to cooperate with the independent and voluntary sector to ensure there are varied options for people to access in order to meet personal outcomes.

(iii) Health – In total there are 18 recommendations associated with improving the health outcomes for people with learning disabilities that will require to be progressed within individual organisations and jointly as health and social care integration develops. A number of the recommendations within this heading are intended to promote equal access to mainstream healthcare and screening for people with learning disabilities. Examples include improved primary care liaison, improved support to people with learning disabilities admitted to general hospitals and improved palliative care pathways.

(iv) Independent Living – recommends that day opportunities for people with learning disabilities should be further developed. A review of Local Housing Strategies should be progressed to ensure the needs of people with learning disabilities are addressed.

(v) Shift the Culture – Keeping Safe – includes recommendations to develop befriending services for people with learning disabilities, improved availability of short break services and enhanced anticipatory care planning for carers of people with learning disabilities.

(vi) Break the Stereotypes – includes recommendations that transition pathways are improved for young people with learning disabilities, ensuring training and lifelong learning opportunities can be accessed. In addition, supported employment opportunities should be developed along with volunteering opportunities for people with learning disabilities.

(vii) People with Profound and Multiple Learning Disabilities – contains a variety of recommendations including development of shared commitment to the implementation of a developing Scottish Quality Framework for the delivery of invasive procedures such as gastrostomies, ventilation and responding to seizures.

(viii) Criminal Justice – it is well evidenced that there are significant numbers of people with learning disabilities in the criminal justice system and the recommendations require that accessible and easy to read versions of criminal justice related literature should be developed, along with the establishment of a National Criminal Justice Action Group to provide support for people with learning disabilities involved in the Criminal Justice system.

(ix) Complex Care – joint discharge agreement protocols are to be developed to minimise delays in discharging people with learning disabilities from hospital. A national group will consider how capacity is built in Scotland to

provide specialist services more locally with high cost support packages being considered nationally to enable exploration of alternative arrangements which would improve outcomes for the individuals.

Over the last decade there have been significant developments both locally and nationally that have changed the lives of many people with learning disabilities, their families and carers. The principles established by "The same as you?" continue to be valid. The ten year strategy 'The keys to life' reinforces these principles and has a strong emphasis on human rights, recognising that to be truly accepted in society means being treated fairly and equally in every way. 'The keys to life' sets out a vision for improved partnership working to deliver better outcomes for people with learning disabilities, their families and carers.

Autism is a national priority with the creation of the 'The Scottish Autism Strategy', launched by the Scottish Government in 2011, which identifies what services need to provide for people with autism across Scotland. Strategic action is required both nationally and locally. Children and adults on the autism spectrum each have a unique set of needs which will not necessarily fall within the areas of learning disabilities or mental ill health, although these conditions may be present. Autism is a pervasive disorder which impacts on the whole life experience of people. They need to be supported by a wide range of services such as social care, education, health, housing, employment and other community based services. The Scottish Autism Strategy (2011) directs local authorities and the NHS, as the joint commissioning bodies, to give high priority to redesigning services around the principles of prevention, early identification of problems, early intervention, assessment, diagnosis, support and management of transition throughout the lifespan of autism.

2.1.5 Health and Social Care Integration

In 2014, the Scottish Government published the Public Bodies (Joint Working) (Scotland) Act. This legislation set out the intentions for Health and Social Care Integration. It recognised the future benefits of a strategic shift towards greater interdependence between a wide range of agencies, stakeholder and professional groups. Health and Social Care Partnerships (HSCP) are now in place across Scotland. NHS Tayside has entered into formal partnership with Angus, Dundee, Perth and Kinross Councils for the Angus, Dundee, Perth and Kinross Health and Social Care Partnerships. Overseen by their respective IJB, the Partnerships have separate legal identity and specific duties set out in statute. Integration Authorities have responsibility for strategic planning and commissioning of a range of health and care services. NHS Tayside retains the responsibility for property and for the employment of health staff.

A set of governance arrangements underpin delegation of a range of services from the Partner Organisations to the IJB. In Tayside, this includes the vast majority of Mental Health and Learning Disability services with Child and Adolescent Mental Health Services and Regional Medium Secure Services remaining within the direct management of NHS Tayside. All community services are directly delegated to the IJB and are managed in an integrated way alongside a range of other services across defined localities. In patient Mental Health

Services are managed through a hosting arrangement. The hosting arrangement is an agreement between the Integration joint boards and the partner Agencies that allows services to be managed together across Tayside for reasons of safety, effectiveness and efficiency. A defined list of hosting arrangements is set out in the Schemes of Integration for each IJB. Perth and Kinross IJB is responsible for the hosting arrangements applicable to In-Patient Mental Health and Learning disability services. Dundee IJB is responsible for hosting Tayside- wide Psychology services. As noted in section 2.1.1 above Figures 1 and 2 attached at Appendix Eleven highlights the range of Mental Health and Learning Disability services provided in Tayside and where responsibility for their delivery now sits.

2.1.6 Community Mental Health Services

Community Mental Health Services are currently planned and commissioned by each of the three IJBs. The majority of community services are delivered by third and independent sector organisations with the statutory bodies of NHS Tayside and the three local authorities being responsible for providing services to those people in active treatment or in need of protection. A detailed breakdown of current community service provision is included in Appendix Two.

In planning for future community services we require to consider national drivers particularly The National Clinical Strategy for Scotland, the National Mental Health Strategy 2017-2027, Keys to Life and Health and Social Outcome Indicators, including:

- Being community focussed, supporting self-management and independence for everyone by supporting people to fully understand and manage their problems, promoting a focus on prevention, rehabilitation and independence.
- We must not provide an overall system that defaults to medical solutions (such as admission to hospital) when the needs are predominantly social.
- Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons and transform nursing roles to develop Advanced Nurse Practitioners.
- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. An early intervention will reduce likelihood of a crisis and requirement for inpatient care.

The new IJB structures provide joint opportunities to create enhanced home treatment and support, bringing care for mental health and learning disabilities closer to people's homes thus creating less dependency on an inpatient admission to gain access to the right care and support.

The focus for the further development of community services will continue to progress with a more integrated model with all statutory, independent and third sector partners. People tell us the factors that they value most highly. These factors, which can include having a job or other meaningful occupation, somewhere to live, social relationships, and equality of participation as citizens,

can lead to significant improvements in mental well-being. The role of medical and therapeutic interventions: specialist services still have an important role to play in the recovery of a good quality of life and public protection. These specialist clinical services are nested within a broader framework of understanding of mental health and learning disabilities as influenced by personal, cultural and social experience. The integration of specialist clinical interventions within a wider framework of support is essential as those who experience mental health problems face many barriers to their full inclusion in the social and economic life of the community.

The Mental Health Strategy acknowledges that working to improve mental health care is not just the preserve of the NHS and requires a wide range of services to provide the broadest range of opportunities to help people improve their mental health and well being.

2.1.7 Shifting the Balance of Care

For many years, clinical practice has been moving away from hospital care towards community based care for the majority of people. There is still further work to be done to rationalise the delivery of hospital based care across Tayside and to remodel and strengthen the community services in Angus, Dundee, Perth and Kinross

IJBs have a specific responsibility to design services that are centred on the needs of patients and carers and to provide a range of services that are based in communities.

This obligation requires engagement with a wide range of stakeholders from service users through statutory and non statutory provider organisations, professions and the wider public. It is only through the involvement of service users, carers, communities and those who work within the Mental Health and Learning Disability services that the IJBs can ensure that services and the way in which they are delivered, have the best chance of being both fit for purpose and sustainable and meet the need of the population of Tayside.

.

Integration bodies also have an obligation to wherever possible, move from traditional responsive services towards services that are designed to anticipate and prevent the avoidable consequences of ill health and inequalities and again input from stakeholders in designing future services is key to their success The most recent Health and Social Care Delivery plan (December 2016) places an expectation of a measurable decrease in emergency hospital admissions and has set a target of a 10% shift in the year 2017/18. It is in engagement with communities and the third sector that we see opportunity for early intervention that should reduce the root causes and manage the requirements of people for significant elements of the known root causes of acquired mental illness.

To successfully further shift the balance of care a process is required which engages and empowers staff as well as patients and their carers who are best placed to identify where services need to be improved, how these can be improved and where there are current waste and inefficiencies.

2.2 Case for change

- The current model of adult inpatient care is widely dispersed across Tayside. It is resource intensive with NHS Tayside having a far higher spend and higher staffing levels per head of population in inpatient services than all other Boards in Scotland. This inhibits our Mental Health and Learning Disability services to further develop and implement a 'whole system' approach in line with the national strategic objectives that focus greater emphasis on community based support for patients and carers.

- As a consequence of significant workforce challenges, the current configuration of clinical inpatient services is no longer sustainable. The current service model is introducing significant risks to the provision of safe effective patient care that must be addressed urgently. NHS Tayside is experiencing the impact of a national shortage of Mental Health specialist clinical staff. Shortages of both Medical and Nursing workforce are particularly acute in Tayside though there are similar issues experienced across Scotland, particularly in more remote and rural areas. The workforce profile is ageing with early retirement opportunities for Mental Health employees affecting a large proportion of more experienced staff. The twice yearly out-turn of Newly Qualified Practitioners is insufficient to match the projected numbers of people leaving the service. Tayside is competing with other Health Boards/Countries for a finite pool of staff. Like many areas in Scotland, National and Local Shortages of Junior and Senior Medical staff and Registered Mental Health Nurses are driving redesign. It is projected from staffing age profiles that within the next 5 years Mental Health and Learning Disability services will see retirements in current Nursing workforce of circa 35% and 24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years. Ten locums are currently employed out of a total of 64 consultants across Tayside Mental Health and Learning Disability services.

- The current model for Learning Disability services is incapable of supporting person-centred care, rehabilitation and enablement. The poor quality of the environments from which services are provided are preventing delivery of services that meet the needs of some of our most complex patients.

2.2.1 In line with the Mental Health Service Redesign Transformation Programme's aims and objectives there is a need to provide:

- Models of care which support safe, effective and person-centred care and treatment across community and hospital mental health and learning disability services that focus on prevention of admission and timely supported discharge
- A shift in the balance to primary and community care and care at home.
- Hospital services that are designed to provide interventions and care that can only be delivered in an inpatient facility. (94% of people who access secondary care mental health services each year do so in the community)
- Models of care that ensure equity of access to services across Tayside

- Service models that support safe, effective and sustainable deployment of staff across Tayside
- Best Value and optimal use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. Opportunities to disinvest in outdated estates and capital assets to reinvest in patient care.
- Effective recovery through close collaborative and co-productive relationships with family, carers and supporting community groups/organisations that complement statutory services.
- An environment that supports clinically effective and safe services
- A values based culture that promotes innovation in practice and enables staff to maximise their potential.
- A pleasant physical environment that promotes health and wellbeing
- Opportunities to redesign the patient pathway through care to improve patient experience, reduce length of stay and maximise use of scarce resources

To achieve this NHS Tayside and the IJBs must develop future service models for General Adult Mental Health and Learning Disability that will meet the requirements of patient safety and service sustainability, within the constraints of workforce availability and financial affordability.

As well as improving patient environments, NHS Tayside must make best use of existing PFI/NPD buildings and dispose of surplus property that is no longer fit for purpose or able to provide appropriate accommodation to deliver modern healthcare.

2.2.2 Current and future challenges to be addressed by the MHSR Transformation programme.

.

- Significant current and anticipated workforce shortages impacting on recruitment and retention of staff across all staffing groups
- Known age profile of current workforce across Mental Health and Learning disability services and anticipated retirements over the next 5 years
- Early retirement opportunities for Mental Health (staff can retire at 55)
- Requirement to optimise and balance available resources (staff, buildings and supplies are deployed as effectively, efficiently and fairly as possible)
- Redress the current weighting of resource envelope towards specialist inpatient services by shifting the balance of care to provide more community based services to reach the majority of population requiring services.
- Reduce variation in clinical practice across Mental Health and Learning Disability inpatient services in Tayside. (currently creates differences in service provision experienced by service users and their families)
- Providing safe services to as close to the service users home as possible, for communities living in both rural/remote and urban/deprived areas.

The Option Appraisal is a major step towards delivering this strategic vision to create sustainable, high quality safe, effective care and treatment through making best use of workforce skills and the resources at their disposal.

Although the Option Appraisal has focussed on inpatient service provision for adult mental health and learning disability, effective clinical services depend on a number of factors; effective prevention; support for recovery; timely return to living at home following hospital treatment, social inclusion and access to a range of supports in the wider community that maintain and promote health and well being.

Furthermore, effective treatment and recovery from mental ill health and optimum functioning and quality of life for people with learning disability is not solely determined by clinical interventions. The supports and opportunities required for people to regain and sustain mental well-being and fulfilling lives, lie within families, carer networks and local communities who are supported by a wide range of services and organisations.

To access and benefit from these services in future, care and treatment will be delivered through interagency collaboration. Individuals will move within communities through primary care, social care and housing services, voluntary organisations and a range of independent and private sector providers. The alignment of Mental Health and Learning Disability services with Health and Social Care Partnerships will improve the approach to service planning and delivery.

3. SCOPE OF THE STRATEGIC REVIEW

The Mental Health Service Redesign Transformation Programme was commissioned by NHS Tayside in partnership with the three local Integration Joint Boards to review Mental Health General Adult Psychiatry and Learning Disability services across Tayside.

This review includes inpatient services currently being provided from:

- Murray Royal Hospital in Perth
- Carseview Centre in Dundee
- Susan Carnegie Centre on Stracathro site near Brechin, Angus
- Strathmartine Centre in Dundee

The review will look at General Adult and Learning Disability service models for delivery of inpatient and community based care to the population of Tayside aged between 18 and 65 (circa 250,000)

4. WHAT DECISIONS HAVE ALREADY BEEN MADE?

NHS Tayside currently provides inpatient services for GAP acute admissions in three separate sites and Learning Disability services from two sites and across three Integration Joint Board structures and through hosting arrangements.

In 2014/15 an initial option appraisal was undertaken to review the sustainability of services, the provision of care in the community, and future inpatient provision. This informed a report presented to NHS Tayside Board on 10th March 2016. At this

meeting, the Board approved a proposal to deliver general adult psychiatry acute inpatient services delivered from two sites in Tayside instead of three sites, as currently provided. In March 2016, NHS Tayside Board also requested that further work was undertaken to consider services being delivered from one single site in Tayside.
The Programme team provided further information to the NHS Tayside Board in April 2016 to share plans for a further option appraisal exercise, describing the approach to be taken to ensure full stakeholder engagement in the process.

The initial finding of the option appraisal exercise and scoring were then presented to NHST Boards and the three Integration Joint Boards through August 2016 to endorse process followed and agree next steps for Programme.

Whilst the focus of the Programme and its review was on inpatient services it was apparent from the outset that this work was would be the first step towards a wider remodelling of mental health services.

An “acute care pathway” refers to the route that a person would take whilst being cared for from initial presentation with an acute mental health problem, to their ultimate discharge to care in the community or in their own home. This is as relevant to patients with a Learning Disability as it is for all other patients.

Such a pathway requires a range of different services and good links between them. Designing and implementing such a pathway is beyond the scope of this review.

However once the preferred options for inpatient units are defined, it will then be possible to look at options around creating acute care pathways which are more responsive to the needs of patients and their carers. During the public and staff engagement undertaken to date this was raised frequently as a key issue for discussion and had universal support

5. PREVIOUS INVOLVEMENT AND ENGAGEMENT ACTIVITIES

The Mental Health Service Redesign Transformation Programme team recognises the strength of public opinion around our Mental Health services in Tayside which has been evident throughout the process and in all engagement activities. The programme has held two option appraisal workshops and two subsequent option modelling events which have included representation from a wider range of stakeholders which included service users, carers, third sector and voluntary organisations as well as staff and other statutory services. In addition several information sharing and presentations have been undertaken across Tayside over the last two years. The Programme’s communication and engagement team are committed to learning from early experiences and ensuring the process for the review involves as many of the above noted key stakeholders as possible in each stage of the process in an open and transparent way to ensure build of trust and more likelihood of meaningful engagement. The programme is committed to engaging and valuing the input received from all stakeholder groups. All engagement activity undertaken to date is recorded in the communication and engagement plan for the programme and is attached in Appendix Three and the plan for the consultation period is attached with this report as a separate paper.

6. DUTY TO INVOLVE AND MAJOR SERVICE CHANGE

NHS Boards in Scotland have a duty to involve people (health service users, patients, staff, member of the public, carers, volunteers and the voluntary organisations they represent) in designing, developing and delivering the health care services they provide for them*. NHS Tayside and the IJBs fully support this approach, and believe that co-production of solutions with service users, carers, the voluntary and third sectors, the wider public and all staff groups is an essential way of building consensus. The involvement process for the Mental Health Service Redesign Programme moving forward will be set out in the draft Consultation Plan discussed in Section 12 and detailed in Appendix Eleven, which will be further developed in partnership with these key stakeholders to agree how they wish to be consulted with and best approach for the particular stakeholder groups (ie, specific needs/ support etc). The Programme is committed to ensuring we engage with as many stakeholders as is possible throughout this process to ensure as many views and opinions can be captured to support NHS Tayside and IJBs make an informed decision on a preferred option. This process has been based on the Scottish Government guidance "Informing, Engaging and Consulting People in developing Health and Community Care Services.** The National Standards for Community Engagement will also be used to support the process.

*NHS Reform (Scotland) Act 2004
** www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf

Although national guidance does not define major service change, the MHSRT Programme team have completed the Scottish Health Council (SHC) checklist/major service change template and has agreed that there is the potential for the options being considered in the review to lead to major service change and as such are following the associated principles of engagement and subsequent planning for consultation period as outlined in draft plan in section 12. The national guidance also states that in these cases the Board should continue to seek further advice from the Scottish Government Health Department (SGHD).

The MHSRT programme director and the communication and engagement team have regular contact and meetings with both representation from the SHC and SGHD.

7. PROCESS FOLLOWED

In the absence of National guidance for joint service planning across NHS Boards and Health and Social Care Integration Joint Boards, the updated Scottish Capital Investment Manual Guidance (2015) has been followed to establish the stages to be followed for service changes such as those being considered under this programme of work. In addition, guidance has been sought from the Scottish Government to ensure clarity of the expected process. The content and detail of the attached Option Appraisal report was noted by the Scottish Government to be of an extremely high standard. In addition the Scottish Health Council have been involved in the process and present at Option Appraisal events and have provided subsequent letter of support regarding process undertaken to date.

The Option Appraisal Report attached at Appendix Four describes in full the process that has been undertaken to identify and present options for the reconfiguration of GAP inpatient services to be provided from either a single site or two sites in Tayside and options for the future configuration of learning disability inpatient services.

Board members are directed to the attached paper for the detailed description, content and outcome of the Option Appraisal and the associated appendices.

8. DESCRIPTION OF CURRENT SERVICES

8.1 Bed Types

8.11 Acute Adult Inpatient Care

Acute psychiatric inpatient services are provided to deliver a high standard of treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of mental illness, and whose circumstances or acute care needs are such that they cannot, at that time, be treated and supported appropriately at home or in an alternative, less restrictive setting (The Commission on Acute Psychiatric Inpatient Care, 2015)

An inpatient service is defined as a unit with 'hospital beds' that provides 24-hour nursing care (as opposed to residential care beds). Many patients are informal but the service must be able to care for patients detained under the Mental Health (Care & Treatment) (Scotland) Act, with Section 22 approved psychiatrist(s) appointed as Responsible Medical Officer for all patients admitted. The service must be able to offer same-day admission at any time of day or night.

All units / patients should have access to the full range of skills of the multi-professional team. In order to provide evidence-based care a full range of disciplines should be available including doctors, nurses, pharmacists, psychologists, occupational therapists, physiotherapists, dieticians, speech and language therapists, support staff, advocacy, mental health officers, spiritual care and social work and care colleagues. Not all patients will require all these disciplines to be involved in their care, but they do need to be available for those patients who have particular needs.

People should be treated in an inpatient setting only when their illness cannot be managed by either GPs in Primary Care or by mental health teams based in the community (including Crisis Resolution and Intensive Home Treatment Teams).
At the point of needing to be treated in hospital, patients are often in crisis, afraid and vulnerable. In many cases they will be at risk of self- harm or suicide, and have significant needs which can only be met via the concentration of specialised resources that an inpatient setting will offer (Joint Commissioning Panel for Mental Health, 2013). Therapeutic activity and intervention is a key component of treatment and recovery.

Admission should be based on severity of the symptoms of illness and the associated risks that result due to those symptoms rather than the specific diagnosis itself.

Approximately **only 6%** of people who access secondary care mental health services each year, need to access care within inpatient services. 94% of the population access service in the community.

There needs to be a close relationship with Crisis Resolution and Home Treatment Service as this is the access route to Acute Adult Inpatient Services.

For those patients who are admitted to hospital for short term crisis alleviation, there needs to be active and early supported discharge facilitated through the CRHTT to ensure when safe to do so, these patients are supported to return to community living.

8.12 Intensive Psychiatric Care Unit (IPCU)

IPCU provides care for patients who cannot be managed safely on an acute ward. The ward is locked and entry and exit of patients and visitors is controlled. Staffing levels are of a higher patient: staff ratio than on an acute adult inpatient ward. Patients have access to the range of disciplines as they would in an acute adult inpatient admission ward.

The IPCU generally receives patients who cannot be managed on the acute inpatient wards due to the level of risk the patient poses to themselves or to others. Occasionally patients may also be referred from rehabilitation wards or from the courts. Admission to the IPCU is usually due to an acute or florid exacerbation of a patient's existing condition or it can be during a person's very first episode of illness. There is often a corresponding increase in risk to themselves or others, which does not enable their safe, therapeutic management and treatment in an acute ward.

The IPCU is a small unit with lower levels of stimulation that provides intensive care for patients across all localities and services. Patient's length of stay is normally short, ranging from a few days to a few weeks, depending on the patient's needs. Occasionally patients with very complex needs coupled with difficult behavioural aspects will be in IPCU for longer than a few weeks.

IPCU should not be located on an isolated site; it needs to be co-located with other psychiatric ward(s) due to occasional requirements for additional staffing support at very short notice. It must be able to accept patients any time of day or night. Patients in IPCU will usually be detained under mental health or criminal procedures legislation. There is therefore regular input from MHOs and Advocacy services required.

A patient would not normally have authorised time out from an IPCU. Low stimulus diversional activities are a key aspect of treatment. As the patients starts to respond to treatment they are usually returned to the acute inpatient ward or rehabilitation ward as soon as their risk has reduced and difficult behaviours settle, to enable them to engage in a mix of more psychological and therapeutic interventions to

support recovery before discharge to community. In some complex cases they will require a period of Rehabilitation treatment and preparation before being discharged to community care.

8.13 Rehabilitation and Complex Care Services

Rehabilitation units are provided for adults with severe and enduring mental health problems who have ongoing symptoms and functional impairments and cannot manage independent community living, even with support. At any time, around 1 % of people with schizophrenia receive inpatient rehabilitation. Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, co-morbid physical long-term conditions (such as diabetes, pulmonary disease) substance misuse and challenging behaviours.

This service is required for a relatively small group of patients but, with such complex mental health needs and lengthy admissions, associated costs are high. There is good evidence that with suitable rehabilitation even those with the most complex needs can progress to supported community living.

The units accept referrals direct from acute admission wards and from forensic mental health services and are planned (i.e. they would not normally happen as an emergency OOHs). The aim of treatment is to develop skills for a successful return to community living with appropriate support. Community-based units provide a more homely environment than hospital-based units and usually support clients to carry out domestic tasks, whereas these tasks are performed for clients in hospital units. The expected usual length of stay should be one to two years, however in some cases length of stay can be longer.

It is essential that patients who need this type of hospital care can access it as soon as they are ready to ensure they can receive appropriate intervention to support their recovery. Access to rehabilitation is also essential to prevent acute admission wards from having 'blocked beds' thus preventing people with acute illness getting into hospital when they need to or having patients cared for in excessive levels of security in low secure services (this can be legally challenged by patients).

Time out of hospital to support 'testing out' of living skills, problem solving and resilience building is a component part of treatment therefore patients need to be able to be supported to access community based facilities and resources to support their recovery and rehabilitation. Most patients from this service will require robust packages of care in the community after discharge, either in supported accommodation (usually purchased through local authority commissioning and provided by third sector organisations) or in their own tenancy with 'wrap around' care.

8.14 Learning Disability

People with learning disabilities (LD) have a significant lifelong condition that begins before adulthood and affects their development. They need appropriate and additional support to access information, learn skills, and live as independently as possible. About 16,000 school-aged children and young people, and 26,000 adults

in Scotland live with a learning disability that requires a range of support. There are more boys and men with LD than girls and women, although at older ages the gender distribution equalises, as women generally live longer. Population statistics suggest that 6 people in every 1,000 in Scotland have a Learning Disability. In Tayside, this rate rises to 9.2/1,000 (1,132 adults) in Dundee, drops to 5.5/1,000 (525 adults) in Angus and 3.9/1,000 (479 adults) in Perth and Kinross.

As with adult mental health, it is important to consider all Learning Disability in-patient beds as a whole pathway. Although the aim is for all patients to move through to the community, it has to be recognised that not all will move at a predetermined pace all the way through the care pathway. For patients who stay in hospital for long periods, there should be demonstrable evidence of ongoing therapeutic input. This will include psychiatric input, nursing care, pharmacist, availability of psychological therapy, occupational therapy, physiotherapy, speech and language therapy, rehabilitation activities that include educational and vocational opportunities, and supervised or independent access to the community (Royal College of Psychiatrists, Faculty Report FR/ID/03 July 2013).

8.15 Learning Disability Assessment Unit

These are acute admission beds in specialist learning disability unit. This clinical service model is intended for the assessment and treatment of patients with Learning Disability and severe mental health and/or behavioural problems, of an intensity which poses a risk that cannot be safely managed in a community setting, while not meeting the risk threshold to be considered for a forensic bed.

Treatment is provided by specialist staff that have experience and skills in the mental health of people with learning disability. The unit should be particularly suitable for those with learning or developmental disadvantage allowing people with learning disability and mental health or behavioural difficulties to achieve the same equity of outcome as others with the same mental disorders.

Clinical presentations are usually a complex mix of learning disability, mental illnesses and other developmental disorders. The natural course of these mental disorders suggests that there may be both crisis situations and situations where symptoms or behavioural disturbance persist in spite of adequate treatment. During those times, they need a safe setting with professionally qualified staff who can treat them.

For some people who present with challenging behaviour, physical and mental health issues are intricately linked with each other and often it can be difficult to tease out whether the presentation is because of an underlying organic (physical) condition. In many of these complex presentations, continuous nursing observation, physical investigations, medical and psychiatric expertise may be needed within an in-patient setting for an accurate diagnosis and effective treatment.

8.16 Learning Disability Forensic Rehabilitation (Open LD Forensic)

This service is for people who have ‘stepped down’ from low secure forensic units with enduring issues of risky behaviours. Their legal status and current risk

assessments still emphasise the need for ongoing therapeutic input and robust external supervision for the protection of the public. The availability of these hospital beds, often in locked or open community units, allows them to receive treatment in a less restrictive setting

8.17 Learning Disability Complex Continuing Care and Rehabilitation (Behavioural Support & Intervention)

This service model is for people who have undergone the initial acute assessment and treatment but for a variety of reasons, including enduring mental illnesses or severe behavioural problems that have not responded adequately to treatment, ongoing risks arising from neglect or vulnerability or persisting risks to the safety of others, a safe transition into the community has not been possible. Persistent challenging behaviour, which poses a level of risk that is unmanageable in a community setting, may be the manifestation of some other underlying mental health difficulty that requires careful assessment and treatment in the safe setting of an in-patient resource.

The availability of these beds allows a process of rehabilitation and re-skilling in a safe, structured and therapeutic environment at a pace that patients can tolerate, and minimises the risk of 'revolving-door' patterns of hospital admissions to the Learning Disability Assessment Unit

8.18 Forensic services

Forensic mental health services locally include North of Scotland Regional Medium Secure Unit (32 beds) and Tayside Low Secure Unit (35 beds) and a Tayside wide Forensic Community Mental Health Team. Forensic mental health services are provided for individuals with a mental disorder who because of their mental disorder present a risk of harm to others. This because of the need for specialist assessment of patients who may be awaiting trial or where the seriousness of the offence or risk of harm requires additional monitoring, supervision and treatment which is not provided by General Adult Psychiatry services.

Low secure units mainly form a rehabilitation function to plan and facilitate the safe discharge of patient into the community. The care and treatment for non LD and LD patient has the same aim but due to the differences in the nature of the mental disorders there is a significant difference in what care and treatment is delivered and how this is delivered.

Staff working in these settings are of the same disciplines as those required for adult inpatient services but they have knowledge, skills and experience specific to providing robust risk assessment, risk management which uniforms care and treatment in a secure environment.

8.2 Community Services

Community Services are delivered in clinics and people's homes across Tayside. IJB commission a number of third sector organisations to provide carer support, promote independent advocacy, empower service users in local and strategic planning and deliver employment services for people with mental health conditions.

Specialist supported accommodation is provided for people with severe and enduring mental health problems and to those with learning disabilities.

Adult Psychological Therapies Services assess and treat the following conditions: Mild to moderate depression, bulimia nervosa with no physical complications, panic disorder, generalised anxiety disorder, agoraphobia, specific phobia, social phobia, post-traumatic stress disorder, obsessive compulsive disorder and other psychological disorders where the presenting problem is likely to respond to brief psychological treatment

Multi-Disciplinary Community Mental Health Teams manage the following conditions: Severe and persistent mental disorders with significant effects on day to day functioning. This will predominately be people with psychotic illness such as schizophrenia, bipolar disorder and other types of psychosis, other long term non-psychotic disorders which require care and treatment that require a level of support and expertise that cannot be delivered by the primary care team alone, any disorder where there is also a significant risk of self harm, harm to others or risk of suicide and severe Personality Disorder where these can be shown to benefit from a care package involving secondary care.

Learning disability resource centres, enablement, health & wellbeing and college support, employment schemes, befriending projects all support people to maximise their outcomes.

The Health and Wellbeing Poster attached below highlights an example of good practice and meets the outcomes outlined in the national Mental Health Strategy

Mental Health & Wellbeing Nurse in Primary Care

Time limited option with GP

Delayed assessment and early intervention
Delayed treatment

Lack of awareness of alternatives to meet individual needs
Inappropriate referrals

Referral to wrong service
Overprescribing of antidepressants

Increased unnecessary demand on statutory services

Measures

Satisfaction feedback of service
CARE Questionnaire

% of referrals to statutory services

% of referrals to self management/third sector
Staff and patient narrative

Raised awareness of local population

self management needs

Clear CMHT Pathway to meet early intervention to crisis management
Delivers on the national health and wellbeing outcomes

Standard operating procedure in place

Appropriate referral to right agency at right time

Early intervention and preventions

Appropriate use of prescribed medication

Raised awareness to mental health and wellbeing within GP practices

Appropriate referrals to statutory services
Increased capacity and reduced demand on statutory services

Improved understanding of self management for individuals

Seen by same skilled Nurse every time

Timely signposting to meet individuals needs

8.3 Current Service provision

NHS Tayside currently provides General Adult Psychiatry acute admission inpatient beds are provided from three sites in Tayside:

- Mulberry Ward in Susan Carnegie Centre, in Stracathro, Angus, (25 beds)
- Moredun Ward in Murray Royal Hospital, in Perth (24 beds)
- Ward One and Decant Ward in Carseview Centre in Dundee (40 beds plus 4 Advanced Intervention Service (AIS) Beds)

In addition to GAP acute admission, Tayside wide GAP services for Complex Continuing Care and Rehabilitation, Tayside wide Substance Misuse services, Tayside wide Low Secure Services and Regional Medium Secure Forensic services are provided from Murray Royal Hospital in Perth and Tayside Wide GAP IPCU beds in the Carseview Centre, Dundee.

The Carseview site requires refurbishment and improvements as set out in the original Adult Mental Health Review Outline Business Case approved in 2005/06. The refurbishment of the site was originally suspended when the building owner of the PFI site went into administration and then reinstated in 2011 to review potential movement of Psychiatry of Old Age services from Royal Dundee Liff site in Dundee. Further internal reviews regarding building utilisation of the site were then undertaken and a subsequent review of Tayside wide IPCU service models highlighted a requirement for a review of all GAP care pathways and future utilisation/refurbishment requirements. A resource previously earmarked for the refurbishment of the site has been discussed with Scottish Government and will now be subject to the SCIM approval process following option approval.

Tayside wide Learning Disability Assessment Unit inpatient beds are provided from the Carseview Centre, Dundee and Tayside wide open and locked forensic Learning Disability inpatient beds and Behavioural Support and Intervention inpatient beds are provided on the Strathmartine site, Dundee.

The Strathmartine site is an ageing estate with significant backlog maintenance requirements and is unable to be further refurbished/redesigned to provide modern single bedroom en-suite healthcare facilities. Whilst such environments do not stop Learning Disability services from providing high quality care, operating from these buildings continually force these services to make compromises. These can compromise on the dignity and respect of the service users looked after at incredibly vulnerable times in life. These compromises also can impact on the efficiency of services and compromise on the motivation of staff by demanding their very highest standards whilst asking them to work in an environment known to be difficult.

Services for Psychiatry of Old Age are also provided from Whitehills Community Care Centre and Susan Carnegie Centre in Angus, Murray Royal Hospital in Perth and Kingsway Care Centre in Dundee.

Current inpatient beds are supported by a range of varying levels of community support through community mental health teams, outpatient clinics, day services,

assertive outreach, rehabilitation teams, crisis response and home treatment teams as well as interventions from multi disciplinary professionals such as Allied Health Professionals and Psychology services described above. The majority of service users are supported within the community through access to third sector and voluntary organisations and contact with General Practice.

8.4 Review of Current Medical Workforce Position

8.4.1 Consultants in General Psychiatry

14 General Adult Psychiatry consultants are employed on a regional basis to work in Angus, Dundee or Perth & Kinross. Inpatient consultant responsibility is organised differently in the three hospital sites

- Stracathro Hospital has one consultant working an inpatient only job plan with sessional input from a community based consultant. Cover for periods of leave for the inpatient only consultant is provided by colleagues working in the community
- Carseview Centre has five consultants covering the two inpatient wards. They have job plans which are split between inpatient and community work. Cross cover is provided by other consultants with inpatient responsibility.
- Moredun ward, Murray Royal Hospital is covered by a single consultant and cover for leave is provided by community consultants to their own sector patients
- Rehabilitation Psychiatry is based at Murray Royal Hospital and is covered by two consultants who cover each other.

There are Ten Locums currently employed across all Mental Health services. Seven locum consultants are currently employed within GAP services as follows

- In Angus two locums work in the Community Mental Health Teams (CMHTs) in Arbroath.
- In Dundee one locum works in both the Intensive Psychiatric Care Unit (IPCU) and instead of providing ward cover is now providing medical cover for the Crisis Response Home Treatment Team (CRHTT). The two other locum consultants work in CMHTs.
- In Perth & Kinross one locum works in the Moredun Ward, Murray Royal Hospital (MRH) and one in the North East Perthshire CMHT.

There are only three Higher Trainees in General Psychiatry at present in NHS Tayside which is not sufficient to meet this need even if all three wished to work in Tayside. The position nationally is similar with fewer trainees completing training than the number of vacant consultant posts.

Options of overseas recruitment have been explored in the past with no result but this option is again being looked at.

8.42 Consultants in Psychiatry of Learning Disability

There are three consultant psychiatrists working in the Learning Disability service. A long term full time vacancy exists and despite advertising it has not been possible to recruit to this post due to no applicants coming forward. This is filled with a long term locum by reconfiguring consultant job plans and having a SAS doctor work in the consultant role. This means the service is reduced in SAS provision as it has not been possible to fill that position with a locum most of the time.

It may be possible to recruit a local Higher Trainee to this post in the next couple of years but there are unfilled consultant posts nationally with insufficient number of trainees to meet this need.

8.43 Consultants in Forensic Psychiatry

Since 2012 the service has been able to recruit 4 new consultants to fill vacant posts which have arisen over that time due to retirement and resignation.

NHS Tayside funds three consultant posts to cover the low secure unit at Rohallion Clinic, Murray Royal Hospital, the Forensic CMHT and visiting psychiatrist sessions to HMP Perth and HMP Castle Huntly. These posts are all filled with substantive consultant appointments.

The North of Scotland consortium of health boards funds three consultant posts to cover the regional medium secure unit (MSU) at Rohallion Clinic. These posts involve significant amounts of travel across Scotland to other secure units and prisons. It has never been possible to recruit to one of these posts.

Over the past five years vacancies in consultant posts have been mitigated by various measures such as Higher Trainees employed on three month acting up positions, employing a long term locum for 12 months, a Service Level Agreement with the State Hospital for two years and most recently a retired consultant appointed on a part time basis to the MSU.

Sourcing locum consultants with the necessary knowledge and experience to work in the MSU is not easy. As a result the workload is being covered by the other consultants.

There are no Higher Trainees in Scotland who will be likely to apply for such a post until February 2018 at the earliest. It is planned to readvertise the post this summer but it is not encouraging that NHS Fife advertised a post working in a LSU within the past two months and received no applicants.

8.44 Future consultant numbers

Employing locum consultants does mitigate the impact on service delivery for services and provides safe patient care. However it can be unsettling to patients,

carers and multidisciplinary teams because of problems with continuity of care. It is also a significant cost to NHS Tayside.

It should be highlighted that the locum consultants employed in Moredun ward and IPCU are both providing leadership in service development and a high level of patient care. Unfortunately both consultants, for personal reasons, will leave their posts in the next 6 to12 months. It is anticipated that other locum consultants will be employed and there are plans to reconfigure the post in IPCU and CRHTT to improve the chance of this.

Services are looking at their medical workforce plans to identify how they can maintain current level of service without the need for locum consultants and make vacant posts more attractive to potential applicants.

Reorganisation of consultant posts with inpatient responsibility could, in some of the options, release some consultant sessions. However these may be required to be invested in CMHTs and/or CRHTT to help prevent admission and support early discharge.

- This has already happened to an extent with the implementation of the contingency plan in February 2017 there was a move from 25 to 20 beds in Mulberry which freed up 2 DCC PA. These are being used to provide enhanced CMHT functions in Arbroath/Carnoustie and Monifieth.

- Also when medical cover to the Angus CRHTT made the service unsustainable in recent years 1 consultant PA was transferred to the Forfar and Montrose consultants to provide enhanced CMHT functions.

As described above there is no short term solution to consultant vacancies within the Higher Training schemes. Numbers of Higher Trainees are set nationally and recruitment is also national which makes it impossible for individual boards to have much influence over this.

The position is predicted to become worse with retirement rates greater than recruitment rates for the past couple of years. It will be some years until the cohort of consultants eligible for Mental Health Officer status have all retired.

24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years.

8.45 Non consultant grade staff

NHS Tayside employs 11 SAS doctors. Two work in General Psychiatry, three in Learning Disability and three in Forensic Psychiatry. The other three work in Child and Adolescent Mental Health Services.

These doctors provide valuable service delivery but anecdotally it is very difficult to recruit to these posts. This may be due to the ready availability of higher paid locum work. In general SAS doctors are more likely to work less than full time.

In the medical workforce plan for Forensic Psychiatry there is an allocation for three whole time equivalent (wte) SAS doctors to cover the MSU. This recognised that no doctors in training would be allocated to the MSU to support the consultants. It has only been possible to recruit to 2.0 wte. However the underspend has allowed the service to employ sessions from a General Practitioner to provide primary care across the inpatient service.

In 2016 the Forensic service offered part of its medical budget to employ an additional Physician Associate as part of NHS Tayside's Physician Associate Programme. Since September 2016 one Physician Associate has been working in the MSU. This has been a positive experience for all. Due to the limited training the Physician Associates get in psychiatry during their course their role appears mainly in providing primary care and physical health issues. There could be scope for other services to explore this option if NHS Tayside intends to employ an increased number of Physician Associates.

8.46 Doctors in training

The traditional model of doctors in training providing a substantial amount of planned care and service delivery out of hours appears unsustainable. This is largely due to insufficient numbers of doctors able to work out of hours rotas across three hospital sites but also because of the need to have a better balance of planned community experience compared to inpatient and emergency work.

Murray Royal Hospital is under scrutiny by the Deanery on behalf of the GMC because of persistent red flags about training and supervision in the National Trainee Survey. The next Deanery visit is in July 2017 to monitor progress on the action plan to remedy concerns. If the hospital is placed in Special Measures by the GMC after this visit and concerns about training remain then it is possible training status will be removed from the hospital This will risk service continuity for Moredun ward in particular but also have significant impact on all subspecialties in the hospital and potentially the out of hours medical cover to other hospital sites.

It requires 32 doctors to staff out of hours rotas across three hospital sites. There is funding for 28 training posts in psychiatry across Tayside. The numbers of trainees and funding is set nationally.

- Three of these posts are Foundation Year 1 doctors who provide limited service and cannot take part in out of hours emergency work.

- Six posts are Foundation Year 2 doctors. These doctors cannot be on a Stracathro Hospital rota because of concern about the support arrangements in the hospital out of hours.

- Nine Core Psychiatry Trainees. Since 2016 Stracathro Hospital has been assessed as an unsuitable training environment for Core Psychiatry Trainees because of the lack of emergency psychiatry experience.

• 10 GP Specialty Trainees. These doctors are organised on a local area basis and gaps in posts in one area are not covered by GP trainees from another area.

8.47 Current Medical Workforce position

NHS Tayside currently has 89 acute General Psychiatry inpatient beds and 10 Intensive Psychiatric Care Unit. There are 4 beds funded separately for the Advanced Intervention Service which are not included in this total or scope of the Review. The 10 IPCU beds are also not affected by any of the options in this appraisal.

The consultant Programmed Activities (PA) for Direct Clinical Care to the 89 inpatient beds (excluding IPCU) are allocated as follows

- Stracathro 10 PA
- Carseview 20 PA
- Moredun 12 PA

Currently the number of consultant PA allocated to cover the inpatient wards is consistent with guidance from the Royal College of Psychiatrist's contained in its report "Safe Patients and High Quality Services. A Guide to Job Descriptions and Job Plans for Consultant Psychiatrists"

Learning Disability:

The Learning Disability service has been unable to recruit following the retirement of a Consultant in 2014. This has been mitigated by reconfiguring consultant job plans and having an Associate Specialist work in a consultant role.

Forensic Psychiatry has also been unable to recruit to a full time consultant post in the regional medium secure unit. Since 2012 the service has been able to recruit 4 new consultants to fill vacant posts due to retirement and resignation. This post in the medium secure unit is funded from regional money but has never been filled since the unit became fully operational.

It is anticipated that over the next two to three years it will be hard to fill these vacancies with trainees who are currently working in Tayside.

These vacant posts reflect the position nationally with difficulty recruiting to substantive posts due to a lack of suitable applicants.

9. OPTIONS CONSIDERED

The full detail of the list of long and short of options is contained within the Option Appraisal report attached at Appendix Four.

The top four options which scored highest from the option appraisal events were:

9.1 Top Four Options

- **Option 3A**

Single site option for General Adult Psychiatry (GAP) acute admission beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth to be provided from four refurbished wards in the Carseview Centre in Dundee and provide 84 beds for Tayside as per Table Two in section 9.3 below. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a single site option for Learning Disability services which would relocate current inpatient beds from Strathmartine and Carseview sites to a refurbished combined ward in Murray Royal. This ward will provide inpatient beds for Learning Disability assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 4A**

Two site option for GAP acute admission inpatient beds with relocation of current inpatient beds provided in the Moredun Ward in Murray Royal in Perth to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Mulberry ward, Susan Carnegie Unit, Stracathro, Angus and from existing

GAP acute admission inpatient beds in the Carseview Centre in Dundee and provide 87 beds for Tayside.. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Moredun ward within the Murray Royal hospital site would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 5A**

Two site option for GAP acute admission inpatient beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro, Angus, to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Moredun Ward on Murray Royal site in Perth and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 8**

This option is a new option generated at the Option Appraisal events.

Single site option for General Adult Psychiatry (GAP) acute admission beds from a single inpatient ward for Tayside for acute assessment on the Carseview centre in Dundee. The inpatient beds provided from the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth and in the Carseview Centre in Dundee would then change function to provide step down/treatment inpatient beds for each locality and provide a total of 89 beds (18/22 Acute Admission). This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability inpatient services which would relocate from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds in one ward and 8 open forensic inpatient beds in a second refurbished ward on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

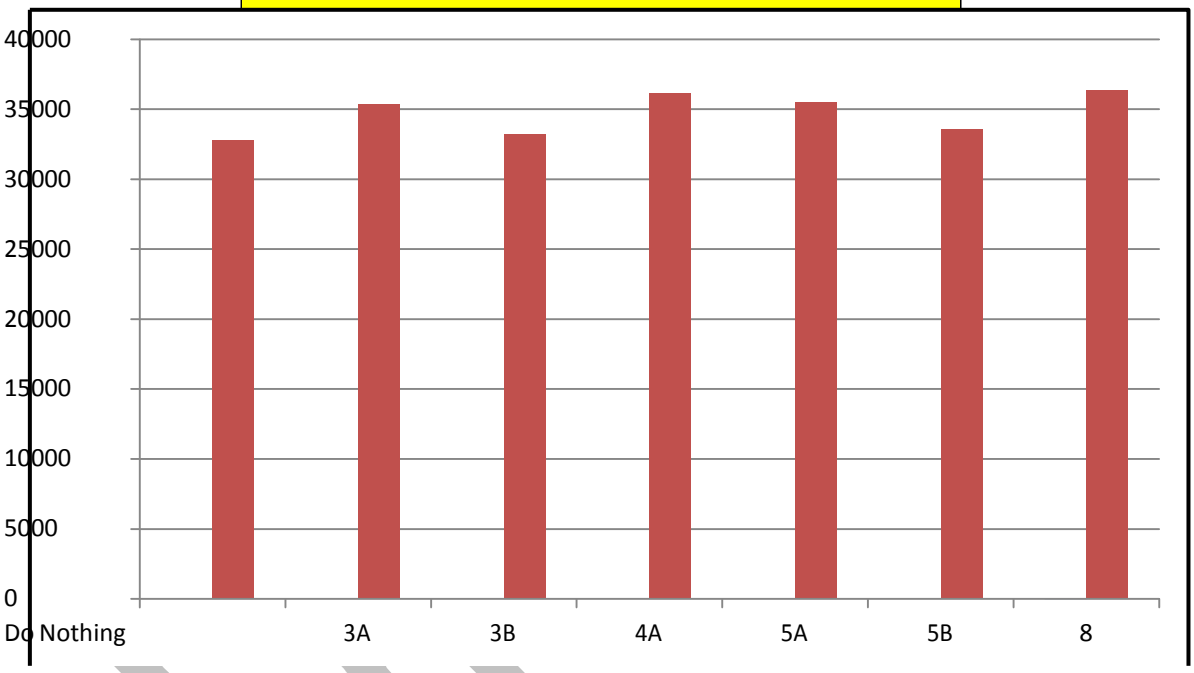
Appendix Twelve of the full Option Appraisal Report (attached at Appendix Four) provides further descriptor of other NHS bed provision currently provided around each of these options.

9.2 Option scoring

As the scoring results in Table One below demonstrates the four options scored extremely closely and therefore have been subject to further clinical appraisal, workforce review and financial appraisal of benefits.

Table One – Scoring of Short List option results

Option		Score	Rank
1 – Do Nothing		32811	7
3A		35349	4
3B		33223	6
4A		36146	2
5A		35496	3
5B		33528	5
8		36337	1



Option 8 which was the new model proposed at the workshops scored highest. The chart above demonstrates the proximity of the scores. Having reviewed each of the individual scoring sheets, generally the majority of participants adopted a similar approach to how they allocated the scores. This gives an indication that the general understanding of what each option would deliver was understood by participants.

Please note; due to the scoring system used to capture this information, it was found to be very subjective dependant on how strongly each individual felt about the specific question being posed to them. This threw up many outliers which in turn skewed several of the results up or down. There were a number of scoring sheets which were disproportionately scored. The full spread of tabular scores illustrates this and is provided for background information in Appendix Thirteen of the full Option Appraisal Report attached in Appendix Three.

The two options that scored highest, from the two workshops that were held to facilitate the process, still have services for adult mental health being provided from three sites across Tayside, albeit the acute admissions wards are either on a single site or two sites; and therefore met the criteria requested by NHST Board.

The difference in scoring between the top four options was marginal; therefore the top four scored options have been presented in this paper to ensure the scope requested for a single site or two sites for adult inpatient services is presented and the identification of a preferred option is clear.

10. OPTION COMPARISON

10.1 Option Modelling

Following the option appraisal events held in June 2016 and subsequent reporting of results to NHST Board and the three Integration Joint Boards in August 2016, it was agreed that further option modelling work would be required to support identification of a preferred option which was feasible in terms of clinical safety, sustainability, workforce availability and financial affordability. The Board requested the programme undertake the detailed modelling work with the involvement of key stakeholders to identify a single preferred option to progress an Initial Agreement report and move to period of consultation. Further guidance received from Scottish Government in mid December has advised that the Consultation Period will be required prior to the production of the Initial Agreement Report which is reflected in the revised timeline as shown in section 13.

An option modelling event to review the top four GAP options being considered was held on 29th September 2016. 61 nominations were received through the Integration Joint Boards however 55 were in attendance at event.

It was assumed that the detailed work for Learning Disabilities would be progressed through the Learning Disability work stream set up as part of the Programme. However work did not progress as timeline required or have sufficient representation of stakeholders involved in group. Following positive feedback of the option modelling event held for GAP services and recognition of the wider stakeholders involved in that process, the work stream leads requested a similar approach was required and a subsequent Learning Disability option modelling event was arranged and undertaken on 8th December 2016.

44 nominations were received for the Learning Disability option modelling event on the 8th December 2016 however only 29 attended.

The Option modelling events were facilitated by members of NHS Tayside Service Improvement team at Ninewells and hosted in the Improvement Academy. Both GAP and Learning Disability events followed the same format.

Service user and carer group representatives, clinicians, managers, AHPs, Psychologists, third sector, voluntary organisations and staff side representatives were initially presented with the background to programme and overview of process followed to date, detailed information highlighting the 5 year nursing workforce projection for services, a report on current junior and senior medical workforce issues and an outline of the next steps of the process to be followed

The participants were then separated into four pre-selected groups (membership ensured representation from all locations/clinical groups/third sector were in each group) and allocated an option to consider in the first of four sessions. The facilitators then took each group through discussion to provide identification of the patient pathway for the option and then a series of questions regarding the viability of the option. Each group then moved round to examine the next option and consider the comments of the previous group. This process was repeated four times to cover all options being considered.

As the Learning Disability options had three potential options (Option 4A and Option 5A same for Learning Disabilities) the opportunity was taken to use the fourth session to examine the option of whether the Locked Forensic Learning Disability services could be relocated from Strathmartine Flat One to a low secure ward in the Rohallion unit at Murray Royal in advance of the process as all four options had agreed this move in the option appraisal scoring exercise and would provide significant improvement to current environments for the 6 to 8 patients affected. NHST Board in August had approved in principle the suggestion to relocate these services but requested further information and therefore the fourth session sought to clarify the option, the ability to progress and issues this presented Feedback from the Learning Disability stakeholders who participated in the option modelling event did not feel it was viable to move services in advance of the options being considered, however this has been subject to further challenge and discussion and will continue to be explored with the preferred option.

The Low secure Forensic inpatient service will require to move from three wards to two wards in each of the top four options being considered. This will have implications of how this unit currently operates. The current model for Low Secure makes use of three wards to provide one ward for Assessment and Treatment and two wards for Rehabilitation. A re designation of one ward in the low secure unit will mean a reduction of 50% of rehabilitation beds if the same model of care is used. Other models which can be considered are to provide only rehabilitation with no admissions directly from prison, community or IPCU, or to develop a mixed function of assessment and rehabilitation in one ward which would still allow timely transfer of prisons in particular. This re- organisation could be done relatively quickly given the current patient numbers.

It was the view of senior clinicians and managers in the Forensic Service, that there is a benefit to both Learning Disability patients and staff if this element of the programme could be brought forward in advance of the current programme. Acceleration of the relocation of the locked LD forensic patients will have no impact on other parts of Low Secure Forensic services whichever option is

chosen but will greatly improve the environment for current Learning Disability locked forensic patients.

The patient pathways identified for each option have been demonstrated in flow charts in Appendix Five.

Full reports from these modelling events are included within Appendix Six.

10.2 Review of each option

Each option detailed below is compared to highlight changes from current models, what the option would require to work in practice and the pros and cons of each,

Table Two below highlights the proposed bed numbers for each option being considered:

Table Two – Bed Numbers by options

General Adult Psychiatry	**Current**	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Carseview					
Acute Admission	40	84	62	62	18
Advanced Intervention Service (AIS)	4	4	4	4	4
IPCU	10	10	10	10	10
Acute Step Down beds	-				22
Murray Royal					
Acute Admission	24			24	
Rehabilitation	16	16	16	16	16
Complex Care	10	10	10	10	10
Acute Step Down beds	-	-	-	-	24
Susan Carnegie Unit					
Acute Admission	25		25		
Acute Step Down beds	-				25
Total GAP Beds	**129**	**124**	**127**	**126**	**129**
Learning Disability and Low Secure Forensic	**Current**	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Carseview					
Learning Disability Assessment (LDAU)	10	-	-	-	-
Learning Disability LDAU/Behavioural support & Intervention (BSI)/Open Forensic combined in LDAU area	-	-	22	22	-
Learning Disability LDAU/Behavioural support & Intervention (BSI) combined in					16

LDAU area					
Separate Open Forensic LD					6
Murray Royal					
Learning Disability LDAU/BSI/Open Forensic combined in Acute ward	-	22	-	-	-
Low Secure Forensic	35	25	25	25	25
Locked Low Secure LD	-	10	10	10	10
Strathmartine					
BSI	6	-	-	-	-
Open Forensic	6	-	-	-	-
Locked LD Forensic	10	-	-	-	-
Total LD & Low Secure Forensic Beds	**67**	**57**	**57**	**57**	**57**

The Mental Health Transformation Programme impacts primarily on General Psychiatry, Psychiatry of Learning Disability and the Forensic Mental Health Service. However the consequences of reconfiguring the acute care pathway for General Psychiatry will undoubtedly have implications for other subspecialties medical cover out of hours.

In the options below there are scenarios where it is not guaranteed that safe medical cover can be provided with the current and predicted medical workforce. When balancing the pros and cons of each option it is suggested that this issue is the main priority.

Serious concern exists about the viability of delivering safe medical cover with two of the options below (4A and 8). This is because of problems in the number of doctors in the current and predicted medical workforce.

The subspecialties which are directly affected by the Mental Health Service Redesign Transformation Programme all currently have long term consultant vacancies which will be highly relevant to the implementation of whichever option is chosen.

Options which allow manageable job plans, which have ease of cross cover arrangements and offer the potential for career development will be more likely to be successful in retaining staff and improving the chance of future recruitment.

Options which make the best use of the existing consultant workforce and do not anticipate an increase in consultant numbers are more likely to be sustainable in the longer term.

There is also a persistent issue about insufficient number of doctors in training to deliver both planned and emergency care which is explained in greater detail above and below.

10.3 Option 3A

Option 3A provides a single site option for General Adult Acute Admission inpatient beds from the Carseview Centre in Dundee and a single site option for Learning Disability inpatient services from the Murray Royal site in Perth.

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.3.1 What changes?

Current acute admission inpatient beds provided from both the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) and Moredun Ward in Murray Royal Hospital, Perth (24beds) would relocate to Carseview Centre in Dundee to two refurbished 22 bed wards. Carseview site would therefore provide four acute admission wards (84 beds)

Learning Disability assessment unit inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the vacated refurbished Moredun Ward at Murray Royal in Perth. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the Moredun Ward at Murray Royal in Perth. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Unit in Murray Royal, Perth

Over the past two years there has been significant shift in how the forensic community patients have been managing dynamic risk factors. Instead of a first response of hospitalisation an approach of supporting and helping patients self manage their risk factors has been successful in reducing re admissions. Closer working with local authorities and housing in particular has brought benefit to patients in discharge planning which have been more successful in keeping patients living in the community. As a consequence 35 inpatient beds have not been required for over 12 months. It is anticipated that this is not a short term situation and there is a genuine reduced demand which brings NHS Tayside more in line with similar services across the country and would allow the accommodation of Learning Disability patients within the clinic.

Low secure Forensic beds for Tayside would therefore reduce current capacity by 10 beds to accommodate Learning Disability beds and provide services from two wards rather than three wards.

10.3.2 What would this model require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment which

would be required for both an increase community services and recognition of estimated requirements for additional escort of patients etc.

Learning Disability day treatment services currently provided on Strathmartine site would require to be re-provided either/both from the Murray Royal site or in local community based settings. Current services benefit from workshops/gardens on the Strathmartine site and feedback has identified that these should be replicated. Detailed modelling of how (NHS/Local Authority/Social Enterprise models) and where (each locality/Centralised/beside inpatient beds) these services could be provided will be developed on selection of a preferred option.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.3.3 What are the pros/ impact on service users/carers/staff?

A single site for GAP acute admission inpatient beds and a single site for Learning Disability services would provide the opportunity to reinvest some resources into community and home treatment services across Tayside. This remodelling and reinvestment of services would assist in further shifting the current balance of care towards provision of more treatment closer to or in the service users own home and meet the requirements of almost all strategic drivers. More intensive community services prevent admissions to hospital, improve service user experiences and streamline the pathway into and out of hospital on discharge when they are most acutely unwell. This reinvestment will help people get better closer to home. This will make a very real and lasting difference to the lives of all the people who use mental health and learning disability services

By accommodation of all GAP acute admission and IPCU inpatient wards on one site in Dundee and Learning Disability services on the Murray Royal site with other Tayside wide specialist services, NHS Tayside has the opportunity to create a “Centre of excellence” for both GAP and Learning Disability services on both campuses. The concentration of inpatient staffing resource allows for consistency of approach, improved patient safety, creation of a shared learning/teaching environment and an increase in provision of staffing cover across specialties.

Table Three below highlights a recent study undertaken on 46 Newly Qualified Practitioners (NPQs) geographical and specialty preferences

Table Three – NQP preferences by location and speciality

Locality	Service	Number of Applicants	% of Total
Dundee	General Adult Psychiatry	18	39.1
	Community	5	10.9
	CAMHS	3	6.5
	Forensic	3	6.5
	Psychiatry of Old Age	2	4.3
	Total	**31**	**67.4**
Perth & Kinross	General Adult Psychiatry	3	6.5
	Forensic	5	10.9
	Psychiatry of Old Age	1	2.2
	TSMS	1 (HNC)	2.2
	Prison Health Service	1	2.2
	Total	**11**	**23.9**
Angus	Community	2	4.3
	Learning Disabilities	1	2.2
	Psychiatry of Old Age	1	2.2
	Total	**4**	**8.7**

As can be seen from the table above, of the 46 current NQPs 67% (31wte) have identified their preference is to work in the Dundee area and almost 40% in Dundee GAP services versus 7% in Perth and 4% in Angus GAP services. Therefore moving forward with a model where the majority of General Adult Psychiatry nurse staffing are required in Dundee area would fit with where NPQs are likely to seek employment when finish training.

As noted in Learning Disability comments below, it has traditionally been harder to recruit to LD nursing in Dundee. Perth is more accessible from the central belt and is more attractive to potential LD and Forensic applicants.

This model would also support improved medical responsiveness; improved training for junior doctors, concentration of on call would further free up trainees for training and other service related tasks and allow for a specialist model of impatient practice to develop.

Possible impact of the option on medical workforce

In this option the numbers of acute General Psychiatry beds reduce from 89 to 84.

Having all acute beds on one site allows for:

- Better consultant cross cover arrangements
- Greater peer support for consultants currently working single handed
- Reduction in variation of practice
- Greater resilience in dealing with vacancies in doctors in training posts through cross cover arrangements.
- The opportunity to look at developing primary care aimed at improving physical health of long term in patients with severe mental illness.
- The opportunity to innovate more non pharmacological approaches to treatment with greater patient numbers to sustain groups

The Royal College of Psychiatrists recommends an allocation of 7.5 DCC PA for 15 to 20 patients. The more complex the case load and higher turnover in patient numbers the more appropriate it is for the figure to be at the lower end of the range. More than 20 patients can be managed by a consultant provided there is additional senior medical support such as a Specialty Doctor or Higher Trainee.

It will be for the General Psychiatry service to develop a model for consultant inpatient work. This may be based on consultants working inpatient only jobs or split community / inpatient posts. Developing manageable job plans which make best use of consultant time may require considering greater flexibility in job plans and the consultant cover not strictly based on community team sectors.

The General Psychiatry acute inpatient wards currently have 42 PA allocated to cover inpatient wards, excluding the IPCU. Using a model of inpatient only post and using the midpoint of the College recommendation then consultant cover to four General Psychiatry wards could potentially be delivered with 36 PA. If the medical budget is used to recruit SAS doctors for the inpatient service rather than locum consultants then the number of consultant sessions could reduce to 32 PA.

All Learning Disability inpatient services are provided at MRH in this option. This allows for:

- Co located wards sharing medical staff and other resources to make better use of medical time.
- A smoother transition between locked secure wards and the open secure wards

There is no reduction in total LD beds from 32. Any savings in LD consultant PA will most likely come from transfer of the LD locked secure service to Forensic.

The model would also allow for a complimentary approach to treatment with more sharing between disciplines and make it easier to deliver the service.

The model would improve skill mix and consistency of care.

The Carseview site is also adjacent to Ninewells Accident and Emergency (A&E) department, which provides emergency medical response to the population of Dundee and Angus and the most complex emergency services to the population of P&K.

The assessment and crisis response services for the population of Dundee and Angus are currently based in Carseview Centre, Dundee from 3pm until 9am daily and 24 hours per day at weekends. Current contingency plans have seen the relocation of assessment and crisis response for Perth and Kinross provided on a temporary basis from Dundee due to current staffing shortages. The assessment and crisis response services provide a gate keeping role for admission to inpatient beds and therefore would be on site at Carseview and prevent service users having to transfer back to localities for admission following assessment during a period of where they are most acutely unwell.

GAP services would benefit from improved refurbished environments at Carseview.

LD services would benefit from significantly improved environments on the newly built Moredun ward and in the purpose built forensic building in the Rohallion Clinic at Murray Royal. The accommodation for these services currently on the Strathmartine site are not fit for purpose and often commented on during Mental Welfare Commission Audit Reviews.

Care and treatment for Learning Disabilities would be delivered in modern and fit for purpose accommodation improving both patient experience and journey whilst enabling staff to be part of specialist secure care services that would promote and facilitate ongoing and continual professional development. This proposal would also alleviate concerns from the mental welfare commission and would meet the standards required for the delivery of learning disability services and its low secure care. There are many benefits associated with this model and it would enable the service to address and meet some of the workforce planning challenges. There is a national shortage of learning disability nurses, most reside within the central belt geographical area, and historically it has been difficult to recruit to the location of Dundee. Perth is more accessible from the central belt and is more attractive to potential applicants. In addition being part of the wider secure care services would enhance recruitment opportunities based on forensic core competencies rather than just learning disability experience

This option, where all Learning Disability inpatient Services are placed in Perth, would enhance and support a step down model for Learning Disability forensic care by having a Learning Disability Open Forensic Ward on site for patients moving out of the Learning Disability Locked Forensic Ward. In addition the Forensic Community LD team could be co-located with the Forensic Community Mental Health Team in Birnam on the Murray Royal Hospital site. The other options being considered spit these services across sites.

This option is consistent with other Board areas across Scotland who have moved to a single site provision for GAP and LD services

10.3.4 What are the cons/ impact on service users/carers/staff?

Access – the main area of concern raised throughout the process and when considering each of the options for both GAP and LD was the ability to access inpatient beds from the most rural areas within Tayside. Any reduction in the current site provision will mean that service users and their carers/families from north Angus and areas of Perthshire will have an increased distance to travel to access a General Adult Psychiatry acute admission inpatient bed. This option will also impact on Learning Disability service users and their carers/families in Dundee and Angus having an increased distance to travel to Perth for an inpatient stay.

Feedback throughout the process has highlighted the importance of family and carer support and their ability to visit service users when in an inpatient facility provides support and assists recovery.

Current links with Perth Royal Infirmary A&E department liaison may be reduced.

Re-provision of current day treatment was a major concern for LD stakeholders. Day treatment models would need to be developed in conjunction with the three local Integration Joint Boards to provide alternative integrated day treatments which do not necessarily require to be on a hospital site and may be provided in local communities through models such as social enterprises etc.

Links between Learning Disability Inpatient services and Angus and Dundee Learning Disability community services would require to be reviewed in this model.

Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to the small numbers from each area, alternative ways of providing these valuable services will need to be further developed and appropriately resourced during the detailed review of a preferred option.

Increases in the need for rehabilitation beds in a reduced forensic low secure unit has the potential to create a problem in transfer of patients from prison or the medium secure unit. Prisoners would always be prioritised in this situation and it may be that the medium secure unit looks to adapt its model of care. Currently patients in the medium secure unit do not have regular unescorted community access. If the pathway to the low secure unit is slowed due to reduced capacity then it may mean patients remain in the medium secure unit longer than necessary. This could be offset however by adopting models used in the other two medium secure units of allowing regular unescorted community access as part of discharge planning for less complex patients and further mitigated by much improved patient pathways and joint working between Low secure, IPCU, Rehabilitation/Complex Care and GAP services.

The full impact on service users/carers/families will be assessed and monitored as part of the equality Impact assessment to ensure actions are taken to try and mitigate the impact any service change may have. This is an ongoing process

and during consultation on the preferred option, actions taken to reduce impacts will be monitored and evaluated to ensure equity of service provision across Tayside. Solutions required to address any access issues will be explored during this period

Other disadvantages of this option are:

- Disruption to medical staff in relocating their base
- Moving two General Psychiatry wards with accompanying medical and admin staff will place a strain on the already fully occupied accommodation and car parking arrangements.
- Input from consultants working in CMHTs to pre discharge meetings will mean increased travel for those based in Perth & Kinross and Angus. This could be reduced however with the use of video or tele conferencing.

Cross cover – Psychiatry of Old age services in Angus would no longer have the Mulberry Ward onsite to provide emergency cross cover. This would however be on a non recurring basis and require bridging resources to cover until a further option appraisal exercise could be undertaken by the Angus Integration Joint Board to agree utilisation of the vacated Mulberry ward.

10.4 Option 4A

Option 4A provides a two site option for all General Adult Acute Admissions from the Carseview Centre in Dundee and the Mulberry ward in Susan Carnegie Unit, Stracathro, Angus and a two site option for Learning Disability inpatient services from both the Carseview Cente in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Carseview site would therefore provide three acute admission wards (62 beds) and one ward on Susan Carnegie Unit (25 beds)

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.4.1 What changes?

Current acute admission inpatient beds provided from the Moredun Ward in Murray Royal Hospital, Perth (24beds) would relocate to a refurbished 22 bed ward in the Carseview Centre, Dundee.

Learning Disability Assessment Unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the refurbished LDAU ward on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Clinic in Murray Royal, Perth

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.4.2 What would this option require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment required for an increase to community services in Perth to support relocation of beds and in recognition of requirements for escort etc.

Learning Disability day services currently provided on Strathmartine site would require to be re-provided either or both from the Carseview site or in local community based settings.

Low Secure Forensic services will need to provide services from two wards rather than current three ward model. This will mean combining admission and rehabilitation within these areas. A crisis suite will need to be included within one of the wards to ensure provision for crisis is available in both remaining environments.

This option will continue to require medical staffing cover across the three sites (Susan Carnegie, Carseview and Murray Royal).

10.4.3 What are the pros/ impact on service users/carers/staff?

Retention of local beds in Angus was seen as a preferred option for Angus service users/carers/families with reduced travel and access issues for rural North Angus residents.

Some reduction in nursing workforce requirements could be achieved through economies of scale with co-location of three GAP acute admission wards on the Carseview site.

Three GAP acute admission wards on Carseview site would increase ability to cross cover wards.

In this option the General Psychiatry beds at MRH transfer to Carseview Centre and the number of acute beds reduce from 89 to 87. The Mulberry Unit remains at Stracathro Hospital.

It is important to highlight that this option was considered as part of the contingency planning to deal with the reduced number of doctors in training in

February 2017. It was not supported because of the inability to provide medical cover to Stracathro Hospital with a reconfigured rota and the impact on the ability to safely provide medical cover to MRH.

This option however has the advantage of

- Better consultant cross cover arrangements than exist in MRH currently
- Reduction in variation of practice
- It is expected some of the current allocation of doctors in training will transfer to Carseview Centre with the inpatient unit from MRH. This could improve resilience at Carseview in dealing with vacancies in training posts but not Stracathro Hospital.

Retention of LDAU, BSI and Open Forensic Learning Disability services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services.

LD services would benefit from improved environments on a refurbished Carseview site and LD Locked low secure inpatient services in the purpose built forensic building in the Rohallion Clinic at Murray Royal. The accommodation for these services currently on the Strathmartine site are not fit for purpose and often commented on during Mental Welfare Commission Audit Reviews.

10.4.4 What are the cons/ impact on service users/carers/staff?

The option will require continued GAP medical and nursing cover across three sites as although acute admission beds are on two sites (Susan Carnegie and Carseview), the Complex Care and Rehabilitation beds would still require to be provided from Murray Royal in Perth. This option is therefore unsustainable and unsafe given current workforce profiles and future projected staffing levels.

Disadvantages to this option are

- The minimum number of junior doctors to cover the out of hours rota in this option is 32. This is because it requires three sites to be staffed out of hours. It is not anticipated that the number of doctors in training will ever increase close to this number in the future
- Savings as a consequence of job plan review of General Psychiatry consultants in Moredun and Carseview are likely to be minimal as there is only a reduction of two inpatient beds.

This is a two site LD option which has an advantage of
One consultant who works in the LDAU could remain at Carseview Centre

However this model has an increase in bed capacity at Carseview Centre from 10 to 22 with a mixed function of the unit. It is likely this will require more consultant and supporting medical staff input. This will most likely come from staff working in the community or MRH. It is anticipated this will require additional travel and possibly additional consultant PA for this option.

This model was considered to have a negative impact on the patient pathway and would not significantly improve the patient environment; concerns were also noted regarding the ability to respond to patients with complex needs and in order to develop the model further would require a review of the workforce in relation to safe staffing levels.

The model does not fit for training of junior doctors and training status could be placed at risk.

Isolation of single acute admission ward in Angus would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of ward.

The impact on the Forensic service is described above

This option would also reduce the ability to provide cross cover to the Complex Care and Rehabilitation wards on the Murray Royal site.

This option would mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.

Access – The ability to access inpatient beds from the most rural areas within Perth and Kinross is a concern with this option. The relocation of Moredun Ward from Murray Royal to Carseview will mean that service users and their carers/families from some areas within Perth and Kinross will have an additional distance to travel to access an inpatient bed.

Feedback throughout the process has highlighted the importance of family and carer support and ability to visit service users when in an inpatient facility provides support and assists recovery.

Re-provision of current day services was a concern for LD stakeholders. Again Day treatment models could be reviewed and developed in conjunction with the three local Integration Joint Boards to seek alternative day service/provision whether through local NHS/Local authority/Social enterprise models. Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to small numbers from each area, alternative ways of providing these valuable services will need to be further developed and resourced during the detailed review of a preferred option.

Relocation of LD locked forensic services to Rohallion will mean Angus and Dundee LD service users/carers and families will have an excess distance to travel to access an inpatient bed.

10.5 Option 5A

Option 5A provides a two site option for all General Adult Acute Admissions from the Carseview Centre in Dundee and the Moredun ward in Murray Royal Hospital, Perth and a two site option for Learning Disability inpatient services

from both the Carseview Centre in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Carseview site would therefore provide three acute admission wards (62 beds) and one ward on Murray Royal site (24 beds)

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.5.1 What changes?

Current acute admission inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) would relocate to a refurbished 22 bed ward in the Carseview Centre, Dundee.

Learning Disability Assessment Unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the refurbished LDAU ward on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Clinic in Murray Royal, Perth

As noted in option 3A above, Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.5.2 What would this option require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment which would be required for an increase to community services in Angus which would be required to support relocation of beds and in recognition of requirements for escort etc.

Learning Disability day treatment services currently provided on Strathmartine site would require to be reprovided either or both from the Carseview site or in local community based settings.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To

implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

This option will require reduced junior medical staffing and nurse cover across two sites (Carseview and Murray Royal), which is more sustainable and safe given current workforce profiles and future projected staffing levels.

10.5.3 What are the pros/ impact on service users/carers/staff?

As above this option can be provided by the forecasted reduced junior medical staffing numbers and nurse staffing cover across two sites (Carseview and Murray Royal), which is more sustainable and safe given current workforce profiles and future projected staffing levels. However current Perth and Kinross GAP acute admission inpatient ward is covered by the use of Locum consultants and as highlighted in the workforce section there is significant risks around use of locums and future Consultant availability.

It was felt that this model was broadly clinically safe and could provide for easier cross cover and better training of junior doctors.

In this option the General Psychiatry beds at Stracathro Hospital transfer to Carseview Centre and the number of acute beds reduce from 89 to 86. This has the advantage of

- Better consultant cross cover arrangements than exist in Stracathro Hospital.
- Reduction in variation of practice
- It is expected some of the current allocation of doctors in training will transfer to Carseview. This could improve resilience at Carseview in dealing with vacancies in training posts but not Stracathro Hospital. This has not been realised however with the implementation of the contingency plan as is only an interim move and therefore Mulberry remains a separate operational unit from a medical perspective.

This is also is a two site LD option identical to 4A with the same implications on medical workforce
Retention of local beds in Perth was seen as a preferred option for Perth and Kinross service users/carers/families. This option would mean a reduction in travel time and improved access issues for rural Perthshire residents.

Some reduction in nursing workforce requirements could be achieved through economies of scale with co-location of three GAP acute admission wards on the Carseview site.

Three GAP acute admission wards on Carseview site would increase ability to cross cover wards.

Retention of LDAU, BSI and open forensic learning disability inpatient services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services.

10.5.4 What are the cons/ impact on service users/carers/staff?

The option will require continued GAP consultant cover across two sites for acute admission beds which is currently sustained in Perth through use of locum Consultant staff. There is therefore a risk as to whether this option is therefore sustainable and safe given current workforce profiles and future projected staffing levels.

Disadvantages to this option appear to be that:

- Savings as a consequence of job plan review of General Psychiatry consultants in the Mulberry Unit and Carseview Centre are likely to be minimal as there is only a reduction of three inpatient beds.

This is also is a two site LD option identical to 4A with the same implications on medical workforce

The single acute admission ward in Perth would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of Moredun ward.

This option would also reduce the ability to provide cross cover on an interim basis to Psychiatry of Old Age services on the Susan Carnegie site until a further option appraisal was undertaken to utilise the vacated Mulberry ward.

This option would mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.

Access – The ability to access inpatient beds from the most rural areas within North Angus is a concern with this option. The relocation of Mulberry Ward from Susan Carnegie to Carseview Centre in Dundee will mean that service users and their carers/families from North Angus will have an excess distance to travel to access an inpatient bed.

Feedback throughout the process has highlighted the importance of family and carer support and ability to visit service users when in an inpatient facility provides support and assists recovery.

Re-provision of current day services was a concern for LD stakeholders Again Day treatment models could be reviewed and developed in conjunction with the three local Integration Joint Boards to seek alternative day service/provision whether through local NHS/Local authority/Social enterprise models. Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to small numbers from each area, alternative ways of providing these valuable services will need to be further developed and resourced during the detailed review of a preferred option.

Relocation of LD locked forensic services to Rohallion Clinic at Murray royal in Perth will mean Angus and Dundee LD service users/carers and families will have an excess distance to travel to access an inpatient bed.

The impact on the Forensic Service is described above

10.6 Option 8

Option 8 provides a single site option for all General Adult Acute Admissions from a single ward on the Carseview Centre in Dundee and a two site option for Learning Disability inpatient services from both the Carseview Cente in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Three GAP step down/treatment wards will be provided from Susan Carnegie Centre, Angus, Carseview in Dundee and Murray Royal Hospital in Perth.

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.6.1 What changes?

Current acute admission inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) and Moredun Ward would relocate to a single refurbished 22 bed ward in the Carseview Centre, Dundee. Three step down/treatment wards would be provided from the Mulberry Ward in Susan Carnegie Unit, Angus, Moredun Ward in Murray Royal in Perth and Ward One in Carseview Centre in Dundee.

Carseview would therefore provide one acute admission ward (20/22 beds) plus a step down/treatment ward (20/22beds), a step down/treatment ward on Susan Carnegie Unit (20/25 beds) and a step down/treatment ward on Murray Royal Hospital (26 beds)

Learning Disability assessment unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current refurbished LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would relocate to a separate refurbished Ward Two on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward in the Rohallion Clinic in Murray Royal, Perth

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining

low secure wards to ensure provision for crisis is available in both remaining environments.

10.6.2 What would this option require to work in practice?

Acute / Sub-Acute Adult Inpatient Care (Model proposed in Option 8)

This type of service is one that combines Acute Inpatient Care services as described above, with a 'sub acute' service that provides care to people who are moderately less acutely ill, less florid in their presentation, less behaviourally disturbed and or not thought to be at high risk of suicide, but who still require treatment in hospital. There are descriptors from American, Australian and English literature.

In England a National survey of in-patient alternatives to traditional in-patient care (Lloyd-Evans; Johnson, Slade et al, 2010) identified sub acute care units as a variety of small residential units that provide care for patients in crisis and are usually closely geographically located to traditional inpatient care facilities. Australian models are similar to the English models, involving residential care provided in small units, usually by non statutory agencies. In both these models these are usually commissioned services and patients are classed as 'residential' therefore requiring funding allocations from local authority.

An Australian model described step-up step-down residential services for people requiring direct support during a time of crisis. They offer short-term residential support until symptoms have stabilized. Sub-acute, short-term residential mental health services have been developed to provide support and accommodation for people with mental illness in a less restrictive environment than inpatient units, often with a focus on development of skills necessary for successful community living, such as budgeting, domestic and interpersonal skills. These services are not hospitals and cannot care for detained patients; they are designed to provide an alternative to hospital treatment, taking some of the pressure off inpatient units, and comprising a more cost-effective delivery of services in a least restrictive environment (Lloyd-Evans et al., 2009). Step-up step-down units are increasingly being implemented in the Australian mental health system as part of system reforms to better meet the needs of mental health clients. Although the research evidence is limited, several studies have found sub-acute residential units to be effective in providing positive clinical outcomes and they appear to comprise a cost-effective alternative to hospitalization (Thomas & Rickwood, 2013).

In America there are sub acute adult inpatient services funded through healthcare insurance. Admission criteria includes clinical evidence that the patient has a diagnosis of mental illness that is amenable to active psychiatric treatment however they are not sufficiently stable to be treated outside of a highly structured 24- hour therapeutic environment. Patients require nursing supervision and intervention seven days per week, 24 hours per day to remain safe, manage symptoms and develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and

aftercare services, and to develop the adaptive and functional behaviour that will allow them to return to live in the community.

Patients would not be suitable for sub-acute care if they exhibit a risk to self or others or require enhanced observation and engagement due to disturbed behaviour.

Increased and remodelled home treatment and community services would be required in each locality to support service users for longer in their own home environments and to prevent admission.

Concerns were raised that with Option 8 staff will not be able to see acutely unwell patients getting better, concerns regarding changes of staff teams, and therapeutic relationships with potential for multiple transfers between teams. This also highlighted issues re potential burn out of staff and the ability to manage turnover of staff and skill mix required to sustain this model

The model has a high dependency on good communication.

The option described an optimal length of stay and raised further concerns as to how this was calculated and impact on patient experience in ward if patient where patient population was transient and everyone was acutely unwell

It was felt this model of care could not provide any advantage to the current model of care and could disadvantage patients in relation to continuity of inpatient care.

Option 8 also considers the use of crisis house models in each locality to support step down/treatment

Learning Disability day treatment services currently provided on Strathmartine site would require to be re-provided either or both from the Carseview site or in a community based setting.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.6.3 What are the pros/ impact on service users/carers/staff?

Service users would have local bed provision during the step down/treatment phase of their admission.

Staff currently working in local areas could remain in situ.

Retention of LDAU, BSI and open forensic learning disability inpatient services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services. The provision of LD inpatient beds in two refurbished wards on Carseview site provides increased flexibility and space

The advantage of this model is that the majority of the patient care is delivered locally allowing easier visiting from family and carers. Discharge planning may also be easier and it increases the likelihood CMHT staff can be a practical source of help in this.

This model requires a robust system in place to manage not only capacity but flow through the system. With an acute admission ward and three separate step down units it is predicted there will be a higher turnover of patients and transition of care relatively early in the admission journey of a patient.

It will require a proactive discharge planning otherwise it risks the step down services not being able to take patients from the acute admission ward. As described above this type of model will probably require a higher number of consultant PA to manage the complexity and turnover of patients.

This is also is a two site LD option but with a different configuration of wards to accommodate the step down unit at Carseview Centre. It is anticipated this will have similar implications on the medical workforce as 4A and 5A.

10.6.4 What are the cons/ impact on service users/carers/staff?

There have been two tests of 'Assessment - Treatment' models of acute admission wards and step-down sub acute care wards in NHS Lanarkshire 2008-2009 and in NHS Forth Valley. There were similar experiences in both Board areas and the model was converted back to the Acute Adult Inpatient Care model after evaluation.

The Lanarkshire model was run for approximately 12 months and was ended due to demand for acute care beds being greater. Patients had to be transferred to the sub-acute wards whilst still very acutely unwell. Staff burn-out in the acute admission ward was a concern as all admissions were filtered through the single ward and staff felt their skills in therapeutic and psychological interventions were being lost as they were only involved with patients for the first 48-72 hours of admission.

The model describes acute admission for three days before transfer to step down/treatment ward. Clinical colleagues have raised concerns regarding the ability to fully assess a patient in three days and that this time period would only allow for medication of a patient.

Patients may not then become acutely unwell again whilst in the step down/treatment ward and require transfer back to the acute assessment ward. This could mean a patient may "yo-yo" back and forth between wards and staff dealing with them, this would impact on patient care, safety and experience.

Concerns were also expressed re the ability to maintain the patient pathway and flow of patients deliverable through this model and the likelihood that wards would fill up quickly and lower number of acute admission beds would prevent ability to transfer patients when became more acutely unwell.

This option will continue to require medical staffing cover across the three sites (Susan Carnegie, Carseview and Murray Royal), which is unsustainable and unsafe given current workforce profiles and future projected staffing levels.

The ability to maintain safe medical cover at Stracathro Hospital is not possible as described above.

It is anticipated that there will at least be no reduction in consultant PA allocation in this option as there is neither a reduction in bed numbers or number of hospital sites to be covered.

The model does not fit for training of junior doctors and training status could be placed at risk.

This option would also impact on service user/carer travel and access as patient may be transferred back and forward from local bed to centralised admission ward on several occasions throughout episode of care.

Isolation of single GAP step down/treatment ward in Angus would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of ward.

The provision of step-down/treatment beds across Tayside would lead to a clinical imbalance with 25 beds in Angus, 26 beds in Perth and Kinross and only 22 in Dundee. This is likely to lead to patients from Dundee being transferred out of their own geographical area for step down and lead to additional problems with transition to community services. It was also noted that the option provided a complex clinical pathway with no correlation between the proposed locality bed numbers and the population of Tayside.

Clinical colleagues also raised concerns that the model would build in complexity and potential pinch points to a system that already finds it difficult to manage current throughput. It was felt that the option would increase transitions between services/beds and therefore increase clinical risk

The option described also considered use of crisis house models in each locality to support step down/treatment. Modelling work reviewing crisis house provision reviewed current examples such as those provided in Edinburgh which identified services required larger centres of population to become viable, i.e. current Edinburgh crisis house provides 4 beds for the city (population of approx 500,000 equivalent to whole of Tayside – report attached in Supporting Document Appendix Nine)

The use of two wards on Carseview site for LD services would lead to under utilisation of Ward Two floor area for Low Secure Learning Disability services which would provide 8 beds in an area which could accommodate 22 beds.

This option would also mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.
The impact on the Forensic Service is described above and in detail below.

10.7 Forensic Low Secure and learning Disability Locked Forensic beds

Flat 1, Bridgefoot House, SMH, is currently an 8 bedded male low secure unit that is operationally, clinically and strategically part of Learning Disability In-Patient Services.

The accommodation for this service is not fit for purpose and is often commented on during Mental Welfare Commission Audit Reviews.

During the option appraisal process there was opportunity for staff, patients, carers and other key stakeholders to participate in a process to help shape and plan for future service provision. Each of the four option appraisal outcomes has recommended the transfer of the locked forensic LD service to the Low Secure forensic Unit at Rohallion Unit in Murray Royal Hospital, Perth. In addition there has been further engagement with this staff and patient group to determine whether a fast track to Rohallion would be an option worth considering and this was highlighted to the NHS Tayside Board meeting in August 2016.

Inpatient management have noted that there has been a positive response from within Flat 1 which notes that the general opinion is that accelerated transfer would be in the patients and service best interest. Care and treatment would be delivered in modern and fit for purpose accommodation improving both patient experience and patient journey whilst enabling staff to be part of specialist secure care services that would promote and facilitate ongoing and continual professional development. This proposal would also alleviate concerns from mental welfare commission and would meet the standards required for the delivery of low secure care.

There are many benefits associated with this proposal and it would enable the service to address and meet some of the workforce planning challenges. There is a national shortage of learning disability nurses, most reside within the central belt geographical area, and historically it has been difficult to recruit to the location of Dundee. Perth is more accessible from the central belt and is more attractive to potential applicants. In addition being part of the wider secure care services would enhance recruitment opportunities based on forensic core competencies rather than just learning disability experience

Based on these additional discussions with the service and management, it is estimated that an accelerated transfer to Rohallion Site would be realistically achievable within a 12 week period.

There are some risks associated with this such as provision of medical cover, psychology, therapy provision and available nursing resources. Recruitment into secure care is a far more attractive proposition for medics rather than the speciality of learning disabilities and there is a possible option of ongoing cover from within the current LD medical staffing establishment (A medical review of this is noted in further section below).

Psychology provision into Flat 1 at present is limited to 4 x 1 hour sessions per week which includes participation in group work based at Strathmartine. There should be no disruption to this service provision as there would be sufficient resources to maintain links and attendance to these groups at Strathmartine. Patients within Flat 1 receive approx 70 therapy sessions per week at Strathmartine including, adult education, music therapy, art therapy and a variety of recreational and leisure activities ranging from 30 minutes to 2 hour sessions on both an individual and group basis.

Patients transferring to Rohallion should not experience a reduction in the level of service provision. Additional resources have already been put into therapy department at Strathmartine and these risks can be mitigated through the transfer of resources to Rohallion for the purpose of delivering therapy sessions.

In addition certain activities could be replicated at Rohallion or existing links could be maintained for attendance at group sessions within Strathartine on interim basis until final decision is made re future sighting of remaining LD inpatient services.

At present management are reporting that a large percentage of the workforce within Flat 1 are, keen, motivated and willing to transfer to Rohallion. This would however require to be discussed with all staff on a one to one basis and supported by Human Resources and staff side representatives through organisational change policies. It is envisaged that any staffing shortfalls could be covered by existing staffing resources within Rohallion and any staff member wishing to remain within Learning Disability Services in Dundee would be accommodated into existing vacancies.

Part of the proposal to relocate these services in advance of decision regarding other options would also require consideration of the transfer of the Community Forensic Learning Disability Team including MAPPA resource. Some discussion and engagement has already begun with this team. This proposal would continue to allow the interface between this team and the impatient ward to continue and it would support the transition from one site to another whilst maintaining existing links with the Strathmartine site.

The potential accelerated transfer of Flat 1 to Rohallion would free up accommodation on the Strathmartine site which could be used to allow for the LDAU on Carseview to decant into Flat 1 and allow Learning Disability Services to consolidate service delivery on a single site prior to any potential future service move. This would assist with the logistics of planning for the refurbishment works to be undertaken on the Carseview site and provide an empty ward for decant. In addition this would mitigate the risk of moving a service off site to ensure there

were appropriate and suitable staffing resources at hand to deliver safe and effective service delivery. The unintended consequence would be a reduction in supplementary staffing costs as it would be easier to redeploy staff on a single site as opposed to multiple sites. This model would support any potential recommendation for Learning Disability Services to be placed in Perth and would enhance and support a step down model for forensic care by having a Learning Disability Open Forensic Ward also on the Murray Royal site in the future under option 3A. This option would also allow for income generation potential from three of the ten beds available as this service is in demand nationally and other Boards have already noted an interest in purchasing LD locked secure beds.

.

A medical workforce review of the above has noted the following key issues.

All the options have the same reconfiguration for LD Locked forensic beds and the reduction in Forensic Low Secure beds. The key decision to be made for these services is what the operational management structure will be. It is recommended this is made as early as possible to allow the two services to enter detailed discussion well in advance of any moves

The Medium Secure Unit is funded by a consortium of North of Scotland health boards and hosted by NHS Tayside. The Forensic Low Secure Unit is managed by NHS Tayside. The current LD Locked forensic unit is based at Strathmartine Centre and hosted by Perth & Kinross Integration Joint Board.

This raises a number of questions about co locating a service managed by an IJB with a service which is not and to what extent they share resources such as staff and facilities.

If the LD Locked forensic service remains under the LD service

- Due to the reduction in forensic beds there will be a reduction in 5 PA for Forensic Psychiatry consultants. This will mean that consultant sessions to HMP Perth and HMP Castle Huntly which are currently allocated as Extra Programmed Activities (EPAs) will be regularised into job plans
- Medical cross cover arrangements for LD patients could be a challenge unless the other LD services relocate to MRH and not Carseview
- LD patients will not have access to the care and treatment to patients in the Low Secure Unit which is currently funded from the Medium Secure Unit medical budget e.g. primary healthcare from a GP.
- LD staff will not be able to use the support for nursing and Allied Health Professional staff which is funded from the Medium Secure Unit medical budget e.g reflective practice.
- LD Locked forensic unit will be covered by the general on call medical rota unlike the rest of Rohallion Clinic which has a separate Consultant Forensic Psychiatrist on call.

If the LD Locked forensic service comes within the Forensic Service

- The Forensic service will assume consultant cover without a need for additional PA

• Savings of about 2.5 PA in consultant LD sessions but this allocation is considered an under allocation for what the work involves.

• Consultant cross cover would be from the Forensic Service including out of hours.

• Access to all services funded from the forensic medical budget

• The removal of LD locked forensic service from the LD service creates a barrier in the pathway from secure care for LD patients

• This option limits the current access of patients to specialist LD care and treatment including specialist LD consultants

• Access to LD group therapies may be limited particularly if the LD service is split between Dundee and Perth

The issue of deciding on operational management goes beyond the medical workforce. It is anticipated that the current Allied Health Professional and Psychology workforce at Rohallion Clinic will need to be reviewed. This is to ensure appropriate mix of professionals e.g. increased need for a Speech and Language Therapist. It is also anticipated there will need to be a greater resource allocation of Psychologist and AHP time to ensure treatment interventions are delivered. The levels of reinvestment will require further review of requirements for these specialties.

Some of this could be achieved by transfer of the existing staff but as described above there will be a need for robust planning around this in line with organisational change policies and support from human resources and staff side representatives.

11. Workforce

11.1 Medical

One of the most compelling and linked drivers for the reconfiguration of services in many health boards is their capacity to provide appropriate medical cover 24/7(King's Fund, Briefing 2011).

In-patients in Mental Health Hospitals need to have access to medical assessment 24 hours per day, 7 days per week. Doctors must be available to patients in the community who are experiencing current mental health problems and give advice on their management. The population of Tayside require reliable access to urgent medical assessment 24 hours per day, 7 days per week.

Normally this cover is provided by doctors in their first 4 years of training. To do this safely across all sites, NHS Tayside and the three IJBs require 31 junior doctors to sustain current rotas. These doctors are in training for general experience or specific experience for a career in General Practice or Psychiatry. The doctors in training are allocated centrally by the Deanery (the responsible training organisation). Mental Health Services have no influence in relation to who is placed in services and how many posts are filled. National shortages of doctors in training over the last few years have resulted in significant numbers of

vacant posts across a number of specialties including Mental Health. Under these circumstances, NHS Tayside has filled vacant posts, wherever possible, with additional locum doctors. The shortage of junior doctors nationally has also had an effect on the numbers of locum doctors currently available which has led to some unfilled posts in Mental Health Services.

The reduction in working hours for trainees has led to a decrease in their level of experience and this also now impacts on the consultant workload and service provision. It is vital that NHS Boards and IJBs recognise that these challenges may mean the requirement for more senior input earlier in the patient pathway in order to maximise patient outcome. As such it must be acknowledged that appropriately supervised doctors in training remain a valued and integral part of our sustainable workforce and their needs have to be addressed. An important facet for doctors in training within Tayside is the opportunities they have for education and learning, which must run parallel with service provision. The General Medical Council regulates all stages of medical training and professional development, both undergraduate and postgraduate. An annual training survey by the regulator assesses the quality of training programmes to ensure a safe learning environment for patients and trainee staff. Currently NHS Tayside mental health service is at risk of failing to meet the required standards due to the current shortages and workloads.

From February 2017, there have been significant gaps in junior doctor availability. Only 18.6 of the 31 posts required to maintain Mental Health and Learning Disability services have been filled. NHS Education Scotland currently funds 29 core training posts in mental health services in Tayside. This is made up between Core Psychiatry Trainees, General Practice Specialty Trainees and Foundation Programme Doctors. There are also gaps in the numbers of Higher Trainees who also deliver routine and emergency services across the psychiatric subspecialties. This again is a national issue with under recruitment and NHS Tayside has little ability to influence this as allocation of trainees is on a national basis. The reconfigured Out of Hours rota working across two sites can be operated with the 18.6 wte numbers available however it has still been necessary to employ locum doctors to fill unfilled posts and cover for maternity leave in the services.

It is anticipated that NHS Tayside will not be able to find enough locum doctors of sufficient knowledge or experience in the future to fill all the vacant posts which will have an impact on provision of both emergency and non emergency services. This will leave NHS Tayside with insufficient doctors to provide safe cover across all of the current inpatient and assessment units.

National figures for the next 5 years remain at low levels and reflect these reduced numbers for a prolonged period. As most of Tayside's in-patient services (including services for younger people, people with a learning disability, long term rehabilitation care and forensic services), are based either in Dundee or Perth and Kinross, it is therefore deemed clinically appropriate to consolidate services within these geographical areas.

All subspecialties within the scope of the MHSRT Programme have Consultant Psychiatry vacancies. NHS Tayside currently employs 7 locum consultants and 6 locum junior doctors to fill long term vacancies and to maintain service provision across the current configuration of services. These locums are at a premium cost (current annual cost pressure of approx £1M).

The current Consultant workforce levels required are currently sustained through use of 10 Locum Consultant Psychiatrists across all Mental Health and Learning Disability Services.

In Angus locums cover the Community Mental Health Teams in Arbroath, in Dundee one locum covers the IPCU and Crisis response Home Treatment Team, in Perth one locum cover the Inpatient unit and a second covers the Community Mental Health Team in North East Perthshire. Learning Disabilities have been unable to recruit following a retirement and cover is currently provided by reconfiguration of job plans and Associate Specialist providing cover to a Consultant role. Forensic services have also been unable to recruit to a full time post in the Regional Medium Secure unit since became operational. It is anticipated that over the next two to three years it will be hard to fill these vacancies with trainees who are currently working in Tayside. These vacant posts reflect the position nationally where difficulties are being experienced recruiting to substantive posts due to lack of suitable applicants.

An analysis of the senior medical workforce in Mental Health and Learning Disability services shows that at least 8 will reach the retirement age of 55 within the next 5 years at a time where there is a national shortage in Consultant Psychiatrists and the recruitment climate is extremely difficult. Consultants who are eligible for Mental Health Officer status prior to 1995 can retire at age 55. Due to recent changes in Pension rules around earnings and tax it is now no longer financially viable for Consultant staff who have Mental Health Officer status to stay on after 55 and can only return to work on part time basis. The continued reliance on the use of locum medical staff to manage workforce gaps places pressure on the commitment to deliver safe care, with a sustainable workforce and delivery of financial balance. The use of locum Consultants also impacts on the quality of care received by service users and their experience if having constant change of Consultants they are being assessed and treated by.

Consultant and Junior Medical figures - Table Four

Mental Health & LD	Consultant staffing levels	Junior Medical staffing levels
Current	64	34
Option 3A	62	24
Option 4A	64	34
Option 5A	64	24
Option 8	65	34

11.2 Nursing

NHS Tayside currently recruits the majority of their Mental Health and Learning Disability nursing workforce from university graduates once per year. Last year of the 92 students who qualified NHS Tayside managed to successfully recruit 42. Therefore less than 50% of those trained in Tayside were successfully retained in NHS Tayside. This low recruitment is due to the number of students from Northern Ireland and England who come to Tayside to train then return to their home localities on completion of training. The colleges are unable to assist us in addressing this as are required to support equal opportunities and access to placements and therefore this is out with NHS Tayside's ability to address. This low intake of young staff, coupled with an aging profile of current nursing workforce and similar issues regarding Mental Health Officer status retirement at 55, presents Mental Health and Learning Disability services significant workforce challenges to sustain current and future services. On examination of current staff profile it is estimated that over 30% of staff are eligible to retire in next 5 years. In some teams this figure rises to almost 50% which means the most experienced staff in current GAP and LD services are likely to retire over this period.

The nursing workforce implications for each model have been prepared in correlation with the Associate Nurse Director for Mental Health and Learning Disability Services, the Senior Nurse, Workforce Development and Planning and reviewed with the Senior Nurses within Operational Managers posts who have responsibility for Nursing Care Governance for each service.

These workforce estimates will be subject to review as more detail regarding the preferred option becomes available.

The staffing models presented have been developed by utilising national nursing & midwifery workforce planning methodology acknowledging the current evidence base and incorporating the following key rationale:

- Ratio of Registered nurse (60-65%) to Healthcare Support Worker (35-40%)
- Senior Charge Nurse in a non-case holding leadership role
- Ward Assistant/Housekeeper role for each Ward environment
- Minimum of 2 Registered Nurses on Night Duty per Ward environment
- Equity of staffing resources across speciality wards
- Secure Care Wards remaining on a 12hr shift pattern
- All remaining Wards utilising a standardised shift pattern

Inpatient Ward	Current Wte	Option 3A	Option 4A	Option 5A	Option 8
Nursing Workforce					
Combined LDAU/BSI	56.62	43.16	43.16	43.16	43.16
LD Locked Forensic	25.87	24.30	24.30	24.30	24.30
LD Open Forensic	25.67	24.30	24.30	24.30	24.30
Amulree Complex Care & rehab (16 beds)	31.76	31.76	31.76	31.76	31.76
Rannoch Female Complex care	21.50	22.58	22.58	22.58	22.58
GAP Acute admission Ward One Carseview 22 Beds	27.80	28.30	28.30	28.30	45.45
GAP Acute admission Decant ward Carseview 18 plus 4 AIS Beds	29.50	28.30	28.30	28.30	28.30
GAP Acute admission Ward Two Carseview 22 Beds	-	28.30	28.30	28.30	-
GAP Acute admission into LDAU ward at Carseview 22 Beds	-	28.30	-	-	-
Moredun Ward Murray Royal	39.80	-		39.80	34.01
Mulberry Ward SCC	38.39	-	38.39	-	34.01
IPCU 10 Beds	28.20	28.30	28.30	28.30	28.30
Liaison/Patient Escort		10.29	6.86	6.86	13.72
Total	**325.11**	**297.86**	**304.53**	**305.94**	**329.88**

All of the above options contain an allowance for Liaison and patient transportation shown under the calculations for each ward. These figures do not reflect any potential economies of scale from ECT and nurse management workforce that will be subject to review following identification of the preferred option.

11.3 Allied Health Professionals

The availability of multidisciplinary therapeutic input distinguishes good in-patient facilities from those that are no more than settings of containment (*RC Psychiatrists Faculty report FR/ID/03 July 2013).* The Allied Health Professionals are a key part of the Mental Health and Learning Disability workforce and have knowledge, skills and approaches that are highly valued by service users and carers as they help individuals to maximise their potential and enable productive and independent living. AHPs are a diverse group of professions, who as members of the multiagency/ multidisciplinary teams provide a wide range of interventions and contributions to promote good mental health, independence and recovery from illness. They constitute a very important resource for people accessing mental health services, but this also provides a challenge in ensuring that the AHPs skills are profiled and deployed to the maximum benefit of service users. There are core Allied

Health Professions working in MH/LD services; Art Therapists, Dieticians, Occupational Therapists, Physiotherapists and Speech and Language Therapists with other professional services inputting as part of an individual's pathway of care such as Podiatry.

Rehabilitation skills are core to the services provided by all AHPs, this can be considered the main contribution of AHPs to MH/LD services. Their rehabilitation orientation enables them to focus beyond symptoms to:

- Promote psychosocial function and social inclusion
- Support emotional, spiritual and physical wellbeing
- Respect diversity and choice and the absolute right of the person to self determine
- Focus on what a person can do, rather than what he or she cannot do (a strengths based approach)
- Work collaboratively with service users and carers (*Realising Potential, Scottish Government, 2010*).

The numbers and skill mix of AHPs employed across Tayside (in-patient units, community teams for partnerships and pan Tayside) varies considerably with a significant percentage of the workforce working across 2 or more settings. This flexible (and person focussed) approach to service delivery works in the patient's favour. However this makes the financial calculation (as to the discrete and accurate identification of AHP staff attached to the in-patient units identified within the options) extremely challenging. It has therefore been difficult to identify, at this stage, the specific workforce implications for the range of AHP services providing service to the patients in an inpatients setting.

The table below provides a high level workforce snapshot of the total Tayside AHP resource funded across Tayside for all adults requiring access to services for conditions of a mental health and learning disability origin (extract Feb 2016).

Professional background	**Resource wte**
Arts Therapies	2.40
Nutrition and Dietetics	3.54
Occupational Therapy	44.31
Physiotherapy	8.22
Podiatry	0.20
Speech and Language Therapy	6.26
AHP Support workers (often work across 2+ disciplines)	30.87
Total	95.80

This totals an AHP workforce of 95.8 wte for all inpatient and community settings.

The critical challenge for the Allied Health Professions is the absence of validated workforce and workload tools available nationally or internationally. Ideally using the 6 steps methodological approach, workforce planning requires the active involvement of the lead staff AHP in the redesign of the clinical

pathways to enable capacity building and succession planning to be robustly taken forward, optimising the unique skills and skill mix opportunities of a flexible highly skilled workforce.

For the options detailed within the paper, it should be clear that any adjustment to a bed base does not in the first instance affect the AHP resources as, in the main; these resources are directed to meet patient need and are not modelled on a bed complement. The requirements for AHP input and therefore the workforce model should be determined by population need, direct outcome and impact and contribution to community based/coproduced models with a focus on self management.

There will be no reduction in the AHP resources required and in some instances, through the further work conducted on the clinical and patient focussed pathways and population profile, there be an increased understanding of future need and investment.

There will be a direct impact on existing staff clinical interface time and capacity in terms of travel and caseload capacity as they conduct their business across a larger geographical area dependant on the option finally selected if single or dual sited. A key determinant for where AHP services are delivered will be informed by the availability of areas fit for service user need and subsequent AHP related activity (access to gyms/therapy kitchens/outdoor space /workshops/etc)

Recruitment to a range of the professions is recognised as a challenge e.g. Nutrition and Dietetics and Physiotherapy. This challenge increases significantly when trying to recruit to specialist areas of practice such as Forensic particularly when posts are part time in nature and the opportunities for gaining experience is limited.

There are a number of HEIs providing undergraduate AHP education in Scotland (note Tayside is not one of the areas). Tayside provide a significant number of undergraduate placements across all the professions; continued investment in delivering robust, high quality education from experienced, highly skilled and motivated clinicians is pivotal in maintaining ability to recruit post qualification.

Further detailed analysis of current AHP workforce division between inpatient and community based settings has been undertaken but further work is required to enable a full analysis of future AHP requirements to support models which will progress following identification of the preferred option. The initial work undertaken to map existing AHP workforce and a projection of future manpower requirements has highlighted a requirement for some reinvestment to address historic shortfalls in services. This work will continue to be refined throughout the consultation period and the work to progress in the remodelling of existing community services.

11.4 Psychology

Psychology services in Tayside had historically struggled to recruit to vacancies within GAP and LD services due to national shortages in Psychology trainees.

More recent work around recruitment of trainees has supported filing of vacancies. An initial review of psychology workforce levels required to sustain inpatient models has highlighted requirements to invest in Psychology workforce and skill mix to meet the predicted demand on these services to support enhanced inpatient care. The Psychological Therapies review undertaken in 2005/06 secured resources to fund posts to provide Level 2 and Level 3 community psychology services. The Review did not address requirements for inpatient interventions which were later presented in a Level 4 report which was supported but not resourced. LD psychology services have also been historically underfunded. A review of community psychology requirements will be undertaken with all other staffing specialities for the preferred option moving forward to support prevention of inpatient admissions.

Psychology Staffing Workforce –

Inpatient and Community	**Current Wte**
Psychology Workforce	
GAP	
8A Clinical Psychologist – Dundee CMHT	4.8
8A Clinical Psychologist – Angus CMHT	2.8
8A Clinical Psychologist - Perth CMHT	1.8
8D Clinical Psychologist – Dundee CMHT	0.4
8C Clinical Psychologist – Angus Lead	0.3
8D Clinical Psychologist - Perth Lead	0.2
8A Clinical Psychologist - Tayside Rehab Service	1.5
Total	**11.8**
	Current Wte
Psychology Workforce	
LD	
8D Consultant Clinical Psychologist LD and Tayside wide	0.8
8B Clinical/Forensic Psychologist - Forensic Tayside	1.0
Band7 Applied Clinical Associate - Dundee	0.4
8B Psychology Services - Dundee Community	1.0
8A Psychology Services - P&K Community	0.6
8A Clinical Psychologist - Community Angus	0.6
Band 4 Assistant Psychologist - Dundee & P&K	1.0

Band 4 Assistant Psychologist - Forensic	1.0
Band 4 Assistant Psychologist - Angus & BSI	1.0
Total	**7.4**

11.5 Pharmacy

An initial analysis of Pharmacy requirements have been undertaken and based on the needs assessment carried out by NHS Tayside pharmacy and NHS Fife. Pharmacists work in an integrated way on each site across all sub-specialties to deliver the same standard of service to patients irrespective of whether they are in GAP, POA, forensic or Substance misuse beds.

The figures being reviewed currently highlight historic shortfalls in pharmacy resources to cover the community mental health and learning disability services. There is currently no dedicated learning disability resource.

These current shortfalls are managed by using staff funded to cover other in- patient areas and specialities. If there are no GAP inpatient services in a locality then there will be a requirement to review the need for increased pharmacist expertise within the community mental health teams. This would mean higher requirements for options without local beds as the community service is currently unmet need.

It should also be noted that there are significant medicine cost pressures in Mental Health services and more patients on high risk/ high cost medicines within the community mental health service will require a dedicated pharmacy resource to manage this.

As such the Pharmacy workforce requirements will be further progressed from the initial assessment work undertaken as part of the review of community investments in each locality through the local Integration Joint Board Strategic Planning groups for the preferred option.

Staff Grade	**Current Wte**
Band 8b	0.8
Band 8a	1.3
Band 7	1.3
Band 6	1
Band 5	2.7
Band 2	2.3
Total Pharmacy	**9.4**

Admin and clerical and support services staffing levels will also be subject to detailed review following selection of the preferred option and are currently being reviewed.

Key to the delivery of sustainable services is ensuring a highly skilled workforce and a strong approach to workforce planning, recruitment and retention of staff. As can be seen from the above nursing and medical workforce figures, Option 3A will enable NHS Tayside to respond to the current and future workforce challenges particularly facing Medical and Nursing specialties, to deliver safe, sustainable services into the longer term for the benefit of the population and allow for a greater shift in the balance of care and subsequent remodelling and reinvestment in home treatment and community services to allow patients to be cared for in their own homes for as much of the time as is possible.

12. ESTIMATED COST OF OPTIONS

The NHS as a whole and NHS Tayside as a Board are facing unprecedented financial challenges which mean that all services require to look to ensure best value for the financial resources allocated. NHS Tayside is one of the highest spenders in Scotland on their Mental Health services and has been in the top three for best part of last two decades. NHS Tayside tasked the MHSRT programme to review how GAP and Learning Disability services can be delivered within this resource envelope to ensure delivery of the best service models for the population of Tayside whilst minimising variation, assuring high quality, safe, and sustainable person centred care. Better care does not always require additional resources and conversely improving care has the potential to reduce costs. It is clear that other areas in Scotland have made significant changes in their investment profile in Mental Health and Learning Disability services and longer travelling distances to access inpatient services are not uncommon.

12.1 Mains Points

- One of the Option Appraisal parameters required that any proposals brought forward must cost no more than current services in terms of recurring revenue funding.
- The estimated costs of the proposals require to remain within the current budget
- The estimated costs require to identify any bridging funding which may be necessary on a non recurring basis to cover any additional temporary double running or cross cover issues
- The proposals would include initial estimates for any refurbishment capital/cash prepayment costs. These are at very early design stage and will require further detailed design work with stakeholders before considered as part of the IA and OBC documentation required for presentation to the Capital Investment Group at Scottish Government for approval of any additional funding requirements

12.2 Financial Case – Overall Affordability

This section explains and provides summarised detail of:

1. Recurring revenue costs
2. Potential non recurring (bridging) costs
3. Estimated capex cost of options

4. Financial appraisal of options

12.2.1 Recurring revenue costs

The initial estimated recurring revenue implications for each option are summarised in Table Five below, the detailed breakdown to these estimated costs are provided in Appendix Six of the report.

These costing will require further detailed analysis once a preferred option is identified and will require to include implications for all potential staffing groups affected (administration and clerical staff, support services, day services, third sector, advocacy, Mental Health Officers). Full analysis of all potential building running cost implications and savings are required, this has the potential to increase with identification of other site retraction savings which may be achievable from further property disposals which may arise if other services relocate to the vacated areas available in Options 3A, 4A and 5A

Figures below reflect comparisons of estimated costs versus current recurring budgets, however there are significant cost pressures currently within GAP and Learning Disability services.

Further detailed analysis of estimated cost pressure reduction will be undertaken once identification of a preferred option.

Table Five – Recurring Revenue Implications

Inpatient Ward	Current Budget £000	Option 3A £000	Option 4A £000	Option 5A £000	Option 8 £000
Nursing Workforce					
Combined LDAU/BSI	2,108	1,546	1,546	1,546	1,546
LD Locked Forensic	932	906	906	906	906
LD Open Forensic	927	906	906	906	906
Amulree Complex Care & rehab (16 beds)	1,121	1,121	1,121	1,121	1,121
Rannoch Female Complex care	730	838	838	838	838
GAP Acute admission Ward One Carseview 22 Beds	1,025	1,045	1,045	1,045	1,637
GAP Acute admission Decant ward Carseview 18 plus 4 AIS Beds	1,096	1,045	1,045	1,045	1,020
GAP Acute admission Ward Two Carseview 22 Beds	-	1,045	1,045	1,045	-
GAP Acute admission into LDAU ward at Carseview 22 Beds	-	1,045	-	-	-
Moredun Ward Murray	1,374	-	-	1,374	1,228

Royal					
Mulberry Ward SCC	1,358	-	1,358	-	1,228
IPCU 10 Beds	1,034	1,045	1,045	1,045	1,045
Liaison/Nurse Escort		298	199	199	397
Total Nursing Costs	**11,704**	**10,841**	**11,054**	**11,070**	**11,870**
Variance – investment/(budget release)		**(863)**	**(650)**	**(634)**	**166**
Low Secure ward resource release	-	(883)	(883)	(883)	(883)
Low Secure ward Nursing reinvestment		195	195	195	195
Total Variance – investment/(Budget release)		**(1,551)**	**(1,338)**	**(1,322)**	**(522)**
Medical Workforce					
Senior Medical Staffing	4,067	3,867	4,067	4,067	4,187
Junior Medical Staffing	774	546	774	546	774
Total Medical Costs	4,841	4,413	4,841	4,613	4,961
Variance – investment/(Budget release)	-	**(428)**	**0**	**(228)**	**120**
Estimated changes to building running costs					
Additional Unitary Charge for Carseview	-	291	308	308	120
Strathmartine running costs	**-**	(288)	(288)	(288)	(288)
Variance – investment/(budget release)		**3**	**20**	**20**	**(168)**
Assumed potential income generation available from 2 beds in Low secure LD Forensic beds	**-**	**(442)**	**(442)**	**(442)**	**(442)**
Total Projected Variance – Investment/(Budget Release)		**(2,418)**	**(1,760)**	**(1,972)**	**(1,012)**

Current Medical cost pressures of approx £1M per annum exist through use of Locum Medical staffing. Continued requirement to provide medical cover across three sites in options 4A and Option 8 will therefore not allow for any potential reduction in the use of locums and therefore require to be offset against any savings identified above. Locum costs will continue to be incurred for all options considered until Consultant vacancies are able to be filled on a permanent basis, this will be reviewed on an ongoing basis to try and further reduce locum costs.

Building costs for current sites at Murray Royal and Susan Carnegie will remain regardless of option considered and therefore have been excluded from this analysis. It is NHS Tayside's continued intention to fully utilise these new facilities for the life of the building contracts and therefore no saving or additional cost for these sites are assumed as part of this Programme. It is recognised that options 3A, 4A and 5A may release additional site savings as noted above from relocation of other services into vacated areas within these two buildings.

Further detailed planning for the remodelling and reinvestment in community based services will now be progressed through each of the three Local Integration Board strategic planning groups through partnership with NHS Tayside Board, Local Authority and third sector organisations. It will be through this local planning and evaluation of current community service provision that further detail regarding the resources required can be identified.

It has therefore prudent at this stage not to attempt to quantify any potential reinvestment required in community services for any relocation of inpatient beds until further detailed mapping work of community services is undertaken.

This work cannot be progressed in detail to date until a preferred option for inpatient services could be identified and through the support of the three Health and Social Care Partnerships. The formal planned consultation period will support the gathering of information/feedback on the preferred option to assist IJB Strategic planning groups in planning of remodelled future community services and evaluation of the level of resources required within each area. Resources must be remodelled and invested to meet the needs of the varying local populations/demographics and improve current community provision further shifting the balance of care across both GAP and LD services

As highlighted in Table Five above Option 3A provides the most efficiency in terms of economies of scale from inpatient services to release resources which may then be utilised to invest into community based services, whilst still achieving a saving on recurring resource envelope and reducing current % spend on impatient services.

12.2.2 Potential non recurring (bridging) costs

There are a number of areas within each option which will require an element of non recurring bridging resources. The resources are required in the short term to support potential double running cost when services are initially being

implemented, short term impacts or issues which may arise as a knock on effect from a change or for time limited costs such as excess travel (4 years).

The quantification of these at this stage in the process is extremely difficult and subjective as will not be known until detailed implementation planning is undertaken on a preferred option.

Double running costs may arise where numbers of staff are unable to relocate through organisational change policies and retained within services as displaced staff. The quantification of any potential impact would only be able to be quantified accurately following agreement of a preferred option and subsequent one to ones with any staff impacted by change.

Each of the options in turn will have a potential bridging implication as noted below and scored within the financial appraisal exercise.

Potential bridging implications will require to be met from savings achieved on a non recurring basis.

Option 3A

Potential bridging implications may arise from:

Potential additional staffing cover required to support temporary isolation of remaining POA wards on Susan Carnegie site on non recurring basis until a further Option Appraisal undertaken to utilise vacated Mulberry ward.

Excess Travel costs for GAP staff relocated to Dundee from Mulberry ward in Susan Carnegie unit in Angus and from Moredun ward in Murray Royal in Perth.

Excess Travel costs for Learning Disability staff relocated from Strathmartine site and Carseview sites in Dundee to Murray Royal site in Perth.

% of GAP staff in Angus and Perth who may not be able to transfer to Carseview Centre in Dundee. (subject to organisational change)

% of Learning Disability staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and for Learning Disability services relocation to combined Moredun ward at Murray Royal and changes required to Rohallion Clinic for Forensic Services.

Removal expenses and patient transfer costs

Option 4A

Potential bridging implications may arise from:

Excess Travel costs for GAP staff relocated to Dundee from Moredun ward in Murray Royal in Perth.

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of GAP staff in Perth who may not be able to transfer to Carseview Centre in Dundee. (subject to organisational change)

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and changes required to Rohallion unit for relocation of Forensic Learning Disability services.

Option 5A

Potential bridging implications may arise from:

Potential additional staffing cover required to support temporary isolation of remaining POA wards on Susan Carnegie site on non recurring basis until a further Option Appraisal undertaken to utilise vacated Mulberry ward.

Excess Travel costs for GAP staff relocated to Dundee from Mulberry ward in Susan Carnegie unit in Angus

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of GAP staff in Angus who may not be able to transfer to Carseview Centre in Dundee (subject to organisational change)

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and changes required to Rohallion Clinic for relocation of Forensic Learning Disability services.

Removal expenses and patient transfer costs

Option 8

Potential bridging implications may arise from:

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and changes required to Rohallion Clinic for relocation of Forensic Learning Disability services.

Removal expenses and patient transfer costs

12.2.3 Estimated capex cost of options

Given the availability of capital funding at a local and national level, a revenue based finance solution is required to deliver any building works associated with this programme. Initial modelling undertaken as part of the original Adult Mental Health review OBC in 2005/06 considered the use of a cash prepayment option to progress refurbishment of Carseview Centre which is an existing PFI site. This work was updated in 2011 but again placed on hold pending review of strategic vision for site. The original resource earmarked for this work has not been utilised to date but would require to be approved by SG given the time period which has elapsed and the change in economic climate since original approval granted.

Initial modelling work undertaken indicated the Programme would be affordable in revenue terms if this cash prepayment resource is made available to buy out the capex implications associated with any refurbishment/development of Carseview site.

Initial capex high level costing estimates have been undertaken by NHST property department with support from Gauldie Wright & Partner Architects, are detailed in Table Four below which note building inflation of 34% on previous capex estimates provided for Carseview. These will be revised and refined once identification of a preferred option and further more detailed design work can be undertaken.

Public sector capital allocation will be required on completion of scheme to meet current outstanding planning consent commitments to provide external cladding to the modular decant building at Carseview. The ward was originally constructed following approval in 05/06 on a temporary planning approval application (originally intention was to relocate on completion of requirement as decant) however subsequent discussions with Dundee City Council Planners have indicated a requirement to ensure exterior of building matches the finish of the main building if NHS Tayside wishes to retain in situ on a permanent basis. Initial estimates identified an associated cost of £250k this will be subject to review and detailed costing on progression of a preferred option but will be

required regardless of option approved. This is not currently contained within NHS Tayside capital plan and will require to be progressed through the Capital Scrutiny Group approval process. Timing for the works will be agreed following further discussion and clarification of preferred option plans with the planning department during the consultation period. It is not envisaged this will be a requirement until the end of any Programme of refurbishment work.

Capital receipt from disposal of surplus assets would be available from the proposed closure of the Strathmartine site. Any capital receipts received from sale of property are not retained by NHS Tayside and are returned to Scottish Government. Current estimated receipt is noted in table below and is reflective of actual receipt envisaged; this has been reduced from previous estimates of £1M to reflect current market position, recent NHS capital receipts for similar sites such as Little Cairnie, planning restrictions and expected conditions placed on sale. Any preferred option which identifies vacant areas of buildings at Murray Royal or Susan Carnegie sites will be subject to a further option appraisal exercise to agree which alternative services could occupy empty ward. These alternative services may relocate from NHS sites/areas which could then become available for disposal and generate further capital receipt.

Any amendments required to the NPD buildings at Murray Royal and Susan Carnegie sites can be made as variation to contract and either funded through the traditional PFI/NPD route (increase in annual payment) or through buy out of the additional cost from revenue. It is proposed that as the amendments for each of the options relate to refurbishment of the Murray Royal site that these could be met by a combination of revenue funding then offset against potential SG DEL funding allocation and also through negotiation with the NPD/PFI providers to meet costs from their existing life cycle funds i.e. for decoration etc if area is due to be repainted every 3 years then they would undertake as part of the planned maintenance of site.

Initial estimated capex costs in Table Six below are based on a first review of likely accommodation requirements. These requirements will further identified through detailed design works undertaken with key stakeholders for the preferred option. Estimates below have been based on original 2011 costing work undertaken for the Carseview site Phase 2 refurbishment and have been uplifted to include building inflation uplift of 34%. This uplift for inflation increases costs beyond the original estimated £5M cash prepayment required and will be subject to further review. These estimates have not been reduced to reflect work which has already been undertaken under lifecycle programme on site, the recent Ward Two refurbishment under the contingency plan and ongoing refurbishment in relation to Health & Safety improvements across all Mental Health sites. These will be refined with progress of a preferred option.

Table Six – Capex estimated costs

Site/Ward	Option 3A £000	Option 4A £000	Option 5A £000	Option 8 £000
Capital				
Cladding of Decant	250	250	250	250
Total Capital	**250**	**250**	**250**	**250**
Capital Receipts				
Strathmartine Site Disposal	**(600)**	**(600)**	**(600)**	**(600)**
Other	Subject to further Option appraisal	Subject to further Option appraisal	Subject to further Option appraisal	0
Total capital receipts	**(600) may increase following further OA**	**(600) may increase following further OA**	**(600) may increase following further OA**	**(600)**
Cash Prepayment				
IPCU ward upgrade	2,102	2,102	2,102	2,102
Ward One upgrade to decant ward standard	247	247	247	247
Ward Two upgrade a GAP ward	2,076	2,076	2,076	
LDAU upgrade as GAP ward	2,550	-	-	-
LDAU upgrade as combined ward (LDAU,BSI and Open forensic)	-	2,985	2,985	-
LDAU upgrade as combined LDAU & BSI ward only	-	-	-	2,313
Ward Two upgrade as Open Forensic Ward	-	-	-	1,218
Total Cash Prepayment	**6,975**	**7,410**	**7,410**	**5,880**
Revenue – refurbishment				

(DEL funding)				
Moredun ward refurbishment to combined LD ward	58	-	-	-
Amendments to Rohallion for additional crisis suite	12	12	12	12
Total Potential revenue/(DEL funding)	**70**	**12**	**12**	**12**

Detailed breakdown of financial costs are included in Appendix Seven and design drawings included in Appendix Nine.

12.2.4 Financial Appraisal of options

In order to compare each of the options in terms of affordability not purely on revenue or capex costs but across the spectrum of financial implications, a financial appraisal has been undertaken by the Finance representatives on the MHSRT Programme team and Operational Finance team colleagues who manage Mental Health and Learning Disability and Capital resources within the Integration Joint Boards and NHS Tayside.

The detailed scoring of the appraisal is attached in Appendix Eight

The appraisal highlights that Option 3A provides the greater recurring resource release from site closure running costs, increase opportunities for capital receipts from disposal of surplus properties, increased opportunity to remodel and reinvest in community services to further shift the balance of care through associated economies of scale and reduce current cost pressures associated with Medical and supplementary staffing costs across both GAP and Learning Disability services. This option would require additional non recurring bridging funding to progress and the continued availability of previously agreed Scottish Government cash prepayment to allow full refurbishments of the sites identified to be undertaken.

13. IDENTIFICATION OF PREFERRED OPTION

As can be concluded from the information provided above in terms of the criteria used to consider options:

Safety and Sustainability: Option 3A provides the safest most sustainable service for the future, ensuring sufficient medical cover, nursing, AHP and Psychology workforce who can share learning and experiences across speciality services. This option will allow remodelling and reinvestment in community workforce to provide services to the majority of the population and prevent unnecessary admissions for both GAP and LD services. By shifting the balance of care and

providing centralised specialist services it reduces variation and provides ease of acute care pathway.

Workforce Availability: Option 3A is the only option which will provide sufficient safe inpatient staffing levels to provide services for the immediate future and next 5 years. This option also makes the most efficient use of workforce and would maximise the number of posts available for transfer to local community services.
Financial Affordability: Option 3A allows for the greatest release of resources from current inpatient services to allow for a remodelling and reinvestment in local community and home treatment services, whilst maximising use of the current estate portfolio and allowing disposal of properties which have significant backlog maintenance costs.

Criteria/Ranking	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Option Appraisal ranking	4	2	3	1
Safety/Sustainability ranking	1	3	2	4
Workforce Availability	1	3	2	4
Financial Affordability & Analysis	1	3	2	4
Overall ranking if criteria weighted equally	**1**	**3**	**2**	**4**

Option 3A would therefore be the recommended preferred option for NHST Board and the three Integration Joint Boards to progress to Consultation phase.

A move from the status quo inevitably involves change. Almost the most controversial aspects of the Programme and strategic review is the possible centralisation of acute admission beds for both GAP and Learning Disability services. Each option outlined above brings its own benefits and problems.

However the creation of a centralised service provides the opportunity for synergistic learning through close contact with professionals, service users and carers who would otherwise have been in separate services with different goals and potentially different quality standards.

Option 3A will allow for the above and creation of a “Centre of Excellence” for both GAP and Learning Disability services and a future model of care which is both sustainable from a workforce availability, environment and financial affordability.

By contrast travelling time for professionals, service users and carers will be significantly increased in some cases and the problems this can bring re escorts etc. Further exploration of the impacts on service users and their families will require to be considered throughout the consultation period and planning for any option implementation. Through the use of the EQIA report (appendix One) and quantification of the potential impacts on the population the programme will

continue to monitor and evaluate and take actions necessary to support access wherever possible.

Bed Numbers

Whilst the Royal College of Psychiatrists have traditionally provided guidelines on bed provision for GAP, as has the Scottish Needs Assessment Programme, the National Services framework in England have moved away from this using this detail. This reflects an understanding that inpatient care is only one element of overall service provision with usage potentially regulated by explicit care pathways and arrangements into and out of inpatient care. On discussion throughout the MHSRT Programme a key message emerged repeatedly in response to question "Have we got the bed numbers right?", the message and answer has continuously been that in themselves the bed numbers are less important than how patient pathways are developed and facilities are going to be used. Changes in the numbers of beds and people providing community services need to be reflected in a progressive self-examining, modern and evidence based culture associated with the care, treatment and recovery of people with mental health problems. As such the number of beds required for the future provision of the preferred option will be further questioned and examined in relation to provision of community based services as the preferred option is further progressed and developed during the subsequent detailed business case stages in line with the strategic plans of the three IJBs and the National MH strategy to shift the balance of care

14. CONSULTATION PLAN

The MHSRT Programme communications and engagement work stream in partnership with the three local Integration Joint Boards strategic planning groups are developing a robust consultation plan and programme for the three month formal consultation period, building on the engagement work undertaken to date.

Scottish Government and Scottish Health Council have provided guidance and support to the MHSRT Programme team throughout the option appraisal and engagement process and in preparation of the consultation plan. The programme team will continue to seek their support, guidance and assurance that the correct processes and procedures are followed for this next stage in the Programme.

Stakeholders must be part of the consultation planning process and advise on best practice, methods of communication, approach to take and format they require to be consulted with, particularly within Learning Disability services where service users may require additional support to fully participate.

There are a range of ways which can be used to raise awareness of the consultation, including media releases; targeted distribution of consultation paper and feedback questionnaires; wide distribution of a consultation flyer (which would be required in English and other languages); information on NHST website and MHSRT Programme links, Facebook page, a Twitter profile: as well as using the internal communication tools to raise awareness amongst all staff. (Staffnet,

bulletins, Spectra etc): face to face meetings, public meetings, events, one to ones with staff and patients and their families who may be directly affected by any proposed change: focus groups of stakeholders; open responses (letter and email); staff briefings: presentations to groups and committees

The consultation plan is attached as a separate summary report. Supporting website and materials are being prepared with support of the NHS Tayside communications team. This team will assist in the presentation the above information in a format which is easily presented and understood by the range of stakeholders and general public likely to be impacted upon by the proposed preferred option. A soft start approach is planned during June 2017 where posters, flyers, newsletters and press releases will inform of the Programme and the forth coming consultation and provide details of how people can become involved and points of contact to note interest in being involved in the process. The formal consultation period is planned to commence on the 3rd July 2017 and continue through to the 3rd October 2017.

15. CONCLUSION AND NEXT STEPS

The Boards are therefore asked to consider the information presented above and the process which had been followed to allow identification of the presented preferred option; that being Option 3A.

On approval of the process which has been followed regarding the selection of the preferred option, the MHSRT Programme would then proceed to the period of formal consultation with wider stakeholder and public involvement. The draft consultation plan is attached and outlined above. The consultation period will allow for the gathering of as much feedback, comment and opinion on the proposed preferred option to ensure further review and production of an Initial Agreement report which will then be presented to Boards for final approval.

The Programme reporting governance structure is attached in Appendix Eleven.

Business Case Stages and Programme Timeline for Approval

Option Review Report Update and Consultation plan approval	June 2017 Committees/Boards
Consultation Period	3rd July 2017 to 3rdOctober 2017
Initial Agreement Report	December/January 2017/8 Committees/Boards then CIG in January/Feb 2018
OBC report	May/June 2018 Committees/Boards then CIG in May
Financial Close	November 2018
FBC report	December 2018
Refurbishment timeline	January 2019 to December 2019

Mental Health Service Redesign Transformation Programme

Consultation Plan Report

Document Control Information	
Control Status	Draft
Date Last Printed	14/06/2017
Version Number	3.0
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager NHS Tayside

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION (MHSRT) PROGRAMME

1. INTRODUCTION

The consultation plan for the Mental Health Service Redesign Programme has been prepared in line with national guidance on Informing, Engaging and Consulting People in Developing Health and Community Care Services : CEL 4 (2010) (attached in Appendix Twelve of MHSRT Programme Option Review Report) and in compliance with the requirements outlined in the NHS Reform (Scotland) Act 2004. The guidance recognises the need to ensure a consistent and robust approach is adopted when Boards consider and propose new services, or any changes to existing services, and should therefore be referred to in developing a consultation plan.

All service change proposals should be supported by a plan that outlines the arrangements for informing, engaging and consulting people in its development. The formal consultation will build upon the comprehensive option appraisal process which has been followed to date to identify four top options. Following the option modelling events and further detailed work undertaken, each option has been compared for safety and sustainability, workforce availability and financial affordability which has enabled identification of a preferred option for General Adult Psychiatry and Learning Disability inpatient services. The consultation materials and full option review report highlight the approach taken in identifying the preferred option and this will be shared with all stakeholders involved to ensure this process is transparent. The engagement process to date has been approved by the Scottish Health Council. To complete the engagement process the option review report will be available on the programme website alongside all the consultation materials and sent directly to all people who participated in the process to date to provide an update on the selection of a preferred option. This will be done during the soft start launch during the month of June 2017 and highlight the upcoming consultation period commencing July 2017.

2. PERIOD OF CONSULTATION

The formal consultation period will be undertaken during the period 3rd July 2017 to 3rd October 2017. This meets the national guidance requirements of a minimum of three month consultation period.

The MHSRT Programme team will commence a programme of information sharing during the month of June 2017 whilst Boards consider and approve the Option Review report and the draft consultation plan. The information sharing programme in June 2017 will inform the public of the forthcoming

consultation period and explain how people can get involved. It will identify a single point of contact for stakeholders to register an interest to participate and notify of any additional supports which may be required. This will allow further development of the current list of stakeholders held by the Programme Team and highlight any omissions in required supports which are currently being considered.

3. PROCESS FOLLOWING CONSULTATION

Following the formal consultation period the MHSRT Programme Team will require to prepare the consultation report and undertake a further detailed review of the preferred option for final Board and Committee approval in December 2017. A report from the Scottish Health Council on the consultation process will also require to be produced following completion of the consultation period. There requires to be a two week period following the end of consultation period to allow return of any questionnaires/evaluation surveys before the SHC report is drafted and processed through their internal governance process. It is anticipated this could be achieved to meet the December 2017 timetable appreciating NHS Tayside will also have another major consultation running in parallel over the same period.

Once formal approval of the process and preferred option by NHS Tayside and Health and Social Care partnerships, and subject to SHC approval of the process, Ministerial approval will then be required. This approval is required when Programmes or Projects are deemed to be a major service change.

4. RAISING AWARENESS OF CONSULTATION

The MHSRT Programme plans to utilise a full range of methods to raise awareness of the consultation period and process.

Internal

- Information available on staffnet
- Article in NHS Tayside INBOX
- Article in Spectra magazine
- Staff Bulletins/Newsletters
- Direct distribution of consultation materials through service and clinical leads

External

- Media releases to local papers to launch the consultation
- Flyers and posters produced and placed in GP surgeries, Libraries, Community Centres, Churches, inpatient and community bases etc to signpost for further information (email/Website/freephone)
- Information on MHSRT Programme website /NHST internet/Local Authority websites /Partner agency websites

- Information on NHST Facebook Page and Twitter profile
- Direct distribution to key stakeholders identified to date (service users, carers, voluntary and third sector organisations, community councils, minority ethnic groups, Public partner forums, etc and those who register interest
- All materials require to be available in large print, Braille, audio, BSL DVD, and interpreted in the main ethnic community languages.

5. STAKEHOLDER IDENTIFICATION

As part of the MHSRT Programme, a communications and engagement work stream has been in place with representation from across the three localities and all Mental Health Services. This group has identified a list of key stakeholders which have been involved in the option appraisal and modelling events to date. The list has continued to be updated and added to throughout the process. Through raising awareness of the MHSRT Programme using the methods identified above, it is anticipated this will enable other interested persons to make contact to note their interest to participate in the consultation period.

6. CONSULTATION METHODS

There is a wide range of methods which the MHSRT Programme team aim to utilise to gather the views and feedback on the preferred option from service users, their carers and families, staff, third sector and voluntary organisations, the public and any other interested parties. Due to the complexity of the MHSRT Programme and wider implications of the options being considered, it is envisaged that the "face-to-face" methods (such as staff briefings, focus groups, presentations to meetings, discussion groups and public events) will be particularly helpful in enabling attendees to ask questions, raise concerns and receive immediate feedback. This will require dedicated MHSRT Programme team capacity to support this process.

6.1 CONSULTATION MATERIALS

This section identifies the various materials which the MHSRT Programme team plan to utilise to enable feedback on the preferred option being considered. These materials will be shared with some of the key stakeholder groups to ensure they are easily understood and meet the needs of all who may participate in the consultation period.

6.1.1 CONSULTATION REPORT

- A full detailed consultation report will be available online and distributed widely by email and by post where requested
- The website and papers will describe how to obtain the documentation in other languages and formats.

- Accessible and pictorial versions will also be provided for service users and support provided where requested.
- The information contained within the report will contain summary information from the Equality Impact Assessment document which highlights any identified impacts on people and how they might be addressed, for example, transport issues, impact on Scottish Ambulance Services etc

6.1.2 CONSULTATION SUMMARY REPORT

- A Summary consultation report will also be available online and shared as above for those who do not wish to read the more detailed papers. This will contain brief information regarding all options considered and why they have been discounted to arrive at a preferred option.
- Posters, Flyers and the consultation summary report will be provided in the main local ethnic community languages (Polish, Urdu, Hindi, Russian, Lithuanian), Audio and BSL DVD, Braille, and other languages/supports to be explored with the NHS Tayside Interpretation and Translation Department.
- Accessible and pictorial versions will also be provided for service users and support provided where requested.

6.1.3 CONSULTATION FEEDBACK QUESTIONNAIRE

Feedback questionnaires will be prepared to ensure quantitative and qualitative feedback on the preferred option. This will allow for a consistency in recording information and identification of main themes of feedback coming through the various categories of key stakeholder groups.

.

Questionnaires for service users are being devised with support from Speech & Language therapists to ensure that Learning Disability patients in particular have the maximum opportunity to express their views.

Various methods of recording feedback are being explored including use of online systems such as “Survey Monkey”, talking mats, etc People will also be able to email or send in free text comments regarding the proposals to a central email address for MHSRT Programme or via a Freepost mailing address

6.1.4 FREQUENTLY ASKED QUESTIONS

A list of frequently asked questions is currently being prepared and will also be available with the consultation materials on the website and for distribution. These will be updated throughout the process to ensure feedback is captured and are reflective of main issues

and questions being raised and answers are provided wherever possible.

6.1.5 STAFF EVENTS

A number of staff events will be held across the hospital sites in each of the localities. These events (as previous MHSRT Programme Events) will be held three times a day to co-inside with current shift pattern arrangements to present all staff with the opportunity to attend. All staff events/presentations will be supported again by staff side representatives who will be available to answer any queries or concerns individuals may wish to raise.

These meetings will be held early in the consultation period. i.e. beginning of July 2017

6.1.6 FOCUS GROUPS

A number of focus groups/service user and carer interviews will be held and supported by staff, third sector and or voluntary organisations to gain current service user and previous service user and carer views to ensure those most affected are consulted on any proposed amendments to service.

The process will tap into and utilise existing groups and organisations that support service users and their carers to ensure their views are collated. It is anticipated that these will be supported by colleagues from the SHC who will also undertake a joint evaluation.

6.1.7 OPEN MEETINGS

Open/drop in sessions will also be arranged in each locality to enable wider public views to be collated and support further information sharing

The exact format of these sessions is still to be fully developed but is likely to include information displays, a presentation and opportunity for Questions and Answers.

If there is a demand for discussion groups with local ethnic communities these will be arranged in the main local ethnic community languages and facilitated by “face to face” interpreters. NHS Tayside Interpretation and Translation services would also be involved to provide support.

6.1.8 ATTENDANCE AT KEY GROUPS AND COMMITTEES

The MHSRT Programme communications and engagement work stream are currently preparing a list of key stakeholder local groups and committees which have meetings scheduled to take place during the consultation period to request a slot on the agenda.

Groups identified to date are:

- GP sub committee
- Local Community Councils
- NHS Tayside Area Partnership Forum
- NHST Directors meeting
- Dundee, Angus and Perth & Kinross Integration Joint Boards
- Area Clinical Forum
- Clinical Care & Governance Committee
- NHS Tayside Transformation Board
- Perth & Kinross Transformation Board
- MSP briefings
- Dundee Mental Health and Learning Disability Management Team meetings
- Perth & Kinross Learning Disability Strategy Group
- Dundee Learning Disability/Autism Strategic Planning Group
- Dundee Learning Disability Provider Forum
- Angus Mental Health Reference Forum
- Perth & Kinross Mental Health Strategy Group

6.1.9 SOCIAL MEDIA & WEBSITE

Wide use of social media sites such as NHS Tayside Facebook page and Twitter Profile will also be used to support the consultation process and allow feedback to be collated online. A dedicated URL for the Programme has been set up to link to the NHS Tayside internet page which will provide all the Consultation materials, points of contact, questionnaires, support available, calendar of events planned and links to supporting information re national and local strategies, policies, staff side support, HR guidance, etc Other methods such as hashtag # for programme are also being explored to help track Programme on social media.

All these will need to be monitored to ensure we address any concerns or questions throughout the consultation period.

A staffnet page is also being established on the intranet for staff.

We are conscious of the responses received by online petitions and survey monkey responses surrounding the Programme to date and

are keen to utilise as many modern IT approaches to gather as many views as is possible.

7. SUPPORT REQUIREMENTS

The MHSRT Programme is working closely with GAP and LD services, key stakeholder representatives and colleagues from Speech & language (SP&L) therapy services to ensure all information is as accessible and understandable as is possible. Extensive supports will be available for service users and the public to access information in an appropriate format to meet their needs eg. Talking mats, other languages, large letters, Braille, BSL dvd, audio recording, electronic, social media, free postal address, freephone telephone number. It is vital we ensure the joint evaluations are also adapted with SP&L input to ensure we gather feedback from all participants in the process.

8. SCOTTISH HEALTH COUNCIL INVOLVEMENT/GUIDANCE

A report on the consultation process from the Scottish Health Council (SHC) is required by the Scottish Government (SG) to gain Ministerial approval for any proposals which are deemed to be major service change. The report from the SHC will assess whether the Board has involved people in accordance with the expectations set out in the CEL 4 guidance.

It has been assumed for the MHSRT Programme that the options being considered for future GAP and LD inpatient services may be categorised as major service change and therefore is prudent to apply the full CEL 4 major service change guidance.

Scottish Health Council colleagues have been involved in the option appraisal process to date and are members of the communications and engagement work stream where the planning for the consultation has been undertaken. The MHSRT Programme team will continue to work closely with the SHC and representatives from SG to ensure the consultation period is in accordance with guidance and meets the requirements for SHC and subsequent Ministerial approval.

CEL 4 (2010) guidance highlighting the requirements is attached at Appendix Twelve of the MHSRT Programme Option Review Report.

9. RECORDING OF CONSULTATION FEEDBACK AND REVIEW

In order to demonstrate that the Board has involved people in accordance with the expectations set out in the CEL 4 guidance it is imperative that a robust and consistent approach is taken to receiving and recording

stakeholder feedback and views gathered from all consultation activities undertaken.

Examples of good practice have been shared by the SHC and it is the intention of the MHSRT Programme team to ensure that a robust system for the recording of activity is maintained. All communication and engagement activity to date has been recorded in the communications and engagement plan and this will continue to be maintained throughout the process as a live document. This plan is attached in Appendix Three to the MHSRT Programme Option Review Report.

10. DRAFT ACTION PLAN AND PROPOSED CALENDAR OF EVENTS

The detailed draft action plan and proposed calendar of events has been prepared which outlines the tasks to be undertaken, action required, timescale and lead officer.

11. PROVISION OF FEEDBACK TO STAKEHOLDERS AND INTERESTED PARTIES ON OUTCOME

The programme would then seek to provide feedback to all parties involved in the process through:

- Explanation of the results of the consultation process, final proposals and next steps
- Provision of evidence of how views were taken into account in the development of final proposals
- Provision of reasoning for not accepting any widely expressed views
- Provision of outline plans for implementation and further opportunities for engagement throughout the implementation process

Appendix One

Equality Impact Assessment

17.05.23 MHSRT
Programme EQIA Doc

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

EQUALITY IMPACT ASSESSMENT

February 2017

*Document Control Information - **LIVE DOCUMENT***	
Control Status	Live
Date Last Printed	23/05/2017
Version Number	1.8
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager, NHS Tayside M Steven, Mental Health Programme Support Officer, NHS Tayside Reviewed – S Chima, Diversity and Inclusion Manager, NHS Tayside

EQUALITY IMPACT ASSESSMENT

Name of Policy, Service Improvement, Redesign or Strategy:

Mental Health Service Redesign Transformation (MHSRT) Programme

Lead Director or Manager:

Neil Prentice – Executive Lead - Associate Medical Director for Mental Health
Robert Packham – Operational Lead – Chief Officer, Perth & Kinross IJB
Lynne Hamilton – Programme Lead - Mental Health Programme Director & Finance Manager

What are the main aims of the Policy, Service Improvement, Redesign or Strategy?

The main aims of the MHSRT Programme are to review the clinical models of how we sustain and deliver good quality care and to optimise the use of the current facilities from where we deliver that care.

In line with these Programme aims and objectives there is a need to provide:

- Models of care which support safe, effective and person-centred care
- Improved care and treatment across hospital and community mental health services that focus on prevention of admission and timely supported discharge
- Hospital services are designed to provide interventions and care that can only be delivered in an inpatient facility. (only 6% of people who access secondary care mental health services each year, need to access care within inpatient services.)
- A shift in the balance to primary and community care and care at home.
- Models of care that ensure equity of access to services across Tayside
- Service models that support safe, effective and sustainable deployment of staff across Tayside
- Best Value and optimal use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. Opportunities to disinvest in outdated estates and capital assets to reinvest in patient care.
- Effective recovery through close collaborative and co-productive relationships with family, carers and supporting community groups/organisations that complement statutory services.
- An environment that supports clinically effective and safe services
- A pleasant physical environment that promotes health and wellbeing
- Opportunities to redesign the patient pathway through care to improve patient experience, reduce length of stay and maximise use of scarce resources

To achieve this NHS Tayside therefore requires to develop future General Adult Mental Health and Learning Disability service models which will deliver these in terms of clinical service sustainability, workforce availability and financial affordability.

As well as improving patient environments NHS Tayside aims to make most efficient use of its asset base, maximise utilisation of existing PFI/NPD buildings and look to dispose of surplus assets which are no longer able to provide modern healthcare and fit for purpose accommodation.

Description of the Policy, Service Improvement, Redesign or Strategy – What is it? What does it do? Who does it? And who is it for?

The MHSRT Programme was commissioned by NHS Tayside in partnership with the three local Integration Joint Boards to review Mental Health General Adult Psychiatry and Learning Disability services across Tayside.

This would include inpatient services currently being provided from:

- Murray Royal Hospital in Perth
- Carseview Centre in Dundee
- Susan Carnegie Centre on Stracthro site near Brechin, Angus
- Strathmartine Centre in Dundee

The review will look at General Adult Psychiatry (GAP) services for those aged between 18 and 65 (circa 250,000) and Learning Disability (LD) service models (no upper age limit) for delivery of care to the population of Tayside to provide Improved pathways and access to psychiatric care both through inpatient and community care.

What are the intended outcomes from the proposed Policy, Service Improvement, Redesign or strategy? – What will happen as a result of it?- Who benefits from it and how?

The main intended outcome of the MHSRT Programme is to provide safe, sustainable person centred GAP and LD service models for the future.

Through improved access to services in a sustainable way and improved community access/home treatments more people can be cared for as close to home or in own homes as is possible.

The proposed changes will review service user care pathways, workforce availability, service models sustainability, financial affordability and a review of the accommodation from where we provide these models.

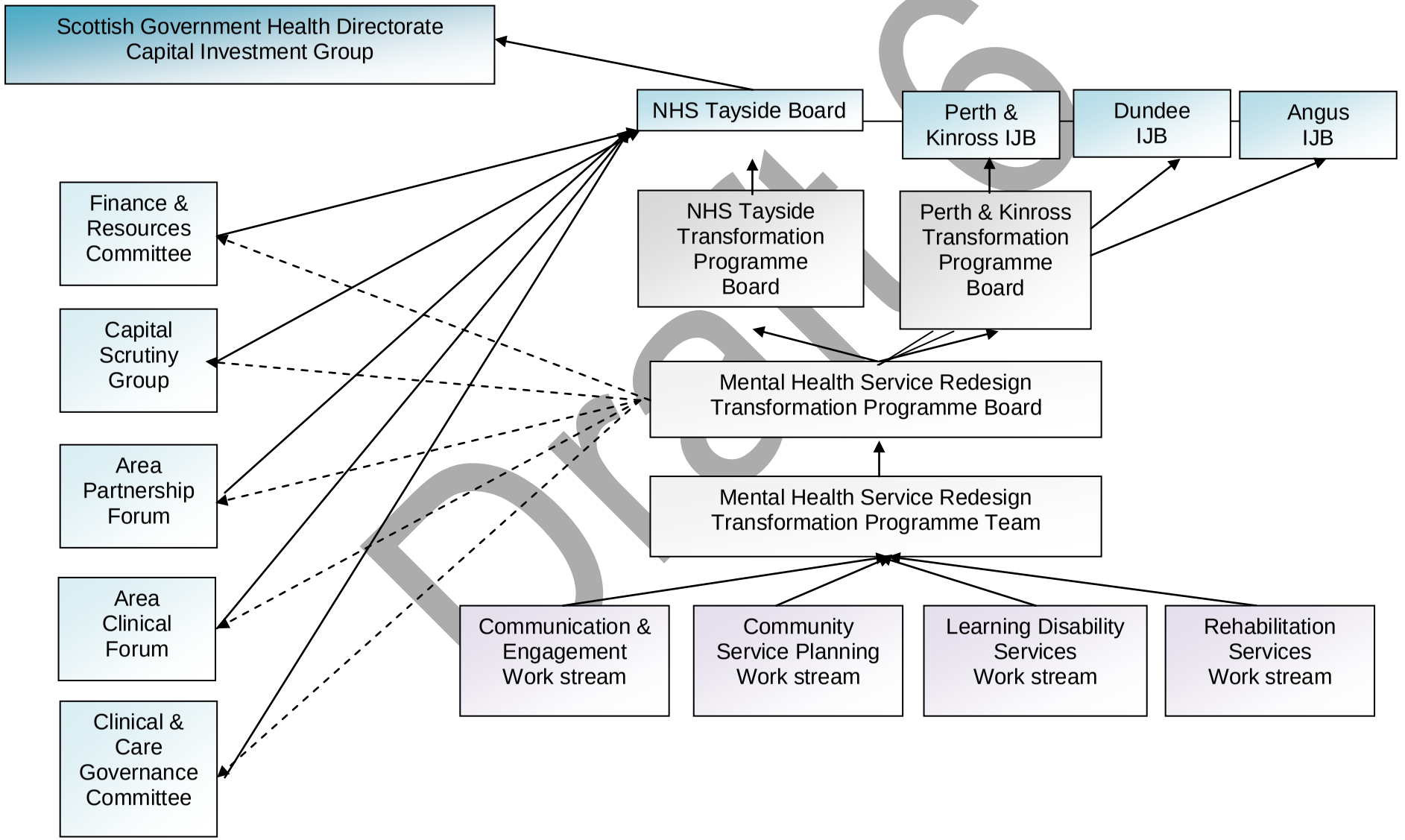
94% of the Mental Health population access MH and LD services in the community and only 6% access specialist inpatient services yet almost 60% of current resources are tied up in inpatient services. The MHSRT Programme seeks to shift the balance of care and investment of resources to more community based services to meet the needs of the population of Tayside.

Name of the group responsible for assessing or considering the equality impact assessment? This should be the Policy Working Group or the Project team for Service Improvement, Redesign or Strategy.

Mental Health Service Redesign Transformation Programme Team and Programme Board will assess and provide draft for approval at committees noted in table below – also see attached supporting reporting structure for MHSRT Programme

Name of meeting	Date of Meeting
Clinical Care Governance Committee	12th June 2017
Dundee IJB	27th June 2017
Angus IJB	28th June 2017
Perth & Kinross IJB	30th June 2017
Perth & Kinross Transformation Board	xxx
NHS Tayside Board	29th June 2017
NHS Transformation Board	xxx
Area Partnership Forum	27th June 2017
Area Clinical Forum	xxx
MHSRT Programme Board	June 2017
MHSRT Programme Team	1st June 2017

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME GOVERNANCE/REPORTING STRUCTURE



Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.1	Will it impact on the whole population? Yes or No. If yes will it have a differential impact on any of the groups identified in 1.2. If no go to 1.2 to identify which groups	No. The MHSRT Programme will not impact on the whole population. Any proposed changes to services will impact on the current % of population accessing NHS Tayside Adult Mental Health and Learning Disability services. Potential changes to service provision will impact on the population with all of the protected characteristics noted in section 1.2 Options being considered for both General Adult Psychiatry (GAP) and Learning Disability (LD) services have the potential to improve services for the majority of the mental health and learning disability population through a shift in balance of resources to the community. NHS Tayside is responsible for meeting the health care needs	Population/demographic statistics – detail attached in population report  NHST2015 Pops.xlsx % of population affected by mental health in Tayside – A major study of psychiatric morbidity in Britain reported that, in 2000, one in six people had a neurotic illness, including anxiety and depression, while one in 200 had a psychotic disorder such as schizophrenia (Singleton et al., 2001; Cooper and Bebbington, 2006). One in seven people in the same survey had considered suicide at some point in their lives (Cooper and Bebbington, 2006) Approximately only 6% of people who access secondary	The MHSRT Programme team in partnership with the three local Integration Joint Board Strategic Planning groups will need to continually review all GAP and LD inpatient and community based services within localities and consider how these can be accessed more widely. Ensure services can be accessed by everyone regardless of age, race, gender and other equality factors. Enhance signposting of mental health services within local communities. Provision of Spiritual care rooms on all sites. Working with partners to look at possibility of

		of just under 500,000 people living in Tayside. Tayside covers 3000 square miles of Urban, Accessible Rural and Rural populations within catchment from four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife The largest populations in Tayside sit within the 50-54 year olds (7.5%) and 20-24 year olds (7.2%) bandings which is consistent with the Scottish average and has implications for Mental Health and Learning Disability service provision for 18 to 65 year olds moving forward. NHS Tayside and the three Integration Joint Boards need to provide the resilience to manage the growing demands for Mental Health and Learning Disability services especially for the majority of the activity which takes place within our local communities and within the service users own home. People with learning disabilities (LD) have a significant lifelong	care mental health services each year, need to access care within inpatient services with 94% of activity taking place within a community based setting or service users own home. The changes proposed will provide greater care in the community and allow patients across Tayside to be cared for longer in their local communities and own home environments. For the residents of South Angus from areas such as Carnoustie, Monifieth, Tealing, Forfar and Monikie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction in travel time and improved transport links for GAP service users requiring acute admission and for their visiting families and carers and NHS staff. Those service users, visitors, staff and carers from North Angus will have increased travel as they are currently closer to current services provided in Susan Carnegie Centre on Stracathro site near	provision of any demand responsive transport solutions where applicable Raise awareness of services available and how to access them in a variety of ways utilising existing networks, newsletters, sign-posting, closer working with general practice, etc. The Integration Joint Board (IJB) as a separate legal entity will operate independently from the Health Board. An annual performance report required by statute will be provided by the IJB The MHSRT Programme team will continue to liaise with equalities team and local identified minority support groups. Cultural aspects/population and

		condition that begins before adulthood and affects their development so they need help to understand information, learn skills, and cope independently. About 16 000 school-aged children and young people, and 26 000 adults in Scotland have LD and require support. Population statistics suggest that 6 people in every 1 000 in Scotland have a LD. This rate increases to 9.2/1,000 (1,132 adults) in Dundee, drops to 5.5/1,000 (525 adults) in Angus and 3.9/1,000 (479 adults) in Perth and Kinross.	Brechin. Approx only 20% of the total current population of Angus live in North Angus. i.e Brechin and Montrose areas which equates to approx 4 to 5 patients of the current 25 acute inpatient admissions Currently 15% of Angus GAP Acute patient admissions have to be admitted out with Angus to inpatient beds within the Carseview Centre in Dundee and Murray Royal site in Perth due to varying bed demands. For the residents of North/East Perthshire from areas such as Invergowrie, Longforgan, Errol/Carse of Gowrie, Alyth and Blairgowrie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction or equivalent travel time and improved transport links for GAP service users requiring acute admission and for their visiting families and carers and NHS staff. Those service users, visitors, staff and carers from South/West and more rural Perthshire will have increased travel as they are currently	geographical trends will be monitored throughout process. Liaise with interpretation and translation and speech and language services to ensure appropriate service provision available for people who require support (particularly within LD service) The MHSRT Programme Team require to monitor and evaluate the ability to deliver service after any proposed change. As below in section 8 benefits realisation will support evaluation against agreed set of deliverables and benefits criteria

			closer to current services provided in Murray Royal Hospital in Perth (furthest additional travel is 21 miles) Approx 27% of the total current population of Perth & Kinross live in South West and more rural areas of Perth & Kinross. i.e which equates to approx 7 patients of the current 26 acute inpatient admissions. Approx 45% of the total current population of Perth & Kinross live in city centre area of Perth i.e which equates to approx 11 patients of the current 26 acute inpatient admissions Approx 28% of the total current population of Perth & Kinross live in the North East area of Perth & Kinross and would therefore be nearer to Carseview Centre i.e which equates to approx 8 patients of the current 26 acute inpatient admissions Currently 7% of Perth GAP Acute patient admissions have to be admitted out with Perth & Kinross to inpatient beds within	

			the Carseview Centre in Dundee and Susan Carnegie Centre in Angus due to varying bed demands. Tayside populations are split across three localities as 36% Perth & Kinross, 28% Angus and 36% Dundee. The relocation of Learning Disability inpatients beds currently provided in Strathmartine and Carseview sites in Dundee to Murray Royal hospital in Perth will mean greater travelling distances for the population of Angus and Dundee (64% of Tayside population) to access services on the Murray Royal site in Perth (of 30 inpatient beds using this % would be approx 19 service users). However in turn this would mean reduced travelling distances for the residents of Perth & Kinross (34% of Tayside population) approx 11 service users.	

SECTION 1 Part B – Equality and Diversity Impacts
Which equality group or Protected Characteristics do you think will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.2	Which of the protected characteristic(s) or groups will be affected? • Minority ethnic population (including refugees, asylum seekers & gypsies/travellers) • Women and men • People in religious/faith groups • Disabled people (refer to 2.2, 2.3) • Older people, children and young people • Lesbian, gay, bisexual and transgender people • People with mental health problems • Homeless people • People involved in criminal justice system (refer to 2.2) • Staff	The MHSRT Programme will impact on all the protected characteristics ranging from individual patient to locality populations although there is no immediate reason to think the service changes (reconfiguration or changes to pathway) would have an adverse impact Minority Ethnic - There is little evidence to demonstrate any link between racial background and prevalence of mental health or LD conditions however from the supporting data gathered from ISD submission it can be noted that few people from ethnic minority groups access mental health 2.4% and learning disability 1% support and services Women and Men – ISD information from inpatient admissions for GAP show more	Ethnicity Figures for Tayside is attached:  Ethnicity Report_2011 Census ISD data :  2565 MH activity Dec14-Nov16.xlsx Supporting research used to review impact: Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015)  ehrc_hidden_in_plain_sight_3.pdf	Review services within localities and consider how these can be accessed more widely. Ensure services can be accessed by everyone regardless of age, race, gender and other equality factors. Enhance signposting of mental health services within local communities. Provision of Spiritual care rooms on all inpatient sites. Working with partners to look at viability of any demand responsive transport solutions.

	• Socio- economically deprived groups	males are admitted to services than females (52% males 47% females), however in LD services this split shows admissions are predominately male dominated (66% male 33% females) Perth & Kinross strategy for gypsies/travellers outlines a higher % of population in Perth & Kinross than elsewhere in Scotland – it highlights that the Scottish Census figures for 2011 included "Gypsy/Traveller" as a classification for the first time and the results were released in September 2013. Nationally 4,212 people were recorded as such with the highest individual local authority population being 415 in Perth and Kinross. Current ISD information recorded 0.1% inpatient admissions in GAP were gypsy/travellers and none recorded in LD services The MHSRT Programme team require to ensure the cultural and religious needs of service users are met. There is no link between religious belief and	The Same as You a Review of Services for People with Learning Disabilities May 2000 The Sam as You.pdf The Key to Life: Improving the Quality of Life for Patients with a Learning Disability June 2013 keys to life.pdf Gypsy/Traveller Strategy for Perth and Kinross 2013 – 2018 P&K Gypsy_Traveller_Stra Health & Social Care Partnerships host mental health services Lesbian, Gay, Bisexual &/ Transgender (LGB&/T) ….A 2012 survey carried out by LGB&/T Youth Scotland of 273 people aged 13-25 found that 40% of LGBT youth consider themselves to have a mental health condition (compared to 25% of the population	Raise awareness of services available and how to access them in a variety of ways utilising existing networks, newsletters, sign-posting. Providing appropriate equality and diversity awareness training for staff and other service providers in line with NHST policy on equality Continue to undertake analysis of any potential impacts identified and continually evaluate throughout life of programme The Integration Joint Board (IJB) as a separate legal entity will operate independently from the Health Board. An annual performance report required by statute will be

		prevalence of Mental Health or Learning Disability The options being considered will impact on people who have a learning disability and those with a learning disability and a major mental illness. In addition will also affect those who have a learning disability and are at a risk of offending behaviour (Forensic) There is the possibility of travelling further to the location/needing different travel / transport issues / arrangements depending on the location of inpatient beds compared to the current nearest inpatient bed. This could have a negative impact where age groups of service users/carers are disproportionally affected by transport issues (e.g less likely to have own transport if older/additional cost of transport) or where service users require assistance to travel or escort Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily	overall), with higher levels of poor mental health reported by transgender individuals (66.7%) and bisexual women (63%). Homophobic and transphobic bullying was reported as a significant contributing factor to mental health problems – Extract from the Mental Health in Scotland Fundamental Facts report – Mental Health Foundation report 2016 NHS Tayside Family friendly policies are in place alongside organisational change policies to support staff.	provided by the IJB. Liaise with equalities team. Cultural aspects/population and geographical trends. Liaison with interpretation and translation and speech and language therapy services are available to ensure appropriate support for those who require and for people with LD and their families. Information is readily available and provided in other languages where requested/required. All programme consultation documentation will be provided in multiple languages. Written information for LD service users may also be required to be

		transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population		in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service External review of LD day treatments to be undertaken and alternative models considered

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.3	Will the development of the policy, strategy or service improvement/redesign lead to • Discrimination • Unequal opportunities • Poor relations between equality groups and other groups • Other	Changes in service provision may have direct or indirect impacts on the Learning disability inpatient population through potential relocation of beds where current environment may be deemed by some service users as their home. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media	Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) No Through Road: Mental Welfare Commission Report (Feb 2016) no_through_road.pdf A National Clinical Strategy for Scotland (Feb 2016) a national clinical strategy for scotland NHS Tayside Clinical Services Strategy for Mental Health (2015) NHST Clinical services strategy for NHS Tayside Health Equity Strategy – Communities in Control (2010)	The MHSRT Programme will continue to maintain and record all comment and views regarding the options considered within the programme communication and engagement plan which records all engagement activity undertaken to date. Feedback on preferred option will need to be obtained / considered during consultation period of the planned changes and appropriate solutions/support put in place to allow all key stakeholders to participate in the process. Various methods of communication and engagement such as evaluation through carer & patient groups/patient feedback questionnaires, focus groups, public events etc will support

		reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population In order to reduce the risk of discrimination the following needs to be considered: Working with partners re demand responsive transport solutions. Ensure that services can be accessed by everyone regardless of age, race, gender and other equality factors. GAP options being considered will impact on access however it should be noted that current GAP beds are Tayside beds regardless of location and patients have been required to travel to other localities for admission when no bed in local area was available. Dundee GAP Patients will not be impacted upon by any of the options being considered. No change to relations between	 Health equity strategy.pdf IJB Strategic Plans NHS Tayside LDP 2015  LDP 2015-16.pdf Patients Rights (Scotland)Act 2011  Patients rights.pdf Convention on the Rights of Persons with Disabilities (UN 2006).  un convetion of the rights of persons with	evaluation of options. Participation must be active, free and meaningful and give attention to issues of accessibility, including access to information in a form and a language that can be understood. Working with partners re demand responsive transport solutions. Ensure that services can be accessed by everyone regardless of age, race, gender and other equality factors.

		equality groups and other groups is foreseen. All options being considered for both GAP and LD services impact on current service provision as options are purely considering change to the location of the service provision Learning Disability options look at the relocation of inpatient services from accommodation that is poor/ageing to brand new purpose built or refurbished accommodation which will greatly improve patient experience and impact on individual.		

SECTION 2 – Human Rights and Health Impact.
Which Human Rights could be affected in relation to article 2, 3, 5, 6, 9 and 11. (ECHR: European Convention on Human Rights)

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
2.1	**On Life (Article 2, ECHR)** • Basic necessities such as adequate nutrition, and safe drinking water	No impact – It is not envisaged that there will be any impact on basic necessities from any of the options being considered for GAP or LD	Adult Support and Protection (Scotland) 2007  ASP Scotland 2007 pdf.pdf Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) Patients Rights (Scotland)Act 2011 MEL 5 (1999) Health Social Work and Related Services for Mentally Disordered Offenders in Scotland,	The MHSRT Programme will require to monitor/evaluate outcomes in relation to these factors– this can be supported by regular review of suicide rates, datix reporting, ligature incidents Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place. Risk Assessments which include risk of suicide to be carried out on all patients. Within inpatients, these would be completed on
	• Suicide	There is no evidence to suggest that prevalence of suicide rates would be impacted upon by any of the changes proposed for GAP or LD		
	• Risk to life of / from others	There is no evidence to suggest that prevalence of risk to life of self or others would be impacted upon by any of the changes proposed for GAP or LD		
	• Duties to protect life from risks by self / others	There is no evidence to suggest that duties to protect life from risk by self/others would be impacted upon by any of the changes proposed for GAP or LD		

	• End of life questions	No impact - It is not envisaged that there will be any impact on End of Life questions from any of the options being considered for GAP or LD	 MEL 5.doc Mental Health Strategy for Scotland: 2012-2015  MH Strategy for Scotland.pdf The Key to Life: Improving the Quality of Life for Patients with a Learning Disability June 2013	admission and reviewed at least daily by the multidisciplinary team. Patients' will engage in therapeutic activities to manage their thoughts and actions associated with risk of suicide. If required patients would be placed on higher level of observations which mean having a dedicated nurse with them 24/7.Ward doors to the unit can also be locked to mitigate risk and access to areas of known environmental risks removed.
2.2	**On Freedom from ill-treatment (Article 3, ECHR)** • Fear, humiliation • Intense physical or mental suffering or anguish • Prevention of ill-treatment, • Investigation of reasonably substantiated allegations of	There is no immediate reason to think the service changes proposed in the options through reconfiguration or changes to pathway would have an adverse impact. A well designed service and accommodation should improve living conditions and the prevention of ill-treatment. Access to gardens/grounds/fit	Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015)	Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place. Participation must be active, free and meaningful and give attention to issues of accessibility, including access to information in

	serious ill-treatment • Dignified living conditions • Standards of care	for purpose buildings/ safe environments Significant delay in transfer from prison can lead to mentally ill prisoners being managed for lengthy periods segregated from others and locked in a cell for almost 24h a day. This can exacerbate mental suffering. Manage separation of client groups regardless of option considered e.g. separate entrances, separation of severity of illness/challenging behaviours etc Some of the options proposed look to improve standards of care through provision of "centres of Excellence" which can enhance ability to train staff and encourage shared learning and experiences	No Through Road: Mental Welfare Commission Report (Feb 2016) Patients Rights (Scotland)Act 2011	a form and a language that can be understood MHSRT Programme team will require to assess and monitor impacts throughout process Review of Advocacy/peer support workers to support options .
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
2.3	**On Liberty (Article 5, ECHR)**	Some potential impact on patients in criminal justice system, however options	Mental Health (Scotland) Act 2015)	Monitored consistently through tribunals/MHCTA etc

	• Detention under mental health law • Review of continued justification of detention • Informing reasons for detention	being considered are not changing the level of detention or right to be detained in the right environment only the potential distance to travel to for service users/carers and families. Levels of security will remain appropriate and consistent with those set out in the MHCTA documentation. People who have a learning disability. People who have a learning disability and a major mental illness.	A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011	Review of requirement for Advocacy services/peer support workers
2.4	**On a Fair Hearing (Article 6, ECHR)** • Staff disciplinary proceedings • Malpractice • Right to be heard • Procedural fairness • Effective participation in proceedings that determine rights such as employment, damages / compensation	Within NHS Tayside any proposed changes to service delivery are the subject of full consultation with employees and staff side representatives. Any changes for employees in relation to their employment would be dealt with in accordance with NHS Tayside policy and practice following consultation with staff, human resources and staff side representatives	Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) NHS Tayside policies/procedures	Any potential impact will be dealt with in accordance with NHS Tayside organisational change policies supported through Human Resources team and staff side representatives. Right to be heard 1:1 meetings Communications and engagement through staff bulletins, Spectra, staffnet, social media,

				staff events etc
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
2.5	**On Private and family life (Article 6, ECHR)** • Private and Family life • Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse • Personal data, privacy and confidentiality • Sexual identity • Autonomy and self-determination • Relations with family, community • Participation in decisions that affect rights • Legal capacity in decision making supported participation and decision making, accessible	The options being considered as part of the MHSRT Programme will allow for the shift in balance of care for both GAP and LD services with an increased focus on community services this should mean fewer patients separated from their carers/ families/children. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010) Appleby and Deeming (2001)	Gain views from service users impacted upon any proposed changes re their wider family and community life Review requirements for Advocacy/peer support workers Ongoing communication engagement and monitoring Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place. Access to information in a form and a language that can be understood. Liaison with

	information and communication to support decision making • Clean and healthy environment	of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population Impact on family life Family and community Through improved clean and healthy environments for inpatient services in GAP and LD Focus on community services should mean fewer patients separated from their carers/families/children.		interpretation and translation services to ensure appropriate for people with LD and their families. Information is provided in other languages where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service External review of LD day treatments to be undertaken and alternative models considered
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
2.6	**On Freedom of thought, conscience and religion**	It is not envisaged there will be any impact from the service	Patients Rights (Scotland)Act 2011	Spirituality services/accommodation

	(Article 9, ECHR) • To express opinions and receive and impart information and ideas without interference	changes being considered		provided on all sites to ensure consistency. Ongoing communication and engagement and monitoring of any complaints.
2.7	**On Freedom of assembly and association (Article 11, ECHR)** • Choosing whether to belong to a trade union	No impact		Monitored and appropriate solutions/support put in place if required.
2.8	**On Marriage and founding a family** • Capacity • Age	Increased access to normalised opportunities within a risk management framework (Forensic) No Impact envisaged for other services	Patients Rights (Scotland)Act 2011 No Through Road: Mental Welfare Commission Report (Feb 2016)	Monitored and appropriate solutions/support put in place if required.
2.9	**Protocol 1 (Article 1, 2, 3 ECHR)** • Peaceful enjoyment of possessions	No change to enjoyment of possessions is envisaged as current restrictions implemented for safety will remain for all options being considered for GAP and LD.	Patients Rights (Scotland)Act 2011	Monitored and appropriate solutions/support put in place if required.

SECTION 3 – Health Inequalities Impact
Which health and lifestyle changes will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
3.1	What impact will the function, policy/strategy or service change have on lifestyles? For example will the changes affect: • Diet & nutrition • Exercise & physical activity • Substance use: tobacco, alcohol or drugs • Risk taking behaviours • Education & learning or skills • Other	Positive impact through improving pathways and access to psychiatric care through inpatient care with a focus on community care. Improvements in capacity and flow in our rehabilitation services which captures our learning education and skills. Promotes autonomy to make lifestyle choices through increased ability to be looked after in the community. Current provision will be matched/re-provided regardless of option selected Staff education – improvements through options which consider centralisation of workforce will allow for creation of “centres of excellence” which will increase training opportunities and promote	Evidence re repatriation of patients from out of areas – change in rehabilitation model and Tayside crisis response and Home Treatment pathway which signposts people towards healthy behaviours and reduction of risk. Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	MHSRT Programme will continue to monitor and evaluate Liaison with interpretation and transaltion services to ensure appropriate for people with LD and their families Information is provided in other languages where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service

		shared learning and experiences. Greater equality and consistency of service provision		
3.2.	Does your function, policy or service change consider the impact on the communities? Things that might be affected include: • Social status • Employment (paid/unpaid) • Social/family support • Stress • Income	Positive impact in options considering centralisation of services where it is proposed that more patients will be cared for in the community/at home and be able to maintain their usual activities/family relationships. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Evaluate and monitor impact. Work with Police to minimise impact/risk Liaise with Scottish ambulance services, local authority with regard to options for transport/other services Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered

		impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population There is a risk of a reduction in social/ family/carer support because of the distance between all inpatient units and their area of residence, particularly for some rural areas of Tayside and where carers may require support to access. This is particularly relevant to those patients with Learning Disabilities as they are more likely to have more contact with family and in particular elderly parents/relatives They also tend to be in hospital for longer. For both sets of patients it is extremely important that any rehabilitation in preparation for discharge is carried out as near the patients home area as possible.		

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
3.3	Will the function, policy or service change have an impact on the physical environment? For example will there be impacts on: • Living conditions • Working conditions • Pollution or climate change • Accidental injuries/public safety • Transmission of infectious diseases • Other •	The options being considered for both GAP and LD will increase ability to recruit and retain staff this can also be supported through staff engagement, imatter, Options considering a single or two site solution will support ability to provide more safe and sustainable medical rotas, consultant cover and staffing levels within inpatient services. Options which look at centralisation of services encourage provision of Centres of excellence, which will in turn assist in up-skilling of workforce, training and shared learning and experiences. Improved local links with colleges Options being considered will provide far improved working conditions for staff and living environments for patients. Some options being considered for patients within current LD	Will be managed and mitigated through NHS Tayside organisational policies. Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Continue to monitor patient experience and evaluate impact Monitoring of benefits realisation Liaise with Scottish ambulance services, local authority with regard to options for transport/other services Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered Improve links with colleges

		environments will benefit from significantly improved environments within fit for purpose single bed room en-suite accommodation., football pitches, gyms, activity space, hub shop, café etc Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work		

		forward. 4. Potential impacts on access to day service and psychology services for LD population		
3.4	Will the function, policy or service change affect access to and experience of services? For example • Healthcare • Social services • Education • Transport • Housing	Yes the proposed service change will improve access to services in a sustainable way and improve community access for GAP Mental Health services through redesigned community models and enhanced home treatment services. The options which allow for a shift in the balance of care to provide more support in the community will benefit the majority of the population who come in contact with services (94%) who will receive improved care and support as close to or in own home as is possible. This will also be case for Learning Disability service users through improvements in both service provision and physical environments. There is a risk of a reduction in social/ family support because of the distance between all	Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Communication and engagement plan will continue to capture all comment and feedback received re experiences and stakeholder views Qualitative data gathered highlighting Patient experience. Liaise with Scottish ambulance services, local authority with regard to options for transport/other services Liaise with equalities team re cultural aspects and any supported minority groups. Liaison with interpreter services to ensure appropriate for people with LD and their families Information is provided in other languages

		inpatient units and their area of residence. This is particularly relevant to those patients with Learning Disabilities as they are more likely to have more contact with family and in particular elderly parents/relatives They also tend to be in hospital for longer. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and		where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered

		delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population		
tem	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
3.5	In relation to the protected characteristics and groups identified: • What are the potential impacts on health? • Will the function, policy or service change impact on access to health care? If yes - in what way? • Will the function or policy or service change impact on the experience of health care? If yes – in what way?	A potential reduction in 30% of the planned low secure rehabilitation beds will mean less availability for treatment of patients in a therapeutic secure environment. However current activity has remained below these levels since the opening of the unit in 2012. This could increase the likelihood individuals will continue to engage in harmful behaviour to themselves and others with an impact on their mental health if demand increased beyond envisaged capacity and therefore subsequent places may then have to be secured out of area. We anticipate the proposed	See Supporting Data Appendix Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Communication and engagement plan will continue to be updated and include all feedback received Qualitative data gathered re Patient experience Liaise with equalities team re cultural aspects. Liaison with interpreter services to ensure appropriate for people with LD and their families Information is provided in other languages where required, requested, in

		changes will rebalance care towards community treatment and widen access to healthcare at a local level. Access and Travel impacts as per previous sections		relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service

SECTION 4 – Financial Decisions Impact
How will it affect the financial decision or proposal?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
4.1	• Is the purpose of the financial decision for service improvement/redesign clearly set out • Has the impact of your financial proposals on equality groups been thoroughly considered before any decisions are arrived at	Yes. The MHSRT Programme Option Review Report provides detailed financial plans and potential estimated impact of both GAP and LD options being considered. These costings include initial high level estimates of recurring revenue, non recurring bridging plans, potential capital implications and any capital receipts available from the options being considered. The MHSRT Programme aims are to make more effective efficient use of current revenue resources within the existing resource envelope for both GAP and LD services. The options being considered present no reduction of current services but look at options to potentially relocate services which could allow for	MHSRT Programme Option Review Report – Financial section 10 and Appendix 6 & 7 Patients Rights (Scotland)Act 2011	MHSRT Programme Team will continue to review and work up more detailed costing information as progress through formal business cases stages to production of an Initial Agreement report through to Outline and Full business Case stages. Continued review of required workforce and safe staffing levels for the preferred option once identified. Requirement to work closely with Human Resources and staff side to ensure adherence to organisational change

		investment in more local based community services, enhancing provision of services for the majority of GAP and LD services whilst sustaining inpatient services and increasing safety and staff training opportunities. Economies of scale through relocation of workforce in some of the options being considered will mean a reduction in current inpatient workforce but additional community services		policies.
4.2	• Is there sufficient information to show that "due regard" has been paid to the equality duties in the financial decision making • Have you identified methods for mitigating or avoiding any adverse impacts on equality groups • Have those likely to be affected by the financial proposal been consulted and involved	Due regard has been paid and no disadvantage has been paid to any individuals See item 1.3 in terms of duties Options which consider relocation of services in Angus may need support in interim basis to provide cost cover for remaining Psychiatry of Old age wards on short term basis until a further OA would be conducted and alternative service could occupy.	MHSRT Programme Option Review Report – Financial section 10 and Appendix 6 & 7 Patients Rights (Scotland)Act 2011 EHRC: Making Fair Financial Decisons, A guide for decision-makers in Scottish Public Authorities (January 2015) EHRC: Assessing Impact and the Public Sector Equa;lity Duty, a guide for public authorities in Scotland	MHSRT Programme Team will continue to review and work up more detailed costing information as progress through formal business cases stages to production of an Initial Agreement report through to Outline and Full business Case stages.

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
5.	Involvement, Consultation and Engagement (IEC) 1) What existing IEC data do we have? • Existing IEC sources • Original IEC • Key learning 2) What further IEC, if any, do you need to undertake?	The MHSRT programme has a detailed communications and engagement plan which has included staff events, reference forums, information sharing events, stakeholder bulletins, website updates, press releases etc of all activity undertaken with GAP and LD service users/carers/voluntary organisations. The document also records all presentations to relevant committees and organisations and feedback and comment received to date. Option Appraisal events and Option modelling events have been undertaken for both GAP and LD services and a further period of formal consultation of 3 months will be undertaken following identification of preferred option. Formal CEL04 guidance has been followed and support and advice received from the Scottish Health Council (SHC) and SG	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Attached MHRST Programme Communication and Engagement plan Patients Rights (Scotland)Act 2011 Accessibility Information Policy NHS Health Scotland (May 2015)  5893-accessible-information-policy-support	MHSRT Programme team and Board through the Communications and Engagement work stream will continue to follow SG and SHC guidance in relation to IEC in the preparation of the consultation plan and proposed formal consultation process. Ensure key stakeholder support in planning for consultation period for advise re best approach and any additional support requirements (i.e speech & language support, interpreter services, communication methods, use of technology/social media) Continue to review best practice and other examples undertaken by

	throughout the process to date.		other NHS Boards i.e NHS Grampian Maternity services consultation report/web site

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
6.	Have any potential negative impacts been identified? • If so, what action has been proposed to counteract the negative impacts? (if yes state how) For example: • Is there any unlawful discrimination? • Could any community get an adverse outcome? • Could any group be excluded from the benefits of the function/policy? (consider groups outlined in 1.2) • Does it reinforce negative stereotypes? (For example, are any of the groups identified in 1.2 being disadvantaged due to perception rather than factual information?)	MHSRT Programme service model options being considered could potentially lead to unequal opportunities for both GAP and LD populations through: 1.Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2.Public perception around perceived loss of inpatient services rather than relocation of beds 3.Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4.Potential impacts on access to day service and	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Patients Rights (Scotland)Act 2011 As per previous sections above	Programme Team and Programme Board will continue to monitor and evaluate any potential negative impacts identified throughout the process. Programme Team will look to work with partners to look at viability of any demand responsive transport solutions. Programme leads will continue to share information and provide updates regarding options and progress to formal consultation on preferred option to gather further stakeholder information and more detailed understanding of impact of change. Use of positive media coverage regarding

		psychology services for LD population Yes. Negative comment/ feedback has been received from a number of staff/ service users/carers/vol orgs whom may be impacted upon by changes to service models being proposed. No unlawful discrimination. Reduced bed capacity to admit prisoners transferred to hospital for treatment and to admit accused persons in custody requiring assessment in hospital. No negative stereotypes reinforced		proposed improvements to service provision and increased community supports to be made available Further detailed modelling of day service models for LD and LD Forensic psychology group work required once preferred option identified. Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
7.	Data & Research • Is there need to gather further evidence/data? • Are there any apparent gaps in knowledge/skills?	We will continue to follow the Scottish Capital Investment Manual re Scottish Government approved process of option appraisal and CEL 04 guidance and advise from Scottish Health Council to support with relevant demographic/population information.	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report	Programme Team/Board will continue to review data/evidence requirement regarding impacts throughout process.
8.	Monitoring of outcomes • How will the outcomes be monitored? • Who will monitor? • What criteria will you use to measure progress towards the outcomes?	Benefits realisation process will be used to record the potential impact and improvements to services throughout the programme The programme will consider and monitor outcomes against the agreed benefits criteria used to score the options being considered as part of the option appraisal process.	Benefits realisation pro-forma used by the MHSRT - Programme Whiteboard example  EPR_eWhiteboard_BusinessCase_V1[1].0 Benefits Criteria used to score options in OA – 1. Supports safe, effective and person-centred care 2. Improved care and treatment across hospital and community mental health services with a focus on prevention of	Programme team and Programme board will monitor and evaluate benefit realisation documentation against benefit criteria

			admission and timely supported discharge 3. Ensures equity of access to services across Tayside 4. Supports effective and sustainable deployment of staff across Tayside 5. Makes best use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. 6. Emphasis on maintaining effective recovery through close relationships with family, carers and supporting community groups and organisations that compliment NHS services.	
9..	Recommendations State the conclusion of the Impact Assessment	EQIA identifies clear actions within this live document which will be updated as part of ongoing communication and engagement with relevant stakeholders and throughout the	Benefits realisation report updated throughout process an implementation phase.	Continuously monitor and evaluate and provide update as required.

		business case process into implementation. Highlights requirement to review the effect of indirect/direct impacts on certain groups including those with noted protected characteristics.		

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
10.	Completed function/policy • Who will sign this off? • When?	Tayside NHS Board and Dundee, Angus and Perth & Kinross IJB Boards February Board meetings	Board minutes	Continue to update as live document and present at each stage of business case approval process
11.	Publication	NHST and Dundee, Angus and Perth & Kinross Integration Joint Board minute from June 2017 Ongoing document reviewed and revised through Programme Team and Programme Board	Option Review Report & Supporting Appendices Board and Committee minutes	As 10. above

Conclusion Sheet for Equality Impact Assessment	
Positive Impacts (Note the groups affected) Ability to invest more resources in community to provide enhanced services for the majority of population. Centralisation of services allows for creation of centres of excellence, support training and support shared learning and experiences for both GAP and LD services	Negative Impacts (Note the groups affected) Potential additional travel for some service users, carers and families particularly coming from rural areas of Tayside.
What if any additional information and evidence is required User/Carer/third sector/staff/voluntary organisation feedback will be collated and provided within final Board paper	
From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 5 - 10) NHS Tayside and three local Integration Joint Boards to give consideration to the proposed preferred service model option for approval to progress to formal consultation at Board meeting in June 2017	

This conclusion sheet should be attached to the relevant committee report.

MUST BE COMPLETED IN ALL CASES

Appendix Two

Community Services

Tayside Map of MH community services l

Tayside Map of LD community services l

Dundee 2017 JOINT LD HEIRARCHY OF NI

ANGUS	DUNDEE	PERTH & KINROSS
LEVEL 4	**LEVEL 4**	**LEVEL 4**
Cliffview Court - Supported Accommodation provided by Angus HSCP	Supported accommodation 8 block of flats run by 3rd sector for CMHT clients commissioned by local authority Carr Gomm Richmond Transform Seagate Gowrie Care – Martingale Gardens	Simpson Square
Chapel Bond- Supported Accommodation provided by Angus HSCP		CIC
		Scone Project-Supported Accommodation
LEVEL 3	**LEVEL 3**	**LEVEL 3**
Montrose/Brechin, Forfar/Kirriemuir and Arbroath/Carnoustie/Monifieth Community MH Teams	Wedderburn CMHT Alloway CMHT	North Perthshire CMHT, Perth City CMHT, South Perthshire CMHT
Substance Misuse Team.	MAPS	Move Ahead Day Opportunities Team,
MAPS	Addiction services	Wellbeing Team
	Eating Disorder Services Tayside wide	Therapeutics/ECT Team,
	Tayside Adult Autism Consultancy Team	Substance Misuse Team
		MAPS.
LEVEL 2	**LEVEL 2**	**LEVEL 2**
Angus Adult Psychological Therapies Service.	Psychological Therapies Service	P&K Adult Psychological Therapies Service.
Contract with Penumbra to provide Employment, Education and Leisure.	Dundee Independent Advocacy Support Partners in Advocacy	Perth Independent Advocacy

LEVEL 1	LEVEL 1	LEVEL 1
Tayside Carer Support,	DAMH Outcome focussed interventions for Dundee citizens. Funding from various sources.	Support in Mind/Tayside Carers support (Carers)
Angus Voice (Service user Group)	The Haven Main funding big lottery Budget	PLUS (Service user Group)
Insight Counselling	Art Angel	Mind Space Counselling.
Angus Independent Advocacy	SAMH outreach and carers respite budget	The Walled Garden.
PAMIS	Penumbra Enabling and Carers Support	PKAVS
	Drama-therapy	PAMIS
	Chrysalis gardening project run by SAMH	Minority Ethnic Communities
	Insight counselling	Tayside Forensic Voices
	Service User Network and Voluntary co-ordinator, DVA	PUSH
	Gowrie Outreach	
	Dundee Carers service	
	Turning Point	
	PAMIS	
Additional Info	**Additional Info**	**Additional Info**
Self Directed Support- Richmond, SAMH, Penumbra, Turning Point -	DAMH:- outcome focussed mental health interventions commissioned mainly by local authority. Some other external funding The Haven run by hearing voices network lottery funded Art Angel for people with mental health issues some statutory funding SAMH outreach service commissioned by local authority Penumbra Enabling service commissioned by local authority Drama-therapy commissioned by local authority Chrysalis gardening project run by SAMH	Self Directed Support- Richmond, SAMH, Penumbra, Turning Point, The Bield. Choose Life Scottish Care

	some funding from health Insight counselling Service User Network drop in 2 times per week Penumbra carers support	
General services people with mental health services use for their mental health needs but not funded directly for this purpose - Angus Carers Voluntary Action Angus	Some supported accommodation no longer fit for purpose, but is being reviewed.	Crisis Response and Home Treatment (CRHTT) deliver in the community and also Learning Disability community and day treatments and Tayside Eating Disorder Services

ANGUS	DUNDEE	PERTH & KINROSS
LEVEL 4	**LEVEL 4**	**LEVEL 4**
Residential Care **The Gables – Local authority care home registered for 17 people** **Cairnie Lodge (HC-One) – 6 contracted beds** **Other Residential / Nursing home placements – 60 spot purchase agreements** **Supported Accommodation – contracted by block purchase** **Sense – Lentlands Court, Forfar** **Gowrie – Silverway, Montrose** **Doocot Park, Arbroath** **Lousen Park, Carnoustie** **River Street, Brechin** **River View, Brechin** **ARK – Burnside Drive, Arbroath** **Windmill Brae, Forfar** **RLO – Broomfield, Montrose** **Lilywynd, Forfar** **Turning Point – Walton Mill, Dundee**	**White Top Day Support Service (PMLD)** **White Top Respite (PMLD)** **Weavers Burn – Care at Home/Housing Support Service (Complex needs/challenging behaviour)** **Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music)** **LD Clinical Psychologists** **Community LD Nurses** **LD Acute Liaison Nurse** **Weavers Burn Nursing Staff** **PMLD Nurse – White Top Centre** **Fleuchar St Respite – Sense Scotland** **Day Opportunities–Hillview–Sense Scotland** **Day Opportunities/Enabling–Sense Scotland** **<u>Care at Home / Housing Support Services</u>** • **Rose Lodge** • **Dudhope Villa** • **Westlands** • **Cornerstone** • **Turning Point Scotland** • **Scottish Autism** • **Sense Scotland**	**Residential Care** **The Grange** **Dalguise Court / Orchard Court** **Ericht View (Muirton House)** **Corbenic Upper Springlands (LD / PD)** **Supported Accommodation – contracted by block purchase** **Gowrie** **Burnside Court (4 people)** **An Cala (4 people)** **Airlie View (4 people)** **Milnabstreet(7 people)** **Ark Housing** **Ark Brae (9 people) and outreach** **Ark Blairgowrie Outreach (11)** **Turning Point** **Tulloch road (6 people)** **Springlands (4 people)** **Richmond St.Madoes** **(2 people &1 funded by Edinburgh))** **Mungo Foundation (5 people)** **Sense (4 people)** **Autism Initiative Earn project (10 people)**

LEVEL 3	LEVEL 3	
Adult Resource Centres – **Lilybank Forfar** **Rosehill Montrose** **Lochlands Arbroath** **Angus Integrated Community Learning Disability Teams –** **Inland & Coastal, Social Work, LD Nursing and AHPs**	**Wellgate Day Support Service** **LD Care Management Team – Social Workers / Mental Health Officers/Social Care Workers** **Dundee Community Living - Care at Home/Housing Support Service** **Supported Living Team - Care at Home/Housing Support Service** **Weavers Burn – Care at Home / Housing Support Service** **Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music)** **LD Clinical Psychologists** **OT Employment Support Worker – Forensic bridge** **Community LD Nurses** **Weavers Burn Nursing Staff** **Hawkhill Nursing Staff** **PMLD Nurse – White Top Centre** **LD Nurse Seconded into LD Care Management** **Leisure & Recreation Team - including Autism specific post.** **<u>Day Opportunities/ Enabling</u>** • **City Quay– Capability Scotland** • **CLS/FSS - Capability Scotland** • **Cornerstone** • **The Inclusion Group**	**Adult Resource/Day Opportunity (PKC** **Gleneagles** **Blairgowrie** **Kinnoull** **Supported Living team PKC**

	• Jean Drummond Centre • North Lindsay St - Scottish Autism **Care at Home / Housing Support Services** • Carr Gomm – Rosefield Street • Cornerstone • Gowrie Care **Care Home Placements**	
LEVEL 2	**LEVEL 2**	
Community Opportunities Team – **Enablement, Health & Wellbeing and College Support** **Care and Support –** **self directed support individual agreements provided by; Abbey care, Camphill, Care About Angus, Cornerstone, Enable, Margaret Blackwood,** **My Care, Quarriers, Real Life Options, Richmond, SAMH, Sue Ryder, Turning Point, Tus Nua, Voluntary Service Aberdeen**	**Employment Support Service (generic Community Care service hosted within LD cost centre)** **Through Care and After Care** **Adult Placement (usually follows on from Foster Care)** **Community LD Nurses – Health Shop ,Sexual Health Clinics, Mental Health support, Parenting Network, Down`s Screening Clinics, LD Epilepsy Clinic, Links to GP Practices** **Leisure/ Recreation Team** **Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music)** • Student Support Service – Gowrie Care • Dundee Independent Advocacy Support • Advocating Together • Partners in Advocacy • PAMIS	**Employment and Further Education** **Check In (Giraffe)** **Stepping Stones** **S.R.U.C. (Elmwood)** **Day Care** **Camphill Blair Drummond** **Camphill Newton Dee** **Camphill Village Trust** **Corbenic camphill** **Hayfield** **Individual packages** **Ashdene** **Avenue Care** **C-Change** **Cornerstone** **Elite Care (Scotland)** **Enable** **Gowrie Care** **Hansel**

	• Dundee & Angus College • Dundee REP Theatre • Tayberry Social Enterprise Organisation • Barnardos - transition caseload and Growing Up Project	Kibble education & Care Mears care Richmond fellowship RIGIFA Autism Initiative Scottish Autism Sense Scotland Judith and Tim Smith Turning Point Capability Scotland Care Services
LEVEL 1	**LEVEL 1**	
PAMIS – **Service level agreement to provide information & support to people with profound and multiple disability and their carers**	**Assistance, training and guidance from any element of the specialist LD Health team can be provided on a case by case basis to assist universal services to provide care and intervention to LD Individuals.**	**Independence Advocacy** **PUSH social inclusion** **PAMIS advice and support**
HOPE – **Service level agreement to Hospitalfield Organic Project Enterprise for horticultural training & work experience**		
Additional Info		
General services **Angus Carers** **Voluntary Action Angus** **Angus Independent Advocacy**		

DUNDEE INTEGRATED COMMUNITY LEARNING DISABILITY SERVICE –for TRANSFORMATIONAL CHANGE PROGRAMME

Arlene Mitchell, Locality Manager Dundee Health & Social Care Partnership. 4/4/17

Health Services

Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)
Community LD Nurses
Weavers Burn Nursing Staff
PMLD Nurse – White Top Centre
LD Acute Liaison Nurse

Area Wide In-Patient LD Services (including Nursing & AHPs)
- *LD Assessment Unit Carseview*
- *Behavioural Support & Intervention Unit and BSI Outreach Team*
- *Craigowl Unit*
- *Autism Unit*

Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)
OT Employment Support Worker – Forensic bridge
Community LD Nurses
Weavers Burn Nursing Staff
Hawkhill Nursing Staff
PMLD Nurse – White Top Centre
LD Nurse Seconded into LD Care Management
Leisure/ Recreation Team - including Autism specific post.
LD Psychiatrists and Clinical Psychologists

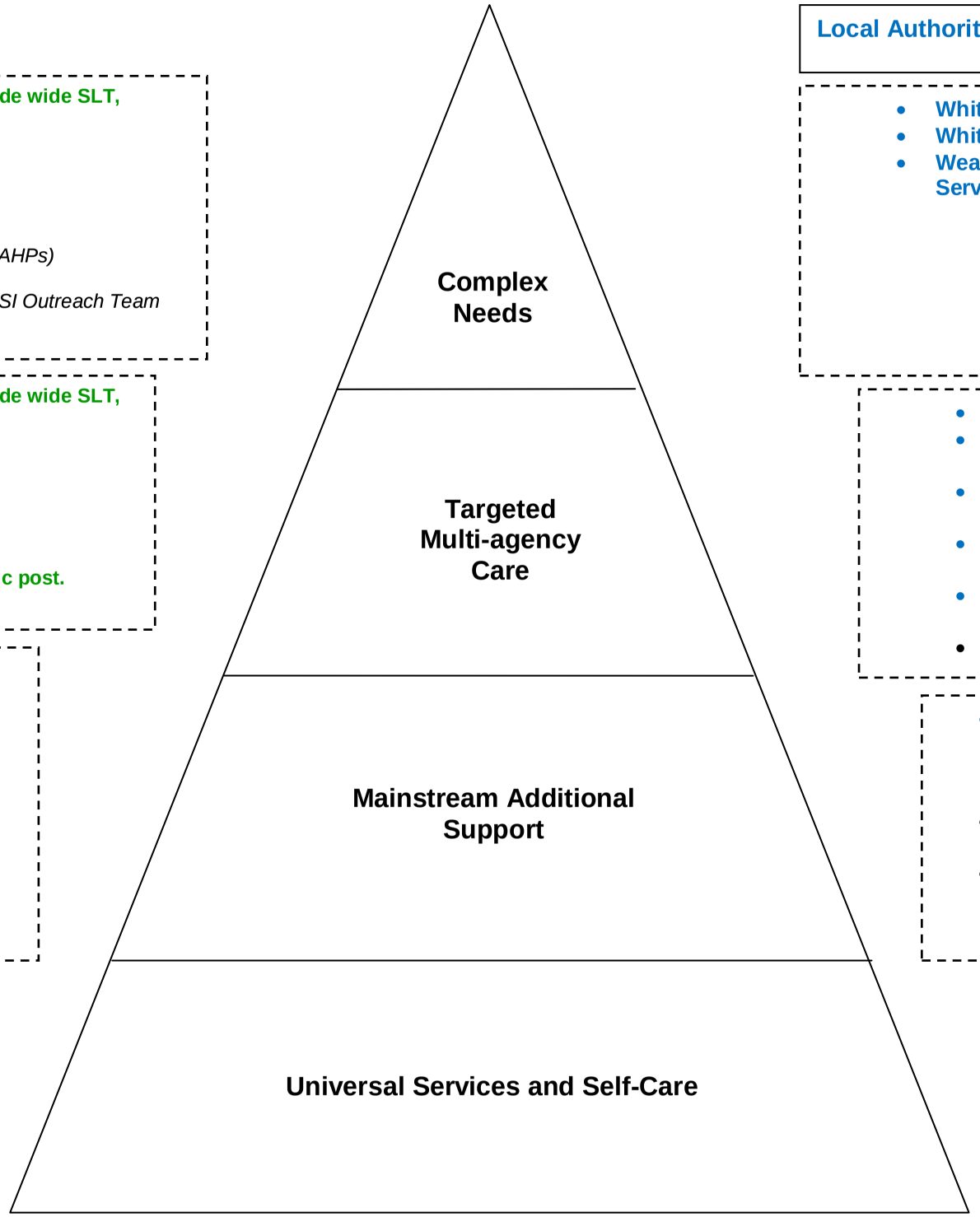
Community LD Nurses – Health Shop
- **Sexual Health Clinics**
- **Mental Health support**
- **Parenting Network**
- **Down`s Screening Clinics**
- **Links to GP Practices**

Leisure & Recreation Team
Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)

RNIB – Bridge to Vision Project
RNID
Epilepsy Specialist Nurse

Assistance from any element of the specialist LD Health team can be provided on a case by case basis to assist universal services to provide care and intervention to LD individuals.

Public Health Initiatives



Local Authority Services

- **White Top Day Support Service (PMLD)**
- **White Top Respite (PMLD)**
- **Weavers Burn – Care at Home / Housing Support Service (Complex needs/ challenging behaviour)**

- **Wellgate Day Support Service**
- **SW Care Management Team (LD) – Social Workers/ Mental Health Officers /Social Care Workers**
- **Dundee Community Living - Care at Home/Housing Support Service**
- **Supported Living Team - Care at Home/Housing Support Service**
- **Weavers Burn – Care at Home / Housing Support Service**
- *Mental Health Officer Team*

- **Employment Support Service (generic Community Care service hosted within LD cost centre)**
- *Through Care and After Care*
- *Adult Placement (usually follows on from Foster Care)*

- *Community Alarm*
- *Leisure & Culture Services (including leisure centres, parks, community centres, libraries, theatres)*
- *Welfare Rights*

Procured Services (Voluntary/Independent Sector)

Fleuchar St Respite – Sense Scotland
Day Opportunities–Hillview–Sense Scotland
Day Opportunities/Enabling–Sense Scotland
Care at Home / Housing Support Services
- **Rose Lodge**
- **Dudhope Villa**
- **Westlands**
- **Cornerstone**
- **Turning Point Scotland**
- **Scottish Autism**
- **Sense Scotland**

Day Opportunities/ Enabling
- **Anton/Ogilvie– Capability Scotland**
- **CLS/FSS - Capability Scotland**
- **Cornerstone**
- **The Inclusion Group**
- **Jean Drummond Centre**
- **North Lindsay St - Scottish Autism**

Care at Home / Housing Support Services
- **Carr Gomm – Rosefield Street**
- **Cornerstone**
- **Gowrie Care**

Care Home Placements

- **Student Support Service – Gowrie Care**
- **Dundee Independent Advocacy Support**
- **Advocating Together**
- **Partners in Advocacy**
- **PAMIS**
- *Dundee & Angus College*
- *Dundee REP Theatre*
- *Tayberry Social Enterprise Organisation*
- *Barnardos - transition caseload - Growing Up Project*

TRANSITION

PATHWAYS

Additional Support Needs | Autism | Mental Health & Wellbeing | Complex Care & Anticipatory Planning | Challenging Behaviour including Forensic | Dementia | Palliative

Underpinned by Equitable Access to community based Health Promotion & Health Screening Initiatives

TRANSITION

KEY : areas in black *Italics* are either not `owned` by the Dundee LD Service but are accessed by LD service users **or** depict Co-Production Partner Agencies

Appendix Three

Communication and Engagement Plan

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

COMMUNICATION AND ENGAGEMENT PLAN

Document Control Information	
Control Status	Draft
Date Last Printed	02/05/2017
Version Number	Draft 1.14
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager NHS Tayside

Index

1. DESCRIPTION AND BACKGROUND OF PROJECT / SERVICE CHANGE

The Mental Health Service Redesign Transformation Programme formerly known as the Steps to Better Health Care Mental Health Improvement Programme commenced in 2013. Initial work established by the newly formed Mental Health Leadership team looked primarily at clinical pathways and areas to improve these and a review of the accommodation from where these services are currently provided to ensure that services are safe; of a high quality; meet clinical governance standards; are sustainable; and that all resources are being optimised and used as efficiently as possible.

The work of the programme progressed initially in two phases

Phase 1 of the Programme looked to address areas highlighted within General Adult Psychiatry (GAP) services of immediate clinical concern. Several work streams were established in 2013 to 2015 to progress the work of Phase 1. These work streams were –

Moredun Work stream – which reviewed the Moredun GAP acute admission ward at Murray Royal Hospital environment, workforce and service model. This work stream progressed the required refurbishment of the Moredun ward at Murray Royal to split the environment into two separate male/female areas and reduce the size of the ward from 30 beds to 24 beds. This refurbishment addressed concerns re size and safety of large ward environment and allowed separation of patients in the ward. Workforce shift patterns, workforce plans and working patterns were also reviewed and consistent approach applied and a revised service model was updated and agreed.

Rehabilitation Workstream - which implemented changes to environments in Rannoch, Kinclaven and Amulree wards at Murray Royal Hospital to increase capacity for GAP rehabilitation, improved environments and provided a dedicated ward with an increase in beds for female patients with complex needs

Property Workstream – which looked at all Mental health accommodation and supported the relocation of day services for Learning Disabilities from Birch Avenue to brand new day hospital accommodation at Murray Royal.

Phase 1 has also included a review of clinical pathways across GAP and Learning Disabilities, the initial implementation of Tayside wide Crisis Response and Home Treatment teams and assisted workforce planning for the opening of the third medium secure ward at Rohallion

Secure Care Clinic at Murray Royal.

Phase 2 of the Programme began in 2014 and initially commenced with a review of our Intensive Psychiatric Care Unit (IPCU) pathways which quickly highlighted a requirement to undertake a wider review of all Mental Health Services pathways across Tayside to look at the clinical models of how we deliver care and the current facilities from where we deliver that care.

Work commenced in 2014 through a series of workshops undertaken with Capita (external Health Care Planners appointed to support process) which looked at reviewing a wide range of options for future GAP and Learning Disability services identified by key clinical stakeholders. As this initial work was part of a proposed HUB initiative the option appraisal work progressed with Capita also included review of Psychiatry of Old Age, Medicine for Elderly and Centre for Brain Injury services in Dundee only.

Initial scoping work was presented to NHS Tayside Board in March and highlighted significant concerns with maintaining current GAP services across three sites in Tayside. NHS Tayside Board agreed in March 2016 that future GAP acute admissions services could no longer be sustained from three sites and the Programme should undertake a further review of options providing GAP acute admissions from either two sites or from a single site.

During 2014/2015 work progressed around the current IPCU service pathway review and improvements have been made to service delivery, enhanced environment (now able to accept female admissions previously sent outwith Tayside) and has improved patient experience, lengths of stay and function of IPCU

2. AIM / PURPOSE OF ENGAGEMENT

The aim of the programme is ensure as wide engagement as possible with all stakeholders identified below to assist and inform the review of current service models, planning of future service models, workforce requirements and a review of accommodation from where services are to be provided.

3. PROJECT / SERVICE LEAD

Executive Lead – Neil Prentice
Operational Lead – Robert Packham
Programme Lead – Lynne Hamilton

4. TIMETABLE

- **PROJECT**
- **ENGAGEMENT / CONSULTATION**

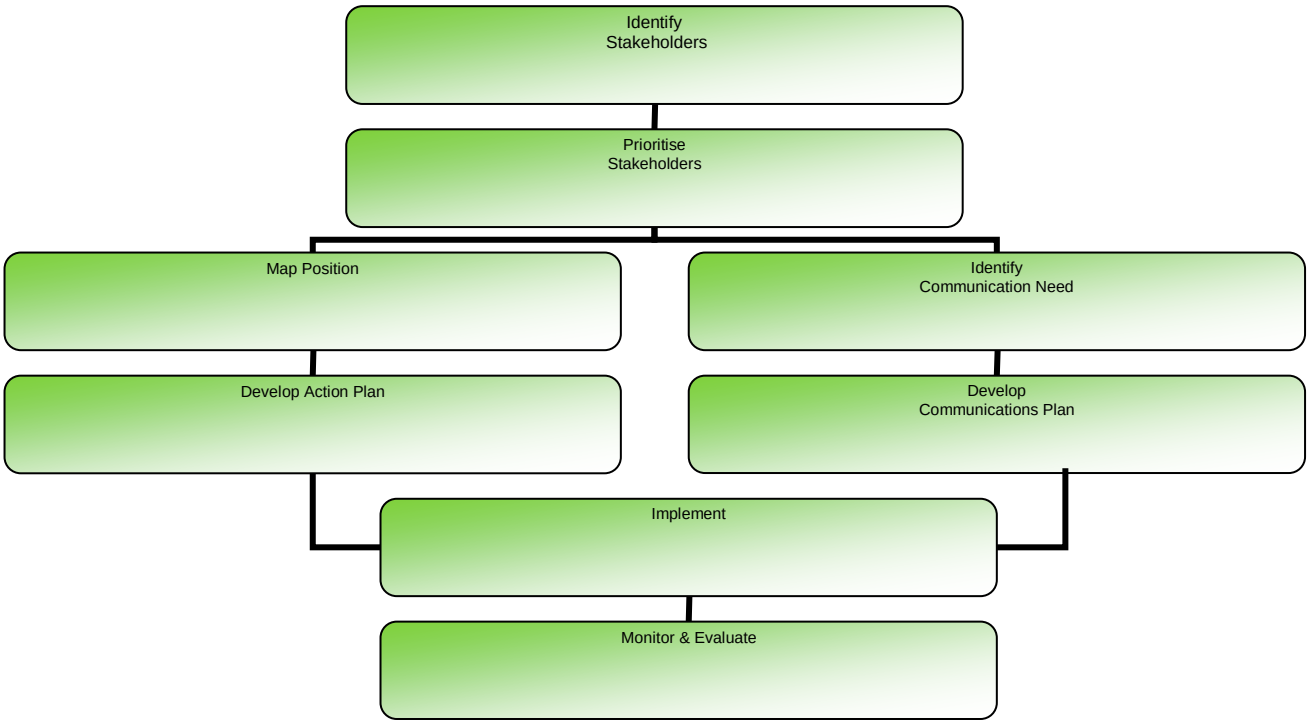
Programme– Draft Outline Programme

Task	**Date**
Capita Report received	July 2015
Complete financial option appraisal	August/ September 2015
Presentation of Capita work and option appraisal to stakeholders involved in original workshops	October 2015
Option appraisal paper presented to NHST Board for information to inform of progress with programme and wider engagement of service options	October 2015
Commence wider engagement regarding options	January to March 16
Paper presented to NHS Tayside for consideration of proposed service models	March 2016
Paper presented to NHS Tayside Board for approval of proposed engagement and Option Appraisal Process to be followed	April 2016
Option Appraisal Training session – Kings Cross	June 2016
Option Appraisal Workshops – Invercarse and The Steeple, Dundee	June 2016
Option Appraisal Paper presented to NHS Tayside Transformation Board, NHS Tayside Board, IJBS, ACF,CCGC, APF	August 2016
Option Modelling event – General Adult Psychiatry – Improvement Academy Ninewells	September 2016
Option Modelling event – Learning Disabilities – Improvement Academy, Ninewells	December 2016

Option review report submitted for approval	February 2017
Consultation plan presented to Boards for approval	March 2017
Formal Consultation Period on Preferred Option with all stakeholders	April to July 2017
Initial Agreement Report submitted for approval	August/Sept 2017
Outline Business Case submitted for approval	Nov/Dec 2017
Detailed design work /wider engagement	August 2017 to December 2017
Financial Close	January 2017
Construction commence	January 2018
Full Business Case submitted for approval	February 2018
Construction complete (assumes 18mth Build/Decant - to be reviewed)	July 2019

Throughout the development of the programme there will be various key stages where engagement/ consultation will take place in line with the above programme.

5. ENGAGEMENT PLAN



6. METHODS OF ENGAGEMENT TO DATE (OUTLINED IN DETAIL IN SECTION 8 & 9)

- Focus Groups
- Workshops
- Reference Forums for users/carers/voluntary organisations
- Staff sessions in each locality
- Briefing sessions for staff
- Information sharing events
- SBAR reports and briefings
- Presentations to various groups/meetings/committees
- Newsletters
- Media releases
- Steps to Better Healthcare Staffnet site
- Steps to Better Healthcare Display
- Steps to Better Healthcare Road shows and events
- SPECTRA
- Website for Programme

7. STAKEHOLDER IDENTIFICATION BY PROGRAMME TEAM AND THROUGH PARTNERSHIP WORKING WITH INTEGRATED JOINT BOARDS

STAKEHOLDERS

- Current General Adult Psychiatry, Forensic and Learning Disability inpatients
- Past patients/ service users of General Adult Psychiatry, Forensic and Learning Disabilities that are now living in the community that currently attend outpatient appointments/ day services.
- Past patients/ service users of General Adult Psychiatry, Forensic and Learning Disabilities that are now living in the community who attend third sector organisations
- Relatives
- Carers
- Current General Adult Psychiatry, Forensic and Learning Disability inpatient staff (NHS Tayside) – Senior and Junior Medical staff, Service Management, Nurses, Clinical Psychologists, Occupational Therapists, Physiotherapists, Speech & Language Therapists, Dieticians, Pharmacist, Art therapist, Administration and Clerical Staff and support staff/FM contract staff.
- Local Authority (Angus, Dundee and Perth & Kinross) – Service managers and Social Work Leads

- Community Mental Health Teams
- Community Learning Disability Teams
- Community Forensic Teams
- Crisis Response and Home Treatment Teams
- Learning Disability Day service staff
- Forensic Day service staff
- Community Mental Health Allied Health Professionals
- Community Learning Disability Allied Health Professionals
- Ancillary staff
- General public
- Steps to Better Healthcare (SBH) Project Team/Board, Executive Leads and Project Leads
- Neighbouring NHST services/ staff on any proposed site
- Other services - Psychiatry of Old Age, centre for Brain Injury and Medicine for the Elderly services
- Scottish Health Council
- NHST Transformation Programme Board and Perth & Kinross IJB Transformation Board
- Voluntary organisations such as:

  - Hearing Voices
  - Angus In Advocacy
  - PAMH
  - Dundee Outreach and Carers Service
  - Penumbra
  - Advocating Together
  - Forensic Voices
  - Richmond Fellowship
  - Art Angel
  - Nova Service
  - Dundee Voluntary Action
  - SAMH
  - Support in Mind
  - Voluntary Action Angus
  - Forensic Voices
  - DAMH
  - Hot Chocolate
  - Carr Gomm
  - Angus Voice
  - Mindspace
  - PLUS Perth
  - PKAVS
  - PAMIS
  - PLUS Perth
  - MEAD project Perth

- Local politicians/MSPs
- Scottish Government and Scottish Futures Trust

- Neighbouring properties located in close proximity to site (once a site has been identified)
- Bell rock (SPV for Carseview)
- Taycare (SPV for Murray Royal and Stracathro)
- Steps to Better Healthcare Ambassadors & Champions
- GPs and GP Sub Committee
- Media Partners
- Partner Agencies – i.e Police, Fire Brigade, Scottish Ambulance Services etc
- Joint Clinical Improvement Board for Mental Health
- Area Partnership Forum
- Integration Joint Boards

8. EARLY RELEVANT ENGAGEMENT ACTIVITY

DETAILS OF ANY EARLIER RELATED ENGAGEMENT/CONSULTATION ACTIVITY

The original SBH MHI Programme began in June 2013 following appointment of the Programme Director. However, an earlier review of Mental Health services commenced in 2001/02, and work progressed under the Tayside Adult Mental Health Review Programme until approval of an Outline Business Case in 2005/06. The Adult Mental Health Review programme identified a five year plan for future service model delivery and the accommodation required to support it. The Programme included a significant amount of consultation work which was undertaken across Tayside and assisted in the delivery of the new builds at Murray Royal and Susan Carnegie Unit, at Stracathro, which were completed in 2011/12. Amendments required to the Carseview site were part of the original Outline Business Case in 2005/06; however, these were subsequently delayed when the PFI contractor for the site went into administration. Further engagement/ consultation work has taken place with new site owners regarding alternative refurbishment options for Carseview however a further review of service models was required and refurbishment project was placed on hold.

In 2013 the SBH Mental Health Improvement Programme commenced a further review of service model options which will include a review of utilisation of Carseview site and any refurbishment/extension work which may be required.

The original Adult Mental Health Review Engagement and Consultation work undertaken was as shown below -

Date	**Service**	**Activity**
21 October 2003	GAP	Dundee City Council – Presentation
16 September 2003	GAP	Dundee Carers, Carseview, Dundee
25 September 2003	GAP	Staff Consultation, Carseview, Dundee

14 October 2003	GAP	Staff Consultation, Carseview, Dundee
1 September 2003	GAP	Staff Consultation Event, Carseview, Dundee
21 October 2003	GAP	Dundee City Council – Presentation
31 October 2003	GAP	Little Wing, Users Group, Dundee
4 November 2003	GAP	Locality Focus Group, Dundee
26 November 2003	GAP	Dundee Carers
4 December 2003	GAP	Benefit Criteria Event, Carseview
12 December 2003	GAP	Consultation Event, West Park Centre, Dundee
January 2004	GAP	Two Open Meetings with Staff
20 January 2004	GAP	Benefit Criteria Event, West Park Centre
May – September 2004	GAP	AMHSR Report sent to various stakeholders (list available)
May 2005	SCC	Information Briefing Number 1 issued
31 July 2006	GAP/POA/SCC	Approved Outline Business Cases sent to: Angus Council and Main Library Dundee City Council and Main Library Perth and Kinross Council and Main Library Scottish Health Council SEHD Main Library NHS Tayside Staff Partnership Representative Grampian NHS Board office Highland NHS Board office Orkney NHS Board office Shetland NHS Board office Tayside NHS Board office
9 January 2007	GAP/POA/SCC	Tayside Area Partnership Forum
15 January 2007	GAP/POA/SCC	Tayside Carers Support Group Briefing
22 January 2007	GAP/POA/SCC	Scottish Health Council
7 May 2007	GAP/POA/SCC	Meeting with NHST Partnership Representatives

9. STEPS TO BETTER HEALTHCARE PROGRAMME / MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME – RECORDED ENGAGEMENT ACTIVITY

Ongoing - from June 2013	Face to Face meeting – Monthly Programme Team meetings
Ongoing – from June 2013	Face to Face meetings – Six weekly Programme Board meetings
Ongoing – from November 2013	Monthly face to face Communication and Engagement Group Meetings – Board Secretary, Public Involvement Manager, Diversity & Inclusion Manager, Communications Manager, Staffside and programme representatives in attendance.
Ongoing from – July 2013	Face to face meetings – monthly Work stream meetings held for – Phase 1 – Moredun, Rehabilitation, Property, TSMS/Rannoch
22 August 2013	Initial SBH MHI Programme paper presented to NHST Board to request move forward to engagement on Phase 1 work and plan Phase 2.
4 September 2013 and as and when required	Face-to-Face meetings – Presentation of Phase 1 of programme to Area Partnership Forum. Updates to Area Partnership Forum
11 September 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
31 October 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Murray Royal Hospital, Perth
13 November 2013	SBH MHIP Presentation slides and question/answer session undertaken with SBH Ambassadors and Champions. Positive Feedback received
November 2013	Communications and Engagement plan developed
November 2013 to present	Provision of monthly, bi monthly and adhoc update papers requested for SBH PET and SBH Board
November 2013	Branding developed
14 November 2013	SBH Ambassadors/ Champions workshop – Presentation giving overview of programme
11 December 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Ninewells Ian Lowe Centre
December 2013 to present	Impact Assessments – Ongoing – Phase 1 Moredun Impact Assessment completed Phase 2 in progress
December 2013	Staffnet – Staffnet micro site to be developed – Part of SBH website

December 2013	Vital Signs, Staffnet, inbox – General information about Mental Health Improvement Programme to all staff
December 2013	Newsletter – 1st Moredun Newsletter circulated to all staff and users/carers re Phase 1 works
January 2014	Spectra - Article on MHIP and MH Leadership team
January 2014	4pp A5 booklet developed Information booklet developed for patients and their families and carers to share information about the Mental Health Improvement Programme re Moredun Phase One improvements
4 February 2014	Face to face meeting – Paper presented to NHST Endowment Committee to request progress of Phase 1 Moredun environmental changes.
February 2014	Newsletter – 2nd Moredun ward update newsletter released to all staff and patients/carers
February 2014	Newsletter – 1st MHIP newsletter giving overview of Programme and MH Leadership Team
6 March 2014	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
12 March 2014	Presentation of MHIP Programme update to Staff side Area Partnership Forum.
16 April 2014	Presentation of MHIP Programme update to SBH PET (Programme Executive Team)
15 May 2014	Face-to-Face meeting – Reference Group meeting held with key Stakeholders, Carers, Service Users/Representatives
6 June 2014	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
May to August 2014	Face to face meetings – Series of work shops run by Capita with key stakeholders from Mental Health, LD, POA, MfE and CBIR present to undertake review of current service models, look at future model requirements and then agree criteria and conduction option appraisals – work ceased in August due to early maternity leave of Programme Director
Jan to March 2015	Face to face meetings – Work shops with Capita restarted under James Henderson SBH Programme Director and completed work with Capita to review criteria and consider options. Option appraisals undertaken with key staff present from each service.
July 2015 and ongoing quarterly meetings	Face to Face meetings – Provision of SBH MHIP progress update to Mental Health and Learning Disability Joint Clinical Improvement Board (JCIB)
August 2015	Face to Face meetings – Provision of Patient Benefits report to SBH PET and SBH Programme Board.

Commenced August 2015 to present	Face to face meetings – Work Streams – Phase 2 – Learning Disability
24 September 2015	Face to face meeting – Presentation of SBH MHIP Programme update by Karen Ozden to NHS Tayside Board Development event.
30 September 2015	Completion of SBH Programme Health check for SBH Programme Board
30 September 2015	Updates for staff via SBH Newsletter updating progress of programme
30 October 2015	Paper presented to NHST Board to update on programme and request approval to progress to engagement of options considered
25 November 2015	Face-to-Face meetings – Presentation of Phase 2 of programme to Area Partnership Forum. Updates to Area Partnership Forum
9 December 2015	SBH Roadshow
12 January 2016	Face to face – 3 x Staff engagement sessions at Stracathro (10am, 2pm and 8pm)
13 January 2016	Face to face – 3 x Staff engagement sessions at Carseview (10am, 2pm and 8pm)
14 January 2016	Face to face – 3 x Staff engagement sessions at Strathmartine (10am, 2pm and 8pm)
20 January 2016	Face to face – 3 x Staff engagement sessions at Rohallion Unit at Murray Royal Hospital (10am, 2pm and 8pm)
26 January 2016	Face-to-Face meetings – Presentation and update of programme provided to Area Partnership Forum meeting
28 January 2016	Face to face – Users and carers reference forum – Kings Cross Hospital (40 invited)
11 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Stracathro (10am and 2pm)
12 February 2016	Questions and Answers information pack distributed to Angus Reference Forum in advance of meeting.
15 February 2016	Face to face – 2nd Users and carers reference forum for Angus users/carers/vol orgs – held Stracathro (42 invited)
15 February 2016	SBAR Paper presented to GP Sub- Committee to provide update on programme for discussion and to request feedback regarding options
17 February	Face to face – 2nd events for Staff engagement – 2 x sessions at

2016	Rohallion Unit, Murray Royal (10am and 2pm)
19th February 2016	SBAR paper and presentation slides circulated to Local Authority representatives in each locality for General Adult Psychiatry, Learning Disabilities and Forensic services to request feedback regarding options being considered and to note any potential impact on services.
19th February 2016	SBAR paper and presentation slides circulated to Police and Scottish Ambulance Service representatives to request feedback regarding options being considered and to note any potential impact on services
22nd February 2016	Update report provided to Mental Health Leadership Team re Programme Progress and feedback re engagement undertaken to date.
23rd February 2016	Face to face – Presentation and update provided to Mental Health Joint Clinical Improvement Board to request feedback
24 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Strathmartine (10am and 2pm)
25 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Carseview (10am and 2pm)
26 February 2016	Face to face – 3rd Users and Carers reference forum for Learning Disability/Forensic user/carers and vol organisations at Strathmartine
1 March 2016	Letter of concern received from Angus resident. Prof J Connell responded 21 April 16
10 March 2016	Paper presented to NHST Board to update on programme, consider options and approve way forward.
15 March 2016	Face to Face – 4th Reference Forum for Forensic service – meeting arranged with Forensic Voices – preliminary discussions undertaken
24 March 2016	Letter of complaint received via A Angus from Jenny Laird. Response sent offering to meet face to face. . Meeting held 27 April 16
24 March 2016	Letter of complaint received from Angus Voice. Response sent 26 March from CE offering to meet. Meeting held 27 April 16
24 March 2016	Letter of complaint received from Angus Independent Advocacy. E-mail response sent 25 March 16 offering to meet to discuss. Meeting held 27 April 16
25 March 2016	Complaint received via The Courier to Comms Team. Response provided by Comms Team 25 March 16
5 April 2016	E-mail received via N Fraser from J Megoran SG re Angus Council Concerns. Dr K Ozden responded 22 April 2016 following discussion with Chief Executive/Chairman
12 April 2016	Facilitated session to agree way forward for Communication and Engagement

21 April 2016	Update report provided to NHS Tayside Board re communication and engagement plans to take programme forward
22 April 2016	Staff Bulletin circulated re outcome of Board meeting and impact on staff
26 April 2016	Face to Face with Perth & Kinross Chief Finance Officer to update on programme and discuss finance
27 April 2016	Face to Face – Angus Voice – Jenny Laird, Dennis Roark, Callum Whitelaw to discuss Mulberry Ward and GAP
27 April 2016	Face to Face – Angus Independent Advocacy – Suzanne Swinton plus 2 Directors to discuss programme consultation process.
28 April 2016	Face to Face – Friends of Stracathro reps. Meeting rearranged. Due to take place 5th May 16
29 April 2016	Letter of concern received from Angus Presbytery. Dr Karen Ozden responded May 16
5 May 2016	Face to Face – Meeting with Friends of Stracathro to discuss position re Mulberry Unit and GAP
25 May 2016	Letter received from Penumbra re OA events. Invitation to OA Events /training sent on 24 May 16
31 May 2016	Update on current position provided in response to e-mail received 24 May 2016 from Minister for Health re engagement process
9 June 2016	Telecon with Pennie Taylor Independent facilitator for OA events
10 June 2016	Face to face – Meeting with Perth & Kinross Chief Officer to discuss programme for OA/Scoring events
16 June 2016	Face to face – Option Appraisal training event – Kings Cross – facilitated by SHC and Tracey Williams (35 in attendance)
16 June 2016	Face to Face – Tayside Advocacy Forum to discuss ongoing work within MH Programme
17 June 2016	Face to Face – MSP Briefing –Overview provided of ongoing work within MH Improvement Programme
18 June 2016	Telecon – Susan Scott PLUS Perth re OA and Scoring process
20 June 2016	Option Appraisal workshop held at Invercarse Hotel, Dundee– Long list to Short list of options agreed (88 stakeholders attended of 110 confirmed)
29 June 2016	Face to Face – Susan Scott PLUS Perth to discuss OA – meeting held with Susan and two other colleagues from PLUS. Subsequent e-mail received to give apologies for event and further email to be sent to R Packham copied to L Hamilton explaining reasons for not participating in OA
30 June 2016	Option Appraisal workshop held at The Steeple, Dundee – Benefit Criteria agreed, ranked and weighted. Options scored against criteria and four top scoring options agreed (84 stakeholders attended of 105 confirmed) 74 attendees participated in scoring exercise

10 July 2016	Dr K Ozden provided update to Minister for Health following request for further information.
1 August 2016	Meeting with APF leads regarding outstanding action from previous APF requiring update
2 August 2016	Presentation of Draft Option Appraisal report to NHST pre Agenda Meeting.
4 August 2016	Communications and Engagement group met with Yvonne Summers regarding communication and engagement to date, advice regarding consultation, SCIM guidance re papers and associated timeframe
5 August 2016	Face to face with POA Manager to provide update on progress of programme
12 August 2016	Response to Press enquiry – Brechin Advertiser re Option Appraisal events
17 August 2016	Face to Face – Presentation of Option Appraisal update to staff side APF meeting
24 August 2016	Option Appraisal Report provided to NHS Tayside Transformation Programme Board
24 August 2016	Option Appraisal Report provided to Perth & Kinross Transformation Programme Board
25 August 2016	Option Appraisal Report provided to NHS Tayside Board
26 August 2016	Programme Bulletin circulated to all Stakeholders to update re outcome of Board meeting
26 August 2016	Option Appraisal Report and update provided to Perth & Kinross IJB re outcome of NHST Board meeting
30 August 2016	Option Appraisal Report and update provided to Dundee IJB re outcome of NHST Board meeting
31 August 2016	Option Appraisal Report and update provided to Angus IJB re outcome of NHST Board meeting
2 September 2016	Face to Face – Scottish Health Council –Overview provided of ongoing work within Programme
21 September 2016	Face to face – Option Appraisal Report and update provided to APF meeting
29 September 2016	Facilitated stakeholder GAP Option Modelling event held in Improvement Academy, Ninewells. (61 invited 55 attended)This information has now been used to produce the Option Review report which will propose a preferred option to go out to formal consultation.
27 October 2016	Update provided to NHS Tayside re revised timeline
4 November 2016	Update provided to Perth & Kinross Transformation Programme Board re revised timeline

8 November 2016	Face to face – Ann Gourlay /Maureen Summers Service User and Carer representatives P&K IJB to provide background and update re programme
18 November 2016	Progress update provided for MSP Briefing meeting
23 November 2016	Face to Face - Update provided to APF meeting
25 November 2016	Face to Face – Cabinet Secretary/Yvonne Summers visit to Carseview – Update provided re Programme background and progress
7 December 2016	Face to face - Update provided to Capital Scrutiny Group re timelines and progress
8 December 2016	Facilitated stakeholder Learning Disability Option Modelling event held in Improvement Academy, Ninewells (44 invited 29 attended). This information has now been used to produce the Option Review report which will propose a preferred option to go out to formal consultation.
12 December 2016	Face to Face – Meeting arranged with representatives from Perth & Kinross 3rd sector and voluntary organisations (Mindspace offices) to provide background, progress of Programme, highlight next steps and request their input into planning consultation process.
15 December 2016	Information provided to P&K service users and carers (PKAVS) regarding the Mental Health Service Redesign Transformation Programme work to date.
16 December 2016	Programme bulletin circulated to all stakeholders re revised timeline, progress update and next steps
17 January 2017	Meeting with P&K service users and carers (organised with PKAVS) to provide background, update and next steps. Press present
23 January 2017	Feedback received for P&K Public Partners meeting held on 17th January 17
23 January 2017	E-mail received from Support in Mind Carers Service with collated feedback and responses from Perth & Kinross Carers
23 January 2017	Media enquiry received re Adult Acute Admission Beds in Murray Royal Hospital.
24 January 2017	E-mail received from Positive Steps seeking further information regarding bed numbers in options being considered.
25 January 2017	E-mail received from Claire Forbes Support in Mind Carers Service with responses/feedback
26 January 2017	Email sent in response to Positive Steps e-mail of 24 January 17 providing further info. Thank you e-mail received from Positive Steps requesting any further information as it becomes available.

27 January 2017	Meeting with Yvonne Summers Scottish Government re draft Option review report and advice regarding consultation planning.
6th February 2017	Angus Public Event – City Hall Montrose
16th February 2017	Angus Public Event – YMCA, Montrose
24 April 2017	Angus press enquiry re delay in decision on the future of Mulberry Unit
25 April 2017	Response to Angus press enquiry sent
24 April 2017	Dundee Press enquiry re funding for mental health provision
24 April 2017	Response to Dundee Press enquiry sent
22 May 2017	Visit to Mental Health Services by Professor Sir Lewis Ritchie (GAP, POA, Rohallion atMRH, Carseview, CRHTT,CAMHS, Strathmartine) Background Information re Programme provided.

Attached Appendix provides all comment and option/feedback gathered to date

17.05.23 App 1
MHSRT Programme C

‘

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

Engagement Feedback

Engagement Event	Attendees
1st Angus event	18
2nd Angus Event	12
1st Carseview event	24
2nd Carseview Event	12
1st Strathmartine event	36
2nd Strathmartine Event	28
1st Rohallion event	40
2nd Rohallion	8
Tayside Reference Forum	12
Angus Reference Forum	44
Learning Disability Reference Forum	29
Area Partnership Forum	32
General Practice Sub- Committee	
Police	1
Ambulance	2
Local Authority	6
Option Appraisal Training event 16th June 16	35
Option Appraisal Workshop 20th June 16	88
Option Appraisal Workshop 30th June 16	84
PLUS Perth	3
Advocacy Services	7
Staff Side APF	12
TOTAL	533

Engagement Feedback Section Index

1.25 E-mail from Positive Steps request information re options and response sent.

1.26 Angus press enquiry re delay in decision on the future of Mulberry Unit

1.27 Dundee press enquiry re mental health provision

1.1 COLLECTIVE FEEDBACK FORM RESPONSES

Main themes from feedback forms received.

1. Enough information was presented
2. Background to programme was understood
3. Opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Understood next steps

Comments from feedback forms received

1. Felt decision had already been made/lack of evidence
2. More information on costs/info that decision made are based on quality of care/more info to take away
3. Not enough time to process information given
4. Would have liked more information about POA.
5. What models would be used for CMHT/CRISIS Teams if went to 2 sites.
6. Sessions should have been done by end of 2015 this suggest that decision is already made.
7. Model of CMHT in relation to Integration.
8. Very informative.
9. This is the first introduction to SBH - not involved in consultation process.
10. Wasn't aware enough - didn’t know about this until today.

1.2 FEEDBACK FROM ANGUS STAFF EVENT – 12TH JANUARY 2016 -

18 Attendees

Comments/Questions noted on day

1. Impact on other services - POA services/Medical rotas/ECT
2. Low morale/rumours/impact on recruitment & retention/de-stabilise current services/risks around continuation of services
3. Will the accommodation proposed be of similar standard?
4. Need for robust timeline to reassure staff
5. Quality of care in Angus be recognised
6. Advanced Nurse Practitioner roles – could we consider?
7. Knock on effect to community – how will be mapped out
8. Travel for staff (other side of Dundee)? Accommodation for staff?
9. Review medical role – demand /capacity/ what should be priority?
10. Need to be realistic /open and honest re what we can do
11. Shifting values – Prevention rather than reaction.
12. Triage of patients at OOHs before secondary care

FEEDBACK FROM 2ND STAFF EVENT IN ANGUS – 11TH FEBRUARY 2016

12 Attendees

Comments/Questions noted on day

1. Equity of service – having to travel 30 miles at night.
2. OOH Services
3. Feeling of centralisation
4. Can't get into current service so many will be the same and can't get into beds when service is transferred.
5. Knock effect of other services in Angus – Brechin/Montrose/OOH
6. Difficult to feel valued because of what happened with OOHs and the way it was handled.
7. Communication and engagement timing too late.
8. 18 months of rumours in the community

9. Low staff morale
10. No input/influence
11. In 2 years 75% of staff will walk
12. Knock on effect on stability/staff morale
13. Has Ninewells and PRI been considered as alternative site?
14. Oil workers – re-training
15. Critical mass – what does that mean? – Contradicts equity of service
16. What is/was the psychology input to relocating beds?
17. How many patients are detained under the MH Act?
18. Availability of beds versus reduction in beds in a crisis situation
19. Stress re waiting for transfer.
20. What was the feedback/concerns from users/carers/patients
21. Mulberry ward is dangerous as no male staff on at night.
22. % of population nearer to Dundee
23. Isolated population have further to travel.
24. What will the impact be on recovery process by being further away.
25. How secure is Carseview
26. Will there be more cross cover on larger sites.
27. Impact on wider recruitment

COLLECTIVE FEEDBACK RESPONSE RECEIVED FROM MULBERRY STAFF AT SUSAN CARNEGIE IN ANGUS

Many of the staff did not have an opportunity to attend the staff consultation sessions so as a group of staff we have complied our feedback in relation to the Steps to Better Healthcare Programme proposal of 2 site model.

For ease of reading it has been spilt into sections but many of sections do overlap.

Inequality for patients and carers

- Angus has over 230 years of local mental health provision and this 2 site model would mean inconsistent service provision across Tayside resulting in inequality for Angus patients only. I.e. No in-patient ward in Angus when there is already no CHRTT locally in contrast to mental health patients in Dundee and Perth.
- From 2014/15 data, only around 26 - 30% of patients admitted to Mulberry actually live closer to Carseview than Mulberry. This means the majority will be disadvantaged.
- Disadvantaging patients – further to travel for admission and higher costs for travelling there. Patients have many practical issues that can be resolved much easier if the ward they are in is local. For example – tending to pets, collecting clothing from home.
- Disadvantaging family and carers – further to travel to visit relatives and of course higher costs incurred to do so.
- Patients will have further to travel and incur more costs to participate in the necessary treatment plans. For example, graded exposure programmes, passes. These patients are already on low income or unemployed so centralisation will create further inequalities.

Quality of care/patient experience

- Mulberry provides high quality person centred recovery focussed care. This is reflected in feedback from patients and other organisations such as Mental Welfare Commission. In the past year, feedback from patients have been that 95% state service provided was excellent or very good.
- In 2014, NHS Tayside recognised the good quality of care provided and the on-going improvement ethos within Mulberry. This was shown by them selecting Mulberry to undertake part of the Health Foundation work by undertaking several projects. NHS Tayside were awarded monies from the Health Foundation for this and then decided to use it in an area that they were considering closing.
- There is a low incidence of violence and self harm in Mulberry. The factors which attribute to this low numbers include staff attitude, ethos of ward, environment, and accessibility to activities on ward, recreational room and local community facilities. This will not be replicated in centralisation.
- Maintaining links with the voluntary sector and local authority services will be a real challenge for patients to access when they are being cared for out with their local area in terms of their early supported discharge and recovery.
- Maintaining contact with family and social networks will be a challenge for patients.

Staff

- The leadership team convey that Mulberry is isolated from other GAP services so therefore must be at more risk, however the evidence on violence and aggression does not support that. In practice being isolated has helped staff to be more adept to managing difficult complex situations with limited resources.
- Staff will incur additional costs to wear and tear of their vehicles.
- Up to 75% of Mulberry staff has stated they would be unwilling to travel to Dundee to work, this will result in a potential loss of experienced staff from GAP including AHP staff who know the patient group and the community services.
- There will be additional costs with protection of banding/unsocial hours payment/travel costs for these staff. Out of a staff group of 40+ only 5 staff live closer to Carseview. Thus affecting the work life balance for the majority of the staff group.
- Loss of multidisciplinary team who together have continued to work hard at providing excellent care and working through many challenges.
- Staff work closely in partnership with their POA colleagues on the Stracathro Hospital site for mutual support and management, this would be lost.
- A move to Dundee would incur additional costs to POA wards in Stracathro Hospital as they would need to look at increasing their staffing as no longer supported by GAP staff during violent emergency situations.
- Junior medical staff cover the whole Stracathro Hospital site during out of hours, by removing GAP junior doctors from Stracathro site will ensure additional costs and recruitment problems to other NHS Tayside services.
- Centralisation would have an impact on CMHT staffing and resources. There would be increased travel and time to visit their patients and/or attend case reviews/ward meetings. This would affect the CMHT's capacity and also affect the quality of care patients receive.

Environmental

- Mulberry was built just 4 years ago to remain in Angus, the new environment would need to provide equal environment to Mulberry if quality of care to be maintained.
- The unit was purpose built and compared to modifying a current ad hoc ward it would be impossible to replicate the same environment Angus patients already have.
- Also it seems like a waste of public money to spend money on something that already exists and is evidenced to be successful in terms of providing high quality care.
- The current environment supports recovery focussed care this would be difficult to replicate in a refurbishment.

Miscellaneous points

- Staff consultation has been poor – insufficient number of sessions to safely release staff to attend whilst meeting the clinical needs and safety of the ward. Insufficient time for staff to be made aware of first session in January with 24 hours' notice given to staff.
- There is no nursing or AHP recruitment issues in Mulberry.
- Our experience of centralisation in terms of accessing rehabilitation or IPCU beds has been fraught with challenges in the past. There is a strong believe Angus patients would soon have same difficulties in accessing GAP beds in a centralised unit in Dundee.
- The Mulberry team will be diluted across various services so the learning achieved

through the Scottish Patient Safety Programme and The Health Foundation work will be lost. Also the culture and ethos of the ward will be lost in this process.

1.3 FEEDBACK FROM CARSEVIEW STAFF EVENT – 13TH JANUARY 2016 –

24 Attendees

Comments/Questions noted on day

1. Impact on other services – Learning Disability day services
2. Medical Rota issues / Two sites easier to cover
3. Impact on travel time – staff/users/carers
4. Proposed increase in community include home treatment?
5. Numbers of open Forensic and low secure Forensic Learning Disability patients?
6. Inpatient exit to community care – what are links and who will provide?
7. Look at skills elsewhere – Local Authority/Leisure
8. Resource for Rehabilitation – clarity re patient pathways?
9. Workforce planning – AHP skill mix
10. Money Tayside has invested in PFI schemes
11. Delayed discharges in Learning disability – Local authority and Vol Organisations
12. Learning disabilities forgotten service in MH

FEEDBACK FROM 2ND CARSEVIEW STAFF EVENT – 24TH FEBRUARY 2016-

12 Attendees

Comments/Questions noted on day

1. Can see more positives than negatives
2. Cross cover
3. Training/learning /development opportunities
4. Running course for junior positions
5. Running course for support staff to train for support posts for future
6. How do we influence recruitment
7. 2 sites would improve physio services as greater ability to share resources
8. What if Board says no?
9. Why have Board spent so much on PFI?
10. How do we continue to cover if Board say no?
11. Is NHS cost cutting to affect planning?
12. Do we review sickness rates as part of this?
13. Clinical nurse specialist as solution to Junior Doctor rota
14. OOH's operational issues – lid on it – CRISIS Team
15. Crisis team no longer existing – staff weren't consulted with no communication – this happened over night – operational

16. Importance of partnerships in each locality with Local Authority
17. How was this received in Angus
18. 30 miles outside Tayside not your home
19. Pharmacy input required – include in planning if more move to Community
20. How will rehab pathway be managed in each area if moved back into Community with partner agencies
21. Step down from people out of MRH but services aren't available

1.4 FEEDBACK FROM STRATHMARTINE EVENT – 14TH JANUARY 2016-

36 Attendees

Comments/Questions noted on day

1. Criteria 1 and 2 feel like the same thing?
2. Where will day care/day service and community models sit/access issues/impossible to cover across sites?
3. Finance focussed/capital receipts do we keep the money?/ rumours re sell site for housing as next door being developed?
4. Students need to be recruited at right time /right place – not done very well currently – how are retirements to be covered?
5. Will patients be involved in process?
6. Feel like getting leftovers – what about new build for LD? Scope to build on Strathmartine site?
7. Impact on patients/carers – support needs identified?
8. Travel issues for patients re Angus Forensic patients/visitors to Perth
9. Could training for MH and LD be combined so can cover both areas?
10. How long are NHS tied into PFIs?
11. Inclusion of support services
12. Local Authority input

FEEDBACK FROM 2ND STRATHMARTINE EVENT – 23RD FEBRUARY 2016-

28 Attendees

Comments/Questions noted on the day

1. Equity of access for Angus patients
2. % of patients from Angus
3. Impact on clients/travel component
4. Number of patients ending up in custody increasing due to lack of access to treatment
5. Support to travel to Perth/ staff time - waiting on access to treatment
6. Impact on ability of group therapy - high number of angus patients in current group
7. Impact on day service
8. Sex offender treatment group wouldn't be feasible

9. Communication on one site is good – separation would reduce ability to communicate effectively.
10. Cardiff/Swansea models – access on 1 site more effective/responsive –
11. Providing LDAU/BSI/Open Forensic together at Carseview would alleviate these concerns
12. Split of forensic could affect communication – quality needs to be received at same or higher level – if split then may lead to less communication re high risk patients.
13. Difficulties in accessing IPCU and LD in general with GAP
14. Environment – autism / retro fit
15. Delays in Pinel / need to make sure work completed
16. Car parking – impact on site/extensions
17. How will all this fit on site – Day care
18. Treatment facilities are as important as clinical facilities
19. More treatment facilities needed
20. “Quality of life” – whole integration of services which provide improvements
21. Outdoor space – football – team building
22. Carseview – risk re mix of patients with GAP
23. Group potentially going to MRH re treatment options – access to activity space if shared with forensic
24. Day services?
25. Loss of resources for services – workshops, gardens, out door space
26. Freedom of space – football space
27. Impact on Angus LD Community – currently unable to provide any services due to high demand
28. OT resource pulled into more generic work
29. Improvement in community services ?
30. Will LD services monies be retained for LD services or used for other services
31. Patients starting to return to Strathmartine
32. Security blanket/place of safety

33. Feedback received following event by email: -

Good to get feedback on the current position. Noted below is some of the issues raised from a Forensic LD Psychology perspective :

Concerns/issues raised regarding simply clients travel to Dundee from Angus as noted on slide, it is an issue regarding the 'equity of access' to Forensic Psychological intervention for community based clients. Forensic Psychology services are a considerable and significant part of the Psychological Forensic Service for offenders with intellectual disability at Strathmartine. There is a significant percentage of sexual offenders within the client group although anger management and social problem solving are also focuses of intervention for Psychological Group Therapies.

The groups on the whole are attended by males however occasionally females attend the group therapy setting. The individuals on the whole may have attended court and received a disposal to the service as a part of a direction of treatment on a Criminal Justice Order. This is achieved through working with the courts and Forensic Psychologists or Psychiatric Colleagues providing a report on possible rehabilitation disposals available to them when sentencing offenders with intellectual disability in general and sex offenders in particular due to the expertise on site. Equally some of the clients may have received no disposal from court e.g. due to capacity to stand trial etc. but are identified as being able to participate in Psychological intervention where assessment has indicated this is warranted.

The Psychological Treatment groups that are available for offenders (Social Problem Solving, Anger Management, Sex Offender Treatment) are evidenced as effective and are run weekly (each Monday, Wed and Thursday) within Strathmartine Centre. These groups can be attended separately or as an integrated pathway of intervention (decided clinically) and are based on many modules of treatment but are also based on peer support and peer challenge as an effective method of attitude change. Numbers within the groups are essential for effectiveness. Having looked in the past at the provision of such group therapies in the separate areas (Angus, Dundee, Perth) this is not feasible firstly due to numbers within each group setting required for effectiveness, cost of running three groups (one in each area) in time, travel costs, lack of capacity within the service to do so and also situational risk management in so far as finding sites where risk can be managed for a gathering of sex offenders and also sites where risk is manageable for staff and a response available if required.

All Psychological interventions are based on a 'Good Lives Model'. This model is evidenced as best practice for sex offender intervention in particular but is utilised in all Psychological Group Therapies with good effectiveness. Basically alongside the provision of a Cognitive Behavioural Therapy model of intervention, we look to improve the offenders everyday life to aid desistance from offending behaviour (the offender becomes protective of his quality of life achieved and the work he has carried out to achieve this, and in turn has too much to lose to want to offend) hence the title 'Good Lives Model'. Significant dynamic risk items for sexual offending are recognised as loneliness and poor self esteem. Loneliness may often occur through poor social problem solving within interpersonal relationships (Social Problem Solving group therapy) and poor Self Esteem (Occupational therapy to build skills, education self confidence and appropriate social interactions). Thus work as an integrated treatment model for offenders with intellectual disability on an evidenced based model of intervention. This underpins the reasoning for any change in service provision to maintain the ability of disciplines to integrate seamlessly, as currently happens on the Strathmartine site, to provide effective therapeutic intervention as often directed by the

courts to offenders with intellectual disability alongside risk management to prevent future offending behaviour.

There is also a body of research evidence which suggests that service effectiveness in challenging behaviour is most effective when those working within a team are housed in the same building and free communication can occur between and within staff teams. This is also important to effectiveness of the team of staff within the Strathmartine service. There are a number of occasions where staff will stop one another and pass on information, whether its regarding the complexity of Timetabling for OT services to match up with the days an offender may be accessing Psychological Group therapies, it may be to organise, within a risk managed framework, communication regarding an offenders actual attendance at outings with Community Nurses, it may be simple communication of issues that have been passed on by care staff in the private sector as they have some concerns regarding an offender due to come to the service that day (it may be a risk issue that requires additional vigilance of the staff team working with him on the day or additional risk management to be put in place) it may be to share communication from offender management officers in Tayside Police of CJSW workers within criminal justice social work. Whatever the reason having the staff teams of various disciplines housed in the same area facilitates excellent risk management within the area and facilitates communication. This is all important to effective intervention and dynamic risk management of this group of clients.

This is evidenced through a 20 year follow up study as having an effective service to date and clearly with 'Steps to Better Healthcare' are always looking to improve our service and the provision of better healthcare however this also has to be able to support the current methods of best practice on delivery of interventions and risk management of this at times, complex client group.

1.5 FEEDBACK FROM ROHALLION EVENT – 20TH JANUARY 2016

40 Attendees

Comments/Questions noted on day

1. Had assumed SBH was GAP only and not LD or Forensic
2. Implications for staff on Rohallion site from any potential ward closure?
3. Staff in Rohallion were unaware of any impact on their site
4. Levels of expertise/potential to lose expertise if reduce a ward/who will look after Learning Disabilities ward?
5. Impact on day services at Birnam?
6. What is national strategy re Low secure beds?
7. What is age profile of Learning Disability patients? Will be males and females?
8. Have considered Pharmacy cover?
9. What % of patients from other areas? Angus patients being moved to Perth?
10. Which ward in Rohallion is being considered – size, fit, function?
11. Will learning from building this building be used for refurbishments?
12. Rehabilitation and Complex Care – need for clearer pathways

FEEDBACK FROM 2nd ROHALLION EVENT – 17TH FEBRUARY 2016-

8 Attendees

Comments/Questions noted on day

1. Which ward would be low secure?
2. How would it be chosen?
3. How many patients and would staff be transferring to new facility?
4. What outdoor space is there?
5. Would there be training for rehab?
6. Lessons learned
7. Gardens/workshop facilities

1.6 FEEDBACK FROM USER, CARER AND VOLUNTARY ORGANISATIONS

TAYSIDE REFERENCE FORUM - Held 28th January 2016 at Kings Cross Hospital - - 12 Attendees

Main Themes from Feedback Forms received.

1. Enough information was presented
2. The purpose of the discussion group was partially understood
3. Opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Understood next steps

Comments from feedback forms received

1. What other criteria were considered
2. Very internal review
3. Smaller group discussions would have been helpful
4. Not enough time to process information given
5. Earlier involvement
6. Would have hope for more time for further discussion
7. Information issued prior to meeting to enable a better understanding

1.7 ANGUS REFERENCE FORUM – Held 15th Feb 16 Stracathro-

44 Attendees

Main Themes from Feedback Forms received

1. Not enough information was presented
2. Uncertainty around background, purpose and process
3. For the majority of time opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Uncertainty over next steps

Comments from feedback forms received

1. Too much irrelevant information
2. Session felt like a delivery of information not a consultation
3. How can insufficient beds equate with supposed lack of demand locally
4. Acoustics very poor
5. Felt decision had already been made/lack of evidence
6. Presenters did well considering the feeling in the room
7. Presenters didn't have the opportunity to fully explain the point they were trying to make due to constant noise and interruptions from floor.
8. Not enough time to process information given
9. Late notice of meeting raised suspicions as to the actual purpose of the meeting
10. No prior consultation
11. Why was the hospital closing?
12. Unsure of the funding streams
13. Language used was too technical and unfamiliar
14. Earlier involvement
15. Would have hope for more time for further discussion
16. Information issued prior to meeting to enable a better understanding
17. Provision of user friendly information

Comments/Questions noted on day

1. What would happen in terms of visiting Dundee/Perth?
2. Should the workforce not be more integrated with social care
3. Better links with community – preventative
4. Cinderella Service
5. How does A& E link in – self-harm, suicide attempts
6. Further trauma/distress due to being discharged with no follow up
7. Why cant money be put into peer support/3rd sector
8. Would a drop in safe place not be better use of resources for crisis care
9. Long term chronic issues not supported
10. Money before people seems to be what's happening
11. Why not ask inpatients their views?
12. Why is there such a push for short admissions?
13. Can we guarantee that these proposals will not result in more community treatment orders?
14. Will more resource go into Angus Community Services?
15. How can closure of local hospitals be called improvement?
16. What are the plans for Mulberry Unit?
17. OOH's must be re-implemented/improved - even a team on the phone can prevent crisis developing further.
18. Experience by experience

The following is a survey carried out by Angus Voice amongst some service users, carers and others in Angus. This survey was circulated on 9th February, prior to the Angus Reference Forum where information about the Mental Health Improvement Programme and the proposed options was presented to this group.

It has been suggested that the Mulberry ward might close and patients would instead have to go to Murray Royal in Perth or Carseview in Dundee.

Use this scale to show what you think of this idea
1: Good
2: Unsure
3: Bad

Total responses 58

What is your general feeling about the suggestion?

1. Good 1.79%
2.Unsure 5.36%
3. Bad 92.86%

How would you feel if you or someone you care for was told they had to go to hospital in Perth or Dundee rather than Stracathro?

1. Good 1.75%
2.Unsure 5.26%
3. Bad 92.98%

How would family and friends feel about this proposal?

1. Good 1.75%
2.Unsure 7.02%
3. Bad 91.23%

How would going to Perth or Dundee impact on a persons recovery?

1. Good 1.82%
2.Unsure 10.91%
3. Bad 87.27%

How do you think a hospital stay in Perth or Dundee would affect contact with friends and family?

1. Good 1.75%
2.Unsure 1.75%
3. Bad 96.49%

How would the financial and time constraints affect friends and family travelling out-with Angus?

1. Good 1.75%
2.Unsure 1.75%
3. Bad 96.49%

Do you think there would be a difference in how passes could be used if a person is in hospital in Perth or Dundee rather than Stracathro?

1. **Yes 76.79%**
2. **No 23.21%**

What would you identify as significant issues for a person going to Perth or Dundee rather than Stracathro?

- I feel it would be detrimental to their recovery. The individual would be taken out of their community and this would make it difficult for them to then integrate back into the community. It would cause difficulties for CMHT and voluntary organisations within Angus to then support the person back into the community. What would this mean for information sharing between ward staff and Angus based CMHTs/third sector organisations (e.g.Penumbra)
- Strain on both patients and their visitors both physically and financially
- I feel this would add considerable stress for individuals who are already struggling and make the experience even more daunting for people. Community support to aid transition upon discharge would also be problematic due to the logistics of travel.
- Distance is big factor. Visitation and access to legal help vital
- Distance
- Being away from family/friends and familiar surroundings
- Distance from family & friends, unfamiliar area.
- Travel
- Lots of families struggle with transport and this would limit their visiting time which i feel is crucial to recovery of patients
- Too far from loved ones
- Persons overall recovery as they itch to get home
- Travel issues.
- Stress of long travel

- Further away from family
- Too stressful when you are already ill
- Lack of family support due to travelling
- Travel
- Family being further away for visits.
- Time, money, stress on family
- Even further away from family, bigger hospital which could make the patient feel even worse and cut off from the world.
- Too far for Family & friends to have to go
- Less visitors as it's too far to travel
- Having support in the immediate area.
- Separation from family.
- Place near home, comfort.
- If a patient was to be admitted to hospital and there was no mulberry unit it would affect the individuals recovery, they could be further away from home e,g if home is in Montrose. This would mean further for family to visit, and not everyone can drive! It's a stressful time anyway when a loved one is in hospital never mind them being even further away from you. It would also affect passes home as there was be more arrangements to be made for travel and it would take up time.
- Cut off from their local community and family
- I wouldn't be able to get visitors, I'd also be even more isolated then I already am, it would also cost the NHS more in the long run, with transport.
- One more less local facility that would mentally ill people needing to go further for treatment and possibly worsening family connections but also Dundee cant as it is.
- Well for one it would be too much travelling for people.
- Isolation, cost factors, lack of support by loved ones.
- Being so far away from home with the impact of family/friends not being able to visit as much due to travel times/costs. Also if on a pass this will be extremely difficult for them to go out and about and will not be able to go home for a visit as this is to far to travel for the day back home.
- Lack of family/friend support, no access to services they will use on discharge so less prepared, time in travel for vulnerable people, options for day release etc would be limited - it wouldn't be feasible to go home for the day due to distance, or to take part in local groups/facilities in that time, isolation.
- Isolation-difficult to have contact with family and friends
- No local support with services, even more feeling of isolation from family, expensive/difficult for family to visit, they might end up being admitted at crisis stage if they know they won't be in hospital locally, day passes won't work . . .
- Over-crowding and would have a negative impact on individuals well being
- Upset and lonely
- Getting into the hospital in the first place due to reduced number of beds; once, the person we care for had to go to Dundee because of a shortage in Sunnyside. How much worse would it be with Stracathro closed?
- Travel for the individual. Change for the individual. Safety for the individual. Options for the individual. Choice in an individual’s care.
- Access to the community is a huge part of the recovery process; it would be difficult to strengthen community relationships and ties when so far away from the local community.

- This would potentially be an unfamiliar environment which could affect the patient's recovery and the use of passes
- As someone who has been an inpatient in Stracathro it was important to me to be close to my home in Angus so that my family and friends could be a part of my recovery, if Stracathro was closed and was moved to Dundee my family and friends wouldn't be able to visit due to distance or time constraints because of other commitments. Family and friends are an important part of recovery. It also helps being in the angus area for going on day or over-night passes as it's closer to home and I don't go to Dundee or Perth as I find it too busy and stressful and I don't know them well so day passes and over-night passes would fail before they even started as I'd have to find my own way home from a town I don't know. Where as in Angus I know the area well. The Muller unit is also a much nicer open wars in peaceful surroundings which is of proven benefit to help people more than busy areas in busy surroundings.
- Loss of contact with friends and family and community due to distance and time taken to travel. Stracathro is a General hospital - less stigma involved. May know
  staff at Stracathro already also some other others receiving services - less fear about
  going to hospital if relationships are already
  established.
- Much busier units. Not enough activities.
- Better staffing levels and less access to dual carriageways
- People visiting, travelling
- Lonely, isolated from friends, fear of a strange place. travelling back and forth to home visitation
- Unfamiliar, too far away, family unable to visit as much, expenses for travelling home, feeling isolated from normal environment, negative impact on patient self esteem and recovery as a result of the distance
- Access to Angus services
- Travel and costs
- Less contact with friends, loved ones and a strange environment wound impact negatively on a person's recovery.
- Transport would be the main issue for Perth. However, I believe it is easier to travel to Dundee from Angus than it is to Stracathro.

How important do you think it is to keep the ward at Stracathro? Would you like to say in your own words what you think of the proposal?

- I think it is essential that a inpatient ward remains in Angus
- I think it is extremely important to keep services local and that the proposal is a very bad idea
- I understand that the NHS may have to make changes due to financial constraints and savings that need to be made, however surely patients/local people should have been consulted during this process?!
- Have poor opinion of MH services
- Very important, I think the proposal would be a very bad idea as it was bad enough Sunnyside moving from hillside.

- I think it is shocking and more money should be spent on helping people

recover and feel safe and close to home

- Very very worried about it closing, it's a lifeline for a lot of people, will have major impact on individual's mental health and recovery.
- Bad idea
- Very....a fantastic place which has helped a speedy recovery of a good friend of mine.

  Dundee and Perth are too far away.
- Extremely important, having loved ones close by in my opinion is the best way to recovery knowing they are not far
- Its very important I think the proposal is utter crap and would effect people's recovery
- Very important. Convenience for the mentally ill and her/his family is vital for recovery.
- It's a terrible idea, for some people even Stracathro is very difficult to get to
- Very
- I struggle with mental health and would hate to think help is going to be further away.
- Very important to keep local support
- Very important to keep the ward
- Bad idea
- think it would have a massive impact, closing another ward could mean a shortage of beds, patients having to travel further than needed and strain on family.
- Very important it's a lovely hospital in beautiful grounds
- Ridiculous. ! Make this emotional time easier not harder
- Very important. First Sunnyside closes forcing family and friends to travel to Stracathro. Moving patients further afield would be very detrimental to the recovery of patients.
- It will be the same as closing Sunnyside, I think it will put patients off of being admitted for treatment due to the possibility of relatives and friend not being able to visit as much.
- Not beneficial to recovery or the family unit
- I think it's very important that mulberry unit stays open to help give reassurance to those living in Angus that the unit is there to help them. You would be taking more care that is highly needed away from those who need it.
- Closing the ward is going to disadvantage Angus residents when it comes to mental health services. Recovery will be slower for them and less people will want to seek help when unwell for fear of having to go to Perth or Dundee for treatment.
- It's extremely important to keep Stracathro open, as a patient I would be more isolated from my friends, family and community. Also I've been transferred to an out of area hospital before due to lack of beds and the whole ordeal was very distressing. I couldn't get visitors because I was too far away, I was also told due to the shortage of beds in Scotland I could be sent to England which was even more distressing!
- We need beds not closures and I think it's just another cut in mental health services.
- Cause it’s so close to town and isn't too far for people who don't drive
- Huge impact on local support services and partnership working moving away from locality working
- I think it is unfair to expect someone to be so far away from home, this also

makes it harder to make connections with community when being discharged through other services.

- I think it would be a huge mistake and very short-sighted at a time when mental health services are already stretched, to leave Angus with no inpatient beds, when Carseview and Murray Royal are already stretched and have no room. This will result
in more patients having to go even further to be admitted. Mulberry has close ties with
local facilities and services in Angus which help the transition from hospital to home, this would not be in place.

  Add to that the fact that Murray Royal is Perthshire, Dundee is separate from Angus and you will have staff struggling to get in place support on discharge as they are dealing with different areas so don't have the same access - what happens in Angus is different from Perth or Dundee - I have firsthand experience of this with a relative being released from Murray Royal back to Angus and the strain it puts on staff having to organise follow ups and aftercare. Combine this with the lack of contact with family, friends, local support and people will be discharged unprepared, resulting in an increase in re-admissions.

  Looking also at the cost and time of transport and staff hours spent on transport and there will be a significant rise in unnecessary costs, that is before you even consider the impact on the patient who is already in a vulnerable state and may be in a state of distress, psychosis, or other. The potential for risk in this situation is already high without adding in what could be a 2 hour or more journey and delay in start of treatment in a safe and secure environment. This also has the potential to impact on a patient's recovery time again leading to an increased cost of longer stays, meaning less space for new patients.

  I would question if the implication on financial costs has been thoroughly investigated, as whatever saving has been suggested by closure of the ward will almost certainly have to go towards the extra costs incurred, not just through the inpatient stay, but also on discharge into the community. And I doubt very much that the full implications of the cost to patients health has been considered.
- Needs to be kept local- people are used to Stracathro; it means they can stay in their local authority area and can maintain relationships.
- It is shocking, particularly as there appears to be more and more people needing support with their mental health issues, and a stay in hospital can provide care, support and stabilisation of their illness. Angus residents are being discriminated against. Many people who end up in hospital feel isolated and disempowered. It will even more difficult to engage with their local services.
- Important, don't think its beneficial for anyone
- Stracathro has a much better outlook to help recovery
- Vitally important. Uncaring, unimaginative, crass, ignorant.
- Recent research in England shows many reasons why travelling significant distances is detrimental. Look into it before making a knee-jerk reaction! There are never beds available in Dundee anyway. Surely we should be increasing service provision to mental healthcare and making moves to reduce barriers and increase choices rather than give mental health patients the short straw as usual. Each person is an
individual so ask them, they are human beings, ask them! I am very very

disappointed to hear about these misguided bureaucratic decisions being made at a level with not enough consultation with those involved first hand.

- Extremely important to keep services including hospitals local. I am concerned that the proposal has not been thoroughly thought about. The impact on recovery for patients is huge. Not everyone can drive or access public transport easily. The most vulnerable people will be the ones to suffer should this proposal go ahead.
- Friends and family may not have access to transport and may be unfamiliar with the bigger cities of Dundee and Perth. There is also frequently a shortage of beds in Angus anyway and patients are sent even further afield than Dundee or Perth so oversubscription of beds may be an issue.
- I think it's very important to keep the ward at Stracathro open and I think that the proposal is awful.
- I have been a patient at Stracathro and it is a nice hospital in peaceful surroundings with access to bus routes for day passes. The ward is bright and welcoming and has a safe atmosphere to it. I have close friends who have been in the psychiatric wards in Perth and Dundee as patients whom I have visited while they were there and it's completely different. The wards don't feel safe or welcoming or peaceful or relaxing. It's the polar opposite of Stracathro. Most other wards are locked wards and there needs to be unlocked wards available too as a lot of people don't need to be on locked wards. I personally feel that if the ward at Stracathro closes it will be a huge loss to the mental health teams in Angus and I would be more stressed in any other hospital not only because they are not as good/nice as Stracathro but because my contact with my family and friends who are very important in my recovery would be very little compared with if I was in the ward in Angus where all my family and friends live.
- A betrayal of those requiring services and their families. A lack of vision in recruitment of staff to fill positions at Stracathro. These proposals are not in keeping with known factors instrumental to Recovery for both users of services and their families. The proposal should be scrapped.
- It's a lovely unit. Very tranquil and in a peaceful location. Staff very good and plenty of activities for patients.
- The ward at Stracathro is understaffed and dangerous. Travel to Dundee or Perth is probably easier to co-ordinate. It reduces the chance of "unwanted" visitors bringing in "contraband" it may also focus the individuals in getting better as will feel much less than a home from home
- I think it's wrong and immoral to expect people from Angus to travel all that way
- The proposal is a ridiculous one people with mental health issues and their families work and pay taxes and deserve a real alternative, How would someone maintain a normal life when they are separated from their family. This feels like going back into the dark ages of psychiatry where we are separated from the normal population.
- Vital
- Very, it's a busy ward and needed
- it's a special built unit made for this care
- I think it is important to have an Adult ward in Angus
- It essential that people with mental ill health can be treated in their communities, the proposal is typically without consultation with patients and carers, arrogant.
- I think I need more information and understand all the risks of staying in Stracathro ot moving elsewhere. It is important we get all sides of the debate.

What would be the best or worst things about being in a Perth or Dundee hospital?

- The worst thing about the closure of Mulberry ward would be the negative impact this would have on vulnerable adults living in Angus. It would be distressing in itself for the person to travel that distance, being so far away from home (despite everything else that would be going on for them at that time). In terms of recovery, it would put barriers in place for people being able to integrate back into the community with the support of services like Penumbra ad CMHTs.
- Being further away from family and friends is definitely the worst thing. Time goes slow in hospital and having visits is what you look forward to
- Best can't see there would be anything good about this for people living in Angus. From a providers point of view staffing issues possible made easier. Bad= distance, visitors unable to make the trip, unfamiliar surroundings, purpose of day pass not fully met if people unfamiliar with local area and wouldn't be accessing upon discharge, less of a recovery focus evident in the care of inpatients in Dundee hospital
- Have very poor opinion of MH services
- To much money to travel and less visiting.
- Can't think of any good being away from family/friends overcrowding
- No good if you're from Angus, too far away, probably no visitors, detrimental to relationships and recovery.
- Travelling
- Too far a distance for vulnerable people to be from their families
- Best wider range of help, worst families strain and overall contact with person
- The travel and decline in quality of treatment.
- Worst thing being so far away from friends and family
- Travelling costs, time, feeling lonely as friends and family wouldn't be close by
- Its too far away for family to visit
- Further away from family support
- Distance
- Families being so far away it might impact on persons recovery.
- All bad, time, money & stress on family
- More central for different facilities
- Even further away from family and bigger could make the patient feel worse
- Too far to travel, meaning patients would get less visits from friends or family.
- Being in strange surroundings, far away from home with more limited contact to loved ones. Also many people who are in numerous times come to know staff and feel that these familiar faces help their recovery.
- Too far from family. Travelling. Expenses. Isolation from loved ones.
- travelling makes people visit less
- The worst thing about the thought of a loved one having to go to Perth or Dundee hospital would be knowing that the loved one is already in distress about going into hospital never mind one further away.
- People who are seriously ill should be in hospital in their local area. There is no argument apart from money, to send patients miles from home, it is not in the patient's best interest.
  Isolation
- There are no more beds there that's the reality so why are you giving them as

options.

- Nothing good about it being in Dundee or Perth they have done so much work with people.
- Worst thing would be lack of contact from loved ones if travel was an issue
- Being so far away from their home town/family/friends and connections with their community e.g. other services.
- I can see no benefit except being out of the local area may occasionally be a preference of one or two patients, although with the proposal that would no longer be the case as there are likely to be other patients from the same area. The worst thing would bending so isolated. Potentially having no visitors, no link to your life, no chance to meet people who may be involved in your support, worrying about what support there will be on discharge which is already inadequate in some cases, staff telling you that they can't do much as it all has to be passed to the Angus CMHT to sort out. Add to the fact that the care in Carseview especially is not of the same quality as the care in Stracathro (based on patient experience) then there is an added concern. Dundee and Perth areas also do not have the same integration and high level of cooperation which exists in Angus between health, social care and third sector services who all work closely together.
- Worst- far away, difficulties with travel/contact with family/friends.
- Worst - see 8 above.
- Family visits and travel time
- lack of visitors change of environment
- Best: Dundee is a good hospital (but so is Stracathro). Worst: further for some people to visit.
- Out of comfort Zone so feeling unsafe. Family and friends at too big a distance away.

  Basic comforts. Lack of beds. Feeling so far from home, in a city, different.
- Too far from home. I dont know how anyone would manage visits to see friends or loved ones if they were in hospital in either Dundee or Perth.
- Not everyone is familiar with an urban environment, particularly those from rural Angus, and this could be a daunting prospect, both for the patient and visitors.
- I have no positives at all if this was to happen.. It would actually put a lot more stress on me if I was to become ill again as I wouldn't want to go into hospital in Perth or dundee, which would lead to me either not being truthful about how bad I was feeling, or acting on an impulse out of feeling I had no other option because I have nowhere else to turn. The worst thing would be being so far away from my home, in a town I don't know and getting very little visits from family and friends if any visits at all
- The worst thing about being in hospital in Perth or Dundee is that you are a visitor to the hospital and have to move on another area eg Fife if the bed is needed for a Dundee user of services. This can mean even less contact with family and friends who are important is a person's recovery.
- Not as personal in busier units. Not good for mental health having on a few structured activities. Visiting easier if family live in Dundee.
- Everything bad
- No best things because this is a ridiculous proposal and just because it saves money is not enough reason condemn those with a mental health issue with
- Too far away for passes and visitors not conducive to recovery travel would be a big problem
- Being far away from home - not being able to recover in local environment
- I see no positives and the worst thing would be patients suffering isolation

and loneliness as a result.

- The same as any hospital-poor care

Transcript of a letter Mr Bill Troup received from a service user dated 21st Feb 2016

Dear Bill

Re: Better Healthcare Consultation meeting Mon 15th February

Further to the meeting I feel obliged to write to you as a patient who is rather concerned by some of implications of this meeting.

Although I fully understand the need to develop pathways to ensure 'Best Practice' it rather worries me that a large community like Angus may be without vital in-patient care.

As a person with mental illness I had to spend a 2 week period in the Mulberry Unit at Stracathro, I had to restart medication and appreciate how the facilities and staff helped me to get back into the community.

It appears from the meeting that facilities for Adult Patient Care may be in Carseview Centre, Dundee or Murray Royal Hospital, Perth.

This would concern me in terms of visiting and also in terms of the quality of care being replicated like the Susan Carnegie Centre.

A large sum of money would have been spent on the Mulberry Unit and it would be sad to see it close. Therefore, I hope as a patient that opinions will be considered before change is occurring.

Further comments/feedback received:
Comments and concerns raised at the Angus Mental Health Officers Forum 26.2.16 in relation to negative outcomes for service users were there to be a closure of these units, specifically :

1. Patients subject to the Mental Health Care and Treatment Scotland Act 2003 and the implications for provision of statutory services to service user groups both in terms of care planning and for MHO service provision;

2. The ability to provide the reciprocal arrangements necessary under the Act in a locale outwith Angus

3. The implications for the right to have family relationships supported when patients are so far away;

4. The cost/time implications for visitors

5. The implications for the environment to be provided, especially for those who have been cared for at Strathmartine which provided skills centre in a protective environment which gives maximum freedom to those who can have some time alone within the grounds but who would usually need one to one supervision in more public areas

6. The implications for CMHT's / LD services in being able to undertake good discharge planning and links to inpatient services, which is essential for recovery and good patient care.

1.8 LEARNING DISABILITY REFERENCE FORUM – Held 26th Feb 16 - Strathmartine

29 Attendees

Comments/Questions noted on day

1. Knock down Strathmartine and move to Carseview
2. Time for change
3. What about my mum/niece/sister
4. What will happen to day care
5. What about the workshops
6. How will we get to workshops if it moves
7. What about the garden project
8. I like it here
9. Will the staff move with us
10. What if someone doesn't want to go
11. I lived at the old Strathmartine and this is old now as well
12. Why cant we stay here – its like coming home
13. Why cant we all go to Carseview
14. This has been coming for a long time – its an old hospital
15. Can we all go to MRH
16. How many people would go to MRH?
17. When will this start?
18. Concrete works/gardens where are you putting them
19. I like working hard at the workshops
20. We make things for the gardens
21. Would you bring my mum to MRH/Carseview – Minibus/provide transport

Service User evaluation of choices

 This symbol means you like the choice,

 This symbol means you are not sure

 This symbol means you don't like the choice

Choice 1 Leave everything as it is

 **10**

 **10**

 **5**

Choice 2 Improve LDAU and Strathmartine

 **14**

 **9**

 **2**

Choice 3 Improve LDAU and move BSI and Flat 1 /Craigowl to MRH

 **5**

 **8**

 **12**

Choice 4 Improve LDAU and add BSI and move Flat 1 and Craigowl to MRH

 **7**

 **10**

 **14**

Choice 5 Move all of services from Strathmartine to MRH

 **5**

 **5**

 **15**

Mental Health Engagement Session Summary 12th April 2016

Session One – Claims, Concerns and Issues.

In summary the three key outcomes from this section of the session noted:

Claims

Engagement

1. Open and constructive Involvement of all stakeholders is vital
2. Previous engagement validated by SHC with good history of meaningful engagement at a local/smaller scale level.
3. EQI process commenced and consistent

Why change is necessary.

1. The programme is a solution to the current service challenges and will reduce risks – opportunity to help people/staff understand the difficulties.
2. The programme addresses longstanding issues to providing higher quality of care at an affordable able, sustainable cost.

.

Process of change- OBC/OA

1. The OBC/ Options Appraisal process is consistent and in line agreed standards
2. Further opportunity to establish common baseline of where the improvement programme is with all stakeholders
3. Full business case required by Board for next paper where final decision is made

Concerns and Issues

Engagement

1. Not all stakeholders identified. Not all stakeholders involved i.e. those who use services, those who care for them, those who support – e.g. 3rd sector, those who provide the service.
2. Clinical voice needs to be seen and heard.
3. Heads service are engaged and involved. Included.
4. That we invest in a rigorous means of communicating to service users and their families who have barriers to communication and understanding and that we actually listen to their views.

Why change necessary

1. Looking at Acute Care in isolation may not lead to good solutions.
2. Reports to Board missing vital information, i.e. finance. Board does not get information it requires to make decision
3. Information vacuum will result in damaging rumour.
4. The Dundee IJB is not strategically sighted on the programme as a whole board and is therefore not fully sighted on implication for the population.

Process of change – OBC/OA

1. Engagement process to date may be viewed as a ‘tick box’ exercise with decisions already made
2. Not something we can do in a week/month. Unrealistic deadlines did not enable appropriate planning of comms and engagement events (6 weeks to undertake).
3. More delays, comms programme being rushed, not getting public/stakeholders on board.

4. People don’t understand process and when decision made i.e. How do we dispel the current impression in Angus locality that a decision has been made.
5. NHST Board being inconsistent and hesitant with decision making.
6. Must incorporate and meet staff governance standard.
7. We could go through process and come out the same outcome

Session Two – SWOT analysis

Strengths	Weakness
CEL4 compliant: developing options, criteria, benefit weighting allows us the opportunity to review how we engage people.	Ability to follow the process fully with the resources and buy-in required.
Uses Staff governance strands.	Depended on those who engage/turn up.
Role IJB and hosting arrangements – built in partnership and collective all stakeholders.	Potentially too restrictive re options.
SCIM – capture investments process.	Engagement of stakeholders with different communication requirements, e.g. LD.
Clear process. Include EQIA	Time consuming and requires contingencies.
Have learnt from previous options appraisals.	Credibility? • Previous experience • Board decide differently – large group of staff, patients, public

If we plan for a major service change we will be in a good position. Done well, enables communication tailored to different stakeholder groups who have differing interests.	disenfranchised No guaranteed outcome. Must sit within a broader strategy and vision for mental health and LD services.
Opportunities Outlining benefits and criteria again so public and staff understand what is being proposed and why. IJB – stakeholders – gives opportunity to think of objectively of the model. To have conversation around the future Review an incorporate other best evidence Better communications, especially with groups i.e. LD Opportunity to do brand new sales pitch. Opportunity to improve skills and knowledge in staff around options appraisal process. Making sure people who were involved know what the decision was/why it was	Threats If staff 'messed around' further – impact on morale. People may leave. Too wide an options appraisal that may be rejected by board; e.g. is it about GAP beds or 21st century mental health services. Need clarification. Forced timelines – concern that we will be reactive rather than reflective. Service pressures/operational challenges – may be forced to take decision to keep service safe on patient safety issues alone. No political buy in. Credibility of process given work done to date.

taken. Close loop. To challenge the pace at which the service needs to change. Change the legacy of historical mental health estate.	

Discussion

In summary the key outcomes from this section of the session noted:

Communication & Engagement

1. Public and staff – using established Governance framework for communication and engagement.
2. Advice from Health Board re options and process. Need to know and work with parameters and decision making.
3. Strategic planning requirement communication and engagement for partnerships/IJBs (+/- hosting arrangements). Host board opportunity to scrutinise and discuss with other IJBs to reach informed understanding re shared responsibility.
4. Body corporate approach regarding who is decision maker.

Why Change is Necessary

1. Options appraisal process going forward needs to describe (1 or 2 site model):

- Finance: evidence robustly as part of financial plan and structure, i.e. could cost more
- Patient safety
- Quality services
- Sustainable over time
- Staffing

2. Create modern, effective mental health services (need to remember this more)
3. LD services – needs to be fully reflected -cost and environment

Process of change OBC/OA

1. Reflect changed or new scope
2. CEL4 must be followed
3. Recommendation re timescales should be revised to enable us to establish the impact and effect on other services.

4. Needs to reflect service redesign and BAU- i.e. need to risk manage current state whilst developing future state may mean temporary changes – i.e. clinical issues right now
5. New process needs to reflect the role of P&K IJB re service model change – hosting arrangements post 1 April.
6. Is it major service change or not? (Use template as to way to proceed.)
7. Political timelines, i.e. local elections, etc.

What is the options appraisal about?

What 'model' (operating definition – include community, inpatient and third sector) need to look at if inpatients on one site or two sites? Is it Reduction in GAP beds and/or Development 21st century mental health services?

Session Three – Identifying all stakeholders and best approaches for Engagement

In summary the six key outcomes from this section of the session noted:

1. The programme would recognise the work which had been undertaken and learn from previous engagement programme to ensure user and carer and third sector inclusion in future option appraisal exercises. The programme team must also ensure appropriate timescales are made available to undertake this.
2. The programme should look to the new IJB structures and their strategic planning groups to support identification of key stakeholder groups within each locality and build on established groups and local knowledge available. The group recognised the need to join with IJB partners to progress future engagement.
3. The programme would plan any future option appraisal events following Scottish Health Council advice regarding split of participants i.e 1/3 Clinical, 1/3 Service/Admin and 1/3 Service Users/Carers/Vol orgs.
4. Training sessions would require to be provided for the more technical aspects of the programme to ensure full participation i.e option appraisal process. These sessions would be offered to all participants.
5. All future engagement and information sharing had to ensure a clear, honest and consistent message was circulated which reached all staff and stakeholders and provided adequately detailed information wherever possible
6. The programme would provide a post option appraisal event in each locality to allow sharing of outcomes and preferred option from events. These sessions would be held prior to preferred option submission to NHST Board.

1.9 FEEDBACK FROM COMMITTEES

Area Partnership Forum 26TH Jan 16

Presentation and update of programme was provided.

The report was received favourably by members. .

Questions were asked regarding the ability to staff new models of care and whether NHS Tayside had any ability to make any savings through existing resources expended annually from PFI/NPD schemes. Staff side sought assurances that any changes for staff would be progressed inline with current organisational changes policies.

GP Sub Committee 15th Feb 16

Paper provided to update on programme for discussion and to request feedback from group.

Feedback received:

There were concerns raised by Angus GPs that the lack of inpatient beds in Angus may require all patients to travel to Carseview both for inpatient care and assessment. Given that urgent psychiatric problems often arise as emergencies and are more likely to seen by the GP in the afternoon the fact that OOH psychiatric assessment seems to be starting at 3 pm makes it difficult to get patients assessed by local teams. This was felt to be a particular risk given the increasing numbers of recent patient cases where communication between inpatient and local teams has been an issue.

Total capacity across Tayside was raised as a concern as even now Murray Royal seemed to be at capacity fairly regularly with patients shifted to Carseview.

It was noted that action was required as Tayside apparently has the highest spending on Mental Health in Scotland and that stronger community services could both improve care and save money, but it would be disastrous if inpatient care was reduced without concomitant support in the community.

The committee will be represented by Dr Humble at the upcoming Mental Health JCB where it was hoped there would be further discussion.

Mental Health Leadership Team 22nd Feb 16

Update report provided re Programme progress and feedback re engagement undertaken to date.

Progress noted by Mental Health Leadership Team

Mental Health Joint Clinical Improvement Board 23rd Feb 16

Presentation and update provided to request feedback.

Attendees noted the content of the presentation. The following were raised as queries/concerns:

Angus GPs had raised concerns via GP Sub-Group re potential impact on Angus patients if ward in Susan Carnegie relocated and the travel distance to Carseview.

By response, it was reported that data had been analysed showing that the majority of MH referrals in Angus were closer to Carseview due to their geographical location in Angus.

POA Lead Clinician raised a query re the impact on other services at Stracathro, i.e. effect on Psychiatry of Old Age who rely on input from junior doctors. This will be reviewed as part of further option appraisal work required regarding future utilisation of Mulberry accommodation following any decision by the Board.

Questions were raised on the impact of relocation of LD and GAP services on integration and IJBs. Attendees were advised that consultation would need to take place regarding this. It was noted that currently 95% of Mental Health Services are provided in the Community.

Presentation and update was accepted and supported by JCIB members present

1.10 FEEDBACK FROM SAS/POLICE

Response received from Scottish Ambulance Service reads:

Thank you for providing an opportunity to feedback on the proposed service delivery models.

The criteria applied to rank the options certainly seems reasonable and appropriate as does the application of a weighting to each criteria. From a Scottish Ambulance perspective, I don't feel we are in a position to offer any view on areas such as accommodation. The move from 3 adult acute admission locations across Tayside to 2 based at Perth and Dundee is probably the key area which has the potential to impact on the Ambulance Service however given the relatively small numbers of journeys, along with the fact that the only site being removed would be Stracathro, this is not a significant concern.

I would have been keen to attend a presentation to ensure we have had an opportunity to hear more details around the review process and the proposal being considered but regrettably, given the short notice, I am not in a position to attend any of the planned events. I hope this brief feedback is of some assistance. If you would like to discuss further, please do contact me.

1.11 Feedback received from Local Authorities

Response received from Dundee

Following attendance at 25th Feb 16 event a collective Dundee view on proposals would be provided. Feedback awaited

Dundee CHP Representative

We would support 3b in line with NHS Tayside reducing sites and resultant costs

Response from Angus and Perth Representatives

Response awaited.

All feedback to date included in March 2016 Board report.

Subsequent Feedback recorded from April 2016

1.12 Feedback received from PLUS - Perth

Response received 17 June 16 reads:

Apologies that we have not decided yet whether we feel it is in our best interests to be involved with this:

We are concerned about whether it is a token gesture as we have heard via an NHS meeting, discussions and the media that Mulberry Unit is to close and MRH will not. That is not to say that would stop us from attending if the event was about some other decisions that has not already been made. The explanation we have already received via yourself read like no decisions have been made at all including the one about which unit will close so we are in a bit of a quandary.

If we decide not to come it is for a good reason – because we really care about what our organisation does and how it influences better healthcare. We would rather have no participation at all than bad participation and be part of something we believe is against our values.

I realise this requires serious consideration and perhaps something you will be unable to answer fully, in that case I am hoping that you can send it on to a person that knows.

Response received following meeting on 29th June 2016 reads:

Thank you very much for coming to meet with us at PLUS yesterday and sharing the bigger picture. We really appreciated you giving us your time, even when you have so much to be getting on with.

Following a discussion later we decided that we would not take part. We want to stress this is in no way at all to do with the way you have been taking forward this part of the process, and have felt wholly listened to and respected by you.

We will send a separate e-m ail with why we are choosing not to be involved to Rob and copy you in to it.

1.13 Note of meeting with Angus Independent Advocacy 27 April 2016

It was explained that, after the 'NHS Tayside Board Meeting' in March, a further piece of 'engagement work' would take place between now and August (Option Appraisal Process). This would be across the three areas in Tayside. It was discussed that identifying those who would be invited to partake in the Option Appraisal would be decided at an Integrated Joint Board level across the three areas.

The Option Appraisal Process would consist of 60 people (20 clinical representatives, 20 service user/carers representatives and 20 management representatives). This would be equally weighted across the three areas.

The Option Appraisal Process would consist of looking at a one or two site option for adult inpatient psychiatric care and inpatient learning disabilities care.

Once the options have been identified there will be wider consultation.

The Scottish Health Council have offered to provide advice on the Option Appraisal Process for participants. They will also attend and offer advice at the two workshop sessions. You hope this will happen in June.

·Independent advocacy will be involved in the consultation with patients in Strathmartine and may include one to one consultations (their independent advocates could support them). You have agreed to meet with the managers from TAF to discuss this further.

I explained that we also support many of the people currently detained in adult care wards as well as many people in the community. AIA only provide one to one advocacy, but other independent advocacy projects across Tayside also provide other models of advocacy.

We also discussed the potential organisational impact on independent advocacy organisations – particularly in a climate where our referrals are increasing. It was agreed again that you would meet with TAF to discuss this potential impact. We also discussed 'Advocacy Planning' and where this sits within the IJB and the future of the Tayside Advocacy Plan.

You also mentioned that we could get access to the minutes of the NHS Board Meeting in March, which includes feedback from the consultation events. I have included the link for TAF members.
http://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_249617&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1

It would be good to arrange a meeting with TAF to discuss the issues identified.

A further meeting was arranged for Thursday 16th June 2016

1.14 Feedback from Option Appraisal Training Event 16th June 16 – Evaluation Forms

Feedback from Option Appraisal trai

1.15 Feedback from tables at Option Appraisal Event 20th June 16

Feedback on tables from Option Appraisa

1.16 Feedback from tables at Option Appraisal Event 30th June 16

Feedback from tables recorded at Op

1.17 Feedback from Option Appraisal workshops 20th and 30th June 16 – Evaluation Forms

16.07.28 Option Appraisal Workshops

16.07.28 Option Appraisal Workshops

1.18 Feedback from Option Modelling Event 29th September 16 – Evaluation Form

Evaluation160929.doc

1.19 Feedback from Learning Disability Option Modelling Event 8th December 16 – Evaluation Form

161208 LD Evaluation.doc

1.20 Feedback received from Dundee LD Service 13th January17


Dundee LD Seniors
LD Modelling Consulta


DUNDEE LD SERVICE
MODELLING VIEWS.d

1.20 Feedback received form P&K Public Partners meeting 15th December 16

Notes from December 15th Mental Health Transformation

Has primary care been involved so far?

How will social care resources be managed to accommodate change in inpatient beds?

Option 8

- Communication/brevity of stay – Very short time in step down process for patients to get to know staff then a change – not conducive to treatment and recovery
- Potential yo yo problem
- Patients beyond crisis phase more able to get more local and family support.
- How is population growth being incorporated?
- What is position of retrospective responsibility? (From member I think this might be with Step down process?)

How are staffing levels being encouraged?

Collection of stories re peoples experience versus statistics?

What age do people convert to adult care, 16?

Need for better listening to 'specialist' family knowledge

Mental health conditions very variable in nature

Change escalates the problem

Transport of patients and carers big issue

Big challenges for carers compound carers own health problems

If Blank Sheet what is best model of care?

Lighthouse project – in trouble if day services are not invested in as this becomes overloaded crisis point.

Manage prevention more locally

Drop in place – safe space, peer support

Prevention doesn't apply to genetic conditions

Needs good communications, avoid early discharge, need team able to deliver

Need free transport so people can support relatives

Succession of family carers is an issue (older family carers)

Is there a cost benefit in going to one site which can release money for other supports?

Models to include 'plan' for absence of carer(family)

Infrastructure to support any new model incorporating all appropriate services.

Issues with things appearing service provider centred.

Carers are still not valued despite their cost saving

Voice of carer MUST be listened to

Mutuality of respect

Lighthouse – place of safety through the night, not existing at moment, manned by volunteers, going through formalities.

Highlights need for time period required for creating other supports

Crisis help needed – crisis house in each area to prevent hospital admission

Manned by carers/peers less threatening than very medical staff

Need to take account of variation in mental health conditions.

Police are quite skilled in identifying where and what problems people are having.

What does service look like without buildings? Is money being invested in community supports?

How is longer term plan being thought about – recruitment, training?

Throwing money at it not the point.

Would it be easier to recruit if healing/treatment process was more person centred?

Engagement process needs to be more supportive and take into account

- difficulty in feeling heard
- Importance of carer support groups

Much earlier prevention with children

Better identification

GPs need guidelines to recognise mental health in children

1.21 Feedback received form P&K Public Partners meeting 17TH Jan 17

Notes from 17.1 17 Mental Health Transformation Information Event

A=Audience

NP=Neil Prentice

LH=Lynne Hamilton

A -Definition of 'Community support' as 'medical' or 'Third sector' voluntary is confusing. Needs to be clear in Reports and Engagement material.

NP -The Health & Social Care Partnership structure gives better potential for integration across sectors.

A - What is being set up to prevent crisis?

NP -Home Crisis treatment package is being worked on.

(Probably need good explanation of what that is.) SAB Note

A -What happens with people growing up with MH in household? Concerns about how this is handled. Can result in future mental health problems for those children.

NP - There is more willingness to speak about MH developing which make things easier but much more work needs done on discussing that.

A - How will Crisis Team work over wide geography?

NP - Crisis response treatment at home will continue.

NP -Need to work on ways of getting people to service if that is necessary.

NP - Crisis assessment available 9am -3pm.

NP - Crisis response occurs until 5pm

A - What is happening in Primary Care to prevent crisis?

A - Need to be more effective with co-occuring disorder?

NP -Large number of physical problem have spells which show themselves like mental health condition.

A - What is the potential of mobile service?

A - There are reservations of people being dealt with in communities as there is feeling of need for much closer understanding of family support and sharing of good information between families and services.

A - Carers have a feeling of not being listened to and the need for more openness around patient support.

NP - Law presents problem if patients request autonomy, even with advance statement in place.

NP - Crisis home treatment would be boosted and prevent hospital treatment being necessary.

A -How do you transport people who are really ill?

LH - Need to look at transport issues at 3 month state of consultation.

A - Worry re expectation of solutions falling onto carers. Limits to neighbour/community support if very difficult circumstances.

A - Much more training needed for GPs in recognising of conditions. Problem with criteria means there is bounceback from Community Mental Health teams to GPs.

A - 20 minute crisis visit. Is that really enough for people? What adjuncts to that crisis support?

A - Need for less barriers from professionals reported.

Specific User /Carer Reports

Severe challenge of trying to drive ill person to hospital while they try and open car door.

Level of mental distress can mean help required 'right now'.

Notes from Service User Public Partner

Option modelling over 2 days based on collected information to be given to IJB and NHST to agree a preferred option in Feb

Consultation as a series of roadshows over 3 months of preferred option

Quality Impact Assessment of demographics, deprivation and ethnicity etc will inform the preferred option

Can access progress on NHST website- our services-mental health

http://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthServiceRedesignTransformationProgramme/index.htm

Integrated approach with Health and Local Authority to redesign new models of care

Therefore need to continue to engage at all levels

1.22 Feedback from Service Users and Carers in Perth received 23rd January 17

NHS Tayside - Mental Health Re-Design
Transformation Programme

Support in Mind Scotland
Perth and Kinross Response

Support in Mind Scotland Carers' Workers were invited to and attended the consultation event at Ninewells on 29th September and represented Carers' views.
As the Mental Health Carers Support project in Perth and Kinross we have worked in conjunction with the Community facilitators and the Carers Representatives on the Integrated Joint Board and Carers Voice, PKAVS. As our project works solely with, and for mental health carers, we ensured all relevant information has been sent to all project carers, and with them, and for them, we have attended the open consultation events.

We have also been in consultation with the other Mental Health organisations in Perth and Kinross and support the Mental Health Community Services Providers Group responses.

Consultation with Carers
We have consulted and gained the views of carers involved within our project on the above paper.

The carers of Support in Mind Scotland are keen that their views are heard through our organisation. We have achieved this through open discussion within the 5 Carer Support groups which are held across Perth and Kinross, and through direct conversations carers have had with us.

For ease this response is arranged taking one point at a time. The issues relate to the options which put forward the closure of Moredun Ward at Murray Royal Hospital. The word "patient" is used throughout as this is concerning in-patient care, but recognising in the community they may be referred to as clients or service users.

1. All carers wanted safe and good in-patient care.

2. Carers expressed that they would prefer to have hospital /inpatient care for the person they care for, as close as possible, and preferably in the community in which the person lives. This they feel reduces stigma, helps recovery, and keeps those they care for closer to their homes, closer to those who love and care for them, and to the staff who keep them well.

Carers feel that mental health patients do not require the large amounts of specialised hospital equipment, which other medical specialties do, and so the in-patient beds they need do not necessarily require to be on a large medical centralised hospital site.

Carers believe that mental health care benefits from consistency of staff, committed staff and staff who are given time to know the patient. Carers want person centred care. Carers see value in the staff, who know the patient when they are well, being able to recognise when the patient is starting to relapse, and so are able to re-act promptly to prevent further relapse and so crisis.

When staff know their patients, they also get to know their carers, and so carers feel, together, they can find ways of jointly of working to maintain the patient's wellbeing and stay included in their community. This centralised policy for beds is more medically driven they feel, than patient centred, although they acknowledge the financial pressures and the staffing issues faced by NHS Tayside.

3. It is felt by carers that increased resources are needed in the community to reduce and prevent admission to in-patient care. Community care resources, carers feel, should not only be increased but also extended to include supports at weekends and in the evening. Most crisis situations seem to come out of regular working hours.

   At present carers feel the community is and has been under resourced, and has had significant nurse and consultant shortages. There has been significant turnover of staff, with locums, all of which has not been of benefit to patients, slowing their recovery, and so putting extra stress on their families, and as a result may have resulted in more hospital admissions. The rurality of P+K can put extra demands on services, but still needs to be supported.

4. There are concerns surrounding the number of beds. The in-patient bed numbers have been reduced since many carers have been involved with the project. The old Moredun "A" and "B" had 22 beds, each with 4 intensive care beds. Once these Wards closed and moved to the new Murray Royal Hospital, 30 beds were deemed to the requisite number for P+K's population. When the ward was re-configured to allow separate male and female rooms the number of beds were reduced again. 24 beds.

   Carers are unsure whether there are sufficient in-patient beds to serve the P+K population. Carers have experienced situations where the person they care for has been unable to be admitted to a bed, and they have had to manage to keep and care for them at home until a bed has become available; others have seen patients sent to other units sometimes in or out of Tayside. Some patients have been discharged early, to free beds, before the carer feels they are fully better, and have therefore had to provide significant supports and care for the patient.

The project would like confirmation on the numbers of beds that are thought required for the current P+K population base, and the prediction of need in the future.

5. Carers are concerned that when Murray Royal Moredun was re-opened by the NHS in 2013 that it was thought to be the "Vision of the Future" and was going to enable "rehabilitation"; however within a short period time planners seem to have re-considered this. Now, 3/4 years later there are new plans, again thought to be the correct way

6. Are the consultants and junior doctors who will care for patients' not in P+K in-patient units, going to be required to provide medical care out in the community of Perth and Kinross? If there is a current shortage of medical cover with in-patient care, will this shortage still transfer into the community, despite where the beds are, which has had difficulties already in recruitment of consultants.

7. We are aware that out-patient medical, and psychology appointments can be held in the in-patient hospital and carers ask if this will remain at Murray Royal or would this stop, with patients then having to travel to Ninewells , which could entail significant increase in travel, which would affect the majority of P+K population.

8. Carers in highland Perthshire and the Aberfeldy area would have appreciated consultation events to have been brought out of Perth, closer to their community, as the implications of the service will have an impact particularly on them, and planners would there be aware of their community and the distances involved.

9. There remains a strong feeling amongst carers that there will be significant pressure on them to provide transport for admissions, discharge, weekend passes, and home rehabilitation time, all of which will put additional stress on carers, especially if they have had to drive a patient for their admission.

   If a long journey has needed to be made by a carer driving to reach the hospital, it could be an unpredictable and stressful time, as the patient could be anxious, agitated, and fearful/not wanting admission. Weekend and day passes also will put time and emotional stress onto carers, and could be harder for them to achieve, due to the amount of time this will require of them to find, and perhaps not taking into account their home situation.

10. Carers would recommend and ask for setting aside a dedicated "Carer " area to support carers who perhaps have travelled far, have waited, and or are exhausted with stress of driving, supporting, waiting for assessments, etc

11. It is now accepted that carers are "Equal Partners in Care", and their role in the recovery of patients is significant. For working carers they may have significantly greater distances to travel and so may have to reduce their visits, and so less

involved in the patients care and recovery. They also may be unable to attend all appointments, due to distances and the time needed away from work.

12. Non - working carers too will be faced with longer journeys, and will need to find more time to make visits, which may bring complications with their home lives, as they may care for another family member, and/or have child care responsibilities. There will also be cost implications with either buses fares or petrol and parking costs, which might have implications to those with limited finance.

13. Visiting mental health patients can bring challenges for carers/ family members, as often those they visit can be unresponsive, resent their admission, want discharge, and can be not grateful for their visit. As a result of this, and if the distance is great, families may opt to visit less, especially those family members less able to cope with handling this behaviour which can come out of the illness.

    Reduced carer visits prevents staff having beneficial discussions with families to help with treatment, and the patients loses the stimulus of families and friends interactions which helps with their recovery as they miss the interaction of their family, the news from home etc.

14. Carers were unsure if the in-patients wards were going to be single sex, as proved more beneficial at Murray Royal; and would like to request that consideration could be given to putting younger patients in the same ward as each other, as transitions from adolescent services and adult services can have difficulties; and also asked about wards being area-specific – ie. Perth and Kinross only.

15. It is important for patients that they have easy access to “green spaces “safe outside space and or the inside courtyards as in the current Murray Royal, all help with patient recovery.

16. There is a concern that families/carers will have pressure on them to drive those they care for to Ninewells for the in-patient assessment. If the patient is subsequently assessed to be not needing admission carers then have drive back home. It is felt that if an inpatient stay is being considered the patient must be un-well so this amount of travel could be extremely difficult for patients and carers, and their help acknowledged. If families/carers do not make the journey, who else would provide the transport?

17. There is also a fear that more detentions may happen if patients have become more agitated due to the distances and the time needed to reach the hospital. Carers are keen that detentions are only used for the right reasons. Has consideration been given to comparing transportation time/admission time and use of detentions?

18. Could there be a crisis assessment centre in P+K to prevent travel in the cases above, and if one was open this might prevent or be able to support patients to prevent admission.

Summary

Carers in Perth and Kinross feel very anxious that this change will have a significant negative impact on the patients and their carers due to:

- Lack of continuity of local staff who know the situation and can intervene early
- Less focus on local rehabilitation and recovery
- Reduction in the number of beds available
- Lack of experienced clinical staff
- Increased distance to travel with huge impact on carers' time, resources and stress - particularly those with other caring responsibilities including childcare
- The specific issues faced by Mental Health Carers such as patients being unwilling to attend, or unwilling to have visits; additional stress and also the issue of detentions.

Carers ask for consideration to be given to these important issues they will face due to losing local facilities.

Sarah Cox
Support in Mind Scotland
Perth and Kinross, Carers' Support Worker

1.23 E-mail received from Jillian Milne, Chief Executive, Mindspace 23 January 17

Thank you again for coming along and meeting with us in December 2016. Further to your request for feedback, please find below collated comments from the Perth and Kinross Mental Health Community Services Providers Group regarding the Transformation and Redesign of Mental Health Services.

Additional Data: Unless this information is in the documents which cannot be opened on p99, there is no information available on the number of hospital admissions (both no' of admissions and no' of individuals). Given the importance of geography to this decision making process, it would also be a useful exercise if this data was further interrogated in terms of the home addresses of patients. This would then give a much more detailed overview of the situation. The 2 day consultation exercise that so many P&K people did not attend/were not invited to seems to consider the situation from a beds/workforce point of view. Ideally, any data analysis would then also tie this in with the community based services available to those patients, and how/where these are concentrated.

Community Based Care: Given the importance of Community Based Care to support this process which is cited throughout the Mental Health Service Redesign Transformation Programme Option Appraisal Report, could information be shared on the approach which is going to be taken to strengthen community based resources across the sectors? In the event that the number of hospital sites will be reduced, it would be helpful to find out more information about how existing resources may be used differently (such as Mental Health Officers, Community Mental Health Teams and voluntary organisations e.g. Mindspace, Support in Mind, Rasac, Women's Aid, Six Circle, PKAVS etc) and whether/how additional services will be commissioned? What opportunities will local service providers, service users and carers be afforded in terms of the planning and co-design of any new community service models? How will the Transformation process dovetail with local Health and Social Care Planning Partnerships to ensure there is an overall planning process focussed on the best outcomes for those who use services?

Admissions Process: There needs to be clarity on the admissions process, and how this will change if the number of sites are reduced. Given the recent changes within the Perth and Kinross Crisis Home Treatment Team (out-of-hours assessments will transfer to the Carseview Centre between 3pm and 9am weekdays and at weekends), it would be helpful to know whether there would be any localised assessment/admission process or whether this would also be hospital based?

Access Issues: In terms of access and public transport issues, if there were a breakdown of home addresses of patients, this would also make the analysis of travel by car/public transport more illuminating. Is it feasible for people living in these areas (and their carers) to get to their designated hospital and back again? What

consideration will be given to their discharge and visiting times? What will happen to outpatient appointments/services? Is there an option for dedicated transport services to be set up? Is there any information on the impact on partners, in particular, the Scottish Ambulance Service and Police Scotland? Moving services out with the local area could significantly increase travel time and cost for the service user, their family and other partner agencies such as the Police, Ambulance and Mental Health Officer services. Has there been any consultation with GPs who may need to support a more complex level of need in local communities if more specialist assessment facilities are less accessible due to transport and travel issues? Some of those who require access to crisis mental health assessments can be quite unwell, distressed or difficult to support and the use of public transport or car is either unmanageable or unsafe. There will need to be a clear policy/criteria on access to NHS transport.

- What formal impact assessment has been completed to date as part of the Transformation process, and have service users, carers and service providers had a genuine opportunity to contribute to these?

You will note that these points emphasise a high level of concern regarding the erosion of local service provision. We look forward to working with you to ensure that the people of Perth and Kinross receive quality mental health provision commensurate with our population, geography and level of need.

On behalf of the P&K Mental Health Community Service Providers Group

Jillian

Jillian Milne

Chief Executive

MINDSPACE

Mindspace Limited

1.24 Feedback from Service Users and Carers in Angus 25 January 17

NHS Tayside - Mental Health Re-Design
Transformation Programme

Support in Mind Scotland
Angus Response

Consultation with Carers

We have consulted and gained the views of carers involved within our project on the above programme. The Angus carers of Support in Mind Scotland are keen that their views are heard through our organisation.

We would echo the sentiments of our Perth & Kinross team, who have submitted the views of our Perth & Kinross carers in a recent response, collated by Sarah Cox, Carers Support Worker.

We have been asked by carers in Angus to raise the following points, in relation to the plans within the programme for the possible closure of the Mulberry Unit at the Susan Carnegie Centre, Stracathro Hospital, and its implications.

- Major concerns in relation to travel – significant pressure on carers, not only for visiting, but also in providing transport for admissions, discharge, weekend passes, and home rehabilitation time, all of which will put additional stress on carers. If a long journey has been made by a carer driving to reach hospital for an admission, it could be an unpredictable and stressful time, as the patient could be anxious, agitated, and fearful at the prospect of admission.

- Emotional and financial impact of additional travel involved - faced with longer journeys (especially if public transport required and limited services in some rural areas), leading to more time needed to make visits, bringing complications with home lives, balancing work, other caring responsibilities and commitments. There will also be cost implications for all carers, but in particular those with limited finance.

- Concerns over implications for strain on Community Mental Health Teams, and worries around what services will be available to provide additional support needed in the absence of local inpatient care - increased resources needed in the community to reduce and prevent admission to inpatient care.

- Concerns over continuity of care within community mental health services, which would be increasingly impacted by these changes – Carers believe that mental health care benefits from consistency of staff. Angus carers have been concerned about their experiences of regular staff changes within teams.

- Concerns over a potentially increased number of unwell patients remaining in the local community, who would not wish to be treated via Perth or Dundee, due to difficulties for family members not being able to visit regularly and provide support to them.

- Angus carers have the same concerns as those in Perth & Kinross, in regards to the number of beds which will be available. This is already beginning to cause anxiety for carers loved ones', who are worrying about what might happen should an inpatient admission be required.

- Carers have expressed concern about the impact on a loved ones' recovery – family support is a significant factor in this, which may be greatly affected if extra time and distance are needed for visiting and giving support during inpatient admissions. Carer interaction with key members of staff involved in their loved ones' care would also be impacted if visits were reduced.

Summary

Angus carers feel very anxious that this change will have a significant negative impact on the patients and their carers due to:

- Lack of continuity of local staff
- Less focus on local rehabilitation and recovery
- Reduction in the number of beds available
- Increased distance to travel with huge impact on carers' time, resources and stress - particularly those with other caring responsibilities including childcare
- The specific issues faced by Mental Health Carers such as patients being unwilling to attend, or unwilling to have visits; additional stress

Carers ask for consideration to be given to these important issues they will face due to losing local facilities.

Georgie Evans
Support in Mind Scotland
Angus Carers' Support Worker

1.25 **E-mail from Positive Steps request information re options and response sent.**

I read the December Newsletter today updating the process to date. I went back to the indicated Board papers but neither there nor in the outline of each option could I find any information on the effect of the proposals on the number or availability of acute beds across the region. Could you please direct me to where I might find this information.

Many Thanks.

Kind Regards,

Richard

Richard Howat

Dear Richard

I have summarised the acute bed numbers for you below.

Current General Adult Psychiatry Inpatient beds are provided as follows:

Angus - Mulberry ward 25 beds
Perth - Moredun ward 26 beds
Dundee - Carseview Ward one and Carseview Decant ward have 40 beds plus 4 Advanced intervention service beds
IPCU - 10 beds for Tayside in Carseview Dundee
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards

Option 3A

Tayside - Carseview Ward One and Carseview Decant ward have 40 beds plus 4 Advanced intervention service beds plus the new two x 22 bed wards = 88 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Option 4A

Perth and Dundee - Carseview Ward one and decant ward 40 beds plus 4 Advanced intervention service beds plus one new x 22 bed wards = 66 beds
Angus - Mulberry ward 25 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity

Option 5A

Angus and Dundee - Carseview Ward one and decant ward 40 beds plus 4 Advanced intervention service beds plus one new x 22 bed wards = 66 beds
Perth - Moredun ward 26 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Option 8

Dundee - One acute admission ward 18 to 22 beds for Tayside plus 4 Advanced Intervention Service beds
Angus - Mulberry ward 20 to 25 beds for step down/treatment
Perth - Moredun ward 26 beds for step down/treatment
Dundee - Carseview 22 beds for step down/treatment
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Each option being considered will require reinvestment in community services to support the inpatient bed model and this is being captured as part of the examination and analysis of each option to allow identification of a preferred option.

Hope this is helpful and please let me know if have any further queries or require any further detail.

Kindest Regards

Lynne Hamilton

Mental Health Programme Director and Finance Manager

1.26 Angus press enquiry re delay in decision on the future of Mulberry Unit

From: Amanda Cameron [mailto:amanda.cameron@jpress.co.uk]
Sent: 24 April 2017 12:49
To: TAYSIDE, Communications (NHS TAYSIDE)
Subject: Mulberry Unit

Good afternoon,

We've have been contacted by Councillor David May from Angus and Mike Rumbles MSP with regard to the decision on the future of the Mulberry Unit.

In their correspondence they have said that they have "criticised the delay of a decision on the future of the Mulberry Unit".

Mr May has said: "It is appalling that this decision has been delayed yet again. I suspect that this is political judgement rather than being in the best interest of patients, their families and the units staff. It has long been suspected that the direction of travel is towards the closure of this unit and it's about time that local people were given some clarity."

Would it be possible to get a comment from the NHS with regard to this matter.

Thanks

Amanda

-- Amanda Cameron
Multimedia reporter
Angus South
Twitter: @acp_amanda
Direct Dial: 01241 435773
VOIP: 6025 5773

1.27 Dundee press enquiry re funding for mental health provision

From: Steven Rae [mailto:srae@dcthomson.co.uk]
Sent: 24 April 2017 13:37
To: TAYSIDE, Communications (NHS TAYSIDE)
Subject: Bi-Polar

Good afternoon,

The co-facilitator of the Dundee Bi-Polar Self Help Group, Eilidh Rankin, has been in touch with us about funding for mental health provisions.

She spoke on the back of the story we had in Friday's paper, about Grant Brady, who claims he was previously "turned away" from Carseview, despite being seriously mentally ill and suicidal.

She said: " "There are definitely issues with mental health provisions in Tayside – and across the UK.

“The users of our group have essentially doubled since we started in September, and that’s for bi-polar people. There are a whole range of mental health problems that people suffer from.

“The most we have had is 20 attend a session, and I wouldn’t be surprised if that number continues to go up.

“As for people apparently being “turned away” from places like Carseview – I am quite shocked.

“Although I can’t go into details, we have had people who come to our group and others across Scotland who have felt they are at a point in their lives where it could be them who are in the situation when they really need that kind of help, it could be a life or death situation, the awful mental state they can be in. But coming to our group and others can really help that.

“The NHS is under so much pressure and mental health service are always being cut. It’s the “Cinderella of the NHS” – poor and underfunded.

“There have been cuts made so far and it will only worsen and already bad situation, I think.

“It’s not surprising that facilities like Carseview and elsewhere are struggling.

“Services have been badly underfunded for a long time and there doesn’t seem to be many people sticking up for increased funding.

“Mental health problems are often an unseen illness, so because you can’t see it, it’s easier to cut. But there is a funding crisis in the NHS.”

- What does NHS Tayside make of Ms Rankin’s claim that mental health provisions are “the Cinderella of the NHS”?
- Is there a funding crisis in NHS Tayside when it comes to mental health provisions, if so, how will that be remedied?
- Any other comment to make?

Could someone get back to me by the end of today?

Thanks

Steven

Steven Rae

Senior Reporter

Evening Telegraph

D C Thomson & Co Ltd
2 Albert Square

Dundee

DD1 1DD

t **01382 575 513**

m **07739778250**

srae@dcthomson.co.uk
www.thetele.co.uk

Appendix Four

Detailed Option Appraisal Report and Appendices

`

NHS Tayside Board
August 2016

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

1. PURPOSE OF THE REPORT

The purpose of the report is to inform NHS Tayside Board of the Option Appraisal process undertaken to identify the preferred options for the redesign of Adult Mental Health Inpatient Services and Learning Disability Inpatient Services being considered through the Mental Health Service Redesign Transformation Programme (formerly the Steps to Better Healthcare Mental Health Improvement Programme). The strategic aims and operational intent of the Programme are described in the NHS Tayside Mental Health Clinical Services Strategy.

2. BACKGROUND

Following the presentation of a paper and proposal to the NHS Tayside Board in March 2016, the Board requested that further work was undertaken to inform and enable Board members to make an informed decision on proposals for the redesign of inpatient adult mental health services. Members specifically asked for assurance that there was wider engagement with stakeholders, in particular service users and carers, in the process to identify options for the reconfiguration of inpatient services. Although in March, proposed options for Learning Disability inpatient services were not presented to the Board as further engagement work was planned, Learning Disability Services are included in the scope of the Mental Health Service Redesign Transformation Programme (MHSRTP) and are included in the attached Options Appraisal report.

3. ASSESSMENT

The attached paper describes the process that has been undertaken to identify and present options for the reconfiguration of adult inpatient services to be provided from either a single site or two sites in Tayside and options for the future configuration of learning disability inpatient services. As the paper describes, the two options that scored highest from the two workshops that were held to facilitate the process, still have services for adult mental health being provided from three sites across Tayside, albeit the acute admissions wards are either on a single site or two sites; in addition the difference in scoring between the top four options was marginal; therefore the top four scored options have been presented in the paper to ensure the scope requested for a single site or two sites for adult inpatient services are

presented. Board members are directed to the attached paper for the detailed description, content and outcome of the Option Appraisal and the associated appendices.

In the absence of National guidance for joint service planning across NHS Boards and Health and Social Care Integration Joint Boards, the updated Scottish Capital Investment Manual Guidance (2015) has been followed to establish the stages to be followed for service changes such as those being considered under this programme of work. In addition, guidance has been sought from Yvonne Summers of Scottish Government to ensure clarity of the expected process. The content and detail of the attached Option Appraisal report was noted by Ms Summers to be of an extremely high standard.

Ms Summers recommended that the next stages to be followed are:

- An Initial Agreement to be developed articulating the case for change and intent of the service change with each of the options further developed with the necessary clinical, workforce and financial information to identify which of the four options is the most feasible / deliverable option that will achieve the aims of the Service Redesign Transformation Programme. This stage should be reached through engagement and discussion with each of the Strategic Planning Groups in the Integration Joint Partnerships; the Area Clinical Forum; the Finance and Resource Committee; the Integration Joint Boards; the Area Partnership Forum; It will be necessary to also convene an extraordinary meeting of the Capital Scrutiny Group sometime in November as the meeting scheduled for September 2016 is too soon in the timeline for the necessary information to be gathered; and presentation to NHS Tayside Board December 2016
- Presentation of the Initial Agreement to the Capital Investment Group at Scottish Government in December 2016.
- Once agreement is reached on a single option through the process described above, there should be a period of three months consultation on that option to ensure all implications of the option have been identified and considered.
- The consultation can run in parallel with the development of the Outline Business Case. The Outline Business case will include detailed design of the environments and the feedback from the consultation process, in addition to the information collated earlier for the Initial Agreement. This will enable the NHS and Integration Joint Boards to make a final decision on the service redesign.
- The Outline Business Case will then be presented before the Scottish Government Capital Investment Group in late spring or early summer 2017.
- If approved, this will be followed by the development of a Full Business Case.

Decision making in respect of the programme proposals at the Outline Business Case stage is not clear cut as the proposed services changes affect accountabilities of both NHS Tayside and the Integration Joint Boards i.e. the adult and learning disability inpatient services are hosted by Perth and Kinross Integration Joint Board / Partnership and associated community services are operationally delegated to the responsibility and accountability of the respective Integration Joint Boards in each locality, whilst forensic mental health secure care services are not part of the delegated arrangements, and the buildings from which the services are provided remain the property of NHS Tayside. Clarity on the decision making process will be requested from NHS Tayside Board in partnership with each of the Integration Joint Boards.

Responsibility for the delivery of the Mental Health Service Redesign Transformation Programme will be passed to the leadership of the Chief Officer for Perth and Kinross. In agreement with the Chief Officer of Perth and Kinross Integration Joint Board it is therefore proposed that the reporting and governance for the programme should be held through the Perth & Kinross Transformation Programme Board, with duplicate reporting to the NHS

Tayside Transformation Board in respect of assurance of the strategic intent of the redesign programme to shift the balance of care through reinvestment of resources into community models of care and potential capital receipt and site savings that will be released if Learning Disability services are relocated from the Strathmartine Hospital site.

4. RECOMMENDATIONS

NHS Tayside Board is asked to:

1. Confirm they are satisfied with the attached report and the process followed to identify the preferred options for future inpatient service provision and in particular wider engagement of stakeholders in the process has been satisfactory.

2. Note the report on the Option Appraisal attached and approve that the Programme should be progressed in the stages outlined as advised above.

3. Consider the proposal for reporting and governance for the Mental Health Service Redesign Transformation Programme through Perth & Kinross Transformation Programme and Integrated Joint Board with duplicate reporting and assurance to the NHS Tayside Transformation Board.

4. REPORT SIGN OFF

Ms Lynne Hamilton
Mental Health Programme Director and Finance Manager

Dr Karen Ozden
Director Mental Health Regional Services / Associate Nurse Director

Dr Neil Prentice
Associate Medical Director Mental Health & Learning Disability

9th August 2016

16.08.15 MHSRT Programme Board Pap

Appendices available on webpage

Mental Health Service Redesign Transformation Programme

Option Appraisal Report

Document Control Information	
Control Status	Draft
Date Last Printed	19/07/2016
Version Number	Draft 1 – Pre Agenda
Author(s)	L Hamilton, NHS Tayside K. Ozden, NHS Tayside N Prentice, NHS Tayside

Table of Contents

Appendices to report (attached as separate report) –

Introduction and Background

The Mental Health Services Clinical Services Strategic Framework, approved and endorsed by NHS Tayside Board in December 2015, reflects the strategic intent of both the NHS Tayside Clinical Services Strategy[1] and the National Clinical Services Strategy[2]. The Framework builds on a 12 year narrative and vision for adult mental health services across Tayside and further chimes with the Scottish Government's 2020 Vision[3] The Option Appraisal is a further step towards this strategic vision and in ensuring sustainable, high quality safe, effective care and treatment whilst making best use of resources and the skilled workforce.

Although the Optional Appraisal has largely focussed on inpatient service provision for adult mental health and learning disability, the effectiveness of clinical services is dependent on a number of factors, not least approaches and interventions aimed at effective prevention; support for recovery; timely return to living at home following hospital treatment, social inclusion and access to a range of supports in the wider community that maintain and promote health and well being. Furthermore, effective treatment and recovery from mental ill health and optimum functioning and quality of life for people with learning disability is not solely determined by clinical interventions. The supports and opportunities required for people to gain and sustain mental well being and be enabled to live fulfilling lives, lie within their local communities and with other services and organisations. In order that people can access and benefit from these assets and services care and treatment needs to be delivered as part of collaboration between agencies and individuals including primary care, social work services, housing services, voluntary organisations, the independent sector and local communities. The establishment of health and social care partnerships should make such partnership working and access to such services easier.

The current configuration of clinical inpatient services is not sustainable and is introducing risks to the provision of safe care as a consequence of significant workforce challenges. The model of adult inpatient care is resource intensive and inhibits the ability to further develop and progress towards this 'whole system' strategic vision. The current model for Learning Disability services does not best support person centred care, rehabilitation and enablement and the quality of the

[1] NHS Tayside (2015). NHS Tayside Clinical Services Strategy. Reshaping Clinical Services for the Future
[2] Scottish Government (2016) A National Clinical Strategy for Scotland
[3] Scottish Government (2011) The Scottish Government's 2020 Vision.

environments that services are provided from are not of a good standard or design for the needs of the patient population.

The Option Appraisal is an aspect of the programme of work that has progressed to date under the umbrella of the Steps to Better Healthcare Mental Health Improvement Programme (SBHMHIP). This will now be renamed the Mental Health Service Redesign Transformation Programme (MHSRTP). The programme has primarily considered improved clinical pathways and a review the inpatient estate/ accommodation from where services are delivered to identify opportunities to optimise patient pathways and make more efficient use of resources.

An initial option appraisal was undertaken in 2014/15 to review future inpatient provision and consider the sustainability of services; this informed a report presented to NHS Tayside Board on 10th March 2016. At this meeting, the Board approved in principle the proposal to have general adult psychiatry inpatient services delivered from two sites in Tayside instead of three sites, as they are currently. The NHS Board also requested that further work was undertaken to consider services being delivered from one single site in Tayside. The Board also requested that in addition to consideration of the number of sites and their location, the proposals would also need to outline any additional requirements to strengthen community models of care and treatment. These should be aimed at enabling people to receive appropriate care and treatment at home and in their local communities in line with national and local strategies and visions. This would be funded through reinvestment and realignment of existing resources.

The Programme team provided a further update to the NHS Tayside Board in April 2016 to share plans for a further option appraisal exercise, describing the approach to be taken to ensure full stakeholder engagement in the process.

Purpose of the Report

This report describes the methodology and results of the option appraisal process undertaken at Invercarse Hotel in Dundee from 10.00am to 4.00pm on 20th June 2016 and at The Steeple, in Dundee from 9.30am to 4.00pm on the 30th June 2016. The Options Appraisal Report will be followed by more detailed clinical, financial and workforce information being collated and presented in an Initial Agreement report which will include a risk assessment to enable a decision to be made on a single preferred option for both Mental Health and Learning Disability services.

Option Appraisal

The purpose of the option appraisal workshops was to evaluate and compare the benefits of inpatient bed models and their locations for NHS Tayside Adult Mental Health and Learning Disability services with a range of service configurations across Dundee, Angus and Perth and Kinross sites considered as part of the appraisal process.

To ensure wide representation from partner Integrated Joint Board areas and community organisations, health and social care Partnership Chief Officers were asked to provide nominations for attendance at the proposed workshops. The Scottish Health Care guidance for options appraisal was followed, which recommends a proportionate split of representation of one third clinical staff, one third service administration staff and one third of representation from service users, carers, and voluntary organisation/ third sector personnel.

The methods used for this process were similar to that used in previous option appraisals facilitated by NHS Tayside, and was guided by Scottish Capital Investment Manual and Scottish Health Council Guidance. This option appraisal forms part of a much larger decision-making process which includes assessment of financial, architectural, planning and risk management implications of the models and site / service options under consideration.

Each of the three geographical areas in Tayside through the new Integrated Joint Board partnership structures has outlined local strategic objectives for people with mental health problems. These objectives aim to promote mental well-being, prevent mental illness, secure a comprehensive and integrated range of services designed to promote independent living, as far as possible, with the fullest of integration into the community without unacceptable risks to patient, carers or society.

These aims were considered alongside the National Clinical Strategy, NHS Tayside Mental Health Clinical Services Strategic Framework and National Mental Health Strategies when agreeing the objectives of the programme and the benefit criteria which was used to score the site options for these services.

Option Appraisal Training

To assist stakeholders in being able to fully participate in the Option Appraisal exercise a half day training session was provided at Kings Cross Hospital in Dundee on the 16th June 2016. The training session was facilitated by NHS Tayside Associate Director of Improvement and included a presentation from the Scottish Health Council who opened the session by setting the context of their role, background to CEL 04 and providing an overview of the engagement process. Presentations used during the training session are attached as Appendix One.

The training session was attended by 35 stakeholders and attendees were asked to provide feedback on the training session to gauge their satisfaction with the training (details of attendees are provided in Appendix Two; feedback forms and responses are attached in Appendix Three).

Stakeholder Participation

Over 150 stakeholder nominations were received for the workshops and 110 representatives confirmed attendance. Of the 110 confirmed attendees 93 were to participate in the scoring exercise (the remainder of people were in attendance to support facilitation, give presentations, organisation of the events, facilitate table top discussions, and to provide supporting information as needed). Of the 93 participating attendees, there was an equal spread of 31 attendees (one third) in each category i.e. 31 service user, carer, voluntary organisations and third sector representatives / 31 clinical service representatives / 31 service administration, management, other partner agencies representatives.

However, only 85 of the confirmed 110 representatives attended on 20th June and 74 of the 93 confirmed representatives attended on 30th June (the full list of nominations and participants who were invited and those who actually attended are detailed in Appendix Four).

The 74 participants who undertook the scoring at the second workshop is detailed below:

SCORING PARTICIPANTS	**CONFIRMED ATTENDANCE**	**% SPLIT**	**ACTUAL ATTENDANCE**	**% SPLIT**
SERVICE USERS, CARERS & VOL ORGS	31	**33.33**	18	**24.32**
CLINICAL STAFF	36	**38.71**	36	**48.65**
ADMIN/SUPPORT/OTHER STAFF	26	**27.96**	20	**27.03**
TOTAL	93	**100**	74	**100**

Outline of workshop Session One held on 20th June 2016

The workshop was attended by 85 representatives from across all three geographic areas; Angus, Dundee and Perth and Kinross.

Both workshop events on the 20th and 30th June were externally facilitated by Pennie Taylor (Freelance Journalist and Broadcaster who specialises in Health and Care issues) and supported by Lynne Hamilton, Mental Health Programme Director & Finance Manager and Tracey Williams Associate Director of Improvement (the workshop Programmes for both dates are attached at Appendix Five).

Each of the ten tables of participants had a nominated lead facilitator, briefed to ensure the correct process was followed to achieve outcomes at each table and to help facilitate discussions and provide any supporting information required.

During the morning session presentations were given to participants to detail the background to the workshops, the reasons for review of the services, key drivers for change and the current issues being faced by NHS Tayside in provision of safe and effective services currently and challenges to future sustainability.

Dr Karen Ozden presented information regarding current and future nursing workforce challenges, Dr Neil Prentice provided an overview of Senior Medical staffing issues and Dr Stuart Doig described Junior Medical rota compliance issues and difficulties in sustaining training across the current number of sites. Supporting information was then presented by Neil Fraser who highlighted national benchmarking information describing where NHS Tayside Mental Health services sit when compared with other Board areas, and Lynne Hamilton set out the context of the programme in terms of the overall NHS Tayside financial position and the current estate / environments services are provided from.

Option Appraisal Objectives

Following the morning presentations, participants were provided with a list of eleven draft objectives to describe what future Mental Health and Learning Disability services must provide. Each table were asked to consider, review and agree objectives and feedback to room.

The four key objectives agreed from participant's feedback were:

1. Our care and support, wherever it takes place, will offer safe, person-centred, effective, equitable access to timely, evidence-based interventions and preventative approaches

2. We will focus on developing and investing in more community-based mental health and wellbeing services and more holistic approaches looking at a person's complete needs jointly with our local health and social care partnerships and other service delivery partners

3. We will look to develop and sustain a workforce for the future by ensuring Tayside is an attractive place to work, where staff can feel valued and supported and workforce models are modern and innovative

4. Our treatment and preventative approaches will be delivered safely in the right place, at the right time, by the right person with the right knowledge and skills

These objectives were then reviewed to ensure harmony with the key ambitions of the 2020 Vision which states:

> *"Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.*
>
> *There will be a focus on ensuring that people get back to their home or community environment as soon as appropriate, with minimal risk of re-admission".* The 2020 Vision. Scottish Government 2010

These agreed objectives are also in line with the Healthcare Quality Strategy for Scotland which identifies the 6 Dimensions of Healthcare Quality as:

1. Person-centred
2. Safe
3. Effective
4. Efficient
5. Equitable
6. Timely

These objectives were used to support the production and agreement of the Benefit Criteria used to score the options at the workshop on the 30th June 2016.

Long List of Options

The remainder of the morning session focussed on the development of the long list of options. Participants were provided with a number of draft 'bed model' options describing current inpatient service configurations and examples of alternative two site and one site inpatient service configurations (attached as Appendix Six). Bed index and descriptor cards were also provided to help describe the current inpatient bed provision across Tayside and the service functions (attached as Appendix Seven). Participants were asked at their tables to review each potential option and provide comment/feedback. Each table were also provided with blank bed model templates and coloured pencils to design additional service configuration models. Participants were asked to be as creative and as thoughtful as possible and consider all possible options they wished considered on the long list.

Tables initially struggled with this session as participants had a tendency to immediately review each option with a view to shortlisting (feedback from the tables is provided in Appendix Eight). Participants at three different tables described a similar additional option during the feedback session which was then added to the long list of options for consideration.

Table One below describes the long list of options as depicted in the bed maps in Appendix Six.

Table One - Long List of Options

Option 1	Do Nothing	• Current provision of General Adult Psychiatry (GAP) acute admission wards at Murray Royal Hospital, Susan Carnegie Centre Angus and Carseview Centre Dundee. • IPCU (Tayside wide) at Carseview Centre Dundee • Male and female complex care and rehabilitation (Tayside wide) at Murray Royal Hospital. • Learning Disability services (Tayside wide) provided from Strathmartine Hospital and Carseview Centre Dundee • One empty ward at Carseview.
Option 1A	Single Site Option	• All GAP acute admissions beds at Murray Royal Hospital site (building expansion required) • Female complex care (Tayside wide) and IPCU (Tayside wide) relocation to current Low secure ward in Rohallion, Murray Royal Hospital (MRH). • Relocation of rehabilitation and complex care male bed provision (Tayside wide) to Susan Carnegie Centre. • Learning Disability services relocated from Strathmartine Hospital to Carseview Centre: locked Forensic LD ward in vacated IPCU ward • Combined LD Assessment Unit/Behavioural Support and Intervention /Open Forensic ward in current LDAU

		on Carseview site. • Three empty wards at Carseview Centre.
Option 1B	Single Site Option	• Single site provision for GAP acute admissions all at Murray Royal site (building expansion required) • Female complex care (Tayside wide) and IPCU (Tayside wide) relocation to Low secure ward in Rohallion, MRH. • Relocation of rehabilitation and complex care male bed provision (Tayside wide) to Susan Carnegie Centre. • All five wards empty at Carseview. • All Learning Disability services provided from Strathmartine site (major refurbishment required).
Option 2A	Single Site Option	• Single site provision for GAP acute admissions all at Susan Carnegie Centre site (building expansion required). • Male and Female complex care and rehabilitation at Murray Royal and • IPCU relocated to Low secure ward in Rohallion, MRH. • Learning Disability services relocate from Strathmartine: locked Forensic LD ward in current IPCU ward; combined LDAU/BSI/Open Forensic ward in current LDAU ward on Carseview site. • Empty ward on MRH site. • Three empty wards at Carseview.
Option 2B	Single Site Option	• Single site provision for GAP acute admissions all at Susan Carnegie site (new build required). • Male and Female complex care and rehabilitation at MRH • IPCU relocation to Low secure ward in Rohallion, MRH. • All Learning Disability services provided from Strathmartine site (major refurbishment required). • Empty ward on MRH site. • All five wards empty at Carseview Centre.
Option 3A	Single Site Option	• Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH • All other LD services relocated from Carseview Centre and Strathmartine to a combined LDAU/BSI/Open Forensic ward in vacated ward on MRH site. • Empty ward on Susan Carnegie site.
Option 3B	Single site Option	• Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • Male and Female complex care and rehabilitation

		remain at Murray Royal • IPCU remains at Carseview Centre. • All LD services provided from Strathmartine site (major refurbishment required). • Empty ward on Susan Carnegie site. • Empty ward at Low Secure Rohallion, MRH. • Empty ward on MRH site.
Option 3C	Single site Option	• Single site provision for GAP acute admissions all at Carseview Centre site (major refurbishment required). • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Carseview and Strathmartine to a combined LDAU/BSI/Open Forensic ward in vacated ward on Susan Carnegie site. • Empty ward on MRH site.
Option	Single site Option	• Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • Male and Female complex care and rehabilitation remain at Murray Royal • IPCU remains at Carseview Centre. • All LD services provided from Strathmartine site from a new build. • Empty ward on Susan Carnegie site. • Empty ward at Low Secure Rohallion, MRH. • Empty ward on MRH site.
Option 4A	Two Site Option	• GAP acute admissions at Carseview Centre site (major refurbishment required) and Susan Carnegie site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward in current LDAU on Carseview site. • Empty ward on Murray Royal site.
Option 4B	Two Site Option	• Two site provision for GAP acute admissions at Carseview Centre site (major refurbishment required) and Susan Carnegie site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH

		• All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward on MRH site. • Empty ward on Carseview site.
Option 5A	Two Site Option	• GAP acute admissions at Carseview site (major refurbishment required) and MRH site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward on Carseview Centre site. • Empty ward on Susan Carnegie site.
Option 5B	Two Site Option	• GAP acute admissions at Carseview site (major refurbishment required) and MRH site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • All LD services provided from Strathmartine site (major refurbishment required) • Empty ward on Susan Carnegie site. • Empty ward at Low Secure, Rohallion, MRH site. • Empty ward on Carseview Centre site.
Option 6A	Two Site Option	• GAP acute admissions at Susan Carnegie and MRH (requires new building extension on each site). • Male and Female complex care and rehabilitation remain at MRH • Relocation of IPCU to Low Secure ward at Rohallion. • All LD services provided from Strathmartine site (major refurbishment required) • All five wards empty on Carseview Centre site.
Option 6B	Two Site Option	• GAP acute admissions at Susan Carnegie and MRH sites (requires two new building extensions at Susan Carnegie site). • Male and Female complex care and rehabilitation remain at MRH • Relocation of IPCU to Low Secure ward at Rohallion, MRH. Learning Disability services relocate from Strathmartine to provide locked Forensic LD ward in vacated IPCU ward and combined LDAU/BSI/Open Forensic ward in current LDAU on Carseview site. • Three wards empty on Carseview Centre site
Option 7	Two Site Option	• GAP acute admissions at Susan Carnegie and MRH sites (requires two new building extensions at Susan Carnegie site). • Male and Female complex care and rehabilitation

		remain at MRH • Relocation of IPCU to Low Secure ward at Rohallion, MRH All LD services provided from Strathmartine site (new build required). • All five wards empty on Carseview Centre site.
Option 8	Additional option from event – Single GAP acute admission, three site GAP step down and two site LD option	• Single site acute admission at Carseview Centre site, • Three acute 'step down' wards provided one each from Carseview Centre, MRH and Susan Carnegie sites. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • Remaining LD services relocate to two wards on Carseview site to provide combined LDAU/BSI ward and an open Forensic ward.

Feedback discussed the requirement for further detailed analysis of the community and day services which would be required to support each model.

Short List of Options

The afternoon session on the 20th June 2016 asked the tables to review the long list of options using a set of parameters and information provided to determine the short list of options for consideration and scoring (the list of parameters is provided in Appendix Eight and the feedback from the short listing process is included as Appendix Nine). During the workshop consideration was given as to whether or not an additional day would be required to give people more time to complete the process. There were requests for additional historical data to be provided and information about community service infrastructures to support each of the options. Following discussion with participants it was agreed the process to short list options could be completed as planned and additional data would be circulated prior to scoring of the options at the workshop scheduled for 30th June 2016. The information was available as requested thereafter.

Table Two below shows the seven options which were short listed for scoring.

Table Two – Short List Options

Option 1	Do Nothing	• Current provision of General Adult Psychiatry (GAP) acute admission wards at Murray Royal Hospital, Susan Carnegie Centre Angus and Carseview Centre Dundee. • IPCU (Tayside wide) at Carseview Centre Dundee • Male and female complex care and rehabilitation

		(Tayside wide) at Murray Royal Hospital. • Learning Disability services (Tayside wide) provided from Strathmartine Hospital and Carseview Centre Dundee • One empty ward at Carseview.
Option 3A	Single Site Option	• Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH • All other LD services relocated from Carseview Centre and Strathmartine to a combined LDAU/BSI/Open Forensic ward in vacated ward on MRH site. • Empty ward on Susan Carnegie site.
Option 3B	Single site Option	• Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • Male and Female complex care and rehabilitation remain at Murray Royal • IPCU remains at Carseview Centre. • All LD services provided from Strathmartine site (major refurbishment required). • Empty ward on Susan Carnegie site. • Empty ward at Low Secure Rohallion, MRH. • Empty ward on MRH site.
Option 4A	Two Site Option	• GAP acute admissions at Carseview Centre site (major refurbishment required) and Susan Carnegie site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward in current LDAU on Carseview site. • Empty ward on Murray Royal site.
Option 5A	Two Site Option	• GAP acute admissions at Carseview site (major refurbishment required) and MRH site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • Locked Forensic LD services relocate from

		Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward on Carseview Centre site. • Empty ward on Susan Carnegie site.
Option 5B	Two Site Option	• GAP acute admissions at Carseview site (major refurbishment required) and MRH site. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview Centre. • All LD services provided from Strathmartine site (major refurbishment required) • Empty ward on Susan Carnegie site. • Empty ward at Low Secure, Rohallion, MRH site. • Empty ward on Carseview Centre site.
Option 8	Additional option from event – Single GAP acute admission, three site GAP step down and two site LD option	• Single site acute admission at Carseview Centre site, • Three acute 'step down' wards provided one each from Carseview Centre, MRH and Susan Carnegie sites. • Male and Female complex care and rehabilitation remain at MRH • IPCU remains at Carseview. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • Remaining LD services relocate to two wards on Carseview site to provide combined LDAU/BSI ward and an open Forensic ward.

Outline of the workshop session on 30th June 2016

Information requested from the workshop on the 20th June was circulated to participants in advance of the second workshop and supporting data requested was also made available in the room on the day (the supporting information that was provided is noted in Appendix Ten)

The workshop was attended by 85 representatives from across all three geographic areas; Angus, Dundee and Perth and Kinross.

The second workshop event on 30th June was opened by external facilitator Pennie Taylor with a recap of the issues facing current services, information shared at the event on 20th June 2016 with an overview of the option appraisal process from Lynne Hamilton and Tracey Williams.

During the morning session short presentations were given to participants to provide further detail of the seven shortlisted options by lead clinicians and discussion was supported to ensure a shared understanding of each option being considered.

Each table was provided with the bed models, bed index and cards, geographical information on maps of Tayside highlighting the populations in main towns and locations, a detailed breakdown of public transport times and mileage distances between all sites and towns across Tayside (attached as Appendix Eleven), the parameters provided previously and the agreed objectives from the initial workshop.

Benefits Appraisal

A key component of any formal option appraisal is the assessment of the non financial benefits that are likely to accrue from the options under consideration. The Programme team elected to carry out the benefits appraisal in an open and transparent environment, inviting the full range of stakeholder to participate in this part of the process. A draft set of benefit criteria was shared with participants to develop and agree during the exercise. The benefits appraisal had three main stages:

1. Define and agree the benefits criteria
2. Weighting of the benefits criteria
3. Scoring of the short listed options against the benefits criteria

Defining the benefit criteria

The mid morning session of the workshop was dedicated to defining the options benefits criteria and then the assigning of weights to these criteria to allow progression to score the shortlisted options in the afternoon session.

Draft benefits criteria were provided and participants were asked to define the attributes which would have a significant impact on the quality and effectiveness of future services. Each table was asked to think about what they felt were the most important criterion and then feedback was discussed in the room. Following discussion and feedback the draft list was amended to an agreed set of benefit criteria as outlined in Table Three below which included one additional criterion added as Criteria 6.

Table Three – Agreed Benefits Criteria

1	Supports safe, effective and person-centred care
2	Improved care and treatment across hospital and community mental health services with a focus on prevention of admission and timely supported discharge
3	Ensures equity of access to services across Tayside
4	Supports effective and sustainable deployment of staff across Tayside
5	Makes best use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities.

6	Emphasis on maintaining effective recovery through close relationships with family, carers and supporting community groups and organisations that compliment NHS services.

Weighting of the Benefits Criteria

Each table reviewed the agreed benefits criteria and each participant was asked to complete an individual weighting sheet which provided their individual ranking and weighting applied to the criteria, to a total of 100 points.

Each table then collated the individual scores as a table total which were averaged and input during the lunch break to arrive at agreed criteria weightings as per Table Four below (individual scoring sheets and table totals are detailed in Appendix Thirteen). Further analysis of the scoring has looked at applying forms of sensitivity analysis around weightings which are reflected in Appendix Fourteen.

Table Four – Agreed Benefit Criteria Weightings

Criteria	Description	Weighting	Rank
1	Supports safe, effective and person-centred care	23	1
2	Improved care and treatment across hospital and community mental health services with focus on prevention of admission and timely supported discharge	21	2
3	Ensures equity of access to services across Tayside	15	4
4	Supports effective and sustainable deployment of staff across Tayside	13	5
5	Makes best use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities.	13	5
6	Emphasis on maintaining effective recovery through close relationships with family, carers and supporting community groups and organisations that compliment NHS service.	16	3

Criteria One – Supports safe, effective and person centred care was considered the most important factor and allocated the highest ranking.

Scoring the Short Listed Options

Using the agreed benefits criteria and above weightings, participants were asked to score each of the options against these criterions. Participants were asked to re consider each service configuration option in line with objectives, parameters, supporting information, transport information, population demographics and the agreed criteria.

Each participant was asked to complete an individual scoring sheet and allocate each option a score from 0 to 10 against each of the benefits criterion. These scores were then totalled and multiplied against the allocated weightings. Calculations were done on the day and the total of these weighted scores then provided each option with a total score which was fed back at the workshop. Recognising that this initial calculation was completed under a time pressure and was based on the scores calculated by each table, the scoring was checked again for accuracy after the workshop. This did identify there had been some error on the day with the calculations that were fed back, however the top four options remain the same but there was a changed order for second and third place and now includes a fourth option. Differences in scores were marginal and the inclusion of the fourth option ensures both 2 site and 1 site options are considered in keeping with the original scope set by NHS Tayside Board.

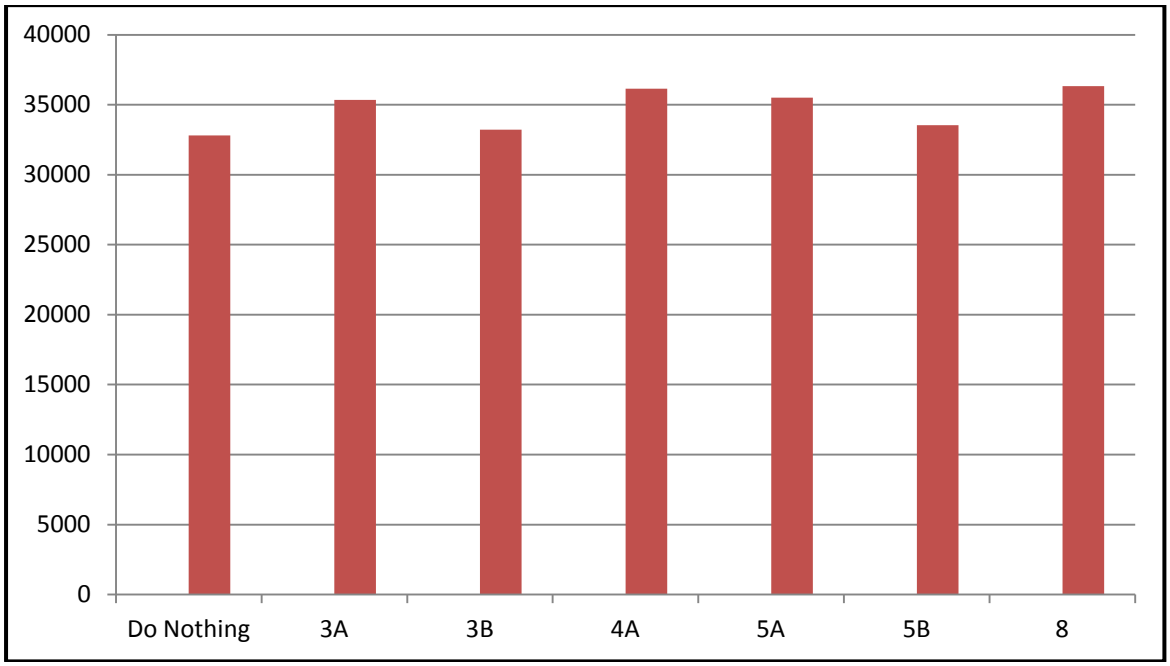
Each table engaged in good discussion and all individuals participating managed to agree scores against each criterion (detailed individual scoring sheets are provided in appendix Thirteen) Individuals were also asked to mark on the sheet which stakeholder group they were representing to allow further analysis of responses. Sensitivity analysis of scoring is provided in Appendix Fourteen.

As the scoring results in Table Five below demonstrate four options scored extremely closely and therefore will be subject to further clinical appraisal, workforce review and financial appraisal of benefits.

Table Five – Scoring of Short List option results

Option	Score	Rank
1	32811	7
3A	35349	4

3B	33223	6
4A	36146	2
5A	35496	3
5B	33528	5
8	36337	1



Option 8 which was the new model proposed at the workshops scored highest. The chart above demonstrates the proximity of the scores. Having reviewed each of the individual scoring sheets, generally the majority of participants adopted a similar approach to how they allocated the scores. This gives an indication that the general understanding of what each option would deliver was understood by participants.

Please note; due to the scoring system used to capture this information, it was found to be very subjective dependant on how strongly each individual felt about the specific question being posed to them. This threw up many outliers which in turn skewed several of the results up or down. There were a number of scoring sheets which were disproportionately scored. The full spread of tabular scores illustrates this and is provided for background information in Appendix Thirteen

Feedback from event on 30th June and table discussions recorded are attached as Appendix Fifteen.

The Top Four Scored Options

Option 8 Ranked No. 1	**What does this Mean?**
Susan Carnegie Centre • Acute adult 'Step down' / Treatment ward **Carseview Centre** • Acute adult admissions Tayside wide • Acute adult 'Step down' / Treatment ward • IPCU **Murray Royal Hospital** • Acute adult 'Step down' / Treatment ward • Male and Female complex care and rehabilitation Tayside wide **Learning Disability Services** • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • Remaining LD services relocate to two wards on Carseview site to provide combined LDAU/BSI ward and an open Forensic ward.	• Patients from Dundee, Angus and Perth & Kinross admitted to Dundee 24/7 then transferred back to 'step down / treatment wards in each locality • Strathmartine Hospital would close and could be disposed of. • People with LD would be admitted to Carseview Centre (major refurbishment would be required) • Alternative accommodation / workshop provision would need to be found for the Day services currently provided from Strathmartine • LD Low secure patients would be cared for in a much improved environment. • Medical rotas would be needed for all three sites as patients in step down wards would still be acutely unwell. • Doesn't address nursing workforce challenges
Option 4A Ranked No. 2	**What does this Mean?**
Susan Carnegie Centre • Acute adult admissions **Carseview Centre** • Acute adult admissions Dundee, Perth & Kinross • IPCU Tayside wide **Murray Royal Hospital** • Male and Female complex care and rehabilitation Tayside wide **Learning Disability Services** • Locked Forensic LD services relocate from	• Moredun Ward at MRH would be relocated to Carseview site (major refurbishment would be required at Carseview) • People from Perth & Kinross would be admitted to Dundee locality 24/7 • Moredun ward at MRH would be a vacant ward. • Strathmartine Hospital would close and could be disposed of. • People with LD would be admitted to Carseview Centre (major refurbishment would be required) • Alternative accommodation / workshop provision would need to be found for the

Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward in current LDAU on Carseview site.	Day services currently provided from Strathmartine • LD Low secure patients would be cared for in a much improved environment. • Medical rotas OOHs needed for SCC and Carseview sites. Medical cover required for MRH site.
Option 5A Ranked No. 3 **Susan Carnegie Centre** • No adult mental health services provided on site **Carseview Centre** • Acute Adult admissions Dundee and Angus • IPCU Tayside wide **Murray Royal Hospital** • Acute Adult admissions • Male and Female complex care and rehabilitation Tayside wide **Learning Disability Services** • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH. • All other LD services relocated from Strathmartine to a combined LDAU/BSI/Open Forensic ward on Carseview Centre site.	**What does this Mean?** • Mulberry Ward at Susan Carnegie Centre would be relocated to Carseview site (major refurbishment would be required at Carseview) • People from Angus would be admitted to Dundee locality 24/7 • Mulberry ward at Susan Carnegie Centre would be a vacant ward. • Strathmartine Hospital would close and could be disposed of. • People with LD would be admitted to Carseview Centre (major refurbishment would be required) • Alternative accommodation / workshop provision needed for the Day services currently provided from Strathmartine • LD Low secure patients would be cared for in a much improved environment. • Medical rotas OOHs needed for MRH and Carseview sites. • (Issues with MFE and POA Medical Rotas still need addressed and POA wards nursing workforce would need reviewed / enhanced as no other psych service on site)
Option 3A Ranked No. 4 **Susan Carnegie Centre** • No adult mental health services provided on site **Carseview Centre** • All adult acute admissions Tayside wide • IPCU Tayside wide **Murray Royal Hospital** • Male and Female complex care and rehabilitation Tayside wide • All Learning Disability services Tayside wide **Learning Disability Services**	**What does this Mean?** • Single site provision for GAP acute admissions all at Carseview site (major refurbishment required). • All patients from Dundee, Angus and Perth & Kinross would be admitted to Carseview site 24/7 • Pathway between IPCU and Acute admissions on single site • Medical rotas OOHs needed for Carseview site only. Medical cover required for MRH • Empty ward on Susan Carnegie site • Strathmartine Hospital would close and could be disposed of. • People with LD from across Tayside would be

• LD services relocated from Carseview Centre and Strathmartine to a combined LDAU/BSI/Open Forensic ward in vacated ward on MRH site. • Locked Forensic LD services relocate from Strathmartine to Low secure ward in Rohallion, MRH	admitted to MRH • Alternative accommodation / workshop provision needed for the Day services currently provided from Strathmartine • LD patients would be cared for in a much improved environment. • (Issues with MFE and POA Medical Rotas still need addressed and POA wards nursing workforce would need reviewed / enhanced)

Conclusion

Overall the option appraisal generated a successful outcome for the programme. The format of the workshops worked well, generated good discussion and debate amongst the participants whilst maintaining a positive approach to each model option.

The results of the option appraisal exercise will now be used within the production of an Initial Agreement and subsequent Outline Business Case. In conjunction with further detailed work on the financial implications for each of the four options and clinical and risk assessments, this will identify the preferred future service configuration for future Adult Mental Health and Learning Disability services. A critical factor for redesign of the inpatient services will be the models of community services required in each locality. The Strategic Planning Groups in each health and social care partnership will be asked to develop the community service models for clinical and non clinical services that will enable successful redesign of the tier 3 specialist mental health and learning disability inpatient services.

Next Steps

As noted above the Programme team will now engage and work in partnership with the locality strategic planning groups to further develop the detailed models for consideration by the relevant committees, Integrated Joint Boards and NHS Tayside Board before presentation to the Capital Investment Group at Scottish Government to agree the resource required for the preferred option.

The proposed timeline for production of an Initial Agreement document is described in Table Six below. It is highlighted that a period of formal consultation will be required if any of the preferred options are to be considered as this will involve relocation of services and potential closure of the Strathmartine Hospital site and may therefore fall within the realms of major service change.

Table Six – Proposed Timeline for Initial Agreement approval.

Committee	Date
Locality Strategic Planning Groups	Dates to be advised

Area Partnership Forum	24th August 2016
Area Clinical Forum	Date to be advised
Dundee Integrated Joint Board	25th October 2016
Angus Integrated Joint Board	26th October 2016
Perth Integrated Joint Board	4th November 2016
Finance & Resources Committee	17th November 2016
Capital Scrutiny Group	(extraordinary meeting to be convened)
NHS Tayside Board	1st December 2016
SG Capital Investment Group	13th December 16

The timeline for completion of the Outline Business case, following approval of the Initial Agreement, will be provided when 2017 committee dates are available but it is envisaged this could be completed within a three month period post Initial Agreement approval. Timelines for final approval will be dependent upon the dates of relevant committees; a conservative estimate is therefore late spring or early summer 2017.

Mental Health Service Redesign Transformation Programme

Option Appraisal Report

Supporting Appendices

Document Control Information	
Control Status	Draft
Date Last Printed	29/07/2016
Version Number	1.13
Author(s)	K. Ozden, NHS Tayside L Hamilton, NHS Tayside N Prentice, NHS Tayside

Table of Contents –

Appendices to Option Appraisal Report –

Appendix One

Option Appraisal Training Presentations

NHS Tayside- Mental Health Improvement Programme

Option Appraisal briefing

www.scottishhealthcouncil.org

Scottish Government Guidance- CEL 4 (2010)

CEL 4 (2010)

10 February 2010

Dear Colleague

INFORMING, ENGAGING AND CONSULTING PEOPLE IN DEVELOPING HEALTH AND COMMUNITY CARE SERVICES

Purpose

To provide revised guidance – Informing, Engaging and Consulting People in Developing Health and Community Care Services – to assist NHS Boards with their engagement with patients, the public and stakeholders on the delivery of local healthcare services. The principles of the guidance should be applied proportionally, to any service change proposed by a Board, including any changes considered to be major.

Summary

The guidance, which has been prepared by the Scottish Government Health Directorate in consultation with a wide range of stakeholders, supersedes the Scottish Home and Health Department circular ("Closure and Change of Use of Health Service Premises") dated 3 June 1975, the draft interim guidance ("Consultation and Public Involvement in Service Change") issued through an HDL in 2002 (HDL (2002) 42), and the draft guidance ("Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services") issued for comment in 2004.

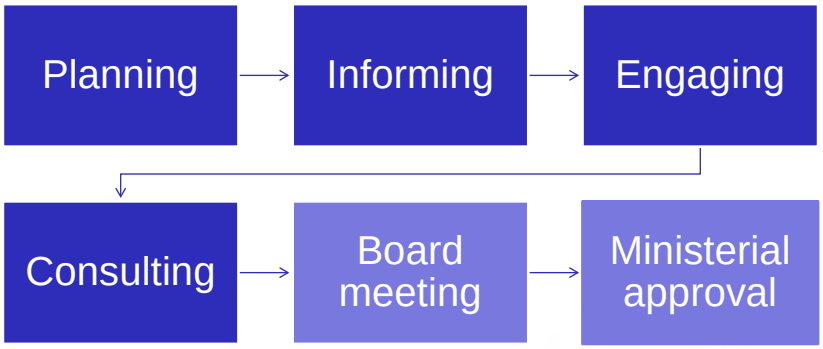
Scope

The guidance:

- Sets out the relevant legislative and policy frameworks for involving the public in the delivery of services;
- Provides a step-by-step guide through the process of informing, engaging and consulting the public in service change proposals;
- Explains the decision making process with regard to major service change and the potential for independent scrutiny; and
- Clarifies the role of the Scottish Health Council.

www.scottishhealthcouncil.org

Key stages in process



Guidance

"The Board should work with local people to develop options which are robust, evidence-based, person centred, sustainable and consistent with clinical standards and national policy. Where this happens, the subsequent consultation process will have greater credibility and authority".

Why involve patients/public in option appraisal?

- tried and tested process
- helps to develop a consensus between participants as to what options are practical
- helps clinicians and staff understand the public view
- more likely that a fair and balanced view will be taken of the potential benefits and disadvantages of options

Important points

- helpful to remember that option appraisal is not a decision but helps to inform the decision making process
- help to develop a shared understanding of the service and the process to be followed, including rights and responsibilities of participants.
- Non- financial appraisal of options

Objectivity

- all participants are expected to score options based on the information and evidence available, and
- not on their own personal preferences, or the preferences of any group(s) to which they may belong.

Sensitivity analysis-

- test how robust the results of the scoring are
- look to see if there have been differing views between the groups that taken part and where there is consensus
- outcome of a weighted scoring process may be considered to be unsound if there is evidence of non-objective strategic scoring by participants.

Other steps in the process

Financial appraisal-

• done separately using a recognised process and information on this should be shared

Equality Impact Assessment-

• consider any positive or negative impacts of the proposals.

Consultation

- on the preferred option(s) is the ***main*** mechanism for obtaining stakeholders' views, however
- genuine consideration should be given to alternative options put forward
- if **major,** then final decision by Cabinet Secretary

www.scottishhealthcouncil.org

“What is Option Appraisal?”

Tracey Williams
Associate Director of Improvement
NHS Tayside

Introduction

- Background to Option Appraisal
- What does it do?
- Who takes part?
- What are the stages of Option Appraisal?

What is Option Appraisal ?

An option appraisal is a process that can be used when looking at different ways to provide health services. This could be when we are considering merging two GP practices, looking at possible locations for a new hospital or clinic, or redesigning services.

It considers the ways in which services could be provided, and scores them against an agreed set of benefits. One of the options always considered is “do nothing”.

Why is Option Appraisal used?

An option appraisal is used to allow a wide number of views to be considered and to create as full a picture as possible of the service.

By enabling people to first look at the benefits they would like to see from the service, it allows each of the options to be assessed by the same criteria. It also means we can more clearly see the reason behind choosing a particular option.

Who takes part?

People who currently use services, have relatives, or care for people, who use services, staff who directly provide services, have links with services, who manage services and who have an interest in services being considered for redesign.

Stages of an Option Appraisal

People involved in ALL stages of the option appraisal

Stage One – Be clear about **WHAT** we are trying to achieve

The first stage in all option appraisals should be to set out exactly what we need to achieve in the project.

Example – Option Appraisal regarding replacement of a hospital canteen

Stage 1: **WHAT** are we trying to achieve:

1. To ensure NHS Board can provide high quality, safe, nutritious and palatable food to service customers on hospital site.

2. Improve the overall satisfaction of patients in respect of the catering service provided.

3. To ensure that any development achieves all legislative, best practice and NHS standards.

4. To ensure any facility created can support potential future catering models and distribution requirements.

5. To provide a staff and visitor retail outlet that meets current customer trends

Stages of an Option Appraisal

Stage Two –

The second stage in option appraisals should be to develop options.

Stage 1 sets out **WHAT** you want to achieve, the options describe **HOW** you could achieve it.

Here you can start considering the different approaches you could take.

It is important to consider a wide range of initial options, which can then be narrowed down.

The list should always include your "**do nothing**" option.

Example – Option Appraisal regarding replacement of a hospital canteen

Development of long list of options :

1. Option 1 - Do Nothing. Leave existing canteen as stands
2. Option 2 – Do Minimum. Refurbish existing canteen
3. Option 3 – New Build kitchen on hospital site
4. Option 4 – New Build kitchen on alternative greenfield site
5. Option 5 – Buy in chilled meals from neighbouring Health Board.
6. Option 6 – Buy in some chilled meals for South of region and build new kitchen for rest of region

Stages of an Option Appraisal

Stages Three and Four

The third and fourth stages in option appraisals should be to gather information to allow a **shortlist** of options to be agreed which are actually **feasible**.

The appraisal needs to take account of future projections and forecasts around things like workforce, population profiles, any available funding, etc.

Example – Option Appraisal regarding replacement of a hospital canteen

Development of shortlist of options :

1. Option 1 - Do nothing. Leave existing canteen as stands
2. Option 2 – Do minimum. Refurbish existing canteen
3. Option 3 – New-build kitchen on hospital site
4. ~~Option 4 –~~ New-build kitchen on alternative greenfield site – No resources to procure additional land/current space available.
5. Option 5 – Buy-in chilled meals from neighbouring Health Board.
6. ~~Option 6 –~~ Buy in some chilled meals for south of region and build new kitchen for rest of region – Insufficient staffing/resources to accommodate both new build and buy-in of meals.

Stages of an Option Appraisal

Stage Five

The fifth stage in option appraisals should be to agree the **Benefits Criteria** which are the most important factors to deliver the project.

You will then rank these factors in order of importance. This is called "**weighting**".

Example – Option Appraisal regarding replacement of a hospital canteen

Development of Benefits Criteria :

1. Improvement in Service Effectiveness - Degree to which the proposed development improves/enhances the effectiveness overall i.e. improves catering service
2. Improvement in Service Quality - Degree to which the proposed development sustain & support service quality and health & safety
3. Location/ Access - Easily accessed by road and public transport, car parking available
4. Sustainability - Degree to which the proposed development ensures service sustainability/deliverability for the next 10-15 years

Example – Option Appraisal regarding replacement of a hospital canteen

Ranking and weighting the Benefits Criteria in order of importance :

Ranking		Weight
4th	Improvement in Service Effectiveness	20%
1st	Improvement in Service Quality	30%
3rd	Location/ Access	24%
2nd	Sustainability	26%

Stages of an Option Appraisal

Stage six

The sixth and final stage in option appraisals should then be to SCORE each of the shortlisted options considered against these agreed criteria on a SCALE OUT OF 10 in terms of how well the option MEETS THE CRITERIA.

The score out of 10 is then MULTIPLIED by the weighting the criteria which was given in stage Five.

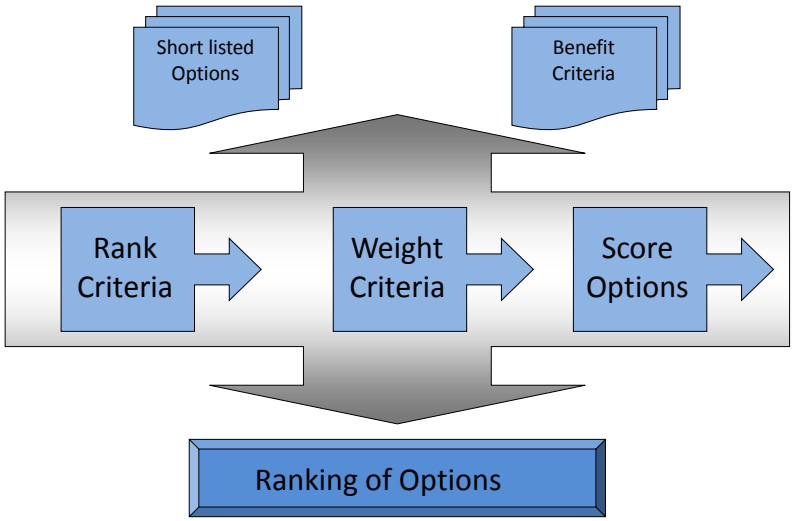
Example – Option Appraisal re replacement of a hospital canteen

Scoring Option 1:	Weighting		Score	Total
Status Quo				
Improvement in Service Effectiveness	20	x	5	= 100
Improvement in Service Quality	30	x	5	= 150
Location/ Access	24	x	9	= 216
Sustainability	26	x	2	= 52
Total Option 1 score				518

Weighted Scores for Options

Option	Weighted score
Option One - Do Nothing. Leave existing canteen as stands	518
Option Two - Do Minimum. Refurbish existing canteen	696
Option Three - New Build kitchen on hospital site	**854**
Option Five - Buy in chilled meals from neighbouring Health Board.	700

Key elements of an option appraisal



What Happens Next?

Mental Health Improvement Programme

Options Appraisal Workshops

Day 1 - Monday, 20 June 2016 – Invercarse Hotel, Dundee

Day 2 - Thursday, 30 June 2016 – The Steeple, Dundee

SEE YOU THERE!

Appendix Two

List of Attendees at Option Appraisal Training Session

Representatives invited / attended Option Appraisal Training 16th June 2016		
NAME	**DESIGNATION**	**Attended / DNA**
Angus Alison	Clinical In patient Team Manager – Perth GAP	DNA
Angus Allyson	Public Involvement Manager – NHST	yes
Ashman Emma	Scottish Health Council	yes
Borthwick Zara	Senior Charge Nurse – Forensic	yes
Brown Alan	Dundee Carers	yes
Brown Catherine	Admin Lead – Forensic	yes
Bruce Karyl	Domestic Supervisor – Stracathro	yes
Burnett Lesley	Dundee Learning Disabilities - Health Team Leader	yes
Burns Joyce	OT Specialist Practitioner – Learning Disabilities	yes
Chima Santosh	Diversity and Inclusion Manager – NHST	yes
Dowie Mrs	Carer (Forensic Services)	yes
Drumm Liz	Community Services Manager – Dundee GAP	yes
Dunning Margaret	Board Secretary – NHST	yes
Elworthy Tim	Consultant Psychiatrist – Substance Misuse Services	yes
Ford Heather	Admin Manager / MHCTA – Dundee GAP	yes
Gilling Grace	Head of Adult Mental Health Services – Perth GAP	DNA
Gordon Julie	Community Learning Disabilities Team Manager - Angus	DNA
Groak Dennis	Angus Voice	yes
Halcrow Dr Jo	Psychologist - Forensic	yes
Hamilton Cathy	Hope & Recovery Worker/Carers Group - Dundee	yes
Hamilton Lynne	MH Improvement Programme Director & Finance Manager – NHST (Facilitator)	yes
Hayward Dr David	Consultant Psychiatrist – Perth GAP	yes
Irvine Terry	Team Manager Social Work – Angus GAP	yes
Kemlo Lynsey	Senior Allied Health Practitioner – Angus GAP	yes
Kettles Patricia	Snr Nurse Clinical Governance & Risk - Forensic	yes
Laird Jenny	Angus Voice	yes
Marshall Sandra	Dundee Carers	yes
McDonald Gill	Senior Physiotherapist – Dundee GAP	DNA
Rankin Karen	Scottish Health Council	DNA
Roderick Malcom	Tayside Forensic Voices	yes
Smith Astrid	Occupational Therapy Consultant – Learning Disabilities	yes
Taylor Mariska	Occupational Therapist – Forensic	yes
Walker Colin	Advocacy Service – Forensic and Perth GAP	yes
Weir Mrs Lesley	Carer (Forensic Services)	yes
Whitefield Dr Elaine	Consultant Psychologist – Forensic	yes
Whitelaw Callum	Angus Voice	yes
Williams Tracey	Associate Director for Improvement – NHST (Facilitator)	yes
Wilson Barbara	Regional Services Manager- Forensic	Apols
Wood Elaine	Senior Charge Nurse - Forensic	yes

Appendix Three

Feedback received from Option Appraisal Training Session on 16th June 2016

`

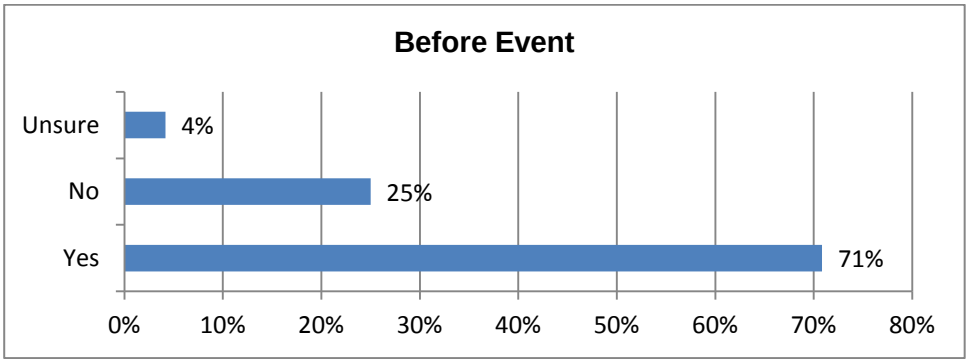
DRAFT

Mental Health Improvement Programme
Options Appraisal Training – 16 June 2016

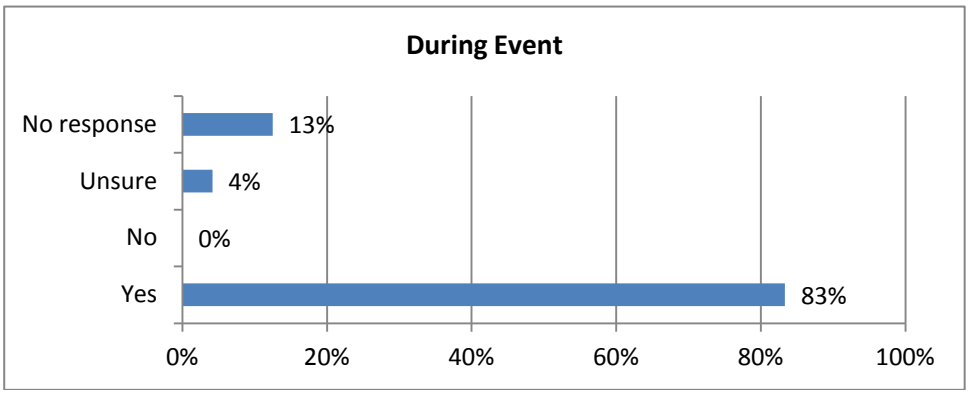
NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal training for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of twenty four questionnaires were completed.

EVALUATION - Analysis

1. Did you get enough information to help you prepare:

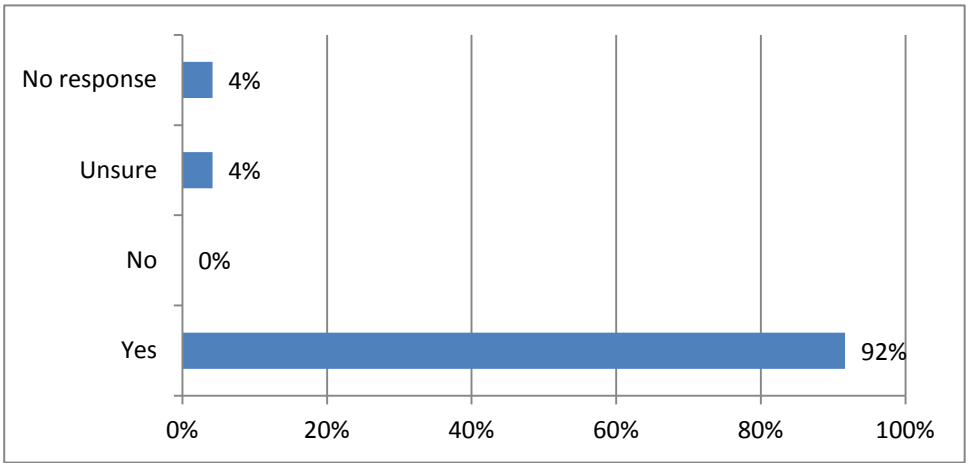


Answer Choices	Responses
Yes	17 (71%)
No	6 (25%)
Unsure	1 (4%)



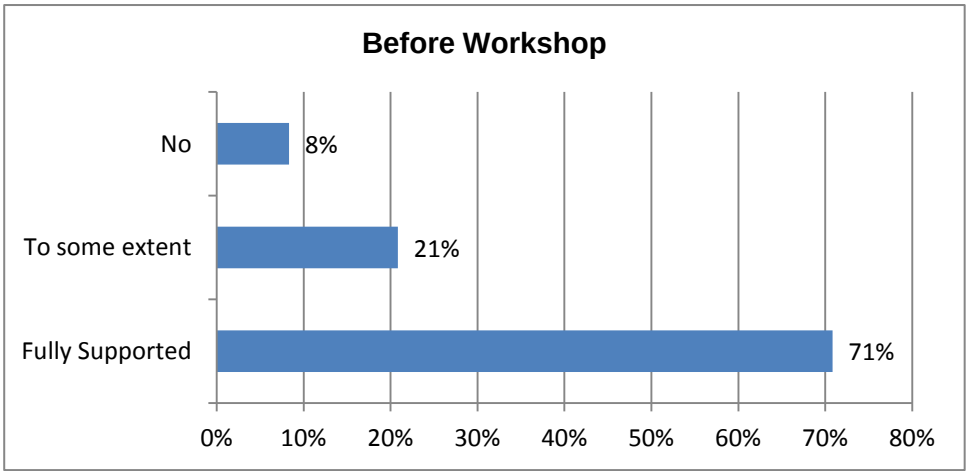
Answer Choices	Responses
Yes	20 (83%)
No	0
Unsure	1 (4%)
No response	3 (13%)

2. Was this information easy to understand?

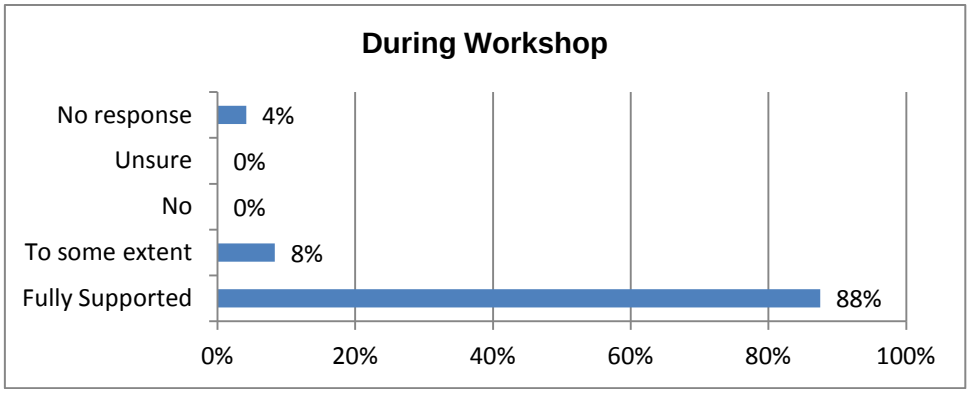


Answer Choices	Responses
Yes	22 (92%)
No	0
Unsure	1 (4%)
No response	1 (4%)

3. Were you provided with the support you needed to participate effectively?

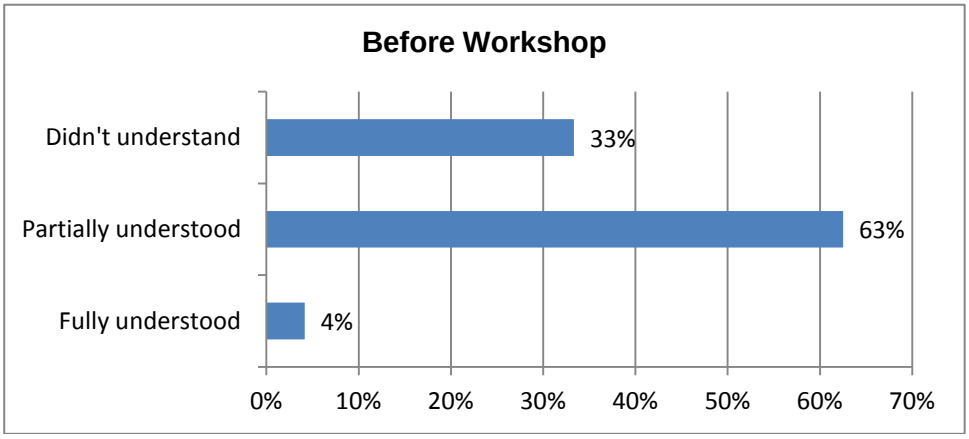


Answer Choices	Responses
Fully supported	17 (71%)
Supported to some extent	5 (21%)
No	2 (8%)

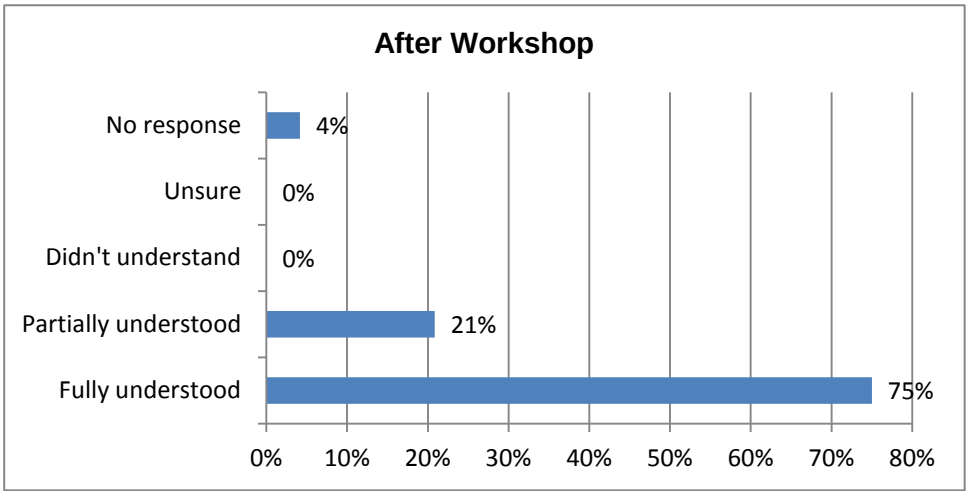


Answer Choices	Responses
Fully supported	22 (88%)
Supported to some extent	2 (8%)
No	0
No response	1 (4%)

4. How well did you understand the optional appraisal process before the training workshop and after?



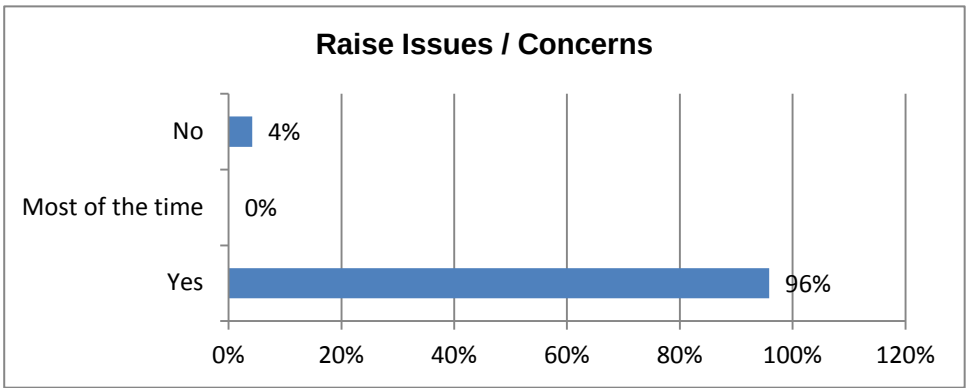
Answer Choices	Responses
Fully understood	1 (4%(
Partially understood	15 (63%)
Didn’t understand	8 (33%)



Answer Choices	Responses
Fully understood	18 (75%)
Partially understood	5 (21%)
No response	1 (4%)

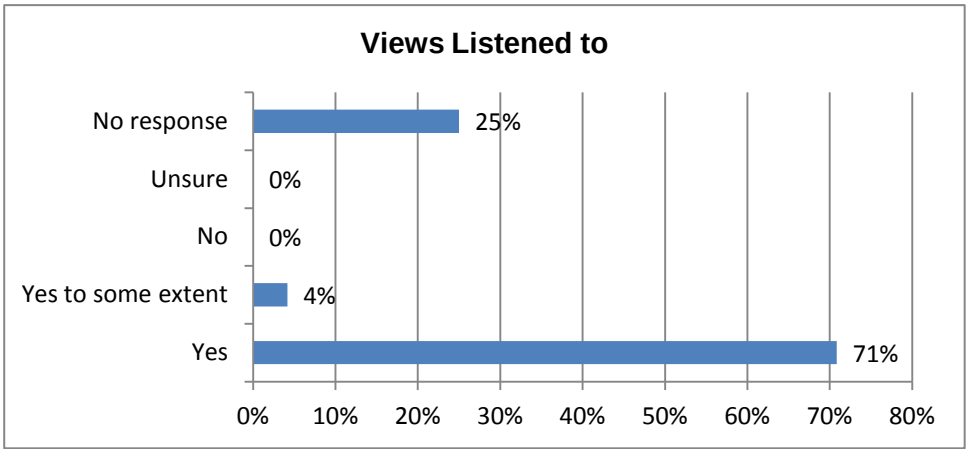
5. During the training workshop did you have the opportunity to ask questions or raise issues or concerns.

100% of attendees had the opportunity to ask questions.

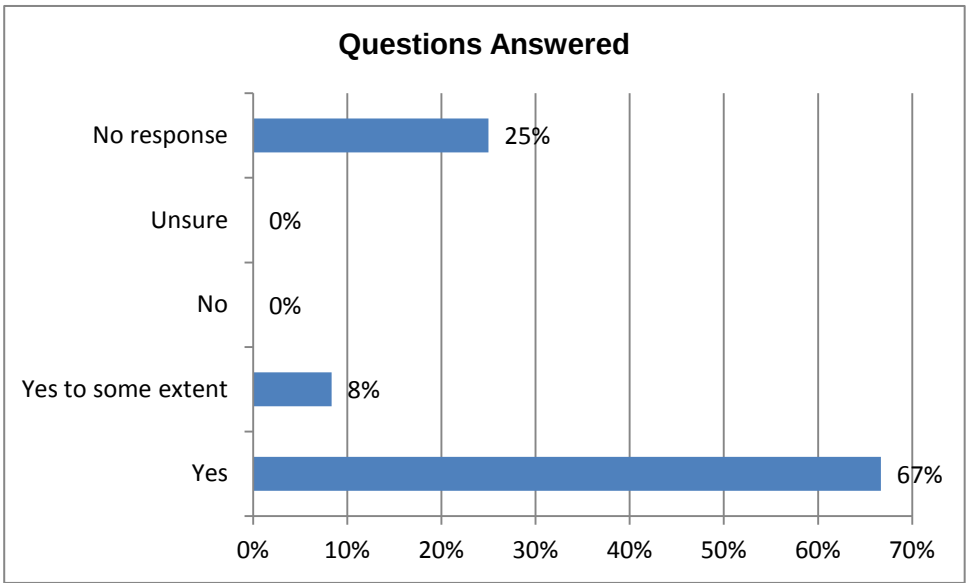


Answer Choices	Responses
Yes	23 (96%)
Most of the time	0
No	1 (4%)

6. Do you feel your views were listened and your questions answered during the workshop?



Answer Choices	Responses
Yes	17 (71%)
Yes to some extent	1 (4%)
No response	6 (25%)



Answer Choices	Responses
Yes	16 (67%)
Yes to some extent	2 (8%)
No response	6 (25%)

7. Were the next steps in the process explained to you?

All attendees said the next steps in the process were explained to them.

DRAFT

Mental Health Improvement Programme
Options Appraisal Training – 16 June 2016

NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal training for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of twenty four questionnaires were completed.

EVALUATION

Analysis

8. Did you get enough information to help you prepare:

There was a mixed response from participants in relation to getting enough information to help them prepare before the workshop. 17(71%) intimated they had enough information, 6(25%) considered they did not and 1(4%) was unsure if they received enough information. The responses demonstrated that they were given enough information during the workshop as indicated by 20 participants of the 21 whom responded to this question.

Participants were asked what additional information would you have found helpful?

The following comments were submitted:-

- *More information about workshop would have been helpful.*
- *Didn't receive email of last minute change of time*
- *Came in place of my manager at short notice. But workshop was informative*
- *An agenda and some bullet points beforehand might have helped to keep the discussion focussed*
- *A summary of what was going to be discussed. Also, change to timing of session should be notified in time to avoid me turning up forty five minutes early*
- *Did not get the email with attachments. Times were changed, no information that the venue had been changed on the 20th June*

9. Was this information easy to understand?

The majority of attendees 22(92%) found the information easy to understand.

Comments to support this:

- *Difficult to follow but understand process.*
- *Very well presented*

10. Were you provided with the support you needed to participate effectively?

17(71%) of the participants indicated they were provided with the support they needed to participate effectively before the workshop and the majority of attendees 21(88%) felt they were provided with the support they needed to participate effectively during the workshop.

11. How well did you understand the optional appraisal process before the training workshop and after?

Only 1 participant fully understood the option appraisal process before the training workshop but following the training workshop, this rose to 18(75%).

The following comments were submitted:-

- *Looking forward to the two days*
- *Very well presented*

12. During the training workshop did you have the opportunity to ask questions or raise issues or concerns.

All in attendance said they had the opportunity to ask questions during the workshop and the majority 23(96%) said they were given the opportunity to raise any issues or concerns.

13. Do you feel your views were listened and your questions answered during the workshop?

Of the18 participants whom responded to this question 17(94%) intimated that their views were listened to and 16(88%) intimated that their questions were answered.

Comments submitted to support this response are noted below:

- *I did not ask any questions but would have felt comfortable doing so*
- *Facilitators did an excellent job in trying to balance the need to answer queries and trying to attend to the larger group*
- *Didn't voice any but felt they would have been addressed*
- *I didn't express a view. The discussion was taken over disproportionally and diverted and I felt it curtailed participation,*
- *I had questions and they were satisfactorily answered*

14. Were the next steps in the process explained to you?

All attendees said the next steps in the process were explained to them.

15. Please let us know if you have any other comments or suggestions about the workshops.

- *Looking forward to the two days. A lot of work expected.*
- *I enjoyed the workshop and felt the information was very good. Thank you.*
- *The training was good, gave a good insight into the option appraisal.*
- *A physical example in the slides of the scoring against east options of the example given may have helped some people in the room. But explained very well. Thanks.*
- *Tracey deserves a medal*
- *Not enough room for all who attended.*

Findings

It was evident that more information could have been provided to help the participants prepare for the option appraisal training workshop. The information which was provided was considered easy to understand.

The results were positive in relation to the support provided to participants in order for them to participate effectively both before the workshop and also during the workshop.

All participants felt they were given the opportunity to ask questions. The majority of participants felt their views were listened to and their questions answered during the workshop.

It was apparent that the option appraisal training increased participants understanding of the process.

Recommendations

Based on the feedback received when planning similar events in the future, ensure sufficient information is provided to help participants prepare.

Appendix Four

Option Appraisal Workshops Programmes for 20th and 30th June 2016

Mental Health Improvement Programme

Option Appraisal Workshop

20th JUNE 2016

PROGRAMME

10.00 am – 10.30 am **REGISTRATION/COFFEE**

MORNING SESSION

- Welcome and Introduction
- Programme for day
- Key Drivers for change
- Objective Setting

11.45 am – 12.00 am **COFFEE**

MID-MORNING SESSION

- Development of Long list of Options (Group work)

1.15 pm – 2.00 pm **LUNCH**

AFTERNOON SESSION

- Agree Short List of Options

3.15 pm – 3.30 am **COFFEE**

MID AFTERNOON SESSION

- Feedback
- Agree Short List of Options / Next steps

4.00 pm **CLOSE**

Mental Health Improvement Programme

Option Appraisal Workshop

30th JUNE 2016

PROGRAMME

9.00 am – 9.30 am **REGISTRATION/COFFEE**

MORNING SESSION

- Welcome and Introduction
- Programme for day
- Feedback from Workshop 20th June
  - Agreed Objectives
  - Shortlisted Options

10.45 am – 11.00 am **COFFEE**

MID-MORNING SESSION

- Development of Benefit Criteria (Group work)
- Feedback & Agreement of Criteria

12.00 pm – 12.45 pm **LUNCH**

AFTERNOON SESSION

- Scoring of Shortlisted Options (Group Work)

2.30 pm – 2.45 pm **COFFEE**

MID AFTERNOON SESSION

- Feedback of scoring
- Agree preferred Option/Options & Next steps

4.00 pm **CLOSE**

Appendix Five

List of Attendees at Option Appraisal Workshops on 20th and 30th June 2016

Stakeholders/Representatives invited / attended Option Appraisal Event 20th June 2016		
NAME	**DESIGNATION**	**Attended DNA**
Anderson Karen	Interim Allied Health Practitioner Director – NHST	yes
Angus Alison	Clinical In patient Team Manager – Perth GAP	yes
Angus Allyson	Public Involvement Manager – NHST	yes
Arbuckle Paul	Service Improvement Lead – NHST	yes
Ashman Emma	Scottish Health Council	yes
Bain Robert	Clinical Team Manager – Learning Disabilities	DNA
Baldwin Sam	Consultant Psychiatrist – Learning Disabilities	DNA
Bean Susan	Domestic Supervisor – Dundee	DNA
Beecroft Caroline	Senior Charge Nurse – Learning Disabilities	yes
Blair Heather	Advocating Together – Learning Disabilities	yes
Blake Roger	Consultant Psychiatrist – Angus GAP	yes
Borthwick Zara	Senior Charge Nurse – Forensic	yes
Brand Alistair	Principal Clinical Pharmacist – NHST	DNA
Bremner Helen	Senior Charge Nurse – Angus GAP	yes
Brewster Eleanor	Consultant Psychiatrist – Learning Disabilities	yes
Brophy-Arnot Bernie	Speech & Language Therapist – Learning Disabilities	DNA
Brown Alan	Dundee Carers	yes
Brown Catherine	Admin Lead – Forensic	yes
Brown Ruth	MH Networking Co-ordinator –Dundee Voluntary Action	DNA
Bruce Karyl	Domestic Supervisor – Stracathro	yes
Burnett Lesley	Learning Disabilities - Dundee Health Team Leader	yes
Burns Joyce	OT Specialist Practitioner – Learning Disabilities	yes
Caesar Dr Liz	Consultant Psychiatrist – Perth GAP	yes
Cameron Ms Avril	Carer (Forensic Services)	DNA
Cameron Lorna	Head of Housing and Care Commissioning Strategy – Perth	yes
Chandler Nikki	Charge Nurse - Learning Disability Service	DNA
Chima Santosh	Diversity and Inclusion Manager – NHST	yes
Cook David	Senior Management Accountant – NHST	DNA
Costello Gillian	Director of Nursing - NHST	DNA
Cowan Christine	Team Leader - Community LD Nursing Team - Perth	DNA
Curran Dr Stephen	Consultant Psychiatrist - Perth	DNA
Doig Stuart	Consultant Psychiatrist - Forensic	yes
Davidson Louise	Scottish Ambulance Service	DNA
Dowie Mrs	Carer (Forensic Services)	yes
Drumm Liz	Community Services Manager – Dundee GAP	yes
Duncan Jane	Head of Corporate Communication – NHST	yes

Duncan Mark	Police Scotland	yes
Dunning Margaret	Board Secretary – NHST	yes
Elworthy Tim	Consultant Psychiatrist – Substance Misuse Services	yes
English Dr Judith	Consultant Psychiatrist – Perth GAP	DNA
Ewan Gavin	Penumbra	yes
Fannin Allison	Planning & Development Manager – Dundee IJB	yes
Feile Matthias	Junior Doctor Representative – GAP	DNA
Forbes Claire	Support in Mind – Tayside Carers Support	DNA
Ford Heather	Admin Manager / MHCTA – Dundee GAP	yes
Fox Tracy	Nursing Team – Learning Disabilities	DNA
Fraser Diane	Head of Housing & Community Care - Perth IJB	yes
Fraser Neil	Strategy & Performance Manager – NHST	yes
Freeburn Kenny	Scottish Ambulance Service	DNA
Furey Sharon	Acting SCN - Learning Disability Service	yes
Gallacher Clare	Independent Advocacy	DNA
General Practitioner	Angus Health & Social Care Partnership	DNA
General Practitioner	Perth & Kinross Health & Social Care Partnership	DNA
General Practitioner	Dundee Health & Social Care Partnership	DNA
Gilling Grace	Head of Adult Mental Health Services – Perth GAP	yes
Glenday Mrs	Carer (Forensic Services)	DNA
Godfrey Lucinda	Dundee Carers	DNA
Gordon Julie	Community Learning Disabilities Team Manager – Angus	DNA
Graham Linda	Consultant Psychologist – Dundee GAP	yes
Graham Val	Senior Charge Nurse – Forensic	yes
Groak Dennis	Angus Voice	yes
Halcrow Dr Jo	Psychologist – Forensic	yes
Hamilton Cathy	Hope & Recovery Worker/Carers Group – Dundee GAP	yes
Hamilton Lynne	MH Improvement Programme Director & Finance Manager – (Facilitator)	yes
Hayward Dr David	Consultant Psychiatrist – Perth GAP	yes
Haut Fabian	Consultant Psychiatrist – Learning Disabilities	DNA
Henderson Gail	Senior Charge Nurse – Learning Disabilities	yes
Irons Vicky	Chief Officer - Angus Health & Social Care Partnership	DNA
Henderson James	Transformation Programme Advisor – NHST	DNA
Irvine Terry	Team Manager Social Work – Angus	yes
Johnson Val	Head of Service – Dundee GAP	yes
Kemlo Lynsey	Senior Allied Health Professional – Angus GAP	yes
Kennedy James	Practice Development Nurse – Angus GAP	yes
Kennedy Linda	Service Manager – Angus GAP	yes
Kettles Patricia	Senior Nurse Clinical Governance & Risk – Forensic	yes
Kubath Marlyn	PLUS Perth	DNA

Laidlaw Shona	Dundee Independent Advocacy Service	DNA
Laird Jenny	Angus Voice	yes
Lyall Emma	Support Manager – Dundee and Angus NOVA centre	DNA
Lynch David	Chief Officer - Dundee Health & Social Care Partnership	DNA
Macaulay Andrea	Consultant Psychiatrist – Forensic	yes
Mackie Aileen	Senior Charge Nurse – Perth GAP	yes
Mackie James	Consultant Psychiatrist – Dundee GAP	DNA
Mackinnon Helen	PKAVS – Perth	DNA
Malcom Laura	Senior Charge Nurse - IPCU	yes
Malone Gary	Voluntary Action Angus	DNA
Manley Alan	Staffside representative - NHST	DNA
Marshall Sandra	Dundee Carers	yes
Mason Wilma	Capital Management Accountant - NHST	DNA
McCallum Lynsey	Dundee Service Users Network	DNA
McCulloch Diane	Head of Social Work - Dundee District Council	yes
McDermott Kate	Staffside Representative – NHST	DNA
McDonald Gill	Senior Physiotherapist – Dundee GAP	DNA
McGlashan Bob	Staffside Representative - NHST	yes
McGurk Alison	Clinical team Manager – Angus GAP	DNA
Mcgregor Piers	Inpatient Manager – Dundee GAP	yes
McIntyre Grant	Assistant Property & Asset Manager – NHST	DNA
McManus Angie	Learning Disability Service Manager – Perth	DNA
Milne Jillian	Mindspace	DNA
Mitchell Arlene	Dundee Learning Disabilities Social Work Manager	DNA
Motion Gill	Senior Community Capacity Building Worker- Perth	yes
Ozden Karen	Director of Mental Health Services / Associate Nurse Director	yes
Packham Rob	Chief Officer - Perth & Kinross Health & Social Care Partnership	yes
Palombo Catriona	PUSH Perth	DNA
Parillion Dr Tony	Consultant Psychiatrist – Perth GAP	DNA
Pell Chris Dr	Consultant Psychiatrist – Angus GAP	yes
Peter-Tennant Kathleen	Tayside Carers Support	DNA
Philip Maureen	PAMIS	DNA
Prentice Neil Dr	Associate Medical Director - Mental Health	yes
Proudfoot Elizabeth	Site/Support Services Manager – Murray Royal	DNA
Provan Hilary	Senior Charge Nurse - Perth GAP	yes
Raich Sheila	Senior Allied Health Professional – Angus GAP	DNA
Rankin Karen	Scottish Health Council	DNA
Reffold Dr Rowan	Consultant Psychologist – Learning Disabilities	yes
Rennie Lucy	Strategy and Performance Manager – Dundee IJB	DNA

Roderick Malcolm	Tayside Forensic Voices	yes
Ross Robin	Angus Independent Advocacy	yes
Russell Andrew	Medical Director – NHST	DNA
Russell Keith	Lead Nurse Mental Health & Learning Disability NHST	yes
Russell Wendy	Senior Charge Nurse – Learning Disabilities	yes
Scott Susan	PLUS Perth	DNA
Scott Vicky	Advocating Together – Learning Disabilities	yes
Sharkie Irene	Lead Clinical Pharmacist – NHST	yes
Smith Astrid	Occupational Therapy Consultant – Learning Disability	yes
Smith Fiona	Team Leader – Crisis Response Home Treatment Team/ Intensive Home Treatment – Dundee GAP	yes
Smith Jane M	Chief Finance Officer - Perth Health & Social Care Partnership	yes
Smith-Hope Avril	Service Manager - Dundee Health & Social Care Partnership	DNA
Steptoe Lesley Dr	Psychologist - Forensic	yes
Steven Muriel	Project Support Officer – NHST	yes
Stewart Sandy	Angus Independent Advocacy	DNA
Subbatayan Dr Aravinthe	Consultant Psychiatrist – Perth GAP	DNA
Swinton Suzanne	Angus Independent Advocacy	yes
Taylor Mariska	Occupational Therapist - Forensic	yes
Taylor Pennie	External Facilitator	yes
Thakore Shoban	Consultant – Accident & Emergency - Ninewells	DNA
Thiyagarajan Singaravelu	Consultant Psychiatrist – Dundee GAP	yes
Timney Brian	Clinical Lead Consultant Psychiatrist – Dundee GAP	DNA
Tippett Arnot	Programme Manager - Dundee Health & Social Care Partnership	DNA
Troup Bill	Head of Service – Angus GAP	yes
Vannet Marie	Staffside Representative	DNA
Walker Colin	Advocacy Service	yes
Walker Sharlaine	Planning Manager – Angus GAP	DNA
Watt Zoe	Community Learning Disability Nurse	yes
Weir Mrs Lesley	Carer (Forensic Services)	yes
Whitefield Dr Elaine	Consultant Psychologist - Forensic	yes
Whitelaw Callum	Angus Voice	yes
Williams Tracey	Associate Director for Improvement – (Facilitator)	yes
Wilson Barbara	Regional Services Manager – Forensic	Apols
Wilson Emma	Penumbra	yes
Wilson Louise	Communications Manager – NHST	yes
Wood Elaine	Senior Charge Nurse – Forensic	yes
Young Helen	Turning Point – Learning Disabilities	yes

Stakeholders/Representatives invited / attended Option Appraisal Event 30th June 2016		
NAME	**DESIGNATION**	**Attended / DNA**
Anderson Karen	Interim Allied Health Practitioner Director – NHST	yes
Angus Alison	Clinical In patient Team Manager – Perth GAP	yes
Angus Allyson	Public Involvement Manager – NHST	yes
Arbuckle Paul	Service Improvement Lead – NHST	yes
Ashman Emma	Scottish Health Council	yes
Bain Robert	Clinical Team Manager – Learning Disabilities	yes
Baldwin Sam	Consultant Psychiatrist – Learning Disabilities	DNA
Bean Susan	Domestic Supervisor – Dundee	DNA
Beecroft Caroline	Senior Charge Nurse – Learning Disabilities	yes
Blair Heather	Advocating Together – Learning Disabilities	yes
Blake Roger	Consultant Psychiatrist – Angus GAP	yes
Borthwick Zara	Senior Charge Nurse – Forensic	yes
Brand Alistair	Principal Clinical Pharmacist – NHST	DNA
Bremner Helen	Senior Charge Nurse – Angus GAP	yes
Brewster Eleanor	Consultant Psychiatrist – Learning Disabilities	Apols
Brophy-Arnot Bernie	Speech & Language Therapist – Learning Disabilities	DNA
Brown Alan	Dundee Carers	DNA
Brown Catherine	Admin Lead – Forensic	yes
Brown Ruth	MH Networking Co-ordinator –Dundee Voluntary Action	DNA
Bruce Karyl	Domestic Supervisor – Stracathro	yes
Burnett Lesley	Learning Disabilities - Dundee Health Team Leader	Apols
Burns Joyce	OT Specialist Practitioner – Learning Disabilities	yes
Caesar Dr Liz	Consultant Psychiatrist – Perth GAP	yes
Cameron Ms Avril	Carer (Forensic Services)	DNA
Cameron Lorna	Head of Housing and Care Commissioning Strategy – Perth	DNA
Chandler Nikki	Charge Nurse - Learning Disability Service	DNA
Chima Santosh	Diversity and Inclusion Manager – NHST	Apols
Cook David	Senior Management Accountant – NHST	yes
Costello Gillian	Director of Nursing - NHST	DNA
Cowan Christine	Team Leader - Community LD Nursing Team - P&K	DNA
Curran Dr Stephen	Consultant Psychiatrist - Perth	DNA
Doig Stuart	Consultant Psychiatrist - Forensic	yes
Davidson Louise	Scottish Ambulance Service	DNA
Dowie Mrs	Carer (Forensic Services)	Apols
Drumm Liz	Community Services Manager – Dundee GAP	yes
Duncan Jane	Head of Corporate Communication – NHST	yes
Duncan Mark	Police Scotland	DNA
Dunning Margaret	Board Secretary – NHST	Apols

Elworthy Tim	Consultant Psychiatrist – Substance Misuse Services	yes
English Dr Judith	Consultant Psychiatrist – Perth GAP	DNA
Ewan Gavin	Penumbra	yes
Fannin Allison	Planning & Development Manager – Dundee IJB	yes
Feile Matthias	Junior Doctor Representative – GAP	DNA
Forbes Claire	Support in Mind – Tayside Carers Support	DNA
Ford Heather	Admin Manager / MHCTA – Dundee GAP	yes
Fox Tracy	Nursing Team – Learning Disabilities	yes
Fraser Diane	Head of Housing & Community Care - Perth IJB	Apols
Fraser Neil	Strategy & Performance Manager – NHST	yes
Freeburn Kenny	Scottish Ambulance Service	DNA
Furey Sharon	Acting SCN - Learning Disability Service	yes
Gallacher Clare	Independent Advocacy	DNA
General Practitioner	Angus Health & Social Care Partnership	DNA
General Practitioner	Perth & Kinross Health & Social Care Partnership	DNA
General Practitioner	Dundee Health & Social Care Partnership	DNA
Gilling Grace	Head of Adult Mental Health Services – Perth GAP	yes
Glenday Mrs	Carer (Forensic Services)	DNA
Godfrey Lucinda	Dundee Carers	DNA
Gordon Julie	Community Learning Disabilities Team Manager – Angus	DNA
Graham Linda	Consultant Psychologist – Dundee GAP	DNA
Graham Val	Senior Charge Nurse – Forensic	DNA
Groak Dennis	Angus Voice	yes
Halcrow Dr Jo	Psychologist – Forensic	yes
Hamilton Cathy	Hope & Recovery Worker/Carers Group – Dundee GAP	yes
Hamilton Lynne	MH Improvement Programme Director & Finance Manager – (Facilitator)	yes
Hayward Dr David	Consultant Psychiatrist – Perth GAP	DNA
Haut Fabian	Consultant Psychiatrist – Learning Disabilities	yes
Henderson Gail	Senior Charge Nurse – Learning Disabilities	yes
Irons Vicky	Chief Officer - Angus Health & Social Care Partnership	DNA
Henderson James	Transformation Programme Advisor – NHST	DNA
Irvine Terry	Team Manager Social Work – Angus GAP	DNA
Jamieson Alistair	Mindspace	yes
Johnson Val	Head of Service – Dundee GAP	yes
Kemlo Lynsey	Senior Allied Health Professional – Angus GAP	yes
Kennedy James	Practice Development Nurse – Angus GAP	yes
Kennedy Linda	Service Manager – Angus GAP	DNA
Kettles Patricia	Senior Nurse Clinical Governance & Risk – Forensic	yes
Kubath Marlyn	PLUS Perth	DNA
Laidlaw Shona	Dundee Independent Advocacy Service	DNA
Laird Jenny	Angus Voice	yes

Lyall Emma	Support Manager – Dundee and Angus NOVA centre	DNA
Lynch David	Chief Officer - Dundee Health & Social Care Partnership	DNA
Macaulay Andrea	Consultant Psychiatrist – Forensic	yes
Macaulay Karen	Advocating Together	yes
Mackie Aileen	Senior Charge Nurse – Perth GAP	yes
Mackie James	Consultant Psychiatrist – Dundee GAP	DNA
Mackinnon Helen	PKAVS – Perth	DNA
Malcolm Laura	Senior Charge Nurse - IPCU	DNA
Malone Gary	Voluntary Action Angus	DNA
Manley Alan	Staffside Representative – NHST	DNA
Marshall Sandra	Dundee Carers	yes
Mason Wilma	Capital Management Accountant – NHST	DNA
McCallum Lynsey	Dundee Service Users Network	DNA
McCulloch Diane	Head of Social Work - Dundee District Council	yes
McDermott Kate	Staffside Representative – NHST	DNA
McDonald Gill	Senior Physiotherapist – Dundee GAP	yes
McGurk Alison	Clinical team Manager – Angus GAP	yes
McGregor Piers	Inpatient Manager – Dundee GAP	yes
McIntyre Grant	Assistant Property & Asset Manager – NHST	DNA
McManus Angie	Learning Disabilities Service Manager – Perth	yes
Milne Jillian	Mindspace	DNA
Mitchell Arlene	Dundee Learning Disabilities Social Work Manager	DNA
Motion Gill	Senior Community Capacity Building Worker- Perth	yes
Ozden Karen	Director of Mental Health Services / Associate Nurse Director	yes
Packham Rob	Chief Officer - Perth & Kinross Health & Social Care Partnership	yes
Palombo Catriona	PUSH Perth	DNA
Parillion Dr Tony	Consultant Psychiatrist – Perth GAP	DNA
Pell Chris Dr	Consultant – Angus GAP	DNA
Peter-Tennant Kathleen	Tayside Carers Support	DNA
Philip Maureen	PAMIS	DNA
Prentice Neil Dr	Associate Medical Director - Mental Health	yes
Proudfoot Elizabeth	Site/Support Services Manager – Murray Royal	DNA
Provan Hilary	Senior Charge Nurse - Perth GAP	DNA
Raich Sheila	Senior Allied Health Professional – Angus GAP	DNA
Rankin Karen	Scottish Health Council	yes
Reffold Dr Rowan	Consultant Psychologist – Learning Disabilities	yes
Rennie Lucy	Strategy and Performance Manager – Dundee IJB	DNA
Roderick Malcom	Tayside Forensic Voices	yes
Ross Robin	Angus Independent Advocacy	yes
Russell Andrew	Medical Director – NHST	DNA

Russell Keith	Lead Nurse Mental Health & Learning Disability – NHST	yes
Russell Wendy	Senior Charge Nurse – Learning Disabilities	yes
Scott Susan	PLUS Perth	Apols
Sharkie Irene	Lead Clinical Pharmacist – NHST	yes
Smith Fiona	Team Leader – Crisis Response Home Treatment Team/ Intensive Home Treatment – Dundee GAP	yes
Smith Jane M	Chief Finance Officer - Perth Health & Social Care Partnership	yes
Smith-Hope Avril	Service Manager - Dundee Health & Social Care Partnership	yes
Steptoe Lesley Dr	Psychologist - Forensic	yes
Steven Muriel	Project Support Officer – NHST	yes
Stewart Sandy	Angus Independent Advocacy	DNA
Subbatayan Dr Aravinthe	Consultant Psychiatrist – Perth GAP	DNA
Swinton Suzanne	Angus Independent Advocacy	yes
Taylor Mariska	Occupational Therapist – Forensic	yes
Taylor Pennie	External Facilitator	yes
Thakore Shoban	Consultant – Accident & Emergency – Ninewells	DNA
Thiyagarajan Singaravelu	Consultant Psychiatrist – Dundee GAP	yes
Timney Brian	Clinical Lead Consultant Psychiatrist – Dundee GAP	DNA
Tippett Arnot	Programme Manager - Dundee Health & Social Care Partnership – NHST	DNA
Troup Bill	Head of Service – Angus GAP	yes
Tucker Barbara	Staffside Representative – NHST	yes
Vannet Marie	Staffside Representative – NHST	DNA
Walker Colin	Advocacy Service	yes
Walker Sharlaine	Planning Manager - Angus GAP	yes
Watt Zoe	Community Learning Disability Nurse	yes
Weir Mrs Lesley	Carer (Forensic Services)	yes
Whitefield Dr Elaine	Consultant Psychologist – Forensic	yes
Whitelaw Callum	Angus Voice	yes
Williams Tracey	Associate Director of Improvement – (Facilitator)	yes
Wilson Barbara	Regional Services Manager – Forensic	Apols
Wilson Emma	Penumbra	yes
Wilson Louise	Communications Manager - NHST	yes
Wood Elaine	Senior Charge Nurse - Forensic	yes
Young Helen	Turning Point – Learning Disabilities	Apols

Appendix Six

Draft Bed Models
Long List of Options

16.07.28 Long List Options - Bed Models

Appendix Seven

Bed Index and Descriptor Cards

KEY TO BED MAP - CURRENT NHS TAYSIDE
BED NUMBERS JUNE 2016

		Dundee	Perth	Angus	Total
	Acute Admission Beds	40	24	25	**89**
	Advanced Intervention Service (AIS) Beds (National)	4	0	0	**4**
	Medium Secure		32		**32**
	Low Secure		29		**29**
	IPCU	10			**10**
	Complex care Females		10		**10**
	Rehab/Complex Care		16		**16**
	SMS (Substance Misuse Services)		6		**6**
	Learning Disability Assessment Unit (LDAU)	10			**10**
	Bridgefoot Flat 1 - Forensic LD Beds	8			**8**
	Bridgefoot Flat 2 -	0			**0**
	Bridgefoot Flat 3 - Behavioural Support & Intervention Service (BSI)	6			**6**
	Craigowl - Forensic LD Beds	10			**10**
		88	**117**	**25**	**230**

GENERAL ADULT PSYCHIATRY

ACUTE ADMISSION BED

NHS TAYSIDE CURRENTLY PROVIDES:

25 BEDS IN ANGUS

40 BEDS IN DUNDEE (PLUS 4 ADVANCED INTERVENTION BEDS WHICH IS A NATIONAL SERVICE LINKED TO NEUROSURGERY AT NINEWELLS)

24 BEDS IN PERTH

GAP acute inpatient hospital beds are for people who need urgent assessment to decide about diagnosis and treatment of mental illness.

LEARNING DISABILITY BEHAVIOURAL SUPPORT & INTERVENTION (BSI) BED

NHS TAYSIDE CURRENTLY PROVIDES:

6 BEDS IN STRATHMARTINE HOSPITAL FOR WHOLE OF TAYSIDE

The Behavioral Support & Intervention (BSI) Service provides inpatient treatment to those who cannot be supported in the community. The BSI service provides community support as well as inpatient treatment to people with LD who have challenging behaviour.

LEARNING DISABILITY ASSESSMENT UNIT (LDAU) BED

NHS TAYSIDE CURRENTLY PROVIDES:

8 BEDS IN CARSEVIEW CENTRE FOR WHOLE OF TAYSIDE

The Learning Disability assessment and treatment unit (LDAU) is for people with a learning disability who also have a mental illness.

LEARNING DISABILITY FORENSIC BED

NHS TAYSIDE CURRENTLY PROVIDES:

18 BEDS IN STRATHMARTINE HOSPITAL FOR WHOLE OF TAYSIDE

The Learning Disability Forensic service provides inpatient treatment in a Low secure, open and locked ward. This is for people with a learning disability who present with offending or challenging behaviour which may bring them into contact with the criminal justice system.

GENERAL ADULT PSYCHIATRY REHABILITATION/ COMPLEX CARE BED

NHS TAYSIDE CURRENTLY PROVIDES:

17 BEDS IN MURRAY ROYAL HOSPITAL FOR WHOLE OF TAYSIDE

The rehabilitation and complex care service provides specialist care for people who have a mental illness which is enduring and difficult to treat. This means they need a longer period in hospital to plan mental health and social care packages prior to discharge.

GENERAL ADULT PSYCHIATRY FEMALE COMPLEX CARE BED

NHS TAYSIDE CURRENTLY PROVIDES:

10 BEDS IN MURRAY ROYAL HOSPITAL FOR WHOLE OF TAYSIDE

The female complex care service provides specialist care for women who have a mental illness which is enduring and difficult to treat. This means they need a longer period in hospital to plan mental health and social care packages prior to discharge.

GENERAL ADULT PSYCHIATRY

INTENSIVE PSYCHIATRIC CARE UNIT (IPCU) BED

NHS TAYSIDE CURRENTLY PROVIDES:

10 BEDS IN CARSEVIEW CENTRE FOR MALES & FEMALES FOR WHOLE OF TAYSIDE

The Tayside IPCU provides mental health care and treatment for people who need a secure environment beyond that which can normally be provided on an open psychiatric ward. This may be because the person is a risk of harm to themselves or to others as a result of their mental disorder.

TAYSIDE SUBSTANCE MISUSE SERVICE (TSMS) BED

NHS TAYSIDE CURRENTLY PROVIDES:

6 TO 8 BEDS IN MURRAY ROYAL HOSPITAL FOR WHOLE OF TAYSIDE & OCCASIONAL ACTIVITY FROM OTHER HEALTH BOARD AREAS

The Tayside wide Substance Misuse Service provides treatment of people with alcohol and drug problems. These beds are used for patients who require detox as part of a rehabilitation programme.

PSYCHIATRY OF OLD AGE FUNCTIONAL BED

NHS TAYSIDE CURRENTLY PROVIDES:

14 BEDS IN MURRAY ROYAL HOSPITAL

12 BEDS IN SUSAN CARNEGIE UNIT IN ANGUS

DUNDEE BEDS ARE CURRENTLY PROVIDED IN KINGSWAY CARE CENTRE

The Psychiatry of Old Age Functional Service provides treatment of older people (age 65+) with 'functional' disorders, the most common of which is depressive illness, but also including people with psychotic illness.

PSYCHIATRY OF OLD AGE DEMENTIA BED

NHS TAYSIDE CURRENTLY PROVIDES:

24 BEDS IN MURRAY ROYAL HOSPITAL PLUS 10 BEDS IN CRIEFF

15 BEDS IN SUSAN CARNEGIE UNIT IN ANGUS PLUS BEDS IN WHITEHILLS AND ARBROATH INFIRMARY

DUNDEE BEDS ARE ALSO PROVIDED FROM THE KINGSWAY CARE CENTRE

The Psychiatry of Old Age Dementia Service provides treatment of people with 'organic' brain disorder such as dementia. Most people are aged 65+

TAYSIDE FORENSIC LOW SECURE BED

NHS TAYSIDE CURRENTLY PROVIDES:

35 BEDS IN ROHALLION UNIT AT MURRAY ROYAL HOSPITAL FOR WHOLE OF TAYSIDE AND OCCASIONALLY GENERATES INCOME FROM PROVISION OF BEDS TO OTHER BOARDS.

The Forensic Low and medium secure services provide a therapeutic environment for mentally disordered offenders who present a risk of serious harm to others.

TAYSIDE FORENSIC MEDIUM SECURE BED

NHS TAYSIDE CURRENTLY PROVIDES:

32 BEDS IN ROHALLION UNIT AT MURRAY ROYAL HOSPITAL FOR TAYSIDE AND NORTH OF SCOTLAND BOARDS (GRAMPIAN, HIGHLAND, ORKNEY & SHETLAND) OCCASIONALLY GENERATES INCOME FROM PROVISION OF BEDS TO OTHER BOARDS.

The Forensic Low and Medium secure services provide a therapeutic environment for mentally disordered offenders who present a risk of serious harm to others.

Appendix Eight

List of Parameters

PARAMETERS

1. **Hospital care should be used only when necessary.**

2. **Increase in access to quality community care is a goal for NHS Tayside.**

3. **Detained patients should be cared for in an environment suitable to manage risk to themselves and others.**

4. **Each site must have a responsible medical officer and full on call cover arrangements – (MH Act 1983)**

5. **Current numbers of medical staff will reduce for the next 5 to 10 years.**

6. **Current numbers of nursing staff will reduce for the next 5 to 10 years.**

7. **Three of our existing sites are PFI / NPD buildings and therefore we must maximise their use to ensure greatest benefit for patients. Strathmartine hospital is an ageing site which is unable to provide modern healthcare facilities.**

8. **No capital resource allocated for any new build for Adult Mental Health Service or Learning Disability services contained within our five year finance plan. A resource in the form of a cash payment is being held for refurbish of Carseview site which has not been utilised to date.**

9. **Current direction of travel for quality mental health services is for more services to be provided in communities and not in hospitals.**

10. **Medium Secure inpatient facility is a regional facility for the North of Scotland and out with the option appraisal. Psychiatry of Old Age Functional and Dementia are out with scope of option appraisal. We have provided them on the bed maps to show them as neighbouring services**

11. **Low Secure inpatient unit is Tayside wide and could only provide locked secure services such as Forensic, Low Secure Learning Disabilities or Intensive Psychiatric Care (IPCU).**

Appendix Nine

Feedback from Short Listing of Options

Feedback on tables from Option Appraisal Workshop 20th June 2016

TABLE ONE

Geography – equity of access to inpatient provision and equity of access from inpatient site to local community resources

- Access for carers/family/friends
- Ease of access re in reach/outreach services
- LD Patients travel
- Female LD patients
- Community Services models and provision including 3rd sector /vol sector
- Transport Links?
- Delayed discharges LD
- Specialist challenging behaviours & complex care – pathway
- LD community teams – community staff
- BSI
- Forensic LD nursing
- Forensic Psychology
- Consultant Psychiatry
- Helpful to have co located with beds but not essential

LD inpatient and community facilities together. Workshops & gardens on a big enough scale

- Community activities accessed by all LD with support work, leisure model to be duplicated in Perth Dundee and Angus, Joint with IJBs
- LD Nursing staff current daily model of care to incorporate the support needed for clients in the community eg travel & activities

Option Feedback

Option 1 A – NO

- LD model is unsafe in the configuration presented.
- Patient mix is not appropriate.
- GAP at MR would require new builds
- GAP equity of access for patients/staff/visitors

Option 1B – Possibility for LD

- GAP as above

Option 2A – NO

- LD as per 1A
- GAP – equity of access, IPCU split from acute admissions and in MR

Option 2B – Possibility for LD as per 1B

- GAP as 2A

Option 3A – NO

- LD patients – equity of access re Angus patients (majority of patients Dundee & Angus)
- Risk management re transporting day patients with forensic needs

Option 3B – YES

- Better equity of access for patients/families/visitors (would require major refurbishment)
- LD forensic to Rohallion
- LDAU to Strathmartine

Option 3C – NO

- LD as per 1A

Option 3D – YES

- Accessibility, central location
- LD new build would allow bespoke model of care
- Central workforce resource

Option 4A – NO

- LD model not safe in 1 ward

Option 4B - NO

- LD equity of access for Dundee & Angus patients
- GAP at Stracthro – difficult to provide workforce model required.

TABLE TWO

Option 1

- Not sure of land availability at MR and Finance
- Carseview – large empty parts?
- Travel issues for those furthest away
- Community services difficult to link in at distance
- B) refurbish less attractive

Option 2

- Similar issues to Option 1

Option 3

- A) moving Strathmartine services – MRH Day care community services need to be maintained.
- Issues with adjacencies regarding rehab GAP acute.

- B) centralising
- C) Geographical split in LD
- D) rebuild – ideal more important to be based together, Rehab not adjacent.

Option 4

- LD centralised in Perth - day service issues 4B and 4A, split services
- Rehab not co-adjacent
- Transport for GAP

Option 5

- Split LD service
- Acute service two sites
- B) Preferable

Option 6 – REJECT

Option 7 – REJECT

Option 8 – Status Quo and new build for LD on Strathmartine site

- ? Sustainable workforce
- Doesn't tackle issue at LD on multiple sites?
- ? viable model across three GAP sites
- Concentrate GAP on one site, LD on one site
- Need to have awareness of community
- Important to keep LD service together

Option 3B } site for GAP supported by enhanced community models across the board

Option 5B } particularly Angus. Two site for GAP. LD on one site preserves Strathmartine well accepted.

Caveats – Need to enhance community model, think beyond medical model. Keep LD on one site, Adjacencies between GAP and Rehab

TABLE THREE

Notes -

Option 1A -

- Concerns re viability – recruitment, pathways for patients, travel, links/outreach & community teams

Option 1B -

- As 1A above

Option 2A –

- Location creates accessibility issues ++ (as for 1A)

Option 2B –

- As 2A

Option 3A –

- Access better for Dundee but LD impact significant
- Low secure/LD beds – not bad!

Option 3B –

- Access to community modelling

Option 3C –

- LD Forensic/Low Secure Perth - Not Bad!
- LD SHX bed base - ?okay
- GAP Dundee – possible

Option 3D –

- Flat 1 better at MRH but services in Dundee & reasonable access??
- (would need better community)

Option 4A –

Option 4B –

- LD – Perth
- Angus ISQ

Option 5A –

- LD split
- GAP Dundee & Perth

Option 5B

Option 6A –

- Carseview
- LD Strathmartine

Option 6B –

- LD
- DD GAP and Angus, IPCU

Option 7 –

- DD GAP – Angus

- LD Strathmartine new build

Option 8 –

- Everything on MRH site
- GAP IP beds from SHX
- LD IP beds
- Community modelling

Option 9 –

- Everything on SHX site?
- GAP IP beds
- LD IP beds

Option 10 –

- Beds – as few as your community services can support and /or as many as you can afford.

Shortlisting –

Option 1A – NO

- Viability – recruitment, travel, patients/carers, not good use of estate, long term patients in place, in equity of access.
- Longer stay patients (rehab) in least accessible environment.
- Travel for families – onerous
- Recruitment of staff a challenge in Perth
-
- Community structure pivotal

Option 1B – NO

- Even less accessible
- Worse than 1A

Option 2A – NO

- Yes if locate IPCU close to low secure
- No increase Ambulance transfers for highest risk patients
- Fewest people live in Angus so inequity ++ All GAP beds in SHX

Option 2B – NO

- Worse than 2A
- Reasons above
- Access to Strathmartine now future proofed – isolated

Option 3A – YES

- LD & low Secure +ve
- Acute GAP facilities on one site +ve
- All LD on one site +ve
- Predicated on less beds and more community
- Not designed around local access –ve
- Needs community +++
- Acute crisis response needed for Angus & P&K (-ve)

Option 3B – YES

- As 3A above predicated on less beds and more community

Option 3C – NO

- LD located in 2 sites – diluting expertise
- Recruitment in Angus (-ve)

Option 3D – NO

- LD together (+ve)
- Currently isolated? (-ve) planning for housing?? i.e in 5 years will be better roads and infrastructure?
- Assessment unit on Strathmartine – less access to acute care

Option 3E – NO

- LD forensic in Low dependency in MRH (+ve)
- No better than 3D above re isolation so NO

Option 4A – YES

- Off Strathmartine and all LD together and Low Secure
- Predicated on less beds and increased community

Option 4B – YES

- LD in one site
- Predicated on less beds and increased community
- Access to own community challenging for angus (-ve)

Option 5A – YES

- As above

Option 5B – NO

- Strathmartine – LD NO

Option 6A – NO

- Strathmartine isolated
- Deprivation levels – inequalities ++

Option 6B – NO

- As above 6A

Option 7 – NO

- As above 6A

Option 8 – NO

- As above 6A

Option 9 – NO

- As above 6A

TABLE FOUR

Option 1A – NO (5 votes to 1)

- LD service all together (+ve)
- No as all acute at MR, hard for staff, carers visit – away from local community
- No resource for new build
- No inpatient beds at SHX
- Decreased staff cover, rehab wards at SHX not workable due to location
- Staffing concerns – rehab in isolation in Angus

Option 1B – NO (5 votes to 1)

- Possibly Yes refurb LD all on one site (+ve)
- No to rehab at SHX not using Carseview
- Again acute all at MRH no is=deal for family, services, rehab but LD all together
- Staffing concerns rehab in isolation
- Too rural for Rehab
- Doesn't utilise Carseview, future proofing of Strathmartine not possible due to site

Option 2A – NO (5 votes to 1)

- All services for LD in Carseview (+ve)
- Total split of all sites/services- under use of Carseview
- Splitting off service on all 3 sites, not good idea
- No acute admission in Perth
- Not ideal for Perth as travel for families and carers but LD altogether which would be ideal
- Not enough staff – too far for Perth patients

Option 2B – NO (5 votes to 1)

- LD services in one place if refurb good standard (+ve)
- Not utilising Carseview site

- Splitting of services not good
- Not using Carseview
- As above NO
- Again patients to travel but all LD together is good

Option 3A – YES (5 votes to 1)

- Maximises use of resources and sites
- Possible but not ideal, however issues around moves to MR for LD
- Possibly LD in one area, may be staff resource issue
- Concentration of services on 2 sites
- YES please
- Don't like all admissions to Dundee

Option 3B – YES (5 votes to 1)

- Yes good idea centralisation of services
- Good for LD and GAP
- Good to refurbish Strathmartine
- If refurb good standard for LD
- Possible option
- Doesn't provide best accommodation available for LD and Strathmartine site doesn't have ability to refurb to provide modern services

Option 3C – NO (4 votes to 2)

- Possible option
- Concern for LD staff resource getting to Strathmartine
- Poor Access and transport links for patients from Perth etc
- Isolation of facilities, local services
- NO
- Don't like LD at SHX

Option 4A – YES (5 votes to 1)

- Yes my favourite for LD services
- Possible option
- Yes centralisation of services, good for LD services
- YES
- Like new build for LD
- No capital available for new build (-ve)

Option 4B – NO (4 votes to 2)

- Acute admission in Dundee (+ve)
- Centralisation of LD good
- Yes for LD
- Could see this option working
- Preferred option

- No same as 1A
- NO
- Doesn't utilise all sites
- Not a feasible option – no crisis intervention in Angus
- No standalone
- No staff at Stracathro
- Not keen on all LD at MR

Option 5A – YES (4 votes to 1)

- Maximises estate and provides safe services
- YES LD split
- Think this would work
- Feasible option to consider
- NO

Option 5B – YES (4 votes to 2)

- Yes if good standard of LD refurb
- Feasible option to consider
- YES – better LD
- Like refurb for Strathmartine
- Not ideal option for Angus residents if detained in Perth
- Not best use of accommodation and no capital for refurb / ability to refurb to standard for modern healthcare

Option 6A – NO (5 votes to 1)

- Possible option
- No GAP in Dundee
- Doesn't maximise use of estate – no money for new build
- Not sure if feasible option – isolation of services
- NO money for new build
- Prefer to keep Carseview in some way

Option 6B – NO (5 votes to 1)

- Possible option
- No resource to build at Strathmartine, Carseview under utilised
- Not a feasible option
- NO on-call cover crisis team in Angus
- No GAP in Dundee
- Prefer better use to be made of Carseview

Option 7A – NO (5 votes to 1)

- Possible option
- No money for refurb or new build in capital plan not best for patients
- No GAP beds in Dundee

- New build for LD feasible but not the acute services option
- NO
- Like new build for LD but would like Carseview to be better utilised

TABLE FIVE

Notes –

- All GAP services in Perth
- All GAP services in Angus
- All GAP services in Dundee
- GAP services on 2 sites
- ALL LD services remain on Carseview & Strathmartine (refurbished)
- All LD services to Carseview and Low Secure Perth (2 sites)
- IPCU – Angus
- IPCU remain in Dundee
- Specialist services, rehab, IPCU, Complex care females on one site
- Change nothing status Quo
- All specialist services to Dundee

Option 1A – NO

- Build 2 units yet Carseview remains under utilised
- Day services required for LD
- Distance travel for acute care
- Refurb required for LD ward

Option 1B – NO

- Carseview underutilised
- Refurbishment required for Strathmartine
- New build required

Option 2A – NO

- New build for Stracathro
- Carseview empty
- Refurbishment required for LD
- Moredun empty

Option 2B – NO

- Carseview empty
- New build on Strathmartine
- Refurb required on Strathmartine

Option 3A – NO

- IPCU close to acute GAP
- No new build required
- Can shut Strathmartine
- Money available for Carseview
- LD and Acute GAP further from Angus
- Refurb LD ward required
- Empty purpose build unit at SHX
- Service user negative for Carseview
- Environment
- Not least restrictive option for LD due to mix of patients

Option 3B – NO

- IPCU close to Acute GAP
- Two purpose built wards empty
- Strathmartine needs refurbishment

Option 3C – NO

- IPCU close to GAP
- LD locked separate to rest of LD makes step down/up difficult
- Mulberry needs refurb for LD
- Empty purpose built Moredun
- Day services for LD?

Option 3D – NO

- New build at Strathmartine
- MRH and SHX have empty wards

Option 4A – YES PREFERRED OPTION

- IPCU close to GAP
- Acute GAP close to Dundee and SHX
- Recruitment benefits with GAP and LD (lose MR GAP)
- Good access for LD to acute GAP and medicine
- LD would need refurbish from Carseview money
- Moredun empty
- LD consultant cover for MR
- Day services for LD required

Option 4B – NO

- IPCU close to GAP
- Acute GAP close to Dundee and SHX
- LD ward needs refurbishment
- Day services for LD
- LD recruitment
- No LD services in Angus

- GAP far from MRH

Option 5A – NO

- IPCU and GAP close to each other
- GAP close to MRH and Carseview
- Mulberry new build empty
- Refurbish LD ward
- LD day services
- GAP far from Angus
- Recruitment issue for Gap MR

Option 5B – NO

- Refurb Strathartine
- No LD in Acute wards

Option 6A – NO

- Carseview empty
- New build on Strathmartine/refurb Strathmartine

Option 7 – NO

- Carseview empty
- Stracathro new build
- Strathmartine re build

Option 8 – NO

- GAP acute retained in Angus and Dundee
- Improve recruitment to GAP
- Better access for LD to GAP and general hospital
- LD ward need refurbishment – use Carseview monies
- LD day services

TABLE SIX

Notes

Develop & Implement a ROBUST community mental health service

Need more information as to what was agreed model 10 years ago.

A team will provide continuity of care

Consider Advanced Nurse Practitioner

Take pressure (demand) from inpatient service

A single GAP acute site ? LD Specialist ? Specialist ? Is one site big enough?

Why? Release funding for community – increase improve recruitment and retention of staff

Continuity of care is the community mental health team – they need to be informed of all services (Level one and two)

Where are the specialist staff based?

What needs to be centralised (regional or Tayside or Perth/Dundee/Angus)

Local knowledge is key

We do most of what we do in the community

What is the next step up e.g Regional

Initial Assessment important – what services proposed over 10 years ago? Level 1 and Level 3 and Inpatients

Who are the "experts"

Traige process with the "right people" including senior medical staff

What is safe when triage says no (experts)

How do we work with our referring partners to prevent hospital admissions

Crisis Teams need to work in community – "safe Place"

All this needs to be in place to assist early discharge

Manage delayed discharges

Make Tayside attractive place to work

If all of above in place, this will be answer to how many & where beds need to be.

Option 3A – Releases staffing resource to develop community services. Reduces number of Medical rotas. Supports bigger pool of trainee doctors working together. Best use of buildings.

Not clear how much resource this will release, addresses building needs but not patient needs e.g LD patients all to P&K

TABLE SEVEN

Option 1A – NO (5 votes to 1)

- Not feasible or practical on site
- Empty beds in Carseview, New Builds, IPCU in Forensic
- Cost new build, Carseview under utilised
- Cost empty wards, transport costs, not person centred

- Cost of new builds
- Staff skills and availability a concern
- Ability for HV and community association
  Under use of existing wards and new build?

Option 1B – NO (6 votes)

- Additional cost of rebuild & additional cost of rebuild & empty PFI building refurbishment
- Carseview empty, additional costs new build and refurb, travel costs for people in Dundee
- No
- Cost empty wards & new build
- Complex care not suitable location for Perth Service Users
- Stathmartine – not fit for purpose, cost to refurbish
- Staff skills and availability
- Not person centred
- Carseview empty PFI
- Cost of New builds
- Rehab potential in Angus limited due to location
- Due to refurbishment costs and use of buildings
- Not efficient and not for patients
- Not conducive for recovery to have GAP all together
- Poor use of sites for long term

Option 2A – NO (6 votes)

- Under use of space & cost of new build, Access of GAP patients
- New build cost, empty ward at MR, Carseview underutilised, IPCU – Low Secure
- Empty ward at MR, new build at Stracathro, LD only in Carseview, IPCU-Low Secure
- Due to poor use of buildings & split of GAP services & support
- Not good to have all together
- Not suitable staff skills & availability, empty wards, cost of new build, travel time for HV & community access
- Not person centred
- NO

Option 2B – NO (6 votes)

- Empty PFI and refurbishment costs, empty wards
- GAP stracathro need new build, Carseview empty, not max use of space, IPCU doesn't sit in Low Secure
- NO
- GAP at Stracathro, Carseview empty, Moredun empty, GAP pathway split, staff all needed in Angus
- Costs too high and split services & sites, Empty wards & needs new builds
- Empty wards, staffing

- Cost new builds, cost empty wards, cost refurb Strathmartine, IPCU distance for Angus, not person centred, distance for Perth Acute

Option 3A – YES (5 votes to 1)

- YES
- Single site for admission – centralisation specialist services, one area, better environment for LD
- Yes – Good use of site, combining some & use of staff, but some empty wards
- More potential with this option, GAP centralised better, However LD forensic have to move to MR ? how services are shared
- Strathmartine empty cost? Strathmartine empty positive, 2 x half used ward in MR staff availability ? skills? Rehab all in Perth – NO, Suitable for Dundee and Angus, staff skilled and specialisms available in Perth
- Centralisation of GAP will facilitate efficient use of medical cover and resources. LD all hosted on one site.
- NO feels institutional to service users GAP – not good to pack people together like this

Option 3B – NO (5 Votes to 1)

- YES Strathmartine empty agree, LD 2 locations benefit for person centred planning and staff skill availability
- Too many sites underutilised
- Too many empty beds, Strathmartine needs refurbished ? Would it make environment any better?
- NO
- Empty Wards, refurb cost
- Not practical, conducive to recovery for GAP
- NO Good for staffing across 2 sites but problems with empty wards & provision in Angus
- Strathmartine not cost effective, empty wards costly, skill staff & availability, discharge planning, HV & community visits/amenities

Option 3C - NO (6 votes)

- Too many wards underutilised, LD split
- LD separated MR & Angus, Ineffective use of space, empty areas at MR
- No
- No
- Problem being split across sites & no LD in Dundee but good to close Strathmartine
- No Splits LD

Option 3D – NO (6 votes)

- Cost of new build on 4 sites, too many wards underutilised
- NO
- Not good use of buildings & sites – across 4 areas

- New build poor use of building, costs
- No under utilisation of resources
- Strathmartine new build, not realistic – more costly, Not good use of current buildings
- Inefficient bed use, cost of new build

Option 4A – YES/NO (3 votes to 3)

- Okay of Moredun is considered for other roles/community care
- No New build costs less transfers for admission, 3 sites for RMO
- Benefits for specialisms in 2 sites for SUs but does not fit with current thinking, empty ward at MR – cost? Staffing models, Perth acute travel, rehab central not fit for purpose
- Yes worth exploring further but still on 3 sites
- NO
- No build costs but GAP on 2 sites away from Rehab wards and LD service split
- Under use of space

Option 4B – NO (4 votes to 2)

- Ninewells expansion?
- Strathmartine close benefits, LD perth travel but specialism, empty wards used by other specialisms
- Empty wards at Carseview, under utilised in other areas
- NO
- NO too many empty wards
- Empty wards

Option 5A – YES (4 votes to 2)

- Less sites, no new build costs, some inefficiency in wards
- YES some splitting but some ability to share staff
- YES
- YES with exploring further
- Empty ward Stracathro – cost, staff skills & available – Angus staff transfer, empty wards, need alternative options for empty wards
- Empty ward, underutilised ward in Angus
- Inefficient use of Angus – huge area missing out

Option 5B – NO (5 votes to 1)

- YES
- Empty wards, refurb costs
- NO, too costly & too many empty beds
- Cost – Angus missing out
- Cost for Strathmartine, Carseview empty wards
- Empty ward costs, Strathmartine upkeep costs, staff skills & experience availability

Option 6A – NO (6 votes)

- Cost of empty wards, Strathmartine costly, not fit for purpose, loss of beds/empty beds, IPCU Perth – location – not suitable – impact on police and other staff for transport, not person centred
- NO
- Carseview empty, cost of new build, maintenance, loss of 2x AIS
- Too costly
- NO
- NO too costly re buildings & spend on Strathmartine
- Closed Carseview but beside large Ninewells, new build costs, IPCU in low secure-not feasible, decrease in bed numbers

Option 6B – NO (5 votes to 1)

- YES if Ninewells needs expansion for other NHS use, Mulberry great environment for GAP
- NO needs new build & 66 empty beds Carseview and in MR
- NO
- Refurbishment costs, not good use of wards, inefficient across 4 sites
- No underuse of PFI
- New build in Stracathro, 66 empty beds in Carseview, IPCU in Forensic – not possible
- No GAP in Dundee, Cost of new build, IPCU wrong environment, NO
- Cost new build, Strathmartine close positive, empty beds waste

Option 7 – NO (6 votes)

- Closed Carseview, New build Stracathro not centralising
- Cost of new build, Carseview empty, staffing issues
- NO
- Not practical
- NO too costly with 120 empty beds & gaps in Dundee
- Dundee closed – waste, New Strathmartine – cost, new

Option 8 –YES (6 votes) Tables own option which was 3A plus crisis beds in each area

- Crisis beds good idea, GAP in one area
- 3A+ Assess suite 24/72hrs
- Option for consideration – assessment beds great idea
- Assessment suite great idea for inclusion
- Consider – not sure about GAP all together
- YES
- Yes – includes S/T admission facility

Option 9 – YES/NO (3 votes to 3) Tables own option which was step down plus crisis beds in each area

- YES explore further
- YES

- Great idea
- Best Option Rehab – safe haven use other spaces fund 3rd Sector
- NO rehab beds in Angus – better centralised, works in MR, too many sites not feasible
- No Less assessment beds on Carseview
- Less assessment beds

TABLE EIGHT

CREATING THE OPTIONS

OPTION 1A – NO **=9th Choice**

- Negatives - Poorer for patient/family accessibility
- Not viable for a standalone challenging behaviour unit
- Patient centeredness
- Equity
- No perceived benefit in medical cover
- Positives - Single site for LD in central location, strong sustainability and affordability

OPTION 1B – NO

- As above plus refurb not do-able within existing build

OPTION 2A – NO

- As 1A above

OPTION 2B – NO

- As 1B

OPTION 3A - YES =3rd Choice

- Positives – Believe better location for GAP. Services next to University
- Recruitment
- Potentially OK for rehab
- Potential increase recruitment into LD psychiatry
- Need a refurbishment of Carseview
- Negatives – Patient care outside locality , Fear of Carseview, lack of accessibility

OPTION 3B – NO

- As 1B plus lack of emergency response for complex care areas.
- Less bang for buck as previous option
- Unacceptable distances

OPTION 3C – NO

- Difficult to staff into these localities
- Difficult to staff for emergency response to LD
- May lead to higher level of restriction than patients need

OPTION 3D **–** NO 3rd Choice

- As 1A, plus what about utilisation of MRH? Staffing
- Positives – With refurb of Carseview

OPTION 4A **-** YES/NO equal 4th Choice

- Positives – Continuing good are at Mulberry, doable LD
- Negatives – Staffing, accessibility, efficiency

OPTION 4B – NO 9th Choice

- As 4A, Need GAP beds in Perth & Kinross or centralised in Dundee

OPTION 5A - YES 2nd Choice

- Addresses staffing risks for LTC and Rehab
- Maintained accessibility for Perth & Kinross and Dundee
- Negatives – Poor accessibility for Angus residents

OPTION 5B – NO 9th Choice
- No explanation given

OPTION 6A – NO 5th Choice

- Bed accessibility within an hour
- Distance to IPCU

OPTION 6B – NO 5th Choice
- No explanation given

OPTION 7 – NO 5th Choice

- 2 new builds needed

OPTION 8 – YES 1st Choice

- More focus on recovery, potentially more beneficial therapeutic environment
- Maintain locality preserve and centralise where staffing
- Higher intensity and skill mix

TABLE NINE

Notes

Status quo – maintain existing model
7 days functioning service (targeted)
2 site (combination)
Acute admission/step down beds
One site
Regional commissioning
Co-morbid defined beds e.g. alcohol, drug intoxification, physical/mental health co-morbidities
M.S / L.S Women's services

Option 1A - NO

- New build required

Option 1B – NO

- New build required
- LD maintained at Strathmartine

Option 2A – NO

- New build required
- IPCU disconnected

Option 2B – NO

- New build required
- IPCU disconnected

Option 3A – YES

- Staffing
- Within existing footprint
- Refurb of Carseview

Option 3 B – YES

- But use of footprint
- LD remains on Strathmartine

Option 3C – YES

- But Use of footprint
- Services on Moredun site

Option 3D – NO

- New build required

- Use of existing footprint

Option 4A – YES

- No build
- But Off Strathmartine
- Staffing challenges

Option 4B – YES

- No build
- But off Strathmartine
- Staffing challenges

Option 5A – YES

- No build
- Off Strathmartine
- Connection between

Option 5B – NO

- Empty beds on each site
- LD on Strathmartine

Option 6A – NO

- LD on Strathmartine
- Empty Carseview
- 2 new build

Option 6B – NO

- IPCU and GAP beds
- Disconnected
- New build required

Option 7 – NO

- New build required
- Strathmartine rebuild
- IPCU disconnect

TABLE 10

Notes – New models considered

NEW X model** See coloured in sheet– **(included as top 6 for Table 10)

16.06.20 - Table 10 Option X.pdf

NEW Y model New build mega unit for ALL mental health services on new site with excellent transport links

OPTION 7 New build Stracathro and Strathmartine

NEW Za - One site

- Assessment hub – Focus on preventing admission – Multi-disciplinary (liaison, Senior Nurse, AHP's)
- Spokes to 3 areas – protected home treatment service
- Seven days a week discharge service
- Crisis admissions – in partnership – bed model – off site 'Crisis House'

***NEW Zb** 2 Sites
As above but on 2 sites

OPTION Q One site

- Acute wards – Specialist function e.g. mood disorder, psychosis unit, distress unit
- Recruitment – Links to University, Advanced intervention service

***R** One site

- Same as option Q but with LD Co-location

Notes: Craigmill Skills Strathmartine OT dept – "backbone of the service" – would need to be relocated
Footnote: LD off Strathmartine assurance that 3 x locality community teams are enhanced (LD freeing up whole site – Therefore funding needs to remain in LD Services

LONG LIST OF OPTIONS

OPTION 1 – Yes (6 votes)

- Because it has to be in

OPTION 1A – NO (4 votes to 2)

OPTION 1B – NO (4 votes to 2)

OPTION 2A – NO (5 votes to 1)

OPTION 2B – NO (4 votes to 2)

OPTION 3A – NO (5 votes to 1)

OPTION 3B – NO (4 votes to 2)

OPTION 3C – NO (5 votes to 1)

OPTION 3D – NO (4 votes to 2)

*OPTION 4A - YES (5 votes to 1)

OPTION 4B – NO (4 votes to 2)

*OPTION 5A – YES (4 votes to 2)

*OPTION 5B – YES (5 votes to 1)

OPTION 6A – NO (4 votes to 2)

OPTION 6B – NO (5 votes to 1)

OPTION 7 – NO (4 votes to 2)

OPTION Q – NO (4 votes to 2)

*OPTION R – YES (4 votes to 2)

*OPTION X - YES (4 votes to 2)

OPTION Y – NO (6 votes)

OPTION Za – NO (4 votes to 2)

*OPTION Zb – YES (4 votes to 2)

TABLE ELEVEN

CREATING THE OPTIONS

OPTION 1
Status Quo – Stay the same

OPTION 1A
All GAP at MRH
LD at Carseview
Rehab at Stracathro, includes additional build at MRH

OPTION 3A
All GAP on one site Carseview
All sub-specialities in MRH

OPTION 4A
GAP at Carseview and Stracathro
LD at MRH and Carseview

OPTION5A

GAP at Carseview and MRH
LD at MRH and Carseview

OPTION 8
GAP on 3 sites
LD on 3 sites
Rehab on 3 sites

OPTION 9
Commissioning certain services out with acute
1 site option in Dundee with a step down model such as a halfway house in each locality
GAP – the services for crisis house will be integrated –health, social care etc
A potential to reduce GAP inpatient beds in Carseview which could potentially be used for LD.
"Single site option"
GAP beds at Carseview
Develop 3 crisis houses in each Local Authority area.
LD beds split between Carseview and MRH.
Potential for rehab beds in Carseview.
Moving towards a social and community integrated care model.
Additional spending would be in the community and not in the hospital

LONG LIST OF OPTIONS

STATUS QUO – NO

- Strathmartine not fit purpose
- Workforce challenges
- Non-sustainable long term

OPTION 1A – NO

- Financially not an option – requires money for a new build

OPTION 1B – NO

- As above

OPTION 2A - NO

- As above

OPTION 2B - NO

- Financial loss - 5m from Carseview

OPTION 3A - YES

- Pros and Cons
- All the beds for GAP will be in Dundee and therefore service e user and workforce issues
- LD centralised at MRH – Workforce issues re travel and service user issues re travel

OPTION 3B – NO

- As above same as status quo
- LD not fit for purpose in Strathmartine

OPTION 3C – YES

- Would be using a modern vacant site at Mulberry – could lead to workforce issues re travel. Also same as 3A disadvantage for Perth & Kinross users

OPTION 3D – NO

- No finances for new build

OPTION 4A - YES

- Perth & Kinross users and workforce disadvantaged by travel and access to service

OPTION 4B - YES

- As 4A above

OPTION 5A - YES

- Angus service users and workforce disadvantaged by travel and access to service

OPTION 5B – NO

- SMH

OPTION 6A - NO

- Financial loss and no finance for new build
-

OPTION 6B - NO

- Financial loss
- No finance for new build
- Loss of service at most needed area in Dundee
- Co-location and liaison with Acute services will be lost

OPTION 7 – NO

- Cost of refurbishment of Strathmartine

OPTION 8 – NO

- Non-sustainable as per Status Quo

OPTION 9 – YES

- Preferred option

Appendix Ten

Supporting Information Provided

151201_NHS_Tayside_Mental_Health_Pro

Benchmarking information.docx

Combined_Appendices.pdf

Edinburgh-Crisis-Centre-Annual-Report14:

In_-patient_Briefing_Note%5b2%5d.doc

MH_Clinical_Services diagram.ppt

MHCSS_Final.pdf

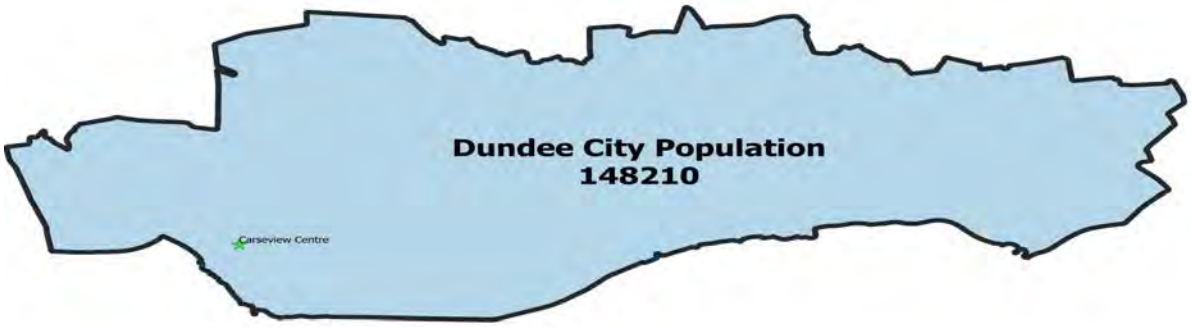
NHST_CSS_June15 (1).pdf

realistic medicine.pdf

Appendix Eleven

Population Maps and Transport Link Information

Dundee



Angus

Perth

Public Transport Travel Times - ANGUS

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Forfar		Carseview		1.14 hrs		1.14 hrs
Forfar		Stracathro		38 mins		51 mins
Forfar		Strathmartine		1.23 hrs		1.23 hrs
Forfar		Murray Royal		2 hrs		2.18 hrs
Brechin		Carseview		1.43 hrs		2.45 hrs
Brechin		Stracathro		16 mins		18 mins
Brechin		Strathmartine		1.50 hrs		2.09 hrs
Brechin		Murray Royal		2.05 hrs		2.29 hrs
Arbroath		Carseview		55 mins		1.40hrs

Arbroath		Stracathro		1.19 hrs		1.32 hrs
Arbroath		Strathmartine		1.50 hrs		2.09 hrs
Arbroath		Murray Royal		1.30 hrs		2.01 hrs
Montrose		Carseview		1.08hrs		1.30 hrs
Montrose		Stracathro		43 mins		43 mins
Montrose		Strathmartine		1.29 hrs		1.48 hrs
Montrose		Murray Royal		1.30 hrs		2.19 hrs
Kirriemuir		Carseview		1.30 hrs		1.30 hrs
Kirriemuir		Stracathro		1.08 hrs		1.36 hrs
Kirriemuir		Strathmartine		1.36 hrs		1.42 hrs
Kirriemuir		Murray Royal		1.52 hrs		2.46 hrs
Letham		Carseview		1.33 hrs		1.56 hrs
Letham		Stracathro		45 mins		1.39 hrs
Letham		Strathmartine		1.42 hrs		1.54 hrs
Letham		Murray Royal		2.22 hrs		2.49 hrs
Edzell		Carseview		2.07 hrs		2.28 hrs
Edzell		Stracathro		15 mins		15 mins
Edzell		Strathmartine		2.16 hrs		2.55 hrs
Edzell		Murray Royal		2.53 hrs		3.17 hrs
Carnoustie		Carseview		48 mins		1.03 hrs
Carnoustie		Stracathro		1.12 hrs		2.19 hrs
Carnoustie		Strathmartine		1.24 hrs		1.30 hrs
Carnoustie		Murray Royal		1.15 hrs		1.49 hrs
Monifieth		Carseview		51 mins		51 mins
Monifieth		Stracathro		1.30 hrs		1.58 hrs
Monifieth		Strathmartine		57 mins		1.18 hrs
Monifieth		Murray Royal		1.34 hrs		1.55 hrs
Dundee		Carseview		23 mins		25 mins
Dundee		Stracathro		1.20 hrs		1.30 hrs
Dundee		Strathmartine		28 mins		46 mins
Dundee		Murray Royal		1 hr		1.15 hrs
Muirhead		Carseview		16 mins		41 mins
Muirhead		Stracathro		2 hrs		2.42 hrs
Muirhead		Strathmartine		47 mins		52 mins
Muirhead		Murray Royal		1.44 hrs		2.54 hrs

Mileage Distances - ANGUS

DESTINATION	LOCATION		Mileage by Car
Stracathro	Forfar		18.0 miles
	Brechin		3.7 miles
	Arbroath		19.6 miles
	Montrose		9.4 miles
	Kirriemuir		19.4 miles
	Letham		16.3 miles
	Edzell		3.7 miles
	Carnoustie		24.1 miles
	Monifieth		33.8 miles
	Dundee		29.8 miles
	Muirhead		33.2 miles

DESTINATION	LOCATION		Mileage by car
Carseview	Forfar		18.4 miles
	Brechin		31.1 miles
	Arbroath		20.9 miles
	Montrose		41.9 miles
	Kirriemuir		23.6 miles
	Letham		22.6 miles
	Edzell		36.0 miles
	Carnoustie		15.4 miles
	Monifieth		10.1 miles
	Dundee		4.0 miles
	Muirhead		4.3 miles

DESTINATION	LOCATION		Mileage by Car
Strathmartine	Forfar		14.0 miles
	Brechin		26.8 miles
	Arbroath		19.6 miles
	Montrose		37.5 miles
	Kirriemuir		19.2 miles

	Letham		18.2 miles
	Edzell		31.6 miles
	Carnoustie		14.0 miles
	Monifieth		9.3 miles
	Dundee		4.4 miles
	Muirhead		3.7 miles

DESTINATION	LOCATION		Mileage by car
MRH	Forfar		34.9 miles
	Brechin		47.7 miles
	Arbroath		39.0 miles
	Montrose		58.5 miles
	Kirriemuir		27.6 miles
	Letham		39.0 miles
	Edzell		52.6 miles
	Carnoustie		33.5 miles
	Monifieth		28.7 miles
	Dundee		22.8 miles
	Muirhead		20.9 miles

Public Transport Travel Times - DUNDEE

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Dundee		Carseview		23 mins		25 mins
Dundee		Stracathro		1.20 hrs		1.30 hrs
Dundee		Strathmartine		28 mins		46 mins
Dundee		Murray Royal		1 hr		1.15 hrs

Mileage Distances - PERTH

DESTINATION	LOCATION		Mileage by Car
Stracathro	Dundee		29.8 miles

DESTINATION	LOCATION		Mileage by car
Carseview	Dundee		4.0 miles

DESTINATION	LOCATION		Mileage by Car
Strathmartine	Dundee		4.4 miles

DESTINATION	LOCATION		Mileage by car
MRH	Dundee		22.8 miles

Public Transport Travel Times - PERTH

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Perth		Carseview		42 mins		57 mins
Perth		Stracathro		2 hrs 1 min		2 hrs 33mins
Perth		Strathmartine		1 hr 30 mins		1 hr 50 mins
Perth		Murray Royal		25 mins		27 mins
Blairgowrie		Carseview		1 hr 3 mins		1 hr 41 mins
Blairgowrie		Stracathro		2 hrs 20 mins		3 hrs 20 mins
Blairgowrie		Strathmartine		1 hr 12 mins		1 hr 26 mins
Blairgowrie		Murray Royal		54 mins		59 mins
Pitlochry		Carseview		2 hrs		2 hrs 22 mins
Pitlochry		Stracathro		2 hrs 50 mins		3 hrs 16 mins
Pitlochry		Strathmartine		2 hrs 19 mins		2 hrs 28 mins
Pitlochry		Murray Royal		1 hr 13 mins		1 hr 46 mins
Kinross		Carseview		1 hr 21 mins		1 hr 59 mins
Kinross		Stracathro		2 hrs 54		3 hrs 52 mins

				mins		
Kinross		Strathmartine		2 hrs 4 mins		2 hrs 11 mins
Kinross		Murray Royal		59 mins		1 hr 6 mins
Coupar Angus		Carseview		53 mins		1 hr 41 mins
Coupar Angus		Stracathro		2 hrs 34 mins		3 hrs 37 mins
Coupar Angus		Strathmartine		1 hr 2 mins		2 hrs 10 mins
Coupar Angus		Murray Royal		41 mins		44 mins
Aberfeldy		Carseview		2 hrs 17 mins		2 hrs 20 mins
Aberfeldy		Stracathro		3 hrs 51 mins		4 hrs 12 mins
Aberfeldy		Strathmartine		2 hrs 48 mins		3 hrs 25 mins
Aberfeldy		Murray Royal		1 hr 41 mins		1 hr 44 mins
Crieff		Carseview		1 hr 33 mins		2 hrs 25 mins
Crieff		Stracathro		3 hrs 6 mins		3 hrs 15 mins
Crieff		Strathmartine		2 hrs 21 mins		2 hrs 47 mins
Crieff		Murray Royal		1 hr 6 mins		1 hr 7 mins
Auchterarder		Carseview		1 hr 17 mins		1 hr 39 mins
Auchterarder		Stracathro		2 hrs 50 mins		3 hrs 28 mins
Auchterarder		Strathmartine		1 hr 55 mins		2 hrs 41 mins
Auchterarder		Murray Royal		50 mins		1 hr 9 mins
Errol/Carse of Gowrie		Carseview		50 mins		1 hr 8 mins
Errol/Carse of Gowrie		Stracathro		2 hrs 25 mins		2 hrs 56 mins
Errol/Carse of Gowrie		Strathmartine		1 hr 25 mins		2 hrs 4 mins
Errol/Carse of Gowrie		Murray Royal		40 mins		40 mins
Dunkeld		Carseview		1 hr 43 mins		2 hrs 7 mins
Dunkeld		Stracathro		3 hrs 13 mins		3 hrs 39 mins
Dunkeld		Strathmartine		2 hrs 26 mins		2 hrs 36 mins
Dunkeld		Murray Royal		1 hr 7 mins		1 hr 20 mins
Kinloch Rannoch		Carseview		2 hrs 35		4 hrs

				mins		
Kinloch Rannoch		Stracathro		4 hrs 10 mins		4 hrs 41 mins
Kinloch Rannoch		Strathmartine		3 hrs 17 mins		4 hrs 10 mins
Kinloch Rannoch		Murray Royal		2 hrs 16 mins		2 hrs 49 mins
Alyth		Carseview		1 hr		1 hr
Alyth		Stracathro		1 hr 44 mins		3 hrs 5 mins
Alyth		Strathmartine		1 hr 10 mins		1 hr 11 mins
Alyth		Murray Royal		1 hr 16 mins		1 hr 21 mins

Mileage Distances - PERTH

DESTINATION	LOCATION		Mileage by Car
Stracathro	Perth		51.58
	Blairgowrie		36.73
	Pitlochry		60.92
	Kinross		65.17
	Coupar Angus		33.21
	Aberfeldy		65.09
	Crieff		69.74
	Auchterarder		64.1
	Errol/Carse of Gowrie		43.83
	Kinloch Rannoch		85.14
	Dunkeld		48.04
	Alyth		32.64

DESTINATION	LOCATION		Mileage by car
Carseview	Perth		19.66
	Blairgowrie		18.66
	Pitlochry		48.37
	Kinross		33.24
	Coupar Angus		13.81
	Aberfeldy		52.54
	Crieff		37.81
	Auchterarder		32.17

	Errol/Carse of Gowrie		11.9
	Dunkeld		36.18
	Kinloch Rannoch		72.58
	Alyth		17.01

DESTINATION	LOCATION		Mileage by Car
Strathmartine	Perth		23.22
	Blairgowrie		17.95
	Pitlochry		51.93
	Kinross		36.81
	Coupar Angus		13.11
	Aberfeldy		56.1
	Crieff		41.37
	Auchterarder		35.73
	Errol/Carse of Gowrie		15.46
	Dunkeld		14.52
	Kinloch Rannoch		76.15
	Alyth		15.15

DESTINATION	LOCATION		Mileage by car
MRH	Perth		1.68
	Blairgowrie		15.51
	Pitlochry		27.24
	Kinross		18.3
	Coupar Angus		13.2
	Aberfeldy		31.41
	Crieff		17.99
	Auchterarder		17.23
	Errol/Carse of Gowrie		10.28
	Dunkeld		15.05
	Kinloch Rannoch		51.47
	Alyth		22

Appendix Twelve

Bed Model Clinical Descriptors

OPTION 3A

Carseview Centre

- 4 x 22 bed acute admission wards (4 beds dedicated to National Service)
- 1 x 10 bedded Tayside wide Psychiatric Intensive Care Unit

Strathmartine –Closed

Murray Royal Hospital

- 1 x Learning Disability ward 26 beds maximum for General Assessment beds, Behavioural Support and Intervention beds and Open Forensic beds
- Tayside Complex care and Rehabilitation up to 26 beds
- 1 x 6/8 bed Tayside wide Substance Misuse ward
- 1 x 10 bed Tayside wide Complex Care female only ward

Secure Beds

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25 Tayside wide Low Secure beds across 2 wards
- 6/8 bedded LD Locked low secure Unit within Rohallion

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bedded dementia wards
- 1 x 14 bedded functional ward

Stracathro

- 1 x older peoples functional ward (Susan Carnegie)
- 1 x older peoples dementia ward (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to wards in Dundee. No acute admission beds available in Angus or Perth. A centralised acute bed base will require a review of community mental health services provision and delayed discharges in Angus,

Dundee and Perth and Kinross to reduce reliance on inpatient care.

- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)

- Adults with Learning Disabilities would require admission to Murray Royal Hospital. This includes the Learning Disability Assessment Unit in Carseview. This would allow for all Learning Disability Services to be accommodated on one site. This would require appropriate ward design as the three very different patient groups require to be separated.

- A review of community learning disability services and supported accommodation would be required in Angus, Dundee and Perth and Kinross to reduce reliance on inpatient care and ensure adequate local day treatment was available.

Staffing

- Impact on staff as inpatient admission wards are centralised.
- Impact on staff employed in Secure Care due to bed reduction in Low Secure Service
- Impact on staff employed in Learning Disability Services with move of service from Dundee to Angus.
- Impact of medical rotas providing out of hours and emergency response.

Estate

- No new builds required.
- Empty ward at Stracathro – would be subject to further Option Appraisal by Angus IJB
- Identified funds to refurbish Carseview
- Disposal of Strathmartine site

OPTION 3B

Carseview Centre

- 4 x 22 bed acute admission wards (4 beds dedicated to National AI `Service).
- 1 x 10 bedded Tayside wide Psychiatric Intensive Care Unit.

Strathmartine

- 6/8 Locked Low secure Forensic beds
- 6 Behavioural Support and Intervention beds
- 8 General assessment beds
- 10 Open Forensic beds

Murray Royal Hospital

- 1 x Tayside Complex care and Rehabilitation up to 26 beds.
- 1 x 6/8 bed Tayside wide Substance Misuse ward.
- 1 x 10 bed Tayside wide Complex Care female only ward.

Secure Beds

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25-35 Tayside wide Low Secure beds across 2 wards.

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bedded dementia wards
- 1 x 14 bedded functional ward

Stracathro

- 1 x older peoples functional ward (Susan Carnegie)
- 1 x older peoples dementia ward (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to wards in Dundee. No acute admission beds available in Angus or Perth.

A centralised acute bed base will require a review of community mental health services provision and delayed discharges in Angus, Dundee and Perth and Kinross to reduce reliance on inpatient care.

- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)

- The Learning Disability Assessment Unit in Carseview will transfer to Strathmartine. This would result in all Learning Disability Services being on one site. This would require significant changes to buildings.

- A review of community learning disability services and supported accommodation would be required in Angus, Dundee and Perth and Kinross to reduce reliance on inpatient care.

Staffing

- Impact on staff as inpatient admission wards are centralised.
- Impact on staff employed in Secure Care due to bed reduction in Low Secure Service
- Impact of medical rotas providing out of hours and emergency response.

Estate

- Empty ward at Stracathro – would be subject to further Option Appraisal by Angus IJB
- Empty ward at Murray Royal – would be subject to further Option Appraisal by Perth IJB
- Identified funds to refurbish Carseview but no allocation in current capital plan for refurbishment of Strathmartine

OPTION 4A

Carseview Centre

- 3 x 22 bed Tayside acute admission wards (4 beds dedicated to National AI Service).
- 1 x 10 bedded Tayside wide mixed sex Psychiatric Intensive Care Unit.
- 1x 20 bedded Tayside wide combined Learning Disability ward

Strathmartine –Closed

Murray Royal Hospital

- 1 x Tayside Complex care and Rehabilitation up to 26 beds
- 1 x 6/8 bed Tayside wide Substance Misuse ward
- 1 x 10 bed Tayside wide mixed sex rehabilitation ward
- Leaves 1 x 29 bed ward empty

Secure Beds

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25 Tayside wide Low Secure beds across 2 wards.
- 6-8 bedded Tayside Learning Disability Locked Low Secure Unit within Rohallion

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bedded dementia wards
- 1 x 14 bedded functional ward

Stracathro

- 1 x older peoples functional ward (Susan Carnegie)
- 1 x older peoples dementia ward (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to wards in either Dundee or Angus. There would be no acute admission beds provided in Perth. This model would require a review of

community mental health services provision but there is only a reduction of 3 in-patient beds within this model. Access to a range of psychological therapies and counselling, as well as Intensive Home Treatment Teams that can provide a range of interventions that are suitable alternatives to hospital admission, 7 days a week.

- Travel arrangements for staff, patients and carers would require review due to the geographical boundaries and rurality of Perth and Kinross to travel to Dundee and Angus.

- This model would continue to require 24/7 crisis support services that link to locality services, particularly social work and MHO services.

- Access to modern ECT facilities that comply with SEAN standards and provide both in-patient and out-patient treatment options.

- Complex needs is reconfigured to provide a separate male and female area within one ward which provides care and treatment for individuals with challenging behaviour and co-morbidities who require more longer term support for both mental health and physical health care.

- Rehabilitation is provided as a separate function within Rannoch ward at MRH which would develop skills, promote independence and autonomy and lead to successful community living through access to support and housing within the wider community

- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)

- Adults with Learning Disabilities would require admission to Carseview, with the locked Forensic beds provided on the Murray Royal Hospital site and operationally managed by the Secure care Service. The proposed model is to provide 3 separate specialist areas within one large ward area, with a flexible environment

allowing sections to be reconfigured to meet demand and clinical activity. This would also support the use of the workforce more flexibly.

- Learning Disability Day opportunities would be developed within localities rather than replicating the Craigmill Skills centre. This will improve accessibility and equity of provision, and reduce significant travel requirements.

- A review of community learning disability services and supported accommodation would be required in Angus, Dundee and Perth and Kinross to reduce reliance on inpatient care and ensure adequate local day treatment was available. This may be achieved by decommissioning the specialist LD teams and relocating into the 3 generic locality community learning disability teams which would increase capacity, skills and team-working.

Staffing

- Impact on staff as inpatient admission wards are across 2 sites
- Impact on staff employed in Secure Care due to bed reduction in Low Secure Service
- Impact on staff employed in Learning Disability Services with move of forensic service from Dundee to Perth
- Impact of medical rotas providing out of hours and emergency response.
- Minimal reduction in in-patient beds does not identify resource to shift balance of care from in-patients to community services
- Specialist multidisciplinary staff for Complex needs and rehabilitation are located on one site

Estate

- No new builds required.
- Empty ward at Murray Royal – would be subject to further Option Appraisal by Perth IJB
- Identified funds to refurbish Carseview
- Disposal of Strathmartine site.

OPTION 5A

Carseview Centre

- 3 x 22 bed Tayside acute admission wards (4 beds dedicated to National AI Service).
- 1 x 10 bedded Tayside wide mixed sex Psychiatric Intensive Care Unit.
- 1x 20 bedded Tayside wide Learning Disability combined ward

Strathmartine –Closed

Murray Royal Hospital

- 2 x 10 bedded areas within Amulree Ward for Tayside Complex Care(separate male and female).
- 1 x 6/8 bed Tayside wide Substance Misuse ward.
- 1 x 10 bed Tayside wide mixed sex rehabilitation ward.
- 1 x 24 bed ward for Tayside acute admissions

Secure Beds

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25 Tayside wide Low Secure beds across 2 wards.
- 6-8 bedded Tayside Learning Disability Locked Low Secure Unit within Rohallion

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bedded dementia wards
- 1 x 14 bedded functional ward

Stracathro

- 1 x older peoples functional ward (Susan Carnegie)
- 1 x older peoples dementia ward (Susan Carnegie)
- 1x 25 bed ward empty (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to wards in either Dundee or Perth. There would be no acute admission beds provided in Angus. This model would require a review of community mental health services provision but there is only a reduction of 3 in-patient beds within this model. Access to a range of psychological therapies and counselling, as well as Intensive Home Treatment Teams that can provide a range of interventions that are suitable alternatives to hospital admission, 7 days a week.

- Travel arrangements for staff, patients and carers would require review due to the requirement to travel to Dundee from Angus.

- This model would continue to require 24/7 crisis support services that link to locality services, particularly social work and MHO services.

- Access to modern ECT facilities that comply with SEAN standards and provide both in-patient and out-patient treatment options.

- Complex needs is reconfigured to provide a separate male and female area within one ward which provides care and treatment for individuals with challenging behaviour and co-morbidities who require more longer term support for both mental health and physical health care.

- Rehabilitation is provided as a separate function within Rannoch ward at MRH which would develop skills, promote independence and autonomy and lead to successful community living through access to support and housing within the wider community

- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)

- Adults with Learning Disabilities would require admission to Carseview, with the locked Forensic beds provided on the Murray Royal Hospital site and operationally managed by the Secure Care Service. The proposed model is to provide 3 separate specialist areas within one large ward area, with a flexible environment allowing sections to be reconfigured to meet demand and clinical activity. This would also support the use of the workforce more flexibly.

- Learning Disability Day opportunities would be developed within localities rather than replicating the Craigmill Skills centre. This will improve accessibility and equity of provision, and reduce significant travel requirements.

- A review of community learning disability services and supported accommodation would be required in Angus, Dundee and Perth and Kinross to reduce reliance on inpatient care and ensure adequate local day treatment was available. This may be achieved by decommissioning the specialist LD teams and relocating into the 3 generic locality community learning disability teams which would increase capacity, skills and team-working.

Staffing

- Impact on staff as inpatient admission wards are across 2 sites
- Impact on staff employed in Secure Care due to bed reduction in Low Secure Service
- Impact on staff employed in Learning Disability Services with move of forensic service from Dundee to Perth
- Impact of medical rotas providing out of hours and emergency response.
- Minimal reduction in in-patient beds does not identify resource to shift balance of care from in-patients to community services
- Specialist multidisciplinary staff for Complex needs and rehabilitation are located on one site

Estate

- No new builds required.
- Empty ward at Stracathro – would be subject to further Option Appraisal by Angus IJB
- Identified funds to refurbish Carseview
- Disposal of Strathmartine site.

OPTION 5B

Carseview Hospital

- 3 x 22 bed acute admission wards (4 beds dedicated to National AI Service)
- 1 x 10 bedded Tayside wide Psychiatric Intensive Care Unit

Strathmartine

- 1 x 8 bed locked forensic ward
- 1 x 8 bed assessment ward
- 1 x 10 bed open forensic ward
- 1 x 6 bed behavioural support unit

Murray Royal Hospital

- 1 x 24 bed acute admission ward
- 1 x 26 bed Tayside wide Rehabilitation and Complex Care ward
- 1 x 6/8 bed Tayside wide Substance Misuse ward
- 1 x 10 bed Tayside wide Complex Care female only ward

Secure Beds at Murray Royal Hospital

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25 Tayside wide Low Secure beds across 2 wards.

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bedded dementia wards
- 1 x 14 bedded functional ward

Stracathro

- 1 x older peoples functional ward (Susan Carnegie)
- 1 x older peoples dementia ward (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to wards Dundee or Perth. No acute admission beds available in Angus

- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)
- Adults with Learning Disabilities would require admission to Strathmartine Hospital. This option details the move of the Learning Disability Assessment Unit from Carseview Hospital to Strathmartine. This would result in all Learning Disability Services being on one site. Refurbishment of the Strathmartine site is/would be required.

Staffing

- Impact on staff employed in Stracathro as inpatient admission ward is closed in this option
- Impact on staff employed in Secure Care due to bed reduction in Low Secure Service
- Impact on staff employed in Learning Disability Assessment Unit with move of service from Carseview to Strathmartine

Estate

- No new builds required
- Empty ward at Stracathro – would be subject to further Option Appraisal by Angus IJB
- Empty Ward at Carseview – would be subject to further Option Appraisal by Dundee IJB
- Reduced bed capacity in Low Secure Service
- Identified funds available to refurbish Carseview but no allocation in current capital plan for refurbishment of Strathmartine
- Retention of all current mental health sites.

OPTION 8

Carseview Hospital

- 1 x 22 bed GAP admission wards (4 beds dedicated to National Service)
  (or e.g. 8 beds for acute admissions and 14 for treatment)
- 1 x 22 bed GAP treatment ward
- 1 x 10 bed Tayside wide Psychiatric Intensive Care Unit
- 1 x 10 bed Learning Disabilities Assessment Unit / 6-8 bed Learning Disabilities Behavioural Unit split ward
- 1 x 6-8 bed Learning Disabilities Open Forensic Unit

Strathmartine - Closed

Murray Royal Hospital

- 1 x 24 bed GAP treatment ward.
- 1 x 26 bed Tayside wide Rehabilitation and Complex Care ward.
- 1 x 6/8 bed Tayside wide Substance Misuse ward.
- 1 x 10 bed Tayside wide Complex Care female only ward.

Secure Beds

- 32 Regional Medium Secure beds available to the North of Scotland across 3 wards
- 25 Tayside wide Low Secure beds across 2 wards
- 8 LD Locked Low Secure beds

Older People Mental Health Beds at Murray Royal Hospital

- 2 x 12 bed dementia wards
- 1 x 14 bed functional ward

Stracathro

- 1 x 20-25 bed Treatment Ward (Susan Carnegie)
- 1 x 12 bed older peoples functional ward (Susan Carnegie)
- 1 x 15 bed older peoples dementia ward (Susan Carnegie)

Care Pathways

- Adults requiring acute admission would be admitted to the GAP admission and assessment beds at Carseview (see attached flowchart)
- Following assessment, if requiring on-going inpatient care, would move to local community GAP treatment beds at Carseview, Murray Royal and Stracathro
- Adults requiring Intensive Psychiatric Care would be admitted to services in Dundee (No change to current arrangement)
- Adults with Learning Disabilities would require admission to Carseview. This option details the move of the Learning Disability Behavioural Unit and Open Forensic wards from Strathmartine hospital to Carseview. This would result in all Learning Disability Services being on one site, except for LD Low Secure Forensic which would be on the Murray Royal site along with other Low Secure Forensic patients.

Staffing

- Impact on staff employed in Carseview which becomes GAP acute admissions site
- Impact on staff employed in LD and Secure Care due to moving of LD Low Secure to Murray Royal Site
- Impact on staff employed in Learning Disability Behavioural and Open Forensic units with move of service from Strathmartine to Carseview site.

Estate

- No new builds required
- Improved utilisation of Murray Royal, Carseview and Stracathro
- Disposal of Strathmartine site
- Identified funds to refurbish Carseview

Appendix Thirteen

Individual Scoring Sheets – Benefits Criteria and Option Scoring results

16.07.28 Option Appraisal Scoring det

Appendix Fourteen

Sensitivity Analysis of Scores

16.08.09 Sensitivity Analysis of scoring Fi

Appendix Fifteen

Feedback from discussion on 30th June 2016 and feedback forms collected from Workshops

Feedback from tables recorded at Option Appraisal Workshop 30th June 2016

Table One

Benefit Criteria

Importance of equity

Ensure and maintain a motivated staff group

Importance of staff to change

Acknowledge current recruitment issues

Option Feedback

Option scoring rationale

Option 1

Current position - Do nothing
LD wishes to stay as they are.
Issues around resource release to upgrade environment to meet changing profile!!!

Option 2

People disadvantaged from local areas
Better use of medical staffing; issues of day services
Concerns about safety/risk management re high risk service users.
May need bigger day services. Issues about community connectiveness.
Transport issues re hours and OOH's

Option 3B

Is there money for refurbishment of Stracathro?
Enablers still have day service

Option 4A

LD - risk management issues
Empty ward at Murray Royal.
No day services provision

Option 5A

Same issues as 4B - Different sites

Option 5B

All LD on Strathmartine

Option 8

Enablers - still have 3 medical rotas
Staffing - Medical - high risk? If will end up with 3 acute wards to support flow)
Is model sustainable?
Keep assessment beds as assessment beds ???
Need community supports

Table Two – No notes recorded at table

Table Three

Benefit Criteria

Patient centred includes

- Promotes autonomy
- Treatment closer to home where possible

Table Four

Benefit Criteria

Better descriptor 1st
2nd for carer re equity of access
Pockets of different services,
Must include housing / provision of services
Feel 2 & 6 similar and also 1 & 2 and scored like that
Understanding what this means
Building doesn't promote equity of access – its service that provides

Option scoring rationale

? LD permutations
Day Services – need to modernise service
Local access to day services
Not large number of patients
Not person centred as all travel – delayed discharge
No equity re staffing – inadequate – criteria 1

Option 4A

? Ability to cross cover – medical
Isolation of ward / safety
Allows disposal of Strathmartine
Introduces another interface

Table Five

Benefit Criteria

Remove 1st line and add "improved" –duplication

Table Six – No notes recorded at table

Table Seven

Benefit Criteria

Criteria 1 & 2 similar - captures journey both input and output "Focus on prevention" - can lead to admission being reviewed regularly
Effective pathway - holistic and joined up - takes account of service user's needs
MH and wellbeing - accommodation and other support
Health focused - links between primary care - across effective care pathway
Not distinct enough
Different understanding
Travel
Criteria - right place, right time - Equity carers a lot, equity with community services
Access to buildings, support accommodation, story of good practice- equity of expertise
Feel this is the driver for the process due to workforce challenges

Option scoring rationale

LD - Investment in community services to relocate day services locally
Lack of discussion around day service, could not come off Strathmartine until re-provided
Lots of unknowns as around funding: refurbs/amendments to other wards
Release of funds implications - community services, how much by when, need to have community infrastructure in place before amendments to beds
Empty ward at Mulberry. Significant disruption to staff:
GAP staff - Dundee. LD staff – Perth
GAP Services located @ Dundee - ward distances from P&K.
Carseview environment(external).
All "eggs in one basket" - business continuity - no decent option.
7 day week CMHT & IHTT. ?
Crisis house.
Complimentary non NHS services/support.
Support housing provision in each area
PROS - Economies of scale for staffing / resources, centralised OOH service
expertise from co-location
Co-location GAP/IPCU, not transferring patients acutely unwell.
Transport infrastructure - especially for patients: costs, risks to patient safety,
Impact on S.A.S
Impact on Police

Option 3B

Costs for LD and Strathmartine
2 empty wards

Option 5B

Strathmartine site - not fit for purpose
Acknowledge effect on a lot
Stigma attached to this

Option 8

Feasibility of model - treatment wards - less medicalised
Interface within admission / assessment wards of locality wards
Number of beds required in this model
Agree if centralisation of GAP beds - need step down beds,
Capacity and flow
From SW perspective - preferred model of care, discharge support and planning
Environment.
Most supportive of model, need robust community teams

Table Eight – No notes recorded at table

Table Nine

Benefit Criteria

Underpins everything
Split with number 1
Recruitment, retention and development

Option Scoring Rationale

Option - Do Nothing

Some difficulty teasing out issues of staffing and opportunities to modernise from the issues of site configuration
As 3B

Option 3A

Where are LD Day services located / delivered.
Should this be discussed as part of strategic shift to communities
(New model of care)
As 4A

Option 3B

Requires refurbishment of Strathmartine site

Option 4A

Some issues around splitting LD speciality across 2 sites (shared expertise/cross cover etc)

Option 5A

As 4A above

Option 5B

As 3B

Option 8
Some concerns about fit of nursing workforce tools
As 4A

Table Ten – No notes recorded at table

FEEDBACK FORMS RECEIVED

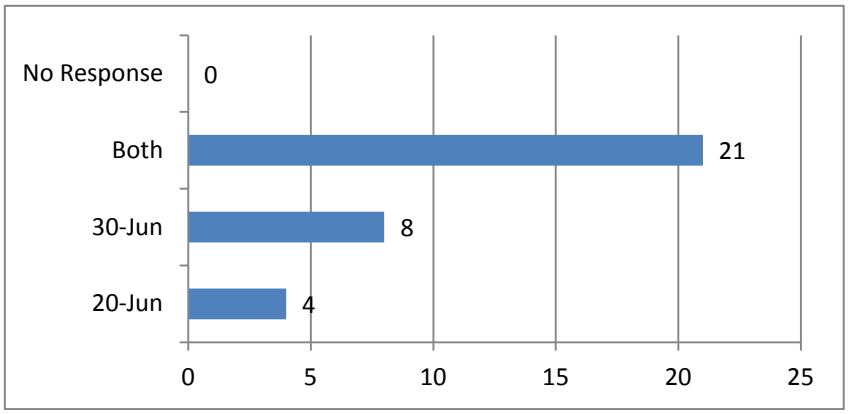
DRAFT

Mental Health Improvement Programme
Options Appraisal Workshops 20th and 30th June 2016

NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal workshops for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of 33 completed evaluation forms were returned.

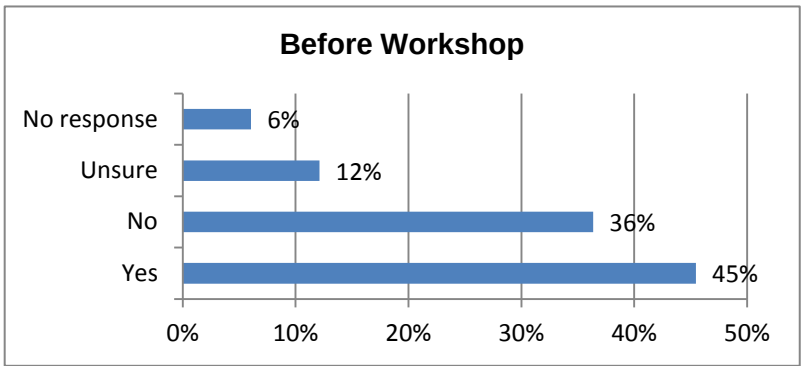
EVALUATION - Analysis

1. Option Development Workshop – Monday 20 June 2016 / 30 June 2016

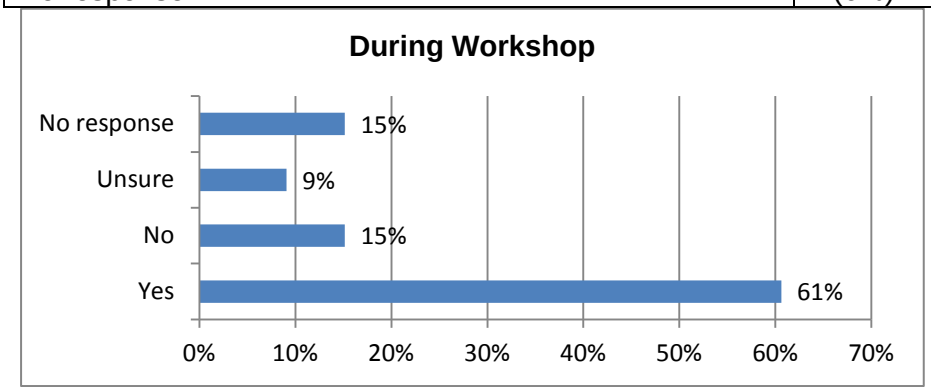


Answer Choices	Responses
Attended Option Appraisal Workshop – 20 June 2016 only	4
Attended Option Appraisal Workshop – 30 June 2016 only	8
Attended both Appraisal Workshops	21

2. Did you get enough information to help you prepare?

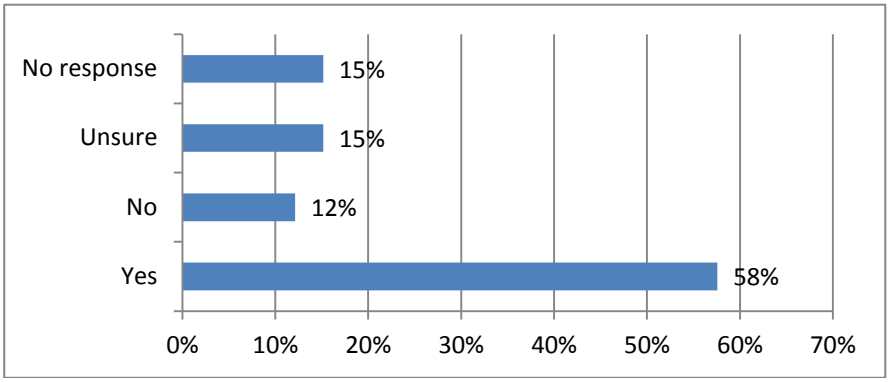


Answer Choices	Responses
Yes	15 (45%)
No	12 (36%)
Unsure	4 (12%)
No response	2 (6%)



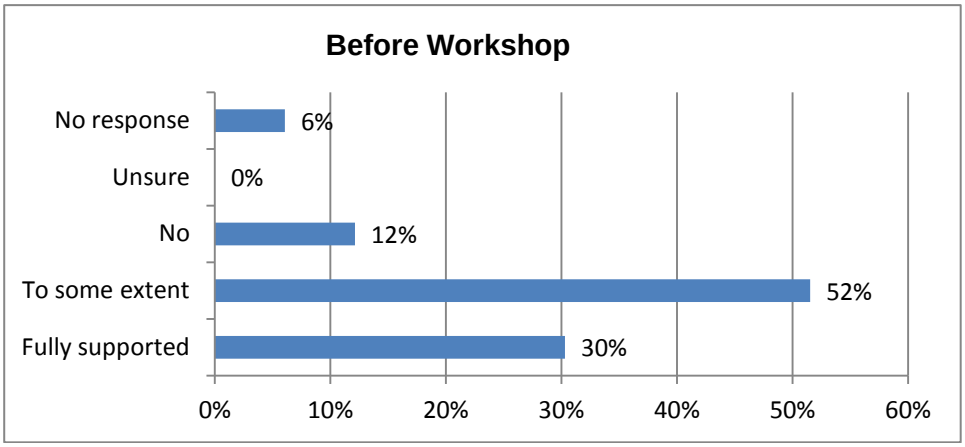
Answer Choices	Responses
Yes	15 (45%)
No	12 (36%)
Unsure	4 (12%)
No response	2 (6%)

3. Was the information easy to understand?

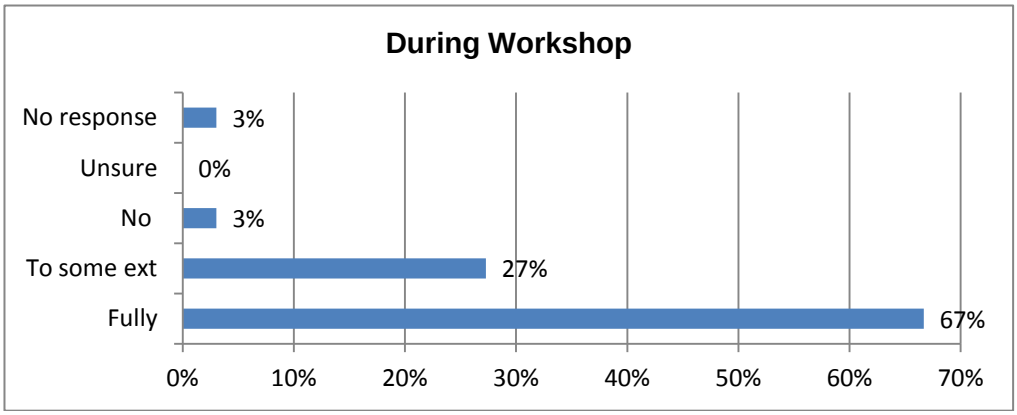


Answer Choices	Responses
Yes	19 (58%)
No	4 (12%)
Unsure	5 (15%)
No response	5 (15%)

4. Were you provided with the support you needed to participate effectively?



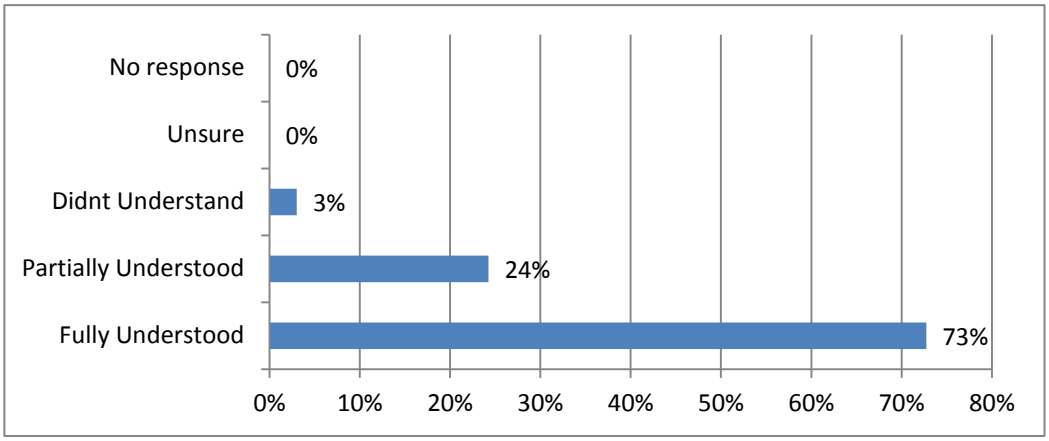
Answer Choices	Responses
Fully supported	10 (30%)
Supported to some extent	17 (52%)
No	4 (12%)
No response	2 (6%)



Answer Choices	Responses
Fully supported	22 (67%)
Supported to some extent	9 (27%)
No	1 ((3%)
No response	1 (3%)

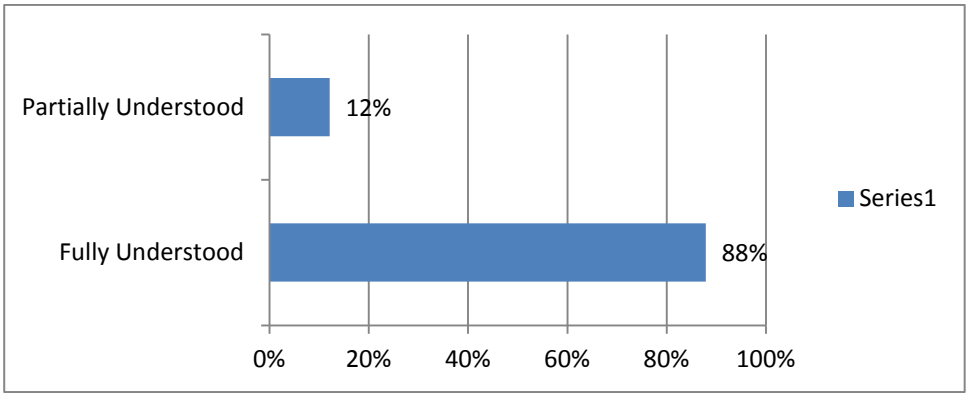
5. How well did you understand the following aspects of the focus group and/or workshop?

Background to Mental Health Improvement Programme



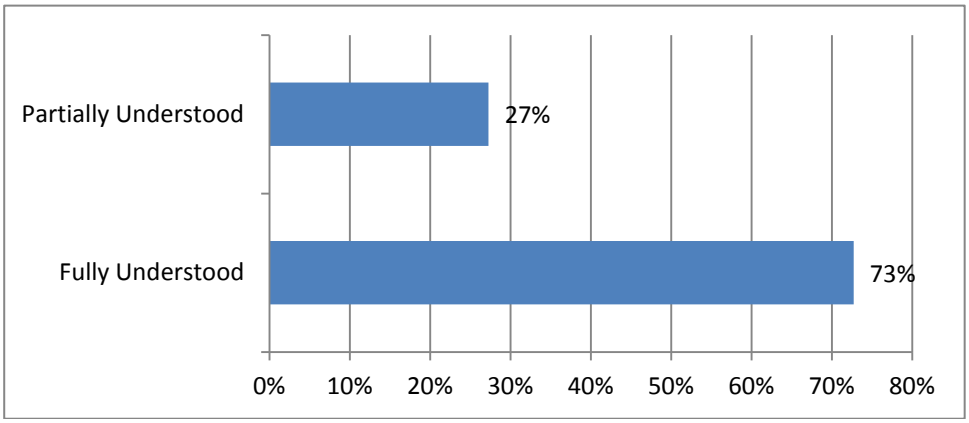
Answer Choices	Responses
Fully understood	24 (73%)
Partially understood	8 (24%)
Didn't understand	1 (3%)

The purpose of the workshops



Answer Choices	Responses
Fully understood	29 (88%)
Partially understood	4 (12%)

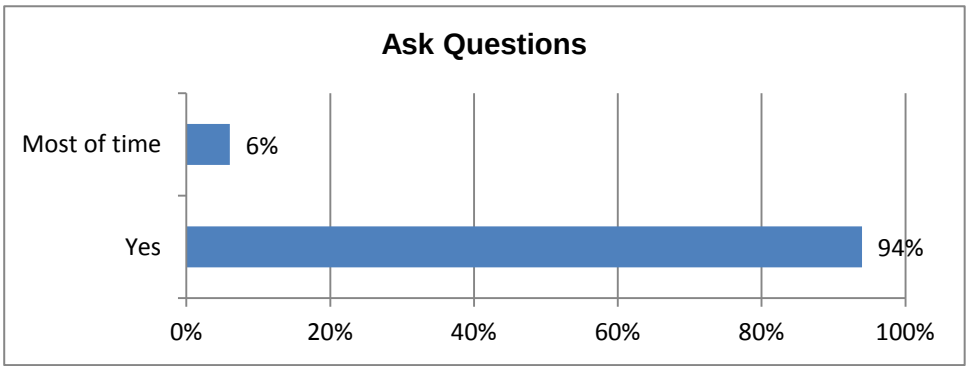
The process used at the workshops



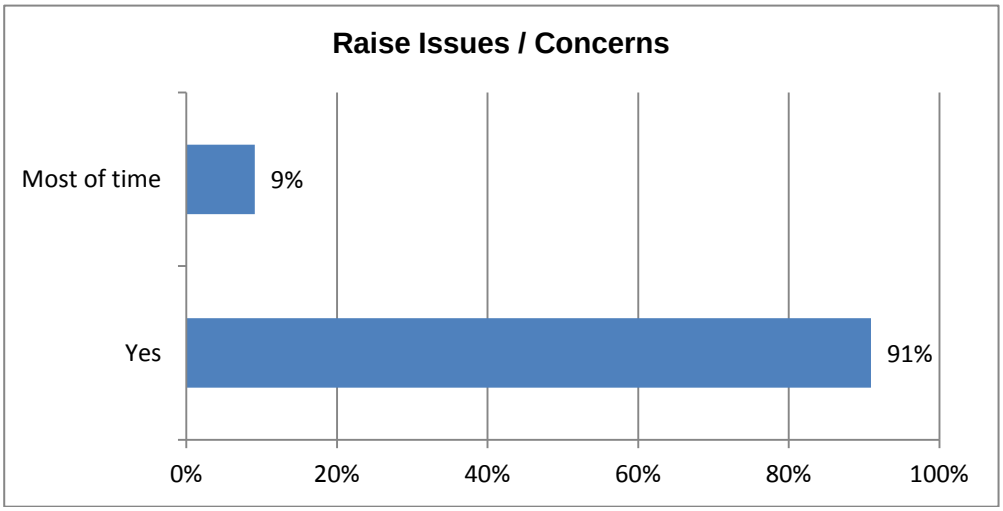
Answer Choices	Responses
Fully understood	24 (73%)

Partially understood	9 (27%)

6. During the workshops did you have the opportunity to ask questions and raise any issues or concerns.

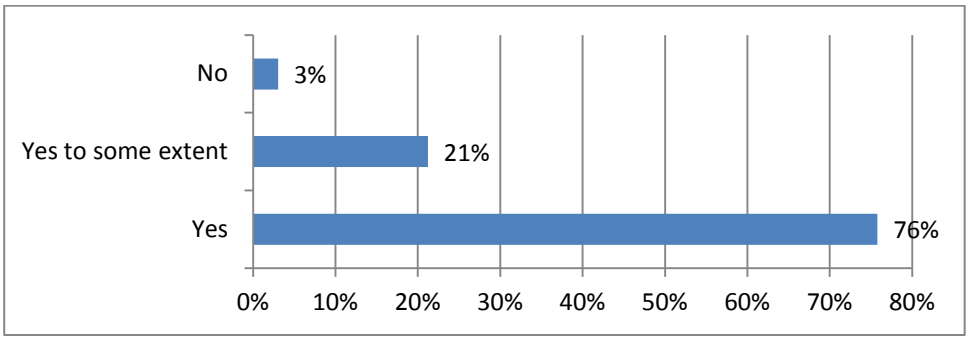


Answer Choices	Responses
Yes	31 (94%)
Most of time	2 (6%)



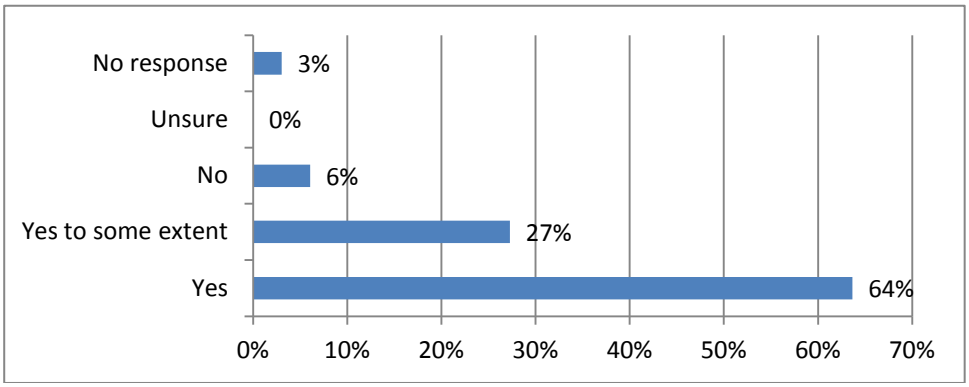
Answer Choices	Responses
Yes	30 (91%)
Most of time	3 (9%)

7. Do you feel your views were listened to during the workshops?



Answer Choices	Responses
Yes	25 (76%)
Yes to some extent	7 (21%)
No	1 (3%)

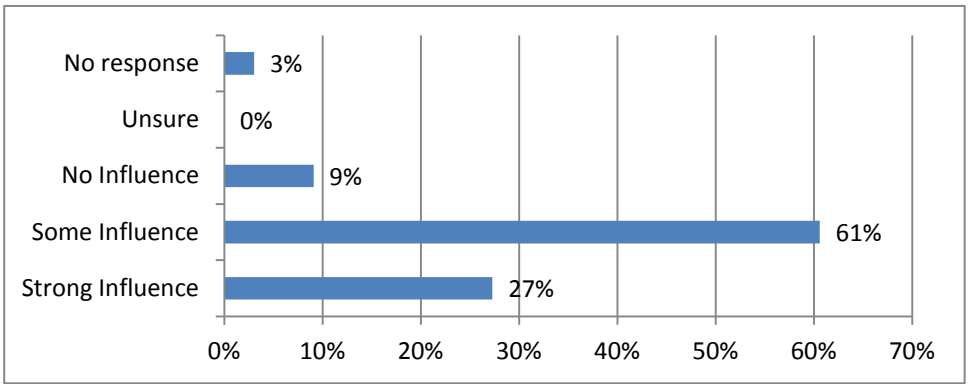
Do you feel your questions were answered?



Answer Choices	Responses
Yes	21 (64%)
Yes to some extent	9 (27%)
No	2 (6%)
No response	1 (3%)

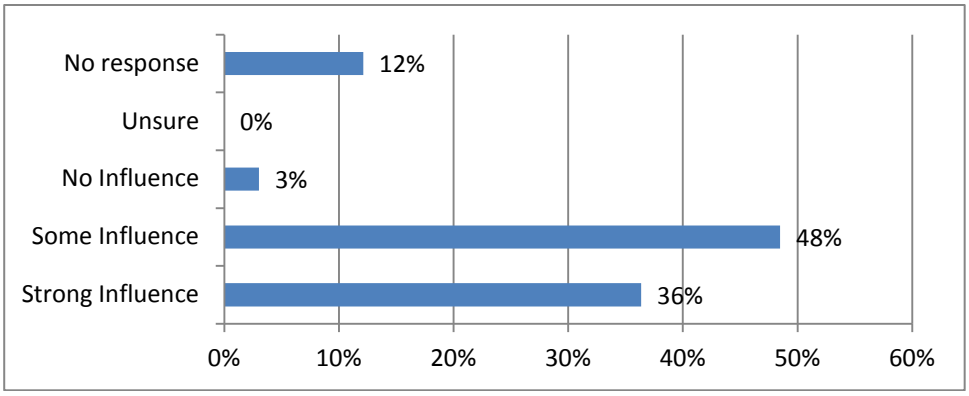
8. How much of an influence do you feel you had over the following:

Agreeing the draft benefit criteria



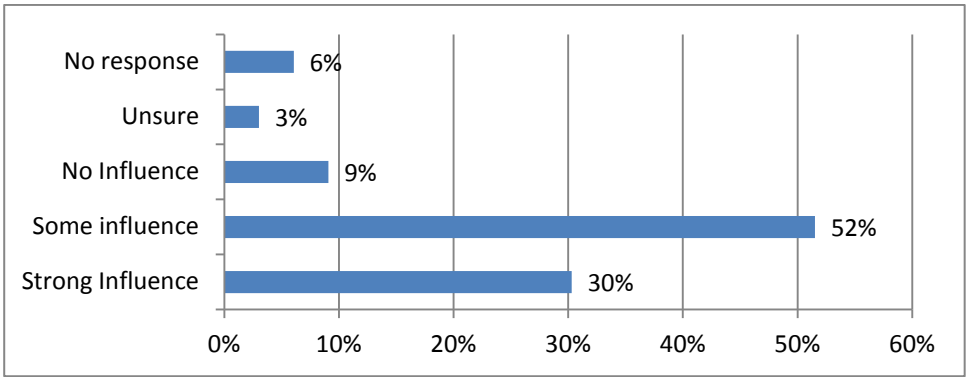
Answer Choices	Responses
Strong influence	9 (27%)
Some influence	20 61%)
No influence	3 (9%)
Unsure	0
No response	1 (3%)

Ranking and weighting the benefit criteria



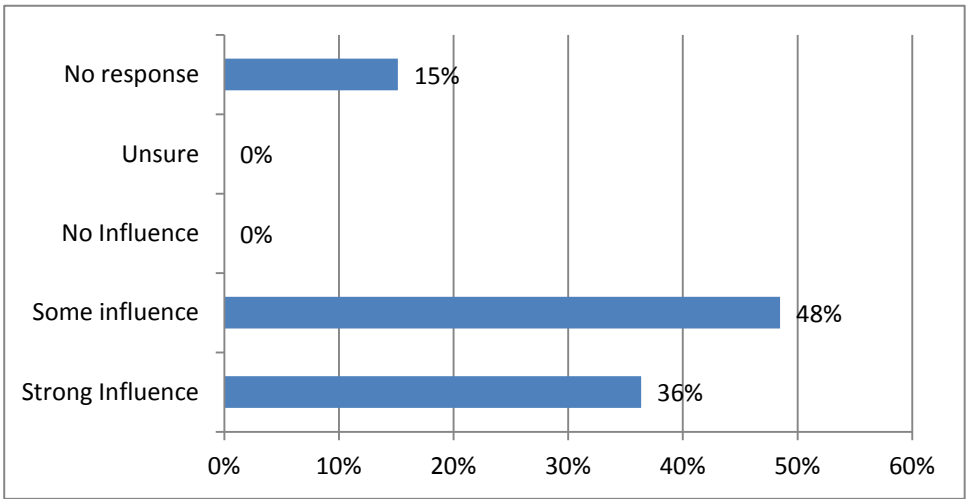
Answer Choices	Responses
Strong influence	12 (36%)
Some influence	16 (48%)
No influence	1 (3%)
Unsure	0
No response	4 (12%)

Agreeing the short list of options



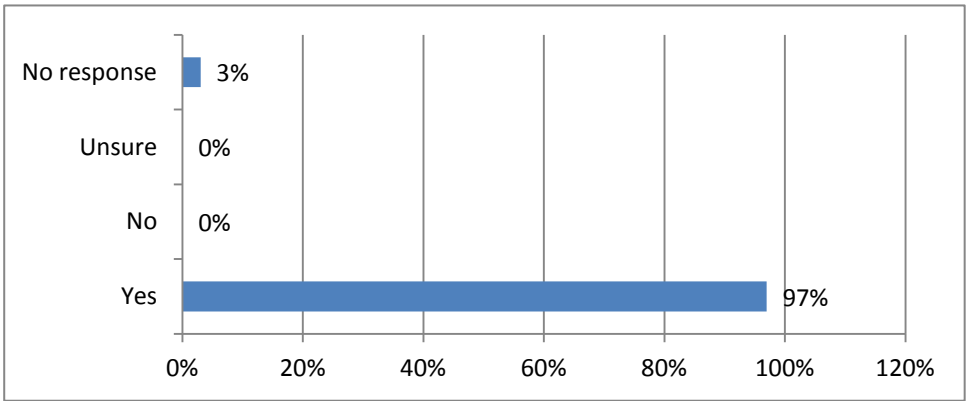
Answer Choices	Responses
Strong influence	10 (30%)
Some influence	17 (52%)
No influence	3 (9%)
Unsure	1 (3%)
No response	2 (6%)

Scoring the short list of options



Answer Choices	Responses
Strong influence	12 (36%)
Some influence	16 (48%)
No influence	0
Unsure	0
No response	5 (15%)

9. Were the next steps in the process explained to you.



Answer Choices	Responses
Yes	32 (97%)
No	0
Unsure	0
No response	1 (3%)

DRAFT

Mental Health Improvement Programme
Options Appraisal Workshops 20th and 30th June 2016

NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal workshops for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of 33 completed evaluation forms were returned.

EVALUATION

Analysis

10. Option Development Workshop – Monday 20 June 2016

Of the 33 completed questionnaires four people attended the Option Development Workshop on Monday 20 June 2016 only, eight people attended the Benefits Criteria and Options Scoring Workshop on Thursday 30 June 2016 only and twenty one people attended both.

11. Did you get enough information to help you prepare?

Nearly half of respondents 15(45%) indicated they received enough information to help them prepare before the workshop, 12(36%) said they did not, 4(12%) were unsure and 2(6%) did not answer this question. During the workshop 20(61%) of respondents intimated that they had received enough information to help them prepare, 5(15%) did not, 3(9%) were unsure and 5(15%) did not complete this question.

If no or unsure, what additional information would you have found helpful?

- Monday 20th felt chaotic and complicated, in spite of understanding the overall process. More copies of evaluation sheets & objective sheets at the table would have helped.
- Would have preferred the information earlier.
- Community set up/infrastructure required to support options.
- Especially the second meeting there was plenty of information.
- A lot to take in and a list of details for ongoing reference for each participant would have been helpful.
- Information earlier.
- Having missed June 20th, a summary of that would have helped.

- Information about existing community modeling and more information about other models elsewhere.
- Wasn't included/invited to Workshop 1.
- Not clear what community provision there would be.
- More information about what situation and proposals are for community care.
- Would have liked options prior to meeting to consider these more fully. Need more information/stats etc – this may be provided for next session.
- Needed a fact sheet with key data on hospital activity, demand, spend and key community data on all community resources including 3rd Sector. Also needed user and carer feedback on range of services.
- This was discussed and sent by email for the next meeting.

12. Was the information easy to understand?

Just over half of respondents 19(58%) considered the information easy to understand. 4(12%) did not find it easy to understand, 5(15%) were unsure and 5(15%) did not respond to this question.

If no or unsure, what could have been done to make the information easier to understand?

- Very complex information to consider given time frame. A lot of which not in my area of expertise.
- Eventually – process is complicated. Somewhat confusing at Monday 20th Workshop.
- Difficult process to follow but good support from facilitator at table.
- Required more time.
- At times unclear and information on community services remains a mess
- Facilitators supported process really well.
- Explaining principles of options appraisal and understanding them is really hard.
- Not enough information for the session including from the presenters. Also needed information on parameters and next steps and on scale and type of consultations being undertaken over next three months.

13. Were you provided with the support you needed to participate effectively?

Before the workshop 10(30%) of respondents felt they were fully supported to participate effectively, 17(52%) felt they were supported to some extent, 4(12%) felt they did not get the support and 2(6%) did not answer.

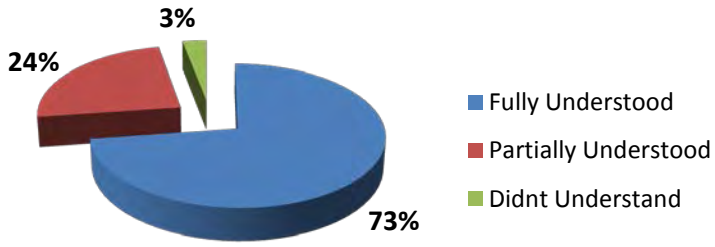
During the workshop 22(67%) of respondents felt they were fully supported to participate effectively, 9 (27%) felt they were supported to some extent, 1(3%) felt they did not get support and 1(3%) did not feel they were provided with the support needed to participate effectively.

If no or unsure, what could have been done differently to support your involvement

- Felt quite rushed at times although facilitators and group conversation helpful.
- Excellent organization of a very complex event.
- Having missed June 20th, a summary of that would have helped.
- Wasn't included/invited to Workshop 1.
- Information should been more comprehensive **and** simpler.
- Need more information prior to meeting re: options.
- Not really! Need more community data – social work, housing, 3rd Sector services, user/carer feedback etc.

14. How well did you understand the following aspects of the focus group and/or workshop?

Background to Mental Health Improvement Programme



The purpose of the workshops

The majority of attendees 29(88%) fully understood the purpose of the focus group/workshops and the other 4(12%) partially understood the purpose.

The process used at the workshops

24(73%) respondents fully understood the process used at the workshops and 9(27%) partially understood the process.

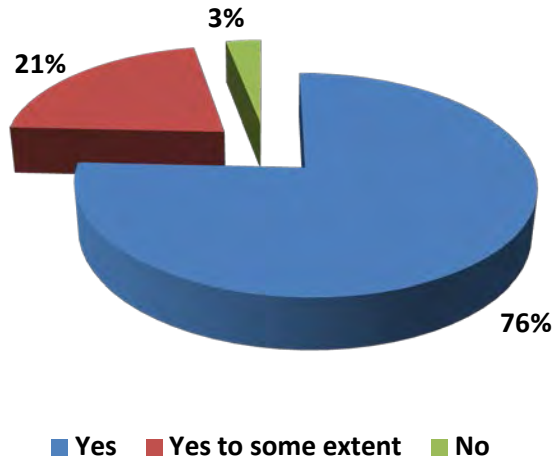
If there was anything you didn't understand, what could have been done to help improve your understanding?

- Complicated.
- A lot to take in – better if I had attended both workshops.

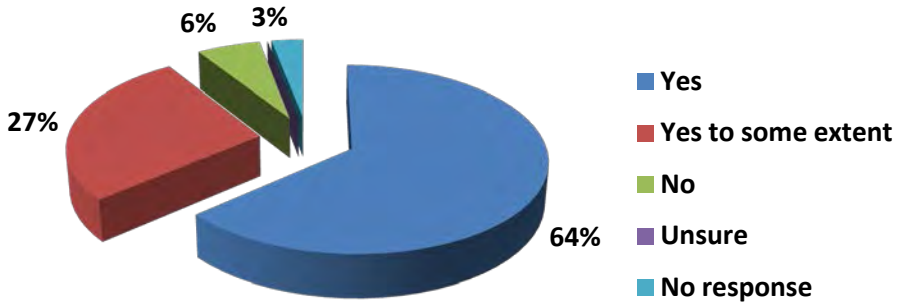
15. During the workshops did you have the opportunity to ask questions and raise any issues or concerns.

The response to this question was very positive with 31(94%) respondents intimating that they had the opportunity to ask questions during the workshops and 30(91%) advised that they were given the opportunity to raise any issues or concerns.

16. Do you feel your views were listened to during the workshops?



Do you feel your questions were answered?



Please tell us why you feel this way

- Conversations often dominated by Health/Medical model perspective although around the table other delegates did listen particularly during 2nd workshop.
- Although, the times was tight for the pieces of work set to groups, this had the potential to leave a feeling that there was time to be innovative and free to discuss options if the set pieces of work were completed as requested.
- Great facilitation and having a wide rand of different speakers was helpful.
- Discussion was good, but perhaps 100+ contributors was too many.
- Some additional detailed information was needed.
- Not really re: data gaps.

17. How much of an influence do you feel you had over the following:

Agreeing the draft benefit criteria

Of the thirty three respondents, 9(27%) felt they had a strong influence in

agreeing the draft benefit criteria, 20(61%) considered they had some influence, 3(9%) didn't think they had any influence and 1(3%) did not respond to this question.

Ranking and weighting the benefit criteria

Of the thirty three respondents, 12(36%) felt they had a strong influence in ranking and weighting the benefit criteria, 16(48%) considered they had some influence, 1(3%) didn't think they had any influence and 4(12%) did not respond to this question.

Agreeing the short list of options

Of the thirty three respondents, 10(30%) felt they had a strong influence in agreeing the shortlist of options, 17(52%) considered they had some influence, 3(9%) didn't think they had any influence, 1(3%) was unsure and 2(6%) did not respond to this question.

Scoring the short list of options

Of the thirty three respondents, 12(36%) felt they had a strong influence in scoring the shortlist of options, 16(48%) considered they had some influence and 5(15%) did not respond to this question.
Please tell us why you feel this way?

- I was in a good group of mixed attendees who all expressed their individual take on views but were willing to take other points of view into consideration.
- Agreeing the criteria and their "testing" this before using all the options. Once started found the scoring very difficult.
- Group was well chosen and we worked together.
- One vote out of 100 is significant but small.
- Was not at Day 1 when these were agreed.
- Within limited knowledge of the alternatives/options eg Community Services and support.

18. Were the next steps in the process explained to you.

Thirty two of the thirty three respondents intimated that the next steps in the process were explained to them and one did not complete this question.

Well organized and good explanations. Excellent venues on both days.

19. Please let us know if you have any other comments or suggestions about the workshops.

- Fab facilitator, really boosted the experience and helped challenge the professionals.
- Well planned and great facilitation from Pennie Taylor.
- Thoroughly enjoyed meeting and working with other people outwith my normal area of work.

- Good 2 days work
- I am not happy that the most popular option was one which did not meet the 2 site criteria, had not been raised in the previous session and has been trialled in another area and found less than satisfactory.
- It would be good to run some consultation events using improvement tools to help people think out the box and put people/patients/users at the centre of future options rather than staff and services. These future developments are not just for NHS – the implications are far wider. Need 3rd Sector, Police, Ambulance, Social Work, Housing etc etc.
- Very good facilitation by Grace Gilling and very good mix at Table 7.

One individual form received also provided the attached feedback :

The options appraisals process is a well tried and test procedure, which is widely acknowledged as being critical to ensuring that important interventions are fully informed and based upon robust evidence. You will see from my scoring of question 5 that the background, purpose and process were all fully explained to my satisfaction. Unfortunately the current options appraisal, whilst laudable in its intentions and aims, sadly fell well short of the mark when it came to providing participants with sufficient (and in some cases accurate) information on which to then base any rational decisions, thus rendering any outcome invalid.

I found it astounding to have a room containing so many individuals who practice evidence based medicine being expected to made decisions based upon poor information.

One of the repeated themes which cropped up at both workshops was questions surrounding the area of enhanced community care provisions to enable more “patients” to be treated in the community rather than in hospital. We were told that NHS Tayside has on the highest numbers of inpatient nurses and AHP’s per head of population and one of the lowest numbers of community nurses.

On day one the following was read out from the minutes of the NHS Tayside Board meeting in March:

“During discussion the following points were highlighted:…….

- The decision made 10 years ago had included the proviso that community services would be extended but this had not happened in full as per the original Adult Mental Health Review recommendations”

It was agreed that further information would be made available to participants regarding information on extending community services for the second day. This was not forthcoming. The only additional document supplied related to a Penumbra crisis centre in Edinburgh.

The presentations made to the participants on both days did not provide a balanced view.

At the first workshop we heard from Clinicians that there is an acute shortage of Consultants, Junior Doctors and Nursing Staff. We also heard that the current physical estate is not fit for purpose and that consequently we were looking at options of one or two sites rather than three. We did not hear any information from anyone regarding how enhanced care in the community might alleviate any pressure on the need for inpatient care, and how different staffing models might help this come about.

Before the second workshop we received further reading which unfortunately did not include any substantial information regarding community services and also included some factually incorrect and misleading information:

"Across Tayside there are three multi disciplinary Crisis response and Home treatment teams (CRHT) serving Angus, Dundee and Perth and Kinross respectively".

After questioning it was revealed that there are not currently three teams.

At the second workshop we were given presentations on the various options. To accompany the presentations some written "Fact" sheets were distributed. This included the "Do Nothing" option sheet which clearly states –

"Secure Beds

- Tayside wide Low Secure beds across 2 wards".

After questioning it was revealed that patients are currently on three wards. Several of the models appeared to assume that one Low Secure ward could be made available without any impact on existing patients. No substantial further information was given.

The presentations on day two also included one new option which it would appear had been largely constructed by a consultant working at one of the three sites. His presentation was afforded more time than the other ones and his delivery was unfortunately too rushed for me to catch all the details he was trying to put across.

There was insufficient time given for rational consideration of the options. Likewise we were given conflicting information by those speaking. On day one we were told by the presenters that we were there to consider one or two sites for delivering the inpatient care and on the other a model including three sites was produced. Participants might had made different decisions on day one if they had thought that a three site model was a possibility.

The constant pressure for the process to move forward rather than rationally examine information or lack of it was evident on both days.

At the conclusion of the second day participants were asked to indicate on their response sheets whether they came from a clinical, managerial, or service user/carer/representative background, so that the results could be analysed.

For the process to be fully meaningful the results should also be processed according to other variables such as the geographical area the participant came from and their particular field of interest e.g. LD, GAP etc. This information was not gathered.

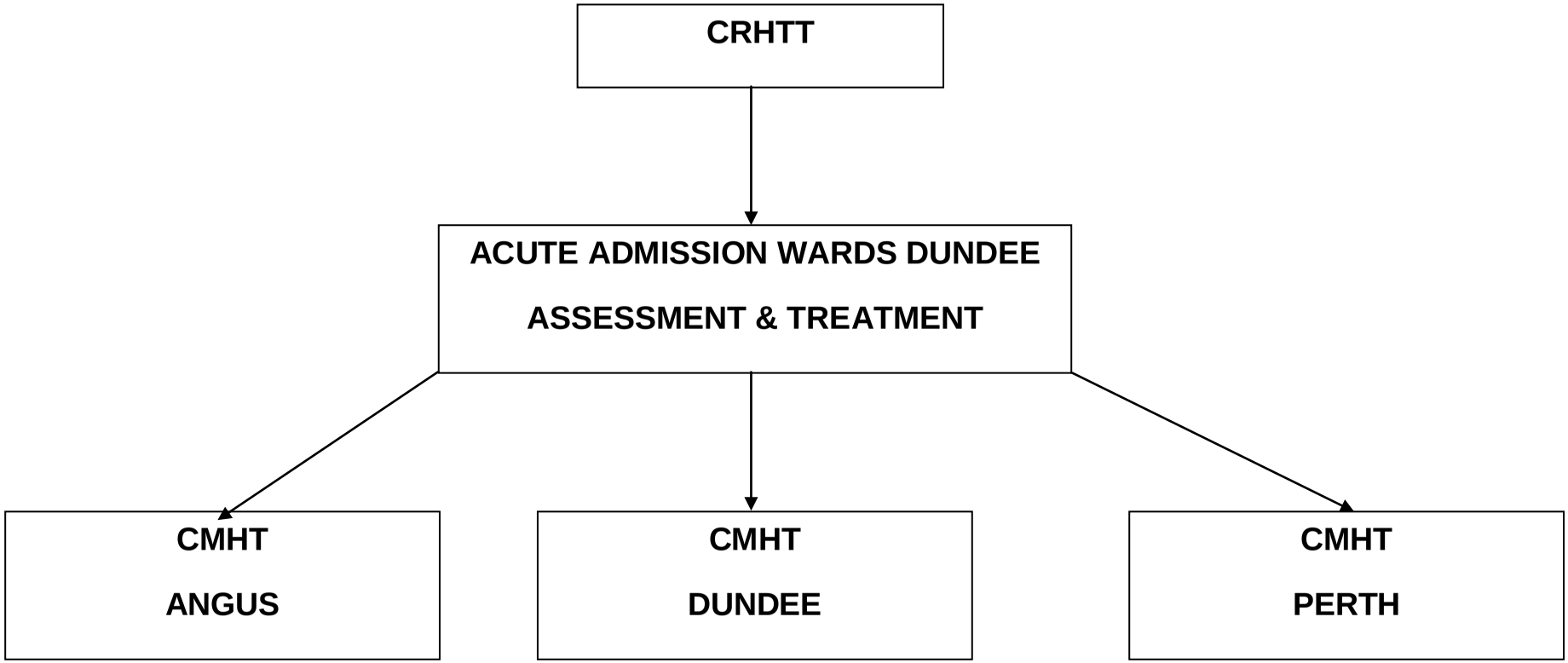
At the end of the two days I was reminded of the old computer system acronym GIGO.

The process is the process and cannot be criticized but when poor information is put into the process and insufficient time is given to logically evaluate information then the end result is questionable.

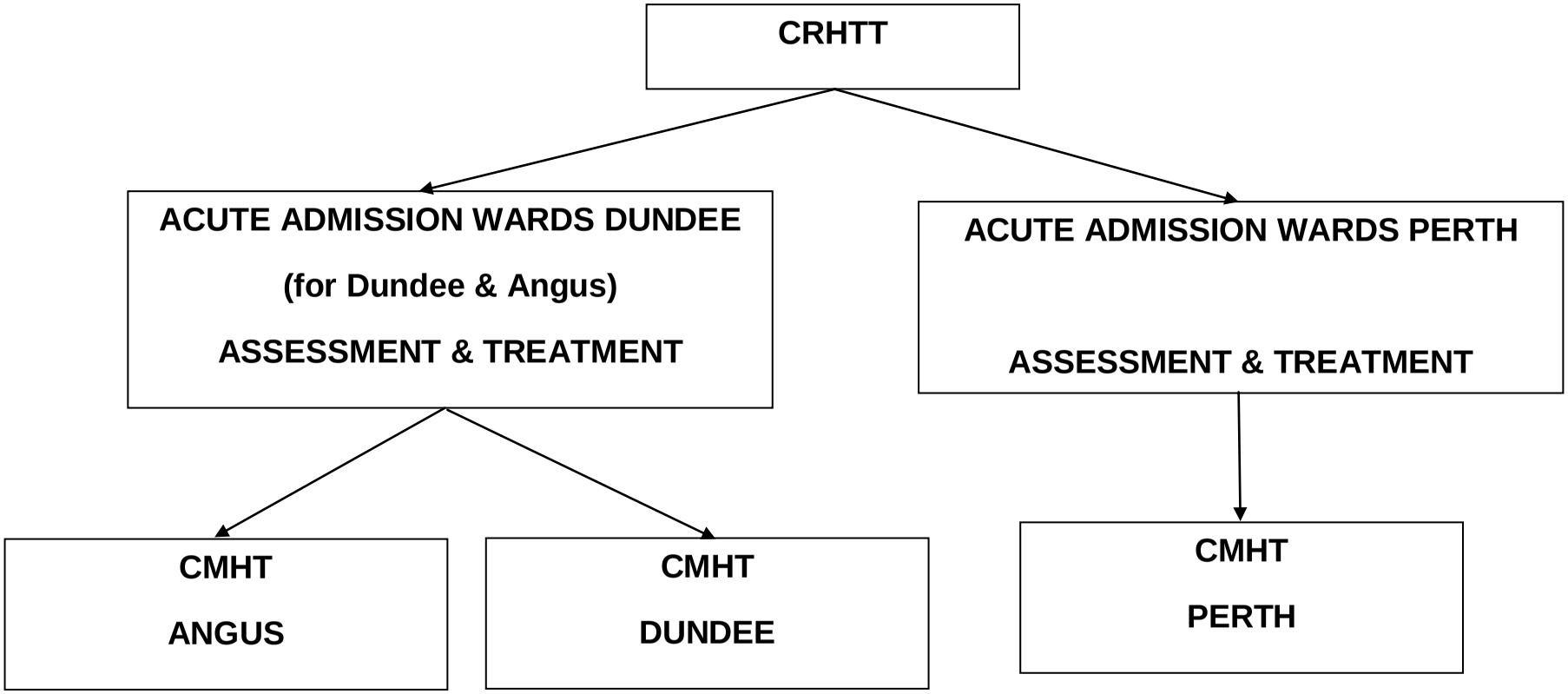
Appendix Five

Option Flow Charts

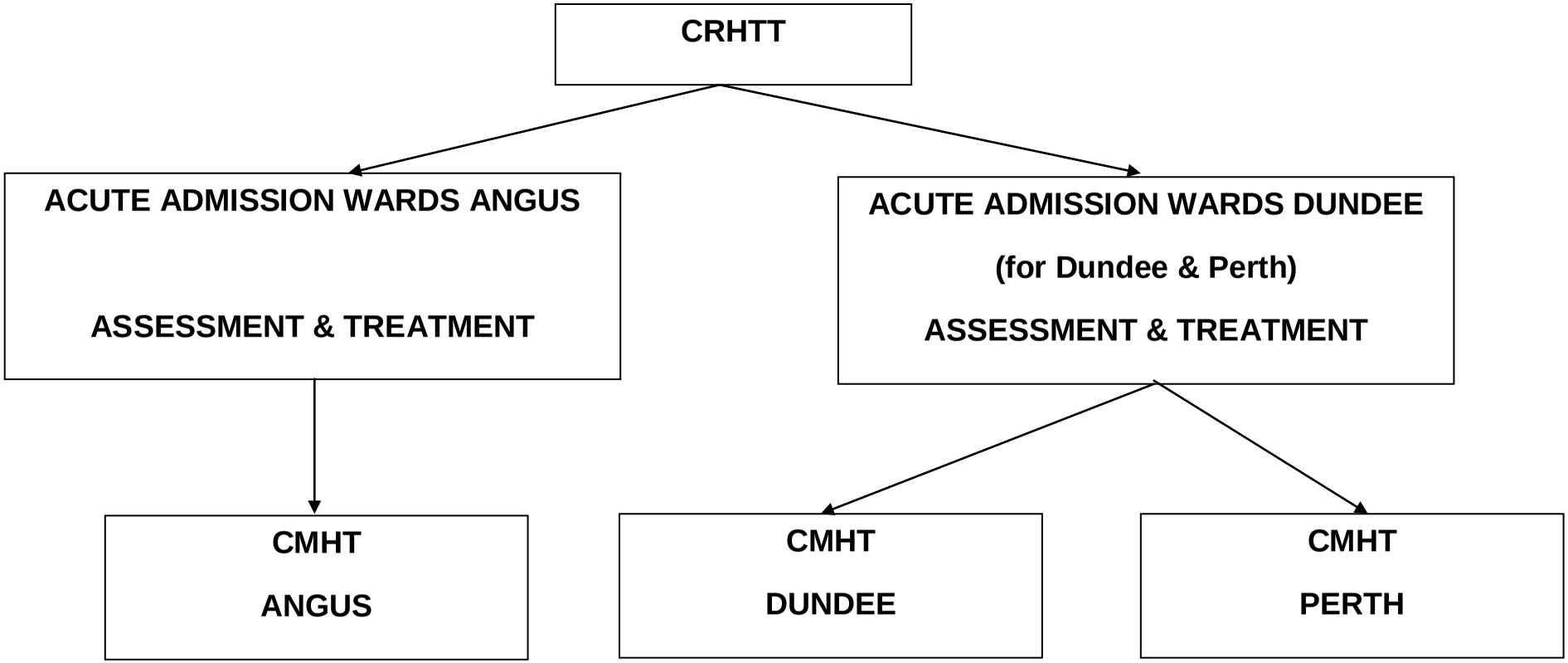
OPTION 3A


CRHTT
ACUTE ADMISSION WARDS DUNDEE
ASSESSMENT & TREATMENT
CMHT
ANGUS
CMHT
DUNDEE
CMHT
PERTH

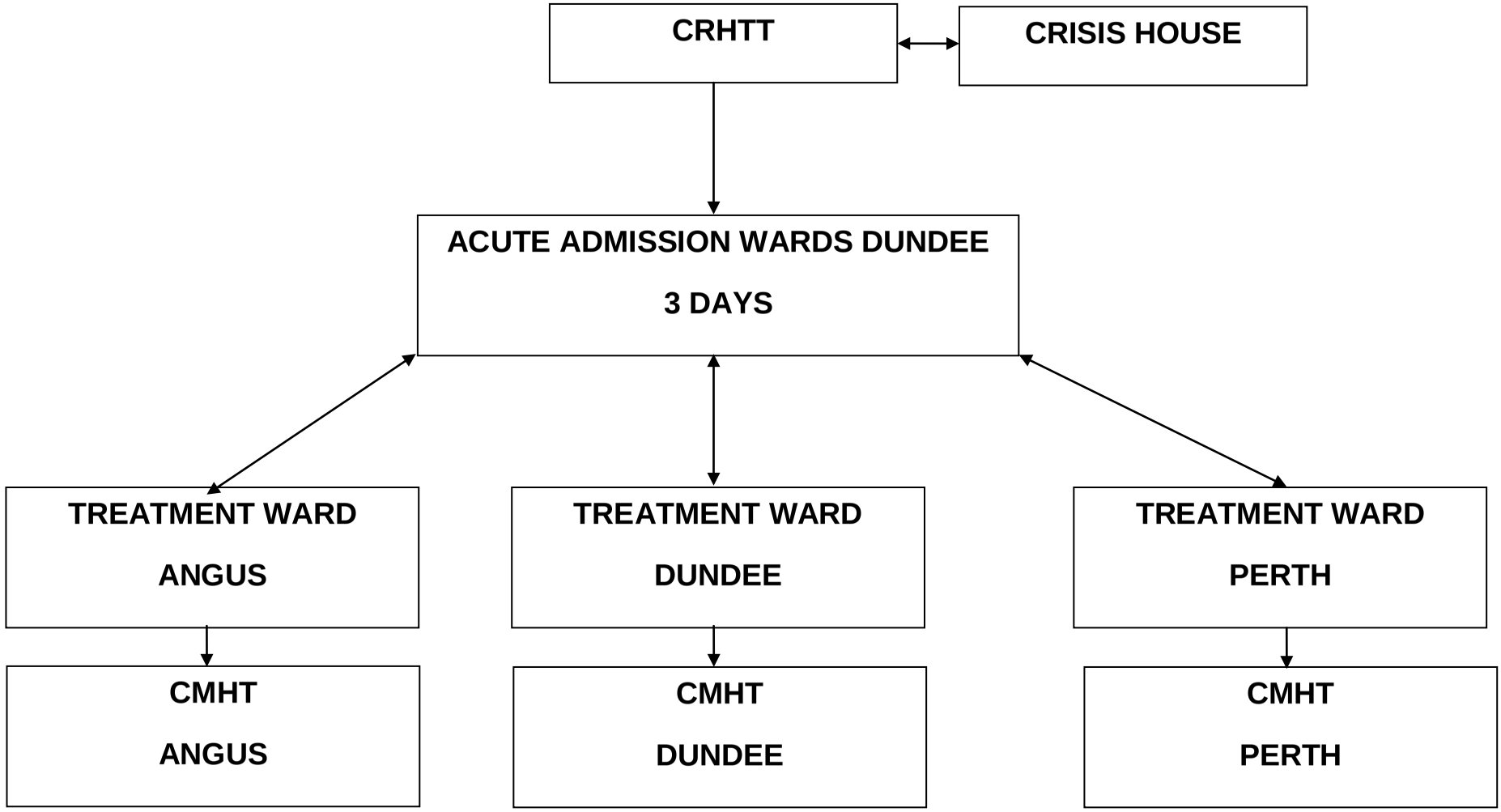
OPTION 4A


CRHTT
ACUTE ADMISSION WARDS DUNDEE
(for Dundee & Angus)
ASSESSMENT & TREATMENT
ACUTE ADMISSION WARDS PERTH
ASSESSMENT & TREATMENT
CMHT
ANGUS
CMHT
DUNDEE
CMHT
PERTH

OPTION 5A


CRHTT
ACUTE ADMISSION WARDS ANGUS
ASSESSMENT & TREATMENT
ACUTE ADMISSION WARDS DUNDEE
(for Dundee & Perth)
ASSESSMENT & TREATMENT
CMHT
ANGUS
CMHT
DUNDEE
CMHT
PERTH

OPTION 8


CRHTT
CRISIS HOUSE
ACUTE ADMISSION WARDS DUNDEE
3 DAYS
TREATMENT WARD
ANGUS
TREATMENT WARD
DUNDEE
TREATMENT WARD
PERTH
CMHT
ANGUS
CMHT
DUNDEE
CMHT
PERTH

Appendix Six

Modelling Event Facilitators Reports and Workshop Evaluations

GAP Option Modelling Facilitator Write Ups


MHIP Notes 29th Sep 16 Blue corner (1).do


MHIP Notes 29th Sep 16 Green corner.doc›


MHIP Notes 29th Sep 16 Red Corner.docx


MHIP Notes 29th Sep 16 Yellow Corner.doc


Option 4A.JPG


System of Care 3a.JPG


WP_20160929_16_31_35_Pro.jpg

LD Option Modelling Facilitator Write Ups


MHIP Notes 8th Dec Green corner.docx


MHIP Notes 8th Dec Red corner.docx


081216 SystemofCare 3a.JPG

Blue and yellow corner notes to be added on receipt

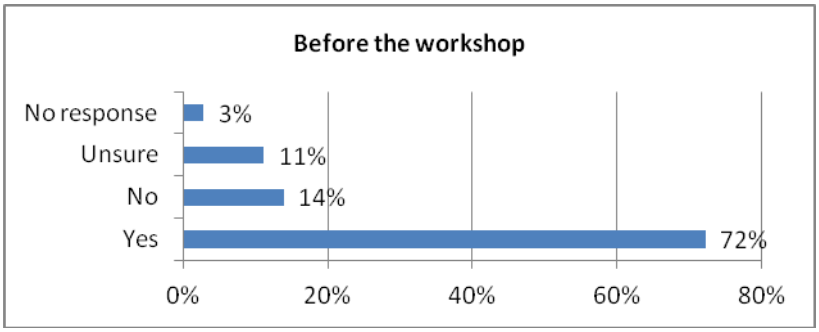
Workshop Evaluations

Mental Health Service Redesign Transformation Programme

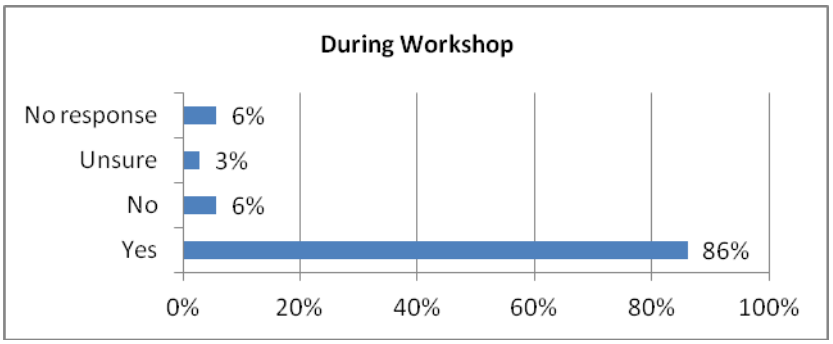
Option Modelling Workshop

29th September 2016

1. Thinking about the meeting - did you get enough information to help you prepare:



Answer Choices	Responses
Yes	26
No	5
Unsure	4
No response	1



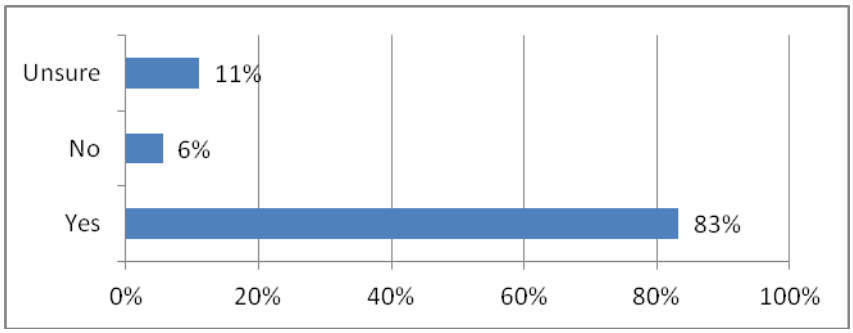
Answer Choices	Responses
Yes	31
No	2
Unsure	1
No response	2

If no or unsure, what additional information would you have found helpful?

- More detailed quantitative data eg workforce, costs etc
- Detailed information on each option

- Options not worked up to level that would encourage a direct focus on options. Only option 8A had volume or data required. Some data requires more scrutiny and explanation eg staffing.
- More information in advance on current configuration of services and list of abbreviations
- More explanation of models
- A lot of discussion centred on services and staffing out of ward areas
- Inpatient length of stays – how long – in each area. Distance to travel to hospital sites. Issues re recruitment and retention – CMHT and hospital in each area
- No time to read the information on the table

2. Was this information easy to understand?

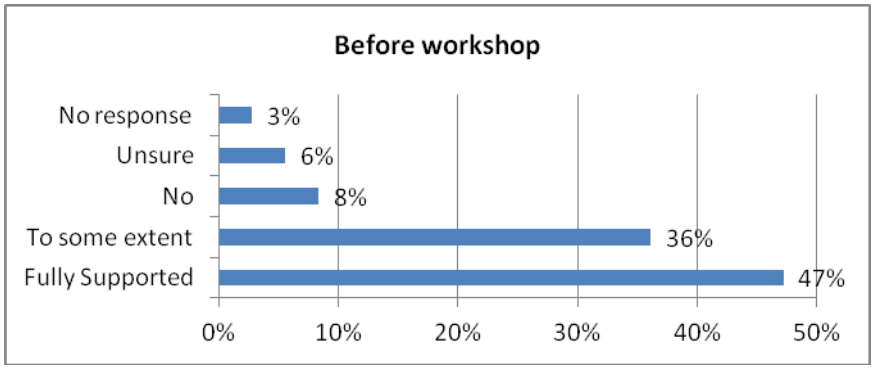


Answer Choices	Responses
Yes	30
No	2
Unsure	4

If no or unsure, what could have been done to make the information easier to understand?

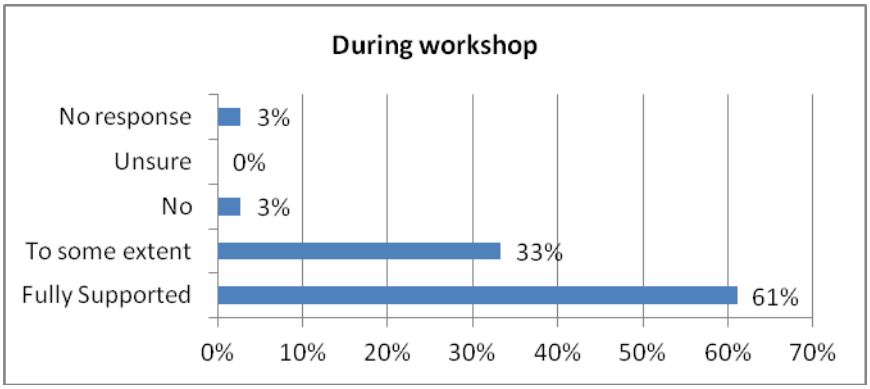
- Although there was little useful information anyway
- Data more available – transparent – able to be scrutinised and interpreted
- Reliant on nursing and medical input – with their knowledge
- Clearly presented in large format was helpful

3. Were you provided with the support you needed to participate effectively?



Answer Choices	Responses
Fully supported	17
To some extent	13
No	3

Unsure	2
No response	1

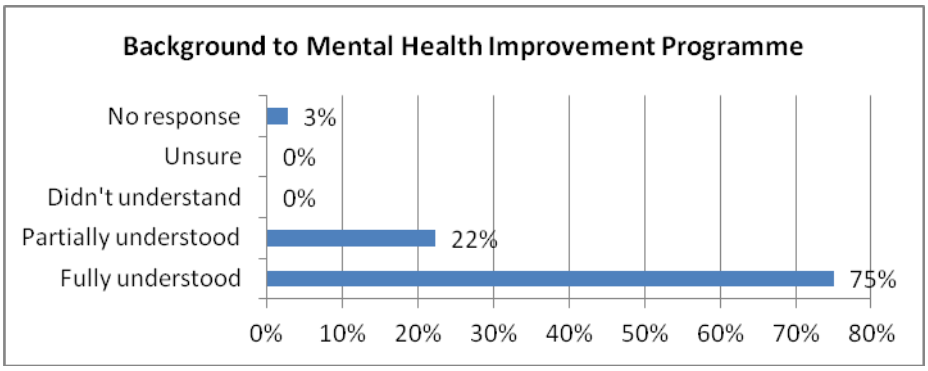


Answer Choices	Responses
Fully supported	22
To some extent	12
No	1
Unsure	0
No response	1

If no or unsure, what could have been done differently to support your involvement?

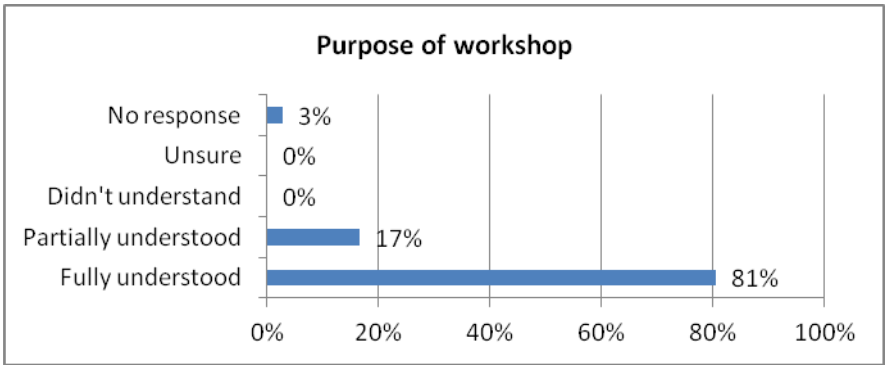
- The facilitators were helpful but in my view the options should have been presented in more detail with financial information
- Referring back to level of information; quality of information; provided pre and during meeting
- Excellent facilitation and all participants participated and displayed helpful and honest communications
- The clarifying of every model on the day let to a further degree of uncertainty on that model

4. How well did you understand the following aspects of the focus group and/or workshop?

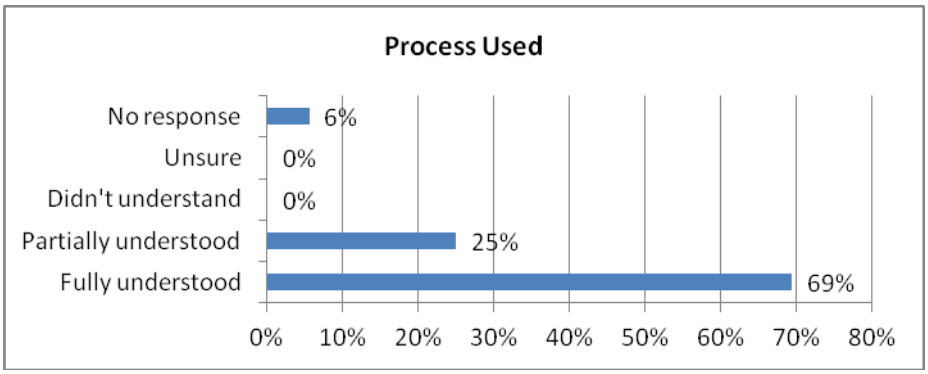


Answer Choices	Responses
Fully understood	27
Partially understood	8
Didn’t understand	0
Unsure	0

No response	1



Answer Choices	Responses
Fully understood	29
Partially understood	6
Didn't understand	0
Unsure	0
No response	1

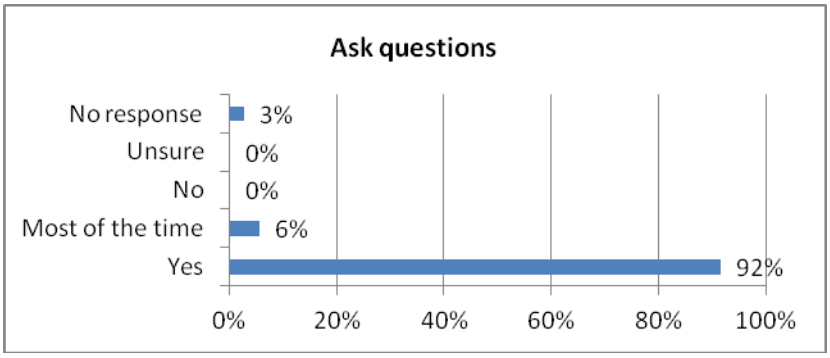


Answer Choices	Responses
Fully understood	25
Partially understood	9
Didn't understand	0
Unsure	0
No response	2

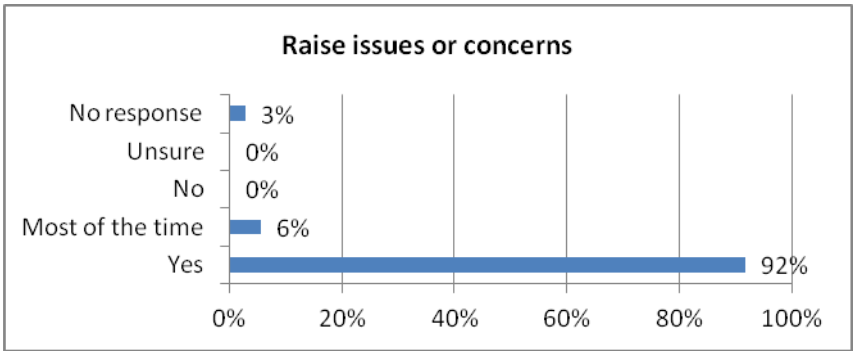
If there was anything you didn't understand, what could have been done to help improve your understanding?

- Main issue was design of the workshop
- Clarity – information, retaining focus, evidence base. Lots of discussion conjecture and anecdotal to weigh service change for moving units is indicated

5. During the workshops did you have the opportunity to:

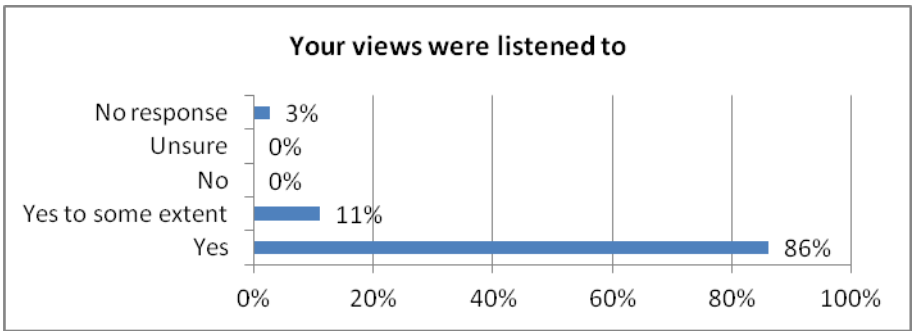


Answer Choices	Responses
Yes	33
Most of the time	2
No	0
Unsure	0
No response	1



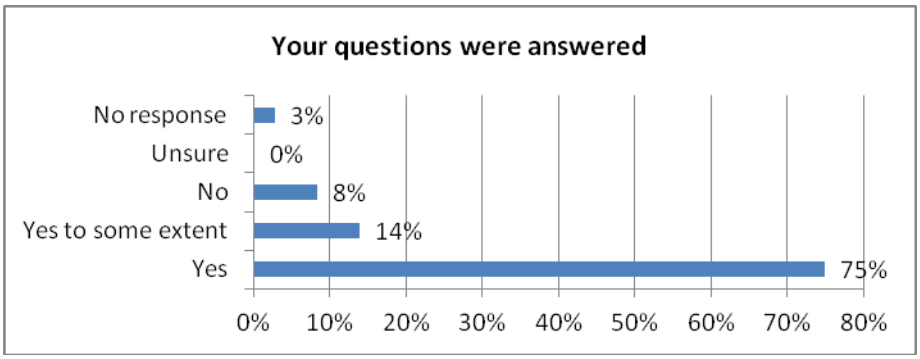
Answer Choices	Responses
Yes	33
Most of the time	2
No	0
Unsure	0
No response	1

6. Do you feel:



Answer Choices	Responses
Yes	31

Yes to some extent	4
No	0
Unsure	0
No response	1

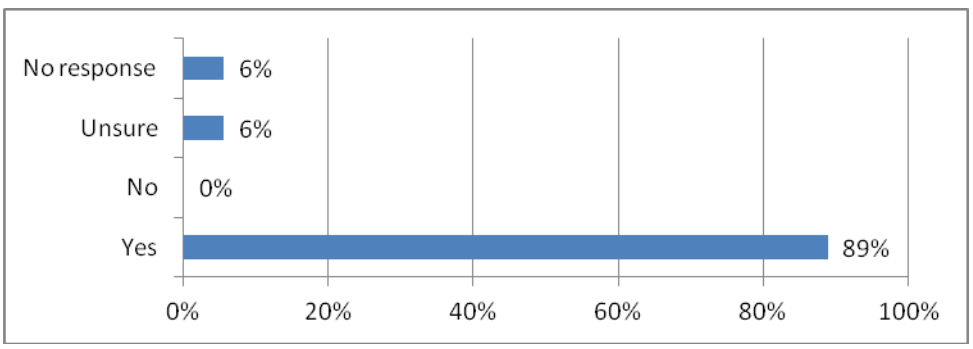


Answer Choices	Responses
Yes	27
Yes to some extent	5
No	3
Unsure	0
No response	1

Please tell us why you feel this way

- Facilitators were not in a position to ask questions
- Wider questions – evidence, data and information not available from facilitators
- Questions were answered as far as possible
- As time / groups went on slightly repeating same
- Time to have discussions and good size of group that supported participation and good mix of representation
- Answers were not the purpose of the workshop
- Unknown entity

7. Were the next steps in the process explained to you?



Answer Choices	Responses
Yes	32
No	0
Unsure	2
No response	2

8. Please let us know if you have any other comments or suggestions about the workshops

- Not a positive or uplifting experience
- An exhausting but informative and useful experience
- Well facilitated
- Area conversations
- Difficult to look at options as there is a question over community structures
- Good mix involved – staff. Good idea for each group to add to what undertaken by previous group – aids understanding across board and reduces duplication
- Thank you
- Potential for an option with reduced bed model was considered. If it is part of the work, this was not my understanding before attending; Staff are not aware of this option being considered and would need supported

Mental Health Service Redesign Transformation Programme

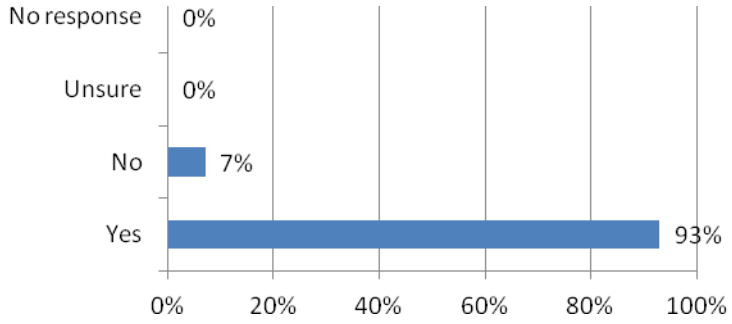
Learning Disability Service Option Modelling Workshop

Improvement Academy, Ninewells

08 December 2016

A total of 28 evaluation forms were completed

1. Thinking about the meeting - did you get enough information to help you prepare during the workshop:

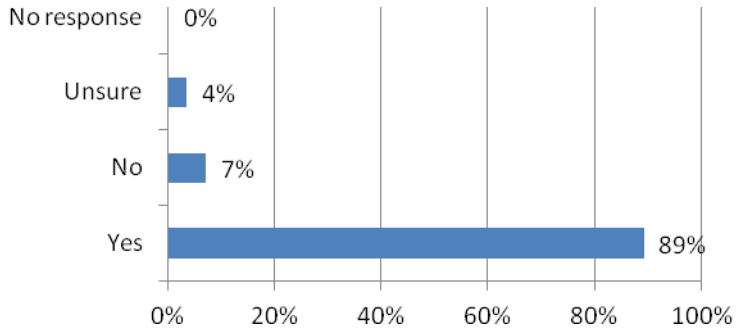


Answer Choices	Responses
Yes	26
No	2
Unsure	0
No response	0

If no or unsure, what additional information you would have found helpful?

- I would have found it helpful to have had the "parameters and top four options" information emailed before the meeting.
- No was unsure how the day would go.
- Clearer information on the actual situation at Rohallion would have been helpful. There are currently three wards operating in low secure – one admissions and two rehab. All of the options will have an impact on this.
- Not much time to look at and process information. Have not attended previous workshops.
- Many unknowns however make full discussion in decision making challenging ie staffing resources to be allocated to various options.
- But would have liked access to laminated 'Bed' information in first group.

2. Was this information easy to understand?

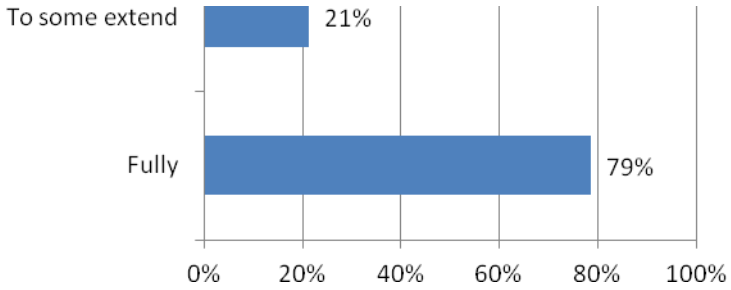


Answer Choices	Responses
Yes	25
No	2
Unsure	1
No response	0

If no or unsure, what could have been done to make the information easier to understand?

- Nature of information may have influenced this. More reference made to some of the information available on each table. It would have been helpful to only have had the coloured option charts relating to that table.
- Confused at times about which option has been discussed at each table given all options were displayed.
- As easy as it could be! Difficult topics – complex.
- Tables not 100% in sync with descriptions.

3. Were you provided with the support you needed to participate effectively?

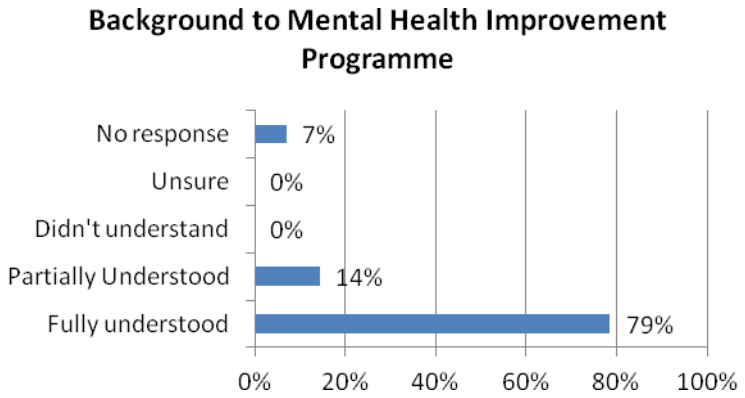


Answer Choices	Responses
Fully supported	22
To some extent	6
No	0
Unsure	0
No response	0

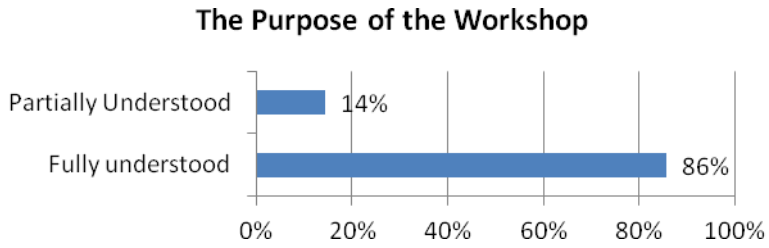
If no or unsure, what could have been done differently to support your involvement?

- Excellent Facilitation

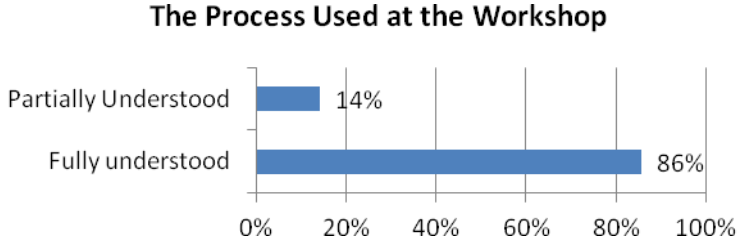
4. **How well did you understand the following aspects of the focus group and/or workshop?**



Answer Choices	Responses
Fully understood	22
Partially understood	4
Didn't understand	0
Unsure	0
No response	2



Answer Choices	Responses
Fully understood	24
Partially understood	4
Didn't understand	0
Unsure	0
No response	0

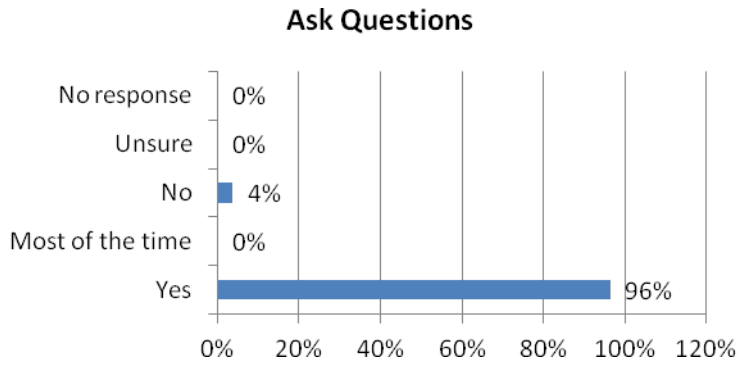


Answer Choices	Responses
Fully understood	24
Partially understood	4
Didn't understand	0
Unsure	0
No response	0

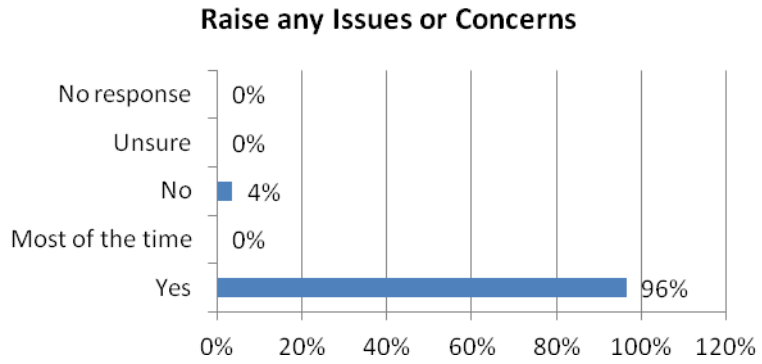
If there was anything you didn't understand, what could have been done to help improve your understanding?

- As I don't work in many of the contexts it was hard work following what people meant.
- Felt everything was explained very well throughout the workshops. Very supportive.

5. During the workshop did you have the opportunity to:

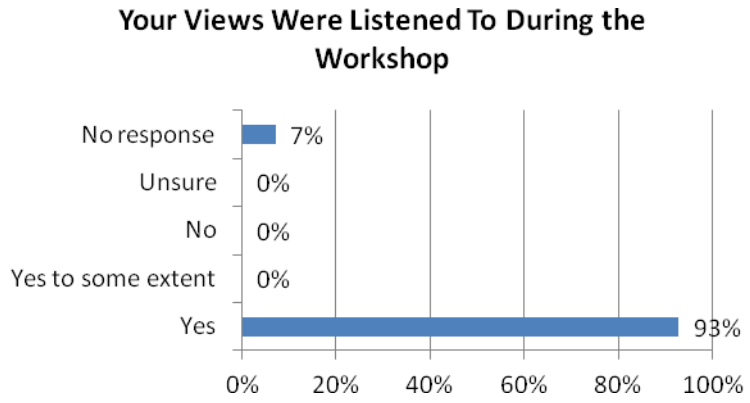


Answer Choices	Responses
Yes	27
Most of the time	0
No	1

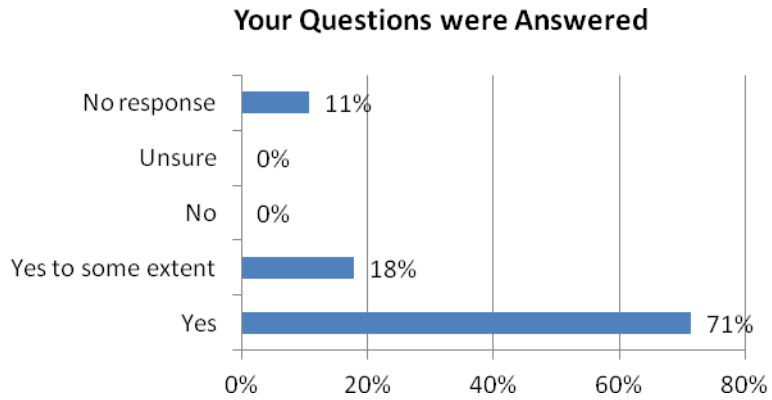


Answer Choices	Responses
Yes	27
Most of the time	0
No	1

6. **Do you feel:**



Answer Choices	Responses
Yes	26
Yes to some extent	0
No	0
Unsure	0
No response	2

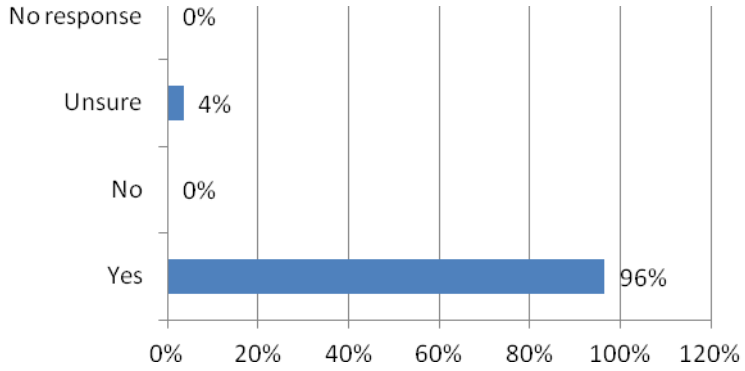


Answer Choices	Responses
Yes	20
Yes to some extent	5
No	0
Unsure	0
No response	3

Please tell us why you feel this way

- Same questions nobody can answer at the moment. More detail required.
- Some are future decisions but need to be highlighted.
- Very supportive.

7. Were the next steps in the process explained to you?

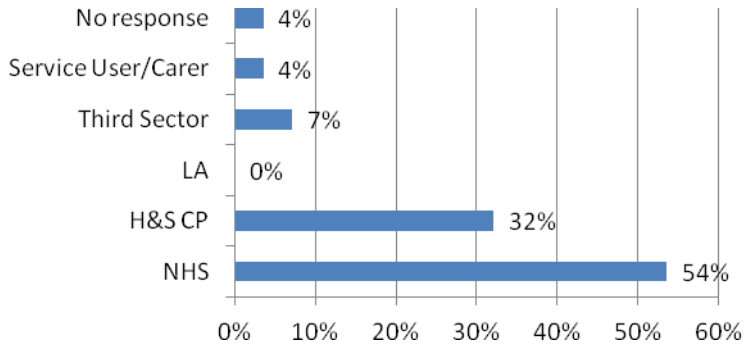


Answer Choices	Responses
Yes	27
No	0
Unsure	1
No response	0

8. Please let us know if you have any other comments or suggestions about the workshop.

- Regular feedback to staff and other interested parties.
- During the workshops it became clear that there is another possible option which would actually address the needs of the LD and GAP populations better – how do you put forward an improved option at this stage?
- No biscuits!!
- Still think the needs of people with LD whose main difficulties/challenging behaviours are due to Autism are not being considered enough. Experienced staff need to also support/mentor community providers. (Third Sector also representing views heard from people with LD and/or Autism)
- 8.30 start was impractical.
- Great facilitators.
- Well facilitated. Well done all!

9. Please indicate which area you represented.



Answer Choices	Responses
NHS	15
Health & Social Care Partnership	9
Local Authority	0
Third Sector	2
Service User / Carer	1
No response	1

Facilitator: Paul Arbuckle

What do we need in place to deliver this model?

BLUE GROUP

These notes refer to the **blue ink** in system diagram, this was the first group who drew the initial diagram in this corner.

Intensive Home Treatment (IHT) needs to be available 7days/ week in all localities.

Crisis assessment is needed 24/7

Revised CMHT operating hours needed – 7 day service provision in all localities and potentially extended hours needed, but this strengthened community service could also be achieved by more effective working with 3rd sector partners.

Inpatient length of stay needs to reduce in order to moderate the impact of greater distance between beds and home for some patients.

If community services are not increased in Angus, there is a potential increased Length of stay (LOS)

Changes to how advocacy services are provided currently would be required – they'd need to reflect the change in bed location to an extent – but not completely remove advocacy from Angus community patients.

Work is required around threshold for IPCU beds – may need to be reviewed due to reduction in low secure beds.

Work needed to better describe how each part of the system functions effectively and efficiently – with home as the starting point not inpatient beds

Work also needs to attend to the interfaces across the system – it needs to be connected.

RED GROUP

These notes refer to the **blue ink** in system diagram, PLUS the **red ink**. this was the second group in this corner.

Angus	P&K	Dundee
CRHTT: Based within CMHTs within localities IHT 9AM – 9PM Mon-Fri CMHT hours 9AM – 5PM	CRHTT as per current set up (Sep 2016) 24/7/ 365 crisis assessment IHT 9AM – 9PM 7 days	CRHTT as per current set up (Sep 2016) 24/7/365 crisis assessment IHT 9AM – 9PM 7 days
CRHTT presence at Stracathro or GP OOH Arbroath	Based at MRH	Based at Carseview
Likely to cost around £400k	-	-

15 WTE nurses 1 WTE Consultant	?15 WTE nurses 3 sessions of consultant input	?25 WTE nurses ?1 WTE consultant
All locality services would need access to psychology, AHP, community (non MH) services.		

The model also needs detail about how the inpatient model of care would function.

Lastly the transition of care from inpatient to community is harder under this model.

Specifically the use of pass beds could be problematic in this model.

RB proposal about the Junior Doctor Rota:

All Junior Doctors would be on one OOH rota, based in Dundee but covering all localities.

6 x FY2, 1:6 on call in daytime with "Team Consultant" and would be supernumerary.

20-30:

- Psych ST 1-3

- GP ST 1-2

Hybrid

1:10-15 on call

1:10-15 full shift

Team consultant – time cost when on night/ post nights.

YELLOW GROUP

These notes refer to the **blue ink** in system diagram, PLUS the **red ink** PLUS the **black ink**. This was the third group in this corner.

IHT would need to be based in each locality

A clearer and stronger offering around IHT is required in all areas to make this model work.

Extended hours of IHT – provided by CRHTT OR by 3rd sector OR a combination is needed.

CMHT extended hours would be needed.

This group was uncomfortable with "threshold" – preferred the idea of a pathway as a focus.

Fewer sites means less chance of movement between sites, thus potentially reducing the undesirable aspects of transition in care.

GREEN GROUP

These notes refer to the **blue ink** in system diagram, PLUS the **red ink** PLUS the **green ink**. This was the fourth group in this corner.

This group feels that this option necessitates a ward closure – not a ward transfer. All other notes from this group therefore applies to option 5a having no AMH inpatient beds in Angus, and the existing complement of Dundee beds maintained rather than added to. The enhanced community service provision that would be essential to a functioning version of option 5A can only be realised (in the group's view) by closing the beds and reinvesting in the community services in all localities.

This option would require a single site crisis assessment service in Dundee, which would have to be able to provide transport back to another locality if needed. The Crisis Assessment function would require a bed coordinator role that would gate keep all AMH inpatient beds across NHST.

It would have IHT bases in each of the 3 localities, performing IHT and early supported discharge. IHT would be given to same standards of care in all localities, 7 days, 9AM-9PM, 365 days/ year.

CMHT input would increase around some of the work currently going to CRHTTs in the form of crisis support before the NHST crisis assessment service is engaged.

There would be a Ninewells and a PRI liaison psychiatry offering. (in each locality)

Focus is on prevention of admission.

Each part of the current system would have to deal with a higher level of acuity than it currently does, in order to support fewer beds.

Medical cover for the whole Stracathro site (not just AMH and/ or POA) would need to be revised if no AMH ward at Stracathro.

ECT in Angus – funding, medical and nursing staffing for ECT would need to be identified as could not be simply continued at current service provision levels if mulberry goes

Impact of changes in this and all other models, from the carer perspective, must be considered

There may be a perceived disadvantage to Angus service users from a cultural perspective (particularly the rural vs urban aspect).

The following table summarises the comments made by each group against the specific questions posed of option 5A:

	Blue Group	Red Group	Yellow Group	Green Group
Is this configuration clinically safe?				
Nursing – cross cover	Yes	Better for AMH beds, worse for POA Angus beds	Yes	Better for AMH beds, worse for POA Angus beds
Nursing – responsiveness	-	As above	Yes	As above
Medical – cross cover	Better	Better for AMH beds, worse for POA Angus beds	Easier	Easier, but needs to be worked thru for Angus POA
Medical responsiveness	-	As above	Easier	As above
Junior Doctors – cross cover	Yes – and training better	Needs a single Tayside-wide rota and cross cover – see flipchart notes for red group. GP cover easier to arrange under this model than presently.	-	As above
Junior Doctors – responsiveness	-			As above
AHP/ Others – cross cover	Slightly better for some inpatient units		2 sites better than 3 but not sure this is possible.	Easier in Carseview than presently.
AHP/ Others – responsiveness	-		-	Easier in Carseview than presently.
Potential negative impact on patient pathway?	Yes, travel for Angus pts and families	Yes – potential increase in detention rates	This group does not agree re detention rates.	
Improved patient pathway?	-	Potential increase in specialist service provision	Minimal disruption for the LD move.	
Improved environment?	-		Needs investment in Carseview	Needs investment in Angus community services
Is this configuration able to work with OOH?				
Nursing – ability to cover out of hours/ crisis response/ home treatment	Investment needed	-	-	-
Nursing – ability to increase out of	Investment needed	-	-	-

hours/ crisis response/ home treatment				
Medical – ability to cover out of hours/ crisis response/ home treatment	-	-	Better with 2 sites rather than 3, but not as good as from 1 site	-
Medical – ability to increase out of hours/ crisis response/ home treatment	-	-	Better with 2 sites rather than 3, but not as good as from 1 site	-
Junior Doctors – ability to cover out of hours/ crisis response/ home treatment	Improved but Stracathro weakened.	Slight improvement in Junior Doctor cover	-	-
Junior Doctors – ability to increase out of hours/ crisis response/ home treatment	Yes	-	-	-
Can we staff this configuration safely and effectively?				
Nursing	Potentially easier for inpatients than currently, harder for Angus community services	Harder to recruit, hard to move current staff, and MORE staff would be needed in the community in Angus	Yes	ECT at Stracathro may be an issue
Medical		May lose a consultant from Angus if they leave Tayside because of this move.		ECT at Stracathro may be an issue
Junior Doctors				
AHP				
Psychology				Yes
MHO	Could be harder	Increased MHO workload, increased MHO travel time so less direct care time	Increased MHO workload, increased MHO travel time so less direct care time	Increased MHO workload, increased MHO travel time so less direct care time
Advocacy	Could be harder		Yes	Could be harder
Support Services/ Other				What would we do with the surplus support staff if Mulberry closes?

Is there an ability to shift balance of care?				
Requires additional community service provision?	Yes. Needs to be costed. Resource also needed to fund the change from current.	May increase LOS because of less effective pass beds, greater distance between community and inpt beds	Yes	Yes – only if the ward closes
Allows for shift of resource to community to increase provision?	Yes, but needs quantified – may need site closure	Yes	Yes	Yes – only if the ward closes
Ability to staff additional community service provision?	Not really	-	Yes	Yes – only if the ward closes
Is this configuration affordable?				
Requires bridging plan (short term double running costs)?	Yes	Yes	Yes	Yes
Releases resources through economies of scale	We think so…	Not necessarily	Yes	Depends on what happens with vacated ward
Is it more expensive than current and requires investment?	Potentially	Yes	Potentially	Yes
Allows a review of current management structures to allow resource release?	Unsure	No	No	Minimal
Releases operational site resource through potential disposal? Allows for potential site/ sites capital receipts from disposal?	Yes	No	Yes	Yes – only LD.
Requires additional investment in current environments? What? Where?	Yes – refurb of carseview, more premeses for Angus community services,	Yes	Need to look at transport to support inpatient admission Need to look at MHO, all CMHT premeses, IT,	Crisis assessment centre would need investment. Advocacy service would need investment. Rohallion would need investment.

Facilitator: Karen Gunn

What do we need in place to deliver this model?

GREEN GROUP

These notes refer to the **green ink** in system diagram, this was the first group who drew the initial diagram in this corner.

Please note that the Green group had home as th start point on the left hand side and hospital on the on the right hand side

Needs a good primary care system

Keep locality based team (? even expand)

Look at ways to prevent admission from home

Early supported discharge in all localities required

Single point of access for patients to contact

Better liaison service with the police

Need to be better at anticipatory care planning

Closer links with social work

Gate keepers needed for assessment

Bed co-ordinator 24/7 who would know where the beds available are

Crisis assessment would be on a single site and for this model it would be Carseview 24/7 for new patients- or locality teams see in hours

Assessment- challenge out of hours-workforce

Need a robust integrated assessment

The crisis assessment could be done by a doctor or an appropriately trained nurse

The assessment should take no more than 90 minutes for the patient; however it may take longer if a bed is required

Look at, home treatment, self management, ref CMHT, ref back to primary care or inpatient admission

If inpatient admission is required then the team would try to make sure that the patient is place as close to locality as possible, Perth patient would go to Carseview, if however there was not a bed available then it would be Stracathro

A safe mode of transport would be required to transfer patient to the site for admission- if a patient is being detained this would mean 3 to 4 people to escort, this would mean you need appropriately trained staff. May require to be taxied, get an ambulance or the police to transfer. Could possibly contact the transport hub for assistance in hours.

Patient will only be an inpatient for as long as required, length of stay can vary

Would require a strong transitional team to integrate back into their own community especially after long lengths of stay as an inpatient- good discharge planning,

Robust liaison service

Need to look at types of treatments available- at home treatments

Need to look at what the carers needs are as well

The underpinning things that are required for this model is: that there is good communication between the teams, that the protocols and documentation are the same across the service

BLUE GROUP

These notes refer to the **green ink** in system diagram, PLUS the **blue ink**. This was the second group in this corner.

Primary care is more than GP's, 3rd sector involvement

Hub instead of single point of access

Take out the assessment- challenge out of hours- workforce

Gate keepers- inpatient beds

How do we support outpatients to get to Perth

Self management should hopefully happened at start

Liaison Service- liaison nurse, in localities, resources community partners

Bolster community support in all 3 areas: intensive home treatment, early supported discharge, extended community mental health services= investing (longer hours)

3rd Sector- advocacy invest more heavily. Peer support workers

Health and Social Care- Partnership working, create better links to see what is out there

Consultants- with 6 junior doctors wouldn't be able to have out of hours- develop a nurse/medical liaison service

Where the patients actually are- economy of scale. Is it reasonable for perth and Kinross patients going to Angus instead of Dundee

Sphere of influence of Ninewells

If Moredun closed nursing staff cover for rehab will be difficult

Would this slow down discharge

RED GROUP

These notes refer to the **green ink** in system diagram, PLUS the **blue ink** PLUS the red**ink**. This was the third group in this corner.

More business as usual- just more Perth and Kinross patients

Will be Issues with transfers and repatriation

More robust Crisis team in Perth and Kinross

Angus- no home treatment team just now, would need more funding

Perth and Kinross- more investment needed in prevention

Still provide GAP- POA staff cover (Angus) at present at MRH, specialist rehab services, staff from Moredun help

There would be x2 isolated units, Carseview and Stracathro

Mental Health Officers- you would need x1 Perth and Kinross, x1 Carseview and x1 for Stracathro

Out of Hours- not completely functional

Staff travelling across sites- Perth, Dundee and Angus

HR Issues- potential loss of staff, this can cause disruption initially but can also have continual/potential benefits in the short, medium term

Waht is reasonable for staff to be travelling (need to think of staff's home base)

Is this the wrong time to do this with the PFI's still in affect?

Is it clinically safe now?- let's look at ways of working and staffing

Is it easier to recruit across just two sites?

Shouldn't we be addressing the recruitment and retention issues

Empowering staff to make changes

What workforce profile?

Need to make it attractive for staff to work in NHS Tayside

Out of Hours Stracathro/MRH- no junior docs would be available within the 20 minute it would be one hour instead. Would need to up skill nurses and this takes time

Lots more travel involved or disinvest in Perth

Job plans make this difficult- need clinicians to make improvements and lead clinical leadership

This is 'not patient centered'

There has been no discussion with patients, families or carers in Perth and Kinross

Dis-joint between board's decision and the public's wants for mental health

Issue with Integrated Joint Boards etc, agreeing on one model- if it is the wrong one who will be held responsible?

Need to think /look about future finances/ staff- look at efficencies

Yellow GROUP

These notes refer to the **green ink** in system diagram, PLUS the **blueink** PLUS the **red ink**. The **yellow group** is written in **black ink.** This was the fourth group in this corner.

Complex needs, forensic-isolated

Appropriate assessment for correct service

70% of Angus patients live closer to Dundee. 60% of activity. Coupar Angus closer to Dundee than Perth

Issues with transport- look at the distance people would have to travel

Increased inconvenience for people having to travel- lets no inconvenience patients

Staff will look for posts closer to home

'Person Centred?'

Perth and Kinross, mental health officers are struggling to fill out of hours rota at present. There is an increase in private guardianships, this model will add to the pressure

Look at enhanced community model for Perth and Kinross

Equitable for all

ADDITONAL POST IT NOTESFROM ALL GROUPS-

HR Issues for staff

Closed ward no real savings

Means removing 4 junior docs with this model

May help staff in other areas of MRH

All we are doing is moving the beds

Have CPN's based in the wards

Be clearer where this data has come from

Forensic patients being referred in ???

What is the figures that are approximately admitted

Stop being risk averse

Discharge planning- common infrastructure

No acute, MRH, Strcathro or Carseview

POA would find it difficult to triage with new model

Staffing with bank nurses in unsustainable

The following table summarises the comments made by each group against the specific questions posed of option 4A:

	Blue Group	Red Group	Yellow Group	Green Group
Is this configuration clinically safe?				
Nursing – cross cover	No- issues of skill mix of workforce. GAP don't cover POA in MRH	Not for MRH- rehab unsafe. GAP potentially better though not across the whole site (MRH)	Concerns for patients with complex needs, need to call the police. Concerns for POA at Mulberry- police would be the backup or transfer to IPCU	No change to Mulberry, however it would require a review of the workforce for safer staffing levels for POA
Nursing – responsiveness	As above	As above	As above	As above
Medical – cross cover	Can cross cover- but makes it difficult and make it more like OOH	No	If I could fill every post yes- but that is doubtful	No
Medical responsiveness		No	As above	No
Junior Doctors – cross cover	Can't run it with 6 junior docs, trainees would get taken away and only be left with GP trainees	No	Be easier as no night cover would be required for MRH	No
Junior Doctors – responsiveness		No	As above	No
AHP/ Others – cross cover		No	Would struggle with Ahp's if long term sick	No
AHP/ Others – responsiveness	Resources would e transferred to inpatient	No	As above	No
Potential negative impact on patient pathway?	Will have problems in community	No	Home visits would be difficult	No
Improved patient pathway?	No	No	Yes	No
Improved environment?	No	No	Refurbishment to Carseview	No
Is this configuration able to work with OOH?				
Nursing – ability to cover out of hours/ crisis response/ home	Wouldn't have home treatment. Transfer	No clear enough- new staff would be needed	With additional resourceand rural locations makes it more	No

treatment	PRI to Carseview OOH		complex- double up to be equitable	
Nursing – ability to increase out of hours/ crisis response/ home treatment	No	As above	As above	No
Medical – ability to cover out of hours/ crisis response/ home treatment	Risks about sustaining junior doctors at MRH- effort needed to be safe. Would be waiting an hour plus, need a clear plan in place- restraint time	Single On Call model- concern regarding all unseen consequences of all crisis coming to Dundee	Slightly improve position	-No
Medical – ability to increase out of hours/ crisis response/ home treatment	As above	Job's plans make it difficult to make it appealing for medics to come her	Quite demanding on medical time, less time for community	-No
Junior Doctors – ability to cover out of hours/ crisis response/ home treatment	Patient safety will be compromised	Single on call model required	-Be the same	-No
Junior Doctors – ability to increase out of hours/ crisis response/ home treatment	As above	As above	As above	No
Can we staff this configuration safely and effectively?				
Nursing	No	Would need more information- but feel that more community staff would be needed that current model	Challenges for staff travelling	No- challenges with staff from Perth travelling
Medical	No	If centralised rota to single site	No	No
Junior Doctors	This model is not fit for training and feel the junior docs would be pulled	Single on call roat for Dundee- core training already out in Perth – might be beneficial cover on MRH	No	No- worries about junior medics being pulled

		OOH		
AHP	Band 5 inpatients physio/OT/dietician shared resources- retention issues	Don't know	Retention and recruitment issues	Issues with bands 5 OT's as they get promoted quickly. Need more involvement form community pharmacy
Psychology	Yes	Yes cause Moredun does not have any at present	Issues with recruitment	Need more for every stage of the journey- no consistency in patient journey, needs a better skill mix
MHO	Expecting them to travel with patients	Have to travel with patient	Would have to travel to area with patient	Challenging as they have to follow the patient
Advocacy	Depends on patients length of stay	Increase for advocacy on site then need to travel out	Would have to travel with patient- would need investment	Would not work, would require a review of funding
Support Services/ Other	Yes	No change	Family/carers would struggle to travel	If footprint changes this will change
Is there an ability to shift balance of care?				
Requires additional community service provision?	What is the resource to transfer	Doesn't shift, needs additional resources- problem in community provision 0.05/7 population go into inpatient beds	Needs additional resource. Less economy of care	No
Allows for shift of resource to community to increase provision?	No but site closure might	Need the figures for inpatient GAP. Costs of PFI's. Moving a ward isn't the answer	Less economy of care	No
Ability to staff additional community service provision?	No	-No	There is no money- would need resource transfer built in, size of community for more staff. Poor transport links makes it difficult	No
Is this configuration affordable?				
Requires bridging plan (short term	Yes (no additional	Yes	Yes	Yes

double running costs)?	source work)			
Releases resources through economies of scale	It should but how do we quantify	Small amount	Slight but lose in other areas	No
Is it more expensive than current and requires investment?	Don't know yet	Yes	Yes	Yes
Allows a review of current management structures to allow resource release?	Yes	Done it already- so no	No	Yes
Releases operational site resource through potential disposal? Allows for potential site/ sites capital receipts from disposal?	Yes for Strathmartin	Potentially	Strathmartin- further option for re-use of Moredun	No depends on Learning Disabilities
Requires additional investment in current environments? What? Where?	Yes for Carseview and low secure MRH	Yes for Carseview	Yes for Carseview	Yes- Carseview refurbishment- finance has been held for the last 6 years

Can we staff this configuration safely and effectively?

Breach travel policy to move staff / transport
Staff satisfied patients in acute never see patients getting any better
Environmental design for intensive would need to be different
Not cross house increase locality
Staff rotations not staff centred
Need transfer team in place
Really medicalise care
Skill mix + ratio in acute needs to be higher
Release 5 beds little impact on cost reduction
Therapeutic relationship – getting to know
GP use of Dundee Centred
Creates new transition acute and sub-acute and back the way
CTO – non compliant – suspension retention need to go back to hospital discharge form
What achieve – rapid diagnosis – rapid treatment
Staff burnout
Sausage machine – consideration of patient needs
Staff 9/9/7 acute ward!
Facade of local beds but make like status quo but increase transitions increase risk
More likely to witness something traumatic
Level of disturbance
People
Support ancillary staff to manage turnover
? Attractive training environment increase level burnout
Blockages need really intensive treatment in treatment + CMHT
Apprenticeship model
Increase travel for junior doctor – is this safe?
WTE assessment
Skill mix / skills and experience
Rotate nursing staff
Maintain competency
Recruit to crisis team
Is it attractive due to increased intensity, increased turnover
16% increase in junior doctor apply Scotland from England
SPR / Trainee
Loss medical staff if IP units close in Angus
Angus no trained physio
Art Therapy – variation AHP
MDT – access to / or on site
Retain 90% train – work beyond retirement not have recruitment problem
Workforce plan difficult
Lack of duty of care
Crisis house model attractive to carers

Increase Skill / Turnover, decrease Stress – why over 55 going

Is there ability Shift Balance of Care?

Evidence crisis teams is large urban centres

Crisis house in Dundee, would patients want to go to city

Centres difficult transport carers relatives

Home treatment and early supported discharges

5 beds out of Angus to pay for Crisis service increase medical cover protect CMHT capacity i.e crisis patients > CMHT could have home treatment element into community teams

No shift to community

Rural series reduced across effective crisis services

Staffs travel CMHT to see staff

Rural setting – efficiencies of scale – i.e carers leave or sickness by centralising vs. access locally

SW different structures SW and different line management

Is this configuration affordable?

Impact for patients in Rohallion and need environmental change

5 beds in Angus, 10 crisis

Need increased skill mix in acute assessment

No decrease staff Perth and Dundee

AIS where would this go?

Moredun need some staff re facility – need psychology to Moredun & IPCU

Reduce 17 beds in total

Need more staff assessment needs

Dundee MHO service as all patient capacity increase funding to local authorities

Perth out crisis service, will they contribute tayside

MHO re OOH cover

MHO OOH = voluntary angus not provided

Is this configuration clinically safe? What do we need in place / can we deliver?

Treatment ward reread admission documents. Etc
Single point access is positive ie central crisis team
Increase vulnerable due to rapid changeover
In hours needs to be focussed split early discharge and home treatment in crisis team
? trainees and consultant Angus / Perth
? 2x ward work
Increase incidents OOH Moredun in treatment ward when issues OOH
Crisis house ? responsibility not acute admission
Solution to how will this improve push / pull?
? will people need to stay >3 days – will be moved too quickly – retention – same clinical issues as step down
LOS < in high acuity area
Nature of disorder = acute ward filed / blocked
3 days ? assume what treatment is needed in acute admission
* not having acute admission to treatment ward *
? enough detail to assess how safe treatment ward will be
What is admission unit full?
Dundee < beds by 19
Increase transfer multiple times
What clinical advantage to this model from status quo
What if becomes acutely unwell in treatment wards
What if people not mobile – ie disabled etc into the area
Treatment plan changes in transition
Short term detention where review
Increase level of enhanced observation – ? can we staff this
10 beds not to therapeutic level
Staff burnout and patient burnout
Communication between sites
What if patient cannot travel to central crisis Dundee
Forensic or suicidal but easier to get to locality team
What is optimal length of stay?
Minimise effect of peer support
Constantly responding to crisis from Dundee treatment ward
Not guarantee admission / step down to local areas
More patients at night to maintain from 24/7
? role HCS in acute and build in escort nurses
Voluntary admission would want to go to central acute ward
Optimum treatment team?
Gender split beds ? 5/5 safeguard
? be so frightened I would want to leave ? detention increases
Patient suicides
Robust review process – discharge process be slicker
Need protocols and policy re admission
45 minimum not safe
Where ECT? Currently all 3 sites
Technology to connect / communicate
Retain and rotate skill sets
Regulatory bodies – define who / what done – needs definition
Dedicated advocacy worker on site
Everybody acutely unwell – how does this feel?

Impact ambulance and police in central model
How does cross carer work?
Not addressing purpose of admission
Take away drug induced psychosis (volatile) = TSMS / GAP resource
? rotation and managing staff
Therapeutic relationship balance
Disintegration of acute care
What happens if acute admission full? Where do they go?
Transition for rejection / stability exacerbation symptomology
Increased patient risk not using patient need to drive patient care forcing through model fixed timescales
Safety? How get from acute admission ward to treatment ward
Occupancy less than 100% local wards
What treatment model? ? injections to settle
Older person age versus needs led
Reduce early treatment plan
Patients don't get well after 3 days
Patients 3 days post acute admission - ? where carer
Rebuild of wards
First interaction governs how feel about yourself – 16/17
What focus of ward – hold people for 3-5 days
NQP increase nurse holding power
Admission ward becomes holding bay
Patients have concern about model
Who suitable for each ward?
Difficult to recruit to
Positive view crisis element and potential to improve
Does this add another element to patient journey
Load balancing not built in? Increase errors
? need more AHP because conscious of flow coming in plus community
ANP + work OOH beyond
? distribution Angus / Dundee / Perth patients
Add another step for no gain
If patient comes in on Friday will care be safe
Receiving centre
Patient suicides - top reason communication and levels of occupancy

Threshold

Discharges early and treatment early – concentrate expertise

Delayed discharge – minimised / limited

Step down not improve do where community support

Flow pulls not push

Consistent care planning

Consistent relationships i.e. known

Benefit of LT patient community through central acute

Borderline personality disorder – is this suitable?

Confusion detained why admit central

Ward round in treatment

Catchment

Treatment ward

Incident of patient being cared for post acute out of their own area, 25% improvement

Patient may still be admitted out area

In hours	1. Assessment	2. Home treatment
Anugs	Perth	Dundee
CMHT		
Acute assessment	Crisis team	Crisis team and urgent assessment

Urgent 72 hrs CMHT – CMHT – Crisis

Take acute assessment out of CMHT

GP emergency 4hrs > crisis

GP 72 hrs > CMHT

Urgent routine

Change –

Dundee – urgent

Angus – stop emergency

MHIP Notes Yellow Corner (Option 3a) 29th September 2016

Facilitator: Alison Nicoll

What do we need in place to deliver this model?

YELLOW GROUP

These notes refer to the **black ink** in system diagram. This was the first group who drew the initial diagram in this corner.

Sources of referral to Carseview GAP wards: CMHT, CRHTT, IPCU, A&E, Police, Unplanned Self-Referral (patient turning up on site). Patient transport to Carseview is a key issue, particularly the time taken to get from Angus and P&K – Scottish Ambulance Service and Police would need to be involved in any planning.

Carseview GAP will assess and decide whether patient is admitted or not.

There needs to be a clear pathway for patients who are not admitted after assessment.

The following issues need to be considered if patients are to be admitted to a single site:

- Travel for carers (they may travel a long way to find the patient doesn't want to see them)
- Travel for MHOs and advocacy workers
- Access to local facilities as part of treatment – what will Angus and P&K patients do?
- Passes home for Angus and P&K patients
- ECT – where will it be delivered? Currently delivered in localities.

Average stay expected to be around 21-28 days (based on current figures).

Patients transferred out to: CMHT – discharge planning, Amulree/Rannoch Ward, IPCU, specialist accommodation – nursing care, primary care. Improved communication and links required.

GREEN GROUP

These notes are in addition to the **black ink** in system diagram. This was the second group in this corner.

Disagree that Carseview GAP should take the decision whether or not to admit. The CRHTT should act as 'gatekeeper' and should be the first point of contact for CMHT, A&E, Police, etc. Patients presenting at the ward should be directed to primary care for assessment/triage. It was noted GPs can detain patients and requests for admission will also come from this source.

Green group designed a detailed pathway when discussing option 4. They also want to integrate it into this model.

Additional issues to be considered when admitting to a single site:

- TSMS workers – inreach
- Third sector – different ways of working in localities – how would it work?

- Could telehealth solutions help with distance issues – CMHT workers, etc.
- ECT patients – issue of unwell patients with complex physical problems having to come to Dundee.

Patients can also be transferred to home treatment and also to acute services.

There will be major issues around discharge planning communications. Need to address issues to make discharge work.

BLUE GROUP

These notes are in addition to the **black ink** in system diagram, PLUS the **green ink**. This was the third group in this corner.

Admission should be the last resort and there will need to be a very different pathway for community and primary care if this model were to be adopted.

If the new patient pathway is good it may lead to an increased length of stay if patients are more acutely unwell.

Discharge planning involves much more than improved communication and links referenced by the yellow and green groups: travel, getting patient back to locality, ability of Carseview site to accommodate visiting workers, third sector links.

RED GROUP

These notes are in addition to the **black ink** in system diagram, PLUS the **green ink** PLUS the **blue ink**. This was the fourth group in this corner.

Will there be a centralised CRHTT making admission decisions or will there be locality teams?

Major problems for patients/carers coming to Dundee.

The model doesn't address patient-centredness. What are patients' views?

Involve CRHTT in discharge planning.

The following table summarises the comments made by each group against the specific questions posed of option 3a:

	Yellow Group	Green Group	Blue Group	Red Group
Is this configuration clinically safe?				
Nursing – cross cover	Risk to MRH and Stracathro.	Yes – but POA issues. Could money from a closed ward help with staffing increase in Stracathro?	Yes – but could leave POA vulnerable.	Yes for GAP, no for other sites.
Nursing – responsiveness	Yes.	Yes – but POA issues. Could money from a closed ward help with staffing increase in Stracathro?	Yes – but could leave POA vulnerable.	Yes for GAP, no for other sites.
Medical – cross cover	Appealing in terms of cross cover.	Yes but need to consider MRH and Stracathro.	Needs major review of job plans. Consistent with what other boards are doing.	Will improve cross cover.
Medical responsiveness	Yes.	Yes but need to consider MRH and Stracathro.	Needs major review of job plans. Consistent with what other boards are doing.	Less good for clinical acuity.
Junior Doctors – cross cover	Could change patterns of cover. Would improve training for junior docs.	Yes but need to consider MRH and Stracathro.	Needs major review of job plans. Consistent with what other boards are doing.	Will improve cross cover.
Junior Doctors – responsiveness	-	Yes but need to consider MRH and Stracathro.	Needs major review of job plans. Consistent with what other boards are doing.	Less good for clinical acuity.
AHP/ Others – cross cover	Improved skill mix.	Psychology – wouldn't be unsafe but not best patient journey. Better for AHPs.	-	Helpful for service delivery.
AHP/ Others – responsiveness	Improved skill mix.	Psychology – wouldn't be unsafe but not best patient journey. Better for AHPs.	-	-

Potential negative impact on patient pathway?	Yes.	Yes.	Yes – some patients will be a long way from home. Issue of transporting patients to Dundee.	Yes – travel; possible increase in number of detentions because patients don't want to go to Dundee.
Improved patient pathway?	Yes – with community investment	Stay the same.	Patients will not 'yoyo' between sites. Increased ability to manage bed base. Transition is crucial.	Yes – more consistency of care, same models.
Improved environment?	No	Not really. But what do patients think? Different perspectives.	Carseview would need investment to develop/refurbish.	Depends on Carseview refurb.
Other?	-	-	-	Issue of recruitment and retention. People leaving if they have to move.
Is this configuration able to work with OOH?				
Nursing – ability to cover out of hours/ crisis response/ home treatment	Depends on the model. Needs investment.	Impact on some hospital sites.	Possibly – but needs investment. Could see and admit in one location. Fewer transport links. Issue – all acuity in one place.	Yes – if OOH was centralised and CHRTT nurses centralised.
Nursing – ability to increase out of hours/ crisis response/ home treatment	Would give an imperative to strengthen this – needs investment. Could keep patients out of hospital if reprovision sensibly.	Potentially – could allow to flex capacity to locality depending on numbers.	Not in current format. Needs investment.	Yes – if OOH was centralised and CHRTT nurses centralised
Medical – ability to cover out of hours/ crisis response/ home treatment	As above.	Yes – but would need duty doctor cover for other sites.	Yes – currently working on OOH medical cover.	Yes – for GAP. Who covers MRH doctors?
Medical – ability to increase out of hours/ crisis response/ home treatment	As above.	Yes – but would need duty doctor cover for other sites	Issue of on call in Carseview and community work in locality. Need liaison cover in PRI. Can't review liaison until have decision on this.	Possible negative impact on other service.

Junior Doctors – ability to cover out of hours/ crisis response/ home treatment	As above.	How do we manage junior doctors going on call in Dundee and day shift in another locality? But pan-Tayside rota could be much better. Needs good oversight.	Yes – currently working on OOH medical cover.	-
Junior Doctors – ability to increase out of hours/ crisis response/ home treatment	As above.	How do we manage junior doctors going on call in Dundee and day shift in another locality? But pan-Tayside rota could be much better. Needs good oversight.	Issue of on call in Carseview and community work in locality. Need liaison cover in PRI. Can't review liaison until have decision on this.	-
Can we staff this configuration safely and effectively?				
Nursing	Yes – but issues. People might stop coming to Perth and Angus.	Yes – but would depend on review of bed numbers.	Would allow a specialist model in mental health practice. Attractive.	No in short term. Yes in medium-term and long-term.
Medical	Yes	Yes – but has impact on OOH.	Yes – could help MRH cover.	Safer for GAP. Not for POA, etc.
Junior Doctors	Concentrating on call could free up trainees to do other things. Helps retention.	Yes – but has impact on OOH.	Good training if Tayside-wide rota. Would need proper liaison service for PRI.	Safer for GAP. Not for POA, etc.
AHP	Issues with students – training is in Aberdeen and Edinburgh. Don't want to do mental health or come to Dundee. Longer term – aging workforce.	Potentially a more concentrated resource – if bed numbers reviewed.	Allows complementary approach to treatment. More sharing between disciplines. Social aspects – able to consider this.	Would be easier to deliver service.
Psychology	Similar to AHPs.	Yes.	Yes.	Easier to deliver service, better for patients.

MHO	Not in Angus and Perth (recruitment and retention issues).	Very big impact.	Possible big impact. Needs joined up thinking.	Travel issues, time issues.
Advocacy	Would need increase in funding for all areas due to travel costs.	Very big impact.	Would need investment.	Difficult for them to cross boundaries. Variation.
Support Services/ Other	Support services – staff employed on PFI contract at Carseview. Carers – issues with visiting.	Increased level of work if ward reopened. PFI contract, etc. Staff turnover.	No issue.	Not an issue.
Is there an ability to shift balance of care?				
Requires additional community service provision?	Yes	Yes (lots). And multi-agency involvement. Community services will have to develop.	Yes.	Yes. Angus crisis service needed. Travel time.
Allows for shift of resource to community to increase provision?	? Yes. Depends on services.	Only if bed model decreases – gives significant savings.	No – same bed base. But if decrease bed numbers – eventually.	No – if beds stay same. Could suck resource from community.
Ability to staff additional community service provision?	Service dependent – could help planning.	Money dependent. Could decrease management structure. People could transfer to community.	Possibly – site closure savings need reinvested.	Perhaps – if invest in CRHTT – staff might prefer to work in community.
Other?	Voluntary sector – how can they be involved? Use of supported accommodation.	Impact on transition between adult and POA. Impact on police and Scottish Ambulance Service. Independent sector involvement.	-	Need more detailed data to analyse this.
Is this configuration affordable?				
Requires bridging plan (short term double running costs)?	Yes.	Yes – but don't have the staff to double staff.	Yes.	Yes. How do we manage risk around this project? Timescales?

Releases resources through economies of scale	Potentially.	Not much money released.	What can other agencies do? Do they need resource?	Perhaps – but what is scale of that? Could also be disbenefits.
Is it more expensive than current and requires investment?	No – but model to support it would need investment.	No – but need redistribution of resource. Could be cheaper (locum costs, etc.).	Could be a cost to patients or carers – travel, etc. Need proper infrastructure in place for early supported discharge. Initial costs – staff travel.	Yes – in community teams, Carseview.
Allows a review of current management structures to allow resource release?	Yes.	Yes.	Yes – due to single site.	No.
Releases operational site resource through potential disposal? Allows for potential site/ sites capital receipts from disposal?	Yes. But what do you do with money?	Yes – if we consider LD.	Yes – if Strathmartine goes.	Maybe.
Requires additional investment in current environments? What? Where?	Yes. Rohallion – adapt wards. Moredun – LD. Community – rooms overflowing already.	Yes. Carseview - refurb. Moredun – LD. Rohallion. Community.	Carseview – refurb. Moredun – LD. Rohalllion – LD forensic. Community staff – accommodated in hubs.	Carseview. Moredun.


WHAT IS THE SYSTEM OF CARE?
What are the benefits to the population?
VISITS COULD LEAD TO PLACEMENT BREAKDOWN
NEED CLOSE LINKS BETWEEN SERVICES
TEAM WORKING BENEFITS ALL ON ONE SITE
SIGNIF INVESTMENT TRIPS OUT
FORENSIC
WHO RUNS THE SERVICES
DEPENDS WHERE PATIENT IS FROM
SOCIAL DISADVANTAGE
FAMILY CARE
REFERRAL TO COMM FORENSIC TEAM
KEEPING LINKS WITH COMMUNITIES
CURRENTLY AT STRATHMARTINE
WOULDN'T HAVE TO BE BASED IN PERTH
IT TO SUPPORT
REMOTE WORKING AT A DISTANCE
SUPPORTED ACCOM
WHO FUNDS THIS NEED TO SUPPORT ACCESS
IJB
AS ABOVE
LDAU BSU OPEN
ACCESS TO SERVICES AT MRH
OPPORTUNITY TO LOOK AT SERVICE PROVISION (PROVIDE SUPPT SERVICES DIFFERENTLY)
ETC
POSSIBLE PRESSURE ON SERVICE PROVIDERS
WHETHER THIS IS AN ISSUE
MAPPA OFFENDERS
ENGAGEMENT WITH COMMUNITY
CHANGES TO MOREDUN
REMODEL
KEEP CLIENT GROUPS SEP.
ACCESS TO OPEN SPACE.
NOT AUTISM FRIENDLY.
HOW DO NURSES OBSERVE PATIENTS.
NEEDS OF FORENSIC & LD PATIENTS
WORKSHOPS
ADDITIONAL COST
ADMIN SUPPORT
PSYCHOLOGY
PHYSICAL SPACE
ROOMS - GROUP
INDIVIDUAL TREATMENT
DOES THIS TAKE INTO ACCOUNT KEYS TO LIFE
LOW ACUITY
PATIENT VIEWS - DON'T WANT TO GO TO PERTH / PERTH TO DUNDEE.
3 SEPARATE POINTS OF ACCESS.
PSYCH ALSO DO WORK IN COMMUNITY
CONTRACTS ALLOW THIS
MODEL 3A
CAR PARKING ISSUES
EVIDENCE BASE
PASSES - PATIENTS MORE ISOLATED FROM CARERS. DIFF TO GO ON PASS.
HR ISSUES DISCRIM.
DAY SERVICES NUMBERS - COULD BE DIFFICULT TO RUN GROUPS
FORENSIC SPECIFIC
PUBLIC PROTECTION RISKS
IN HOSPITAL
DISABILITY ACCESS - HILL
IS THIS THE OPEN MODEL?
WHAT CAN WE LEARN FROM MEDIUM SECURE
LENGTH OF STAY RANGES WEEKS TO YEARS
LIAISON TEAM
LDAU, BSU OPEN
ISSUE OF MIX OF PATIENT GROUPS - VULNERABILITIES
BALANCING STAFF WHO WORK IN COMMUNITY & INPATIENT
BED NOS - NEED BETTER COMMUNITY TEAM APPROACH & REQ. FUNDING
DELAYED DISCHARGES
NEED BETTER COMM SERVICES, HOUSING
PHYS HEALTH NEEDS / COMORBIDITY ISSUES
OOH COVER / PRI
CAN'T INCREASE INEQUALITY AS A RESULT OF THE DECISION.
INCREASED TRAVEL COSTS
SETTLEMENT OF PATIENTS (HISTORICAL)
MRH LOW SECURE
PATIENTS - MAY NOT ATTEND DS OR AGREE TO ADMISSION. COULD LEAD TO ↑ DETENTION OR COMP. TREATMENT
BUY IN FROM STAFF
WHO RUNS SECURE SERVICE - LD OR FORENSIC (FH OPEN-MINDED)
REDEPLOYMENT OF FORENSIC NURSES (NEXT STAGES)
DIFFICULT FOR CARERS TO VISIT (CURRENT ISSUE WITH LDAU)
STATE HOSP
COURTS
FILTERED BY COMM TEAM
COMM LD TEAM
GPS
SW
GAP
SELF REFERRAL
ACUTE
PRISON
CHILD (CAMHS)
ROSSIE
OUT OF AREA
POLICE
(ASDA!)
PROVIDERS
A&E (TO OOH)
HIGH ACUITY
OOH ASSESS / LINK


OPTION 5A
HEALTH & SOCIAL CARE
INDEPENDENT SECTOR, 3rd SECTOR
PARTNERSHIP / HOUSING
What is the system of care in this model?
LOW SECURE BEDS
P+K MRH (Horselaw)
P+K PATIENTS
IPCU
M/F
HOSPITAL
CARSEVIEW WARD 1
CARSEVIEW WARD 2
CARSEVIEW DESANT
DUNDEE + ANGUS PATIENTS
Close a ward rather than relocate
REHAB / LONG TERM CARE
TSMS
3RD SECTOR PARTNERS
PRISON/CUSTODY
GATEKEEPING OF INPT BEDS
CRISIS ASSESSMENT
INTENSIVE HOME TREATMENT
EARLY SUPPORTED DISCHARGE
MHO
OOHS
LIAISON PSYCHIATRY
A+E
EATING DISORDERS SERVICE
NOT THIS
TSMS
CMHTs ANGUS
+ SMS ANGUS
CMHTs DUNDEE
+ SMS DUNDEE
CMHTs P+K
+ SMS P+K
FCMHT (TAYSIDE)
PRIMARY CARE PSYCHOLOGY
PCP
PCP
PCP
MAPS
3rd SECTOR
PRIMARY CARE
HOME
TSMS

Facilitator: Karen Gunn

What do we need in place to deliver this model?

GREEN GROUP

These notes refer to the **green ink** in system diagram, this was the first group who drew the initial diagram in this corner.

The Green Team started by looking at the routes that patients come into hospital and agreed that admission to any unit would be the very last choice

Needs good links with the primary care system

Locality based teams, one for each area (nurses, occupational therapists in P&K meet at weekly allocation meetings)

Early intervention

Home visits to try and prevent admissions to hospital, including working more closely with the 3rd sector

Police and criminal justice system

Social work

Families and other liaison teams

Crisis response

General Psychiatry

Crisis response team (Out of Hours)

BSI Teams- MDT put in support plans

Green group also stated that another reason why patients may be admitted as in patients is when their care packages have failed or have become exhausted and the patients needs cannot be met in the community at this time

Assessments in community

Assessment of mental illness

Crisis management

Behavioural management advice

Functional assessment

Support for GP's

Medication administration/ monitoring

Psychiatry outpatient

CLDN/OT.SLT Home visits

Support to care providers/parents

Education/ training care providers

Patient education

Psychology assessment

Group interventions- offence focused, anger, alcohol, problem solving

CLDN/AHP groups- dietician, healthy living, live active

Sign posting and linking in to community resources

Speech and language assessment

Once the above had been exhausted and the patient required admission into a unit the Green group looked at what the function of the hospital admission is

Assessment of mental illness

Crisis management

Behaviour management

Functional assessment (AHP's Monday to Friday only)

Rehabilitation forensics for LD patients

Also it was felt that maybe better use could be made of the Independent Sector and ASC

What is needed for the model to work

In Carseview the units have to be distinct and separate

Would need an increase in specialised staff

Would need off ward areas for inpatients for day services, option to go elsewhere

Forensics in MRH would need an increase in psychology especially if more 121 sessions are needed than group work

Need new ways of working

Day Service provision

Better public transport links

RED GROUP

These notes refer to the **green ink** in system diagram, red **ink**. This was the second group in this corner.

Don't want to lose anything in case of day services

Agreed with the green group around the provision of psychology and AHP provision would need to be increased

Also agrees that there would need to be a distinction of the units within Carseview as different patients have different needs, noise etc

Need peer support for inpatient and outpatient Carseview and Forensics

BSI and LDU are similar units

Can look at money available

Good for nursing staff

Need better transport links for forensics

Be patient centeredness of this model 6-8 MRH

Good proximity to Ninewells

Yellow GROUP

These notes refer to the **green ink** in system diagram, PLUS the **red ink** PLUS the **yellow group, the yellow group** is written in **black ink.** This was the third group in this corner.

THIS GROUP ASKED THAT THE NOTES FROM THE PREVIOUS STATION BE USED WHEN LOOKING AT ROHALION AS THEY FELT IT WOULD JUST BE DUPLICATION

What would be the impact on staff at Rohallion??potential for redeployment

These clients are the closest group to the forensic service

Is there anything legally that would need to be considered if this work was to progress ahead of overall programme?

Need to understand what impact this would have on LDAU

Need clarity on what the management structure would be

Cannot replicate current service provision for this client group on Rohallion site – 2 site to 2 site model, impact on most staff groups

Need to determine what the best staff model for this client group is

What would the impact on the remaining clients at Strathmartine –these are the 2 most volatile groups

There is an evidence base for provision of learning disability services currently delivered within an MDT framework – this service cannot be delivered generically

Difficulties in ensuring regular risk assessment reviews are carried out – very small pool of staff to pull from.

Will it affect ability of Bank staff cover? – Travel etc

May provide opportunity to develop enhanced roles –i.e. nurse prescribing

How will the workplace / functional activities be provided? These currently give clients connections to community /self purpose

Clinical and admin support needs to be identified prior to move as well as car parking, office space etc.

Greater degree of risk doing this early rather than financial benefit

This work still needs fully scoped

Complexity and depth of overall programme of work makes it difficult to separate this piece out. Could be an earlier move once site option for overall programme agreed and resources identified.

Strong feeling across group for not expediting

Has to be an evidence based model

Need therapeutic inpatient space

Centrally located in Tayside fits with the psychiatric guidelines model- CARSEVIEW

Agreed that it was good to have it on the Ninewells site for proximity to acute services

Forensics day care

Needs additional psychology and Ahps's

BLUE GROUP

These notes refer to the **green ink** in system diagram, PLUS the **red ink**. The **yellow group** is written in **black ink.** PLUS the blue ink, this was the fourth group in this corner

Carseview would need to be distinct separate units

Off ward area for day services, with an option to go elsewhere

BSI needs a space for a therapeutic room

Good proximity to Ninewells

Learning exchange- centre of excellence

ADDITIONAL NOTES- CAR PARK

Green Group

In/off ward day at tenders

Locality teams

Lots of phoning around looking for beds

LDAU always over bed capacity 11 beds when only meant to have 10

Delayed discharges

Consultants in LD work in hospitals and community

Carseview would need environment looked at- open spaces, ground passes

Mini Craigmill

Does Ninewells own the land behind Carseview

Transport issues for people travelling from Montrose down to Perth

RED GROUP

Separate Units- risks, vulnerability, patients own protection as well as others

Day services- issues with staff on multi sites

Behavioural, mental health issues and able patients

Can't replicate what we currently have- environmental (Craigmill)

Carseview would need a major refurb and extension

Public transport an issue at Strathmartine

Numbers of patients from Angus, Dundee and Perth and Kinross- what are the actual numbers (what we currently have)

Need to look at the workforce

Craigmill- make it more patient centred and flexible so that patients do not need to spend the whole day there. Involve the 3rd sector more, see what they can offer. Make outpatients more based in the patient's localities

Carseview already has some occupational services- need to expand these (kitchen)

Should we be providing outpatients on a hospital site?

Any opportunities to reduce beds, put money into community services to allow for more prevention

Who else can do some of the things our nurses currently do

YELLOW GROUP

Carseview would need refurb and extension added

This model seems feasible

Money needs clarification

Can we move medical records and make that area a workshop on Carseview

Similar model. Ensure we maintain links we already have

Minimise impact on LD client group

Day Care- help with discharge/admission/previous admission

Forensic patients may need to travel to centrally located groups- needs nurses for observation, transport (no minibus currently at MRH) can be quite staff intensive escorting patients. Patients needs and patients mix to be looked at.

Managerial structure- who???? Is this going to be different from what we already have

Have a specialised service that is research based

What is the proportion/equity of monies for LD patients- other wards in Rohallion will nedd modified and this will need money

Need to look at lessons learned from before

Improves the quality of accommodation for clients

Carseview more LD appropriate

Car parking will be an issue at Carseview

Is the Carseview site going to get crowded- affect LD needs

Reduced freedom of movement- important they have the opportunity to self regulate

Needs to suit an older LD community as well (needs bigger rooms to accommodate equipment (?x2 rooms in carseview already suitable)

Staff training needs

Delayed Discharges- complex patients- not the appropriate community resources

Birth to older age in system, medical issues that come with this

Develop community infrastructure first generic/forensic LD

BLUE GROUP

There are patients in lDU that should be in BSI- delayed discharges, not enough beds. Patients needs change from when they where first admitted (inevitable)this should be getting planned for, will always have them.

Why is there no stepdown available

Not enough community resources, houses, staff etc

We can't staff the wards at present

Can't see the space working at Carseview- BSI needs space, Forensics needs space, additional entrance required

Ability needs, needs to be looked at for patients/families and carers

LD patients tend to look after each other

Will LD Carseview be as nice as MRH

Need closer links with 3rd sector for activities

Therapy/therapeutic room needed- need clever storage and ways to reduce noise levels

Use flexible accommodation models to allow us to change the space in the future

Needs community buy in- more open type of spaces (patients, families)

Ninewells learning centre

The following table summarises the comments made by each group against the specific questions posed of option 4A:

	Green Group	Red Group	Yellow Group	Blue Group
Is this configuration clinically safe?				
Nursing – cross cover	Yes	Yes	Yes for Carseview	Yes
Nursing – responsiveness	Yes	Yes- more accessible than Strathmartine	Depends on operational it works on Rohallion- planned and appropriate skills	Yes
Medical – cross cover	Yes it's solvable at MRH site	Yes	Yes if planned and cordinated	No difference
Medical responsiveness	Yes	Yes	Yes if planned and cordinated	No difference
Junior Doctors – cross cover	Yes in some ways it makes it easier	There are issues currently	There are issues currently	Issues for 4a
Junior Doctors – responsiveness	Yes in some ways it makes it easier	There are issues currently	There are issues currently	Issues for 4a
AHP/ Others – cross cover	OT's need to look at their structure. Still need other input, physio dietetic would find it difficult	Needs further discussion regarding provision of services	Two site cover will cause issues	Co-location, much the same
AHP/ Others – responsiveness	As above	As above	As above	As above
Potential negative impact on patient pathway?	None given	Losing Craigmill	Depend on funding in the community	Patients/families expectations, Carseview is looked on negatively by some people
Improved patient pathway?	Opportunity to make it more joined up for patients	More positive than negative, Strathmartine not fit for propose	None given	Day service, co-location, closer working
Improved environment?	None given	Yes if Carseview reconfigured	Yes, Rohallion, Ot, day services. Funding transport to Carseview	Yes if investment done properly. Have people who work in the service help design it with stakeholders

Is this configuration able to work with OOH?				
Nursing – ability to cover out of hours/ crisis response/ home treatment	Yes	Yes/ no at prevention	No difference from communities	No change
Nursing – ability to increase out of hours/ crisis response/ home treatment	Yes	Yes	Shouldn't finish at 1700hrs on a Friday	Don't have the provision
Medical – ability to cover out of hours/ crisis response/ home treatment	Yes	Yes	? generic rota No change (internally done in rohallion)	No change may be a bit easier GAP 4a isue
Medical – ability to increase out of hours/ crisis response/ home treatment	Yes	Yes	As above	No difference
Junior Doctors – ability to cover out of hours/ crisis response/ home treatment	Yes	Yes	As above	4a issue
Junior Doctors – ability to increase out of hours/ crisis response/ home treatment	Yes	Yes	As above	4a issue
Can we staff this configuration safely and effectively?				
Nursing	Recuritment and expertise issues, need like for like- more have MH training than LD	Yes skill mix needs worked on, the preventative work/ rehab, retention and recruitment of staff	More likely to retain staff in Dundee- issue with moving staff (to Perth). Rohallion works different shift patterns	More opportunites on one site- recruitment and retention
Medical	Yes unfilled vacancies in forensic LD	Will be a challenge (not taking into account CHP)	Challenge covering two site, links between forensics	Short on middle staff
Junior Doctors	Yes	Be a challenge	Be a challenge	H@N may help resolve this
AHP	OT will need to look at role to make it appealing	Need to look at workforce. Better if all one site, Carseview logistically	Need to look at workforce. Better if all one site, Carseview logistically	Physio cover both wards, investment needed in staff needed for both sites to maintain standards-

				reworking.
Psychology	Will need an increase- medical helping out at secure	Better on one site divide MRH- directed treatment meeting weekly	Need increased staffing	Include more travel time
MHO	Already go in	Short across the piece	Just the same, travel and time	No big changes to forensics
Advocacy	Already goes in	Go in there anyway	No change apart from moving to Perth	No changes
Support Services/ Other	Yes	MRH/Carsveiw PFI Strathmartine may have a reduction on sites	Increased demand for services Carseview	From Strathmartine through appropriate processes
Is there an ability to shift balance of care?				
Requires additional community service provision?	Yes	Yes (needs to be shift in resources to fund it)	Yes	Needs it regardless
Allows for shift of resource to community to increase provision?	Facilites	Yes it is desired ?? Saving from estate management No can't divert funds challenges	No still duplicating two sites Still need to be developed. Commitment of seeing it through	If properly resourced
Ability to staff additional community service provision?	Can do it	Not at the moment- aspirational Is the money there to improve Carseview, most central for patients	Community needs to be devloepd first, needs resource transfer Complexity of patients, coordinated communication	Same capacity could be free'd up by 3-1 Should be greater investment across different areas. Are we using the resources we have 100% efficiently. Should we be looking at the models
Is this configuration affordable?				
Requires bridging plan (short term double running costs)?	No	Money available	Needs money	Some double running cost- travel
Releases resources through economies of scale	Yes	Yes used differently	Strathmartine site	Yes to a certain degree

Is it more expensive than current and requires investment?	Initially Yes but long term no	Short term investment	Yes current needs investment also	Longer term same. Economies of scale via nursing
Allows a review of current management structures to allow resource release?	Yes	This has been completed already	Opportunities as one in Carseview	More at GAP services
Releases operational site resource through potential disposal? Allows for potential site/ sites capital receipts from disposal?	Yes- Strathmartine	Yes- Strathmartine	Yes- Strathmartine	Yes- Strathmartine and Mulberry for something else
Requires additional investment in current environments? What? Where?	Yes- MRH, Carseview grounds and inpatient crisis areas	Carseview and Rohallion (all three wards)	Yes both sites	Yes Carseview and Rohallion

MHIP Notes Red corner 8th December 2016

Facilitator: Karen Kendall

Explore the feasibility of expediting the work to move clients from Flat 1 at Strathmartine to Rohallion ward by taking this piece of work out of the overarching programme of work.

RED GROUP

Current environment is not ideal

Rohallion has excellent facilities and maybe the best the option for these clients

Would need to assess what the impact might be for the current client groups at Rohallion and what potential environmental changes might be required. Risk assessment for patient mix required.

If this group moves to Rohallion – is there a risk that capacity may not be available for urgent admissions? All of the client group from Flat 1 are planned admissions

Would need to understand what the pathway would be for these clients? - would they follow current forensic pathways?? Need to consider exit pathways.

Staff would prefer to move with the clients

Clients would be better managed as part of the wider forensic service – for AHP and psychology

Need to ensure social and work based activities /needs are met i.e. current day services are based around Dundee.

Infrastructure changes would need to be undertaken prior to move.

Need to understand what impact there would be on clients' families – what are the home localities for current clients??

Is there sufficient capacity for future proofing if there is an increase in this client group??

Out of area placements- would there be a plan to bring these clients back into Tayside in future? There are none at present

Communication an engagement essential – staff /staff side/service users/ families / community/ third sector

Need to ensure workforce plan is in place for all.

YELLOW GROUP

What would be the impact on staff at Rohallion??potential for redeployment

These clients are the closest group to the forensic service

Is there anything legally that would need to be considered if this work was to progress ahead of overall programme?

Need to understand what impact this would have on LDAU

Need clarity on what the management structure would be

Cannot replicate current service provision for this client group on Rohallion site – 2 site to 2 site model, impact on most staff groups

Need to determine what the best staff model for this client group is

What would the impact on the remaining clients at Strathmartine –these are the 2 most volatile groups

There is an evidence base for provision of learning disability services currently delivered within an MDT framework – this service cannot be delivered generically

Difficulties in ensuring regular risk assessment reviews are carried out – very small pool of staff to pull from.

Will it affect ability of Bank staff cover? – Travel etc

May provide opportunity to develop enhanced roles –i.e. nurse prescribing

How will the workplace / functional activities be provided? These currently give clients connections to community /self purpose

Clinical and admin support needs to be identified prior to move as well as car parking, office space etc.

Greater degree of risk doing this early rather than financial benefit

This work still needs fully scoped

Complexity and depth of overall programme of work makes it difficult to separate this piece out. Could be an earlier move once site option for overall programme agreed and resources identified.

Strong feeling across group for not expediting

BLUE GROUP

Could use vacated Flat 1 to accommodate LDU patients as an interim to allow refurbishment of Carseview – no benefit to LDU client group, environment in Flat 1 not good.

Good to go bus – reducing numbers on Strathmartine site might mean bus no longer viable – maybe best to wait until all clients move from Strathmartine

Re question of future proofing raised by Red group –Rohallion can take up to 10 clients

There is a purpose built gym, football pitches, music rooms at Rohallion

Living environment space is good, but concerns about losing outside work focussed activities

? Opportunities to develop gardening work for clients

This group need a high level of purposeful physical activity.

This move would create stretching of current community ties – lose links as too far away

This work will not release any savings

Is there an opportunity to use the beds planned for Flat 1 clients in Rohallion to income generate by taking clients from other health boards on a temporary basis??

GREEN GROUP

Activities at Rohallion include furniture restoration, kiln, arts work. These facilities are used by medium secure patients as well, these clients are subject to searches on return, would this happen for LD clients as well?

Mix of client groups would need careful consideration – low secure, medium secure, low secure LD – increased threshold of risk

These clients are used to going out / they need a working day structure

Who would /should manage these clients? Forensics /LD

Rohallion is currently fully staffed plus bringing a team from Strathmartine – how will this work?

Moving early destabilises the Strathmartine site - Flat 1 and 3 provide cross cover /rapid response to situations

Doing this doesn't prejudge any other option though

If this was to be advanced quicker then the 2 options for LDU client group need to be considered carefully in this as well and the potential for the safety risks at Strathmartine.

Beds at Rohallion are available now; environmental changes could be done within months, changes to therapeutic service delivery ???????????? – timescale unknown

The following table summarises the comments made by each group against the specific questions posed of option to expedite move from Flat 1 to Rohallion:

	Red Group	Yellow Group	Blue Group	Green Group
Is this configuration clinically safe?				
Nursing – cross cover	Learning disabilities training and experience essential. ? Require increase in LD nursing team to allow cross cover. Great opportunities for HCSW role. May open up opportunities for Mental Health dual training.	Different shift patterns may be a problem. . May encourage dual MH training.	Group unable to comment	OK in Rohallion? safety issues at Strathmartine
Nursing – responsiveness	Strathmartine site may be vulnerable	LD staff provision /skill mix may be an issue Skills and competencies not in place to respond if work progressed too quickly	Group unable to comment	Flat 1 staff not able to assist Flat 3 colleagues at short notice.
Medical – cross cover	No issue, full consultant team on Rohallion	Potential dual site working makes it difficult	Consultant taking care of these clients may be Perth based in future –if so no issue	Need to determine if cover from Forensic service or LD
Medical responsiveness	Only if consultant from LD transfers with client group, will be a delay if consultant remains based at Strathmartine	As above	Depends if consultant is Dundee or Perth based	As above
Junior Doctors – cross cover	If sufficient numbers shouldn't be a problem	No junior doctors	No issue, Input is currently minimal	Need to clarify if junior doctors are moving or not. If so they would be part of

				normal cover arrangements
Junior Doctors – responsiveness	If sufficient numbers shouldn't be a problem	As above	As above	As above
AHP/ Others – cross cover	Needs further work up to understand what the issues might be	Need to match capacity to demand. Travel time may impact	Need to match capacity to demand. Travel time may impact	Don't foresee any change
AHP/ Others – responsiveness	As above	As above	As above	As above
Potential negative impact on patient pathway?	Need to think about any unintended consequences e.g. on the current Rohallion client group. Possibly if infrastructure not there to support Flat 1 clients – i.e. daily work structure	Yes pathway not there currently, work support structure not in place although living environment would be better. Distance from families. Therapeutic input may be adversely affected	For LDAU if interim move to Flat 1. Yes until local services are available i.e. services based around Dundee and Angus currently have moved to Perth Impact on other clients left at Strathmartine, destabilisation of site.	If clients are cared for under Forensics it may be difficult to refer back to community services – client now has a label. Should forensic LD community service sit under Forensic service for smoother pathways of care?
Improved patient pathway?	Current evidence would suggest yes	Yes if fully considered thought through plan in place with investment that is based on client need	Difficult to say	Difficult to say
Improved environment?	Yes living space definitely.	Living space	Forensics yes, LDAU no if moved to Flat 1	Nicer living environment
Is this configuration able to work with OOH?				
Nursing – ability to cover out of hours/ crisis response/ home treatment	All groups did not feel any sections of this question were relevant	NA	NA	NA
Nursing – ability to increase out of hours/ crisis response/ home treatment	NA	NA	NA	NA
Medical – ability to cover out of hours/ crisis response/ home	NA	NA	NA	NA

treatment				
Medical – ability to increase out of hours/ crisis response/ home treatment	NA	NA	NA	NA
Junior Doctors – ability to cover out of hours/ crisis response/ home treatment	NA	NA	NA	NA
Junior Doctors – ability to increase out of hours/ crisis response/ home treatment	NA	NA	NA	NA
Can we staff this configuration safely and effectively?				
Nursing	LD training and experience essential. Challenges of older workforce May make service more attractive	OK for Rohallion but??? for rest of teams	? open up recruitment opportunities	Skill mix key Community LD forensic team input these clients currently
Medical	Need resource to move with clients	Travel time for consultants, possibly covering 3 sites	Might help a little bit as consultant taking on these clients may be Perth based? Is it possible this group could be managed by Forensic psychiatry??	Who will manage these clients? If forensics would need to recruit
Junior Doctors	Junior medical cover fragile currently May attract more due to improved working environment	Depends on future structure of medical team. Recruitment is a general issue.	Should make no difference	No difference
AHP	LD training and experience essential. Current service would need to be replicated/ enhanced.	Recruitment is an issue	Stretched –a lot of group based activity currently – how would this work??	Could Rohallion AHP group model be adapted? Difficult to staff from LD teams? Need to recruit.

Psychology	Could services be provided locally in Perth rather than Dundee Is there an option for nurse led psychology in future?	Replication of group therapies difficult to resource	Replication of group therapies difficult to resource	??? group unsure
MHO	Angus MHOs travel time	Travel time increased/ ?increased costs	? group unsure	Travel time
Advocacy	Service works across Tayside	Travel time increased/ ?increased cost	? most money for this client group	?group unsure
Support Services/ Other				
Is there an ability to shift balance of care?				
Requires additional community service provision?	Yes more local day services, need to explore what is currently available services in Rohallion are for medium secure clients	Yes daytime work structure needs a plan in place for this group. What is available currently in Perth?	Needs local service redevelopment for therapeutic care	? daytime occupation structure for clients
Allows for shift of resource to community to increase provision?	No	No	No	Not obviously
Ability to staff additional community service provision?	No	Depends on what happens with existing staff groups.	No	Not obviously
Is this configuration affordable?				
Requires bridging plan (short term double running costs)?	Yes	Needs investment to make Rohallion site fit for purpose	Yes staffing implications Bridging but not ongoing for infrastructure in local community	Group unsure
Releases resources through economies of scale	Group unsure	No	No	?less overtime
Is it more expensive than current and requires investment?	Short term investment for infrastructure	Possibly short and long term	Bridging but not ongoing for infrastructure in local	Need to set up another crisis area

	alterations		community	
Allows a review of current management structures to allow resource release?	Possibly	No	Unsure	Possibly
Releases operational site resource through potential disposal? Allows for potential site/ sites capital receipts from disposal?	Releases site for alternative use	No	No	Helps towards this but there will still be other clients based at Strathmartine
Requires additional investment in current environments? What? Where?	Yes Rohallion ward – structural changes	Yes- Rohallion to made fit for purpose	Yes to replicate rehab flat for other 2 wards at Rohallion	To make ward suitable for LD clients. Need areas for intensive nursing

What is the system of care?

- IPCU
- Specialist accomm - nursing care
- Travel for carers - they travel long way + patient not want to see.
- Major issues for Perth/Dundee coming to Dundee
- Pathway might lead to ↑ in length of stay if patients are more acutely unwell (is good pathway)
- ECT - where delivered? Unwell complex phys problems (cardiac) to come to Dundee
- Passes home for Angus + P&K patients
- Travel for MHOs and advocacy groups
- Major issues discharge plans communication. Need to address issues to make discharges work.
- Involves much more than this - travel, patient getting back to locality, can site accomodate visiting workers. 3rd sector links
- Would need improved communities + links
- Help - CMHT workers, etc
- Avg stay 21-28 days
- Treatment - for ~~crisis~~ acute illness
- Back to CMHT - discharge planning
- + home treatment
- Involve CMHT
- Different ways of working - 3rd sector - how would it work?
- Travel for CMHT workers
- Access to local facilities as part of treatment
- Hospital
- Acute Hospital
- Rehab Ward
- TSMS worker - inreach
- Non admitted patients need our pathway
- Back to primary care
- High Acuity

Model

- Unplanned Self-referral
- A&E
- Not a pathway in but no wild not assessment / take care. Should go to primary
- ~~CHRTT~~/CHRTT are gatekeepers CHMT / police / A&E to these first
- Community Services - Patient presents CMHT / CHRTT
- ~~Admitted acute assessment~~
- Coreview GAP - need clarity for threshold of admission across Tayside needed
- Transport is key - Signif issues - waits
- Centralised step before admission - assessment CHRTT
- Would it be 1 central CHRTT or 3 localities.
- GP can also detain & req. admission
- ↑ time for patients in Perth + Angus
- SAS needs to be involved + Police.
- Want to integrate Option 4 pathway into this (Green)
- Home
- Admitted
- Not admitted
- Would be decided by crisis team, not ward
- Police
- IPCU
- Admission should be last resort - need single point of access - gatekeeping
- a very different pathway for community + primary care if this model
- Low Acuity

Appendix Seven

Detailed Costing Information

Nursing Workforce Option 3a vFinal.xlsx

Nursing Workforce Option 4a vFinal.xlsx

Nursing Workforce Option 5a vFinal.xlsx

Nursing Workforce Option 8a vFinal.xlsx

17.01.29 P17-006 Murray Royal & Carse

17.01.29 Budget Cost rev B (1).pdf

Summary - Option 3a	Current position			New position			
	WTE	Budget		WTE	Cost		
LD Combined 16 Beds	56.62	£	2,107,505	43.16	£	1,545,909	
LD Secure Forensic	25.87	£	931,675	24.30	£	905,782	
LD Open Forensic	25.67	£	926,846	24.30	£	905,782	
Amulree Complex Care & Rehab 16 Beds	31.76	£	1,120,604	31.76	£	1,120,604	
Rannoch Complex Care (Females)	21.5	£	730,334	22.58	£	837,675	SLIGHT UPLIFT RE SKILL MIX
Acute Admissions Ward 1 22 Beds Carseview	27.8	£	1,025,003	28.30	£	1,045,455	
Acute Admissions Ward 2 22 Beds Carseview	29.5	£	1,096,386	28.30	£	1,045,455	
Acute Admissions Ward 3 22 Beds Carseview		£	-	28.30	£	1,045,455	
Acute Admissions Ward 4 22 Beds + 4 AIS Beds		£	-	28.30	£	1,045,455	
Moredun	39.8	£	1,374,064		£	-	
Mulberry	38.39	£	1,358,256		£	-	
IPCU 10 Beds	28.2	£	1,033,519	28.30	£	1,045,455	
Liaison/Patient transport		£	-	10.29	£	297,866	
	325.11	£	11,704,192	297.86	£	10,840,891	

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD 16 bed combined Ward **BSI, LDAU, Open Forensic**

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	3	10	30	210	257.25	6.86	
	6		60	420	514.5	13.72	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	735	900.38	24.01	
Untrained Staff			0	525	643.13	17.15	
	0		0	1260	1543.5	41.16	
					Check	41.16	

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10.75	32.25	225.75	276.5438	7.37	
Untrained Staff	3	10.75	32.25	225.75	276.5438	7.37	
	6		64.5	451.5	553.0875	14.75	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	855.75	1048.29	27.95	
Untrained Staff			0	603.75	739.59	19.72	
	0		0	1459.5	1787.888	47.68	
					Check	47.68	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	22.01	740,747
	3	17.15	414,087
	2	1.00	21,559
Basic costs incl 22.5% in wtes		43.16	1,310,092
Enhancements at 18%			235,817
Total Cost			1,545,909

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	25.95	873,499
	3	19.72	476,200
	2	1.00	21,559
Basic costs incl 22.5% in wtes		49.68	1,504,957
Enhancements at 18%			270,892
Total Cost			1,775,850

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,147
Sundays	Band 3	52.14	3	156.42	74%	12.35	14,294
PB Hols	Band 3	8	3	24	74%	12.35	2,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	34,679
							226,443
					Band 3		93,764
					Band 5		132,679
							226,443 17.28%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,683
Sundays	Band 5	52.14	3	156.42	60%	17.21	17,366
PB Hols	Band 5	8	3	24	60%	17.21	2,665
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,683
Sundays	Band 3	52.14	3	156.42	74%	12.35	15,366
PB Hols	Band 3	8	3	24	74%	12.35	2,358
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	42,133
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	37,280
							256,204
					Band 3		105,228
					Band 5		150,977
							256,204 17.02%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							121,164
					Band 3		37,163
					Band 5		84,001
							121,164 15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427
							137,475
					Band 3		42,166
					Band 5		95,309
							137,475 15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

	121,164	
Band 3	37,163	
Band 5	84,001	
	121,164	15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427

	137,475	
Band 3	42,166	
Band 5	95,309	
	137,475	15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds ***ASSUMING AS IS***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	10	0	0	0	0.00	
Untrained Staff	0	10	0	0	0	0.00	
	0		0	0	0	0.00	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	0	0.00	0.00
Untrained Staff			0	0	0.00	0.00
	0		0	0	0	0.00
					Check	0.00

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	0.00	-
	2	0.00	-
Basic costs incl 22.5% in wtes		0.00	-
Enhancements at 18%			-
Total Cost			-

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	0	0	30%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	0	0	37%	12.35	0	
							0	
					Band 3		0	
					Band 5		0	
							0	#DIV/0!

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Rannoch Complex Care (females) 10 beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	7.5	15	105	128.625	3.43	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	4		30	210	257.25	6.86	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	402.5	493.06	13.15
Untrained Staff			0	227.5	278.69	7.43
	0		0	630	771.75	20.58
					Check	20.58

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	11.15	375,197
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		22.58	709,894
Enhancements at 18%			127,781
Total Cost			837,675

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	4,039
Sundays	Band 5	52.14	2	104.28	60%	17.21	8,077
PB Hols	Band 5	8	2	16	60%	17.21	1,239

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		114,486	
Band 3		37,163	
Band 5		77,323	
		114,486	16.13%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds
includes liaison staff

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 2 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 2 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

Purely ward staff

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 4 22 Beds + 4 AIS Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

Purely ward staff

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
IPCU 10 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Liaison Patient Transport

Shift hrs per Nursing Directorate

Early Shift		staff	hours	Total	per week	plus 22.5%	/37.5
Drivers	Band 2	0	7.5	0	0	0	0.00
Nursing	Band 3	6	7.5	45	315	385.875	10.29
		6		45	315	385.875	10.29

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	10.29	248,452
	2	0.00	-
Basic costs incl 22.5% in wtes		10.29	248,452
Enhancements			49,414
Total Cost			297,866

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 2	52.14	0	0	44%	17.21	0
Sundays	Band 2	52.14	0	0	88%	17.21	0
PB Hols	Band 2	8	0	0	88%	17.21	0

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	6	312.84	37%	17.21	14,943
Sundays	Band 3	52.14	6	312.84	74%	17.21	29,886
PB Hols	Band 3	8	6	48	74%	17.21	4,585

		49,414	
	Band 3	49,414	
	Band 2	0	
		49,414	19.89%

Summary - Option 4a	Current position			New position			
	WTE	Budget		WTE	Cost		
LD Combined 16 Beds	56.62	£	2,107,505	43.16	£	1,545,909	
LD Secure Forensic	25.87	£	931,675	24.30	£	905,782	
LD Open Forensic	25.67	£	926,846	24.30	£	905,782	
Amulree Complex Care & Rehab 16 Beds	31.76	£	1,120,604	31.76	£	1,120,604	ASSUME AS IS
Rannoch Complex Care (Females)	21.5	£	730,334	22.58	£	837,675	UP DUE TO SKILL MIX
Acute Admissions Ward 1 22 Beds	27.8	£	1,025,003	28.30	£	1,045,455	
Acute Admissions Ward 2 22 Beds	29.5	£	1,096,386	28.30	£	1,045,455	
Acute Admissions Ward 4 22 Beds + 4 AIS Beds		£	-	28.30	£	1,045,455	
Moredun	39.8	£	1,374,064		£	-	
Mulberry	38.39	£	1,358,256	38.39	£	1,358,256	Mulberry remaining as is currently
IPCU 10 Beds	28.2	£	1,033,519	28.30	£	1,045,455	
Liaison/Patient transport		£	-	6.86	£	198,577	
	325.11	£	11,704,192	304.53	£	11,054,404	

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD 16 bed combined Ward **BSI, LDAU, Open Forensic**

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	3	10	30	210	257.25	6.86	
	6		60	420	514.5	13.72	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	735	900.38	24.01	
Untrained Staff			0	525	643.13	17.15	
	0		0	1260	1543.5	41.16	
					Check	41.16	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	22.01	740,747
	3	17.15	414,087
	2	1.00	21,559
Basic costs incl 22.5% in wtes		43.16	1,310,092
Enhancements at 18%			235,817
Total Cost			1,545,909

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10.75	32.25	225.75	276.5438	7.37	
Untrained Staff	3	10.75	32.25	225.75	276.5438	7.37	
	6		64.5	451.5	553.0875	14.75	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	855.75	1048.29	27.95	
Untrained Staff			0	603.75	739.59	19.72	
	0		0	1459.5	1787.888	47.68	
					Check	47.68	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	25.95	873,499
	3	19.72	476,200
	2	1.00	21,559
Basic costs incl 22.5% in wtes		49.68	1,504,957
Enhancements at 18%			270,892
Total Cost			1,775,850

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,147
Sundays	Band 3	52.14	3	156.42	74%	12.35	14,294
PB Hols	Band 3	8	3	24	74%	12.35	2,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	34,679
							226,443
					Band 3		93,764
					Band 5		132,679
							226,443 17.28%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,683
Sundays	Band 5	52.14	3	156.42	60%	17.21	17,366
PB Hols	Band 5	8	3	24	60%	17.21	2,665
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,683
Sundays	Band 3	52.14	3	156.42	74%	12.35	15,366
PB Hols	Band 3	8	3	24	74%	12.35	2,358
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	42,133
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	37,280
							256,204
					Band 3		105,228
					Band 5		150,977
							256,204 17.02%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancemt	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancemt	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancemt	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancemt	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							121,164
					Band 3		37,163
					Band 5		84,001
							121,164 15.78%

Enhancemt	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancemt	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancemt	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancemt	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancemt	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427
							137,475
					Band 3		42,166
					Band 5		95,309
							137,475 15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Shift hrs current

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1 50,426
		6	2 83,274
		5	12.86 432,915
		3	7.43 179,438
		2	1.00 21,559
Basic costs incl 22.5% in wtes			24.30 767,612
Enhancements at 18%			138,170
Total Cost			905,782

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1 50,426
		6	2 83,274
		5	15.26 513,721
		3	8.63 208,424
		2	1.00 21,559
Basic costs incl 22.5% in wtes			27.90 877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		121,164	
	Band 3	37,163	
	Band 5	84,001	
		121,164	15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427

		137,475	
	Band 3	42,166	
	Band 5	95,309	
		137,475	15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds ***ASSUME AS IS***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	4	7.5	30	210	257.25	6.86	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	6		45	315	385.875	10.29	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	6		45	315	385.875	10.29	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	2	10	20	140	171.5	4.57	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	507.5	621.69	16.58
Untrained Staff			0	402.5	493.06	13.15
	0		0	910	1114.75	29.73
					Check	29.73

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	14.58	490,634
	3	13.15	317,467
	2	1.00	21,559
Basic costs incl 22.5% in wtes		31.73	963,359
Enhancements at 18%			173,405
Total Cost			1,136,764

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	4	208.56	30%	17.21	8,077
Sundays	Band 5	52.14	4	208.56	60%	17.21	16,154
PB Hols	Band 5	8	4	32	60%	17.21	2,479

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,765
Sundays	Band 3	52.14	2	104.28	74%	12.35	9,529
PB Hols	Band 3	8	2	16	74%	12.35	1,462

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	2	506	37%	12.35	23,119

		159,096	
Band 3		68,418	
Band 5		90,678	
		159,096	16.51%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	7.5	15	105	128.625	3.43	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	3		22.5	157.5	192.9375	5.15	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	402.5	493.06	13.15
Untrained Staff			0	227.5	278.69	7.43
	0		0	630	771.75	20.58
					Check	20.58

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	11.15	375,197
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		22.58	709,894
Enhancements at 18%			127,781
Total Cost			837,675

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	4,039
Sundays	Band 5	52.14	2	104.28	60%	17.21	8,077
PB Hols	Band 5	8	2	16	60%	17.21	1,239

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		114,486	
Band 3		37,163	
Band 5		77,323	
		114,486	16.13%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

			149,040
	Band 3		43,072
	Band 5		105,969
			149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 2 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 4 22 Beds + 4 AIS Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
IPCU 10 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Mulberry Ward ***Assuming no change to establishment***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	10	0	0	0	0.00	
Untrained Staff	0	10	0	0	0	0.00	
	0		0	0	0	0.00	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	0	0.00	0.00
Untrained Staff			0	0	0.00	0.00
	0		0	0	0	0.00
					Check	0.00

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	0.00	-
	2	0.00	-
Basic costs incl 22.5% in wtes		0.00	-
Enhancements at 18%			-
Total Cost			-

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	0	0	30%	17.21	0	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	0	0	37%	12.35	0	
							0	
					Band 3		0	
					Band 5		0	
							0	#DIV/0!

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Liaison Patient Transport

Shift hrs per Nursing Directorate

Early Shift		staff	hours	Total	per week	plus 22.5%	/37.5
Drivers	Band 2	0	7.5	0	0	0	0.00
Nursing	Band 3	4	7.5	30	210	257.25	6.86
		4		30	210	257.25	6.86

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	6.86	165,635
	2	0.00	-
Basic costs incl 22.5% in wtes		6.86	165,635
Enhancements			32,943
Total Cost			198,577

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 2	52.14	0	0	44%	17.21	0
Sundays	Band 2	52.14	0	0	88%	17.21	0
PB Hols	Band 2	8	0	0	88%	17.21	0

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	4	208.56	37%	17.21	9,962
Sundays	Band 3	52.14	4	208.56	74%	17.21	19,924
PB Hols	Band 3	8	4	32	74%	17.21	3,057

		32,943	
Band 3		32,943	
Band 2		0	
		32,943	19.89%

Summary - Option 5a	Current position			New position			
	WTE	Budget		WTE	Cost		
LD Combined 16 Beds	56.62	£	2,107,505	43.16	£	1,545,909	
LD Secure Forensic	25.87	£	931,675	24.30	£	905,782	
LD Open Forensic	25.67	£	926,846	24.30	£	905,782	
Amulree Complex Care & Rehab 16 Beds	31.76	£	1,120,604	31.76	£	1,120,604	LEAVE AS IS
Rannoch Complex Care (Females)	21.5	£	730,334	22.58	£	837,675	ASSUME SLIGHT UPLIFT FOR SKILL MIX
Acute Admissions Ward 1 22 Beds	27.8	£	1,025,003	28.30	£	1,045,455	
Acute Admissions Ward 2 22 Beds	29.5	£	1,096,386	28.30	£	1,045,455	
Acute Admissions Ward 4 22 Beds + 4 AIS Beds		£	-	28.30	£	1,045,455	
Moredun	39.8	£	1,374,064	39.80	£	1,374,064	
Mulberry	38.39	£	1,358,256		£	-	
IPCU 10 Beds	28.2	£	1,033,519	28.30	£	1,045,455	
Liaison/Patient transport		£	-	6.86	£	198,577	
	325.11	£	11,704,192	305.94	£	11,070,212	

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD 16 bed combined Ward **BSI, LDAU, Open Forensic**

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	3	10	30	210	257.25	6.86	
	6		60	420	514.5	13.72	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	735	900.38	24.01	
Untrained Staff			0	525	643.13	17.15	
	0		0	1260	1543.5	41.16	
					Check	41.16	

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10.75	32.25	225.75	276.5438	7.37	
Untrained Staff	3	10.75	32.25	225.75	276.5438	7.37	
	6		64.5	451.5	553.0875	14.75	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	855.75	1048.29	27.95	
Untrained Staff			0	603.75	739.59	19.72	
	0		0	1459.5	1787.888	47.68	
					Check	47.68	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	22.01	740,747
	3	17.15	414,087
	2	1.00	21,559
Basic costs incl 22.5% in wtes		43.16	1,310,092
Enhancements at 18%			235,817
Total Cost			1,545,909

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	25.95	873,499
	3	19.72	476,200
	2	1.00	21,559
Basic costs incl 22.5% in wtes		49.68	1,504,957
Enhancements at 18%			270,892
Total Cost			1,775,850

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,147
Sundays	Band 3	52.14	3	156.42	74%	12.35	14,294
PB Hols	Band 3	8	3	24	74%	12.35	2,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	34,679

	226,443	
Band 3	93,764	
Band 5	132,679	
	226,443	17.28%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,683
Sundays	Band 5	52.14	3	156.42	60%	17.21	17,366
PB Hols	Band 5	8	3	24	60%	17.21	2,665
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,683
Sundays	Band 3	52.14	3	156.42	74%	12.35	15,366
PB Hols	Band 3	8	3	24	74%	12.35	2,358
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	42,133
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	37,280

	256,204	
Band 3	105,228	
Band 5	150,977	
	256,204	17.02%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			#######

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							121,164
					Band 3		37,163
					Band 5		84,001
							121,164

15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427
							137,475
					Band 3		42,166
					Band 5		95,309
							137,475

15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							121,164
					Band 3		37,163
					Band 5		84,001
							121,164

15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427
							137,475
					Band 3		42,166
					Band 5		95,309
							137,475

15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds ***ASUUME AS IS***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	10	0	0	0	0.00	
Untrained Staff	0	10	0	0	0	0.00	
	0		0	0	0	0.00	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	0	0.00	0.00
Untrained Staff			0	0	0.00	0.00
	0		0	0	0	0.00
					Check	0.00

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	0.00	-
	2	0.00	-
Basic costs incl 22.5% in wtes		0.00	-
Enhancements at 18%			-
Total Cost			-

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	0	0	30%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	0	0	37%	12.35	0	
							0	
					Band 3		0	
					Band 5		0	
							0	#DIV/0!

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	7.5	15	105	128.625	3.43	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	3		22.5	157.5	192.9375	5.15	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	402.5	493.06	13.15
Untrained Staff			0	227.5	278.69	7.43
	0		0	630	771.75	20.58
					Check	20.58

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	11.15	375,197
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		22.58	709,894
Enhancements at 18%			127,781
Total Cost			837,675

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	4,039
Sundays	Band 5	52.14	2	104.28	60%	17.21	8,077
PB Hols	Band 5	8	2	16	60%	17.21	1,239

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		114,486	
Band 3		37,163	
Band 5		77,323	
		114,486	16.13%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 2 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 4 22 Beds + 4 AIS Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	525	643.13	17.15	
Untrained Staff			0	280	343.00	9.15	
	0		0	805	986.125	26.30	
					Check	26.30	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							149,040
					Band 3		43,072
					Band 5		105,969
							149,040 16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Moredun Ward ***Assuming no change to establishment***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	10	0	0	0	0.00	
Untrained Staff	0	10	0	0	0	0.00	
	0		0	0	0	0.00	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	0	0.00	0.00	
Untrained Staff			0	0	0.00	0.00	
	0		0	0	0	0.00	
					Check	0.00	

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	0.00	-
	2	0.00	-
Basic costs incl 22.5% in wtes		0.00	-
Enhancements at 18%			-
Total Cost			-

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	0	0	30%	17.21	0	

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	0	0	37%	12.35	0	

		0
Band 3		0
Band 5		0
		0 #DIV/0!

NHS TAYSIDE - Mental Health Review
Staffing restructuring
IPCU 10 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Liaison Patient Transport

Shift hrs per Nursing Directorate

Early Shift		staff	hours	Total	per week	plus 22.5%	/37.5
Drivers	Band 2	0	7.5	0	0	0	0.00
Nursing	Band 3	4	7.5	30	210	257.25	6.86
		4		30	210	257.25	6.86

Basic	**Band**	**Cost**
Per WTE	7	50,426
	6	41,637
	5	33,655
	3	24,145
	2	21,559

Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	6.86	165,635
	2	0.00	-
Basic costs incl 22.5% in wtes		6.86	165,635
Enhancements			32,943
Total Cost			198,577

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 2	52.14	0	0	44%	17.21	0
Sundays	Band 2	52.14	0	0	88%	17.21	0
PB Hols	Band 2	8	0	0	88%	17.21	0

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	4	208.56	37%	17.21	9,962
Sundays	Band 3	52.14	4	208.56	74%	17.21	19,924
PB Hols	Band 3	8	4	32	74%	17.21	3,057

		32,943	
	Band 3	32,943	
	Band 2	0	
		32,943	19.89%

Summary - Option 8a	Current position			New position				
	WTE	Budget		WTE	Cost			
LD Combined 16 Beds	56.62	£	2,107,505	43.16	£	1,545,909		0
LD Secure Forensic	25.87	£	931,675	24.30	£	905,782		
LD Open Forensic	25.67	£	926,846	24.30	£	905,782		
Amulree Complex Care & Rehab 16 Beds	31.76	£	1,120,604	31.76	£	1,120,604	LEAVE AS IS	
Rannoch Complex Care (Females)	21.50	£	730,334	22.58	£	837,675	SLIGHT UPLIFT RE SKILL MIX	
Acute Admissions Ward 1 22 Beds Carseview	27.80	£	1,025,003	45.45	£	1,636,719		
Acute Admissions Ward 2 22 Beds Carseview	29.50	£	1,096,386		£	-		
Acute Admissions Ward 3 22 Beds Carseview		£	-		£	-		
Acute Admissions Ward 4 22 Beds + 4 AIS Beds		£	-		£	-		
Dundee		£	-	28.30	£	1,019,794	lower than current due to presumed lower level of acuity of patients in step down wards	
Moredun	39.80	£	1,374,064	34.01	£	1,227,574	lower than current due to presumed lower level of acuity of patients in step down wards	
Mulberry	38.39	£	1,358,256	34.01	£	1,227,574	lower than current due to presumed lower level of acuity of patients in step down wards	
IPCU 10 Beds	28.20	£	1,033,519	28.30	£	1,045,455		
Liaison/Patient transport		£	-	13.72	£	397,155		
	325.11	£	11,704,192	329.88	£	11,870,023		

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD 16 bed combined Ward

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	3	10	30	210	257.25	6.86	
	6		60	420	514.5	13.72	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	735	900.38	24.01	
Untrained Staff			0	525	643.13	17.15	
	0		0	1260	1543.5	41.16	
					Check	41.16	

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	9	45	315	385.875	10.29	
Untrained Staff	3	9	27	189	231.525	6.17	
	8		72	504	617.4	16.46	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10.75	32.25	225.75	276.5438	7.37	
Untrained Staff	3	10.75	32.25	225.75	276.5438	7.37	
	6		64.5	451.5	553.0875	14.75	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	855.75	1048.29	27.95	
Untrained Staff			0	603.75	739.59	19.72	
	0		0	1459.5	1787.888	47.68	
					Check	47.68	

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1	50,426
		6	2	83,274
		5	22.01	740,747
		3	17.15	414,087
		2	1.00	21,559
Basic costs incl 22.5% in wtes			43.16	1,310,092
Enhancements at 18%				235,817
Total Cost				1,545,909

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1	50,426
		6	2	83,274
		5	25.95	873,499
		3	19.72	476,200
		2	1.00	21,559
Basic costs incl 22.5% in wtes			49.68	1,504,957
Enhancements at 18%				270,892
Total Cost				1,775,850

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,147
Sundays	Band 3	52.14	3	156.42	74%	12.35	14,294
PB Hols	Band 3	8	3	24	74%	12.35	2,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	34,679
							226,443
					Band 3		93,764
					Band 5		132,679
							226,443 17.28%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	12,116
Sundays	Band 5	52.14	5	260.7	60%	17.21	24,232
PB Hols	Band 5	8	5	40	60%	17.21	3,718
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,683
Sundays	Band 5	52.14	3	156.42	60%	17.21	17,366
PB Hols	Band 5	8	3	24	60%	17.21	2,665
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	6,432
Sundays	Band 3	52.14	3	156.42	74%	12.35	12,864
PB Hols	Band 3	8	3	24	74%	12.35	1,974
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,683
Sundays	Band 3	52.14	3	156.42	74%	12.35	15,366
PB Hols	Band 3	8	3	24	74%	12.35	2,358
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	42,133
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	37,280
							256,204
					Band 3		105,228
					Band 5		150,977
							256,204 17.02%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1 50,426
		6	2 83,274
		5	12.86 432,915
		3	7.43 179,438
		2	1.00 21,559
Basic costs incl 22.5% in wtes			24.30 767,612
Enhancements at 18%			138,170
Total Cost			905,782

Basic	Band		Cost
Per WTE		7	50,426
		6	41,637
		5	33,655
		3	24,145
		2	21,559
Basic	Band	WTE	Cost
For Ward		7	1 50,426
		6	2 83,274
		5	15.26 513,721
		3	8.63 208,424
		2	1.00 21,559
Basic costs incl 22.5% in wtes			27.90 877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		121,164	
	Band 3	37,163	
	Band 5	84,001	
		121,164	15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427

		137,475	
	Band 3	42,166	
	Band 5	95,309	
		137,475	15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
LD Secure Forensic

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	455	557.38	14.86	
Untrained Staff			0	227.5	278.69	7.43	
	0		0	682.5	836.0625	22.30	
					Check	22.30	

Current shift patterns

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	2	9	18	126	154.35	4.12	
	5		45	315	385.875	10.29	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	9	27	189	231.525	6.17	
Untrained Staff	1	9	9	63	77.175	2.06	
	4		36	252	308.7	8.23	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10.75	21.5	150.5	184.3625	4.92	
Untrained Staff	1	10.75	10.75	75.25	92.18125	2.46	
	3		32.25	225.75	276.5438	7.37	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	528.5	647.41	17.26	
Untrained Staff			0	264.25	323.71	8.63	
	0		0	792.75	971.1188	25.90	
					Check	25.90	

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		24.30	767,612
Enhancements at 18%			138,170
Total Cost			905,782

Basic	Band		Cost
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.26	513,721
	3	8.63	208,424
	2	1.00	21,559
Basic costs incl 22.5% in wtes		27.90	877,404
Enhancements at 18%			157,933
Total Cost			1,035,336

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560
							121,164
					Band 3		37,163
					Band 5		84,001
							121,164 15.78%

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	7,269
Sundays	Band 5	52.14	3	156.42	60%	17.21	14,539
PB Hols	Band 5	8	3	24	60%	17.21	2,231
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,789
Sundays	Band 5	52.14	2	104.28	60%	17.21	11,577
PB Hols	Band 5	8	2	16	60%	17.21	1,776
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,288
Sundays	Band 3	52.14	2	104.28	74%	12.35	8,576
PB Hols	Band 3	8	2	16	74%	12.35	1,316
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,144
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,288
PB Hols	Band 3	8	1	8	74%	12.35	658
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,561
Sundays	Band 3	52.14	1	52.14	74%	12.35	5,122
PB Hols	Band 3	8	1	8	74%	12.35	786
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	28,088
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	12,427
							137,475
					Band 3		42,166
					Band 5		95,309
							137,475 15.67%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds ***ASSUME AS IS***

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	7.5	0	0	0	0.00	
Untrained Staff	0	7.5	0	0	0	0.00	
	0		0	0	0	0.00	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	10	0	0	0	0.00	
Untrained Staff	0	10	0	0	0	0.00	
	0		0	0	0	0.00	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	0	0.00	0.00
Untrained Staff			0	0	0.00	0.00
	0		0	0	0	0.00
					Check	0.00

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	0.00	-
	2	0.00	-
Basic costs incl 22.5% in wtes		0.00	-
Enhancements at 18%			-
Total Cost			-

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	0	0	30%	17.21	0	
Sundays	Band 5	52.14	0	0	60%	17.21	0	
PB Hols	Band 5	8	0	0	60%	17.21	0	
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	0	0	37%	12.35	0	
Sundays	Band 3	52.14	0	0	74%	12.35	0	
PB Hols	Band 3	8	0	0	74%	12.35	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	0	0	30%	17.21	0	
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	0	0	37%	12.35	0	
							0	
					Band 3		0	
					Band 5		0	
							0	#DIV/0!

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Amulree Complex Care & Rehab 16 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	1	7.5	7.5	52.5	64.3125	1.72	
	4		30	210	257.25	6.86	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	7.5	15	105	128.625	3.43	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	4		30	210	257.25	6.86	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	1	10	10	70	85.75	2.29	
	3		30	210	257.25	6.86	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	402.5	493.06	13.15
Untrained Staff			0	227.5	278.69	7.43
	0		0	630	771.75	20.58
					Check	20.58

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	11.15	375,197
	3	7.43	179,438
	2	1.00	21,559
Basic costs incl 22.5% in wtes		22.58	709,894
Enhancements at 18%			127,781
Total Cost			837,675

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	4,039
Sundays	Band 5	52.14	2	104.28	60%	17.21	8,077
PB Hols	Band 5	8	2	16	60%	17.21	1,239

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14	2	104.28	60%	17.21	10,770
PB Hols	Band 5	8	2	16	60%	17.21	1,652

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	1,787
Sundays	Band 3	52.14	1	52.14	74%	12.35	3,573
PB Hols	Band 3	8	1	8	74%	12.35	548

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	2	506	30%	17.21	26,129

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		114,486	
Band 3		37,163	
Band 5		77,323	
		114,486	16.13%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds ****72 hour turn around****

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	5	7.5	37.5	262.5	321.5625	8.58	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	8		60	420	514.5	13.72	
Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	4	10	40	280	343	9.15	
Untrained Staff	3	10	30	210	257.25	6.86	
	7		70	490	600.25	16.01	
Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	
Totals	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff			0	805	986.13	26.30	
Untrained Staff			0	525	643.13	17.15	
	0		0	1330	1629.25	43.45	
					Check	43.45	

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	24.30	817,704
	3	17.15	414,087
	2	1.00	21,559
Basic costs incl 22.5% in wtes		45.45	1,387,050
Enhancements at 18%			249,669
Total Cost			1,636,719

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	5	260.7	30%	17.21	10,097
Sundays	Band 5	52.14	5	260.7	60%	17.21	20,193
PB Hols	Band 5	8	5	40	60%	17.21	3,098
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	4	208.56	30%	17.21	10,770
Sundays	Band 5	52.14	4	208.56	60%	17.21	21,539
PB Hols	Band 5	8	4	32	60%	17.21	3,305
Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	7,147
Sundays	Band 3	52.14	3	156.42	74%	12.35	14,294
PB Hols	Band 3	8	3	24	74%	12.35	2,193
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	4	1012	30%	17.21	52,258
Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	3	759	37%	12.35	34,679
							248,411
					Band 3		93,764
					Band 5		154,647
							248,411 17.91%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	2	10	20	140	171.5	4.57	
Untrained Staff	2	10	20	140	171.5	4.57	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	455	557.38	14.86
Untrained Staff			0	350	428.75	11.43
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	12.86	432,915
	3	11.43	276,058
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	864,232
Enhancements at 18%			155,562
Total Cost			1,019,794

Enhancem	Early Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14		3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14		3	156.42	60%	17.21	12,116
PB Hols	Band 5	8		3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14		3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14		3	156.42	60%	17.21	12,116
PB Hols	Band 5	8		3	24	60%	17.21	1,859

Enhancem	Night Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14		2	104.28	30%	17.21	5,385
Sundays	Band 5	52.14		2	104.28	60%	17.21	10,770
PB Hols	Band 5	8		2	16	60%	17.21	1,652

Enhancem	Early Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14		2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14		2	104.28	74%	12.35	7,147
PB Hols	Band 3	8		2	16	74%	12.35	1,097

Enhancem	Late Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14		2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14		2	104.28	74%	12.35	7,147
PB Hols	Band 3	8		2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14		2	104.28	37%	12.35	4,765
Sundays	Band 3	52.14		2	104.28	74%	12.35	9,529
PB Hols	Band 3	8		2	16	74%	12.35	1,462

Enhancem	Night Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253		2	506	30%	17.21	26,129

Enhancem	Night Shift	wks/days	staff		Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253		2	506	37%	12.35	23,119

		146,510	
Band 3		62,509	
Band 5		84,001	
		146,510	16.95%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	6		45	315	385.875	10.29	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	4	7.5	30	210	257.25	6.86	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	6		45	315	385.875	10.29	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	2	10	20	140	171.5	4.57	
	5		50	350	428.75	11.43	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	577.5	707.44	18.87
Untrained Staff			0	402.5	493.06	13.15
	0		0	980	1200.5	32.01
					Check	32.01

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	16.87	567,592
	3	13.15	317,467
	2	1.00	21,559
Basic costs incl 22.5% in wtes		34.01	1,040,317
Enhancements at 18%			187,257
Total Cost			1,227,574

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058	
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116	
PB Hols	Band 5	8	3	24	60%	17.21	1,859	
Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	4	208.56	30%	17.21	8,077	
Sundays	Band 5	52.14	4	208.56	60%	17.21	16,154	
PB Hols	Band 5	8	4	32	60%	17.21	2,479	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077	
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154	
PB Hols	Band 5	8	3	24	60%	17.21	2,479	
Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360	
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720	
PB Hols	Band 3	8	3	24	74%	12.35	1,645	
Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573	
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147	
PB Hols	Band 3	8	2	16	74%	12.35	1,097	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,765	
Sundays	Band 3	52.14	2	104.28	74%	12.35	9,529	
PB Hols	Band 3	8	2	16	74%	12.35	1,462	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 5	253	3	759	30%	17.21	39,193	
Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total	
Out of hou	Band 3	253	2	506	37%	12.35	23,119	
							181,064	
						Band 3	68,418	
						Band 5	112,646	
							181,064	17.40%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Acute Admissions Ward 1 22 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	3	7.5	22.5	157.5	192.9375	5.15	
	6		45	315	385.875	10.29	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	4	7.5	30	210	257.25	6.86	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	6		45	315	385.875	10.29	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	2	10	20	140	171.5	4.57	
	5		50	350	428.75	11.43	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	577.5	707.44	18.87
Untrained Staff			0	402.5	493.06	13.15
	0		0	980	1200.5	32.01
					Check	32.01

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	16.87	567,592
	3	13.15	317,467
	2	1.00	21,559
Basic costs incl 22.5% in wtes		34.01	1,040,317
Enhancements at 18%			187,257
Total Cost			1,227,574

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	4	208.56	30%	17.21	8,077
Sundays	Band 5	52.14	4	208.56	60%	17.21	16,154
PB Hols	Band 5	8	4	32	60%	17.21	2,479

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhancem	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	3	156.42	37%	12.35	5,360
Sundays	Band 3	52.14	3	156.42	74%	12.35	10,720
PB Hols	Band 3	8	3	24	74%	12.35	1,645

Enhancem	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	4,765
Sundays	Band 3	52.14	2	104.28	74%	12.35	9,529
PB Hols	Band 3	8	2	16	74%	12.35	1,462

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhancem	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	2	506	37%	12.35	23,119

		181,064	
Band 3		68,418	
Band 5		112,646	
		181,064	17.40%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
IPCU 10 Beds

Shift hrs per Nursing Directorate

Early Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

late Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	7.5	22.5	157.5	192.9375	5.15	
Untrained Staff	2	7.5	15	105	128.625	3.43	
	5		37.5	262.5	321.5625	8.58	

Night Shift	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	3	10	30	210	257.25	6.86	
Untrained Staff	1	10	10	70	85.75	2.29	
	4		40	280	343	9.15	

Additional Staff	staff	hours	Total	per week	plus 22.5%	/37.5	
Trained Staff	0	0	0	0	0	0.00	ie mon-fri 10 to 6
Untrained Staff	0	0	0	0	0	0.00	ie sat&sun 10 to 6
	0		0	0	0	0.00	

Totals	staff	hours	Total	per week	plus 22.5%	/37.5
Trained Staff			0	525	643.13	17.15
Untrained Staff			0	280	343.00	9.15
	0		0	805	986.125	26.30
					Check	26.30

Basic	**Band**		**Cost**
Per WTE	7		50,426
	6		41,637
	5		33,655
	3		24,145
	2		21,559
Basic	Band	WTE	Cost
For Ward	7	1	50,426
	6	2	83,274
	5	15.15	509,873
	3	9.15	220,846
	2	1.00	21,559
Basic costs incl 22.5% in wtes		28.30	885,979
Enhancements at 18%			159,476
Total Cost			1,045,455

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	6,058
Sundays	Band 5	52.14	3	156.42	60%	17.21	12,116
PB Hols	Band 5	8	3	24	60%	17.21	1,859

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 5	52.14	3	156.42	30%	17.21	8,077
Sundays	Band 5	52.14	3	156.42	60%	17.21	16,154
PB Hols	Band 5	8	3	24	60%	17.21	2,479

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	2	104.28	37%	12.35	3,573
Sundays	Band 3	52.14	2	104.28	74%	12.35	7,147
PB Hols	Band 3	8	2	16	74%	12.35	1,097

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	1	52.14	37%	12.35	2,382
Sundays	Band 3	52.14	1	52.14	74%	12.35	4,765
PB Hols	Band 3	8	1	8	74%	12.35	731

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 5	253	3	759	30%	17.21	39,193

Enhanceme	Night Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Out of hou	Band 3	253	1	253	37%	12.35	11,560

		149,040	
Band 3		43,072	
Band 5		105,969	
		149,040	16.82%

NHS TAYSIDE - Mental Health Review
Staffing restructuring
Liaison Patient Transport

Shift hrs per Nursing Directorate

Early Shift		staff	hours	Total	per week	plus 22.5%	/37.5
Drivers	Band 2	0	7.5	0	0	0	0.00
Nursing	Band 3	8	7.5	60	420	514.5	13.72
		8		60	420	514.5	13.72

Basic	**Band**	**Cost**
Per WTE	7	50,426
	6	41,637
	5	33,655
	3	24,145
	2	21,559

Basic	Band	WTE	Cost
For Ward	7	0	-
	6	0	-
	5	0.00	-
	3	13.72	331,269
	2	0.00	-
Basic costs incl 22.5% in wtes		13.72	331,269
Enhancements			65,885
Total Cost			397,155

Enhanceme	Early Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 2	52.14	0	0	44%	17.21	0
Sundays	Band 2	52.14	0	0	88%	17.21	0
PB Hols	Band 2	8	0	0	88%	17.21	0

Enhanceme	Late Shift	wks/days	staff	Annual	Enhancmt	hrly rate	total
Saturdays	Band 3	52.14	8	417.12	37%	17.21	19,924
Sundays	Band 3	52.14	8	417.12	74%	17.21	39,848
PB Hols	Band 3	8	8	64	74%	17.21	6,114

		65,885	
Band 3		65,885	
Band 2		0	
		65,885	19.89%

1.00 Murray Royal Options

1.01 Option 3A Combined LD Ward (Moredun).

General Description of Works
Exiting Moredun Ward (30beds) to be split to accommodate 16 bed LDAU & BSI (comprising 10no LDAU beds & 6 BSI beds) and a 6 bed Open Forensic ward.

Option 3A
See Sketch layout P17-006_SK-MR-1, which shows the 16no LDAU & BSI beds utilising the top half bedrooms and support accommodation closest to the existing Dayrooms, Kitchen and Dining Areas. The 6no Open Forensic beds would be located in the bottom half of the ward, using 6no existing bedrooms and the remaining rooms used in existing configuration with en-suites isolated to provide support accommodation. Provision of a couple of new doorsets and walls erected to separate the two ward areas. An allowance has also been made for a new fence externally.

LDAU & BSI Ward
- No cost allowance.

Open Forensic Ward
- Allowance for possibly three doorsets and partition walls across corridors to separate two ward areas.
- An allowance has also been made for a new fence externally.

No Allowances have been allowed for:
- Replacement Windows
- Decoration.
- Door upgrades.
- New Floor finishes
- Removal of existing Grab rails
- Assumed that existing sanitaryware retained.
- Assumed existing fixtures & fittings retained.

January 2017 Outline Budget Cost £58,104

1.02 Crisis Suite – Rohallion

We have not provided costs for these works as it was advised at the meeting that the FM Manager would provide these costs.

2.00 Carseview Options

2.01 Option 3A

Existing LDAU Ward converted to GAP Ward - (See sketch drawing P17-006_SK-CV-1)
Exiting 22bed LDAU completely refurbished to accommodate 22no GAP beds. A budget cost for the complete ward refurbishment had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,549,566

Existing IPCU Ward - (See sketch drawing P17-006_SK-CV-2)
Exiting IPCU completely refurbished to accommodate 10no IPCU beds complete with ensuites. A budget cost for the complete ward refurbishment and extension had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,101,673

Existing Ward 1
Ward 1 was refurbished under Lifecycle works a couple of years ago, so no costs have been allowed for general fabric upgrade. The existing services infrastructure were not upgraded as part of these works. Allowance has been made for window replacement and door upgrades to the 22no existing bedrroms and ensuites only.

January 2017 Outline Budget Cost £247,250

Existing Ward 2
Exiting 22bed Ward completely refurbished including some ward infrastructure upgrades. A budget cost for the complete ward refurbishment had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,075,980

2.02 Option 4A & 5A

Existing LDAU Ward converted to LDAU, BSI & Open Forensics
Exiting 22bed LDAU to be reconfigured as sketch drawing P17-006_SK-CV-3 to accommodate 10no LDAU beds & 6 BSI bed and a 6 bed Open Forensic ward. The existing ward is to be completely refurbished.

A budget cost for the complete ward refurbishment and extension had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,984,516

Existing IPCU Ward - (See sketch drawing P17-006_SK-CV-2)
Exiting IPCU completely refurbished to accommodate 10no IPCU beds complete with ensuites. A budget cost for the complete ward refurbishment and extension had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,101,673

Existing Ward 1
Ward 1 was refurbished under Lifecycle works a couple of years ago, so no costs have been allowed for general fabric upgrade. The existing services infrastructure were not upgraded as part of these works. Allowance has been made for window replacement and door upgrades to the 22no existing bedrroms and ensuites only.

January 2017 Outline Budget Cost £247,250

Existing Ward 2
Exiting 22bed Ward completely refurbished including some ward infrastructure upgrades. A budget cost for the complete ward refurbishment had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,075,980

2.02 Option 8

Existing LDAU Ward converted to LDAU & BSI
Exiting 22bed LDAU to be reconfigured as sketch drawing P17-006_SK-CV-5 to accommodate 10no LDAU beds and 6 BSI beds. The existing ward is to be completely refurbished.

A budget cost for the complete ward refurbishment and extension had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,312,591

Existing IPCU Ward - (See sketch drawing P17-006_SK-CV-2)
Exiting IPCU completely refurbished to accommodate 10no IPCU beds complete with ensuites. A budget cost for the complete ward refurbishment and extension had been prepared previously in February 2012 by Gardiner & Theobald. We have taken this cost and allowed an inflation uplift and added window replacement and extra over for higher door specification.

January 2017 Outline Budget Cost £2,101,673

Existing Ward 2 converted to Open Forensics
Exiting 22bed Ward 2 to be reconfigured as sketch drawing P17-006_SK-CV-4 to accommodate 6no Open Forensics in one wing with the rest of ward 2 being used for offices or alternative accommodation. We have only costed the work required for Open Forensics and not allowed any costs for converting the spare accommodation to some other use.

January 2017 Outline Budget Cost £1,218,309

Existing Ward 1 & Decant Building
We have not provided costs for these works as it was advised at the meeting that the FM Manager would provide these costs.

Carseview
Ward 1

Ward 1 was refurbished under Lifecycle works a couple of years ago, so no costs have been allowed for general fabric upgrade. The existing services infrastructure were not upgraded as part of these works.

Current costs			
Windows	30 nr	3,000	90,000
Rate Uplift			
Bedroom doors	22 nr	3,000	66,000
Ensuite doors	22 nr	2,000	44,000
			200,000
Preliminaries		15.00%	30,000
Contingency		7.50%	17,250
Current Costs Total			**247,250**
TOTAL			**247,250**

Carseview
Ward 2

Refurbishment Works - Ward, based on a complete out of existing services and reinstatment and general refurbishment up grade as per G&T Fesability Report - February 2012.	900 m2	1,300	1,170,000
Enabling works			-
External works			-
			1,170,000
Preliminaries		15.00%	175,500
Contingency		7.50%	100,913
			1,446,413
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	491,108
			1,937,520
Current costs			
Windows	30 nr	3,000	90,000
Rate Uplift			
Bedroom doors	22 nr	500	11,000
Ensuite doors	22 nr	500	11,000
			112,000
Preliminaries		15.00%	16,800
Contingency		7.50%	9,660
Current Costs Total			**138,460**
TOTAL			**2,075,980**

LDAU & BSI		
No works required		
		-
FORENSIC		
Subdivision; Corridor doors		15,000
External fencing		32,000
		47,000
MUTUAL		
Separation of Services		
Not required		-
		-
WORKS TOTAL		**47,000**
Preliminaries	15%	7,050
Contingencies	7.5%	4,054
TOTAL		**58,104**

Carseview - Option 3A
G&T Work Zone D
Feb-12

Refurbishment Works - Ward 1	956 m2	1,300	1,242,800
Enabling works			99,600
External works			50,000
			1,392,400
Preliminaries		15.00%	208,860
Contingency		7.50%	120,095
			1,721,355
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	584,460
			2,305,814
Current costs			
Windows	29 nr	3,000	87,000
Rate uplift			
Bedroom doors	22 nr	500	11,000
Ensuite doors	22 nr	500	11,000
			109,000
Preliminaries		15.00%	16,350
Contingency		7.50%	9,401
Current Costs Total			**243,751**
TOTAL			**2,549,566**

Carseview - Option 4A & 5A
G&T Work Zone D
Feb-12

Refurbishment Works - Ward 1	956 m2	1,300	1,242,800
Enabling works			99,600
External works			50,000
			1,392,400
Preliminaries		15.00%	208,860
Contingency		7.50%	120,095
			1,721,355
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	584,460
			2,305,814
Current costs			
Windows	29 nr	3,000	87,000
Rate Uplift			
Bedroom doors	22 nr	500	11,000
Ensuite doors	22 nr	500	11,000
			109,000
New Extension	200 m2	2,200	440,000
			549,000
Preliminaries		15.00%	82,350
Contingency		7.50%	47,351
Current Costs Total			**678,701**
TOTAL			**2,984,516**

Carseview - IPCU
G&T Work Zone A
Feb-12

New Build Extension	96 m2	2,000	192,000
Enabling works			99,600
External works			50,000
			341,600
Preliminaries		15.00%	51,240
Contingency		7.50%	29,463
			422,303
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	143,387
			565,690

Current costs			
Windows	0 nr	3,000	-
Bedroom doors	1 nr	1,000	1,000
Ensuite doors	1 nr	500	500
			1,500

Preliminaries		15.00%	225
Contingency		7.50%	129
Current Costs Total			**1,854**

Total	**567,544**

G&T Work Zone B
Feb-12

Refurbishment Works	550 m2	1,550	852,500
Enabling works			-
External works			-
			852,500
Preliminaries		15.00%	127,875
Contingency		7.50%	73,528
			1,053,903
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	357,837
			1,411,740

Current costs			
Windows	25 nr	3,000	75,000
Ext Doors - Double	3 nr	3,000	9,000
Ext Doors - Single	1 nr	1,500	1,500
Rate Uplift			
Bedroom doors: 1½ leaf	9 nr	1,000	9,000
Ensuite doors	9 nr	500	4,500
			99,000
Preliminaries		15.00%	14,850
Contingency		7.50%	8,539
Current Costs Total			**122,389**

Total	**1,534,129**

Carseview - Option 8
LDAU Ward - LDAU & BSI

Refurbishment Works - Ward	900 m2	1,300	1,170,000
Enabling works			99,600
External works			50,000
			1,319,600
Preliminaries		15.00%	197,940
Contingency		7.50%	113,816
			1,631,356
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	553,902
			2,185,258
Current costs			
Windows	29 nr	3,000	87,000
Rate Uplift			
Bedroom doors	16 nr	500	8,000
Ensuite doors	16 nr	500	8,000
			103,000
Preliminaries		15.00%	15,450
Contingency		7.50%	8,884
Current Costs Total			**127,334**
TOTAL			**2,312,591**

Carseview - Option 8
Ward 2 (Open Forensics)

Refurbishment Works - Ward	425 m2	1,300	552,500
Enabling works			99,600
External works			50,000
			702,100
Preliminaries		15.00%	105,315
Contingency		7.50%	60,556
			867,971
Inflation to 1Q 2017			
BCIS All-in TPI		34.0%	294,706
			1,162,678
Current costs			
Windows	13 nr	3,000	39,000
Rate Uplift			
Bedroom doors	6 nr	500	3,000
Ensuite doors	6 nr	500	3,000
			45,000
Preliminaries		15.00%	6,750
Contingency		7.50%	3,881
Current Costs Total			**55,631**
TOTAL			**1,218,309**

Series:	BCIS All-in TPI			BCIS General Building Cost Index		BCIS Regional TPI: Scotland		
Series number:	101		quarterly	1111	monthly	275		quarterly
Base:	1985 mean = 100			1985 mean = 100		2010 mean = 100		
Last updated:	20-Jan-2017			23-Jan-2017		20-Jan-2017		
Notes:						Derived index based on BCIS Tender Price Studies		
Downloaded:	23-Jan-2017 15:38							
Date	**Index**	**Status**	**Sample**	**Index**	**Status**	**Index**	**Status**	**Equiv. Sample**
Jan-2011				300.4	Firm			
Feb-2011	219		45	302.0	Firm	100		70
Mar-2011				303.2	Firm			
Apr-2011				304.2	Firm			
May-2011	223		33	305.5	Firm	105		68
Jun-2011				306.3	Firm			
Jul-2011				307.5	Firm			
Aug-2011	220		33	307.9	Firm	104		67
Sep-2011				309.3	Firm			
Oct-2011				309.2	Firm			
Nov-2011	223		38	308.9	Firm	103		65
Dec-2011				308.5	Firm			
Jan-2012				308.5	Firm			
Feb-2012	215		42	309.5	Firm	101		61
Mar-2012				310.5	Firm			
Apr-2012				310.6	Firm			
May-2012	230		30	310.1	Firm	104		57
Jun-2012				309.7	Firm			
Jul-2012				309.8	Firm			
Aug-2012	223		33	309.7	Firm	102		55
Sep-2012				309.8	Firm			

602

Series:	BCIS All-in TPI		BCIS General Building Cost Index			BCIS Regional TPI: Scotland	
Series number:	101	quarterly	1111		monthly	275	quarterly
Oct-2012			309.8	Firm			
Nov-2012	224	36	310.9	Firm		104	53
Dec-2012			310.4	Firm			
Jan-2013			313.0	Firm			
Feb-2013	234	36	314.0	Firm		106	50
Mar-2013			314.2	Firm			
Apr-2013			314.5	Firm			
May-2013	236	31	314.5	Firm		111	46
Jun-2013			313.9	Firm			
Jul-2013			313.6	Firm			
Aug-2013	232	32	313.4	Firm		110	42
Sep-2013			313.3	Firm			
Oct-2013			313.5	Firm			
Nov-2013	239	37	313.7	Firm		114	39
Dec-2013			313.8	Firm			
Jan-2014			314.9	Firm			
Feb-2014	247	37	315.7	Firm		117	36
Mar-2014			316.3	Firm			
Apr-2014			316.0	Firm			
May-2014	259	39	316.2	Firm		118	34
Jun-2014			316.4	Firm			
Jul-2014			319.1	Revised			
Aug-2014	257	32	319.1	Firm		126	32
Sep-2014			319.2	Firm			
Oct-2014			319.2	Firm			
Nov-2014	259	31	319.1	Firm		124	30
Dec-2014			318.5	Firm			
Jan-2015			318.0	Firm			
Feb-2015	269	29	318.3	Firm		130	27

Series:	BCIS All-in TPI			BCIS General Building Cost Index			BCIS Regional TPI: Scotland	
Series number:	101		quarterly	1111		monthly	275	quarterly
Mar-2015				318.0	Firm			
Apr-2015				319.2	Firm			
May-2015	280	Forecast	19	319.3	Firm		132	25
Jun-2015				318.8	Firm			
Jul-2015				321.2	Firm			
Aug-2015	271		25	320.4	Firm		123	23
Sep-2015				320.1	Firm			
Oct-2015				320.1	Firm			
Nov-2015	271	Forecast	15	319.5	Firm		120	20
Dec-2015				318.6	Firm			
Jan-2016				318.6	Firm			
Feb-2016	276		21	319.5	Firm		125	18
Mar-2016				319.6	Firm			
Apr-2016				320.3	Firm			
May-2016	288		20	321.5	Firm		130	15
Jun-2016				322.7	Firm			
Jul-2016				322.9	Firm			
Aug-2016	285	Forecast	7	326.8	Firm		131	11
Sep-2016				327.3	Firm			
Oct-2016				328.4	Provisional			
Nov-2016	286	Forecast	5	329.4	Provisional		117	9
Dec-2016				329.3	Provisional			
Jan-2017				330.8	Forecast		Say	
Feb-2017	288	Forecast		331.8	Forecast		132	
Mar-2017				332.6	Forecast			
Apr-2017				334.0	Forecast			
May-2017	289	Forecast		335.0	Forecast			
Jun-2017				335.1	Forecast			
Jul-2017				338.6	Forecast			

604

Appendix Eight

Financial Analysis and Scoring

17.01.29 MHSRT
Programme financial A

Mental Health Service Redesign Transformation Programme
Financial Options Appraisal

Key Criteria		
	Weighting	Equal Weighting
	%	%
1. Option is affordable within existing revenue budgets	38	20
2. Option allows cost pressure reduction/recurring savings	42	20
3. Option requires Capital Investment/cash prepayment	5	20
4. Option requires Non recurring bridging resource	5	20
5. Option allows for potential site disposal/capital receipt	10	20

GAP	Score 0 to 10	Weighted Score	Equal Weighting	GAP	Score 0 to 10	Weighted Score	Equal Weighting
Option 1 - Do Nothing				**Option 3A**			
Current GAP services remain on Mulberry, Carseview and Murray Royal - No change				Single site for GAP Acute Admission impatient beds provided with IPCU inpatient beds with four wards provided on the Carseview site in Dundee and the Rehabilitation & Complex Care inpatient beds provided at Murray Royal in Perth			
Criteria One				Criteria One			
Option is not affordable within current budget limits - current cost pressures exist within Nursing (supplementary staffing costs across Tayside), no ecomomies of scale achievable from ability to cross cover, services remain across disperate sites. Continued reliance on Locum cover for both Senior and Junior Medical across Tayside. Current under utilisation of wards within Carseview site and Rohallion inpatient beds.	2	76	40	Option is affordable within current budget limits - current cost pressures within Acute admission inpatient beds would reduce through ecomomies of scale achievable from having four acute wards on one site, this would also allow for increased ability to cross cover services, staff training, recruitment an dretention of staff. Also potential to review inpatient management reqiurements for GAP if majority of inpatient beds provided from a single site. Carseview site would become fully utilised, Murray Royal site would become fully utilised and a further Option appraisal would be required to optimise use of vacated Mulberry ward	8	304	160
Criteria Two				Criteria Two			
Option does not allow for any cost pressure reduction/recurring savings. inpatient service significantly overspent on current level of resources. Current cost pressures within inpatient services will remain and are forecast to further increase as more of the current workforce retires over the next 5 years and current issues relating to recruitmane and retention of workforce. Continued reliance on Locum cover for both Senior and Junior Medical across Tayside	1	42	20	Option would allow for a cost pressure reduction/recurring savings through economies of scale achievable from four wards provided on a single site. Level of reinvestment required to support additional community/home treatment services to support people in own homes required recurrently. Additional Uintary Charge payment which covers the building running costs at Carseview and increased utilities costs associated with opening of cuurently empty ward two area.	7	294	140
Criteria Three				Criteria Three			
Option will require capital investment of £250k to allow permanent retention of the decant building at Carseview to meet planning consent conditions agreed at time of building.	5	25	100	Option will require capital investment of £250k to allow permanent retention of the decant building at Carseview to meet planning consent conditions agreed at time of building. Option will require use of cash prepayment allocation to refurbish Carseview site for GAP admission wards. Option will require revenue investment for any amendments to Murray Royal site Rohallion clinic and to the Moredun ward at Murray Royal to allow for Leranig Disability relocation. These revenue refurbishment costs will be pursued against DEL allocations from SG.	2	10	40
Criteria Four				Criteria Four			
Option will require non recurring bridging resource to make amendments to all mental health sites (NPD/PFI sites) to improve patient safety issues inline with Health & Safety Executive recommendations	8	40	160	Option will require non recurring bridging resource to make amendments to all mental health sites (NPD/PFI sites) to improve patient safety issues inline with Health & Safety Executive recommendations. Option will require non recurring bridging resource to assist relocation of Mulberry and Moredun staffing transfer- assumption % staff will be unable to relocate to Carseview on permanent basis. Potential temporary level of staffing required to support cross cover of neighbouring services such as Psychiatry of Old Age service until a further OA exercise is undertaken and an alternative service occupies vacated area. Excess Travel/travel time, removal expenses etc	3	15	60
Criteria Five				Criteria Five			
Option will not allow for any capital receipt as all buildings will remain in situ.	0	0	0	Option has will allow for capital receipt from closure of Strathmartine site and has potential to allow for a capital receipt dependant on further option appraisal exercise to determine occupation of vacated Mulberry ward at Susan Carnegie Centre in Angus.	8	80	160
		183	320			703	560
		4	4			1	1

GAP	Score 0 to 10	Weighted Score	Equal Weighting	GAP	Score 0 to 10	Weighted Score	Equal Weighting
Option 4A				**Option 5A**			
Two site solution for GAP Acute Admission inpatient beds with three wards provided with the IPCU in Carseview and a single ward in the Susan Carnegie Clinic (Mulberry ward), Rehabilitation & Complex Care inpatient beds remaining at Murray Royal in Perth				Two site solution for GAP Acute Admission inpatient beds with three wards provided with the IPCU in Carseview and a single ward in Murray Royal (Moredun ward), Rehabilitation & Complex Care inptient beds remaining at Murray Royal			
Criteria One				Criteria One			
Option is not affordable within current budget limits - current cost pressures within Acute admission inpatient wards could reduce slightly through ecomomies of scale achievable from three acute wards on Carseview site, however option will still require medical and junior doctor cover over three sites at premium locum costs which would offset any savings achieved	4	152	80	Option is affordable within current budget limits - current cost pressures within Acute admission inpatient beds would reduce through ecomomies of scale achievable from three acute wards on Carseview site, and relocation of isolated ward from Angus which currently requires additoinal cover. This option would still require medical and junior doctor cover over two sites at premium locum costs and continue to incur higher staffing level requirements at Moredun ward to manage environment/observation levels	6	228	120
Criteria Two				Criteria Two			
Option would allow for some cost pressure reduction/recurring savings through economies of scale achievable from three wards on Carseview site however this would continue to be offest by continued requrement for use of locums for both junior and senior medical cover for 3 sites plus the additional investment required in Perth community/home treatment to support the relocation of Moredun ward from Perth to Dundee	3	126	60	Option would allow for some cost pressure reduction/recurring savings through economies of scale achievable from three wards on Carseview site however this would continue to be offset by continued requrement for use of locums for both junior and senior medical cover for 2 sites plus additional investment required in Angus community/home treatment for relocation of Mulberry ward from Angus to Dundee	5	210	100
Criteria Three				Criteria Three			
Option will require capital investment of £250k to allow permanent retention of the decant building at Carseview to meet planning consent conditions agreed at time of building. Option will require use of cash prepayment to allow refurbishment and extension to provide GAP Acute admission wards and combined LD ward . Option will require revenue investment for any amendments to Rohallion clinic at Murray Royal to allow for Learning Disability relocation. These revenue refurbishment costs will be pursued against DEL allocations from SG.	3	15	60	Option will require capital investment of £250k to allow permanent retention of the decant building at Carseview to meet planning consent conditions agreed at time of building. Option will require use of cash prepayment to allow refurbishment and extension to provide GAP Acute admission wards and combined LD ward . Option will require revenue investment for any amendments to Rohallion clinic at Murray Royal to allow for Learning Disability relocation. These revenue refurbishment costs will be pursued against DEL allocations from SG.	3	15	60
Criteria Four				Criteria Four			
Option will require non recurring bridging resource to make amendments to NPD builds to improve patient safety issues . Option will require non recurring bridging resource to assist relocation of Moredun staffing transfer- assumption % staff will be unable to relocate to Carseview on permanent basis plus potential temporary level of support to existing Murray Royal services for cross cover until vacated area utilised by LD. Excess Travel/travel time, removal expenses etc	4	20	80	Option will require non recurring bridging resource to make amendments to NPD builds to improve patient safety issues . Option will require non recurring bridging resource to assist relocation of Mulberry ward staffing transfer- assumption % staff will be unable to relocate to Carseview on permanent basis plus potential temporary level of support to existing Psychiatry of Old Age services for cross cover until vacated area utilised by alternative service (subject to further OA). Excess Travel/travel time, removal expenses etc	4	20	80
Criteria Five				Criteria Five			
Option has will allow for capital receipt from closure of Strathmartine site and has potential to allow for a capital receipt dependant on further option appraisal exercise to determine occupation of vacated Moredun ward at Murray Royal Hospital in Perth.	6	60	120	Option has will allow for capital receipt from closure of Strathmartine site and has potential to allow for a capital receipt dependant on further option appraisal exercise to determine occupation of vacated Mulberry ward at Susan Carnegie Centre in Angus.	8	80	160
		373	400			553	520
		3	3			2	2

GAP	Score 0 to 10	Weighted Score	Equal Weighting
Option 8A			
Single site solution for GAP Acute Admissions inpatient beds with the IPCU on Carseview site with (3 site solution) for step down/treatment wards, one in each locality at Carseview, Susan Carnegie Centre and Murray Royal Hospital.			
Criteria One			
Option is not affordable within current budget limits - current cost pressures within Acute admission inpatient beds would remain, no ecomomies of scale would be achievable from having three treatment/step down wards over three sites however would not require as intensive staffing models fro step down which would be offset by an increased requirement for the single acute ward. Continued requirement for junior and senior medical cover for 3 sites at a premium locum cost.	2	76	40
Criteria Two			
Option does not allow for any cost pressure reduction/recurring savings as inpatient services would remain overspent on current resources, isolation of ward in Angus would remain with requirement for continued supplementary costs, which would increase for further retirements over next 5 years and projected inability to recruit/retain workforce. Continued reliance on Locum cover for both Senior and Junior Medical across Tayside at premium cost. Option will require additional investment to cover escort and transfer of patients between acute admission and step down/treatment wards	1	42	20
Criteria Three			
Option will require capital investment of £250k to allow permanent retention of the decant building at Carseview to meet planning consent conditions agreed at time of building. Option will require use of cash prepayment to allow refurbishment and extension to provide GAP Acute admission wards and combined LD ward and separate LD open forensic ward . Option will require revenue investment for any amendments to Rohallion clinic at Murray Royal to allow for Learning Disability relocation. These revenue refurbishment costs will be pursued against DEL allocations from SG.	4	20	80
Criteria Four			
Option will require non recurring bridging resource to make amendments to all mental health sites (NPD/PFI sites) to improve patient safety issues inline with Health & Safety Executive recommendations	8	40	160
Criteria Five			
Option will not allow for any capital receipt as all buildings will remain in situ.	0	0	0
		178	300
		5	5

Mental Health Service Redesign Transformation Programme
Financial Options Appraisal

Key Criteria		
	Weighting	Equal Weighting
	%	%
1. Option is affordable within existing revenue budgets	38	20
2. Option allows cost pressure reduction/recurring savings	42	20
3. Option requires Capital Investment	5	20
4. Option requires Non recurring bridging resource	5	20
5. Option allows site disposal/capital receipt	10	20

Learning Disabilities	Score 0 to 10	Weighted Score	Equal Weighting	Learning Disabilities	Score 0 to 10	Weighted Score	Equal Weighting
Option 1 - Do Nothing				**Option 3A**			
Do nothing - leave existing services at Carseview and Strathmartine sites				Relocate all Learning Disability services from Carseview and Strathmartine to Murray Royal - Combined LDAU & BSI with separate Open forensic area within refurbished Moredun Ward at Murray Royal and Locked Forensic in Rohallion Clinic at Murray Royal			
Criteria One				Criteria One			
Option is not affordable within current budget limits - current cost pressures exist within nursing budgets (significant supplementary staffing costs across both sites), no ecomomies of scale achievable from cross cover across two sites. Continued reliance on Locum cover for both Senior and Junior Medical across Tayside at premium cost	2	76	40	Option is affordable within current budget limits - current cost pressures within LD though isolation of single ward area at Carseview and compromised environments at Strathmartine would be removed. Economies of scale from all provision of all LD services together on single Murray Royal site, reduced cost of Low secure LD Forensic beds provided from improved environment (reduced obs etc) in new Rohallion Clinic building at Murray Royal, Reduced reliance on Locum cover for both Senior and Junior Medical across Tayside therefore associated cost pressure reduction	8	304	160
Criteria Two				**Criteria Two**			
Option does not allow for any cost pressure reduction/recurring savings - overspend on current resources and current cost pressures will remain and forecast to increase due to potential retirements over next 5 years up to 50% in some areas of LD coupled with inability to recruit /retain workforce. Continued reliance on Locum cover for both Senior and Junior Medical across Tayside	1	42	20	Option would allow for significant cost pressure reduction/recurring savings from co-location of all LD services on Murray Royal site. Reduced reliance on Locum cover for both Senior and Junior Medical across Tayside. Recurring revenue from reduction of Low secure Forensic ward could be used to offset additional investment required to provide additional support in Angus and Dundee. Recurring revenue available from operations directorate through site closure savings at Strathmartine. Vacated LDAU ward on Carseview would become available for utilisation as single site for GAP services. Rohallion Clinic would be fully utilised. Moredun ward could accomodate all LD services within significantly improved environment.	8	336	160
Criteria Three				**Criteria Three**			
Option will require capital investment to address significant backlog maintentance associated with Strathmartine site.	5	25	100	Option would not require capital investment but will require non recurring revenue invstement for minor refurbishment of Moredun ward to accommodate split of LD beds to provide separation between BSI/LDAU and Open forensic inpatient beds. Minor refurbishment also required for remaining low secure wards to create crisis suite by separating off two bedrooms from other areas. These revenue refurbishment costs will be pursued against DEL allocations from SG.	8	40	160
Criteria Four				**Criteria Four**			
Option will not require non recurring bridging resource as no planned changes	10	50	200	Option will require non recurring bridging resource to assist relocation to Murray Royal - assumption only % staff will be unable to relocate to Murray Royal. Excess Travel, removal expenses etc	5	25	100
Criteria Five				Criteria Five			
Option will not allow for any capital receipt as all buildings remain in situ.	0	0	0	Option would allow for potential capital receipt from potential closure of the Strathmartine site	8	80	160
		193	360			785	740
		5	5			1	1

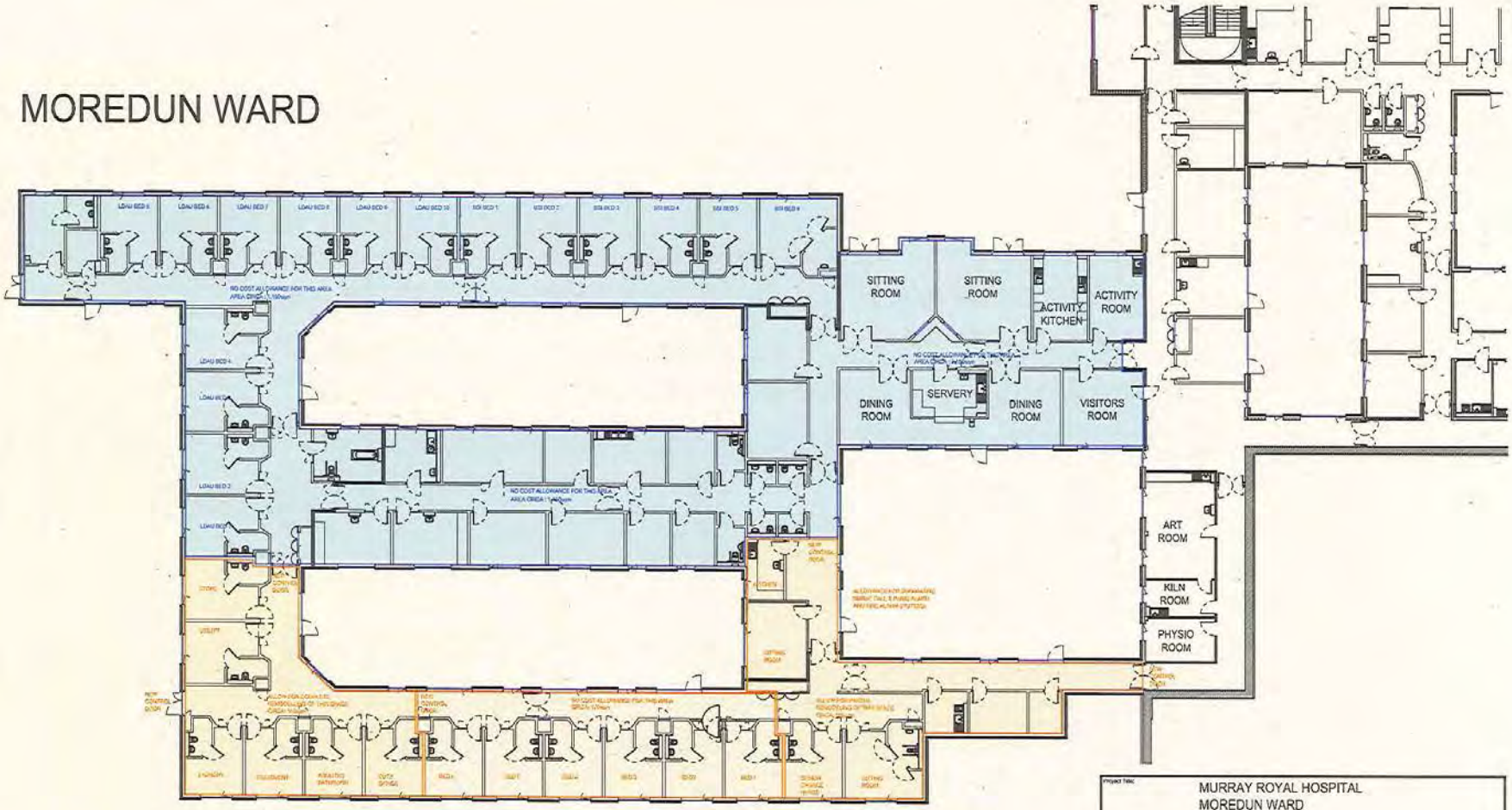
Learning Disabilities	Score 0 to 10	Weighted Score	Equal Weighting	Learning Disabilities	Score 0 to 10	Weighted Score	Equal Weighting
Option 4A				**Option 5A**			
Refurbish current LDAU ward in Carseview to accommodate combined LDAU & BSI with Open Forensic separate area and relocate Locked LD Forensic inpatient beds from Strathmartine to Rohallion Clinic at Murray Royal				Refurbish current LDAU ward in Carseview to accommodate combined LDAU & BSI with Open Forensic separate area and relocate Locked LD Forensic inpatient beds from Strathmartine to Rohallion Clinic at Murray Royal			
Criteria One				Criteria One			
Option is affordable within current budget limits - current cost pressures within LD though isolation of single ward area at Carseview and compromised environments at Strathmartine would be reduced from having a combined ward on the Carseview site however option still has separation of services across 2 sites. Some reduction in cost of Low secure LD Forensic beds provided from improved environment (reduced obs etc) in new Rohallion Clinic at Murray Royal, some reduction in reliance on Locum cover for both Senior and Junior Medical across Tayside therefore associated cost pressure reduction .	6	228	120	Option is affordable within current budget limits - current cost pressures within LD though isolation of single ward area at Carseview and compromised environments at Strathmartine would be reduced from having a combined ward on the Carseview site however option still has separation of services across 2 sites. Some reduction in cost of Low secure LD Forensic beds provided from improved environment (reduced obs etc) in new Rohallion Clinic at Murray Royal, some reduction in reliance on Locum cover for both Senior and Junior Medical across Tayside therefore associated cost pressure reduction .	6	228	120
Criteria Two				**Criteria Two**			
Option would allow for cost pressure reduction/recurring savings from co-location of all LDAU and BSI and open forensic services into single LDAU ward on the Carseview site. Reduction in reliance on Locum cover for both Senior and Junior Medical across 2 sites for Tayside. Recurring revenue from reduction of Low secure Forensic ward. Recurring revenue available from operations directorate through site closure savings at Strathmartine. Rohallion Clinic would be fully utilised. Option still has separation of LD services across 2 sites.	6	252	120	Option would allow for cost pressure reduction/recurring savings from co-location of all LDAU and BSI and open forensic services into single LDAU ward on the Carseview site. Reduction in reliance on Locum cover for both Senior and Junior Medical across 2 sites for Tayside. Recurring revenue from reduction of Low secure Forensic ward. Recurring revenue available from operations directorate through site closure savings at Strathmartine. Rohallion Clinic would be fully utilised. Option still has separation of LD services across 2 sites.	6	252	120
Criteria Three				**Criteria Three**			
Option would not require capital investment but will require cash prepayment funding for significant refurbishment of Carseview LDAU ward to accommodate split of services to provide separation between BSI/LDAU and Open forensic patient group. Non recurring revenue invstement for minor refurbishment required for remaining low secure wards to create crisis suite by separating off two bedrooms from other areas. This revenue refurbishment costs will be pursued against DEL allocations from SG.	6	30	120	Option would not require capital investment but will require cash prepayment funding for significant refurbishment of Carseview LDAU ward to accommodate split of services to provide separation between BSI/LDAU and Open forensic patient group. Non recurring revenue invstement for minor refurbishment required for remaining low secure wards to create crisis suite by separating off two bedrooms from other areas. This revenue refurbishment costs will be pursued against DEL allocations from SG.	6	30	120
Criteria Four				**Criteria Four**			
Option will require increased non recurring bridging resource to assist relocation of forensic LD beds to Murray Royal - assumption % staff will be unable to relocate to Murray Royal. Excess travel, removal expenses etc	7	35	140	Option will require increased non recurring bridging resource to assist relocation of forensic LD beds to Murray Royal - assumption % staff will be unable to relocate to Murray Royal. Excess travel, removal expenses etc	7	35	140
Criteria Five				Criteria Five			
Option would allow for potential capital receipt from potential closure of the Strathmartine site	8	80	160	Option would allow for potential capital receipt from potential closure of the Strathmartine site	8	80	160
		625	660			625	660
		2	2			2	2

Learning Disabilities	Score 0 to 10	Weighted Score	Equal Weighting
Option 8A			
Refurbish current LDAU ward in Carseview to accommodate combined LDAU & BSI and refurbish Ward Two on Carseview for separate Open Forensic LD inpatient ward and relocate Locked LD Forensic inpatient beds from Strathmartine to Rohallion Clinic at Murray Royal			
Criteria One			
Option is affordable within current budget limits - current cost pressures within LD though isolation of single ward area at Carseview and compromised environments at Strathmartine would be reduced from having a combined ward on the Carseview site however option still has separation of services across 2 sites. Some reduction in cost of Low secure LD Forensic beds provided from improved environment (reduced obs etc) in new Rohallion Clinic at Murray Royal, some reduction in reliance on Locum cover for both Senior and Junior Medical across Tayside therefore associated cost pressure reduction .	6	228	120
Criteria Two			
Option would allow for cost pressure reduction/recurring savings from co-location of all LDAU and BSI into the LDAU and open forensic services into ward Two on the Carseview site. Reduction in reliance on Locum cover for both Senior and Junior Medical across 2 sites for Tayside. Recurring revenue from reduction of Low secure Forensic ward. Recurring revenue available from operations directorate through site closure savings at Strathmartine. Rohallion Clinic would be fully utilised. Option still has separation of LD services across 2 sites.	6	252	120
Criteria Three			
Option would not require capital investment but will require cash prepayment funding for significant refurbishment of Carseview LDAU ward to accommodate BSI/LDAU inpatient beds plus major refurbishmenr of Ward Two to accomodate 6 to 8 Open forensic LD inpatient beds. Non recurring revenue invstement for minor refurbishment required for remaining low secure wards to create crisis suite by separating off two bedrooms from other areas. This revenue refurbishment costs will be pursued against DEL allocations from SG.	4	20	80
Criteria Four			
Option will require increased non recurring bridging resource to assist relocation of forensic LD beds to Murray Royal - assumption % staff will be unable to relocate to Murray Royal. Excess travel, removal expenses etc	7	35	140
Criteria Five			
Option would allow for potential capital receipt from potential closure of the Strathmartine site	8	80	160
		615	620
		4	4

Appendix Nine

Initial Design Work / Site Plans / Drawings

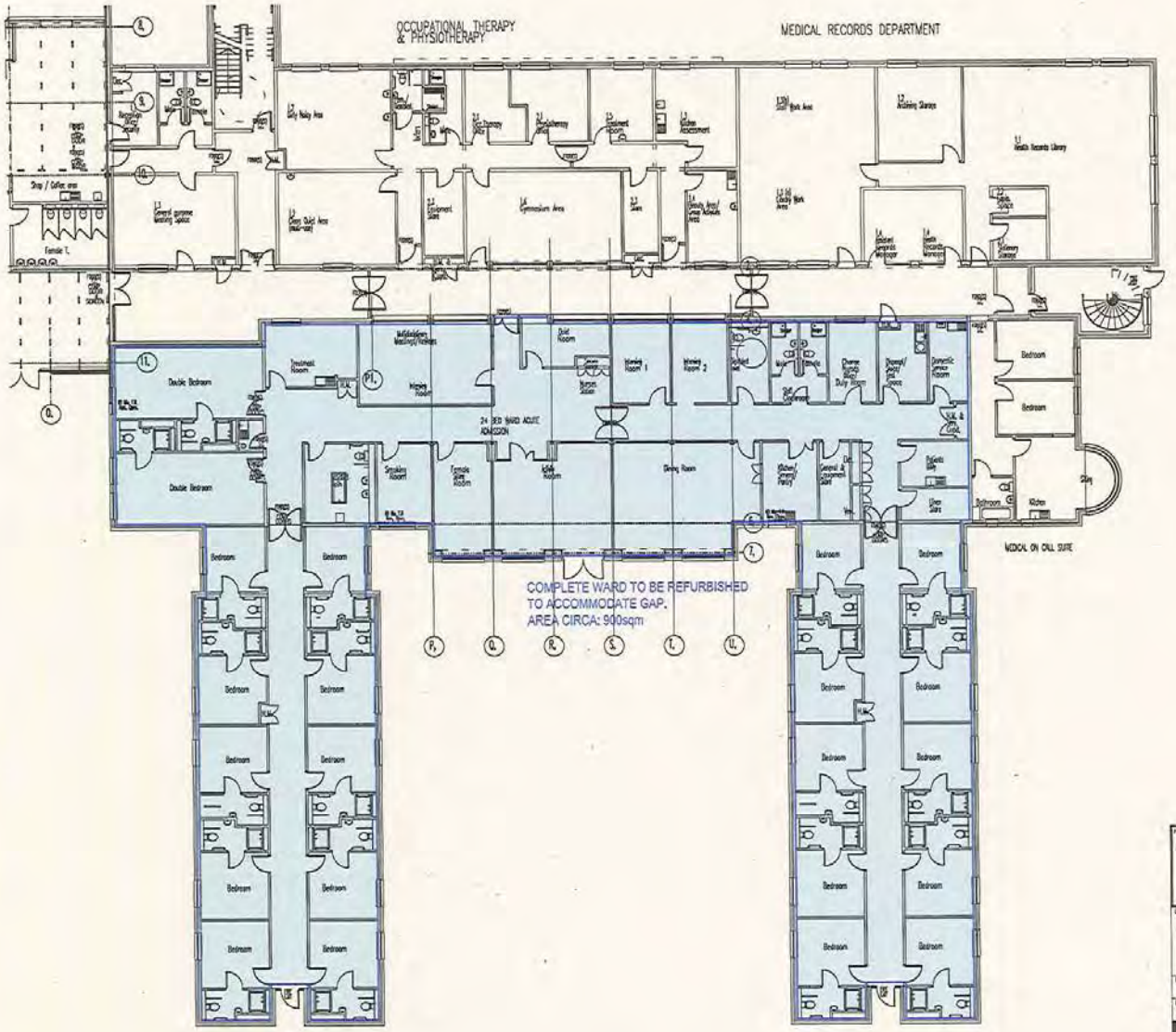
MOREDUN WARD



Project Title:	MURRAY ROYAL HOSPITAL MOREDUN WARD NHS TAYSIDE
Drawing Title:	OPTION 3A POSSIBLE ACCOMMODATION CONFIGURATION
Date: 23.01.2017	Scale: 1:250 @ A3
Project Drawing No:	P17-006_SK_MR_1
Rev:	A
Issue: -	Drawn by: PK

gwp gauldiewright&partners
Chartered Architects

Gauldie Wright & Partners
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1BD
t 01382 669241
e info@gwparchitects.co.uk
w www.gwparchitects.co.uk



LEGEND:

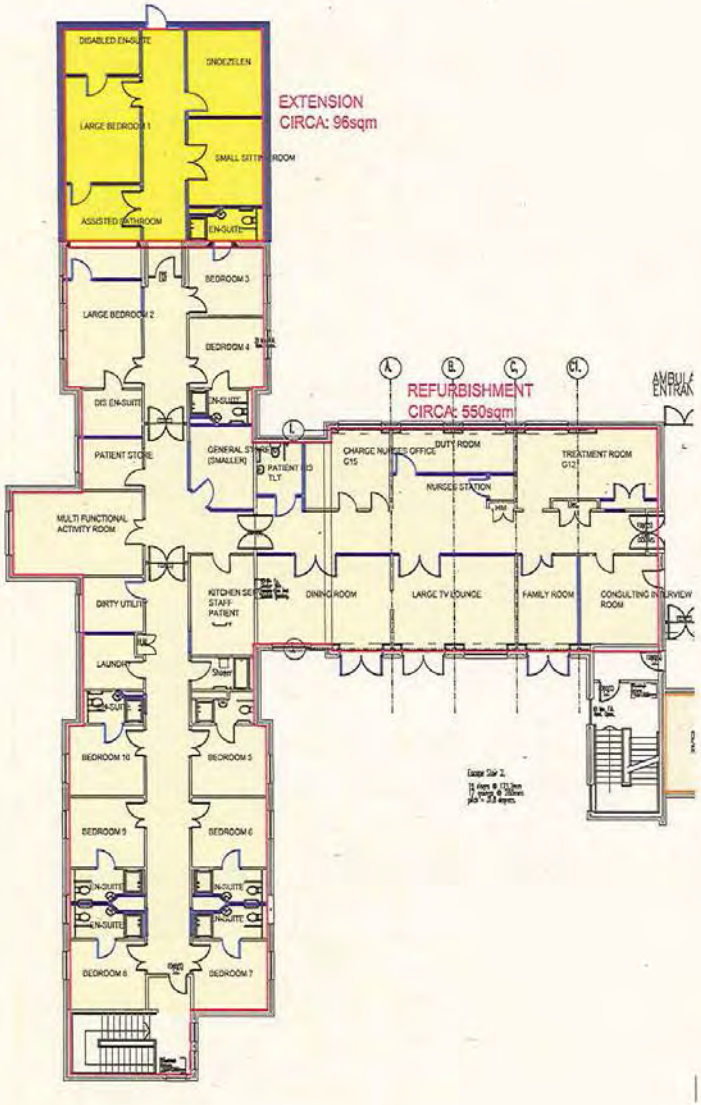
REFURBISHMENT

CARSEVIEW HOSPITAL
LDAU WARD CONVERTED TO GAP
NHS TAYSIDE

OPTION 3A
GAP ACCOMMODATION CONFIGURATION

23.01.2017 | 1:200 @ A3 | P17-006_SK_CV_1 | PK

gauldiewright&partners
Chartered Architects



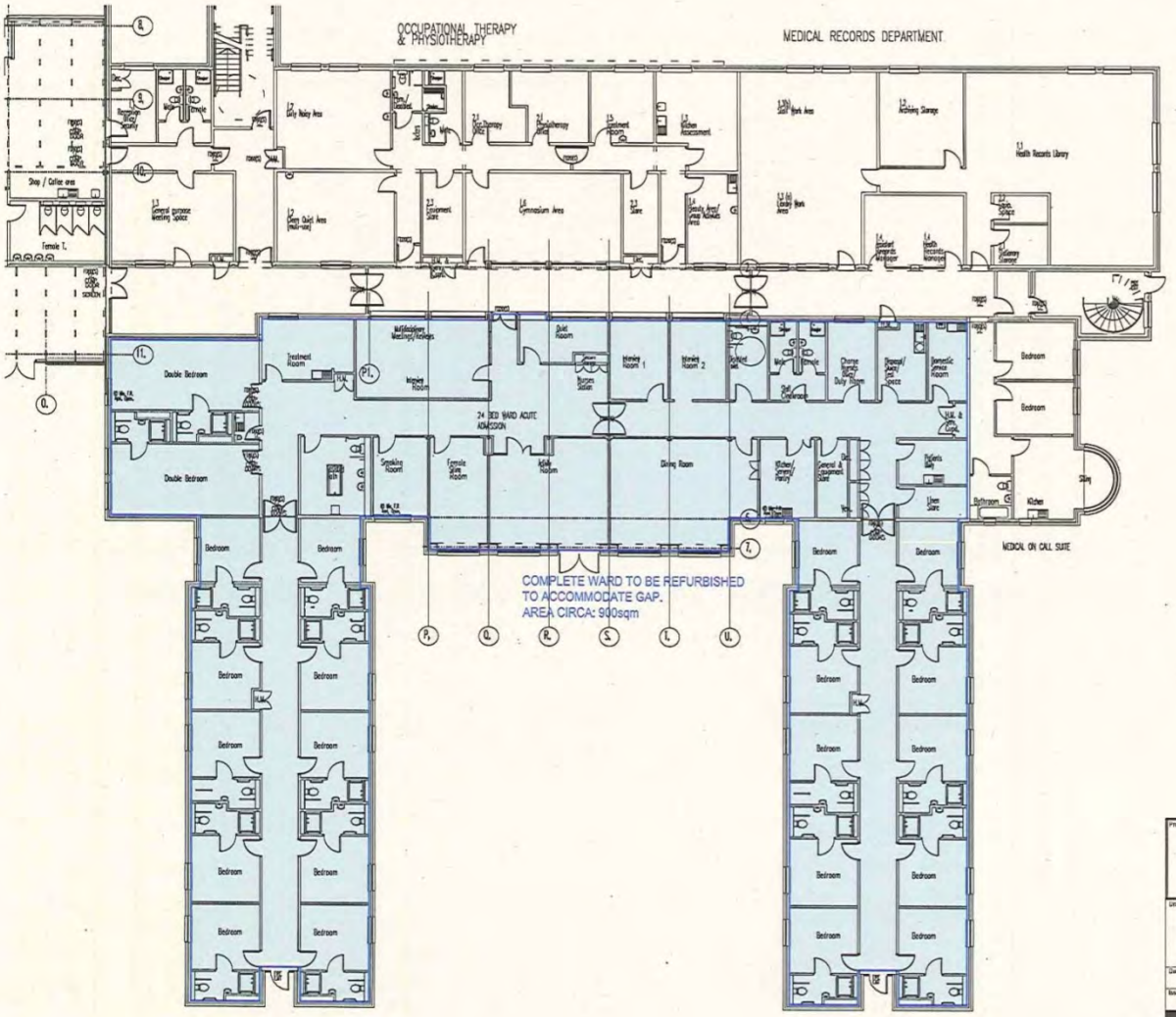
LEGEND:

REFURBISHMENT

EXTENSION

Project Title:	CARSEVIEW HOSPITAL IPCU WARD NHS TAYSIDE
Drawing Title:	OPTION 3A, 4A & 8 POSSIBLE IPCU ACCOMMODATION CONFIGURATION
Date: 23.01.2017	Scale: 1:200 @ A3
Project Drawing No: P17-006_SK_CV_2	Rev:
Issue: -	Drawn by: PK

gwp gauldiewright&partners
Chartered Architects
Gauldie Wright & Partners LLP
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1BD
t 01382 669241
f 01382 649032
e info@gwparchitects.co.uk
w www.gwparchitects.co.uk

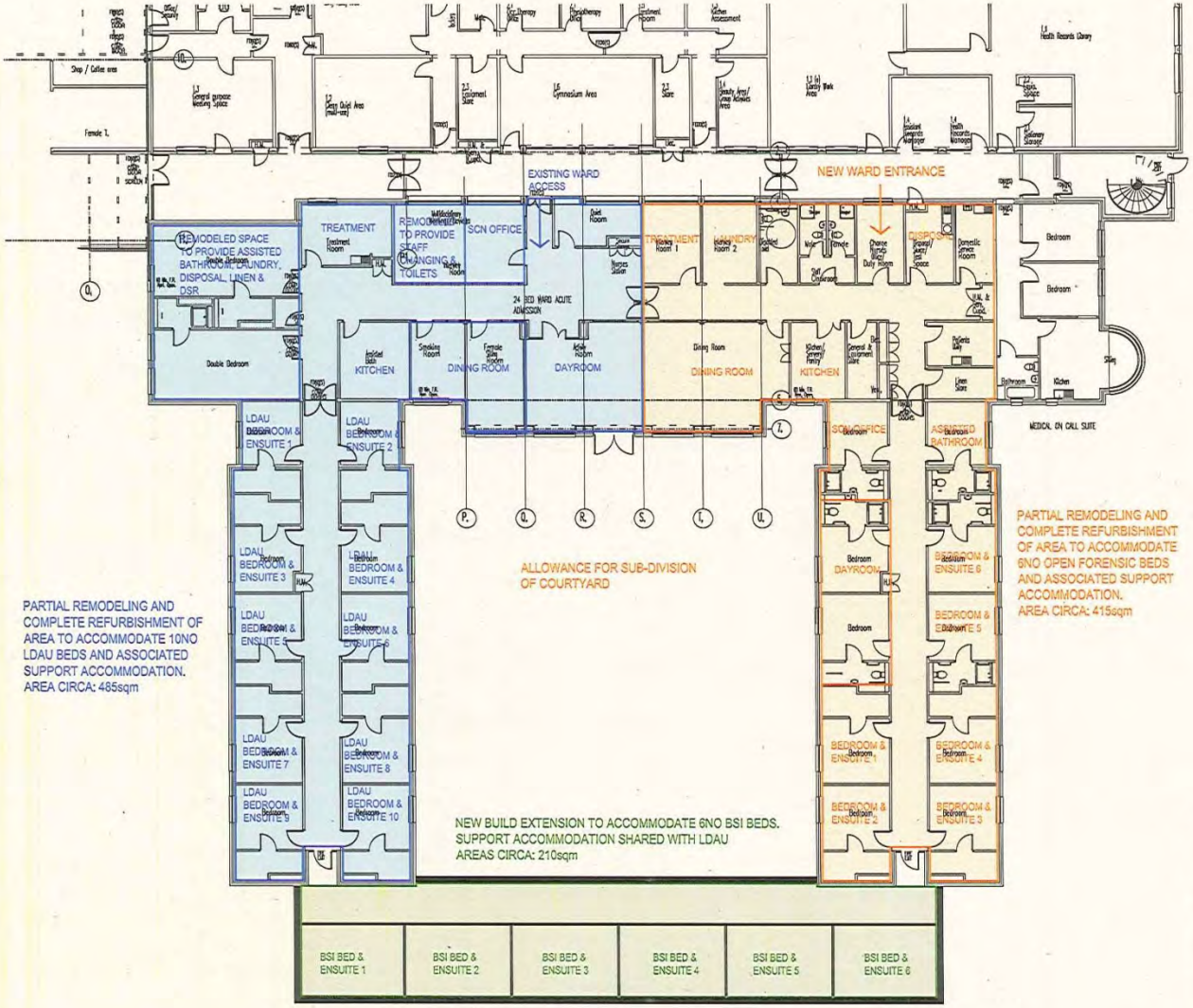


LEGEND:

REFURBISHMENT

Project Title:	CARSEVIEW HOSPITAL LDAU WARD CONVERTED TO GAP NHS TAYSIDE
Drawing Title:	OPTION 3A GAP ACCOMMODATION CONFIGURATION
Date: 23.01.2017	Scale: 1:200 @ A3
Issue: -	Drawn by: PK
Project Drawing No:	P17-006_SK_CV_1
Rev:	-

gwp gauldiewright&partners
Chartered Architects
Gauldie Wright & Partners LLP
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1SD
t 01382 669241
f 01382 669032
e info@gwp-architects.co.uk
w www.gwp-architects.co.uk

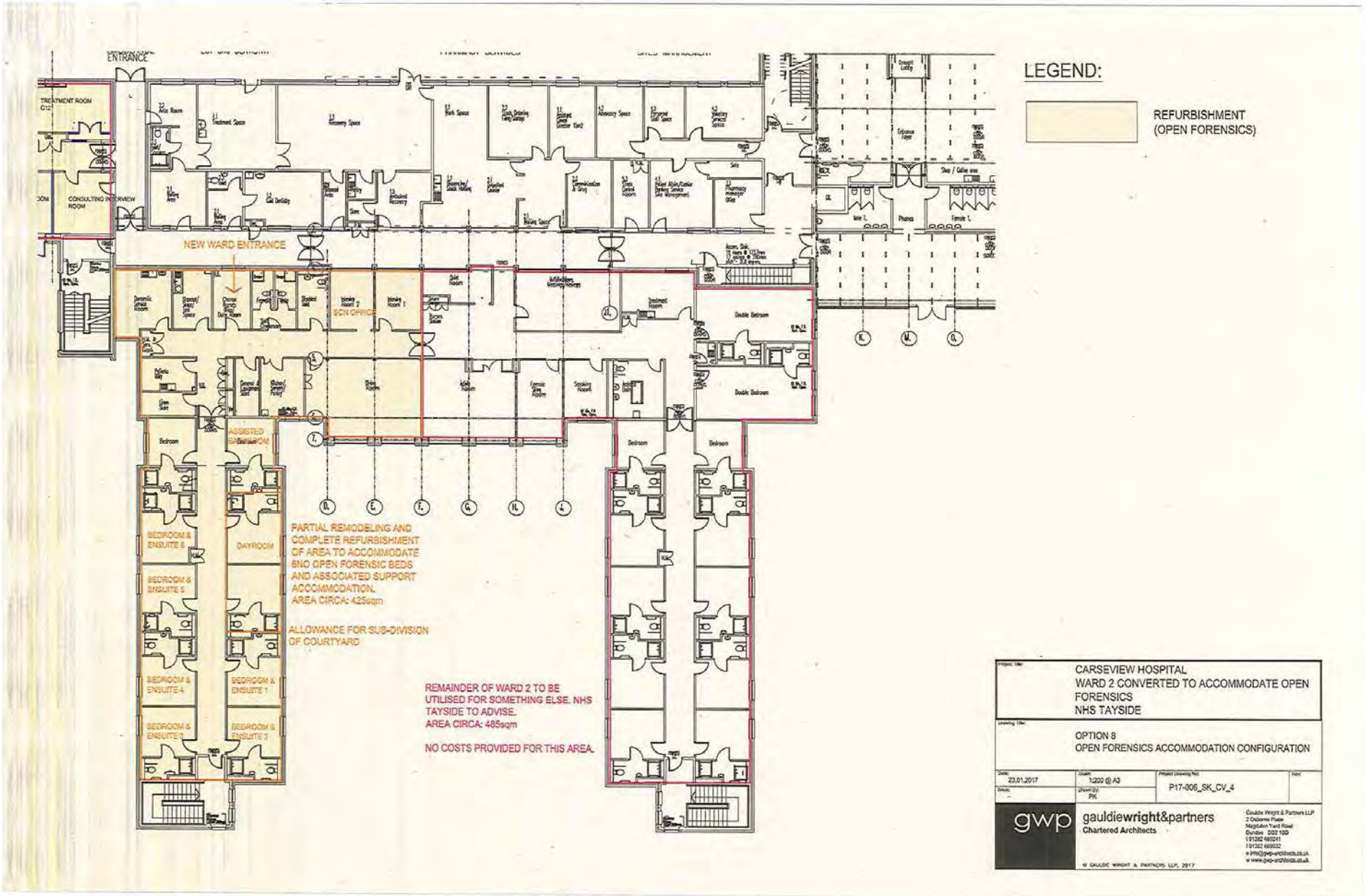


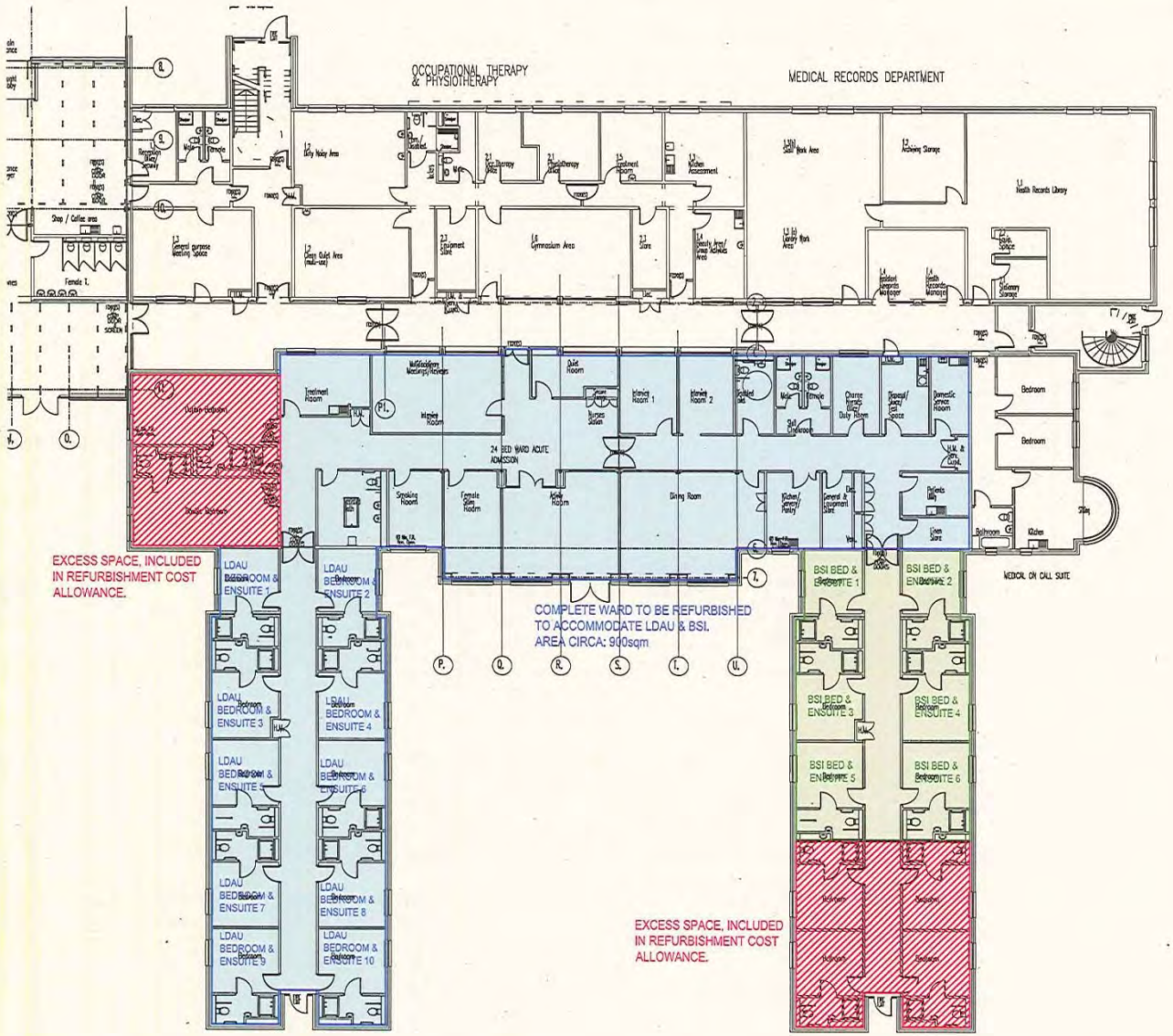
LEGEND:

- REFURBISHMENT (OPEN FORENSICS)
- REFURBISHMENT (LDAU)
- EXTENSION (BSI)

Project Title:	CARSEVIEW HOSPITAL LDAU WARD CONVERTED AND EXTENDED TO ACCOMMODATE LDAU, BSI & OPEN FORENSICS NHS TAYSIDE
Drawing Title:	OPTION 4A & 5A LDAU, BSI & OPEN FORENSICS ACCOMMODATION CONFIGURATION
Date: 23.01.2017	Scale: 1:200 @ A3
Project Drawing No: P17-006_SK_CV_3	Rev:
Issue: -	Drawn by: PK

gwp gauldiewright&partners
Chartered Architects
Gauldie Wright & Partners LLP
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1SD
t 01382 661241
f 01382 661032
e info@gwp-architects.co.uk
w www.gwp-architects.co.uk


ENTRANCE
TREATMENT ROOM G12
CONSULTING INTERVIEW ROOM
NEW WARD ENTRANCE
SCN OFFICE
ASSISTED BATHROOM
BEDROOM & ENSUITE 6
BEDROOM & ENSUITE 5
BEDROOM & ENSUITE 4
BEDROOM & ENSUITE 3
DAYROOM
BEDROOM & ENSUITE 1
BEDROOM & ENSUITE 2
Double Bedroom
Double Bedroom
Bedroom
Bedroom
PARTIAL REMODELING AND COMPLETE REFURBISHMENT OF AREA TO ACCOMMODATE 6NO OPEN FORENSIC BEDS AND ASSOCIATED SUPPORT ACCOMMODATION.
AREA CIRCA: 425sqm
ALLOWANCE FOR SUB-DIVISION OF COURTYARD
REMAINDER OF WARD 2 TO BE UTILISED FOR SOMETHING ELSE. NHS TAYSIDE TO ADVISE.
AREA CIRCA: 485sqm
NO COSTS PROVIDED FOR THIS AREA.
LEGEND:
REFURBISHMENT (OPEN FORENSICS)
CARSEVIEW HOSPITAL
WARD 2 CONVERTED TO ACCOMMODATE OPEN FORENSICS
NHS TAYSIDE
OPTION 8
OPEN FORENSICS ACCOMMODATION CONFIGURATION
23.01.2017
1:200 @ A3
P17-006_SK_CV_4
PK
gwp
gauldiewright&partners
Chartered Architects
Gauldie Wright & Partners LLP
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1SD
t 01382 561241
f 01382 669332
e info@gwp-architects.co.uk
w www.gwp-architects.co.uk
© GAULDIE WRIGHT & PARTNERS LLP, 2017



Project Title:	CARSEVIEW HOSPITAL LDAU WARD CONVERTED TO ACCOMMODATE LDAU & BSI NHS TAYSIDE
Drawing Title:	OPTION 8 LDAU & BSI ACCOMMODATION CONFIGURATION
Date: 23.01.2017	Scale: 1:200 @ A3
Project Drawing No: P17-006_SK_CV_5	Rev:
Issue: -	Drawn By: PK

gwp gauldiewright&partners
Chartered Architects
Gauldie Wright & Partners LLP
2 Osborne Place
Magdalen Yard Road
Dundee DD2 1BD
t 01382 669241
f 01382 669302
e info@gwp-architects.co.uk
w www.gwp-architects.co.uk

Appendix Ten

Supporting Information

10.1

Extract from “A Profile of Mental Health in Tayside”

2. Population

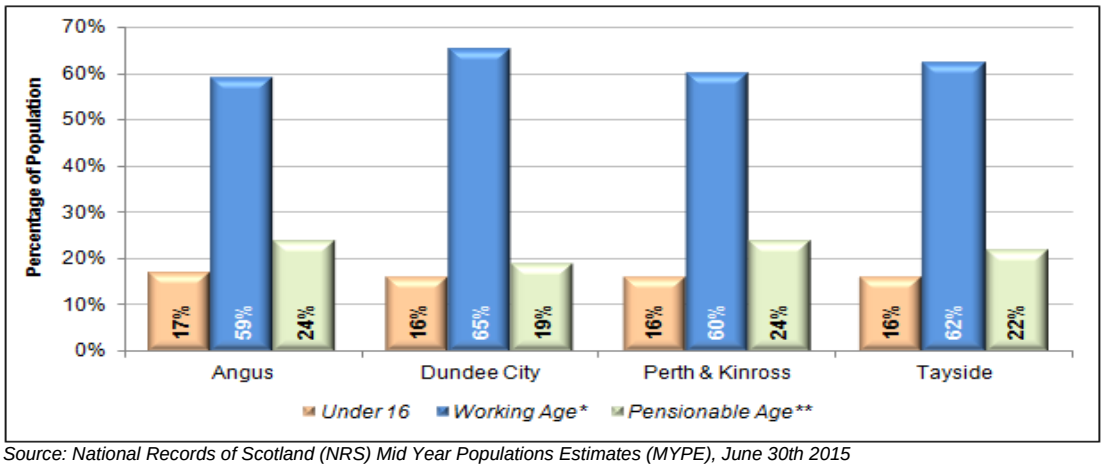
2.1 Demographics

The distribution and attributes of a population is an important factor in tackling health issues, allowing the identification of important target groups. Many conditions and health related behaviours are associated with demographic characteristics such as age and gender.

The estimated population of Tayside on 30th June 2015 was 415,040, an increase of 1,240 (0.3%) from 2014. Similar in proportions to previous years, 48.6% of the population were males and 51.4% females.

Tayside's population is distributed across three local administrative areas, in 2015 there were 116,900 residents [28.2% of the Tayside population] in Angus, 148,210 in Dundee [35.7%] and 149,930 in Perth and Kinross [36.1%]. Figure 1 displays the age structure of the Tayside population and its three administrative areas for 2015.

Figure 1. Age Structure of the Tayside Resident Population, as at 30th June 2015



Source: National Records of Scotland (NRS) Mid Year Populations Estimates (MYPE), June 30th 2015

Notes:
** Working age at 30 June 2015 was defined as men aged 16 to 64 and women aged 16 to approximately 62 years and 237 days*
*** Pensionable age at 30 June 2015 was 65 for men and approximately 62 years and 238 days for women*

The proportions in each age category across Tayside and its administrative areas are relatively similar. However, Dundee City has a higher proportion of the population who are of working age and a lower proportion of those who are pensionable in comparison to its Tayside counterparts.

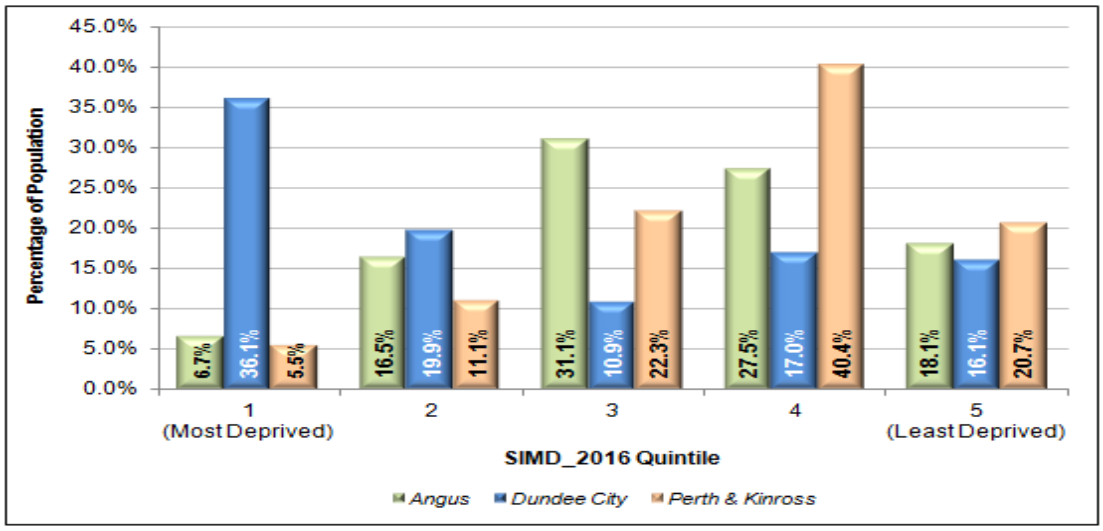
2.4 Deprivation

The "Scottish Index of Multiple Deprivation" (SIMD[1]) is an area-based measure of deprivation, identifying small area concentrations of multiple deprivation in a comparative manner. It combines the domains of income, employment, health, education, skills and training, housing, geographic access and crime based on a ranking system from most to least deprived. These ranks can be grouped into categories, most commonly 'Quintiles', with the focus on 20% most deprived (i.e. SIMD_Quintile 1).

[1] *SIMD_2016 current version is based on 2011 Data Zone, direct comparisons with previous SIMDs is not possible.*

While in a standard population, 20% of the population would be expected to live within each quintile, across Tayside's local administrative areas there are large variations between the differing levels of deprivation. Figure 3 displays the population proportions residing in each deprivation quintile for all three of Tayside's administrative areas.

Figure 3. Percentage of Tayside Resident 2015 Mid-Year Population Estimate by SIMD_2016 Quintile



Source: SAPE 2015 [based on data zones 2011) via National Records of Scotland (NRS) and SIMD_2016 via Scottish Government

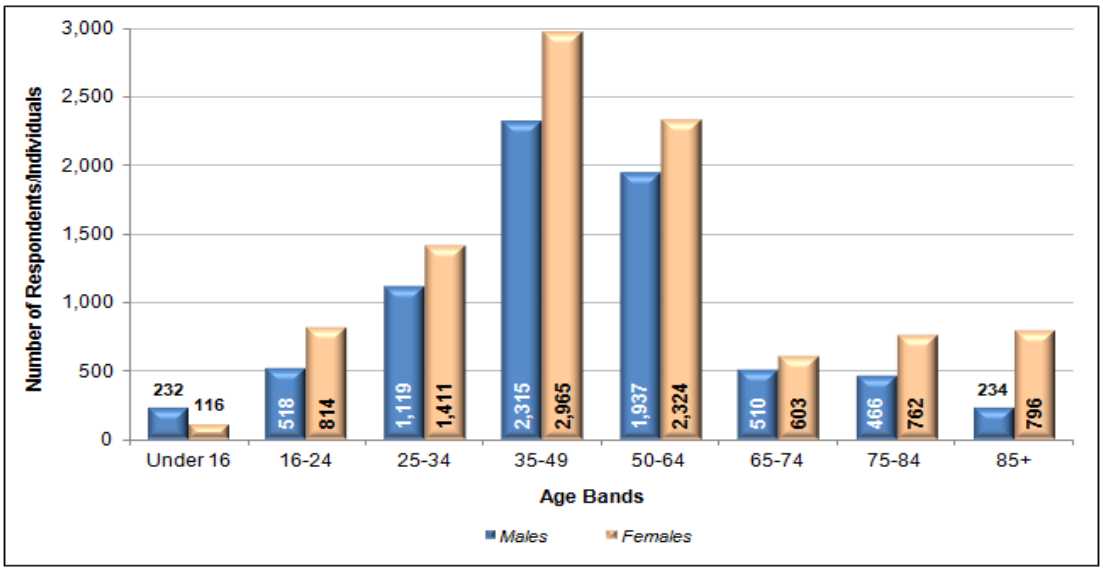
As shown in Figure 3, in 2015 Dundee City had the greatest proportion of their residents living within the most deprived areas (SIMD_Quintiles 1 & 2). In Quintile 1 (20% most deprived) 36.1% of the Dundee City population resided here, more than five times that of its Tayside counterparts within this quintile. In comparison Perth & Kinross recorded the highest proportion of their population residing in the least deprived areas (SIMD_Quintiles 4 and 5).

3. Self-Reported Mental Health Conditions *(2011 Census)*

The 2011 Census asked respondents whether they have a mental health condition that is expected to last. When comparing the rate of self reported mental health conditions across Scotland per 1,000 population the figures show that mental disorders are more prevalent among those living in deprived areas. With a rate of 52.8 per 1,000 population, Dundee City held the fourth highest rate of all Scottish local authorities and was also higher than the Scottish average of 44.0 per 1,000[2]. In comparison, the rates reported in Angus and Perth & Kinross were 37.0 and 34.6 per 1,000 population respectively.

Of the Tayside respondents, 17,122 [41.8 per 1,000 population] reported having a mental health condition. Figure 5 presents these respondents by age and gender, showing that 9.8% of these individuals were aged under 25 years, while 19.7% were aged 65+ years.

[2] *Highest local authority was Glasgow City, rate = 65.1 per 1,000 population.*



4. Quality & Outcomes Framework (QOF)

Prevalence is a measure of the burden of a specific disease or health condition in a population at a particular point in time (and is different to *incidence*, which is a measure of the number of *newly diagnosed* cases within a particular time period). Prevalence data within the Quality & Outcomes Framework[3] (QOF) is collected in the form of practice "registers" for a range of conditions including mental health. Prevalence data derived from QOF disease registers are of value; however they should be interpreted with caution.

A QOF prevalence rate is a “crude” rate, simply the total number of patients on the register, expressed as a proportion of the total number of patients registered with the practice. They are not adjusted to account for patient age distribution, gender profiles or other factors that that influence the prevalence of health conditions between general practices. In addition, while the registers may be restricted (e.g. to only include persons over a specified age) the QOF prevalence rate is based on the total number of persons registered with the practice (practice list size) at one point in time[4] [5].

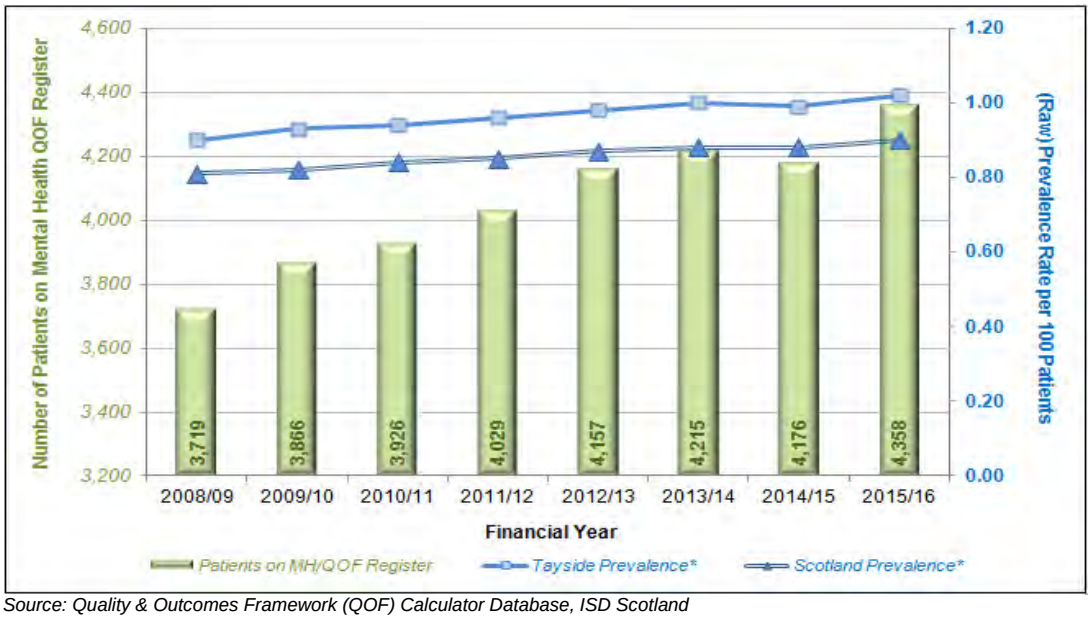
In 2015/16, 66 Tayside practices participated in QOF. Across these practices 4,358 patients were registered as having a mental health condition, demonstrating a raw prevalence rate of 1.02 per 100 patients. This is slightly higher than the Scottish prevalence rate [0.90] for this condition in this year. Figure 6 displays the increase in the raw mental health prevalence rates over recent years and shows how annually Tayside’s mental health prevalence rate is higher than the Scottish rate.

Figure 6. Numbers and Estimated Raw Prevalence Rate of Mental Health Conditions for those Registered with Tayside GP Practices, 2008/09 – 2015/16

[3] *QOF measures a General Practice's achievement against a set of evidence-based indicators. Payments are made to each GP on basis of their achievements, representing one of the main sources of income for UK GPs, a fundamental part of the GMS contract since April 2004. QOF Participation is voluntary - practices with other contract types are not automatically expected to take part.*

[4] *QOF prevalence figures may differ from prevalence figures from other sources because of coding or definitional issues.*

[5] *Year-on-year changes in the size of QOF registers are influenced by various factors including demographic changes, improvements in case findings, changes in definition, data recording, diagnostic practice etc.*



Source: Quality & Outcomes Framework (QOF) Calculator Database, ISD Scotland

Notes:

1. Although the QOF is part of the new General Medical Services (GMS), practices with other contract types (17C or 2C) may also choose to use the QOF. These figures include data from practices of any contract type.
2. QOF registers may relate to a single condition, or a number of conditions and do not always count what they appear to on face value. There may also be restrictions on who is counted on the register, e.g. according to age. For more information on what individual QOF registers count refer to - www.isdscotland.org/qof
3. After October 2016 ISD will no longer publish QOF, it is being decommissioned, with all points being retired and funding transferred to practice core funding. QOF data will no longer be extracted for payment purposes. 2016-17 QOF data will continue to be extracted to support the peer led GP Cluster Continuous Quality Improvement process as part of the latest GMS contract agreement.
** Raw Prevalence Rate (per 100 patients) = number of patients on the specified QOF register, divided by list size, multiplied by 100.*

6. Psychiatric Hospital Activity

This section presents information on mental health (psychiatric) hospital activity derived from Scottish Morbidity Record 04 (SMR04)[6] an episode-based patient record relating to all inpatients and day cases admitted to and discharged from any NHS Scottish mental health specialty. Nearly all records are for inpatient treatment, but there are a few day cases and some care is provided in care homes rather than psychiatric hospitals or units.

It should be noted that an increasing amount of healthcare for mental illness takes place in the community, e.g. through specialist community mental health teams and general practice. Psychiatric hospital outpatient care is another key service.

Activity is measured in '*discharged episodes of care*' and '*discharged individuals*' by area of residence. A 'discharge' represents the end of an SMR04 episode of care and includes deaths, transfers to other specialties, consultants, significant facilities or hospitals and routine discharges home. Individuals (patients) discharged are those persons discharged from a mental health specialty at least once during the financial year. Conversion of these raw activity numbers into an age-standardised rate[7] (per 100,000 population) allows direct comparison between geographies.

6.1 Area of residence

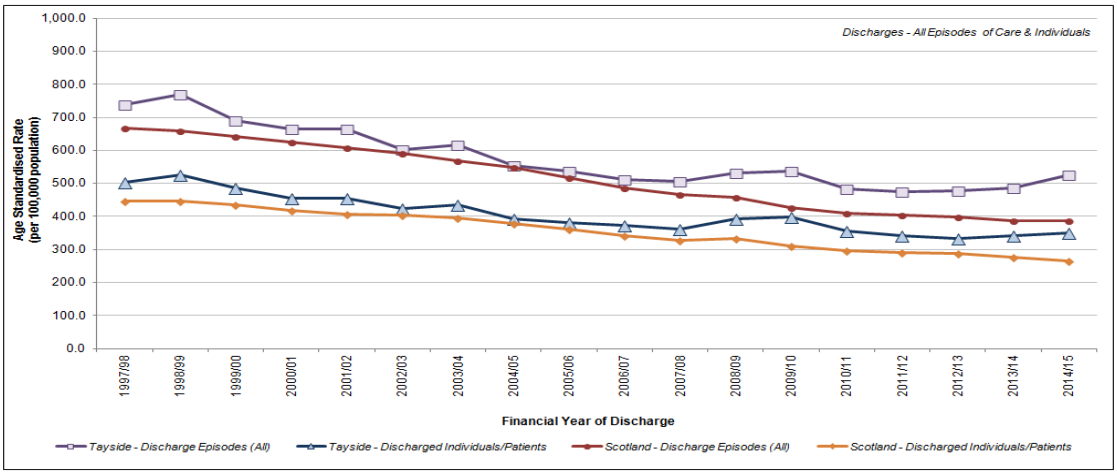
[6] *SMR04 data are dynamic and subject to change. Improvements in the completeness over time may result in differences to previously released information.*

[7] *Age-sex standardised rates are based on the European Standard Population 2013 (i.e. EASR).*

The number of Tayside resident[8] discharge episodes of care from a psychiatric location has shown a gradual decline over time, decreasing from an age standardised rate per 100,000 population of 738.1 [2,866 discharge episodes of care] in 1997/98 to 526.2 [2,154 discharge episodes of care] in 2014/15.

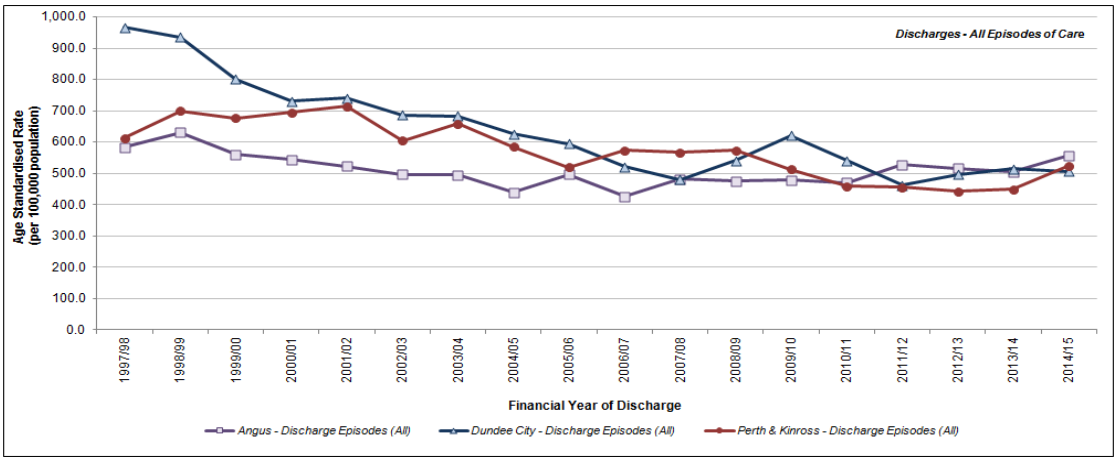
Figure 7 summarises the age standardised rates (per 100,000 population) for all discharge episodes of care and those individuals discharged since 1997/98. When comparing Tayside activity with that of Scotland, annually Tayside discharge rates are higher than the Scottish average for both measures of activity.

Figure 7. Age Standardised Discharge Rates (All Episodes of Care & Individuals) from Psychiatric Hospitals, Comparison of Tayside and Scottish Resident Activity, 1997/98 – 2014/15



Source: Mental Health Inpatient Care Report[9] 2014/15 (Section 2.1 SMR04), ISD Scotland

Figure 8.1. Age Standardised Discharge Rates (All Episodes of Care) from Psychiatric Hospitals by Tayside Administrative Area, 1997/98 – 2014/15



Source: Mental Health Inpatient Care Report 2014/15 (Section 2.1 SMR04), ISD Scotland

Despite annual fluctuations, both types of discharge rate have decreased across all three Tayside local areas. Dundee City residents have recorded the largest reduction in discharge rates by 47.7% compared with its other Tayside counterparts over the last 18 years. Decreasing from an age standardised discharge rate (all episodes of care) per 100,000 population of 967.1 in 1997/98 to

[8] *Data refers to Tayside residents treated in any mental health/psychiatric (SMR04) location, regardless of health board of treatment.*

[9] *Mental Health Care Report: Analysis is based on all ages/gender, all episodes of care and excludes 'learning disability' specialty.*

506.1 in 2014/15, the lowest rate of the Tayside local areas in this year. Similarly, the age standardised rate for individuals discharged decreased from a rate of 635.9 to 365.0 (-42.6%) over the same period for Dundee City residents[10].

For comparison, in 2014/15 Angus residents recorded a discharge age standardised rate (all episodes of care) of 558.0 per 100,000 population, while Perth & Kinross's rate was 524.0. In terms of the individual discharge rate, Angus recorded an age standardised rate of 369.5, with a rate of 325.7 per 100,000 population in Perth & Kinross, the lowest of the three local areas[11,12].

Figure 9 compares the number of Tayside residents who were present in a psychiatric hospital as 31st March 1998 and 2015, by local administrative area. Collectively Tayside has recorded a reduction of 60.3% from 764 to 303 patients in hospital at the end of the financial year. This equates to a reduction of the age standardised rate from 205.8 per 100,000 population to 75.6 in 2014/15.

Figure 9. Number of Tayside Patients in Psychiatric Hospitals, as at 31st March 1998 & 2015

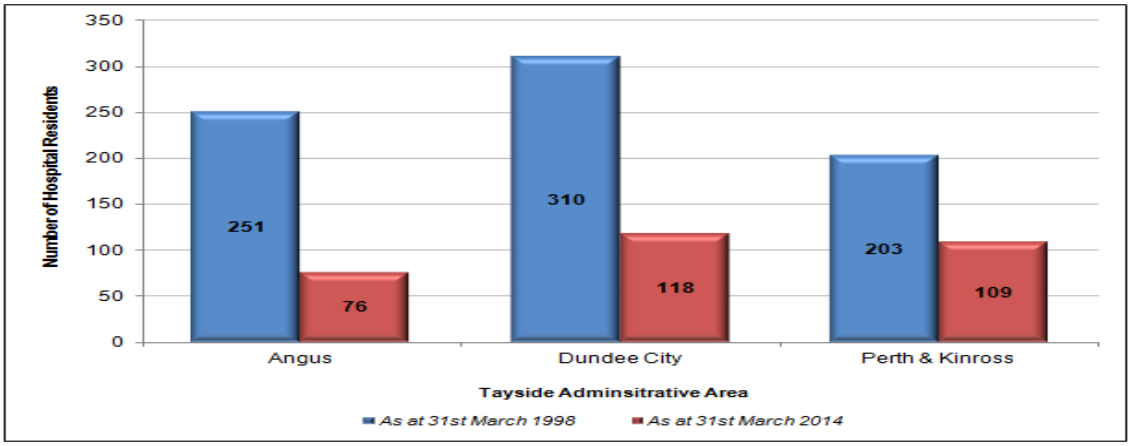


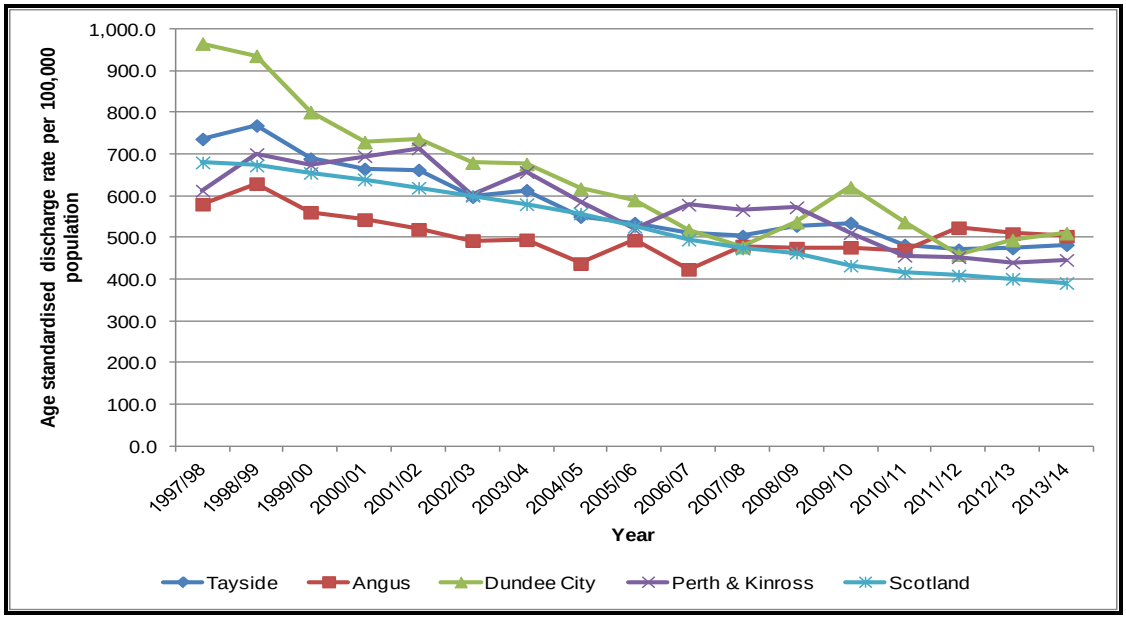
Figure 10 shows the standardised discharge rates from psychiatric hospitals between 1997/98 and 2013/14 and compares Tayside with Scotland. National analysis shows that residents of Tayside, Dumfries & Galloway and Greater Glasgow & Clyde had discharge rates significantly higher than the Scottish average in 2013/14.

Figure 10: Age/sex standardised discharge rates from psychiatric hospitals, Tayside and Scotland 1997/98 – 2013/14

[10] *Dundee City Discharges All Episodes of Care - 97/98 N=1,451; 14/15 N=719; Individuals/Patients - 97/98 N=944; 14/15 N=526*

[11] *2014/15 All Episodes of Care Angus N=643, Perth & Kinross N=792; Individuals/Patients Angus N=427; Perth & Kinross N=493*

[12] *Reductions since 1997/98: Individuals Discharged = Angus -13.5%; Perth & Kinross -22.7%; All Episodes = Angus -4.3%; Perth & Kinross -14.5%*



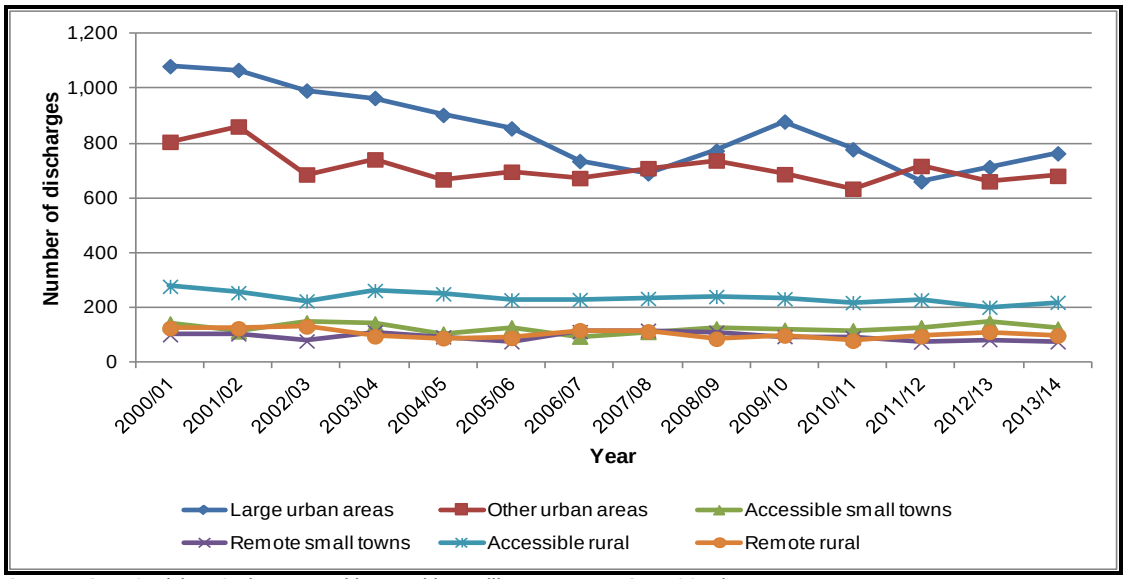
Source: SMR04, ISD Scotland

6.4 Urban rural status

The relationship between rurality and SMR04 activity was examined using the Scottish Government's 6-fold urban rural classification. See Appendix 1 for a breakdown of these classifications.

The rankings of the categories varied a little over time and there was less spread between categories than there was for deprivation quintile. The highest rates were in the 'large urban areas' and 'other urban areas' while the lowest were in the 'remote small towns' and 'remote rural' areas. This pattern may be influenced by prevalence of different mental health problems, patterns of socioeconomic deprivation, patterns of service provision, ease of access to services, stigma associated with mental health problems, and other factors.

Figure 15: Number of discharges from psychiatric hospitals by urban/rural status, Tayside 2000/01-2013/14



Source: SMR04 (via BOXi accessed by Health Intelligence Team Sept 2015)

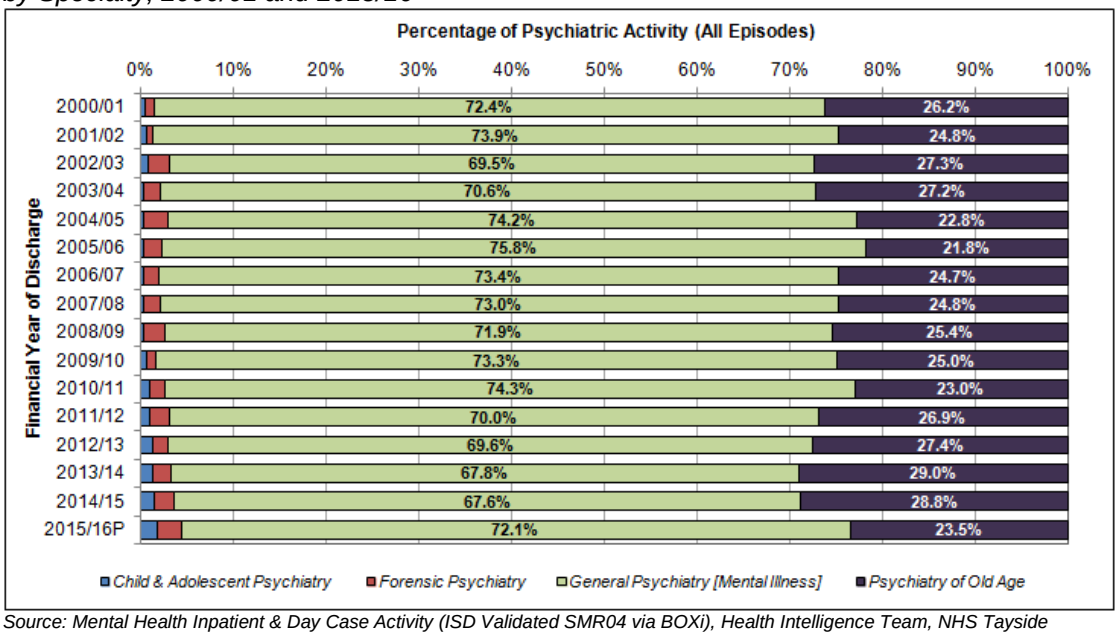
6.5 Specialty

For Tayside residents, on average per year between 2000/01 and 2015/16[P], 97.2% of all psychiatric discharge episodes of care were treated within NHS Tayside, with more than a third being cared for in Murray Royal Hospital.

Mental health activity can be categorised into several specialties. The majority of Tayside resident psychiatric activity over the last sixteen years has been treated under the specialty of "General Psychiatry [Mental Illness]", accounting for on average 71.8% of all discharge episodes per year over this period. "Psychiatry of Old Age" accounted for a further 25.5% of the activity on average per year, with the amalgamated "Child Psychiatry" and "Adolescent Psychiatry" 1.9% and the remaining 0.8% to "Forensic Psychiatry" over this period.

Figure 13 presents the proportion of discharge episodes of care for each specialty between 2000/01 and 2015/16[P]. There has been very little change in the activity proportions over time across these specialities under which Tayside residents have been treated.

Figure 13. Tayside Residents: Percentage of Discharge Episodes of Care from Psychiatric Hospitals by Specialty, 2000/01 and 2015/16[P]



Source: Mental Health Inpatient & Day Case Activity (ISD Validated SMR04 via BOXi), Health Intelligence Team, NHS Tayside

Notes:
1. "Child Psychiatry" and "Adolescent Psychiatry" are amalgamated here for ease of analysis.
2. In a similar manner to national publications, the specialty of "Learning Disability"(G5) is excluded from this analysis.
3. Includes all episodes (Elective, Emergency & Transfer) for all ages/genders. 2015/16 figures are as provisional at time of release.

6.7 Location of treatment

In 2013/14, there were a total of 1,989 discharges (equating to 1,403 patients) from NHS Tayside psychiatric hospitals, a 25.3% decrease in discharges from 2000/01. As at 31st March 2014, there were 323 patients resident in a NHS Tayside psychiatric hospital compared to 598 patients in March 2001.

Figure 19 shows an analysis of the NHS Tayside hospital activity in 2013/14 for those patients aged under 65 years and excluding patients being treated for dementia (ICD10 codes F00-F09). The table is broken down by health board of residence of the patients. Just over two fifths (40.8%) of the activity was in Murray Royal Hospital with 95.6% of these discharges being Tayside residents.

Figure 19: Under 65 years discharges (excluding dementia patients) from NHS Tayside hospitals by health board of residence 2013/14

Health Board of Treatment	Health Board of Residence	TOTAL

		NHS Tayside	NHS Grampian	NHS Fife	Other areas of residence	
	TOTAL	**1317**	**24**	**13**	**35**	**1389**
NHS Tayside hospitals	Murray Royal Hospital	584	18	5	7	614
	Carseview Centre	452	*	6	*	481
	Stracathro Hospital	263	*	*	*	267
	Dudhope House (Young Persons Unit)	11	*	*	*	20
	Other hospitals	7	0	0	0	7

*Note that due to small numbers, some fields have been marked with a **
Note: Murray Royal Hospital and Stracathro Hospital include Psychiatry of Old Age patients; Carseview Centre includes patients with Learning Disabilities
Source: SMR04 (via BOXi accessed by Health Intelligence Team Sept 2015)

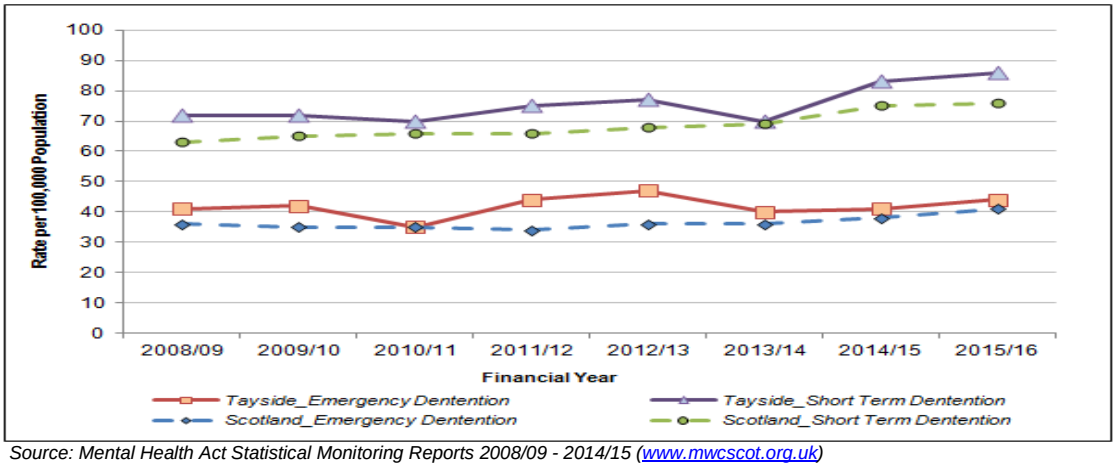
Figure 20 shows the average length of stay in NHS Tayside psychiatric hospitals between 2000/01 and 2013/14 for those aged under 65 years and excluding dementia patients. The chart shows, despite some fluctuations that the average had more than halved from 92 days to 37 days.

10.1 NHS Board Comparisons

A statistical monitoring report is published by the Mental Welfare Commission for Scotland annually to monitor the use of the Mental Health Act since it was implemented in 2005 and examine how treatment orders are being utilised by different NHS Board areas. The most recent report relates to 2015/16 activity.

Figure 27 summarises the Tayside rates (per 100,000 population) for both 'emergency detention' orders and 'short-term detention' orders, showing the latter has consistently recorded higher rates of the two order types over recent years across Tayside.

Figure 27. NHS Tayside Emergency and Short-Term Detention Rates (per 100,000 population), 2008/09 – 2015/16



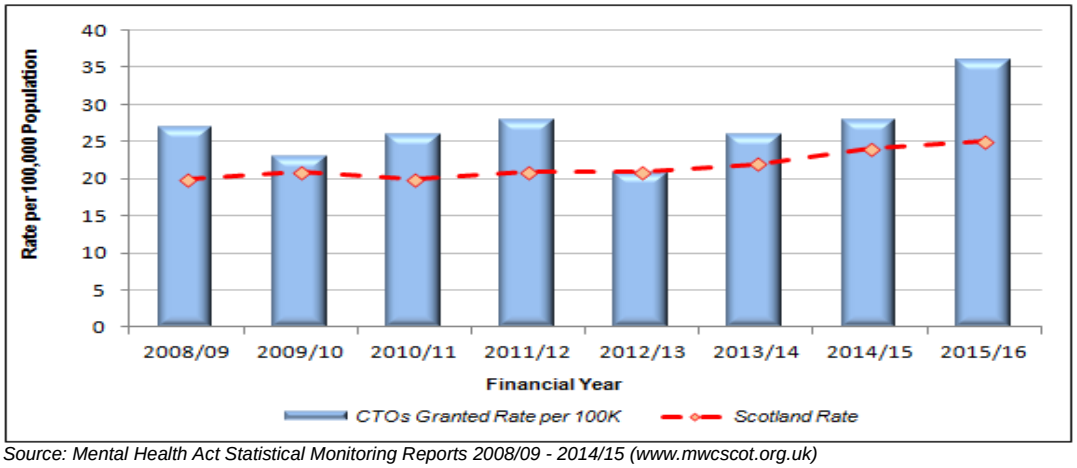
Source: Mental Health Act Statistical Monitoring Reports 2008/09 - 2014/15 (www.mwcscot.org.uk)

Consistently since 2008/09 the Tayside rates for both these types of orders has been higher than the Scottish rates. The rate of use of emergency detention orders across Tayside in 2015/16 was 44 per 100,000 population; slightly higher than the Scottish rate of 41 per 100,000 population. Both rates showing a slight increase from the previous year of 41 and 38 per 100,000 population respectively in 2014/15.

Of all Scottish health boards, Orkney [Rate=65]; Greater Glasgow & Clyde [Rate=63]; Dumfries & Galloway [Rate=56] and Fife [Rate=45] all held rates (per 100,000 population) higher than the Tayside rate in 2015/16 for emergency detention orders.

Figure 28 summarises the Tayside rate (per 100,000 population) for compulsory treatment orders. The figure shows a steady increase in rate for this type of order over the last four years across Tayside.

Figure 28. NHS Tayside Compulsory Treatment Order Rates (per 100,000 population), 2008/09 – 2015/16



Source: Mental Health Act Statistical Monitoring Reports 2008/09 - 2014/15 (www.mwcscot.org.uk)

With the exception of 2012/13, in all other years since 2008/09 Tayside has recorded a rate of compulsory treatment orders higher than that of Scotland. In 2015/16 the rate of these orders in Tayside was 36 per 100,000 population, higher than the Scottish rate of 25 per 100,000 population.

Tayside holds the highest rate for compulsory treatment orders across all Scottish health boards in 2015/16, although very similar to the rate of 35 per 100,000 population for Greater Glasgow & Clyde. This is most likely a reflection of the significant numbers of deprived inner city areas within these health boards where the number of people with major mental illness is likely to be highest.

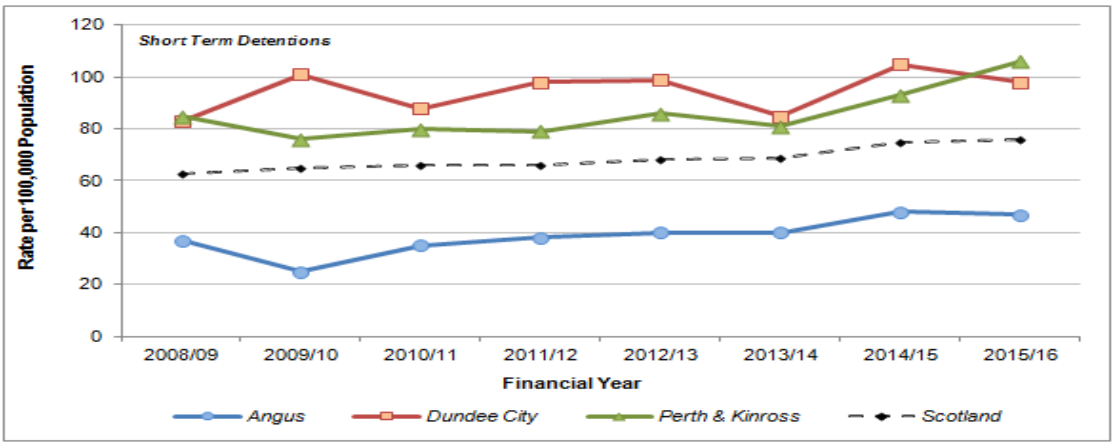
The statistical monitoring report also publishes short-term detention and compulsory treatment orders by local authority area. People with severe and enduring mental illness tend to move towards inner city areas and so this is likely to be a factor where the data shows such local authorities as having higher rates; however some of the data may be skewed by “out-of area” placements.

Figures 29 and 30 display the rate of short-term detention and compulsory treatment orders across Tayside’s three administrative areas since 2008/09. As shown in each of these figures, the rates for both types of orders in Dundee City and Perth & Kinross have been consistently higher than the Scottish average over this period of time.

Despite some annual fluctuations, all three Tayside administrative areas have shown a general increase in short term detention rates (Figure 29). In 2015/16, both Angus [rate=47] and Perth & Kinross [rate=106] recorded their highest rates (per 100,000 population) of this order type since 2008/09. Over this period of time, of the three local Tayside areas, it is Angus that has shown the largest increase in short term detention rates.

Figure 30 show that there are greater annual fluctuations across all three Tayside administrative areas in terms of compulsory treatment order rates. In 2015/16 both Angus [rate=33] and Perth & Kinross [rate=38] recorded their highest rates (per 100,000 population) of this order type since 2008/09. Once again, it is Angus that has recorded the greatest increase in compulsory treatment rates over this period.

Figure 29. NHS Tayside Short-Term Detention Rates (per 100,000 population), 2008/09 - 2015/16



Source: Mental Health Act Statistical Monitoring Reports 2008/09 - 2014/15 (www.mwcscot.org.uk)

Figure 30. NHS Tayside Compulsory Treatment Order Rates (per 100,000 population), 2008/09 – 2015/16

Source: Mental Health Act Statistical Monitoring Reports 2008/09 - 2014/15 (www.mwcscot.org.uk)

In 2015/16 Perth & Kinross's held the highest rates amongst its Tayside counterparts. When comparing with other Scottish local authorities, only Glasgow City [rate=123] and Inverclyde [rate=118] had rates higher for short term detentions. In comparison, only Glasgow City [rate=39 per 100,000 population] was higher for compulsory treatment orders in this year.

10.2

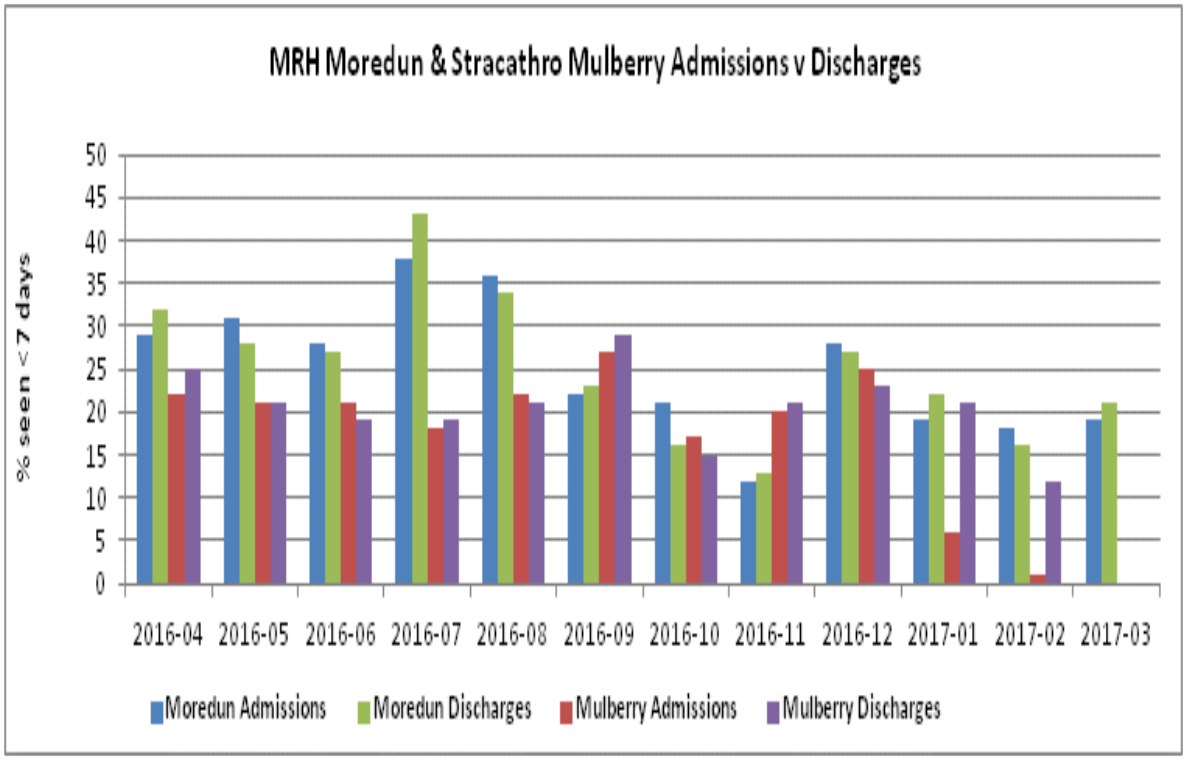
Admissions, Discharges and Occupancy by Local Council Area/Ward

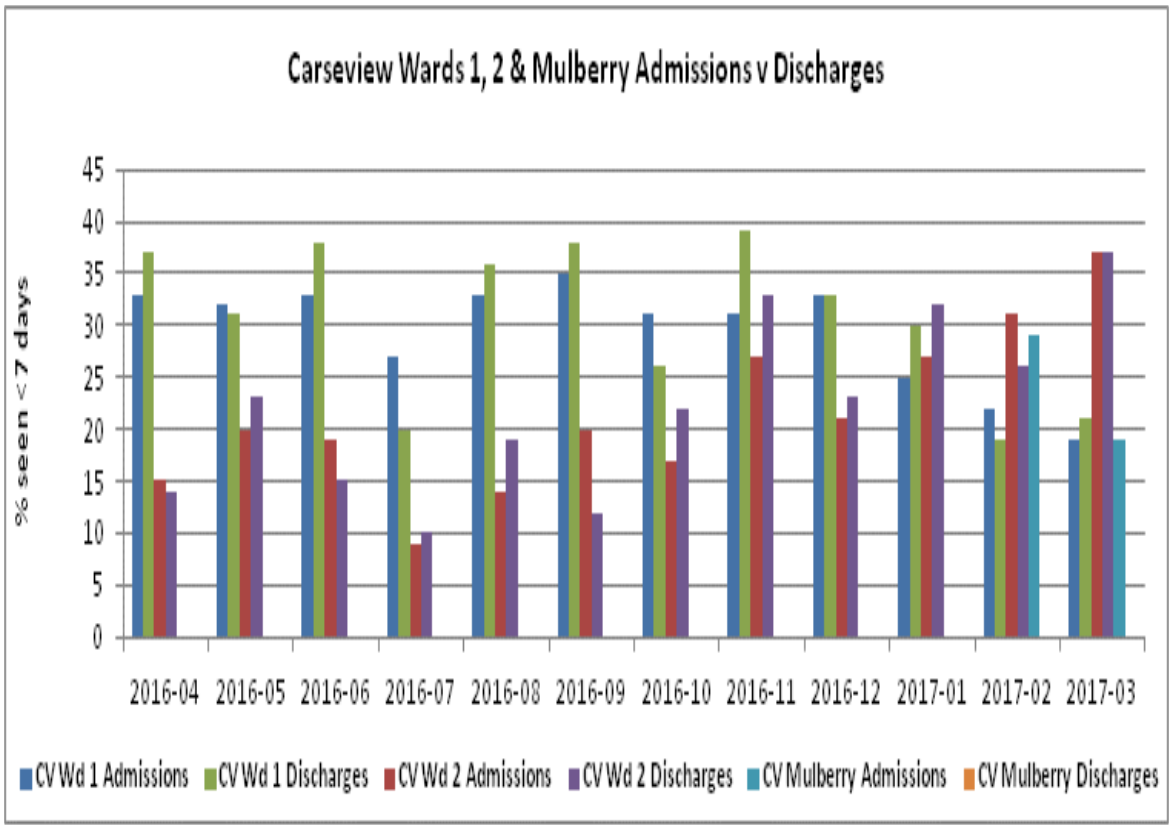
Admissions By Local Council Area

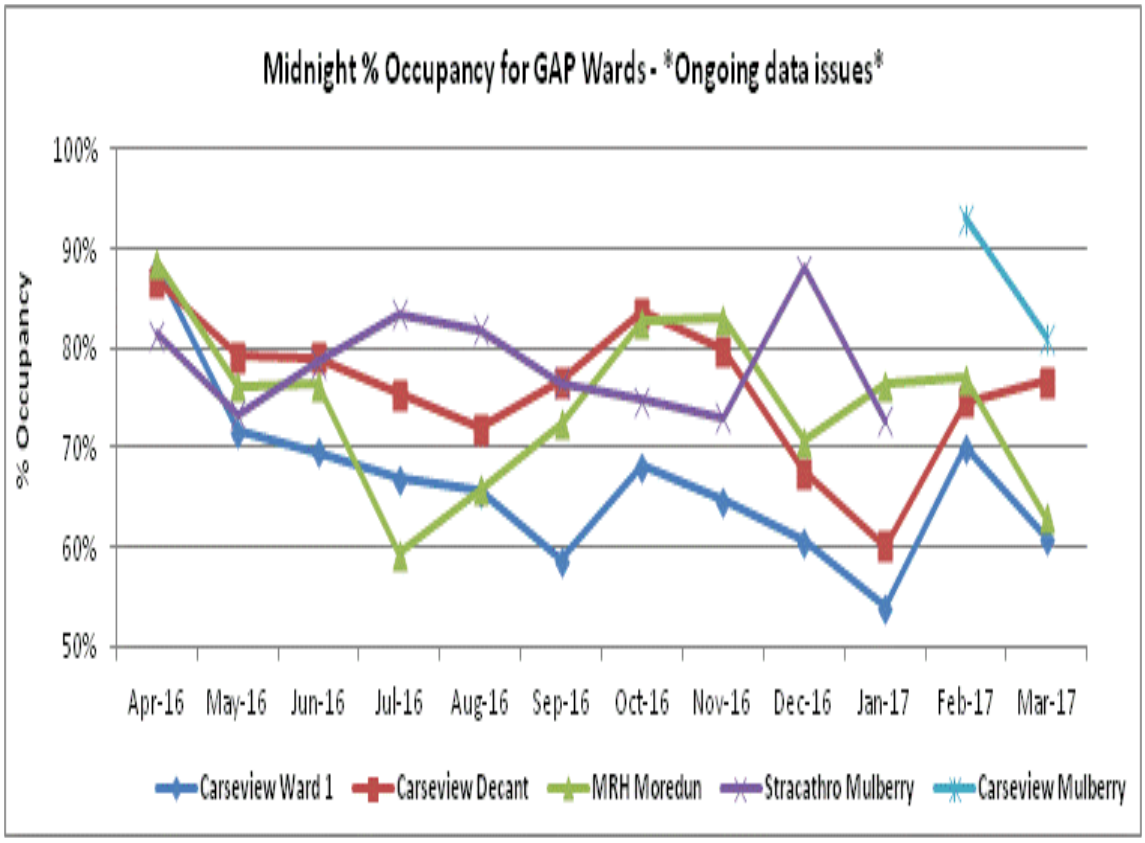
OPS 198

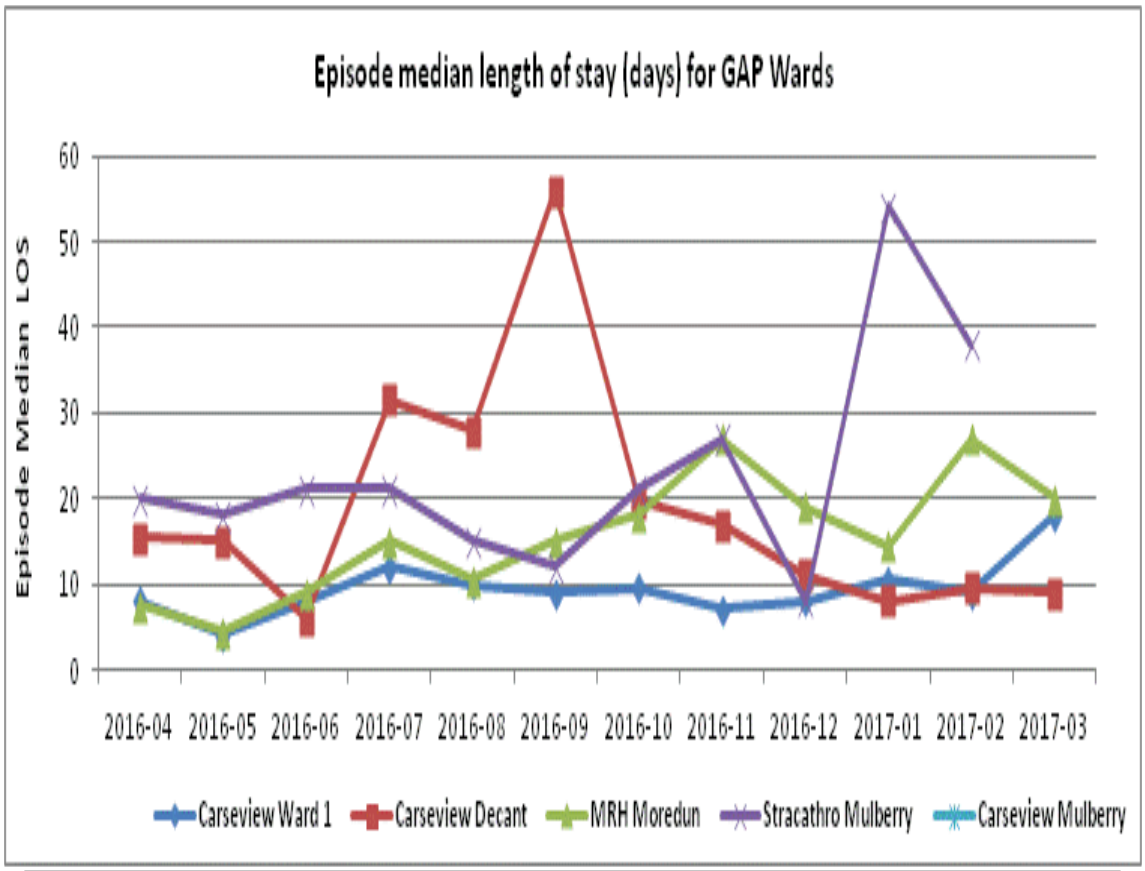
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	%
Carseview Ward 1	Angus	11	6	7	6	12	9	6	11	2	3	5	2	80	6.80
	Dundee	18	23	21	18	18	17	23	15	20	19	13	14	219	18.62
	Perth & Kinross	1	2	5		2	3	1	4	6	2	4	3	33	2.81
	Other	3	1		3	1	6	1	1	5	1			22	1.87
Carseview Decant	Angus	1	1	3	2	3			5	3	6	4	1	29	2.47
	Dundee	11	17	13	7	9	18	13	16	14	18	18	25	179	15.22
	Perth & Kinross	1	1	2			2	3	6	2	2	6	10	35	2.98
	Other	2	1	1		2		1		2	1	3	1	14	1.19
Carseview Mulberry	Angus										25	11	15	51	4.34
	Dundee										4	4	1	9	0.77
	Perth & Kinross											4		4	0.34
	Other													0	0.00
MRH Moredun	Angus		1		8	4								13	1.11
	Dundee	3	4	3	1	1	1	1		1	1		1	17	1.45
	Perth & Kinross	25	24	23	19	28	21	20	12	24	18	18	18	250	21.26
	Other	1	2	2	10	3				3				21	1.79
Stracathro Mulberry	Angus	21	17	18	18	20	23	14	17	22	5			175	14.88
	Dundee		3	1		1	2	1	1	1		1		11	0.94
	Perth & Kinross		1	1		1	1	2		2	1			9	0.77
	Other	1		1			1		2					5	0.43
														1176	100.00

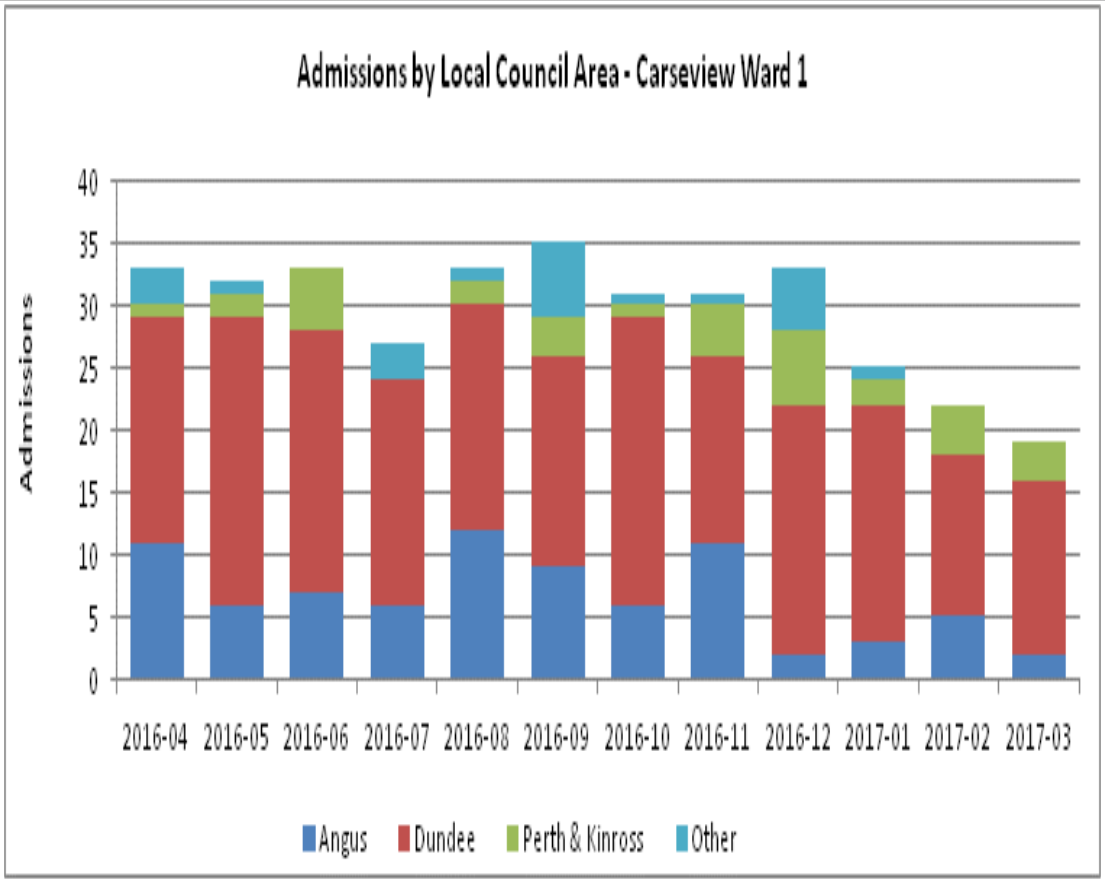
	%	Total patients
% of Angus Patients currently admitted out of Angus	14.71	173
% of Perth Patients currently admitted out of P&K	6.89	81
% of Dundee Patients currently admitted out of Dundee	2.38	28

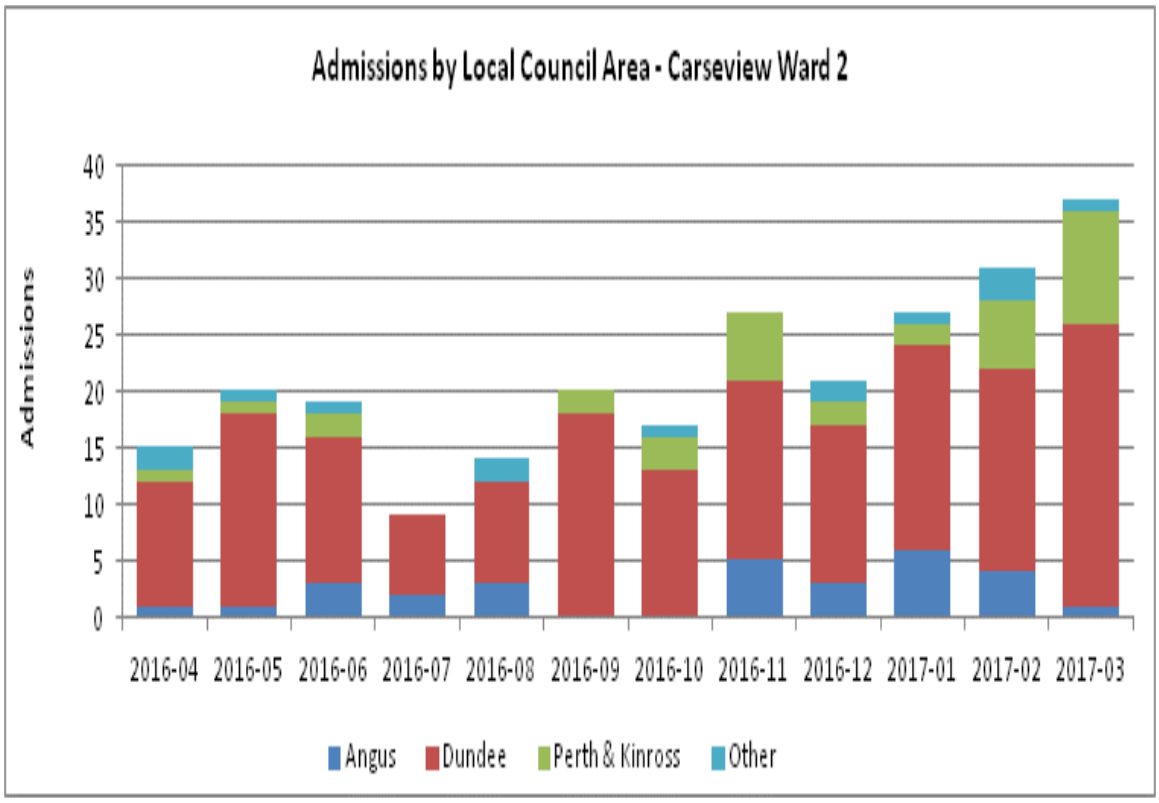

MRH Moredun & Stracathro Mulberry Admissions v Discharges
% seen < 7 days
50
45
40
35
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Moredun Admissions
Moredun Discharges
Mulberry Admissions
Mulberry Discharges

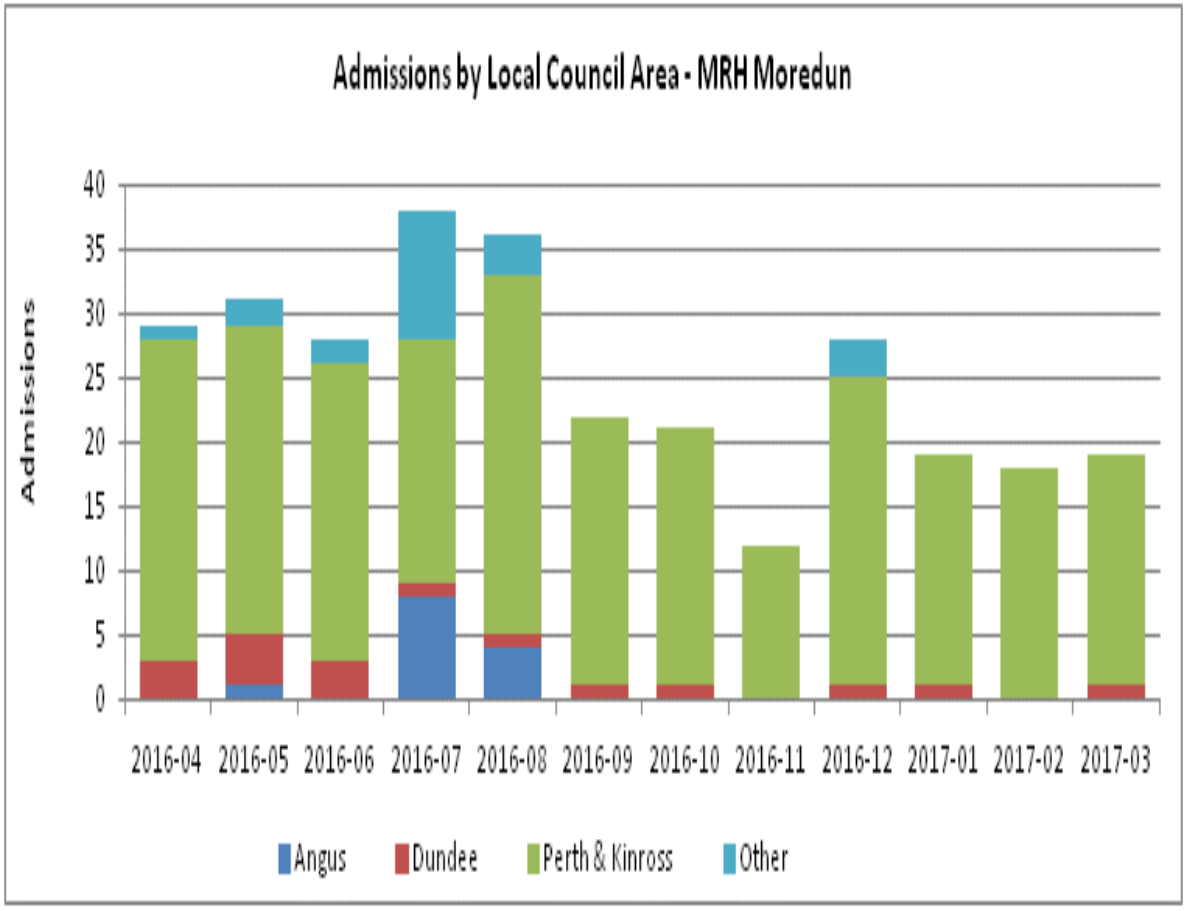

Carseview Wards 1, 2 & Mulberry Admissions v Discharges
% seen < 7 days
45
40
35
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
CV Wd 1 Admissions
CV Wd 1 Discharges
CV Wd 2 Admissions
CV Wd 2 Discharges
CV Mulberry Admissions
CV Mulberry Discharges

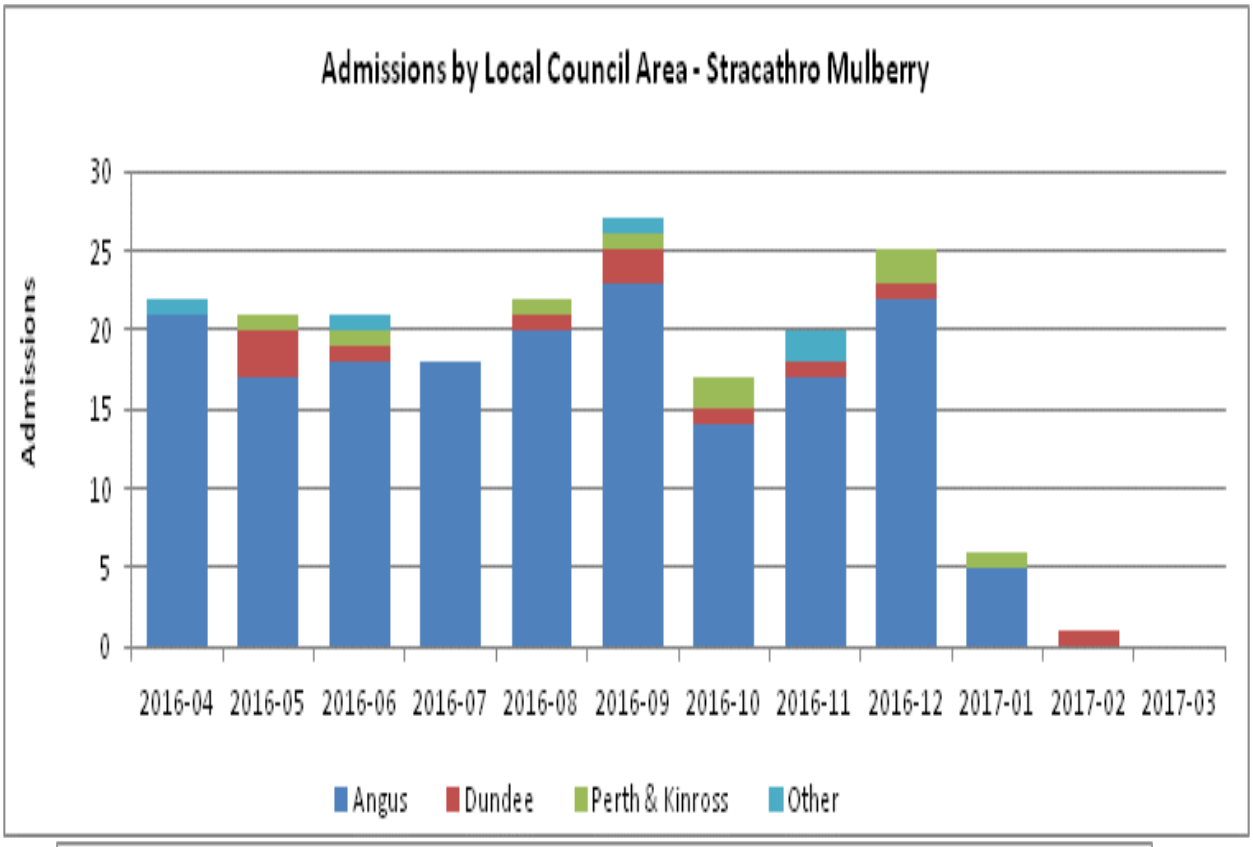

Midnight % Occupancy for GAP Wards - *Ongoing data issues*
% Occupancy
100%
90%
80%
70%
60%
50%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Carseview Ward 1
Carseview Decant
MRH Moredun
Stracathro Mulberry
Carseview Mulberry

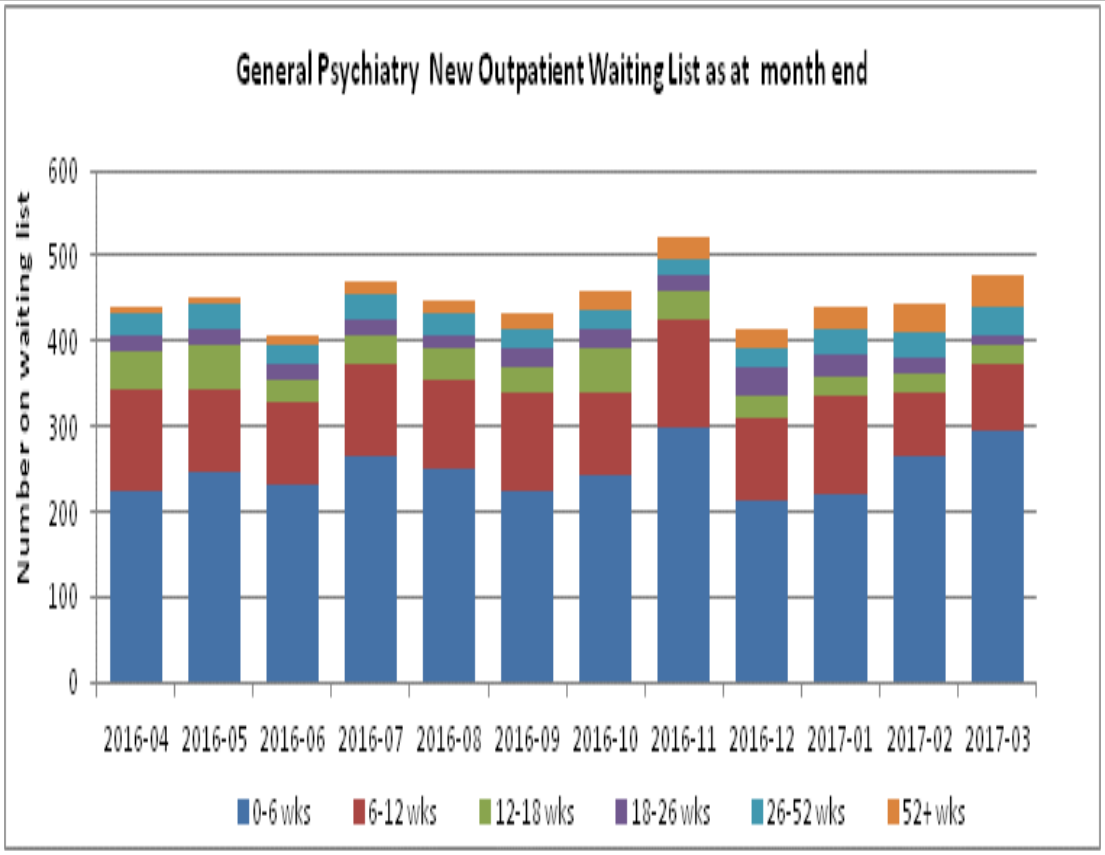

Episode median length of stay (days) for GAP Wards
Episode Median LOS
60
50
40
30
20
10
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Carseview Ward 1
Carseview Decant
MRH Moredun
Stracathro Mulberry
Carseview Mulberry


Admissions by Local Council Area - Carseview Ward 1
Admissions
40
35
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Angus
Dundee
Perth & Kinross
Other


Admissions by Local Council Area - Carseview Ward 2
Admissions
40
35
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Angus
Dundee
Perth & Kinross
Other


Admissions by Local Council Area - MRH Moredun
Admissions
40
35
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Angus
Dundee
Perth & Kinross
Other


Admissions by Local Council Area - Stracathro Mulberry
Admissions
30
25
20
15
10
5
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
Angus
Dundee
Perth & Kinross
Other


General Psychiatry New Outpatient Waiting List as at month end
Number on waiting list
600
500
400
300
200
100
0
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2016-12
2017-01
2017-02
2017-03
0-6 wks
6-12 wks
12-18 wks
18-26 wks
26-52 wks
52+ wks

10.3

Public Health Report on Supporting Information

Public Health - Executive Summary

Background

- Nearly half of all ill health in people under 65 is mental illness and mental illness accounts for 23% of the total burden of disease.
- Prevention and early intervention are the most cost-effective methods of managing mental health disorders. Economic savings and benefits can occur within short time frames and arise from co-ordination and planning with other services.

Tayside Mental Health Data

- The recorded population prevalence of mental disorder is increasing.
- Mental illness is consistently associated with deprivation
- Dundee has the highest rates of deprivation in Tayside and the highest rates of prescribing for mental health disorders (20% of the population).
- Tayside has the highest rates of psychiatric discharges in Scotland at 573 per 100,000 population (Scottish mean 400 per 100,000)
- Rates of psychiatric discharge are reducing. In Dundee discharges have almost halved between 1997/98 and 2013/14. Smaller reductions have been seen in Perth and Kinross and Angus
- Use of inpatient care is dependent on the availability of beds and provision of alternative community care.

Mental Health Service Delivery

Prevention and early intervention - are the most cost-effective methods of managing mental health disorders. Economic savings and benefits can occur within short time frames and arise from co-ordination and planning with other services. To achieve these gains the balance of spend on care must be shifted more towards primary and community care.

NICE guidance recommends a 'stepped-care model' of mental health care which ensures that people receive the least intensive intervention for their need.

Each individual has a spectrum of mental health disorder severity and a spectrum of psychosocial needs. Inpatient care is recommended for those at the most severe end of either spectrum, where community care would be unlikely to be adequate. For all other patients evidence supports better satisfaction and outcomes for community care.

Secondary Mental Health Service Reconfiguration of Inpatient Services

The Kings Fund has collated evidence on reconfiguring Mental Health services:

- Substituting inpatient mental health service provision with a community-based service delivers better outcomes for people with moderate mental health needs at comparable cost.
- Community-based models of care improve user satisfaction, engagement with services, medication adherence and clinical outcomes

- Community services are unlikely to produce ongoing savings and may be more expensive for patients with complex needs.
- There may be arguments for centralisation if this releases capital to invest in improved and safer accommodation.
- Reconfiguration of inpatient services needs whole system change and active management to ensure vertical integration of all care from inpatient provision through to 3rd sector support.
- Strong leadership is required to lead the changes and staff must be supported to develop and change roles.

Points for Consideration

How could transformational change in mental health services be achieved in Tayside?

Should NHS Tayside Mental Health Services be re-designed as a whole in order to shift the balance towards prevention and early intervention?

To what extent does the evidence support a one, two or three site model for GAP? Inpatient provision is a trade off between larger centres of excellence which offer increased effectiveness and greater long term flexibility around the use of resources; versus accessibility.

In rural areas of Tayside could tele-health be used to facilitate access to specialist advice and support?

Population – brief summary to support appendix 9.1 and 9.2

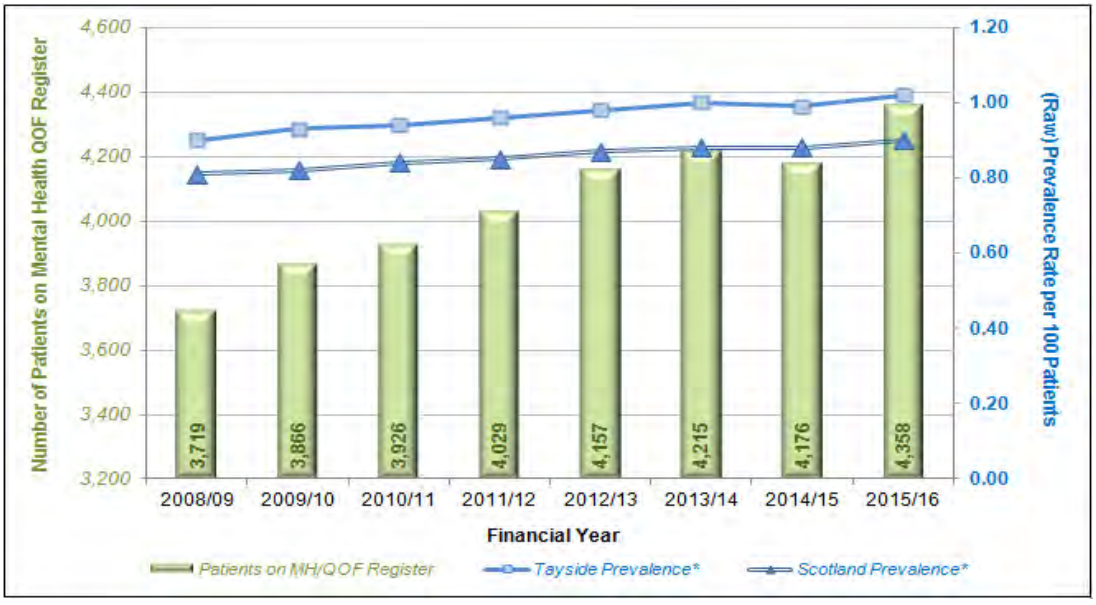
Guidance Note - Routine mental health data collection includes inpatient care and a small amount of primary care information. This limits analysis as outpatient care is the largest component of secondary mental health services. Clinical expertise is required for a full understanding and interpretation of the data.

Mental Health Burden of Disease

There is an increasing recorded prevalence of mental health conditions in Tayside which can be seen in figure 1. In England a 14% increase in the prevalence of mental health disorders is predicted in the next 10 years.[1] Mental health conditions are unusual in that they are diagnosed by symptoms, rather than diagnostic tests and there is a cultural element to their manifestation.

Among people under 65, nearly half of all ill health is mental illness and mental illness accounts for 23% of the total burden of disease. Yet, despite the existence of cost-effective treatments, it receives only 13% of NHS health expenditure. Mental illness is generally more debilitating than most chronic physical conditions yet only a quarter of those with mental disorders are in treatment compared to the vast majority with physical illness.[2]

Figure 1 Numbers and Estimated Raw Prevalence Rate of Mental Health Conditions for those Registered with Tayside GP Practices, 2008/09 – 2015/16 *Source: Quality & Outcomes Framework (QOF) Calculator Database, ISD Scotland*



Estimates of prevalence of common mental health disorders suggest that at any given time common mental health disorders can be found in around one in six people in the community, and around half of these have significant symptoms that would warrant intervention from healthcare professionals.[6] Severe and enduring mental illness is much less prevalent (see table 1) but this is the population who are predominantly treated by secondary mental health care services.

Table 1 Estimates of Prevalence of Mental Illness[9]

Severe and Enduring Mental Illness (lifetime)	
Psychotic disorder	0.7 in 100 people (in past year)
Bipolar disorder	2.0 in 100 people
Antisocial personality disorder	3.3 in 100 people
Borderline personality disorder	2.4 in 100 people
Suicide/Self Harm (lifetime)	
Suicidal thoughts	20.6 in 100 people
Suicide attempts	6.7 in 100 people
Self-harm	7.3 in 100 people
Common Mental Illness (in past year)	
Generalised anxiety disorder	5.9 in 100 people
Depression	3.3 in 100 people
Phobias	2.4 in 100 people
OCD	1.3 in 100 people
Panic disorder	0.6 in 100 people
Post traumatic stress disorder (PTSD)	4.4 in 100 people
Mixed anxiety and depression	7.8 in 100 people
Generalised anxiety disorder	5.9 in 100 people

Mental Disorder and Deprivation

Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society with the poorer and more disadvantaged disproportionately affected from common mental health problems and their adverse consequences.[3] Prescribing rates for mental health medication across Tayside are in accordance with this association where highest prescribing rates are seen in Dundee (see table 2).

Table 2 Health and Wellbeing Profiles 2016 (ScotPHO) [1]Age-sex standardised rate (ISD)2

Indicator	**Angus**	**Dundee**	**Perth and Kinross**	**National Average**
Population	116,900 (28%)	148,210 (36%)	149,930 (36%)	Total 415,040
Population income deprived[1]	10.5%	17.3%	8.6%	13.1%
Patients with a psychiatric hospitalisation (2014/15)[2]	558 per100,00	506 per100,00	524 per100,00	400 per100,00
Population prescribed medication for anxiety/depression/psychosis[1]	17%	20%	15%	17 %
Deaths from suicide (5 year average) [1]	13.3	15.1	10.7	14.5

The Scottish Public Health Observatory mental health profiles also illustrate this in their data on young people and drugs where Dundee has significantly worse figures than the other areas of Tayside and Scotland as a whole (see table 2). Similar data is not collected for adults but it would be expected that the poor mental wellbeing seen in young people in Dundee would be mirrored in the adult population and reflects socioeconomic factors related to deprivation.

Deprivation and poor socioeconomic circumstances contribute to common mental health disorders but also make their management more complicated. Where there are more complex needs, individuals with common mental health disorders are more likely to require referral to secondary mental healthcare services to help assess and manage these complexities.

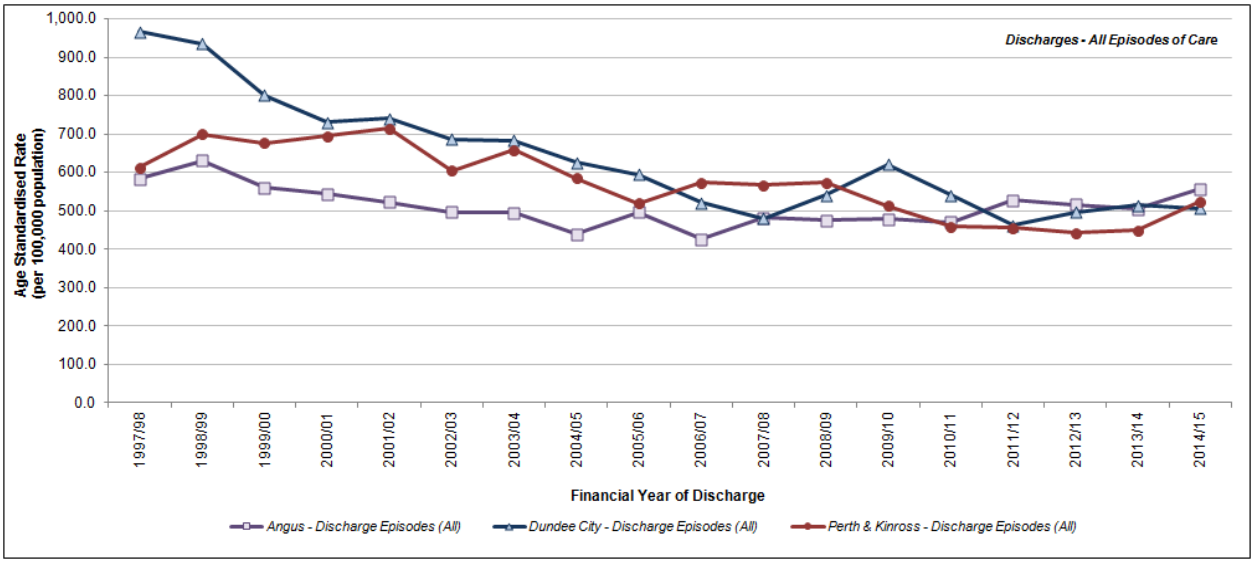
Table 3 ScotPHO Mental Health Profiles (2014) (Red is significantly worse than average lowest 5%, Blue is significantly better than average highest 5%)

Indicator	Angus	Dundee	Perth & Kinross	Scotland average
S2 boys mean mental wellbeing score	49.4	50.5	51.9	51.1
S2 boys emotional and behavioural problems percentage with a borderline/abnormal score	25.1%	27.5%	16.7	24%
S2 boys conduct problems percentage with a borderline/abnormal score	29.3%	34.8%	22.1	27.5%
S2 boys hyperactive percentage with a borderline/abnormal score	34.1%	37.6%	28.1%	29.7%
S2 girls mean mental wellbeing score	48.7	48.0	49.5	49.3
S2 girls emotional and behavioural problems percentage with a borderline/abnormal score	25.3	30.7%	23.9%	26.0%
S2 girls conduct problems percentage with a borderline/abnormal score	20.9%	23.8%	18.5%	19.2%
S2 girls hyperactive percentage with a borderline/abnormal score	28.3%	35.4%	23.8%	27.6%
S4 boys mean mental wellbeing score	50.1	50.2	51.2	50.5
S4 boys emotional and behavioural problems percentage with a borderline/abnormal score	25.5%	29.7%	21.8%	24.0%
S4 boys conduct problems percentage with a borderline/abnormal score	26.1%	34.9%	21.1%	26.3%
S4 boys hyperactive percentage with a borderline/abnormal score	31.6%	37.3%	30.6%	31.2%
S4 girls mean mental wellbeing score	45.9	46.5	48.1	46.8
S4 girls emotional and behavioural problems percentage with a borderline/abnormal score	33.7%	36.7%	26.6%	34.0%
S4 girls conduct problems percentage with a borderline/abnormal score	19.4%	21.2%	15.2%	19.8%
S4 girls hyperactive percentage with a borderline/abnormal score	37.8%	35.0%	31.3%	35.5%
Male prevalence of problem drug use	1.4%	3.4%	2.0%	2.5%
Male drug related mortality	13.4	32.1	8.4	16.7
Female prevalence of problem drug use	0.6%	2.3%	0.5%	1.0%
Female drug related mortality	5.9	13.6	1.9	6.2

Inpatient Data

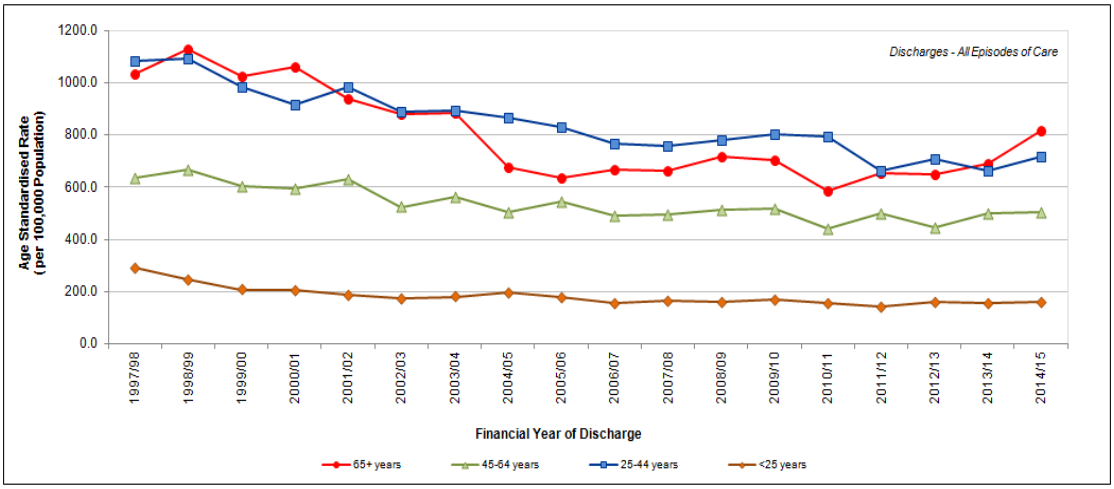
Rates of psychiatric discharge in Dundee have almost halved from 1997/98 to 2013/14. Rates of psychiatric discharge in Angus and Perth and Kinross have had smaller reductions between 1997/98 to 2013/14 (see figure 2).

Figure 2 Age Standardised Discharge Rates (All Episodes of Care) from Psychiatric Hospitals by Tayside Administrative Area, 1997/98 – 2014/1 *Source: Mental Health Inpatient Care Report 2014/15 (Section 2.1 SMR04), ISD Scotland*



Highest rates of discharge are seen in the 25-44 year old age group and the over 55 year olds (see figure 3)

Figure 3: Age Standardised Discharge Rates (All Episodes of Care) from Psychiatric Hospitals for Tayside Residents by Age Band, 1997/98 – 2014/15 *Source: Mental Health Inpatient Care Report 2014/15 (Section 2.2 SMR04), ISD Scotland*



Psychiatric Discharges compared with Scotland

Tayside has the highest rates of psychiatric discharges in Scotland (see table 4).

Table 4 Numbers and European age-sex Standardised rates (EASRs) of mental health inpatient discharges from psychiatric specialities in Scottish hospitals during 2015/16 (ISD)

NHS Board	Psychiatric Discharges (EASR per 100,000 population)
Ayrshire and Arran	365
Borders	430
Dumfries & Galloway	525
Fife	416
Forth Valley	466
Grampian	293
GG&C	441
Highland	370
Lanarkshire	328
Lothian	402
Orkney	193
Shetland	62
Tayside	**573**
Western Isles	214
SCOTTISH RESIDENTS	400

Mental Health Service provision evidence

Prevention and Early Intervention - Prevention and early intervention are the most cost-effective methods of managing mental health disorders. Economic savings and benefits can occur within short time frames and arise from co-ordination and planning with other services. For example £44 is saved per pound spent on suicide prevention through GP training and £18 is saved per pound spent on early intervention for psychosis.[1]

Service delivery model – Scottish Government policy is that as many people as possible should be treated in the community, avoiding hospital admission unless really necessary. The National Clinical Strategy for Scotland suggests that best outcomes are achieved through a smaller number of bigger volume hospital. Inpatient provision is a trade off between larger centres of excellence which offer increased effectiveness and greater long term flexibility around the use of resources; versus accessibility.

NICE guidance recommends a 'stepped-care model' which ensures that people receive the least intensive intervention for their need.[5]
The key components of 'stepped care' are

- Assessment
- Care planned treatment

- Psychological interventions – including self help, group therapies, physical activity as well as more formalised therapies such as cognitive behavioural therapy
- Pharmacological interventions
- Crisis response
- Additional support services – including education & employment support, support groups, befriending, rehabilitation
- Other services – eg specialised residential care for eating disorders

There should be an integrated programme of care, which minimises the need for transition between different services and services should be built around the pathway (not the pathway built around the services).

Primary and secondary care clinicians, managers and commissioners should collaborate to develop these local care pathways that promote access to services for people with common mental health disorders. Responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, which should include primary and secondary care clinicians, managers and commissioners.[6]

Evidence shows that improving primary mental health care support can reduce the use of secondary care services and improve quality of care. Similarly addressing the wider determinants of health can improve health outcomes and reduce service usage. Recovery oriented practice is also important, where individuals use a range of community and self-help resources, reducing pressure on secondary care.[7]

How to transform Secondary Mental Health services - Mental health services have changed dramatically over the last 20 years, moving from asylums to community care. The Kings Fund describes the lessons learned from transforming services which include:

- a system wide approach to change;
- active management to ensure vertical integration of the whole range of care from inpatient provision to social care and 3rd sector support;
- high quality, stable leadership; and
- investment in helping staff to develop and change roles.[4]

The Kings Fund also describes evidence and learning from reconfiguration of mental health services:

- Substituting inpatient mental health service provision with a community-based service delivers better outcomes for people with moderate mental health needs at comparable cost.
- Although one-off savings may be generated by rationalising inpatient provision, community services are unlikely to produce ongoing savings and may be more expensive for patients with complex needs.
- The evidence suggests that some types of community services are more cost effective than others.
- Community-based models of care improve user satisfaction, engagement with services, medication adherence and clinical outcomes.
- Randomised controlled trials have shown that crisis resolution and home treatment teams improve clinical outcomes and user satisfaction.

- Access to specialist early intervention services to detect and treat episodes of psychosis has been shown to be more clinically effective than general Community Mental Health Teams.
- Case studies suggest that Crisis Resolution and Home Treatment Teams, working alongside Community Mental Health Tams, can reduce bed use and improve quality of care.
- Access to outdoor space, single-sex environments or single rooms can prevent suicide, reduce violence, and aid recovery and discharge.
- There may be arguments for centralisation if this releases capital to invest in improved and safer accommodation.
- In rural areas, tele-health can facilitate access to specialist advice and support.[8]

References

1. Practical Mental Health Commissioning (2015)
2. London school of Economics (2012) How Mental Health loses out in the NHS
3. Royal College of Psychiatrists (2010) No health without public mental health http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf
4. Kings Fund(2014) Transformation Lessons Mental Health https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf)
5. NICE Clinical Guideline 90 Stepped care for people with common mental health disorders. https://www.nice.org.uk/guidance/cg90/resources/stepped-care-for-people-with-common-mental-health-disorders-commissioning
6. NICE Clinical Guideline 123 Common mental health disorders: identification and pathways to care https://www.nice.org.uk/guidance/cg123
7. London Health Partnership (2011) Models of care http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/2.-Models-of-care-low-res.pdf
8. The Kings Fund (2014) The Reconfiguration of clinical services what is the evidence? http://www.nhshistory.net/Reconfiguration-of-clinical-services.pdf
9. https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.WTaKs_4U-mw

Extract from “The Gender and Access to Health Services Study” Dept of Health 2008”

1. Introduction and definitions

Mental health disorders are relatively common and services for people with mental illness are delivered across a range of sectors including primary care and specialist hospital services. A major study of psychiatric morbidity in Britain reported that, in 2000, one in six people had a neurotic illness, including anxiety and depression, while one in 200 had a psychotic disorder such as schizophrenia (Singleton et al., 2001; Cooper and Bebbington, 2006). One in seven people in the same survey had considered suicide at some point in their lives (Cooper and Bebbington, 2006).

Although definitions of mental health disorders vary, such conditions can largely be grouped into what are often described as common mental disorders including anxiety and depression, and more serious conditions including psychotic illness such as schizophrenia. In addition, suicidal behaviour, including both completed suicide and suicide attempts or deliberate self-harm, falls under the remit of mental health policy.

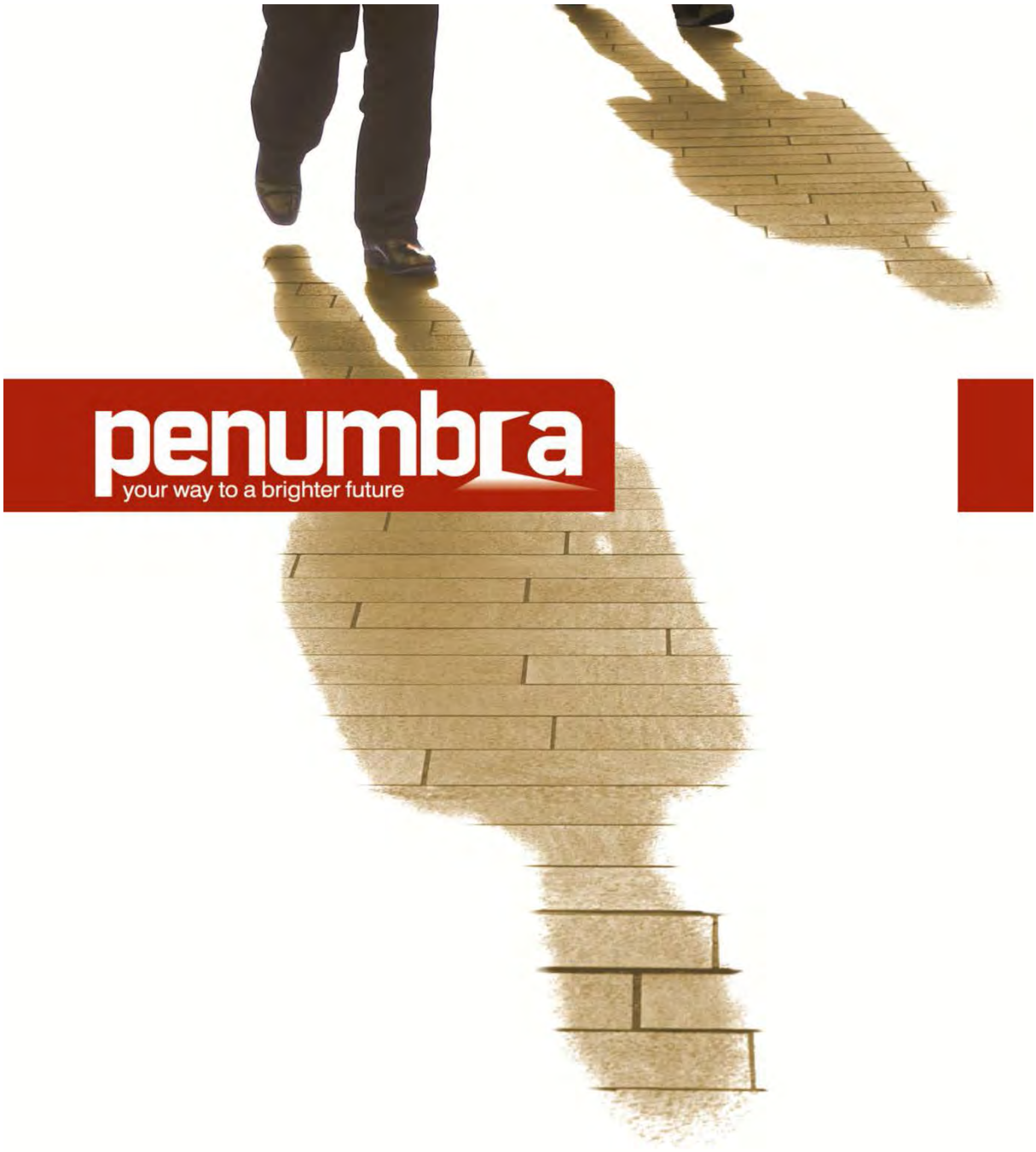
While more serious conditions and those related to substance use are often treated in specialist services, people with such conditions also draw on their primary services for support. Minor conditions are more often wholly treated in the community and by primary care, although depression and anxiety are also common diagnoses among those admitted to hospital. In-patient treatment also includes more serious conditions, including psychotic illnesses and disorders associated with substance use (Cooper and Bebbington 2006; Hospital Episode Statistics, 2005/06). However, many of those with mental health disorders, particularly those described as ‘minor’, do not receive treatment, and people appear to be less likely to consult for depression and anxiety than other mental health conditions. Thus questions about gender differences in unmet need and consulting behaviour are particularly important.

Mental health conditions have been a major focus for health policy in England and Wales for a number of years. Early *Health of the Nation* targets identified suicide mortality as an indicator of mental health and the Department of Health laid out directions for mental health policy in 1999 in the *National Service Framework for Mental Health* (NSF) (DH, 1999c), setting seven standards for mental health services. In 2002, the Department of Health launched the National Institute for Mental Health in England (NIMHE) with the goal of improving quality of life for people experiencing mental health difficulties, working with NHS organisations and others involved in care and services in local areas. Mental health policy has seen a number of initiatives in recent years including the *National Suicide Prevention Strategy* in 2002 (DH, 2002b), *Delivering Race Equality in Mental Health Care* in 2005 (DH, 2005d) and the development of specialised community mental health services including assertive outreach, crisis resolution and early intervention services. The legislation governing mental health is also changing following the 2007 Mental Health Act.

10.5

Crisis House Information

Edinburgh-Crisis-Cen
tre-Annual-Report-2C

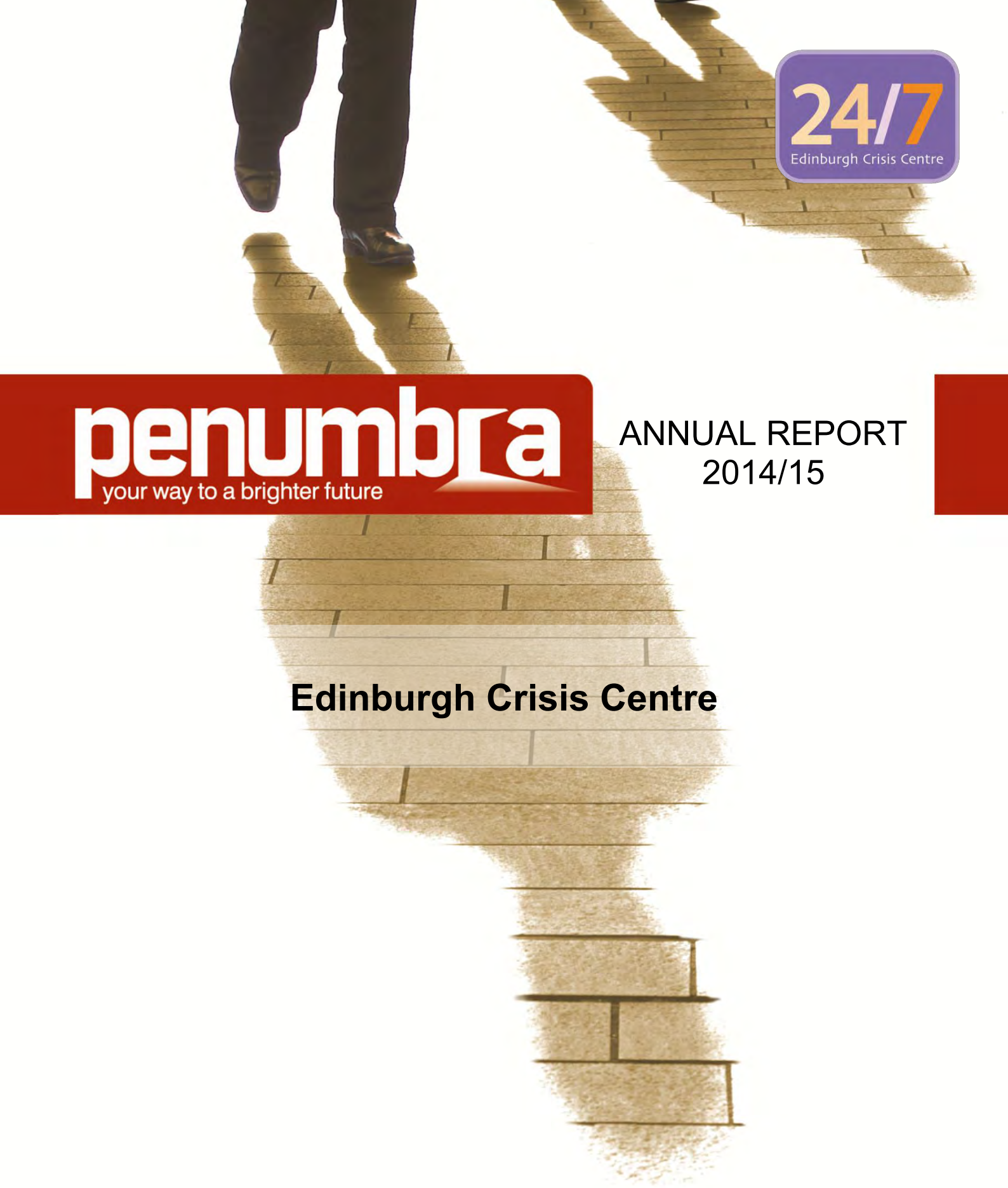


Scottish Recovery Network

See Me
End mental health discrimination

MINDFUL EMPLOYER

Penumbra.org.uk



24/7 Edinburgh Crisis Centre

penumbra
your way to a brighter future

ANNUAL REPORT
2014/15

Edinburgh Crisis Centre

CONTENTS

Penumbra Overview

Penumbra is one of Scotland's largest mental health charities, supporting around 1000 people each week across most of Scotland's Local Authority areas.

We work to PROMOTE mental health and wellbeing for all, PREVENT mental ill health for people who are 'at risk' and to SUPPORT people with mental health problems.

We are recognised for providing high-quality, personalised and recovery focused services to adults and young people who are suffering with mental ill-health. In 2014 Penumbra won the Care Accolade for investing in workforce development for our outcomes focused approach.

Penumbra is also one of the UK's most innovative mental health charities, recently developing an internationally recognised tool to measure personal outcomes and mental health recovery – I.ROC.

Penumbra was founded in 1985 and provided the first registered mental health supported accommodation service in Scotland. Its services now include:

- **Supported Living** – Offering recovery focused practical and emotional support to meet people's needs in their own home
- **Nova Projects** – Wellbeing projects that promote recovery, social inclusion and self-management
- **Supported Housing** – A variety of supported accommodation and tenancy projects
- **Homelessness Service** – Practical and emotional support for people who are homeless or at risk of homelessness
- **Plan2Change** – Peer support services
- **Short Breaks** – Supportive breaks for people to focus on their recovery
- **Self-Harm Projects** – Community based projects for both adults and young people who self-harm and are risk of suicide
- **ARBD** – Recovery Focused support for people with Alcohol Related Brain Damage
- **Employment Support** – For people who are working towards/need support in employment
- **Young Peoples' Projects** – Services that focus on support for young people
- **POWWOWS** – Penumbra workshops on wellbeing

Penumbra Updates

In February 2015 Penumbra celebrated its 30th birthday. Since its inception Penumbra has been recognised for its innovation and for the quality of the services it provides. This year has proved no different with Penumbra staff, people who use our services and other supporters coming together to promote recovery, prevent ill health and support people who are experiencing a mental health problem.

During 2014 Penumbra took part in 10 tenders and was successful in all 10. We were awarded contracts to run Aberdeen Homelessness Service, Aberdeen Nova, Aberdeen Mental Health Service, the ARBD step down service Edinburgh (developed in partnership with NHS Lothian), Borders Mental Health Support Service, West Lothian Mental Health Housing Support, Dundee Carers and self-directed support services in Perth and Kinross. In addition we successfully tendered to retain a position on the Falkirk Framework and Angus Care at Home and Housing Support Framework.

Some highlights of the 2014/2015 include:

New Services

Penumbra Milestone is an innovative new service for people in Edinburgh who have ARBD. The service is provided in partnership with NHS Lothian and the staff team includes nurses, occupational therapy, CPNs, social work and psychologists working alongside Penumbra staff.

The Dundee Carers is a new Project providing information and support specifically to people who care for someone with a mental health problem. The service will provide telephone, 1:1 and group support.

Perth and Kinross: From February 2015 we will be providing a Self – Directed Support development project in Perth and Kinross. The service aims to raise awareness of SDS and assist those who wish to access SDS to do so.

Awards

In 2014 Penumbra won the Care Accolade for investing in the workforce for our outcomes approach. We were runners up in The Personalisation Care Accolade for our NOVA short breaks service.

Our Edinburgh Self Harm service has also been shortlisted In the Mental Welfare Commission 'principles into practice' awards, which will be announced in March 2015.

I.ROC

In 2014 I.ROC went global. Penumbra is currently working with colleagues in Andalucia in Spain to translate I.ROC into Spanish. In the Netherlands we are working with a group of service providers and researchers who translate I.ROC into Dutch and conduct trials in early 2015. Penumbra has also had significant interest in our recovery outcomes counter from mental health services in the USA, Canada, South Africa, Australia, and New Zealand.

We are also currently working with MTC media to develop an I.ROC website and app that will make I.ROC accessible to all.

Tackling Stigma

In an exciting new project Penumbra will work with First Bus in Falkirk to address issues that people have faced on buses in and around the town. The project brings together drivers and people with firs-hand experience of mental health problems to work through the difficulties faced when using public transport.

Care Inspectorate

In 2014 Penumbra continued to receive positive feedback from the Care Inspectorate. Many of our services were awarded grade 6 "excellent" in some or all of the quality themes.

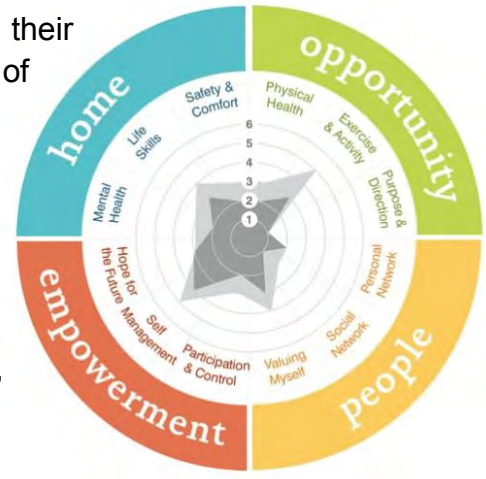
Penumbra Outcomes

Penumbra developed I.ROC as a means of measuring the recovery journey of people who use our services. I.ROC is based on Penumbra's HOPE Framework (Home, Opportunity, People and Empowerment).

Within I.ROC there are 12 indicators of well-being - 3 for each of the 4 areas of HOPE. We aim to improve the well-being of people that use our services by having a positive impact in each of the indicator areas.

I.ROC has 12 questions which correspond to the 12 indicators of wellbeing. Each question is answered by giving a number 1-6. I.ROC is completed by the supported person every 3 months and their scores are recorded.

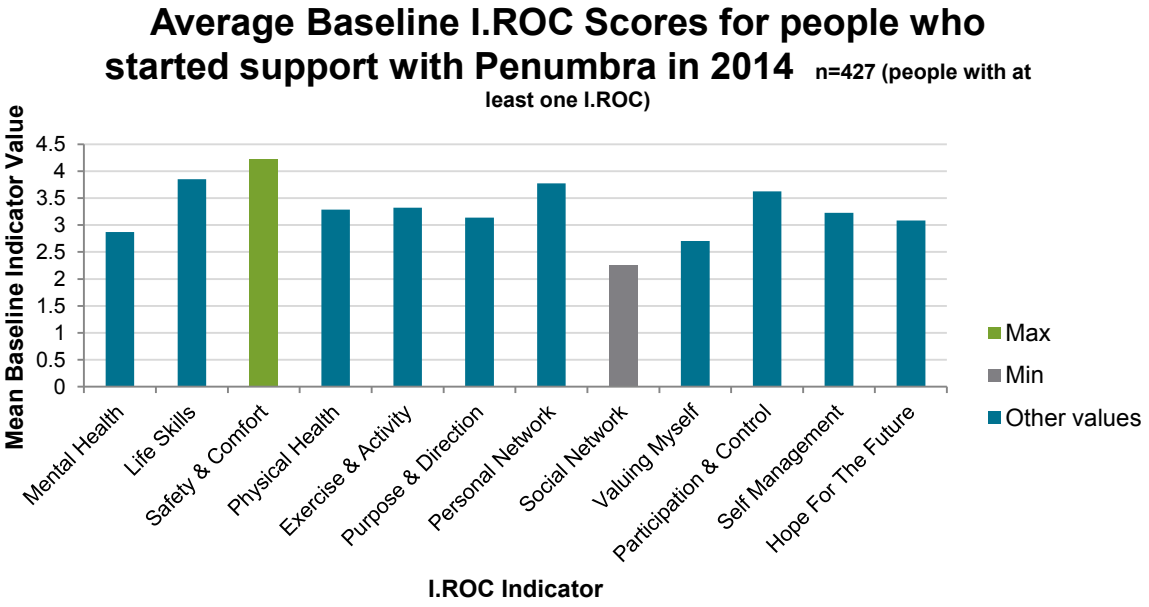
I.ROC offers people who use services and providers an opportunity to identify priorities for inputs, map their recovery journeys and measure the impact of Penumbra services.

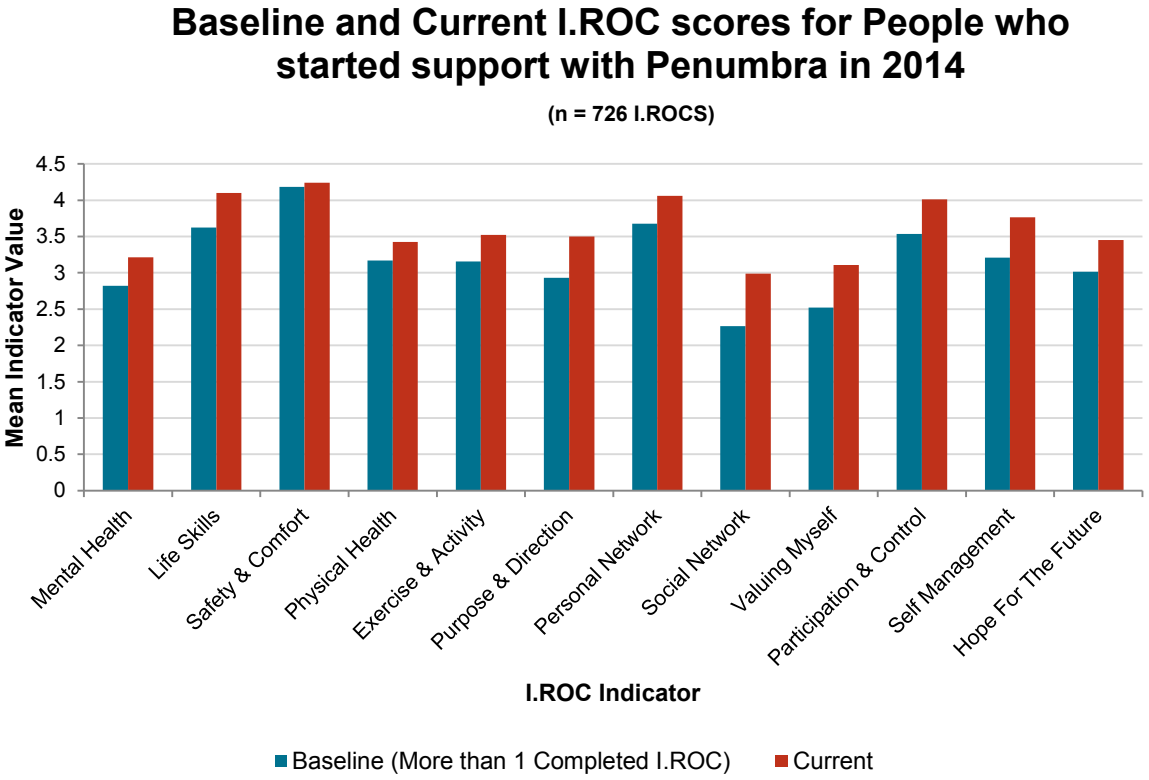


Each I.ROC question has a combination of verbal and visual prompts. Comprehensive guidance on how to facilitate the I.ROC self-assessment questionnaire is available. As is the HOPE Toolkit which contains a range of tools, tips, techniques and resources related to wellbeing.

I•ROC

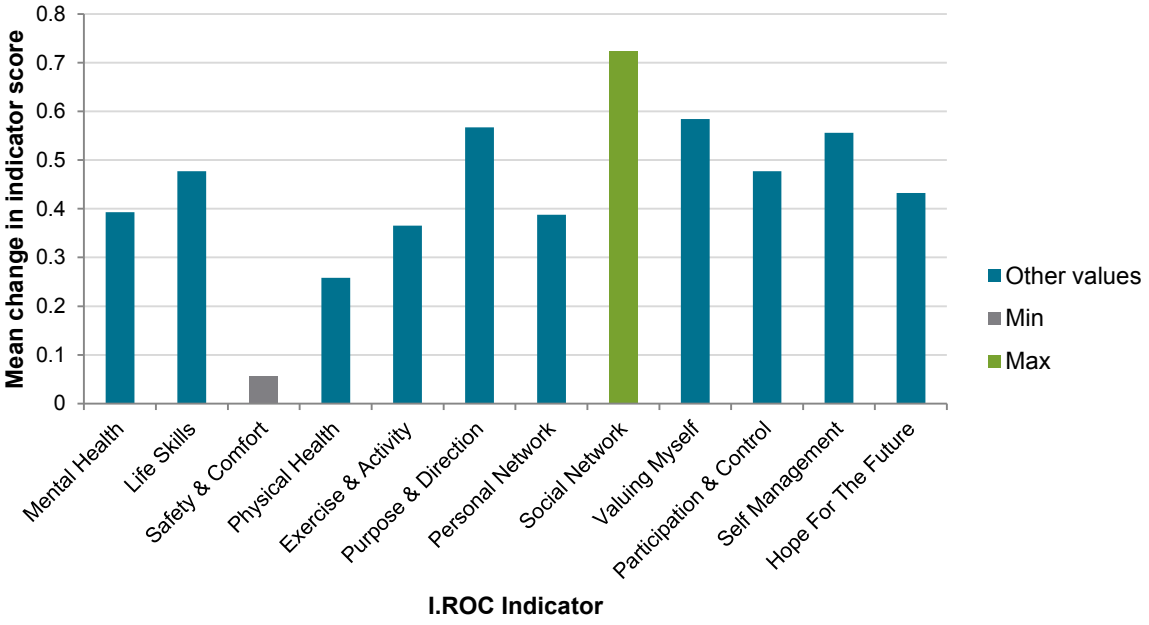
The graphs below represent an analysis of data gathered by Penumbra in December 2014. I.ROC analysis is based on first and latest I.ROC scores per person and is presented for Penumbra as a whole.





Penumbra's overall impact for people who started receiving support in 2014).

Difference Between Baseline (>1 Completed I.ROC) & Current I.ROC Scores for people who started support with Penumbra in 2014 (n=726 I.ROCS)



Edinburgh Crisis Centre Overview

The Crisis Centre is open to any Edinburgh resident who is 16+ and experiencing a mental health crisis or a carer for someone who is. There is no other criteria attached, with support provided either directly through the Project/Crisis Centre Workers on a face-to-face basis, or via a telephone helpline (the helpline is free and confidential). We are members of the Helplines Partnership and Language Line, who provide a translation service for people whose first language is not English.

As recommended by Centre users and carers, the service is community based and is accessible 24 hours a day, 365 days a year. It is important access to the service is as open and as easy as possible. Leaflets about the service are available across Edinburgh, in GP surgeries, student/halls, CMHTs, counselling services and police stations. The Mental Health Assessment Service and Emergency Duty Social Work Team also signpost people to the Centre.

People initially contact the service by email, text or telephone. Crisis Centre staff work with callers to support them through their distress. Where safety is an issue for people in distress, suicidal thoughts and feelings are openly discussed and staff support people to make safe plans.

Depending on the outcome of the discussion and review, a person may be offered the opportunity to visit the Centre for a 1-1 session. Appointments for 1-1 meetings are made as quickly as possible – sometimes immediately and usually within the same day. As with telecommunications support, Crisis Centre staff work with visitors to support them through their distress and if appropriate make safe plans.

In addition to the above and depending on the outcome of the discussion and review at the 1-1, a person may also be offered the opportunity to have an extended or overnight stay. Up to four service users can stay at the centre after their 1-1 session with staff.
Length of stay at the centre is discussed with individuals on an on-going basis during their support, however the agreed maximum stay is up to 7 days. The average stay for most centre users is 2-3 days. This period of time has been shown to be effective in allowing centre users to address their immediate anxieties and plan for on-going support post their stay at the ECC, which can include if required follow up 1-1 and telephone support.

Partnership Group

The Crisis Centre is governed by a partnership group of voluntary and statutory employees and Centre users. This mechanism was chosen to enshrine the longstanding commitment to the involvement of Centre users and carers in the development and management of the Centre.

Centre users and carers have been involved in campaigning for planning permission for the centre building, and continue to be involved in the recruiting and training of staff and developing operational policies.

The Partnership Group meets bi-monthly at the centre and discusses and agrees decisions relating to service usage, development, promotion and support procedures.

The Crisis Centre Partnership Group consists of representatives from Edinburgh City Council, NHS Lothian, Police Scotland, Edinburgh Carers Council, Penumbra, centre user representatives (supported by Advocard).

It remains committed to the principles that the service is:

- Based on Partnership working
- Designed to meet the needs of centre users as agreed with centre users
- Involves centre users through the PG in planning, governing and evaluation of the service

Comments from the Chair of the Partnership Group

It has been another challenging and eventful year for the Crisis Centre. The statistics and service user feedback in this report show that there has been no let-up in the support provided to the people of Edinburgh. All of this taking place in the background of change both in the centre and the world outside.

In the partnership group itself we have increased the representation of service users and welcomed Becky Leach a new representative from the independent advocacy service Advocard. In other changes the partnership group are considering how to increase the opportunities for peer support and using volunteers within the unique service the centre provides.

In March we said goodbye to long time deputy manager Steve Atkinson. The partnership greatly valued his contribution to the service, not least for the extended period where he acted as service Manager. I found his quiet assurance and unflappability made him a terrific ambassador for the Centre on the many times when we shared a platform to promote it. The partnership group wish him all the best in his future career.

In the outside world the imminent integration of Health and Social Care services and the development of services within the city on a four locality basis is causing the partnership group to look at how the service should develop against this background. In consequence the Centre is hosting an away day with representatives from all the partners including service users, carers as well as NHS, Council and Police Scotland.

The aim of the day is to help the Partnership find the future path for the service that will allow it to adapt to this changing environment and still provide a sensitive and flexible service to people who define themselves as in crisis and to support them through the crisis in the way that best suits them.

The coming year will present us with more challenges, especially in continuing to provide the same unique service in harsher economic environment for all services. To meet these challenges I look forward to the continuing support, hard work and innovative ideas and suggestions from all the members of the partnership group.

John Armstrong
Senior Practitioner: Mental Health
City of Edinburgh Council
September 8th 2015.

People Who Use Our Service

Table 1: Overnight Stays Apr 14-Mar15

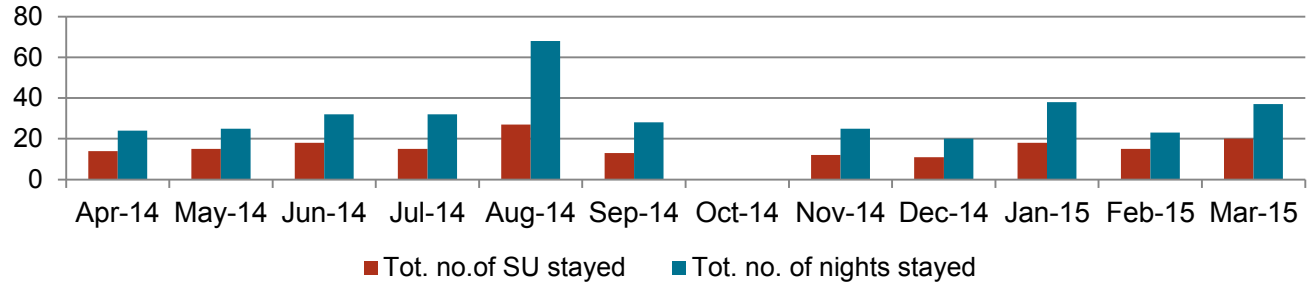


Table 2: 1-1 Appointments Apr 14-Mar15

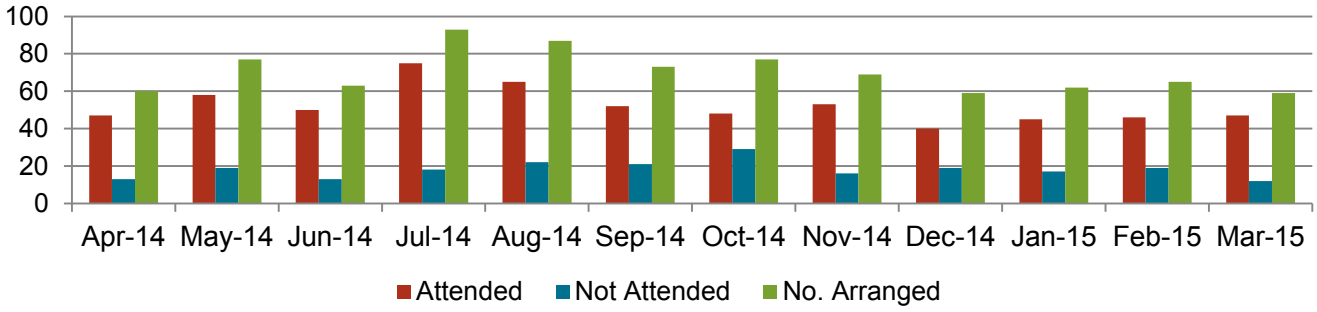


Table 1 includes both new and repeat contacts. The total number of contacts is 1807, which includes 1023 new contacts. Table 2 shows 626 people attended 1-1 sessions, whilst the total number 1-1 sessions arranged was 844. The number of 1-1 sessions not attended was 218.

Table 3: Overnight Stays Apr 14-Mar15

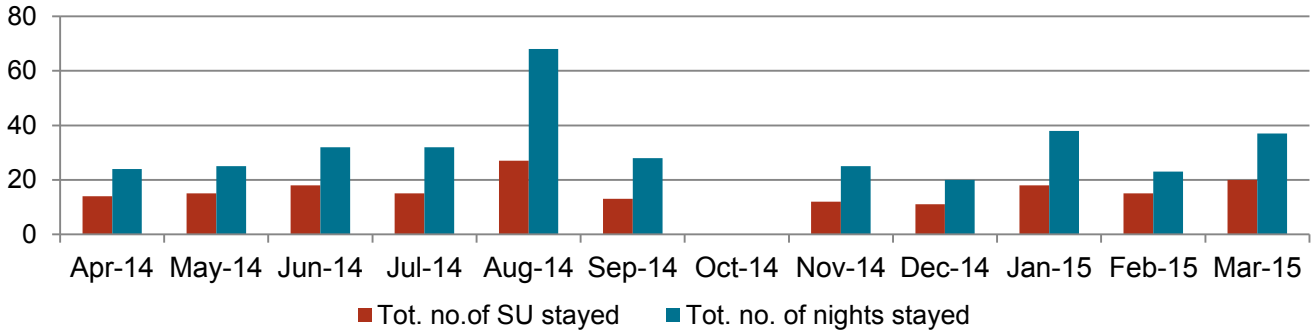
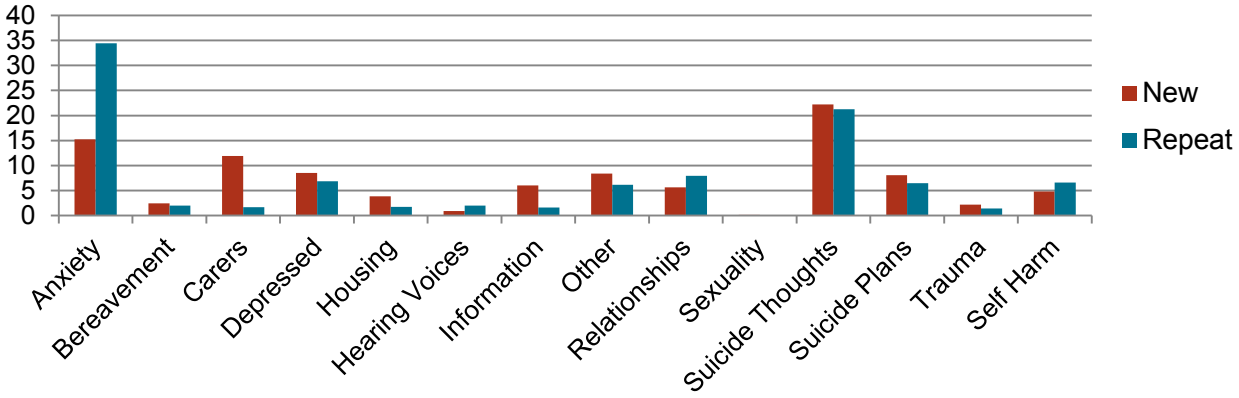


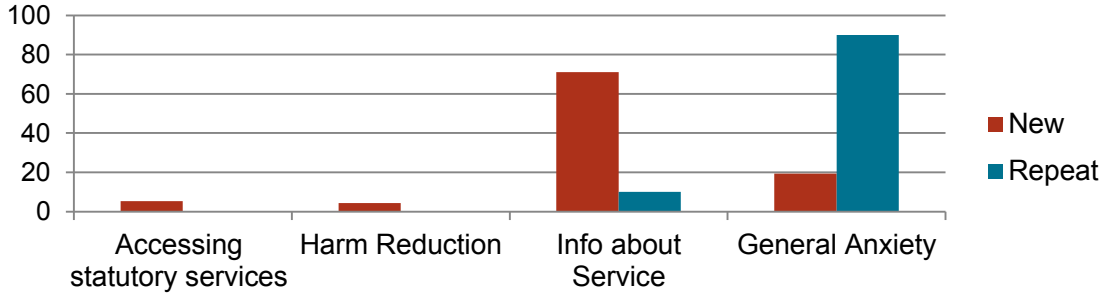
Table 3, the total number of individual centre users staying overnight is 178 and the total number of combined nights stayed at the centre is 352 . There were no overnight stays in October 14 as during this period of the service was temporarily relocated.

Table 4: % Reasons for Contact Apr 14-Mar 15



At first contact staff ask people what has prompted them to contact the service. Table 4 records the reasons people gave over the twelve month period April 2014 – March 2015. The 'other' column includes instances where no reason for contact was provided by the service user or the contact was incomplete.

Table 5: % Carers Reasons for Contact Apr14-Mar15



At first contact staff ask Carers what has prompted them to contact the service. Table 5 records the reasons people gave over the twelve month period April 2014 – March 2015.

Table 6: Underlying Reasons for Suicidal Thoughts

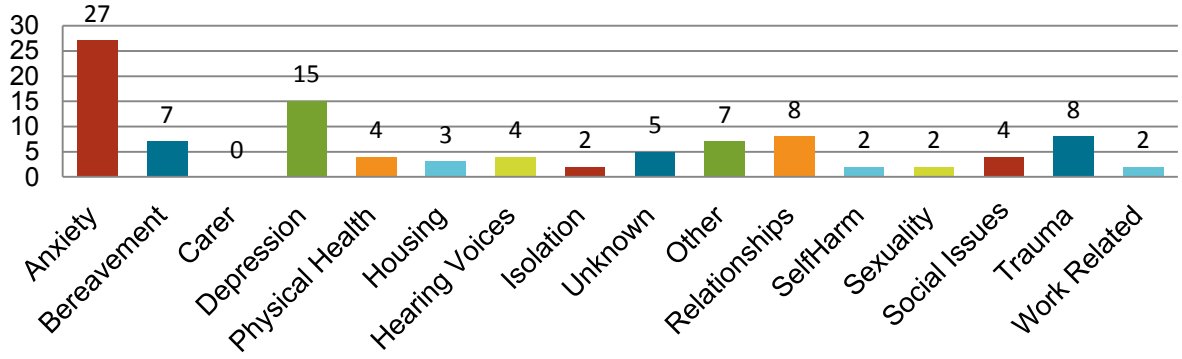
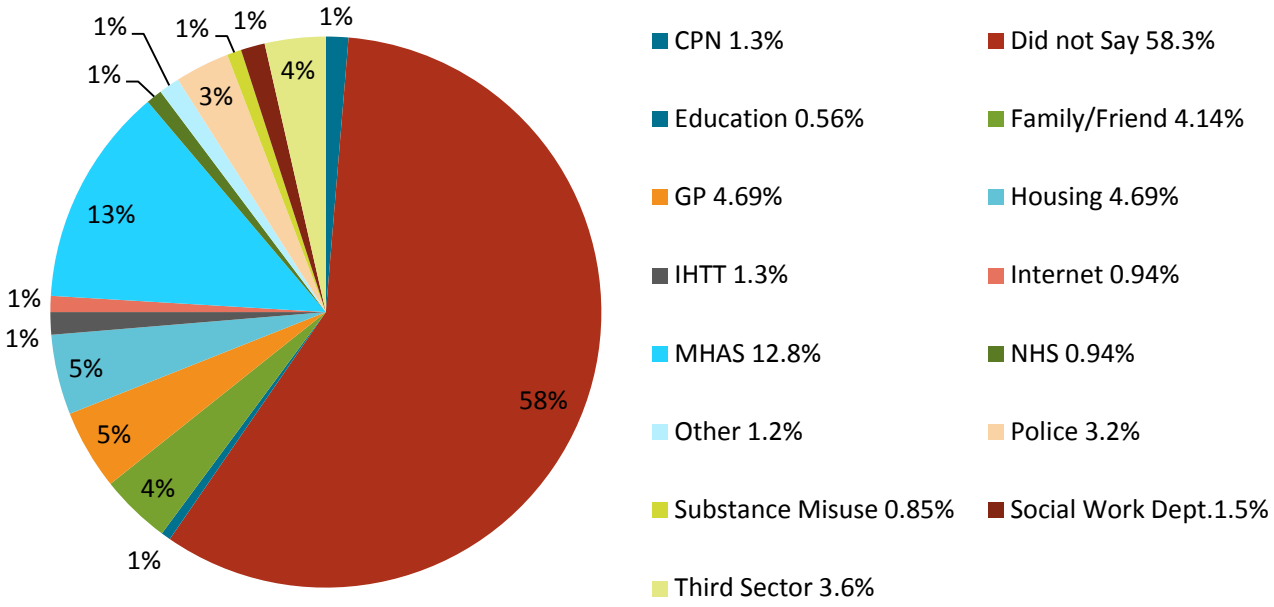


Table 6 records the underlying reasons for suicidal thoughts provided by service contacts over the twelve month period April 2014 – March 2015. The 'Other' column includes 'experiencing difficulties with professional support', 'sexual health' and 'eating disorder'. 'Unknown' specifically no reason given.

Table 7: Services who signposted to ECC



As a self referral service Table 7 is formed by information provided directly from contacts during support conversations over the phone or visiting the Centre.Therefore it does not necessarily provide information on services signposting for all contacts with the centre.

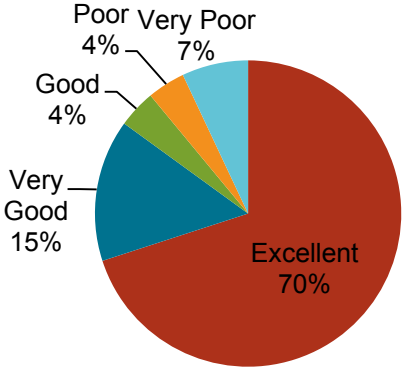
Service Outcomes

Feedback on the quality and effectiveness of the service is provided through anonymous questionnaires. These questionnaires are available directly from the staff for service users who visit the centre and through the ECC website.

There are eight questions on the questionnaire which ask about different aspects of the service, for example telecommunications, 1-1 support or overnight stays.

Each question asks people to score the service between 1 (excellent) and 5 (very poor).

How well did the service help you in managing the crisis?



Additional comments

"proved invaluable in assisting me to stay safe and be supported"

"It went beyond its duty of care"

"Staff are all very supportive".

How useful did you find your one to one meetings with staff?

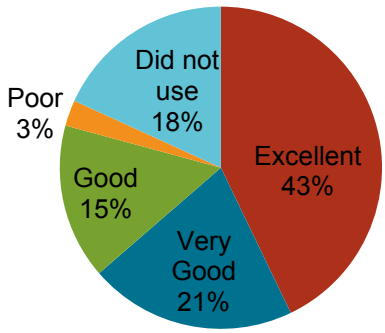
Additional comments

"I really liked how I was heard and not just listened to"

"very understanding and polite"

"they helped me to refocus on the positive things in my life"

If used, how useful did you find the Centre's resources?



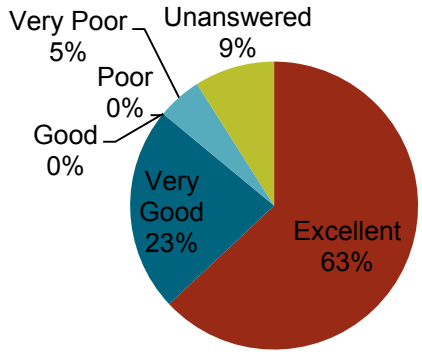
Additional comments

"fast computer in a comfy chair, bright room, it was raining and I was given a nice towel to use"

"helpful reading material, useful websites to access further support"

"decent resources, nice garden"

If you stayed overnight how do you rate the Centre's facilities?



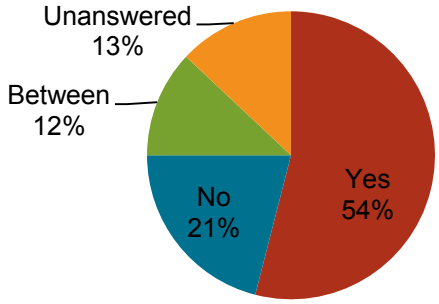
Additional comments

"calm and very peaceful and reassuring"

"room was very comfortable and most importantly felt very safe"

"best sleep in weeks"

Do you feel better prepared to deal with the issues that led to the crisis?

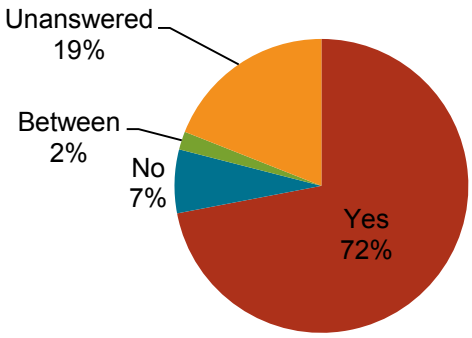


Additional comments

"I know that the centre is available, that helps a lot"

"able to look at situation differently- more positive reinforcement"

Do you think your contact with the Crisis Centre has helped improve your mental health and wellbeing?



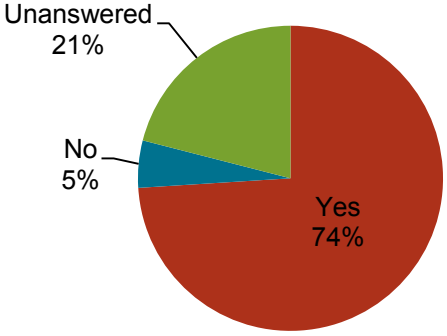
Additional comments

"knowing I have access and support increases my confidence and be able to handle things"

"It kept me alive"

"It got me through crisis without hospital"

Based upon your experience do you think using the Crisis Centre has provided an alternative to a hospital admission?



Additional comments

"I believe I hit rock bottom and needed help. If the centre wasn't there I'm sure I would have been in hospital"

"I probably would have had to return to my parents"

"You kept me alive"

Service Highlights

The last twelve months for the Edinburgh Crisis Centre has seen several developments some temporary and some more permanent.

Volunteer Initiative

Of these developments one of the most prominent is the Volunteer Initiative which has been evolving in earnest since October 2014.There are more details about the initiative later in the review but this is clearly a very new and exciting opportunity for the centre.

Building Upgrades

In October due to necessary building maintenance work the service was temporarily relocated to St Colme Street in central Edinburgh. This was for a period of around four weeks and during this time we continued to provide 24 hour telecommunications and 1-1 support, but were unable to provide overnight accommodation. With the building work completed and safety ensured we have been back in Leith since December and offering the full support service since then.

Opens Days and events

Throughout the year the service holds Open Days to enable people who want to find out more about the centre, to attend in person, receive information and ask any questions they may have. Previously Open Days were held bi-monthly, but following feedback which pointed out that this reduced some people's opportunities to visit, the Open Days are now held monthly. Please see our website for further information.

Throughout the year we have also continued to actively promote the centre and have either hosted or attended events with:

Organisation	Event
Scottish Recovery Network	Morningside Library (Suicide prevention Week)
Community Adolescent Mental Health Service	Leith Library (Suicide prevention Week)
Community Help and Advice Initiative	Cockburn Street Housing Office (Suicide prevention Week)
Support In Mind	Edinburgh Film House (Suicide prevention Week)
	Edinburgh Film House (Mental Health Arts Festival)

We continue to receive regular requests for leaflets and are currently having another print run completed due to such demand.

We also hosted visits to the centre from representatives of health and social care services in Romania and the Czech Republic.

Staff Update

The service complement is 5.5 Project Workers and 5.5 Crisis Centre Workers who work in a combined team on a 24 hour shift rota. Project Workers take the lead role on shift and have a variety of skills backgrounds, including health and social care.

Crisis Centre Workers also have varied skills backgrounds and both roles have a focus on mental health experience. In addition there are a Service Manager and Assistant Manager, who provide support to the frontline staff and 1 full- time administrator.

The Edinburgh Crisis Centre continues to provide 24 hour quality support for people feeling distressed. With support from the Centre Partnership Group members we intend to maintain (and improve wherever possible) this level of support. Already during the year the staff team have been continuing to advance practice as support providers. There has been a particular focus on telecommunication skills such as text support and the further development of Crisis and Safe planning skills and approach.

Recently Steve Atkinson, who had been in post as the centre's Assistant Manager since its opening in 2006, moved on to a new post outside of Penumbra and we all wish him well in his new ventures. Steve was replaced by an equally long serving member of staff, Nick Bell. Over the year we have recruited two Project Workers and 3 Crisis Centre Workers who are now all settled into their new posts.

Staff Overview

Barrie Hunter, Service Manager

Barrie has been in post since March 2013. Barrie has worked in social care for twenty years. He has experience working at both support and management levels within services providing support to people with mental health, substance misuse and housing issues.

Nick Bell, Assistant Service Manager

Nick began his career working in mental health with Penumbra in 2003. He became a project worker at the Crisis Centre when the service opened in 2006. He spent nine years as a project worker before recently becoming the assistant service manager.

Nick helps support the frontline staff on a daily basis, supervising crisis workers, and is part of the management team.

Jacqui Walton, Administrator

Jacqui Walton is the Administrator for the ECC and has been with the service since 2007. As well as providing administrative support for the service Jacqui has a personal interest in mental health issues and is actively involved in a carer's support group and the Choose Life steering group.

Malcolm Steven, Crisis Centre Worker

Malcom applied for the Crisis Centre Worker position after initially volunteering then being employed for Penumbra in a respite care service.

As a Crisis Centre Worker he provides support to service users. This involves non-judgemental active listening, speaking openly about issues and concerns to support people to move forward, and signposting people towards support networks.

At the ECC we work as a team with two to three members of staff on shift together. The shift begins with a handover from the previous shift, then we catch up on notes left in the service users files before arranging our shift plan. We share equally the helpline duties and giving support to service users who may be staying in the building during our shift.

Dale Radley, Volunteer Co-Ordinator

Dale began as a Volunteer Development Co-Ordinator in Nov 2014.

Her role involves looking at how the service can best integrate volunteers into the centre to meet the demands of our service and make it a productive and rewarding experience for volunteers and the Crisis Centre.

Staff Highlights

Volunteer Pilot Project

The volunteer pilot project was created to help incorporate volunteers into the service and integrate a diverse range of qualities, skills and experience in to the wider team.

Volunteer Development Co-Ordinator Dale Radley worked with the Crisis Centre team and partnership group to plan how to incorporate volunteers into the unique service, so that the experience would be beneficial to both the organisation and volunteers.

The project began by asking volunteers to man the crisis helpline, providing a clear role that staff could provide training on and risk assess.

It was identified that the demands of the role could be stressful or emotionally challenging and time was taken to carefully consider all support options for both volunteers and staff. A robust recruitment method was put in place to ensure volunteers were able to meet the requirements of the role.

A volunteer induction and application pack was created, which includes a volunteer agreement, supervision template and feedback forms and relevant policies, protocols and legislation and resources that will support volunteers in their role.

An intensive training programme was also put in place which includes call management, ASSIST, counselling skills, risk assessing, safe planning, mental health awareness, self harm awareness and management, drug and alcohol issues, recovery approach and crisis planning.

Dale also worked to create promotional materials for recruitment of volunteers. Interviews for volunteers have taken place with a Penumbra service user and we are delighted with the people who have come forward to offer their time and skills to our service. The Crisis Centre looks forward to welcoming them into our team as we begin training and induction.

Acknowledgements & thanks

To all members of the ECC Partnership Group for their contribution over the past twelve months.

To all of the ECC staff for their dedication and commitment in continuing to provide a high standard of support in what is often a challenging environment.

Most importantly to the centre's users for choosing the Edinburgh Crisis Centre for support and for the comments and feedback they have provided on how we can develop the service in the future.

Edinburgh Crisis Centre is a partnership between:

Contact Us

Edinburgh Crisis Centre

For support contact

Freephone: 0808 801 0414

Text: 0797 442 9075

Email: crisis@edinburghcrisiscentre.org.uk

General Information

Website: www.edinburghcrisiscentre.org.uk

Tel: 0131 561 0082 (Jacqui Walton)

Penumbra East Area Office

Address:

5 Leamington Terrace
Edinburgh
EH10 4JW

Tel: 0131 228 1335

Penumbra Head Office

Address:

Penumbra
Norton Park
57 Albion Road
Edinburgh
EH7 5QY

Email: enquiries@penumbra.org.uk

Tel: 0131 4752380

Health Equity Strategy 2010 Communities in Control

Health equity
strategy.pdf

NHS
Tayside

HEALTH EQUITY STRATEGY 2010

Communities in Control

HEALTH EQUITY STRATEGY 2010

Communities in Control

Contents

1. Executive Summary

NHS Tayside's 2003 Health Inequalities Strategy laid out that health inequalities are the differences found in various aspects of health between different groups, especially between those who are best off and those who are worst off in society. The 2003 strategy resulted in progress in many areas, however, this strategy suggests a far more radical approach. It describes the devastating effect that health inequalities caused by relative poverty have on the communities we serve. That effect is the enormous scale of poor mental health and wellbeing, long term physical ill health and early death in the poorest communities. It sets out the aim of closing the inequalities gap by aiming for health equity in a generation. That does not mean aiming to completely remove all unfair variation in health, but it does mean reducing the avoidable differences dramatically, to the point where they do not represent the appalling and systemic unfairness we now face. For example, it means reducing the years of life lost annually to poverty in Tayside from being measured in thousands to being measured in hundreds. This goal requires fundamentally different approaches to health from NHS Tayside, not just working harder at our current efforts.

Comprehensive evidence suggests that the one of the main ways relative poverty causes harm is the chronic stress it causes when people experience society's unfairness. Unhealthy lifestyles such as substance misuse which help people cope with this stress are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant. Teenage mothers from deprived areas are most at risk of lacking skills to raise children with normal development. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations. Having a sense of worth, aspiration and confidence can protect people from such harm – it can give them resilience. We can help to build on existing confidence and resilience, and rebuild aspiration where it is harmed by supporting communities to take control of their environment and the services that surround them. This is a very different goal than just aiming for faster or closer services.

This is primarily a strategy for investing in community resilience, investing time and effort in promoting social capital and community enablement. We will primarily do this by offering social responses to social problems. In particular we will support co-production: helping people to plan services and to take back elements of services which do not need to be delivered by health professionals so that in total, services are co-produced by communities and the NHS. This promotes social capital - the importance of a connected and caring society - over institutions. In short we will ensure that our services promote more patient and community enablement, not more dependency on the NHS.

Our range of effort will need to look different in every area of Tayside because people's needs are different, and the community networks which can support them are different. The key is to see people as the start of the solution, not the start of the problem – to recognise that people know what will make a difference and can tackle problems themselves with our help. This is much healthier, in every sense of the word, than the NHS setting out to do things to people and fix things for them.

This is therefore a strategy for NHS Tayside to promote health as much as it cares for ill health. It is about making a cultural change that is already starting to happen consistent throughout NHS Tayside and its partners, so that through joined up effort we can help communities become stronger and healthier. This needs to happen jointly with our traditional partners such as local authorities but also with the parts of the voluntary sector that we tend to have less contact with, such as small charities, self help groups and informal community groups that are in touch with people who are not in touch with us.

We need to see all these actions as related despite some being for shorter term results and some for longer term. For example, actions to make services easier to access or to

promote healthier behaviours are needed in the short to medium term, but they must never be conducted in a way that harms resilience or promotes dependency on our services. Ideally such efforts should inherently promote social capital and empowerment, whether by using co-production, by supporting community networks, by sharing services with the voluntary sector, by offering social prescribing or by increasing empathy of our staff and our organisation.

Throughout the strategy we commit to specific actions, but more importantly we describe the sort of actions that will help and declare our intention to support our staff and communities develop other ideas jointly as we go. In particular we want to focus all these ideas, culture change and actions on breaking the vicious cycle of poverty and ill health early by prioritising the improvement of children's early years.

What is not included in this strategy is a list of all the actions NHS Tayside and its partners will take in the five years that it covers. Strategies need to give direction without being directive. This strategy lays out the culture change and outcomes required in five years, and gives illustrative examples but does not prescribe detail. Specific and detailed actions are laid out in NHS Tayside's annual commissioning plan, in Single Outcome Agreements, in the plans of its Community Health Partnerships and in the plans of partner organisations such as Local Authorities, Colleges, etc. Each year these plans will detail the specific changes (and the associated costs and timescales) that will be undertaken in the coming year. Those plans will include actions for the coming year which will achieve outcomes during that year such as improved access to services, as well as those which will take longer than one year to show benefit. For convenience, a summary list of all commitments which are included in this strategy is in section 2. The rest of the strategy goes on to explain why they are needed and explain them in more detail.

As health equity is such an important topic, NHS Tayside will enhance its already rigorous performance management and scrutiny mechanisms to ensure that this strategy is fully implemented: that the scale of actions are appropriate to the scale of the problem and to the ambition of achieving health equity within a generation.

2. Summary of Commitments

Throughout this strategy a range of commitments are made. To make it easier to see them all they are listed here, broadly grouped by the parts of NHS Tayside which will lead actions. Many actions will affect all areas so this should be treated as a grouping for convenience of reading rather than a strict allocation of tasks. This is also represented as a driver diagram in Figure 1 below.

Board Policy

- Make "Contributing to achieving health equity within a generation" our most important aim, integrating the ideas in this strategy in all work.
- Only approve strategies/plans that are responsive to very local needs and the variations in such health and social needs across our communities, including those in rural areas.
- See all these actions as necessary and inter-related despite them covering short, medium and long term actions.
- Systematically redesign mainstream services within resources instead of using projects based on non-recurring funding.
- Manage performance so that the whole strategy is implemented fully, and in a co-ordinated way across NHS Tayside and our partners.
- Target new resources and those freed up by redesign at these priorities.
- Take progressively bolder actions to re-allocate resources if these approaches fail to achieve the required changes within three years.

Commissioning Early Years Improvements

- Prioritise the improvement of "Early Years", supporting parents to help themselves, and creating communities which are positive places to grow:
    - identify vulnerable young families and provide preventative interventions
    - tailor ante-natal programmes to meet health and social care needs
    - develop evidence-based young parenting programmes
    - promote mutual support networks for parental collaboration
    - work with young people to help them improve their environment and create opportunities for active recreation and fostering aspiration
    - support young people's mentoring and befriending programmes
    - develop measures of childhood development as proxies for long term success in reducing inequalities

Organisational Development

- Promote community networks, resilience and social capital for example by:
    - involving people more in the design of services, especially where they can also take back the delivery of services (co-production)
    - developing time-banks
    - building a community development programme with our partners
    - supporting mainstream services to promote social capital
- Develop reporting mechanisms covering current positions, trends and trajectories for services and committees.

Workforce

- Develop training and development so that all staff see health inequalities as the most important issue, and understand how they can help.

Public Health and Health Strategy

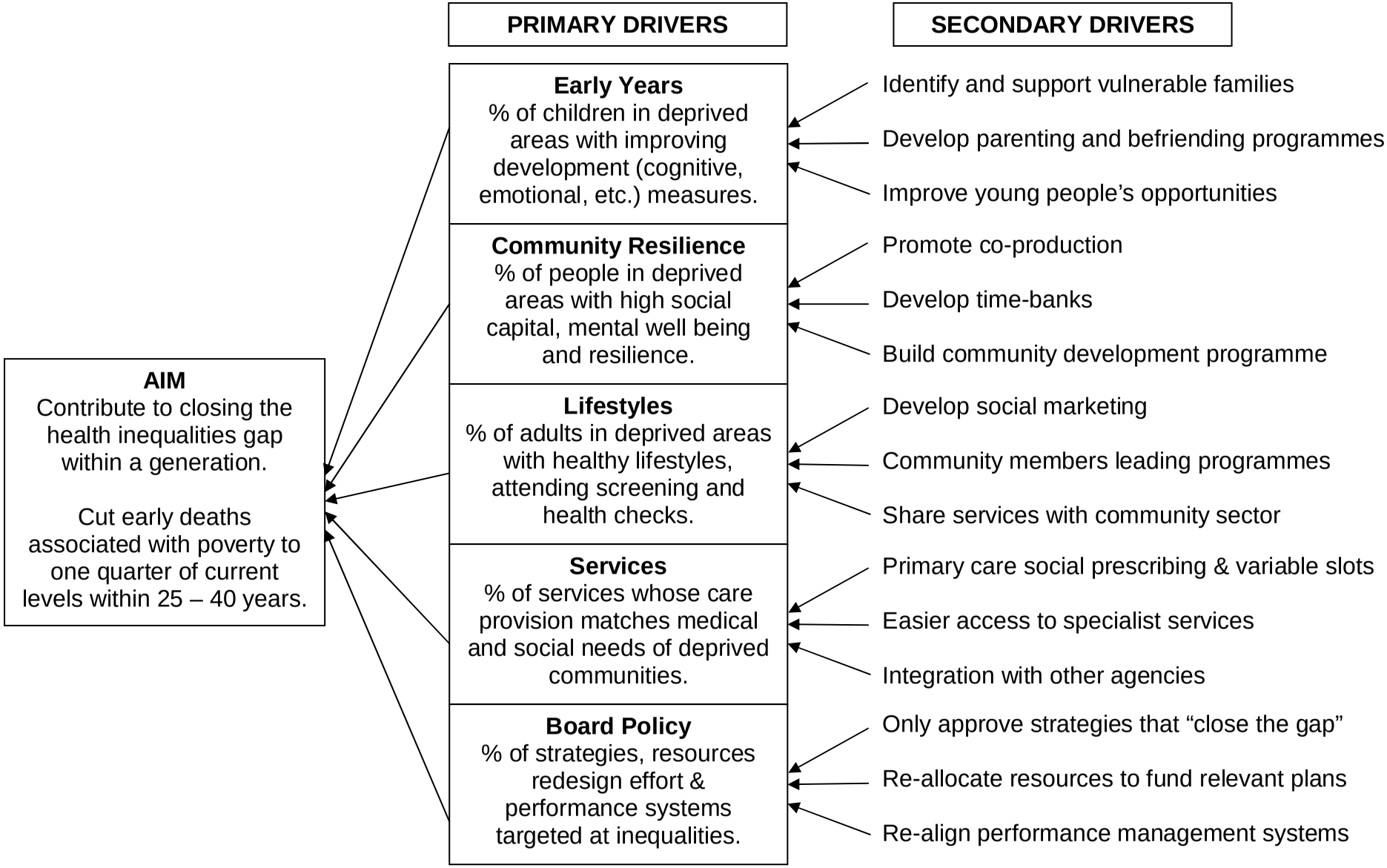
- Support behaviour change more effectively for example by:
    - using social marketing techniques
    - asking people who have already changed to healthier behaviours to help us lead the continued effort
    - asking employers, charities, voluntary groups etc. to carry out health checks and support people with desired changes
- Increase screening uptake in deprived areas using social marketing and community development techniques.
- Continue to refine ideas and build evidence on effective means of tackling health inequalities.
- Develop and agree measures of progress with our communities and partners including:
    - progress on integrated measures of improved mental health and well being, less long term ill health and less early death
    - social capital and childhood development
    - replacing targets that seek average improvements with targets on closing the inequalities gap
    - improving our evaluation capacity
- Develop understanding of differential sources of mental well being, ill health and early death.
- Expand capacity on inequalities health intelligence. For example, to link monitoring systems and expand them to include other useful measures.
- Alignment of staff and strategies in line with the topics in this strategy

Delivery Unit

- Improve service access in areas of greatest need for example by:
    - extending the reach of services that are known to be effective specifically to increase uptake by people in poorer areas
    - adapting principles from the Unmet Needs Pilots to services caring for poor mental health, long term ill health and early death

- Ensure that increased access to care does not promote dependency, but ideally promotes resilience and social capital as well as addressing needs.
- Improve primary care's ability through for example:
    - increasing social prescribing
    - longer consultation times for people with socially complex problems
    - increasing GP empathy and patient enablement
- Integrate services with partner agencies so they are easier to access, and provide more holistic services for people's social and health needs.
- Engage fully with the voluntary sector as part of all these efforts.
- Systematically support volunteering in a much wider range of settings.
- Improve wealth of poorer communities by, for example:
    - expanding the HealthCare Academy so that we routinely employ significant numbers of people from deprived areas
    - expanding work like Discover Opportunities
- Use Improvement Methodology and Triple Aim as methods of co-producing further ideas and implementing this strategy.
- Ensure that work to implement the Scottish Government's "*Towards a Mentally Flourishing Scotland*" and "*Equally Well*" is integrated with this work.

Figure 1: Driver Diagram of NHS Actions



3. Aiming for Health Equity

Contributing to achieving health equity in a generation is NHS Tayside's single most important aim. This is because in the people, families and communities we work with relative poverty is the largest single cause of:

- poor mental health and wellbeing,
- long term physical ill health, and
- early death.

Poor health associated with relative poverty is the most severe form of inequality in society. Our population profile shows that at the worst extreme the poorest people in Tayside have around 10 years more ill health and live 23 years less than the richest people. Whilst NHS Tayside should continue to consider links between the different 'strands' of equality and poor health no other disadvantage systematically cuts healthy life expectancy by over 30 years from around 80 to around 50. This is not just a problem for a few people: over 84,000 people in Tayside live in some of the most deprived areas in Scotland. A snapshot analysis by David Shaw, a GP in Dundee, suggests that over 180 deprived people die early every year. If they had the same life expectancy as people from richer areas they would together live about 3,700 years longer.

Poverty kills.
It kills life, it kills health and it kills spirit.
It kills on a devastating scale.

One of the most surprising facts, explained in section 4, is that relative poverty does not just harm poorer people, it harms richer people too, so it is in everybody's interest to tackle the problem. Society must act not just for these moral reasons, but for economic reasons too. All those extra decades of ill health that kill hundreds of people early every year are also a massive drain on the NHS, and on taxpayers.

This is not a strategy about reacting to these health inequalities, or about reducing them a little. As the World Health Organisation's (WHO) radical report "*Closing the Gap in a Generation*" urges, this is a strategy for **dramatically reducing** them. It is unrealistic to aim to completely remove all variation in health, but we need to abolish its systemic unfairness: to aim for health equity within a generation. If Tayside's early deaths were reduced to a quarter of their current level within 25 to 40 years (to less than a thousand years lost annually), we would be close to Health Equity. That needs all measures of the health gap which are currently widening to stop within five years, and all measures which are currently stable to narrow.

This is such a large scale and long term problem, especially in Tayside, that it will only be solved by wholesale adoption of new and radical approaches to improving health and wellbeing. Promoting community control as a health solution is not new or radical in itself. Many of our partner agencies already understand and adopt it in many aspects of work, but for an NHS Board to adopt it throughout all its work, and for all partners to work systematically together in the same vein to achieve a critical mass of effort **would** be new and radical.

Charles Leadbeater of the Public Service Design Agency describes this shift well:

> "Radical public services innovation will only come from a markedly different starting point. The key will be to redesign services to enable more mutual self-help, so that people can create and sustain their own solutions. The best way to do more with less is to enable people to do more for themselves and not need an expensive professionalised public service... Services do a better job when they leave behind stronger supportive relationships for people to draw on and so not need a service… For most of the last decade, we have seen public services as systems and standards, to be managed and rationalised. Instead, we should re-imagine public services as feeding relationships that sustain us in everyday life".

NHS Tayside cannot achieve such a far reaching ambition of handing control back to people easily or alone, we must work with the people we serve in a completely different way and that will be challenging for everyone. All of the public sector must work in the same way, and the local authorities are ready to lead this change with us. However, we must realise that in setting out to do things differently for ever we will not be able to prescribe in detail how we will do it. Instead, as Harry Burns, the Chief Medical Officer has said, we must describe the culture change we are aiming for and then learn as we go, being nimble to adopt the tactics which work and abandon those that do not. However, to understand why such wholesale changes are needed we need to understand the detail of why and how poverty kills.

4. Understanding Why Poverty Kills

Systematically worse health does not just affect the poorest people. Health worsens with lower salary and social status at every level. This is related to not being able to afford healthy food, pleasant environments to exercise in, transport to health services, etc. However, it is not a problem that can be solved just by increasing salaries: evidence from around the world compiled in Richard Wilkinson and Kate Pickett's book "*The Spirit Level*" shows that health is significantly better when the wealth gap between the rich and the poor is smaller. Rich people in unequal countries like the UK, where that gap is large, are far less healthy than rich people in more equal countries like Sweden where the gap is narrow.

What other people earn affects your health as much as what you earn.

People throughout unequal societies see that they are much worse off than the very rich. We feel conscious of low status and the more relatively deprived we are, in terms of poverty, but also job insecurity, debt, education, housing etc., the more chronic stress and poor mental wellbeing we suffer and the less able to take positive action we become. Whether our behaviours are healthy or not becomes irrelevant when poor mental wellbeing in the form of stress, anxiety and depression dominates, and when the community support networks which protect from harm do not function. The Scottish Government's plan "*Towards a Mentally Flourishing Scotland*" says mental wellbeing includes both *how people feel*: their emotions and life satisfaction, and *how people function*: their self-acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy.

Without positive mental wellbeing we naturally concentrate on individual coping and stress relief rather than healthy behaviours and supporting each other. Income is more likely to be spent responding to peer pressure and expectations instead of on health, and on children's health. Stress relief in these circumstances often comes from physically and

socially harmful habits such as smoking, drinking and taking drugs. These behaviours lead to more poverty and crime and to a dysfunctional and distrustful society generally.

Poor parenting and early childhood experiences affect development and behaviour throughout life, perpetuating the cycle of ill health from one generation to the next. Social pressure is intense: when people all around you indulge in harmful habits, the likelihood of joining in is high. This vicious cycle is social in nature, depending on unfair income distribution, peer pressure and social expectations to sustain it. However, whilst this fact lies at the heart of the problem, it also points to the solution to breaking the cycle and creating a virtuous cycle instead of a vicious one. A virtuous cycle that helps tackle not just health problems but many other problems communities face.

5. Understanding Community Resilience

Social support is as powerful as peer pressure and when people, families and communities come together to support each other, they can improve health as well as addressing many other problems. Studies in the WHO report "*Mental Health, Resilience and Inequalities*" by Lynne Friedli show that whilst narrowing the relative poverty gap improves health, improving mental wellbeing also protects from harm – it gives resilience. Richer communities are naturally more resilient than poorer ones, but poorer communities can boost resilience and hence health by increasing social capital. So when people know, help and trust each other, when one good turns deserves another and when a community feels like a community, not just a place where individuals live, people are able to be healthier, happier and safer.

Community networks are the very immune system of society.

This does not mean that stronger community networks, targeted employment practices or better mental wellbeing, social capital, aspirations and enablement that flow from them will stop people from indulging in health harming behaviour, eliminate teenage pregnancy or remove all inequalities in health. Many other factors influence health and need to be tackled by all public sector agencies together. But they do represent the background against which other problems should be viewed. They represent some of the most effective ways to improve life circumstances and despite being more social problems than medical ones, the whole NHS has a large and significant role to play - a very different role to the one it is currently playing. This role is about how the NHS and other agencies can help communities take more control of their own affairs including health, rather than what the NHS or other agencies can do to, or for, communities to improve their health.

An illustration is that people believe that fixing the obvious causes of ill health such as poor housing will help solve people's problems. Yet studies in an evidence review commissioned for this strategy show this will only help if done in the right way. Some initiatives to improve community housing actually harm physical health. One reason suggested was that in a particular improvement programme, subsequent rents doubled, worsening people's poverty, and reducing their chance of affording a healthy diet. In contrast the Hunter Crescent estate of Perth (now known as Fairfield) was well known for its social and health problems. In the early part of this decade the council, crucially, gave control of the estate redevelopment to the residents. Those residents worked with developers to decide the policies and changes for the area. Not only is housing improvement sustained, but people report that the area is a happier place, and is a viewed by others as a desirable place to live. The people in Fairfield say they feel more enabled than they used to.

Another example is in Malcolm Gladwell's book "*Outliers*". Gladwell describes the "mystery" of the good health of people in a small town called Roseto in America (studied in the American Journal of Public Health). Most people had moved there from Italy and experienced much better health than neighbouring towns and much better than most of America. When the reasons for this were analysed it turned out that superficially the people had similar lifestyles and genetics to others. They ate as badly as others in America (worse than in Italy), took similar amounts of exercise; and people with similar ancestors elsewhere had worse health. The only aspect that differed significantly was the sense of community and subsequent resilience. People talked on doorsteps, spent time in each others houses, socialised together and had strong community networks – they had social capital.

In "*The Wee Yellow Butterfly*" Cathy McCormack writes that for those trapped in a toxic mixture of economic circumstance life can be hard but a strong spirit and a refusal to accept what is given can release energy and creativity for individuals and their communities. In the Cliffburn and Hayshead areas of Arbroath, residents' Association Chairman, Margo Reilly "encourages volunteers to better their community by looking at what the community wants to achieve" she then "helps that to happen by encouraging partnership action which uses the time and talents of the local residents in community planning".

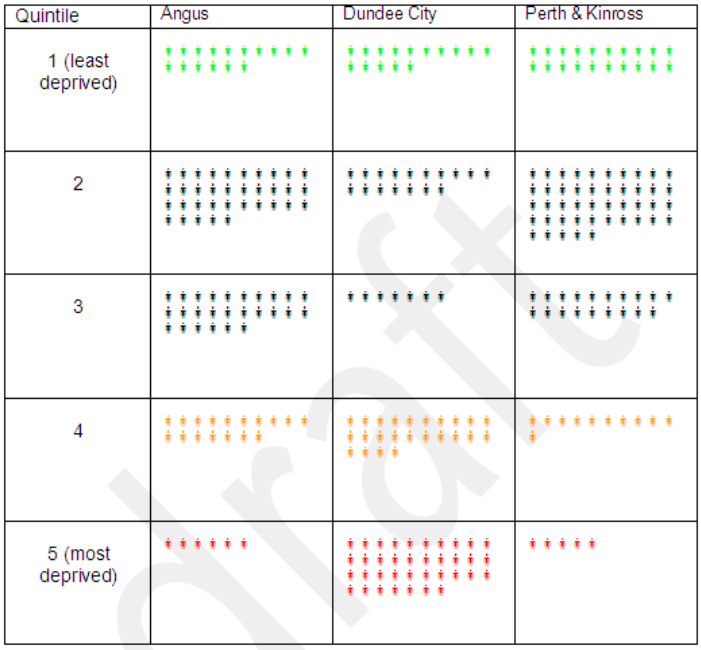
The significance of these lessons to the NHS is huge. Most of us accept that the NHS should improve access to its services in deprived areas, and should enable poorer people to make better lifestyle choices. But if we "do things to" people, without thinking through the consequences on the social and community aspects of health – whether people feel in control of their environment (enabled), and whether they support each other (social capital) - we will be unlikely to help, and more importantly, despite our best intentions, we may even harm inadvertently.

Increased access to traditional NHS services can harm health even more than poor housing action. Not just because imposing solutions on people undermines their own control in the short term, but because people can become dependent on the NHS in the long term. If people seek, and the NHS provides, medical solutions to social problems, people become less able to protect themselves from things that harm health, and less able to cope with all forms of harm. The NHS therefore needs to help people find alternatives to seeking healthcare as a solution to social problems as well as providing appropriate services for medical needs. It might be as simple as letting people know what is going on in their community that they could be part of, or it might be as complex as whole new programmes of community development. The point is that our current style and scale of effort on these types of problems will not come close to solving the problems, no matter how hard we try, which is the main reason this strategy is needed. However such work is supported by the Government's "*Meeting the Shared Challenge*" programme which aims to support a shared understanding of, and a strategic commitment to, a community led approach to health improvement and addressing health inequalities.

6. Understanding Communities in Tayside

Problems of poor health, poverty, teenage pregnancy, crime and addiction are not spread evenly throughout Tayside. In developing this strategy we thoroughly updated our population profile and published it with this strategy. It shows that the majority of severe poverty, ill health and early death is concentrated in Dundee where almost two thirds of the population live in some of the most deprived areas of Scotland (see Figure 2 below). However the concentration of deprivation is not evenly spread: walk through small neighbourhoods in Dundee and see affluence and people with good health; walk to the next street and see the absolute opposite.

Figure 2: Differences in Tayside's Population: Scottish Index of Multiple Deprivation



Similarly, towns of Angus and Perth and Kinross with far less overall poverty and deprivation, still have discrete pockets of severe deprivation where health needs are very different to the rest of the town. Outside towns, rural areas have poverty which is less easy to spot. This poverty is characterised by a combination of low income and isolation from services and communities which are important to health. When taking these aspects into account, almost a quarter of people in Angus, and one sixth in Perth and Kinross, live in some of the most deprived areas in Scotland.

Think about the important points covered already:

- extreme relative poverty destroying wellbeing
- poor wellbeing leading to unhealthy coping behaviours and chronic stress
- individual coping behaviours harming health
- poor parenting harming child development
- family behaviours and peer pressure reinforcing and repeating the cycle
- local communities needing to be resilient and powerful
- community networks being the immune system of society
- agencies taking well intentioned but actually harmful actions

Add to this the differences in poverty, community and health needs comparing one small area with another. It becomes clear that centrally re-allocating resources to push more, say, secondary care services at all poor communities, irrespective of whether they want or appear to need them, and without considering what their whole (especially social) needs are would be inappropriate. The challenge is to work with communities, not to find out what they want and then provide it, but to enable them to take control and provide their own solutions. Communities need to be involved in the delivery of services, behaviour change initiatives and solutions, as well as in their design. This enablement and related ideas are called co-production.

7. Promoting Co-production

On a simple level co-production is about involving people in the delivery of public services. This helps people change the relationship with services from dependency to genuinely taking control. It helps improve public ownership and helps services improve by increasing their relevance. The new economics foundation (nef) pamphlet "*Co-production*" describes deeper and more important reasons for promoting co-production. The skills and values involved are also those that communities need to improve the social capital which is so critical to wellbeing. Co-production on this level is about valuing and rewarding fairly people's everyday contributions to society. One tool which does just this is timebanking. Timebanking is in use in Tayside. For example, Dundee Association for Mental Health's Orbit Approach rewards users for time they commit with complementary therapies.

nef describes other examples of timebanking, both generally and in relation to changing public services. It also describes other examples of co-production. A powerful example is from Lehigh Hospital, Philadelphia. On discharge you are told that someone will visit you at home to make sure you are OK; see if you have enough heating, food etc. That person will be a former patient, not a health professional, and when you are well, you will be asked if you will do the same for someone else. The result is more than a significant cut in re-admission rates: more than people in communities taking back over-professionalised services. It promotes communities looking out for each other, and reduces the dependency that convinces many patients they have nothing worthwhile to offer. It promotes enablement and social capital.

People are at the heart of the solution,
not the heart of the problem.

Co-production as supported by the public sector in general and the NHS in particular should always:

- view people as assets who have skills vital to improving our services
- break down barriers between service provider and user
- promote people supporting each other
- include an element of reciprocity
- build community
- support resilience

The nef pamphlet suggests 10 measures which NHS Tayside and partners could use to gauge our collective success in promoting co-production working with our staff and partners, as well as with communities – these are listed at Appendix 1. We are working with nef to help us develop these ideas and work which will support them. An important note is that the heart of this strategy was created using co-production by many relevant agencies in a dedicated event in Perth.

8. Developing a New NHS Culture

The new NHS culture is therefore not to assume that a policy designed for the average person with a particular health need or demographic label will suit everyone with that need. It is not to lay out precise actions that NHS Tayside has decided to do to, or for, people, even if it has listened carefully. Instead, the new culture is to acknowledge that despite many of the wider determinants of health such as housing lying outside traditional health care, we can act with partners and communities to directly improve wealth, community resilience and social capital. We can do this as well as supporting behaviour

changes and improving access to services. If done to genuinely help communities take control, these actions will improve health just as directly as the wider determinants. They will not just improve health through the direct observable outputs such as better services; they will lay the foundations for communities mentally flourishing and becoming "*Equally Well*".

The NHS can be more of a health service - improving health
Less of a sickness service - delivering care

NHS Tayside will tailor those efforts to be truly responsive to very local needs - not just responsive to obvious health needs, but by working with partners and communities, responsive to all individual, family and community needs. It will promote co-production so that local communities can not only be involved in delivering care and other services, but also in creating or developing community networks that take control of environments and do what is needed for their children to grow up in aspirational families that live in caring, supportive environments.

This approach forms the fundamental context or philosophy that all service improvement effort must adhere to. It forms the essence of the cultural change needed consistently in all services, not just in those departments with staff working on community development. In particular this creates a different perspective from which to evaluate our current efforts. In the old culture where local access and increased uptake were part of the ultimate goal, putting specialist services into communities despite extra cost and decreased efficiency was a good thing, as was offering more local access to screening. In the new culture of empowering people, promoting social capital through co-production and community networks which look after each other in the widest sense, and in particular in decreasing unnecessary and unhealthy dependency on services, these efforts need to be thoroughly re-evaluated to check that access is not at the expense of dependency.

9. Integrating Agency Efforts

A theme of this paper is that health is about more than health care but that the NHS needs to be fully engaged with that wider agenda. That helping people to take control of virtually any aspect of their environment or improve social capital is just as important to improving health as helping them take control of services. In other words, as Derek Wanless described in his series of public health reports, a fully engaged population is part of a public health agenda. The key point here is that this is an agenda every public service needs to be part of. We need to build on existing partnership work particularly in Community Planning Partnerships and evidenced in Single Outcome Agreements. We need to work in a thoroughly co-ordinated way so that communities are not faced with the NHS talking about community networks for health, and police talking about different ones for safety, and the council promoting different ones for climate change solutions. It is also about agencies sharing learning with each other and acting to deliver services in a thoroughly joined up way.

10. Engaging Community and Voluntary Sectors & Promoting Volunteering

The community and voluntary sectors have many vital roles in aiming for health equity. They are often in the best position to promote social capital and develop community engagement. The NHS needs to support such organisations to share community information, support parents, promote healthy choices, spot health problems, deliver aspects of care and develop links with health workers.

We will engage fully with these sectors so that they have a more equitable and esteemed relationship with NHS Tayside and with the public sector generally, so that they are part of the joined up approach across agencies. One aspect where such organisations are well

placed to recognise, develop and support opportunities is in the promotion of volunteering, including the volunteering of our staff. Volunteering can range from informal arrangements to 'help out' through to more formal arrangements, such as Befriending, Buddying, joining Patient Partnership Groups, being a Community Activist, becoming an Expert Patient, training Lay Workers, joining a Peer Supporter network etc.

Volunteering benefits the person receiving support, but it also enhances self-worth and self-esteem, increases wellbeing in the volunteer and can be a strong part of a virtuous cycle of support and development within communities. Often those receiving support go on to help others in similar situations. This encourages continued benefits and improved wellbeing and capitalises on their unique position to understand and support others facing similar issues to their own.

Examples of volunteering abound in Tayside but we need to support them more systematically, including rewarding our staff for volunteering. The Angus Community Health Partnership and Volunteer Centre recently published "*Beyond the Trolley Service*" discussing the benefits of volunteering and how the NHS can support it. An example is Kirriemuir's Friday Night Project, which organised for a sports centre to be available at night. Up to 120 young people attend and it wouldn't happen if it wasn't for the efforts of young people who volunteer to raise young people's awareness about drugs, alcohol and health issues and as befrienders to ensure that young people with learning disabilities and other challenges were able to participate.

11. Towards a Mutual NHS

"Better Health, Better Care" stated that we need a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need an NHS that is truly publicly owned and accountability is shared with the Scottish people and with the staff of the NHS. These concepts are fundamental building blocks on which ideas in this strategy like co-production and community resilience rest. When we consulted with people in the most deprived areas of Tayside about this strategy they told us about the things they felt would help, and that are perhaps obvious:

- that unhealthy behaviours start with children learning them from their parents and friends so that is where we should focus most of our efforts
- that the reason some neighbourhoods feel unsafe is young people hang around because they have nothing to do and nowhere to go

They told us they could see these things for themselves and could tackle them if they were not prevented by laws, or hindered by distant bureaucracies and were instead helped by local services using a little local discretion, effort and flexibility. This is consistent with the Scottish Government's drive to 'shift the balance of care'.

12. Seeing Long Term Connections

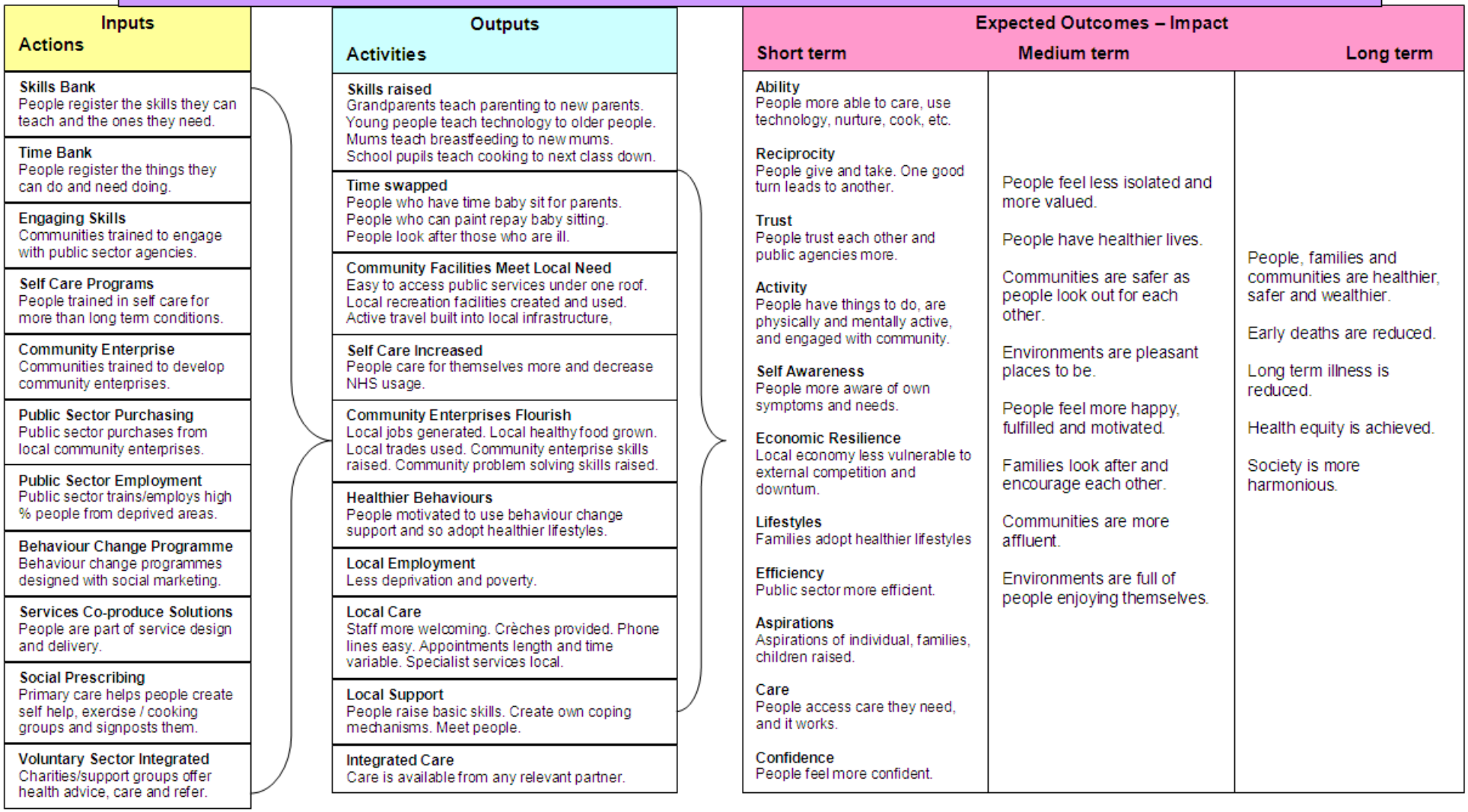
This strategy covers some of the big causes of poor mental health and wellbeing, ill health and early death. It highlights that these problems are far worse in the most deprived areas, where people suffer most poverty and have less enablement and social capital. Individual solutions might appear to be isolated but if we follow their impact we see that they are not. Again paraphrasing Harry Burns, Scotland's Chief Medical Officer, it might look like we can pick and choose aspects that we will work on, but we cannot if we truly want to improve a whole system, as opposed to being seen to do something. The approach of pilots that target single issues and rely on ring fenced funding but then stop might seem attractive, but they are not.

The real issue is that, as with all “wicked” problems, the various factors are not simple or isolated from each other but are complex, entrenched and inter-related. They will not go away if we find some time or money to do extra things in addition to the usual services and ways of doing things. This is why it is difficult to measure the success of individual actions and why it is dangerous to try to list all the actions we will take. It would be impossible, and would imply that they were exhaustive.

Instead this strategy describes the cultural change needed and lists the sorts of actions that ought to help. It is particularly important to say that some actions may have a relatively quick impact, whereas others may take years to make a difference. This does not mean we can delay actions which will take a while to bear fruit, nor can we treat the actions with quicker impact as independent of them.

A good analogy is that of planting a garden. When planting you need to plant the acorns that will take twenty years to grow to oaks, at the same time as taking cuttings for medium sized bushes in a few years, at the same time as planting this year’s annuals. In particular you need to see the various actions as related because it is important to plant things where they won’t harm each other, and to think about how it will all look in the end. The diagram in figure 3 shows the various types of action in this strategy relating to each other. It shows that we should see some results in the short term, but will have to wait longer for the more systemic changes. Whilst all these actions and benefits are probably needed, and need all agencies to work together, they are not exhaustive. Work must continue to develop the actions that will sustain the culture change at the heart of this strategy.

Figure 3: Relationship between wide range of actions (logic model) to aim for Health Equity



Inputs Actions	Outputs Activities	Expected Outcomes – Impact Short term	Medium term	Long term
Skills Bank People register the skills they can teach and the ones they need.	**Skills raised** Grandparents teach parenting to new parents. Young people teach technology to older people. Mums teach breastfeeding to new mums. School pupils teach cooking to next class down.	**Ability** People more able to care, use technology, nurture, cook, etc.	People feel less isolated and more valued. People have healthier lives. Communities are safer as people look out for each other. Environments are pleasant places to be. People feel more happy, fulfilled and motivated. Families look after and encourage each other. Communities are more affluent. Environments are full of people enjoying themselves.	People, families and communities are healthier, safer and wealthier. Early deaths are reduced. Long term illness is reduced. Health equity is achieved. Society is more harmonious.
Time Bank People register the things they can do and need doing.	**Time swapped** People who have time baby sit for parents. People who can paint repay baby sitting. People look after those who are ill.	**Reciprocity** People give and take. One good turn leads to another.		
Engaging Skills Communities trained to engage with public sector agencies.	**Community Facilities Meet Local Need** Easy to access public services under one roof. Local recreation facilities created and used. Active travel built into local infrastructure,	**Trust** People trust each other and public agencies more.		
Self Care Programs People trained in self care for more than long term conditions.	**Self Care Increased** People care for themselves more and decrease NHS usage.	**Activity** People have things to do, are physically and mentally active, and engaged with community.		
Community Enterprise Communities trained to develop community enterprises.	**Community Enterprises Flourish** Local jobs generated. Local healthy food grown. Local trades used. Community enterprise skills raised. Community problem solving skills raised.	**Self Awareness** People more aware of own symptoms and needs.		
Public Sector Purchasing Public sector purchases from local community enterprises.	**Healthier Behaviours** People motivated to use behaviour change support and so adopt healthier lifestyles.	**Economic Resilience** Local economy less vulnerable to external competition and downturn.		
Public Sector Employment Public sector trains/employs high % people from deprived areas.	**Local Employment** Less deprivation and poverty.	**Lifestyles** Families adopt healthier lifestyles		
Behaviour Change Programme Behaviour change programmes designed with social marketing.	**Local Care** Staff more welcoming. Crèches provided. Phone lines easy. Appointments length and time variable. Specialist services local.	**Efficiency** Public sector more efficient.		
Services Co-produce Solutions People are part of service design and delivery.	**Local Support** People raise basic skills. Create own coping mechanisms. Meet people.	**Aspirations** Aspirations of individual, families, children raised.		
Social Prescribing Primary care helps people create self help, exercise / cooking groups and signposts them.	**Integrated Care** Care is available from any relevant partner.	**Care** People access care they need, and it works.		
Voluntary Sector Integrated Charities/support groups offer health advice, care and refer.		**Confidence** People feel more confident.		

13. Enacting the New Culture

The new NHS culture of acting on the wider determinants of health through empowerment and enablement at all levels needs to permeate our thinking and our actions. The aim is to improve mental health and wellbeing so that people are more able and likely to choose healthy lifestyles, more likely to tolerate and control existing illness, and less likely to need care in the future. In the meantime, people who still have much greater health problems still cannot or do not access the sort of health care they need, and should be supported to choose healthier behaviours. The more traditional NHS aims of improving access and supporting behaviour change are still therefore relevant, but they need to be done in a different way with different end goals in mind. That means the three main types of specific action are:

- supporting communities, especially the poorest ones, to improve enabling community networks and so improve their own mental health and wellbeing;
- enabling poorer people and families to choose and maintain behaviours which lead to good health, and reject behaviours which damage health;
- ensure health care and other services are designed to integrate and match people's overall needs (not just obvious health needs) much more closely.

These approaches of supporting mental health, enabling behaviour change and improving access must be integrated so that care becomes more holistic, with staff and services thinking about people's social needs, not just their medical needs. The staff of 'Discover Opportunities in Dundee' already strive for this ideal. They provide help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related. They also recognise that work and socialising are good for health and that confidence and skills help people want to work as well as making it more likely that they will find work.

If this integration is not done there is a real danger that we will make inequalities worse. This is because just giving people with poor mental health extra care for physical illness, without supporting them to improve their wellbeing, and take control of their own health can de-skill them further, creating an unhealthy dependency on the NHS and on medicine in general.

Giving anti-depressants to people with minor depression who do not need them happens regularly. These drugs are no use unless people have major depression, so the NHS wastes money and creates a dependency beyond unwarranted repeat prescriptions. We need to recognise that many problems of low wellbeing are inherently social and lead the way in actively seeking non-medical solutions. This is the essence of why these proposals are radical. The NHS puts most of its effort into faster, more cost effective access to the newest treatments for physical health, but if it forgets that mental health and its social sources are as important as physical health, it can harm health.

This approach makes lifestyle interventions such as well designed smoking cessation programmes more likely to work because people have the strength, will and support to use them. Similarly, training on eating healthily and cheaply is not enough if people do not have access to fresh affordable fruit and vegetables. Exhorting people to exercise without helping them ensure their environments are safe and pleasant is futile. We need to ensure our efforts are truly joined up and thought through, without thinking for people. When we consulted about this strategy it was striking that people could describe the solutions more clearly than many policies. Young people for instance described that they need places to enjoy sports and activities together. Where they do not, and where they lack social support to make better choices, they hang about street corners which scares people, they turn to

drugs, alcohol and smoking for lack of anything else to do, leave school with no ambitions and are more likely to become teenage parents as a result. In this context helping young people get what they need, whether it is a pool table or a father figure, is a bigger priority than more traditional approaches to public health.

A final important point about the new culture is that we are learning all the time about what helps to tackle health inequalities. Current evidence points to social capital, mental health and employment practice as solutions, but it is constantly evolving. We therefore need to constantly monitor ideas and assess our efforts to improve.

14. Improving Early Years

All of the points in this strategy apply especially to children. Reports in the past two years have put the UK bottom of the league of industrialised nations for child wellbeing. 1 in 3 children across Tayside, and more than half of children in Dundee, are from families with low income. Children living in the most deprived areas experience much poorer health, wellbeing and life chances than their more affluent counterparts. Less able richer children overtake more able poorer children by the age of six. The UK has the highest rates of substance misuse and teenage pregnancy in Europe, both of which are symptoms as well as causes of ongoing inequalities.

> ***Our deeply unequal society damages children most of all.***
> Child Poverty Action Group in Scotland

All too often agencies respond to crisis situations and the consequences of failure when it is too late to alter established behaviour. We also tend to treat social problems such as substance misuse, young offending, teenage pregnancy and poor educational attainment as if they were separate from one another, instead of addressing their root causes.

The family is the biggest single influence on young people's lives. Families work with what they know and experience and children copy what they see and hear. The experiences of very early childhood affect the creation of the adult brain and influence behaviour and personality for life. A child brought up in a stable and loving environment is better placed to succeed in life, than a child from a less secure background. It is in the first years of life that inequalities in health, education and employment opportunities are passed from one to generation to the next.

Improving the early years experiences of such children is key to breaking the repeated cycle of poor outcomes. What makes the most difference is a nurturing and secure home environment, and in particular where there is interaction and communication between a parent and child from birth, as well as opportunities for play, learning and developing aspirations.

There is a need to transform the way public services interact with families and young people and the community. We need to shift the focus from crisis management to prevention, early identification and early intervention.

> ***The biggest gains will come from supporting parents – to help themselves - and creating communities which are positive places for children to grow up***. *"The Early Years Framework"*, Scottish Government

14.1 Identifying and Providing the Best Start for Vulnerable Families

Identifying, engaging with, and supporting more vulnerable parents and families to provide a stimulating and supportive early years environment, as well as making sure that there is good access to high quality pre-school and school education, is central to improving the life chances of young people and the overall efforts to combat inequality. Yet we know that those parents most in need are often the least likely to access services.

The NHS comes into contact with almost all women during their pregnancy. It is well placed to identify where women and families need additional support and to work with others, including the voluntary sector, to tailor more holistic ante-natal programmes that meet health and social needs and offer children the best start in life. Newborn babies respond to positive interaction from parents and carers. The importance of communication in the first years of life should be included in the advice that expectant and new parents are given.

Services such as those treating adults with addiction problems, mental illness, learning or physical disability or chronic disease, many of whom have children, should also play a key role in identifying families at risk and referring them for support where appropriate.

Whilst identifying parents at an early stage and providing preventative intervention needs to be a greater priority, we also need to make sure that there is effective access to intensive family support for those who need it.

14.2 Positive Parenting

There is now considerable evidence on the importance of good parenting and the benefits of evidence-based parenting programmes. Parenting programmes have been shown to:

- Improve communication and family cohesion
- Improve academic attainment
- Reduce behavioural problems
- Reduce risk taking behaviours
- Reduce levels of anxiety and depression (amongst parents and children)
- Improve aspiration and wellbeing
- Improved long-term life chances for the children

A Cochrane Review investigating ways to prevent alcohol misuse also identified a parenting programme as the most promising of all interventions in preventing substance misuse and other risky behaviours among young people. "*Pathways to Problems"* noted that the most important factors which influence whether young people will use tobacco, alcohol or other drugs hazardously are family relationships, circumstances and parental attitudes to substance misuse. It concluded that good parenting and stable family life can reduce these risks. This is particularly important as problem drug use is both a symptom of, and one of the most significant contributors to, health inequalities and is a significant factor in child abuse and neglect.

There is also emerging evidence to suggest that parenting programmes have wider protective benefits for communities through breaking the negative cycle. Older children who have been through the programme act as positive peer models for younger children and parents on the programme also spread their learning to families and friends and many go on to develop support networks.

14.3 Positive Economic Return

The argument for investing most effort and resources in early years and parenting is backed up by a strong economic case. The Government's "*Early Years Framework"* highlights the costs of current systems failure and cites the example of providing intensive secure care for a teenager at a cost in excess of £200,000 each year and the costs of impaired health, lack of employment and criminality throughout life at many times that. By contrast, parenting programmes typically involve a modest outlay. Similarly the cost of caring for children looked after by the state is around £170,000 per year and could be avoided.

Economic evaluations of parenting and pre-school programmes have shown a return of up to 27-fold on investment through decreased health, social care and criminal justice costs and higher earnings potential. In the US one parenting programme, the Strengthening Families Programme, was adopted in a number of US States mainly on the grounds of its economic benefits.

Both *"Towards a Mentally Flourishing Scotland"* and a recent economic evaluation by Lynne Friedli and Michael Parsonage "*Mental Health Promotion: Building an Economic Case"* also cited supporting parents and early years and parenting skills training/pre-school education as the **"best buys"** to improve mental health and wellbeing.

14.4 Parental Collaboration

Relying on professionals and professionally delivered programmes will not be enough to tackle the scale of the problem and will not by itself provide the stable and loving families and communities that children need to thrive and aspire. We need to harness the skills, knowledge and commitment of parents, grandparents and communities themselves to provide the positive and safe environment for all our children to grow up healthy, happy and resilient.

In her book "*Detoxing Childhood"* Sue Palmer stresses the importance of parents taking back control of the business of raising their children, and finding their own ways of overcoming the damaging aspects of 21st century life. She gives the example of a father in inner city London who got together with parents living in the adjacent streets to talk about how children didn't play outside any more. They agreed to keep an eye on them so they could play out and agreed boundaries that would ensure that they were safe. Another example is a group of parents in the north-east of England that raised money to turn an unused allotment into a wilderness play area where children make dens and explore the outdoors. In Tayside, we've seen the positive results of mums living in the most deprived areas supporting one another to breastfeed.

As well as directly benefiting from participating in parenting programmes and sharing their experiences, parents can also gain accreditation and help to deliver support to other parents. Parents can form *mutual support networks* for parents to meet up, chat and swap ideas.

14.5 Engaging Young People

Encouraging young people to become actively involved in mutual support networks is vital to increasing the capacity and resilience of individuals, families and communities and in tackling the underlying causes of inequality and some of the more serious social problems facing our community. Just as with their parents, we need to listen to the experience of children and young people and encourage them to use their own resources to be part of the solution.

The new economic foundation (nef) highlights the example of engaging disaffected 16 year olds in the most deprived schools in Chicago to act as tutors for 14 year olds, and the positive impact this has had on academic achievement and on the incidence of bullying.

Many young people are already actively involved as peer educators or in befriending schemes as mentors. Befriending is a supportive and supported relationship offered to vulnerable people finding community living difficult. Mentoring and befriending have benefits for community-led development. As well as improving the young person's experiences of social interaction with a positive role model, it encourages participation in new activities or situations and develops more trusting relationships which can build confidence, self-esteem and recovery and lead to wider community participation as volunteers. A nationwide survey by *Big Brothers Big Sisters* (www.bbbs.org) found that participants in mentoring and befriending services were 52% less likely to skip school, 46% less likely to begin using illegal drugs and more likely to get along with their families and peers.

This type of community development is an example of readily achievable, inexpensive ways of engaging and supporting more vulnerable young people without the need to resort to more traditional medical or other professionally-led interventions. By encouraging young people who have benefited from interventions of this type to themselves volunteer as friends, supporters and mentors to other people, we can begin to create a 'virtuous cycle'.

14.6 Measuring Impact

Waiting a generation to see the impact of action we take today to improve life expectancy or reduce the rate of cancer among the poorest communities can hamper innovative interventions and lessen individual and organisational commitment to tackling inequalities. Measuring the improvement of child development in early years may provide an answer to the difficulty in being able to demonstrate shorter-term impact. Professor John Franks, Director of the Scottish Collaboration for Public Health Research and Policy, advocates that Scotland should adopt sensitive indicators, such as childhood cognitive and educational outcomes (physical health, social and emotional maturity and language and communication skills) which are quicker to show change and have a strong predictive power for lifelong health and wellbeing.

Intervention in the early years of life is the best way to encourage healthy lifestyle habits, build emotional resilience, support aspiration and ultimately break the cycle of deprivation and inequality. It needs to be an overriding priority for NHS Tayside and the work we do with partners and the community.

15. Committing to Specific Actions

The previous sections of this strategy have explained:

- the scale and nature of the problem (that poverty kills)
- the long term ways in which these problems can be lessened (equality of wealth and resilience)
- how these will help in the long term (less chronic stress, better mental health and wellbeing)
- the sorts of actions that will help (co-production and community networks)
- the understanding that is needed (of different needs in different communities)
- the culture change that is needed (seeing wider determinants of health as relevant to NHS work as much as to its partners)
- the style of integrated working that is needed (working with communities, statutory partners, the voluntary sector and volunteers)
- the need to focus on early years (to break the cycle early)

All these elements are necessary to lay out the direction, without listing the specific actions individual services need to take. However, we do need to identify the concrete actions which apply to all of NHS Tayside, and examples of things that will be done differently by specific services. This section lays out concrete actions and examples. Some of them need to be done as described, while others are just illustrations. The people that manage and deliver our services need to take them and work with communities and partners to develop them and related ideas.

Specific service by service actions will be created within annual commissioning plans. They must of course demonstrate adherence to all the principles in this strategy, and demonstrate that they will deliver the sort of progress required. There is a risk in listing examples in this way that they will be deemed as correct and should be imposed on communities, whereas the whole point is that they should be developed **with communities**. In addition the examples are not exhaustive. In other words, services cannot rest if these examples are implemented. They are the start of a process of developing new ways of doing things.

15.1 Building a Community Development Programme

To help communities develop strengths and skills we need to help empower them. This is about helping people, families and communities develop skills and confidence to solve the problems they prioritise. Our communities tell us that this can be about developing fundamental skills that are lost such as cooking healthy foods cheaply. It can be about bringing up children positively to play their full role in society, or caring for each other with less dependency on the NHS. We might help communities create employment, exchange skills and services, or influence public agencies. These and others skills and values are at the heart of healthy, strong communities. They are what communities need most for health equity.

These skills and the values behind them are often called social capital, and helping communities build social capital is one of the most important things the public sector can do. We will systematically co-produce, ideally with our partners, a Community Development Programme which communities want. It will focus on supporting and developing the social capital of communities with most needs, and ensure a scale of ambition and progress adequate to achieve their agendas.

An example is the Perth and Kinross Healthy Communities Collaborative. This project is led by older people and professionals. Community members make improvements for themselves and their communities based on their local knowledge. This enhances relationships and networking between organisations and helps sustainability. In year one they raised awareness about falls through looking at footwear, vision, environment, medication and exercise. Falls reduced in a number of areas by 30% and social capital increased by 10%. In year two indoor curling was introduced to sheltered housing units, lunch clubs, care homes and public events. Eleven curling groups are now established with 110 people taking part. Professionals and community members also qualified as chair based exercise instructors and 16 groups are now running. Year three focuses on mental health and well-being in later life.

However, it is not just such dedicated staff that affect social capital. The way mainstream services work can either help or hinder, so we will work with them to develop ways to help. For example if we can help develop community enterprises, our Supplies Department will purchase all supplies and services legally possible from such enterprises. This will re-invest money in local communities, create local jobs and, importantly, jobs that develop wider skills not just those of the task at hand.

We will look to our community development partners such as Dundee Healthy Living Initiative (DHLI) to help us develop services in ways that our communities need. This helps our services improve and helps communities increase their social capital and enablement. Staff at these organisations too often have to re-apply for funding. We acknowledge the importance of these organisations in delivering this strategy and whenever possible will work with others to transfer funds to recurring sources. In return such organisations will need to ensure that communities build such skills themselves, and do not become reliant on ongoing support from them.

15.2 Improving Service Access for Poorer People

All services need to be easier for people with more health needs to access, and to be more integrated and holistic in their approach. However, increasing access generally can widen health inequalities because people with less health needs often respond more. We therefore need to take services that are known to be effective and extend their reach specifically to increase uptake by people in poorer areas. We will continue offering initiatives disproportionately or exclusively to people from poorer areas, and will adapt the principles from our Unmet Needs Pilots. Those principles were that three key issues facilitated service uptake:

- Perceived and actual ease of access
- Feeling welcome and valued
- Perceived importance and effectiveness

Services that met these criteria appeared more likely to facilitate uptake and longer term engagement. These three issues appeared to be achieved through five potential service characteristics: **proximity, responsiveness, convenience, timing and continuity.**

We will roll out these ideas across services, starting with those whose needs are the greatest, such as those with poor mental health and long term ill health. This will be done on a long term sustainable basis, not with more pilots. This does not mean deciding a final pattern of service delivery from the outset, it means continuing to learn and adopt better ways to improve prevention and access, but as part of the usual way of delivering services, not as projects with fixed term funding. Such efforts should reduce unnecessary

dependency on the NHS and promote social capital. Every opportunity must be taken to work with deprived communities to promote self care and deliver care in an integrated way with other services through partner agencies, community development organisations, community enterprises, the voluntary sector, volunteering and other relevant approaches. To improve basic access by removing the need to visit multiple venues, and to promote this more integrated and holistic approach, services from various agencies will be co-located whenever possible. The joint aims of such efforts are to:

- improve mental health and wellbeing through social capital and community networks;
- motivate people to adopt healthy lifestyles using co-production, social marketing and other techniques;
- ensure that levels of care match need but distribute care appropriately between self care, social network support, community care and NHS care.

There are a number of specific tools and approaches already in use in small areas which will help services to develop in the ways described. We will help priority services adopt these approaches more systematically, and in the process of learning from this, develop toolkits or learning packages which other services can use to roll out the approach more widely. The NHS Scotland Quality Strategy currently in development will also be relevant when developing services.

15.3 Improving Primary Care in Deprived Areas

People and GPs alike tell us that sometimes GPs do not have options available to respond to people with mental health and wellbeing problems. As described above, people in deprived areas have far more mental health and wellbeing problems than those in affluent areas. The response in some cases is to prescribe medicines which provide symptomatic short term relief without addressing the root cause. Different responses such as social prescribing **are** available but we need to work with practices to develop them.

One example is already being trialled in Erskine Practice in Dundee, where patients who need time to talk through their issues but do not need a GP can discuss them with a chaplain. Patients and GPs alike describe the difference that this approach makes. "*When I go to see a GP he does things to me like referring or prescribing. You don't even give me advice; you listen, say things differently and help me make sense of them*". This is about helping people take back ownership of solutions which in the past social support networks would have done.

Because practices with a high proportion of patients from deprived areas face such a high volume of mental health and wellbeing problems and have too few effective means of responding, they are often overwhelmed. The time for consultations is often too short to get into meaningful discussion about the root cause of the problems, and the types of social prescribing or self help that could be useful. Stewart Mercer and colleagues in the West of Scotland have shown that if GPs have a couple more minutes to discuss problems they can get to the root cause, and instead of prescribing medicines can increase the patient's power to take control of the situation. They have also shown that patients who have consulted with GPs with higher empathy levels also have higher enablement. Higher enablement seems to lead to patients being more likely to do what they intended to do at the consultation one month later.

These are just three things that we will support in practices serving the most deprived communities: social prescribing, longer consultations and ways of increasing empathy and patient enablement, such as training and support for GPs.

15.4 Supporting Behaviour Change

Most specific behaviours which continue the cycle of ill health are worse in deprived areas. More smoking, worse diets, less exercise, more problem drinking and drug taking, more teenage pregnancy and less breastfeeding are all significant problems. As described throughout this strategy we need to understand the causes of these problems and address them at source. That is the reason the thrust of the strategy is about promoting enablement through social capital and helping communities take control. We must also do more to help people choose healthier behaviours by helping motivate them to change, and making it easier to change. This work includes a range of tools including social marketing which help staff understand what is important to people. Examples of using social marketing in Tayside include the “Give It Up For Baby” and “Quit 4U” programmes. These pay people from deprived areas in grocery vouchers for quitting smoking in a bid to motivate them through the difficult cravings period.

We will roll out these approaches to other areas including the development of a social marketing toolkit for services, but the culture running through this strategy will be applied. That means that wherever possible such programmes will be tailored to the very specific needs of communities. They will take account of a range of related needs, not just a narrow behaviour, and they will involve those communities in delivering the help. Such help will ideally promote social networks and self help rather than more NHS or state services.

Similarly where we know that it is difficult, despite motivation and support, to choose healthy behaviours we will work with partners to address this. For example, people tell us that they need cooking skills but they also need to be able to buy fresh fruit and vegetables in local communities. We will address these problems, ideally through community enterprises or similar approaches mentioned above.

15.5 Increasing Screening Uptake in Deprived Areas

Some ill health prevention work, such as supporting behaviour change described above, is about avoiding the behaviours that lead to diseases. However we can also reduce the incidence, prevalence and burden of disease by catching diseases early. For example, people in deprived areas develop far more cancers at far younger ages and die from them far more than people in more affluent areas. Cancer screening programmes can detect cancers very early and either prevent them altogether or significantly reduce their harm, extending life by many years but uptake is low in deprived areas. We must therefore work to increase uptake in these areas. However we must not do it by simply sending more screening units or invitation letters to deprived areas. We must work with small communities in the ways described throughout this paper: within the context of a community development programme; to involve people in the understanding of why these are helpful; to find out what would motivate them to attend screening; and to involve them in the programmes we might then develop, both in their design and their delivery. Similarly, health checks can be carried out at people’s place of work or training, and they do not need to be done by NHS staff. We will work to increase the number of people who can do this such as small employers, charities, voluntary groups etc. These are prime examples of opportunities to promote co-production, to build communities and to build social capital as well as opportunities to increase uptake of screening and reduce ill health and early death.

15.6 Increasing Employment in Deprived Areas

As in most areas, the public sector is a large employer in Tayside. We are leading the way in helping people from deprived backgrounds get employment with our Healthcare Academy. The academy gives people work experience in a supportive environment, and guarantees them a job interview. People who have been through the programme tell us

about the difference it has made to their lives, not just to themselves by becoming motivated and confident to go out and earn, but to their children who then see working and taking holidays as a normal way of life. These changes have a dramatic effect in helping to break the cycle of deprivation, but only help relatively small numbers. We will expand these efforts to the point where we routinely employ large numbers of people from deprived areas. This will be in line with expanding the Discover Opportunities approach mentioned above.

16. Delivering

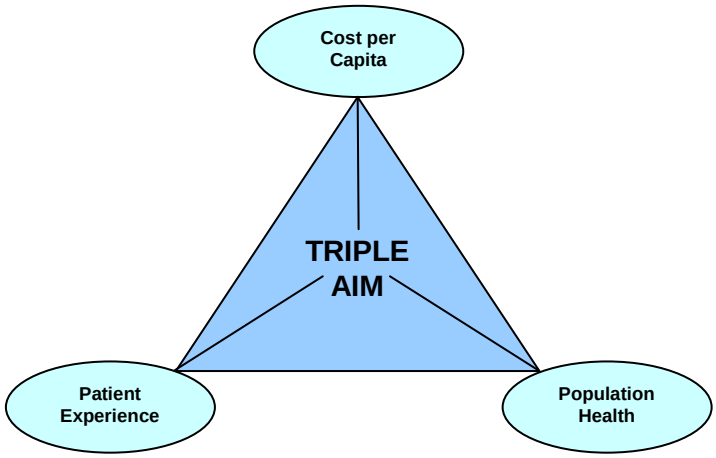
In planning to deliver the improvements this strategy promises we acknowledge that, as illustrated by the examples throughout, we are already using a number of very helpful initiatives, and have many others to draw on from elsewhere. Much of the challenge is about moving from using ring fenced temporary pilots as the way of doing things, to working differently in mainstream services. Much is about the cultural change that's needed for these efforts to gain a critical mass, or perhaps the critical mass of effort which will indicate a change of culture.

Most of the ideas are not new or additional to other strategies and initiatives. It is the systematic adoption and integration of aims that this strategy, crucially, aims to promote. For example, many staff in NHS Tayside already thoroughly understand the concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes. This "Improvement Methodology" is appropriate for delivering this strategy so long as it continues to adapt to working with communities to promote enablement and social capital. Similarly, the concepts of understanding detailed needs of communities, looking at more than health needs and working together with partners and communities is embodied in the Institute of Healthcare Improvement's Triple Aim programme. Growing numbers of staff have been trained and supported in developing these approaches already, and these efforts are being integrated.

16.1 Triple Aim

The Triple Aim Framework is the simultaneous pursuit of:

1. The health of a defined population
2. The experience of care by the people in this population
3. The cost per capita for providing care of this population



These three dimensions pull on the health care system from different directions. Changing any one of the three has consequences for the other two. With the goal of optimising performance on all three dimensions we recognise the dynamics of each

dimension while seeking the intersection of best performance on all three. Over emphasis on any one aspect will distort the system.

Through Triple Aim there is a focus on quality, innovation and productivity, addressing unwarranted variation, procedures and technological usage. It enables discussion between primary and secondary care, uses data to drive decisions, spreads best practice, and prompts the termination of low value interventions.

The WHO has issued a report by Thomson, Foubister & Mossialos on health financing schemes in all of the EU countries. One of the recommendations is to avoid confusing efficiency with expenditure control. Spending on healthcare should not be conditional, rather it should always demonstrate value for money. System level metrics are required which include healthcare, social care and public health.

In Bolton they are using Triple Aim in relation to health equity through community health and wellbeing partnerships. Bolton has developed five themes with the community that guide the work of all the partners within Bolton: Healthy; Achieving; Prosperous; Safe; Cleaner and Greener; Strong and Confident. Measures to monitor progress on each of these themes have also been developed with the community. Through the 'Healthy' theme there will be a balance between individuals receiving what they need alongside wider health gain for the community within a specific healthcare resource.

Our Community Planning Partnership's Single Outcome Agreements are key to integrating effort so we will work with them to maximise the opportunities for joint working. We commit to co-producing the next phases of agreeing this strategy and implementing it with those partners and with the communities we jointly serve.

Many staff across different agencies have recently welcomed the creation of the Scottish Government's report and action plan "*Towards a Mentally Flourishing Scotland*". Again the concepts there have synergy with this strategy and the key will be ensuring effective joint working towards common goals. Similarly the Scottish Government's report and implementation plan "*Equally Well*" helped trigger the creation of this strategy so the concepts are thoroughly aligned. There are however some elements of the "*Equally Well Implementation Plan"* which are too detailed for this strategy but still need to be delivered and monitored. To act on and deliver these strategies NHS Tayside will use its recently agreed framework for Strategic Effectiveness. The commitments in this strategy will be reflected in the annual commissioning plan. Each year they will list the actions that our services will take to deliver these strategies. These will be specific actions and will detail the sections of this strategy to which they relate, the timescales within which they will be achieved and the expected outcomes.

17. Managing Performance

NHS Tayside's Director of Public Health (DPH) is responsible for liaising and agreeing with managers throughout the organisation to ensure the range of actions being taken each year comprehensively cover this strategy over time. In other words the DPH will ensure that the next five annual commissioning plans between them include enough actions to fully implement the five years that this strategy covers. The DPH will also ensure that these actions are coordinated within the NHS and with our community planning partners, and then delivered in a co-ordinated way.

Once those actions are clearly identified and co-ordinated in the relevant commissioning plan and the Delivery Unit's Delivery Plan, it will be the responsibility of each relevant manager throughout NHS Tayside to ensure they are implemented. Performance management of these actions is carried out by senior management and co-ordinated by

the DPH. In any of the above cases the senior manager must take remedial action if the actions being taken are not adequate, and refer persistent irresolvable problems to the Chief Executive.

This range of performance management activity is aggregated at the Chief Executive's TayStat meeting, and the Chief Executive has overall accountability for monitoring that the strategy is being delivered. As this is such an important part of the work of NHS Tayside, we will ensure that the aggregation forms part of a Strategic Review which ensures that individual strategies are being implemented, and that the right strategies are in place. NHS Tayside's Board will annually dedicate meetings of it and its committees to such Strategic Reviews.

18. Developing Our Workforce

As mentioned, the culture of NHS Tayside needs to change so that ALL staff see health inequalities as the most important health issue. In particular we all need to see it as an issue which we can affect, whatever our role. We recognise that this will be extremely challenging as many of the ideas are unfamiliar to many staff focused on treating ill health rather than incorporating ways to prevent it. We will develop our existing training and development for all trainees, new staff and existing staff to incorporate these topics. This will cover a range of issues including understanding:

- the size and nature of health inequalities in Tayside;
- that poor mental health affects lifestyles and leads to ill health and early death;
- that mental health and wellbeing are affected by social and community networks as well as wider sources such as housing, employment, etc.;
- that all services need to be more accessible and responsive to need;
- that attitudes of public sector bodies and employees can help or hinder.

The last issue addresses the "softer side" of attitudes and culture including:

- Wanting people to take responsibility for their own health, but the NHS still tending to tell them what to do.
- Wanting people from deprived populations to use our services but people reporting that some staff are still abrupt, off-putting and make them feel inferior. Some of those services are in the wrong place or delivered at the wrong time to be accessible.
- Wanting people to act on our advice but we are still using leaflets which are photocopied several times making it hard for highly literate people to read them, as well as those with reading difficulties.

19. Measuring Progress

Many of the actions described here can be started immediately but as described, most will need to be developed and will take time to show results. We will therefore agree a range of measures to assure our communities and partners that together we are taking enough actions, committing the right sort of effort and adopting the right approaches. These actions will be priorities for our communities and will be based on as sound health economics as possible to ensure that cost effectiveness is built in. Every action committed to in this strategy will be monitored systematically to ensure it is carried out across the whole of NHS Tayside, promoted in every service development or strategy and reflected in agreements with our partners.

We will also measure medium term objectives such as stabilising the measures of the health gap which are currently widening, and narrowing those measures which are currently stable. Another critical medium term objective is measuring child development.

As mentioned in section 14.6, because life outcomes are predicted by the developmental progress of children as early as three years old, they represent good markers of whether we are making progress on life expectancy without having to wait thirty to fifty years to find out. Finally we need to measure long term progress towards health equity through the ultimate health objectives for the poorest communities of:

- improved mental health and positive wellbeing
- less long term ill health and
- less early death

It is most important that we do not view these objectives or the actions that lead to them as separate issues. We now understand more clearly than ever before the role that poor mental health and wellbeing plays in causing preventable ill health and early death in the most disadvantaged communities. Without good mental health and positive wellbeing, people do not feel motivated or able to take the lifestyle choices which lead to good health. However, our current indicators measure years of life with or without illness separately to years of life with or without mental wellbeing and so inhibit integrated decision making. This is such a fundamental issue that we wish to create new measures of heath that combine the three views. This effort will be linked to national Mental Health indicators work and the development of a HEAT target on mental wellbeing. For example, we need to be able to measure wellbeing and social capital. However current measures are contentious so this will need developmental work. We are currently building the level of health economics expertise needed to ensure all this.

As well as agreeing new actions and measures, we will review our current measures of progress. Too many targets require average improvements in service or health. Such targets allow for large improvements in the health or care of affluent communities and small improvements or even worsening in deprived populations, hence widening inequalities whilst appearing to succeed. We will ensure every target and objective possible focuses on closing the inequalities gap instead of requiring average improvements in health or service delivery.

In developing this strategy we commissioned a review of evidence from around the world which is published with this strategy. It was conducted jointly by the Social Dimensions for Health Institute (SDHI) and NHS Tayside. The review showed that very few initiatives properly evaluate their effect on health inequalities. As we deliver the actions we commit to, we will build in evaluation so as to expand the evidence base. We do not have, and are never likely to have, the research skills and capacity for one central team to assess all these efforts throughout NHS Tayside. Instead we aim to work with SDHI to create capacity to help services redesign and evaluate themselves.

20. Developing Information Systems

We will improve our systems for gathering and reporting up to date information regarding health equity. This is because we currently do not systematically gather or report enough indicators of inequalities in health and wellbeing, or service usage and quality. We will develop reporting mechanisms covering current positions, trends and trajectories so that:

- all services report comprehensively on their inequality efforts;
- all services, performance management and scrutiny receives specific relevant reports on the degree of success in closing the inequalities gap in their area;
- NHS Tayside, its partners and communities understand which factors are the major contributors and determinants of poor mental health and wellbeing, long term ill health, and early death in poorer communities by local area.

All this work on information systems and the progress reporting requirements described above will be detailed specifically for monitoring purposes. We will need to develop our capacity to do this, in particular the linking of financial information, performance information, and public health intelligence. For example, there are specific helpful reports, showing how causes of early death vary with place and age of death, but we cannot currently create them systematically and hence target effort accordingly. Similarly we can show how much spend is dedicated to people from each GP practice but do not currently link that to deprivation or health need. Other technical measures of deprivation such as the GINI co-efficient are also useful but are not currently used and will be developed.

21. Aligning Strategic Aims

NHS Tayside has already agreed that its four strategic aims are:

To improve healthy life expectancy by supporting people to look after themselves

To contribute to closing the health inequalities gap within a generation

To ensure services meet minimum quality standards, especially patient experience

To be cost effective in all decisions, actions and services

Whilst this strategy primarily addresses the second aim (health inequalities), it says as much about supporting people to look after themselves albeit from a community empowerment perspective. Whilst that effort is to be targeted at deprived communities the principles are applicable to all communities. Similarly, whilst the point of promoting community engagement, empowerment, social capital and co-production are the mental wellbeing and physical health benefits that they confer, these also address quality and cost effectiveness. Services which focus more on providing the things that are so specialist that they need to be delivered by the NHS, and to deliver them in a way that communities want are inherently both more cost effective and high quality. In particular, services that deliver help which communities, the voluntary sector etc. could provide better and cheaper waste money. Services which foster unhealthy dependency on the NHS harm health.

22. Working within Financial Constraints

The cost of failing to support disadvantaged communities in tackling health inequality would be continued increases in caring for more and more long term ill health. As stated at the beginning of this strategy, poverty kills early but it also causes decades of ill health before it kills. It is caring for this ill health that costs the NHS, and the taxpayers who fund it, so much money.

NHS Tayside will not be able afford to care for the predicted future burden of ill health and even if it could, it could not recruit enough staff to achieve it. Removing health inequalities and helping the people of Tayside to choose lifestyles which are naturally healthy by supporting them in mental health and wellbeing is therefore needed not just morally, but for NHS Tayside to survive in the long term, and to care for people's remaining ill health which will always be present.

NHS Tayside currently spends around £4.2m on efforts which are knowingly and deliberately targeted at deprived communities. That figure is not exact because methodologies vary when calculating such figures. Specifically it does not include services which are global but which also therefore support people in the poorest communities.

For example the funding for the Scottish Government's "Keep well" programme is included in the £4.2m but funding which pays for health visitors who support anyone including the poorest people is not. The figure represents less than 1% of the 2008/09 revenue available to NHS Tayside.

Severe financial constraints mean that there is likely to be little or no additional money with which to fund the actions to which we commit here. However most of them cost little or no new money, and will generate large savings in the medium to long term. They will mostly be carried out by changing the way we use our current effort and resources in the ways described throughout this strategy. The Directorate of Public Health for example probably used to target less than 10% of its resources at health inequalities, but this has risen to over 30% in the last five years despite its budget having shrunk by around 10% in that time. The directorate plans to continue this rise despite continuing financial challenges. We will go further than this and ensure our staff and strategies are aligned to the key topics in this strategy such as improving Early Years.

Some changes will cost money and NHS Tayside must optimise the use of all available resources in order to significantly reduce this inequity. We must remember though, that without the changes signalled in this strategy, financial balance in the future will be even more difficult than the apparently unprecedented financial challenges we face today.

If, as we monitor the delivery of the strategy, this approach (of advocating that everyone in NHS Tayside changes the way they work) appears to be insufficient within three years we will take progressively bolder action to centrally re-allocate resources. Some people will be disappointed at the implied delay in this stance as they feel that being radical is about, for example, taking health visitors from affluent areas and targeting them at working for deprived areas. However we firmly believe the correct approach is to work differently by us all helping communities to tackle the root causes of ill health, not to throw more traditional resources at ill health. That is why this strategy is called Communities in Control.

Appendix 1 - nef Measures of Co-production

1. Reward reciprocity in funding regimes. Assess the extent to which the ultimate beneficiaries of funded services have been enabled to play a role – and reserve part of the grant to reward this involvement.

2. Reward people for their efforts in the local neighbourhood, and review the benefits system so that it stops discriminating against voluntary engagement to support services by people outside paid employment.

3. Shift the way professionals are trained so that frontline staff are able to learn about the values and skills of co-production and are recognised for putting these skills into practice.

4. Develop ways of capturing the real benefits of co-production and the loss when it is absent so that public service commissioning and measurement recognise and record what is important about mutual support.

5. Set a duty to collaborate not just between services, but bringing together services, their clients and the public, and require all public bodies to involve clients in the design and production of services.

6. Embed networks of exchange, such as timebanking, within public service institutions, including surgeries, hospitals, schools and housing estates.

7. Swap targets for broad measures of well-being that enable practitioners to demonstrate the value of co-production approaches in terms of individual and social well-being.

8. Review current health and safety measures to ensure that unnecessary regulation and a culture of risk aversion doesn't present a barrier to the involvement of service users and the communities based around public services.

9. Launch a co-production award scheme and a co-production fund to encourage innovation in the public and voluntary sectors.

10. Acknowledge the importance of size and innovation rather than looking to roll-out 'scaled up' blue print models of co-production. Recognise instead the importance of human-scale interaction and the ongoing innovation of this approach that leads to the development of appropriate local responses.

Appendix 2 Glossary

Community	Community most often describes a group of people living in the same area. It can also describe a group of people with common attitudes or interests or who work or study in the same place.
Community Resilience	Resilience is the capability to anticipate risk, limit impact, and recover quickly. When a community is resilient it is the network within the community that provides this strength.
Co-production	Active input in the development and delivery of services by the people who need services, as well as – or instead of – those who have traditionally provided them.
Cost Per Capita	The cost of a service divided by the number of people in a defined population.
Discover Opportunities	An organisation in Dundee which provides help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related.
Driver Diagram	A tool used to conceptualise an issue and to determine the components of a system which will then create a pathway to achieve a goal.
Empowerment	Gaining greater influence and control over health and quality of life.
Enablement	Optimising independence and wellbeing at home (or in a homely setting) through self management and rehabilitation.
Healthcare Academy	Part of NHS Tayside which gives people work experience in a supportive environment, and guarantees them a job interview.
Improvement Methodology	The concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes.
Partner Agencies	All of the organisations that work along with the NHS. This includes other public sector organisations as well as those in the voluntary sector.
Relative poverty	A standard of poverty that compares what an individual or group has compared to most people in that society. This is in contrast to absolute poverty where people are said to be in poverty at a particular

	level regardless of the society around them.
Social Capital	The collective value of all social interactions and networks and the motivation that comes from these networks to do things for each other.
Social Marketing	The systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities.
Social Prescribing	Signposting that seeks to link patients up with non-medical facilities and services available in the wider community that they can access to address factors that influence their wellbeing.
Time banks	A way for people to come together to help others and help themselves at the same time. Participants 'deposit' their time/skills in the 'bank' by giving practical help and support to others and are able to 'withdraw' time/skills when they need something done themselves.
Triple Aim	A framework, developed by Institute of Healthcare Improvement, for the simultaneous pursuit of: 1. The health of a defined population 2. The experience of care by the people in this population 3. The cost per capita for providing care of this population
Unmet Needs Pilots	Pilot studies in Tayside funded by the Scottish Government that were focussed on the issue of inequalities in access to and use of both primary and secondary healthcare services.
Voluntary Sector	Also known as the third or not-for-profit sector. This is different from volunteering.
Wellbeing	A contented state of being happy and healthy.

Appendix 3 – Bibliography

Scottish Government Publications

- *Better Health, Better Care: Action Plan* (December 2007) - http://www.scotland.gov.uk/Publications/2007/12/11103453/0
- *Equally Well: Report of the Ministerial Task Force on Health Inequalities* (June 2008) - http://www.scotland.gov.uk/Publications/2008/06/25104032/0
- *Equally Well Implementation Plan* (December 2008) - http://www.scotland.gov.uk/Publications/2008/12/10094101/0
- *Meeting the Shared Challenge* - http://www.scdc.org.uk/shared-challenge/
- *The Early Years Framework* (January 2009) - http://www.scotland.gov.uk/Publications/2009/01/13095148/0
- *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (May 2009) - http://www.scotland.gov.uk/Publications/2009/05/06154655/0

World Health Organisation (WHO) Publications

- *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health (2008) Geneva, World Health Organization - http://whqlibdoc.who.int/publications/2008/9789241563703_eng_contents.pdf
- *Mental Health, Resilience and Inequalities* (2009) Lynne Friedli - http://www.mentalhealth.org.uk/publications/mental-health-resilience-and-inequalities-report/

Other Publications

Beyond the Trolley Service (December 2009) Angus CHP & Angus Volunteer Centre. For more information see http://www.nhstayside.scot.nhs.uk/news/200912/99182_1_2_15-12-09%20Beyond%20the%20Trolley%20Service%20launches%20in%20Angus.pdf

Co-production – new economics foundation (nef) (July 2008) http://www.neweconomics.org/sites/neweconomics.org/files/Co-production_1.pdf

Mental Health promotion: Building an economic case (2007) - Published by the Northern Ireland Association for Mental Health. Available from http://www.chex.org.uk/uploads/mhpeconomiccase.pdf?sess_scdc=cc2b7ed2fc0a9ae0fd1174ea49092fd5

Pathways to Problems (2006) UK home office - http://drugs.homeoffice.gov.uk/publication-search/acmd/pathways-to-problems/

Securing Good Health for the Whole Population: Final Report (February 2004) – Derek Wanless. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4074426

State of Lonliness (1st July 2009) - Charles Leadbeater. The Guardian - http://www.guardian.co.uk/society/2009/jul/01/public-services-reforms

Books

Malcolm Gladwell (2008). *Outliers: the story of success*. London: Allen Lane.

Cathy McCormack with Marian Pallister (2009). *The Wee Yellow Butterfly*. Argyll Publishing.

Sue Palmer (2007). *Detoxing Childhood: What Parents Need to Know to Raise Happy, Successful Children*. Orion.

Richard Wilkinson & Kate Pickett (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better* . London: Allen Lane.

10.7

Population Maps and Transport Link Information

The changes proposed will provide greater care in the community and allow patients across Tayside to be cared for longer in their local communities and own home environments.

For the residents of South Angus from areas such as Carnoustie, Monifieth, Tealing, Forfar and Monikie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction in travel time and improved transport links for GAP service users requiring acute admission and for their visiting families and carers and NHS staff. Those service users, visitors, staff and carers from North Angus will have increased travel as they are currently closer to current services provided in Susan Carnegie Centre on Stracathro site near Brechin. Approx only 20% of the total current population of Angus live in North Angus. i.e Brechin and Montrose areas which equates to approx 4 to 5 patients of the current 25 acute inpatient admissions

Currently 15% of Angus GAP Acute patient admissions have to be admitted out with Angus to inpatient beds within the Carseview Centre in Dundee and Murray Royal site in Perth due to varying bed demands.

For the residents of North/East Perthshire from areas such as Invergowrie, Longforgan, Errol/Carse of Gowrie, Alyth and Blairgowrie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction or equivalent travel time and improved transport links for GAP service users requiring acute admission and for their visiting families and carers and NHS staff. Those service users, visitors, staff and carers from South/West and more rural Perthshire will have increased travel as they are currently closer to current services provided in Murray Royal Hospital in Perth (furthest additional travel is 21 miles)

Approx 27% of the total current population of Perth & Kinross live in South West and more rural areas of Perth & Kinross. i.e which equates to approx 7 patients of the current 26 acute inpatient admissions.

Approx 45% of the total current population of Perth & Kinross live in city centre area of Perth i.e which equates to approx 11 patients of the current 26 acute inpatient admissions

Approx 28% of the total current population of Perth & Kinross live in the North East area of Perth & Kinross and would therefore be nearer to Carseview Centre i.e which equates to approx 8 patients of the current 26 acute inpatient admissions

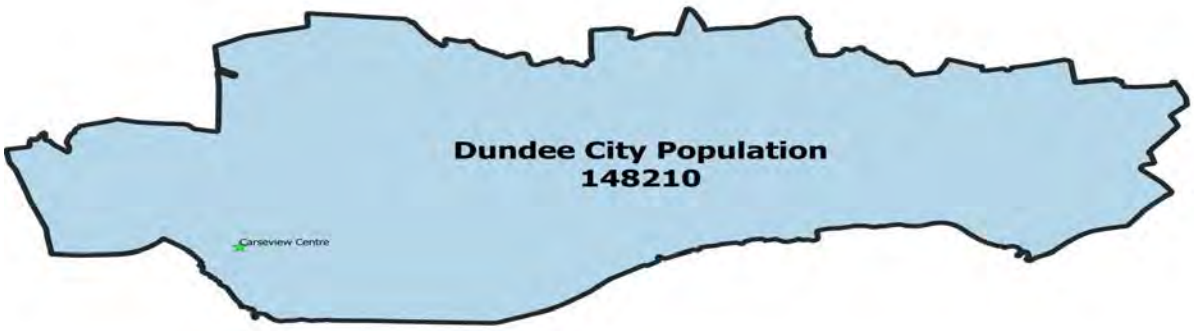
Currently 7% of Perth GAP Acute patient admissions have to be admitted out with Perth & Kinross to inpatient beds within the Carseview Centre in Dundee and Susan Carnegie Centre in Angus due to varying bed demands.

Tayside populations are split across three localities as 36% Perth & Kinross, 28% Angus and 36% Dundee.

The relocation of Learning Disability inpatients beds currently provided in Strathmartine and Carseview sites in Dundee to Murray Royal hospital in Perth will mean greater travelling distances for the population of Angus and Dundee (64% of Tayside population) to access services on the Murray Royal site in Perth (of 30 inpatient beds using this % would be approx 19 service users). However in turn this would mean reduced travelling distances for the residents of Perth & Kinross (34% of Tayside population) approx 11 service users.

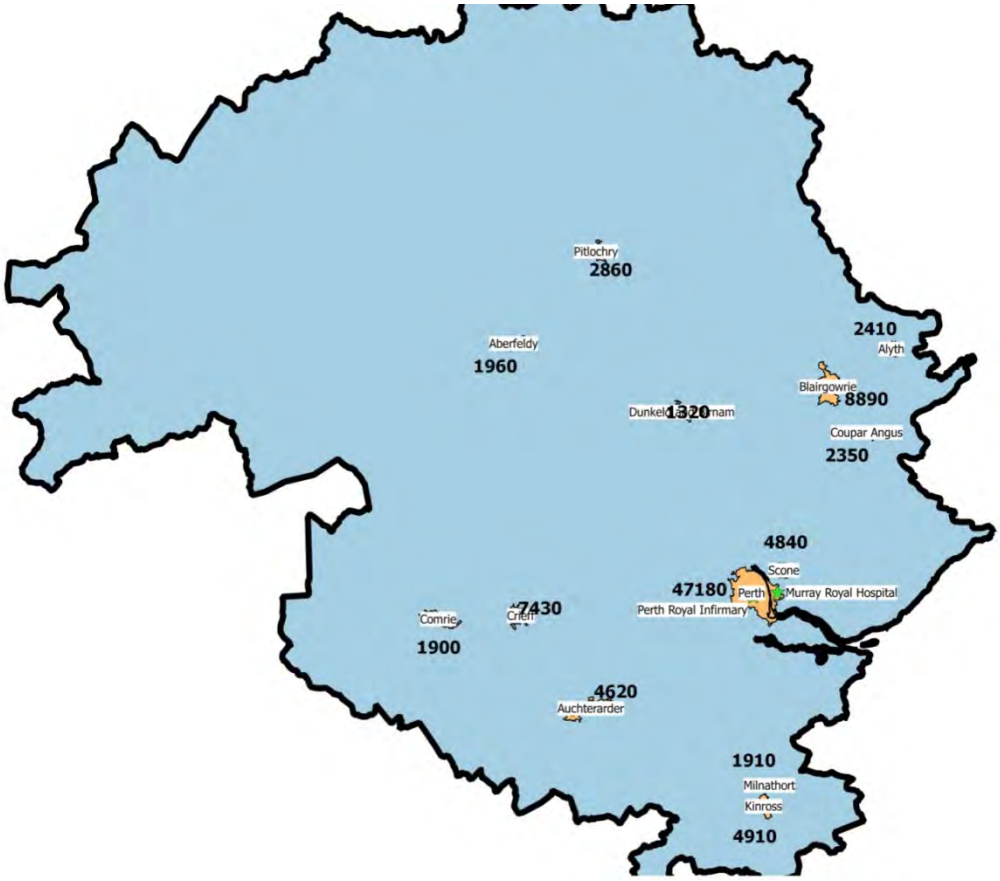
The MHSRT Programme EQIA report considers in full the potential impacts on the population of Tayside and suggested actions to reduce and mitigate impacts.

Dundee



Angus

Perth


Pitlochry
2860
Aberfeldy
1960
2410
Alyth
Blairgowrie
8890
Coupar Angus
2350
4840
Scone
47180
Perth
Murray Royal Hospital
Perth Royal Infirmary
7430
Crieff
Comrie
1900
4620
Auchterarder
1910
Milnathort
Kinross
4910

Public Transport Travel Times - ANGUS

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Forfar		Carseview		1.14 hrs		1.14 hrs
Forfar		Stracathro		38 mins		51 mins
Forfar		Strathmartine		1.23 hrs		1.23 hrs
Forfar		Murray Royal		2 hrs		2.18 hrs
Brechin		Carseview		1.43 hrs		2.45 hrs
Brechin		Stracathro		16 mins		18 mins
Brechin		Strathmartine		1.50 hrs		2.09 hrs
Brechin		Murray Royal		2.05 hrs		2.29 hrs
Arbroath		Carseview		55 mins		1.40hrs
Arbroath		Stracathro		1.19 hrs		1.32 hrs
Arbroath		Strathmartine		1.50 hrs		2.09 hrs
Arbroath		Murray Royal		1.30 hrs		2.01 hrs
Montrose		Carseview		1.08hrs		1.30 hrs
Montrose		Stracathro		43 mins		43 mins
Montrose		Strathmartine		1.29 hrs		1.48 hrs
Montrose		Murray Royal		1.30 hrs		2.19 hrs
Kirriemuir		Carseview		1.30 hrs		1.30 hrs
Kirriemuir		Stracathro		1.08 hrs		1.36 hrs
Kirriemuir		Strathmartine		1.36 hrs		1.42 hrs
Kirriemuir		Murray Royal		1.52 hrs		2.46 hrs
Letham		Carseview		1.33 hrs		1.56 hrs
Letham		Stracathro		45 mins		1.39 hrs
Letham		Strathmartine		1.42 hrs		1.54 hrs
Letham		Murray Royal		2.22 hrs		2.49 hrs
Edzell		Carseview		2.07 hrs		2.28 hrs

Edzell		Stracathro		15 mins		15 mins
Edzell		Strathmartine		2.16 hrs		2.55 hrs
Edzell		Murray Royal		2.53 hrs		3.17 hrs
Carnoustie		Carseview		48 mins		1.03 hrs
Carnoustie		Stracathro		1.12 hrs		2.19 hrs
Carnoustie		Strathmartine		1.24 hrs		1.30 hrs
Carnoustie		Murray Royal		1.15 hrs		1.49 hrs
Monifieth		Carseview		51 mins		51 mins
Monifieth		Stracathro		1.30 hrs		1.58 hrs
Monifieth		Strathmartine		57 mins		1.18 hrs
Monifieth		Murray Royal		1.34 hrs		1.55 hrs
Dundee		Carseview		23 mins		25 mins
Dundee		Stracathro		1.20 hrs		1.30 hrs
Dundee		Strathmartine		28 mins		46 mins
Dundee		Murray Royal		1 hr		1.15 hrs
Muirhead		Carseview		16 mins		41 mins
Muirhead		Stracathro		2 hrs		2.42 hrs
Muirhead		Strathmartine		47 mins		52 mins
Muirhead		Murray Royal		1.44 hrs		2.54 hrs

Mileage Distances - ANGUS

DESTINATION	LOCATION		Mileage by Car
Stracathro	Forfar		18.0 miles
	Brechin		3.7 miles
	Arbroath		19.6 miles
	Montrose		9.4 miles
	Kirriemuir		19.4 miles
	Letham		16.3 miles
	Edzell		3.7 miles
	Carnoustie		24.1 miles
	Monifieth		33.8 miles
	Dundee		29.8 miles
	Muirhead		33.2 miles

DESTINATION	LOCATION		Mileage by car
Carseview	Forfar		18.4 miles
	Brechin		31.1 miles
	Arbroath		20.9 miles
	Montrose		41.9 miles
	Kirriemuir		23.6 miles
	Letham		22.6 miles
	Edzell		36.0 miles
	Carnoustie		15.4 miles
	Monifieth		10.1 miles
	Dundee		4.0 miles
	Muirhead		4.3 miles

DESTINATION	LOCATION		Mileage by Car
Strathmartine	Forfar		14.0 miles
	Brechin		26.8 miles
	Arbroath		19.6 miles
	Montrose		37.5 miles
	Kirriemuir		19.2 miles
	Letham		18.2 miles
	Edzell		31.6 miles
	Carnoustie		14.0 miles
	Monifieth		9.3 miles
	Dundee		4.4 miles
	Muirhead		3.7 miles

DESTINATION	LOCATION		Mileage by car
MRH	Forfar		34.9 miles
	Brechin		47.7 miles
	Arbroath		39.0 miles
	Montrose		58.5 miles
	Kirriemuir		27.6 miles
	Letham		39.0 miles
	Edzell		52.6 miles

	Carnoustie		33.5 miles
	Monifieth		28.7 miles
	Dundee		22.8 miles
	Muirhead		20.9 miles

Public Transport Travel Times - DUNDEE

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Dundee		Carseview		23 mins		25 mins
Dundee		Stracathro		1.20 hrs		1.30 hrs
Dundee		Strathmartine		28 mins		46 mins
Dundee		Murray Royal		1 hr		1.15 hrs

Mileage Distances - DUNDEE

DESTINATION	LOCATION		Mileage by Car
Stracathro	Dundee		29.8 miles
DESTINATION	**LOCATION**		**Mileage by car**
Carseview	Dundee		4.0 miles
DESTINATION	**LOCATION**		**Mileage by Car**
Strathmartine	Dundee		4.4 miles
DESTINATION	**LOCATION**		**Mileage by car**
MRH	Dundee		22.8 miles

Public Transport Travel Times - PERTH

LOCATION		DESTINATION		Min Travel Time		Max Travel Time
Perth		Carseview		42 mins		57 mins
Perth		Stracathro		2 hrs 1 min		2 hrs 33mins

Perth		Strathmartine		1 hr 30 mins		1 hr 50 mins
Perth		Murray Royal		25 mins		27 mins
Blairgowrie		Carseview		1 hr 3 mins		1 hr 41 mins
Blairgowrie		Stracathro		2 hrs 20 mins		3 hrs 20 mins
Blairgowrie		Strathmartine		1 hr 12 mins		1 hr 26 mins
Blairgowrie		Murray Royal		54 mins		59 mins
Pitlochry		Carseview		2 hrs		2 hrs 22 mins
Pitlochry		Stracathro		2 hrs 50 mins		3 hrs 16 mins
Pitlochry		Strathmartine		2 hrs 19 mins		2 hrs 28 mins
Pitlochry		Murray Royal		1 hr 13 mins		1 hr 46 mins
Kinross		Carseview		1 hr 21 mins		1 hr 59 mins
Kinross		Stracathro		2 hrs 54 mins		3 hrs 52 mins
Kinross		Strathmartine		2 hrs 4 mins		2 hrs 11 mins
Kinross		Murray Royal		59 mins		1 hr 6 mins
Coupar Angus		Carseview		53 mins		1 hr 41 mins
Coupar Angus		Stracathro		2 hrs 34 mins		3 hrs 37 mins
Coupar Angus		Strathmartine		1 hr 2 mins		2 hrs 10 mins
Coupar Angus		Murray Royal		41 mins		44 mins
Aberfeldy		Carseview		2 hrs 17 mins		2 hrs 20 mins
Aberfeldy		Stracathro		3 hrs 51 mins		4 hrs 12 mins
Aberfeldy		Strathmartine		2 hrs 48 mins		3 hrs 25 mins
Aberfeldy		Murray Royal		1 hr 41 mins		1 hr 44 mins
Crieff		Carseview		1 hr 33 mins		2 hrs 25 mins
Crieff		Stracathro		3 hrs 6 mins		3 hrs 15 mins
Crieff		Strathmartine		2 hrs 21 mins		2 hrs 47 mins
Crieff		Murray Royal		1 hr 6 mins		1 hr 7 mins
Auchterarder		Carseview		1 hr 17 mins		1 hr 39 mins
Auchterarder		Stracathro		2 hrs 50 mins		3 hrs 28 mins

Auchterarder		Strathmartine		1 hr 55 mins		2 hrs 41 mins
Auchterarder		Murray Royal		50 mins		1 hr 9 mins
Errol/Carse of Gowrie		Carseview		50 mins		1 hr 8 mins
Errol/Carse of Gowrie		Stracathro		2 hrs 25 mins		2 hrs 56 mins
Errol/Carse of Gowrie		Strathmartine		1 hr 25 mins		2 hrs 4 mins
Errol/Carse of Gowrie		Murray Royal		40 mins		40 mins
Dunkeld		Carseview		1 hr 43 mins		2 hrs 7 mins
Dunkeld		Stracathro		3 hrs 13 mins		3 hrs 39 mins
Dunkeld		Strathmartine		2 hrs 26 mins		2 hrs 36 mins
Dunkeld		Murray Royal		1 hr 7 mins		1 hr 20 mins
Kinloch Rannoch		Carseview		2 hrs 35 mins		4 hrs
Kinloch Rannoch		Stracathro		4 hrs 10 mins		4 hrs 41 mins
Kinloch Rannoch		Strathmartine		3 hrs 17 mins		4 hrs 10 mins
Kinloch Rannoch		Murray Royal		2 hrs 16 mins		2 hrs 49 mins
Alyth		Carseview		1 hr		1 hr
Alyth		Stracathro		1 hr 44 mins		3 hrs 5 mins
Alyth		Strathmartine		1 hr 10 mins		1 hr 11 mins
Alyth		Murray Royal		1 hr 16 mins		1 hr 21 mins

Mileage Distances - PERTH

DESTINATION	LOCATION		Mileage by Car
Stracathro	Perth		51.58
	Blairgowrie		36.73
	Pitlochry		60.92
	Kinross		65.17
	Coupar Angus		33.21
	Aberfeldy		65.09
	Crieff		69.74
	Auchterarder		64.1
	Errol/Carse of Gowrie		43.83
	Kinloch Rannoch		85.14

	Dunkeld		48.04
	Alyth		32.64
DESTINATION	**LOCATION**		**Mileage by car**
Carseview	Perth		19.66
	Blairgowrie		18.66
	Pitlochry		48.37
	Kinross		33.24
	Coupar Angus		13.81
	Aberfeldy		52.54
	Crieff		37.81
	Auchterarder		32.17
	Errol/Carse of Gowrie		11.9
	Dunkeld		36.18
	Kinloch Rannoch		72.58
	Alyth		17.01

DESTINATION	**LOCATION**		**Mileage by Car**
Strathmartine	Perth		23.22
	Blairgowrie		17.95
	Pitlochry		51.93
	Kinross		36.81
	Coupar Angus		13.11
	Aberfeldy		56.1
	Crieff		41.37
	Auchterarder		35.73
	Errol/Carse of Gowrie		15.46
	Dunkeld		14.52
	Kinloch Rannoch		76.15
	Alyth		15.15

DESTINATION	**LOCATION**		**Mileage by car**
MRH	Perth		1.68
	Blairgowrie		15.51
	Pitlochry		27.24
	Kinross		18.3
	Coupar Angus		13.2

	Aberfeldy		31.41
	Crieff		17.99
	Auchterarder		17.23
	Errol/Carse of Gowrie		10.28
	Dunkeld		15.05
	Kinloch Rannoch		51.47
	Alyth		22

Population Figures

Perth
populations.xlsx

Population figures - Perth & Kinross			
	Population		%
Ward 1 - Carse of Gowrie [247kb]	9684		
Ward 2 - Strathmore [277kb]	15218		
Ward 3 - Blairgowrie and the Glens [247kb]	10946		
		35848	28
Ward 4 - Highland [309kb]	9252		
Ward 5 - Strathtay [217kb]	1081		
Ward 6 - Strathearn [236kb]	1102		
Ward 7 - Strathallan [246kb]	10394		
Ward 8 - Kinross-shire [247kb]	13208		
		35037	27
Ward 9 - Almond and Earn [246kb]	10802		
Ward 10 - Perth City South [309kb]	13628		
Ward 11 - Perth City North [210kb]	17489		
Ward 12 - Perth City Centre [305kb]	15946		
		57865	45
	128750		

Population figures - Perth & Kinross			
	Population		%
Ward 1 - Carse of Gowrie [247kb]	9684		
Ward 2 - Strathmore [277kb]	15218		
Ward 3 - Blairgowrie and the Glens [247kb]	10946		
		35848	28
Ward 4 - Highland [309kb]	9252		
Ward 5 - Strathtay [217kb]	1081		
Ward 6 - Strathearn [236kb]	1102		
Ward 7 - Strathallan [246kb]	10394		
Ward 8 - Kinross-shire [247kb]	13208		
		35037	27
Ward 9 - Almond and Earn [246kb]	10802		
Ward 10 - Perth City South [309kb]	13628		
Ward 11 - Perth City North [210kb]	17489		
Ward 12 - Perth City Centre [305kb]	15946		
		57865	45
	128750		

10.8

Benchmarking Information (Extracts from Cost Book 2015/16)


R040LS Gen Psy spend per head of po


R040LS Learn Dis spend per head of po


R040LS GAP Staffing.xlsx


R040LD Staff Levels.xlsx


R500 GAP and LD Community info.xlsx

R040LS: SPECIALTY GROUP COSTS - INPATIENTS IN LONG STAY SPECIALTIES

This is an ISD Scotland *National Statistics* release

April 2015 - March 2016

22nd November 2016

Specialty Name	Board Code	Hospital, Board Cipher and Classification	Occupied Beds Days	Discharges	Total Costs								Population	Cost per head of pop
					Gross		Income		Net			Expend		
					Expend-iture £000	Cost per Inpatient Week £	Income ACT £000	Income Other £000	Expend-iture £000	Cost per Inpatient week £	Group Index			£
General Psychiatry	SAA20	NHS Ayrshire & Arran	36,707	2,081	18,947	3,613	-291	-416	18,239	3,478	103	18,239,350	370,590	49.22
General Psychiatry	SBA20	NHS Borders	9,161	437	3,682	2,814	-45	-303	3,334	2,548	76	3,334,309	114,030	29.24
General Psychiatry	SFA20	NHS Fife	48,390	1,039	18,897	2,734	-115	-425	18,358	2,656	79	18,357,974	368,080	49.87
General Psychiatry	SGA20	NHS Greater Glasgow & Clyde	224,093	4,119	104,566	3,266	-	-1,163	103,403	3,230	96	103,402,878	1,149,890	89.92
General Psychiatry	SHA20	NHS Highland	38,996	1,136	19,654	3,528	-11	-396	19,247	3,455	103	19,247,199	321,000	59.96
General Psychiatry	SLA20	NHS Lanarkshire	43,973	1,302	19,598	3,120	-	-10	19,588	3,118	93	19,587,945	654,490	29.93
General Psychiatry	SNA20	NHS Grampian	63,776	1,438	29,555	3,244	-336	-1,862	27,357	3,003	89	27,356,657	587,820	46.54
General Psychiatry	SRA01	NHS Orkney	3	2	1	3,214	-	0	1	3,179	94	1,363	21,670	0.06
General Psychiatry	SSA20	NHS Lothian	94,303	2,427	44,401	3,296	-44	-3,127	41,230	3,060	91	41,230,395	867,800	47.51
General Psychiatry	STA20	NHS Tayside	60,831	1,528	36,261	4,173	-714	-1,706	33,841	3,894	116	33,841,054	415,040	81.54
General Psychiatry	SVA20	NHS Forth Valley	32,388	1,020	14,911	3,223	-	-467	14,444	3,122	93	14,443,857	302,650	47.72
General Psychiatry	SWA01	NHS Western Isles	1,206	214	607	3,525	-5	-13	589	3,421	102	589,347	27,070	21.77
General Psychiatry	SYA20	NHS Dumfries & Galloway	9,541	487	6,281	4,608	-34	-86	6,161	4,520	134	6,160,588	149,670	41.16
								Scottish average		3,283		305,792,915	5,349,800	57.16

R040LS: SPECIALTY GROUP COSTS - INPATIENTS IN LONG STAY SPECIALTIES

This is an ISD Scotland *National Statistics* release

April 2015 - March 2016

22nd November 2016

Specialty Name	Board Code	Hospital, Board Cipher and Classification		Average Staffed Beds	Occupied Beds Days	Average Occupancy Ratio %	Discharges	Net Expend-iture £000	Net Cost per Inpatient week £	Net Group Index	Expend	Population (from R100 published report 1516)	Cost per head of population
Learning Disabilities	SAA20	NHS Ayrshire & Arran		14	4011	77.9	32	3863	6741	170	3,862,579	370,590	10.42
Learning Disabilities	SFA20	NHS Fife		33	10823	89.1	23	7709	4986	126	7,708,625	368,080	20.94
Learning Disabilities	SGA20	NHS Greater Glasgow & Clyde		42	14553	94.8	36	6963	3349	84	6,962,618	1,149,890	6.06
Learning Disabilities	SHA20	NHS Highland		6	1801	81.4	16	1794	6971	176	1,793,631	321,000	5.59
Learning Disabilities	SLA20	NHS Lanarkshire		12	4142	94.3	12	2109	3564	90	2,108,591	654,490	3.22
Learning Disabilities	SNA20	NHS Grampian		18	5008	76.0	32	3092	4322	109	3,092,192	587,820	5.26
Learning Disabilities	SSA20	NHS Lothian		76	24296	88.1	149	10855	3127	79	10,854,612	867,800	12.51
Learning Disabilities	STA20	NHS Tayside		37	12371	92.4	62	7655	4331	109	7,654,648	415,040	18.44
Learning Disabilities	SVA20	NHS Forth Valley		26	8829	92.7	30	4330	3433	87	4,330,171	302,650	14.31
Learning Disabilities	SYA20	NHS Dumfries & Galloway		13	2921	63.3	728	1947	4666	118	1,947,184	149,670	13.01
Learning Disabilities		**Scotland Totals or Averages**		**277**	**88755**	**87.9**	**1120**	**50315**	**3968**	**100**	50,314,850	5,373,000	9.36
Learning Disabilities		**Number of Hospitals: 16**											

R040LS: SPECIALTY GROUP COSTS - INPATIENTS IN LONG STAY SPECIALTIES

April 2015 - March 2016

Specialty Name	Hospital, Board Cipher and Classification	Average Staffed Beds	Occupied Beds Days	Average Occupancy Ratio %	Discharges	Average Staff Numbers		Population	**Nursing** 1 member of staff per no. of population	**Medical** 1 member of staff per no. of population
						Medical & Dental WTE	Nursing WTE			
General Psychiatry	NHS Ayrshire & Arran	132	36707	76.4	2081	30.11	245.75	370,590	1,508	12,308
General Psychiatry	NHS Borders	32	9161	77.8	437	1.60	53.68	114,030	2,124	71,269
General Psychiatry	State Hospital	140	44720	87.5	39	13.28	347.40			
General Psychiatry	NHS Fife	159	48390	83.3	1039	18.69	240.10	368,080	1,533	19,694
General Psychiatry	NHS Greater Glasgow & Clyde	668	224093	91.9	4119	132.35	1298.41	1,149,890	886	8,688
General Psychiatry	NHS Highland	128	38996	83.3	1136	23.50	219.07	321,000	1,465	13,660
General Psychiatry	NHS Lanarkshire	141	43973	85.2	1302	37.08	223.92	654,490	2,923	17,651
General Psychiatry	NHS Grampian	244	63776	71.6	1438	61.02	320.91	587,820	1,832	9,633
General Psychiatry	NHS Orkney	0	3	100.0	2	-	0.01	21,670		
General Psychiatry	NHS Lothian	298	94303	86.8	2427	84.48	568.71	867,800	1,526	10,272
General Psychiatry	NHS Tayside	209	60831	79.7	1528	42.33	349.29	415,040	1,188	9,805
General Psychiatry	NHS Forth Valley	120	32388	73.7	1020	17.43	192.91	302,650	1,569	17,364
General Psychiatry	NHS Western Isles	6	1206	56.2	214	0.50	5.74	27,070	4,716	54,140
General Psychiatry	NHS Dumfries & Galloway	46	9541	56.7	487	8.97	93.80	149,670	1,596	16,686
General Psychiatry	**Scotland Totals or Averages**	**2324**	**708088**	**83.5**	**17269**	**471.34**	**4159.70**	5,349,800	1,403	11,679
General Psychiatry	**Number of Hospitals: 36**									

R040LS: SPECIALTY GROUP COSTS - INPATIENTS IN LONG STAY SPECIALTIES

April 2015 - March 2016

Specialty Name	Hospital, Board Cipher and Classification	Average Staffed Beds	Occupied Beds Days	Average Occupancy Ratio %	Discharges	Average Staff Numbers		Population	**Nursing** 1 member of staff per no. of population	**Medical** 1 member of staff per no. of population
						Medical & Dental WTE	Nursing WTE			
Learning Disabilities	NHS Ayrshire & Arran	14	4011	77.9	32	2.08	61.73	370,590	6,003	178,168
Learning Disabilities	NHS Fife	33	10823	89.1	23	2.43	123.68	368,080	2,976	151,473
Learning Disabilities	NHS Greater Glasgow & Clyde	42	14553	94.8	36	4.44	126.91	1,149,890	9,061	258,984
Learning Disabilities	NHS Highland	6	1801	81.4	16	1.35	27.44	321,000	11,698	237,778
Learning Disabilities	NHS Lanarkshire	12	4142	94.3	12	1.68	26.69	654,490	24,522	389,577
Learning Disabilities	NHS Grampian	18	5008	76.0	32	2.69	45.32	587,820	12,970	218,520
Learning Disabilities	NHS Lothian	76	24296	88.1	149	1.22	244.42	867,800	3,550	711,311
Learning Disabilities	NHS Tayside	37	12371	92.4	62	2.91	97.86	415,040	4,241	142,625
Learning Disabilities	NHS Forth Valley	26	8829	92.7	30	2.51	71.30	302,650	4,245	120,578
Learning Disabilities	NHS Dumfries & Galloway	13	2921	63.3	728	1.83	40.11	149,670	3,731	81,787
Learning Disabilities	**Scotland Totals or Averages**	**277**	**88755**	**87.9**	**1120**	**23.14**	**865.46**	5,187,030	5,993	224,159
Learning Disabilities	**Number of Hospitals: 16**									

R500: COMMUNITY SERVICES: SUMMARY OF SERVICE PROVISION

This is an ISD Scotland *National Statistics* release

April 2015 - March 2016

22nd November 2016

Number of Boards: 14

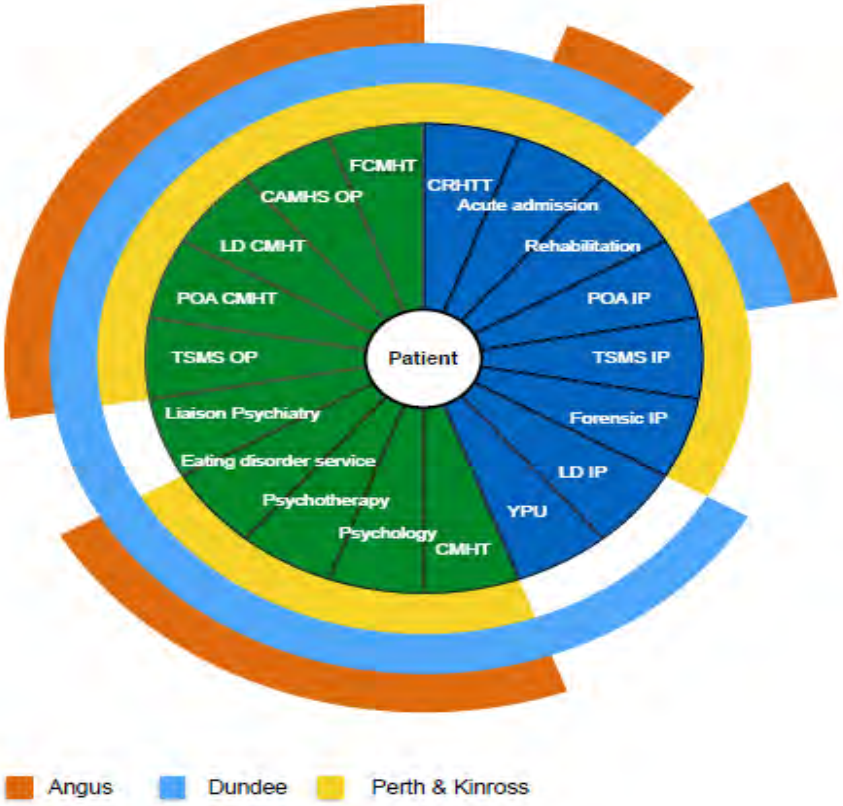
Board		Community Psychiatric Team		Community Learning Difficulties Team		Child Health	Specialist Nursing	Addiction Services	Family Planning	Total Net Expenditure
		Net Expenditure £000	Net Cost per Head of Population £	Net Expenditure £000	Net Cost per Head of Population £	Net Expenditure £000	Net Expenditure £000	Net Expenditure £000	Net Expenditure £000	£000
Totals or Averages		**210,981**	**39**	**36,311**	**7**	**90,724**	**43,300**	**80,922**	**35,898**	**1,706,103**
NHS Ayrshire & Arran	A	15,740	42	2,026	5	6,425	668	5,146	1,197	117,508
NHS Borders	B	7,090	62	963	8	2,128	151	1,076	740	44,941
NHS Fife	F	7,527	20	822	2	7,401	5,239	3,439	2,158	97,119
NHS Greater Glasgow & Clyde	G	65,242	57	12,827	11	28,562	15,762	27,393	13,010	424,664
NHS Highland	H	9,310	29	1,446	5	3,840	1,600	1,628	104	111,813
NHS Lanarkshire	L	28,222	43	2,790	4	9,748	4,612	9,438	2,095	201,733
NHS Grampian	N	12,530	21	3,270	6	4,335	6,803	8,074	2,154	162,328
NHS Orkney	R	349	16	1	0	192	156	489	25	9,847
NHS Lothian	S	33,054	38	6,973	8	15,650	1,323	15,225	10,208	253,665
NHS Tayside	T	16,033	39	2,691	6	5,256	1,824	3,747	2,476	125,735
NHS Forth Valley	V	8,700	29	1,373	5	3,141	2,297	3,188	750	82,622
NHS Western Isles	W	1,055	39	40	1	-	1,948	-	-	14,004
NHS Dumfries & Galloway	Y	5,025	34	1,002	7	3,746	737	1,539	930	50,072
NHS Shetland	Z	1,104	48	86	4	300	179	541	50	10,052

Appendix Eleven

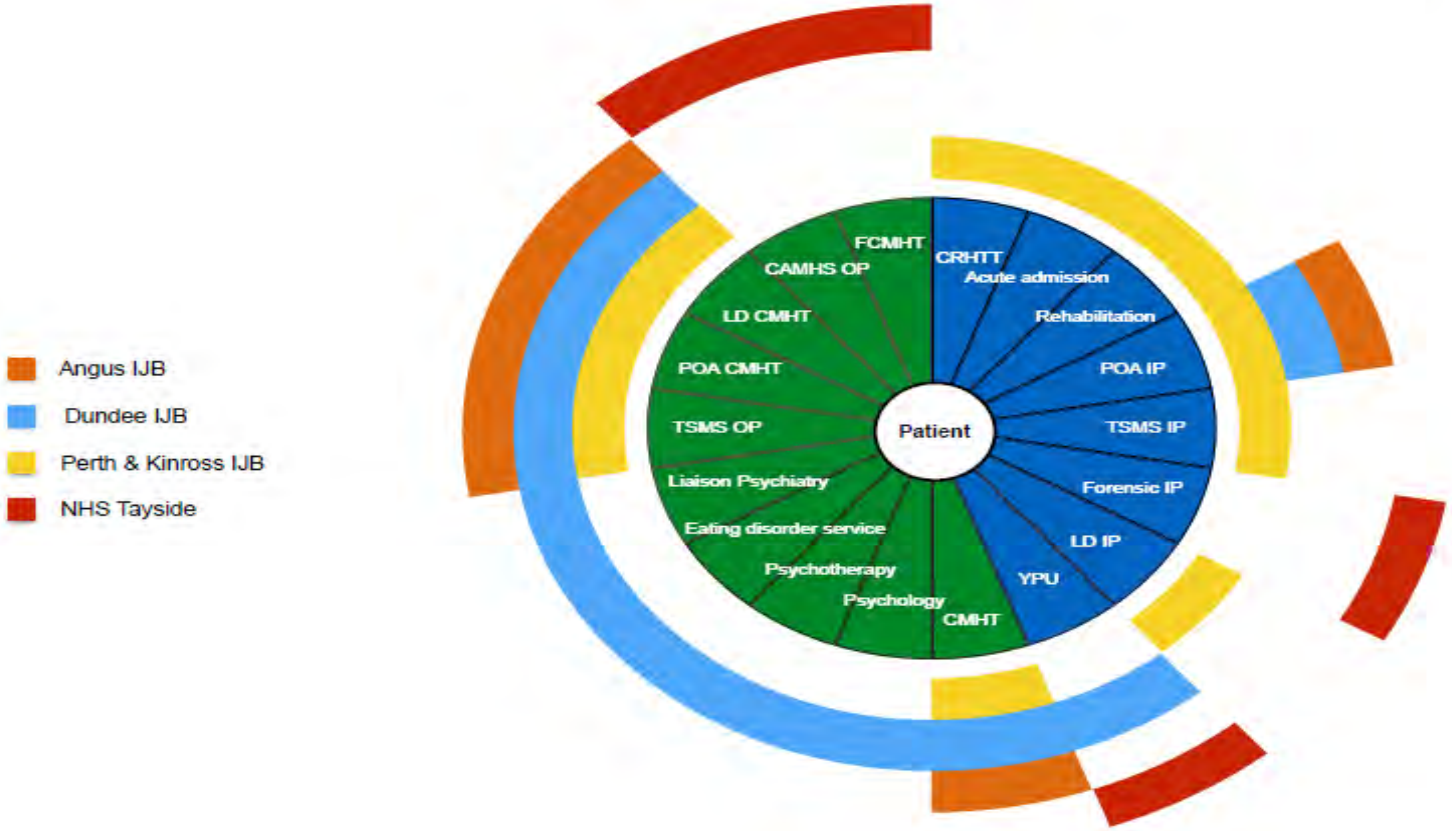
Reporting Governance Structure

Mental health services delivered in each Local Authority area

CRHTT Crisis Resolution Home Treatment Team
IP Inpatient unit
OP Outpatient service
CMHT Community Mental Health Team
FCMHT Forensic CMHT
LD Learning Disability
TSMS Tayside Substance Misuse Service

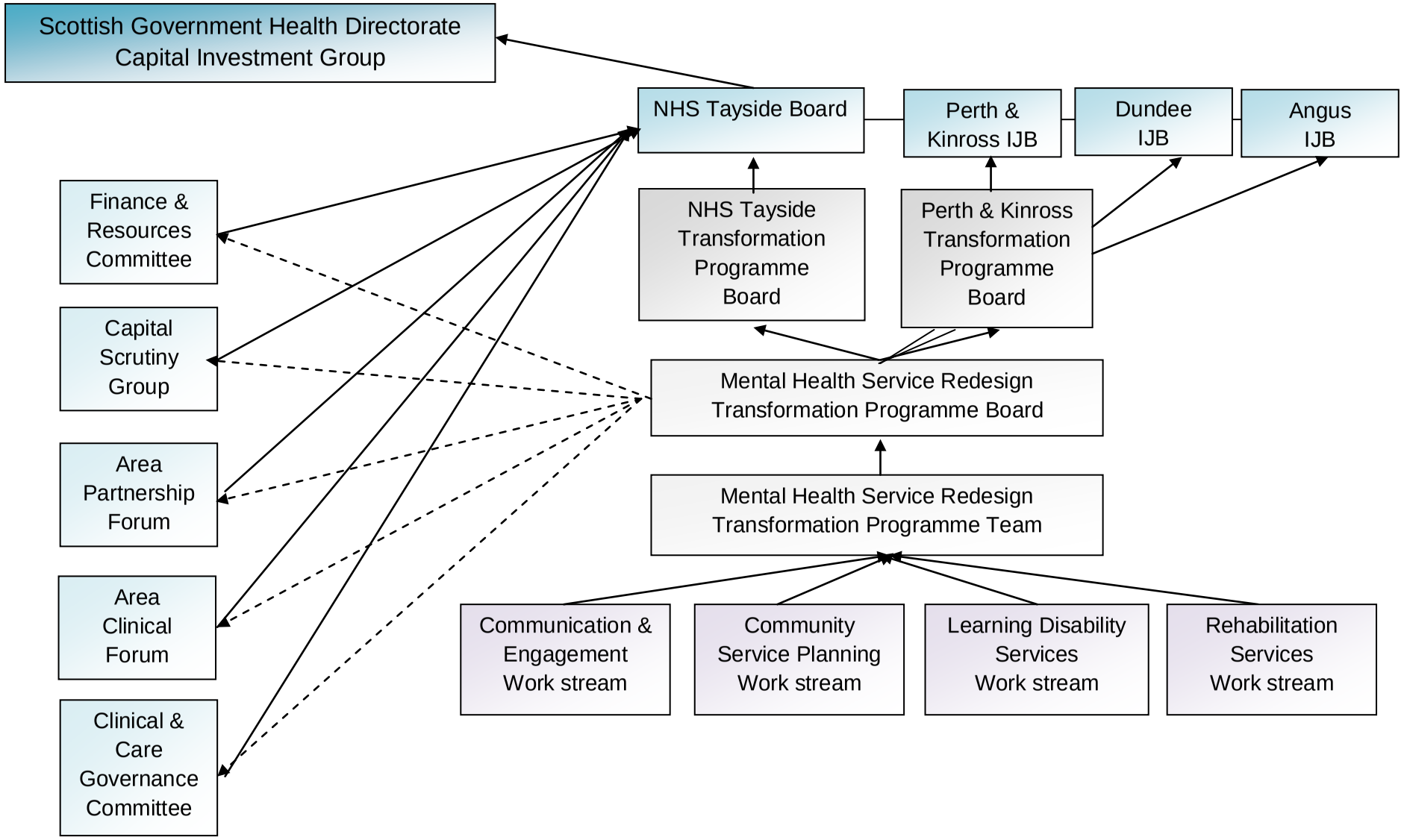


Mental Health Service managed by Integrated Joint Boards and directly by Health Board



MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME GOVERNANCE/REPORTING STRUCTURE

11.3



Appendix Twelve

CEL 4 (2010) Guidance

Director-General Health and Chief Executive NHS Scotland
Dr Kevin Woods

T: 0131-244 2410 F: 0131-244 2162
E: dghealth@scotland.gsi.gov.uk

Dear Colleague

INFORMING, ENGAGING AND CONSULTING PEOPLE IN DEVELOPING HEALTH AND COMMUNITY CARE SERVICES

Purpose

To provide revised guidance – Informing, Engaging and Consulting People in Developing Health and Community Care Services – to assist NHS Boards with their engagement with patients, the public, and stakeholders on the delivery of local healthcare services. The principles of the guidance should be applied, proportionally, to any service change proposed by a Board, including any changes considered to be major.

Summary

The guidance, which has been prepared by the Scottish Government
Health Directorate in consultation with a wide range of stakeholders, supersedes the Scottish Home and Health Department circular

("*Closure and Change of Use of Health Service Premises*") dated 3 June 1975, the draft interim guidance ("*Consultation and Public Involvement in Service Change*") issued through an HDL in 2002 (HDL (2002) 42), and the draft guidance ("*Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services*") issued for comment in 2004.

CEL 4 (2010)

10 February 2010
Addresses

For action
NHS Board Chief Executives;
NHS Board Directors of Planning;
NHS Patient Focus and Public Involvement Designated Directors

For information
NHS Board Directors of Human Resources;
Chairman, Scottish Health Council
Director, Scottish Health Council
;
SWAG;
MSG;
SPF

Enquiries to:
John B Davidson
Public Involvement Manager
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Tel: 0131-244-4152
Fax: 0131-244-2989
john.b.davidson@scotland.gsi.gov.uk

Scope

The guidance:

- Sets out the relevant legislative and policy frameworks for involving the public in the delivery of services;
- Provides a step-by-step guide through the process of informing, engaging and consulting the public in service change proposals;
- Explains the decision making process with regard to major service change and the potential for independent scrutiny; and
- Clarifies the role of the Scottish Health Council.

How to use the Guidance

Whilst decisions regarding the provision of NHS services remain a matter for NHS Boards (with the exception of major service changes), there is a need to ensure a consistent and robust approach is adopted when Boards consider and propose new services or changes to existing services. This guidance should therefore provide a suitable framework to deliver that aim.

The guidance should also be considered alongside associated guidance prepared by the Scottish Health Council on major service change ('*Guidance on Identifying Major Health Service Changes')* and the option appraisal process ('*Involving Patients, Carers and the Public in Option Appraisal for Major Health Services Changes').*

Training

As part of their commitment to the provision of training in support of NHS Boards Patient Focus and Public Involvement activity, NHS Education for Scotland has commissioned training for NHS staff which will assist in the implementation of this guidance. For further information please contact Jane Davies, Educational Projects Manager (PFPI) at NES on 0141 352 2927 or jane.davies@nes.scot.nhs.uk.

Access and Updating

The guidance will be available in electronic format on the Scottish Government website www.scotland.gov.uk and the Scottish Health Council's website http://scottishhealthcouncil.org (where the guidance on major service change and the option appraisal process can also be found). The guidance will be reviewed by the end of 2011, or earlier if required.

Actions for NHS Boards

NHS Boards are asked to ensure that this guidance is brought to the attention of all appropriate staff involved in the provision of new services or changes to existing services. Ministers will wish to see evidence of this when considering proposals for major service change and through Boards' wider patient focus and public involvement activities.

Yours sincerely

KEVIN WOODS

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.scotland.gov.uk

INFORMING, ENGAGING AND CONSULTING PEOPLE IN DEVELOPING HEALTH AND COMMUNITY CARE SERVICES

Introduction

1. This guidance has been developed to assist NHS Boards with their engagement with patients, the public and stakeholders on the delivery of local healthcare services. The principles of the guidance should be applied, proportionally, to any service change proposed by a Board, including any changes considered to be 'major'. When appropriate, Special Boards and the Common Service Agency/NSS Scotland[1] exercising a non-clinical or public-facing function should also follow the principles of this guidance when engaging with their stakeholders.

2. The duty of public involvement covers all Health Boards, Special Health Boards and the Common Services Agency when they are providing a service to the public which they are responsible for[2]. This also includes when services are provided on their behalf, for example by a contractor, to the public. For Health Boards this will cover the majority of their actions but Special Health Boards and the CSA will have to consider whether their actions impact directly on services provided to individuals and, if so, follow the principles of this guidance.

3. This guidance supersedes the Scottish Home and Health Department circular ("*Closure and Change of Use of Health Service Premises*") dated 3 June 1975, the draft interim guidance ("*Consultation and Public Involvement in Service Change*") issued through an HDL in 2002 (HDL (2002) 42), and the draft guidance ("*Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services*") issued for comment in 2004.

Background

4. NHS Boards are required to involve people[3] in designing, developing and delivering the health care services they provide for them. Boards' responsibilities in this area were initially set out in the policy document, *Patient Focus and Public Involvement (PFPI)*. However, to reflect the importance of this agenda, duties of public involvement and

[1] References to NHS Boards or Boards should be read to include reference to Special Health Boards and CSA/NSS where appropriate.
[2] Section 2B of the National Health Service (Scotland) Act 1978, as inserted by the National Health Service Reform (Scotland) Act 2004.
[3] In this guidance the word "people" should be interpreted to refer to health service users, patients, staff, members of the public, carers, volunteers, and the voluntary organisations which represent them.

equal opportunities were placed on NHS Boards in the *NHS Reform*

(Scotland) Act 2004[4].

5. The Scottish Health Council was established to ensure NHS Boards meet their patient focus and public involvement responsibilities, and to support them in doing so. *Better Health, Better Care: Action Plan* (2007) set out a vision for the NHS, based on a theme of mutuality that sees the Scottish people and the staff of the NHS as partners, or co-owners in the NHS. One of the ways in which this will be measured is through the new Participation Standard, and the processes set out in this guidance should help Boards demonstrate their efforts around public involvement.

6. It should be noted that this guidance extends to the services delivered by GPs etc through Primary and Community Care, although it is recognised that the contractual arrangements for GPs, GDPs, GOPs and Community Pharmacists[5] are all governed by particular regulations. While services themselves are provided by contractors, Boards are still required to adhere to this guidance when they are considering changes to the contractual, and other, arrangements for primary care services. While independent contractors are responsible for running their own practices they are also expected to engage in a proportionate way with their patients and relevant community groups (such as Public Partnership Forums) when planning any changes to the way they deliver services.

Community Engagement

7. To fulfil their responsibilities for public involvement, NHS Boards should routinely communicate with and involve the people and communities they serve to inform them about their plans and performance. Where appropriate, this should also include involvement of and partnership working with wider stakeholders and other agencies. In doing so, Boards should follow the principles and practice endorsed by the Scottish Health Council, in particular the *National Standards for Community Engagement.*

8. Public Partnership Forums, established by Community Health Partnerships, provide a mechanism for promoting the routine involvement of local people in the design and delivery of the health services they use. NHS Boards should also work closely with their Community Planning

[4] http://www.opsi.gov.uk/legislation/scotland/acts2004/20040007.htm

[5] In fact, the National Health Services (Pharmaceutical Services) Regulations 2009 at paragraph 2 of Schedule 3, places an obligation on Boards to consult the public when they are considering an application for inclusion on the pharmaceutical list.

partners to consider opportunities for joint working and to minimise duplication in their community engagement mechanisms.

NHS Board responsibilities

9. In accordance with equalities legislation, including the public sector duties http://www.equalityhumanrights.com/advice-and-guidance/public- sector-duties/), a Board is responsible for:

   - ensuring that the informing, engaging, consulting process is fully accessible to all equality groups; and

   - ensuring that any potentially adverse impact of the proposed service change on different equality groups has been taken account by undertaking an equality impact assessment

10. Where a Board is considering consulting the public about a service development or change, it is responsible for:

    - informing potentially affected people, staff[6] and communities of their proposal and the timetable for:
      - involving them in the development and appraisal of options.
      - involving them in a (proportionate) consultation on the agreed options.
      - reaching a decision.
      - ensuring that the process is subject to an e*quality and diversity impact assessment.*
      - ensuring that any potentially adverse impacts of the proposed service change, on, for example, the travel arrangements of
      - patients, carers, visitors and staff, have been taken account of in the final proposal.
      - providing evidence of the impact of this public involvement on the
      - final agreed service development or change.

11. Where a proposed service change would impact on the public in another area, the Board proposing the change should lead the public involvement process. The Board, and any other affected Board(s), should aim to maximise the involvement of affected individuals and communities in the process. Proposed changes to regional or national services should

[6] in this guidance the word 'staff' should be interpreted widely to include those who are employed or contracted to work in or with the affected service. Boards would be expected to demonstrate that they had appropriately involved staff.

also follow the principles set out in this guidance and, as above, the Board proposing the change should lead the involvement process, ensuring that it engages with the public and its wider stakeholders.

The Scottish Health Council's role

12. The Scottish Health Council was established to ensure NHS Boards meet their patient focus and public involvement responsibilities, and to support them in doing so. Boards should therefore keep the Scottish Health Council informed about proposed service changes so that it can provide Boards with advice and, if necessary, support in involving potentially affected people in the process.

13. When a Board proposes a major service change, its staff should work with the Scottish Health Council to ensure that potentially affected people and communities have the information and support they need to play a full part in the consultation process. As the Scottish Health Council is required to quality assure the process as it develops, Boards should engage with it at the earliest possible stage and ensure any issues identified by it are acted upon.

14. The Scottish Health Council does not comment on clinical or financial issues; the adequacy of Board compliance with the technical requirements laid out in *The Green Book* option appraisal process; or the effectiveness of a Board's engagement with its own staff. It will, however, look to the Board to provide evidence that the views of potentially affected people and communities have been sought, listened to and acted on; and treated with the same priority (unless in exceptional circumstances e.g. patient safety) as clinical standards and financial performance.

Major Service Change

15. Where a proposed service change will have a major impact on a patient or carer group, members of equalities communities or on a geographical community, the Scottish Health Council can advise on the nature and extent of the process considered appropriate in similar cases. Boards should, however, seek advice from the Scottish Government Health Directorate (SGHD) on whether a service change is considered to be major and, for those that are, Ministerial approval on the Board's decision will be required. Prior to seeking the Scottish Government Health Directorate's advice on whether the proposed service change is major, Boards should use the Scottish Health Council's guidance "Guidance on Identifying Major Health Service Changes" to help inform their own considerations.

Independent Scrutiny

16. The purpose of independent scrutiny is to promote confidence in the major service change process in the NHS in Scotland, by providing an expert and impartial assessment of the proposals developed by Boards, and the assumptions that underpin them. In some cases - and where the benefits outweigh the costs - Ministers may decide to establish an Independent Scrutiny Panel to assess the safety, sustainability, evidence base and value for money of proposals. The Panel will seek to ensure that proposals are robust, person-centred and consistent with clinical evidence and/or best practice, national policy, and that all practical options have been considered.

17. The Panel will provide a clear, comprehensive and accessible commentary on the evidence presented by the Board, and the notes of the Panel's meetings and its report will be published. The Independent Scrutiny Panel will not reach a view on a preferred option as this will remain a decision for the Board to take as part of the option appraisal process.

18. Independent scrutiny is likely to be conducted prior to the Board's formal public consultation process as the Board will ultimately be expected to demonstrate how they have taken the Panel's findings into account in finalising its service proposals for consultation.

The Process of Informing, Engaging and Consulting

19. Public consultation about a service change should grow naturally out of a Board's everyday communication and dialogue with the people it serves. This guidance should support staff in their efforts to engage the public, and offer potentially affected people and communities a real opportunity to influence the Board's decision-making about the design and delivery of services through their involvement in:

- developing and appraising possible options to decide which should be the subject of a public consultation; and
- the public consultation on the preferred option(s).

20. The public involvement process should be applied in a realistic, manageable and proportionate way to any service development or change, including those that are time limited (temporary) or trialled through a pilot initiative, which will have an impact on the way in which people access or use NHS services. The process should be applied to

any proposed service change, although some additional criteria will apply for any service changes considered to be major. These are:

- The consultation period should last for a minimum of 3 months;
- The Scottish Health Council will produce a report assessing whether the Board has involved people in accordance with this guidance;
- The Board's final proposal will be subject to Ministerial approval

Planning

21. As soon as a Board is aware of a need to consider a change to a service, it should develop an involvement and communication plan which details how the engagement process will be carried out. One tool that could be used to do this is the VOiCE (Visioning Outcomes in Community Engagement) database, which has been developed to help those involved in community engagement activity achieve the National Standards by planning, recording and monitoring community engagement activity.

22. The plan, which can be developed with advice from the Scottish Health Council, should ensure that potentially affected people and communities are provided with the information and support they need to play a full part in the consultation process. The Scottish Health Council can provide:

- views on the type of involvement they would expect to see for the proposed service development or change.
- views on similar work and good practice elsewhere.
- support in quality assuring the process (major service changes only)as it develops.
- guidance on the evaluation process

Informing

23. The people and communities who may be affected by a proposed service development or change should be given information about the:

- clinical, financial and other reasons why change is needed and which may limit possible choices, including reference to any relevant legislation or Scottish Government policies.
- benefits that are expected to flow from the proposed change.
- processes, such as carrying out a transport needs assessment, which will be put in place to assess the impact of the proposal.

24. When appropriate, it is also good practice to inform people about changes to management or organisational structures, even if they do not directly affect service users.

Engaging

25. There should be an open, transparent and accessible process of developing the choices or options which can be delivered within the available resources, in which potentially affected people and communities should be proactively engaged. The Scottish Health Council can be consulted about the communication and involvement techniques to be used which will vary depending on the issue involved, and the people and groups the Board is trying to reach.

Option Development and Appraisal

26. The Board should work with local people to develop options which are robust, evidence-based, person-centred, sustainable and consistent with clinical standards and national policy. Where this happens, the subsequent consultation process will have greater credibility and authority.

27. Boards should ensure that public stakeholders are involved in developing options and in the appraisal process. Clinical and professional staff who work in the service should also be involved and can have an important role in presenting the range of options at meetings and other public involvement events.

28. The development and appraisal of options for major service change should be consistent with the fundamental approach outlined in HM Treasury guidance – *The Green Book*- which will ensure a consistent, systematic and robust approach. *The Green Book* makes clear that in the first place a wide range of service options should be created and reviewed, from which a short-list of options, including a 'do minimum' option, should be selected. To assist with their efforts, Boards should refer to the Scottish Health Council's guidance ("*Involving Patients, Carers and the Public in Option Appraisal for Major Health Service Changes*") and to the Scottish Capital Investment Manual for NHS Scotland, issued under the terms of CEL(19) 2009.

29. There may be occasions where the number of practical options is limited, for example by requirements to comply with national policy or legislation. Where this is the case, the option development process should still be used to involve potentially affected people and

communities, and to seek to achieve a consensus around the limited number of practical options.

30. The Scottish Health Council's advice can be sought about establishing an appropriate open and transparent process to determine which options should proceed to the public consultation stage and how to involve people in this part of the process.

31. In publicising the outcome of the option appraisal process the NHS Board should take care to:

- ensure they accurately incorporate clinical views, financial implications and the views of patients and the public; and
- clearly explain why each option is considered practical, particularly in respect of any clear 'preferred' option that has emerged from the option appraisal process.

Consulting

32. For any service changes considered to be major, Boards should not move to the consultation stage until they have confirmation from the Scottish Health Council that public involvement thus far has been in accordance with this guidance.

The consultation document

33. A consultation document will need to be produced. This should:

- be easy to understand.
- be readily available and accessible.
- outline how the options offered for consultation were developed and agreed.
- offer balanced information in support of each option, including the financial implications
- contain sufficient information for the reader to be able to understand the reasons for the proposal(s) and come to an informed conclusion.
- outline the factors which will be taken into account in arriving at a decision.
- contain information about contacts for further information or clarification and direct consultees to public access points in libraries etc.
- allow sufficient time (at least 3 months for major service changes), for those consulted to consider and respond to the proposal.

34. Innovative and creative methodologies and technologies should be used to enable people who might otherwise be excluded from the consultation process to be involved and provide a response.

35. Where a preferred option is indicated, it must also be clear that all responses to the consultation will be considered. In particular, the Board should give genuine consideration to any alternative suggestions that are put forward as a result of the consultation.

The consultation process

36. Potentially affected people and communities should be consulted on the option(s) for the proposed service development or change. The advice of the Scottish Health Council can be sought about the consultation methodologies to be used in the consultation process.

37. An inclusive process should encourage and stimulate discussion and debate. While it may not result in agreement and support for a proposal from all individuals and groups, it should demonstrate that the NHS listens, is supportive and genuinely takes account of views and suggestions. Ultimately, Boards should demonstrate that there has been a wide ranging consultation, which has taken all reasonable steps to take account of differences of view.

Seeking Ministerial approval

38. For any proposed service changes considered to be major, the Board, when submitting its final proposal to the Minister for approval, should enclose a report from the Scottish Health Council which assesses whether the Board has involved people in accordance with the expectations set out in this guidance.

39. It should be noted that Ministers:

- will not consider a Board's submission unless it gives evidence of how potentially adverse impacts for the affected people and communities will be taken into account.
- reserve the right to ask a Board to carry out a consultation process again in whole or in part if the Scottish Health Council's assessment is that the public involvement process did not comply with this guidance.

Feedback

40. The feedback stage is of vital importance in maintaining public confidence and trust in the integrity of the involvement process and Boards should provide feedback to the stakeholders who took part in a consultation to:

- inform them of the outcome of the consultation process and the final agreed development or change.
- provide a full and open explanation of how views were taken into account in arriving at the final decision.
- provide reasons for not accepting any widely expressed views.
- outline how people can be involved in the implementation of the agreed change, and explain how communities can contribute to the implementation plan.

Evaluation

41. Evaluation is an appraisal of how the informing, engaging and consulting activities undertaken worked; the impact they had on the service change; and the lessons to be learned for future involvement work to be carried out by the organisation. The process should be positive and constructive, designed to highlight areas which may need to be strengthened or developed. It need not be lengthy or time-consuming, and any findings (reports etc) should be made available to interested parties. The Scottish Health Council can provide information and guidance on how to evaluate the consultation.

Scottish Government
Healthcare Policy and Strategy Directorate
10 February 10

Agenda Item No 5 (a)

MINUTE of MEETING of the **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held in the Town and County Hall, Forfar on Wednesday 19 April 2017 at 2.00pm.

Present: **Voting Members of Integration Joint Board**

HUGH ROBERTSON, Non-Executive Board Member, NHS Tayside
Councillor GLENNIS MIDDLETON, Angus Council
JUDITH GOLDEN, Non-Executive Board Member, NHS Tayside
Councillor JIM HOUSTON, Angus Council
Councillor DAVID MAY, Angus Council

Non Voting Members of Integration Joint Board

DAVID BARROWMAN, Service User
SANDY BERRY, Chief Finance Officer
PETER BURKE, Carers Representative
IVAN CORNFORD, Independent Sector Representative
ALISON CLEMENT, Clinical Director, Angus IJB
JIM FOULIS, Associate Nurse Director
VICKY IRONS, Chief Officer
DOUGLAS LOWDON, Consultant Acute and Elderly Medicine
KATHRYN LINDSAY, Chief Social Work Officer
HAZEL BEATS, RGN (proxy on behalf of Barbara Tucker, Staff Representative)

Advisory Officers

GEORGE BOWIE, Head of Community Health and Care Services - South, AHSCP
GAIL SMITH, Head of Community Health and Care Services - North, AHSCP
DAVID THOMPSON, Principal Solicitor – Resources, Angus Council
BILL TROUP, Head of Integrated Mental Health Services (AHSCP)
MICHELLE WATTS, Associate Medical Director, NHS Tayside
WENDY SUTHERLAND, Senior Solicitor, Resources, Angus Council - Observer

HUGH ROBERTSON, in the Chair.

1. APOLOGIES

Apologies for absence were intimated on behalf of Alison Rogers, Non-Executive Board Member, David Coulson, Associate Director of Pharmacy and Drew Walker, Director of Public Health, Barbara Tucker, Staff Representative, all NHS Tayside and Bill Muir, Third Sector Representative.

2. DECLARATIONS OF INTEREST

The Integration Joint Board noted that there were no declarations of interest made.

3. MINUTES INCLUDING ACTION LOG

(a) PREVIOUS MEETING

The minute of meeting of the Angus Health and Social Care Integration Joint Board of 22 February 2017 was submitted and approved as a correct record.

(b) ACTION LOG

The action log of the Health and Social Care Integration Joint Board of 22 February 2017 was submitted and noted.

4. RESIGNATION OF BOARD MEMBER

The Board agreed to note that Mavis Leask, Staff Representative for Angus Council had intimated her resignation. The Staff Representative vacancy was now being progressed. A report would be submitted to the Board in due course.

The Chair confirmed that Councillors Jim Houston and David May were not standing for re-election at the local government elections on 4 May 2017. He also confirmed that Councillor Glennis Middleton was standing as a candidate in the local government elections. The Chair, on behalf of the Board thanked Councillors Houston, May and Middleton for their work, support and contributions to the Integration Joint Board.

David Thompson, Principal Solicitor referred to Standing Order 2.3 and advised that a report outlining the position in relation to the term of office of Members of the Integration Joint Board would be submitted to the next meeting of the Integration Joint Board on 28 June 2017.

5. FINANCE MONITORING REPORT

With reference to Article 8 of the minute of meeting of this Board of 22 February 2017, there was submitted Report No IJB 14/17 by the Chief Finance Officer presenting an update to the Board regarding the financial performance of Angus Integration Joint Board (IJB).

The Report indicated that the Integration Joint Board's detailed forecast financial position for 2016/17 was set out in Appendix 1 to the Report.

Appendix 3 to the Report set out ongoing or emerging financial risks for the Integration Joint Board.

The Integration Joint Board agreed:-

(i) to note the content of the Report including the risks documented in the Financial Risk Assessment; and

(ii) to note that work was still ongoing to refresh the Adult Services budgetary and reporting framework.

6. PRESCRIBING MANAGEMENT

With reference to Article 10 of the minute of meeting of this Board of 14 December 2016, there was submitted Report No IJB 15/17 by the Chief Officer providing an update to the Integration Joint Board on the prescribing management plans in Angus.

The Report indicated that NHS Tayside and Angus prescribing spend was in part due to higher than average prevalence of a variety of chronic diseases and the regional adoption of clinical pathways aimed at providing patients with the best possible care.

Regionally, the Tayside Prescribing Management Group (TPMG) were developing a 5 year strategic plan. Developed in collaboration with clinical teams across Tayside it aimed to deliver the best possible healthcare, at the lowest possible cost, delivering the best experience for patients.

The Angus Prescribing Workplan was attached as Appendix 1 to the Report. The workplan would continue to evolve over the coming year as additional programmes of work were identified through clinical discussions and analysis of data were scoped and included. The key actions proposed for 2017/2018 were outlined in Section 4 of the Report.

Alison Clement, Clinical Director provided an overview and update in relation to Prescribing Management and intimated that a further update report would be submitted to the next meeting of the Integration Joint Board.

Following discussion and having heard from a number of members, the Integration Joint Board agreed:-

(i) to note the current financial position and the actions being taken regionally and locally to ensure safe effective prescribing and delivery of the efficiency savings targets both in the short and longer term;

(ii) that a further update report on Prescribing Management would be submitted to the meeting of the Integration Joint Board on 30 August 2017; and

(iii) to commend the staff involved in the work undertaken to date in relation to Prescribing Management.

7. BUDGET SETTLEMENT FOR 2017/18

With reference to Article 19 of the minute of meeting of this Board of 22 February 2017, there was submitted Report No IJB 16/17 by the Chief Finance Officer updating the Integration Joint Board regarding the proposed Budget Settlements between Angus IJB and both Angus Council and NHS Tayside for 2017/18.

The Report provided an update regarding the status of the budget settlement with Angus Council and the budget settlement proposal with NHS Tayside. The financial challenges set out in the Report were additional to the work already described to the Integration Joint Board, for example, work set out elsewhere regarding Prescribing, Help to Live at Home and proposals considered at the February Board meeting.

Sandy Berry, Chief Finance Officer provided an overview of the Report.

Judith Golden, Non-Executive Board Member enquired as to where the savings outlined in Table 3 of the Report previously described or ongoing were to come from. Having heard the response from Vicky Irons, Chief Officer and George Bowie, Head of Community Health and Care Services – South, Judith requested in future that written reports be provided to the Board rather than verbal updates.

Thereafter, the Integration Joint Board agreed:-

(i) to note the update provided regarding the Budget Settlement with Angus Council including the position regarding risk sharing, residual Savings and Cost Containment Balance, Risk Management and Due Diligence;

(ii) to approve the Adult Services proposals regarding Delayed Discharge funding and additional management efficiencies required to start to partially address the Residual Savings and Cost Containment balance;

(iii) to request feedback to future Board meetings regarding proposals for containing costs associated with Learning Disability and Care Homes;

(iv) to note the information provided regarding the proposed budget settlement with NHS Tayside and, subject to any over-riding caveats, specifically:-

a. to allocate the majority of the £300k uplift received to support Prescribing resources with a balance attributed to services hosted within Angus;

b. the acceptance of the proposed budget for Local Services to NHS Tayside;

c. seek confirmation from Perth and Kinross Integration Joint Board regarding the adequacy of the budgets for Mental Health Services prior to otherwise accepting the proposed budget for Hosted Services;

d. adopt the proposed Prescribing budget as the opening working budget only for 2017/18; to formally indicated to NHS Tayside the view that the budget would be inadequate to support the forecast cost for 2017/18; to note to NHS Tayside that the Prescribing overspend would ultimately translate into an overall Integration Joint Board forecast overspend for 2017/18 triggering the risk sharing mechanisms set out in the Integration Joint Board's Integration Scheme;

e. request the Chief Officer and Chief Finance Officer to explore with NHS Tayside the practicality of extending the risk sharing agreement for Prescribing until prescribing costs could be sustained;

f. accept of the proposed budget for Family Health Services (including GMS) to NHS Tayside;

g. accept the Large Hospital Services budget as a notional budget in advance of more detailed proposals describing a budget that reflects the underlying substance of the working agreement for 2017/18;

h. note that a range of other budget settlement issues need to be resolved and that any overall budget settlement agreement would be subject to resolution of these issues; and

i. request that the Chief Officer and Chief Finance Officer update NHS Tayside regarding the views of Angus Integration Joint Board in line with the recommendations above and stating an expectation that matters would be more fully resolved following the Board's June 2017 meeting;

(v) to note the revised savings/costs containment targets that would result from the proposed budget settlement with NHS Tayside;

(vi) to approve the opening position for the Integration Joint Board's financial planning for local health services for 2017/18 as set out at Section 4.4 of the Report and to request that further updates be provided to the Board in June 2017;

(vii) to note the update regarding the 2016/17 Due Diligence review of resources devolved from NHS Tayside;

(viii) to request a further paper be prepared for the June Board meeting setting out further detail of the Integration Joint Board's budget settlement with both NHS Tayside and Angus Council including presenting the Integration Joint Board's Annual Financial Statement to the Board; and

(ix) to request that a further update report in relation to Help to Live at Home be brought to a future meeting of the Board.

8. DIRECTION OF FUNCTIONS TO ANGUS COUNCIL

With reference to Article 15 of the minute of meeting of this Board of 23 March 2016, there was submitted Report No IJB 17/17 by the Chief Officer recommending the direction of functions to Angus Council in terms of the Public Bodies (Joint Working) (Scotland) Act 2014 for the financial year 2017/18 and beyond.

The Report indicated that Angus Council and NHS Tayside were legally required, both in terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and the Integration Scheme between Angus Council and NHS Tayside (which required the approval of the Scottish Ministers) to delegate functions to the Board. In the case of Angus Council, these functions were identified and outlined in Appendix 1 to the Report and equated to the services identified in Appendix 2 to the Report.

The Integration Scheme and the 2014 Act provided that, in order to secure the performance of the functions referred to in Appendix 1, the Board required to direct the performance of those functions by either Angus Council or NHS Tayside.

The Integration Joint Board agreed:-

(i) to note the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 that required Angus Council and NHS Tayside to delegate certain functions to the Board;

(ii) to note that, in order to secure the performance of the functions referred to in (i) above, the Board required to direct the performance of those functions by either Angus Council or NHS Tayside;

(iii) to authorise the Chief Officer to direct Angus Council to perform the functions referred to in Appendix 1 (which functions were performed by the services identified in Appendix 2) with effect from 1 April 2017 and thereafter on an ongoing annual basis until agreed or amended otherwise;

(iv) that the functions to be directed to Angus Council would require to be performed in accordance with all legal and regulatory requirements and having regard to:-

(a) the Integration Delivery Principles;
(b) the National Health and Wellbeing Outcomes;
(c) the Integration Scheme;
(d) the Angus Integration Joint Board Strategic Plan; and
(e) any equivalent successor documents unless agreed otherwise.

(v) to make available to Angus Council the funding set out in Appendix 3 to the Report for 2017/18; and

(vi) to delegate confirming funding associated with the directions referred to in (iii) above to the Chief Officer in future financial years in accordance with financial plans approved by the Integration Joint Board.

9. DIRECTION OF FUNCTIONS TO NHS TAYSIDE

With reference to Article 16 of the minute of meeting of this Board of 23 March 2016, there was submitted Report No IJB 18/17 by the Chief Officer recommending the direction of functions to NHS Tayside in terms of the Public Bodies (Joint Working) (Scotland) Act 2014 for the financial year 2017/18 and beyond.

The Report indicated that Angus Council and NHS Tayside were legally required, both in terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and the Integration Scheme between Angus Council and NHS Tayside (which required the approval of the Scottish Ministers) to delegate functions to the Board, In the case of NHS Tayside these functions were identified and outlined in Appendix 1 to the Report and equated to the services identified in Appendix 2 to the Report.

The Integration Scheme and the 2014 Act provided that, in order to secure the performance of the functions referred to in Appendix 1, the Board required to direct the performance of those function by either Angus Council or NHS Tayside.

The Integration Joint Board agreed:-

(i) to note the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 that required Angus Council and NHS Tayside to delegate certain functions to the Board;

(ii) to note that, in order to secure the performance of the functions referred to in (i) above, the Board required to direct the performance of those functions by either Angus Council or NHS Tayside;

(iii) to authorise the Chief Officer to direct NHS Tayside to perform the functions referred to in Appendix 1 (which functions were performed by the services identified in Appendix 2) with effect from 1 April 2017 and thereafter on an ongoing annual basis until agreed or amended otherwise;

(iv) that the functions to be directed to NHS Tayside would require to be performed in accordance with all legal and regulatory requirements and having regard to:-

(a) the Integration Delivery Principles;
(b) the National Health and Wellbeing Outcomes;
(c) the Integration Scheme;
(d) the Angus Integration Joint Board Strategic Plan; and
(e) any equivalent successor documents unless agreed otherwise.

(v) to make available to NHS Tayside the funding set out in Appendix 3 to the Report for 2017/18;

(vi) to delegate confirming funding associated with the directions referred to in (iii) above to the Chief Officer in future financial years in accordance with financial plans approved by the Integration Joint Board.

10. PERFORMANCE QUARTERLY REPORT

With reference to Article 12 of the minute of meeting of this Board of 31 August 2016, there was submitted Report No IJB 19/17 by the Chief Officer updating the Integration Joint Board (IJB) on the progress made in developing the annual performance report.

The Report indicated that the annual performance report and additional quarterly performance reports would allow the Integration Joint Board to track progress towards the delivery of the Partnership's vision, strategic shifts and planned outcomes for the people of Angus.

The Quarter 3 performance report aimed to address strategic level performance described in the partnership's performance framework. This included the national core indicators which demonstrated progress against the national outcomes.

Appendix 1 to the Report provided evidence of progress due to start to bring together a report on strategic delivery as well as performance.

The Integration Joint Board agreed:-

(i) to approve the Quarter 3 2016/17 Performance Report for Angus, appended as Appendix 1 to the Report;

(ii) to request the Chief Officer to ensure that updated performance reports were provided to the Integration Joint Board quarterly; and

(iii) to commend and thank all officers and staff involved in the work and delivery of services.

11. DATE OF NEXT MEETING

The Integration Joint Board noted that the next meeting would take place on Wednesday 28 June 2017 at 2.00pm in the Town and County Hall, Forfar.

AGENDA ITEM 5(b)

Action Points Update from Angus Health and Social Care Integration Joint Board

Complete	On Target	Overdue

Current Actions

MEETING	ACTION POINT	RESPONSIBILITY	PROGRESS	Timeline
19 April 2017	Submission of report on the IJB Staff Representative vacancy	Principal Solicitor	In progress	For IJB meeting on 30 August 2017
	Submission of report outlining the position in relation to the term of office of members of the IJB	Principal Solicitor	In progress	For IJB meeting on 28 June 2017
	Submission of further update report on Prescribing Management	Clinical Director	In progress	For IJB meeting on 30 August 2017
	Feedback regarding proposals for containing costs associated with Learning Disability and Care Homes	Chief Finance Officer	Residential Care Home report in progress Learning Disability report in progress	For IJB Meeting on 30 August 2017
	Submission of paper setting out further details of the IJB's budget settlement with both NHS Tayside and Angus Council including presenting the IJB's Annual Financial Statement to the Board	Chief Finance Officer	In progress	For IJB meeting on 28 June 2017
	Submission of a further update report in relation to Help to Live at Home	Head of Community Health & Care Services (South)	In progress	For IJB meeting on 28 June 2017
	Submission of Performance quarter	Chief Officer	In progress	For IJB meeting on

MEETING	ACTION POINT	RESPONSIBILITY	PROGRESS	Timeline
	yearly report			28 June 2017
22 February 2017	Submission of an update report on the Strategic Plan	Head of Community Health & Care Services (South)	In progress	For IJB meeting on 28 June 2017
	Update report on Primary Care	Head of Prison Healthcare, Custody & Forensic Medical Services and Out of Hours	In progress	For IJB meeting on 28 June 2017
14 December 2016	Establish proposals for the future configuration of inpatient facilities in Angus.	Chief Officer	In progress	For IJB meeting on 28 June 2017
	Preparation of half yearly Partnership Fund report.	Chief Finance Officer	In progress	For IJB meeting on 28 June 2017
	Prescribing Report update.	Clinical Director	Report submitted to IJB meeting on 19 April 2017	Completed
	Consider development session on Adult Protection for IJB members	Chief Officer	In progress	For IJB Meeting on 28 June 2017
	Submission of Performance quarter yearly report.	Chief Officer	Report submitted to IJB meeting on 19 April 2017	Completed
31 August 2016	Six monthly Adult Protection Report	Chief Officer	In progress	For IJB meeting on 28 June 2017
18 May 2016	To prepare an Annual Report on progress against the Equality outcomes as part of the annual Performance Report.	Chief Officer	In progress	For IJB meeting on 28 June 2017

AGENDA ITEM NO 5 (c)

MINUTE of MEETING of the **ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE** held in the Committee Room, Town and County Hall, Forfar, on Wednesday 19 April 2017 at 12.30pm.

Present: **Members of Audit Committee**

Councillor JIM HOUSTON, Angus Council
DAVID BARROWMAN, Service User
PETER BURKE, Carers Representative

Advisory Officers

SANDY BERRY, Chief Finance Officer
VICKY IRONS, Chief Officer
DAVID THOMPSON, Principal Solicitor – Resources, Angus Council

Also in Attendance

RACHEL BROWNE, Senior Audit Manager, Audit Scotland
TONY GASKIN, Chief Internal Auditor, Fife, Tayside & Forth Valley Audit and Management Services (FTF)
GILLIAN WOOLMAN, Assistant Director, Audit Scotland
WENDY SUTHERLAND, Senior Solicitor, Resources, Angus Council – Observer

1. APOLOGIES

An apology for absence was intimated on behalf of Alison Rogers, Non Executive Board Member, NHS Tayside.

2. WELCOME AND INTRODUCTIONS

Introductions took place. The Chair, on behalf of the Committee, welcomed Peter Burke, Carers Representative to his first meeting.

3. DECLARATIONS OF INTEREST

There were no declarations of interest made.

4. MINUTE OF PREVIOUS MEETING

The minute of the previous meeting of 14 December 2016 was submitted and approved as a correct record.

5. INTERNAL AUDIT CHARTER

There was submitted Report No IJB 20/17 by the Chief Finance Officer presenting the proposed Internal Audit Charter for Angus Integration Joint Board.

The Report indicated that the Internal Audit Charter has been drafted in line with the requirements of the Public Sector Internal Audit Standards applicable to both Health and Local Authority Internal Audit services. The Charter would take effect from the date of approval until such times as it was revoked or replaced.

Having heard from the Chief Finance Officer and Chief Internal Auditor, the Audit Committee agreed to approve the proposed Internal Audit Charter.

6. AUDIT ARRANGEMENTS – EXTERNAL AUDIT ANNUAL AUDIT PLAN

There was submitted Report No IJB 21/17 by the Chief Finance Officer providing members with information regarding the 2016/17 External Audit Annual Audit Plan.

The Report indicated that the Angus Integration Joint Board was required to produce a set of Financial Accounts. These would be produced in accordance with updated guidance from IRAG (Integrated Resources Advisory Group) and LASAAC (The Local Authority Scotland Accounts Advisory Group).

The Annual Audit Plan contained an overview of the planned scope and timing of the audit of the Angus Integration Joint Board and was carried out in accordance with International Standards on Auditing (ISAs), the Code of Audit Practice, and any other relevant guidance. The plan identified the audit work to provide an opinion on the financial statements and related matters and to meet the wider scope requirements of public sector audit.

The Annual Audit Plan for 2016/17 was attached as Appendix 1 to the Report. The Audit would be undertaken to meet statutory reporting requirements. To meet these timescales, the Audit Committee would require to approve the unaudited accounts at their next meeting on 28 June 2017 and to agree the audited accounts at the following meeting on 30 August 2017.

Gillian Woolman, Assistant Director, Audit Scotland provided an overview and update in relation to the External Audit Annual Audit Plan for 2016/17.

The Audit Committee agreed to note the External Audit Annual Audit Plan, as appended to the Report.

7. RESERVES POLICY

There was submitted Report No IJB 22/17 by the Chief Finance Officer setting out the proposed Reserves Policy for the Angus Integration Joint Board (IJB) for consideration and approval and described the purposes for which reserves may be held.

The Report indicated that Angus Integration Joint Board had the same legal status as a local authority and was empowered to hold reserves under Section 106 of the Local Government (Scotland) Act 1973. The IJB's financial regulations, Section 6.1.1 set out the requirement to develop a Reserves Policy. The purpose of the Reserves Policy was outlined in Section 2.3 of the Report.

The proposed Reserves Policy recommended setting a prudent level of contingency general reserve at 2% of the IJB net expenditure. It was acknowledged that due to the financial constraints on the IJB, this would be challenging to deliver in the early years and could only be delivered when the need to maintain an appropriate level of service delivery for the population in each year had been met. Earmarked Reserves related to specific funds for specific purposes and would only be used for these purposes. Any change of use, or decisions relating to residual balance would require to be approved by the Integration Joint Board.

It was important for the long term financial stability of both the Integration Joint Board and the parent bodies that sufficient usable funds were held in reserve to manage unanticipated pressures from year to year.

The Board noted that due to the structure of the IJB, at any given year end reserves are actually held by one of the IJB's Partners. It was noted that how this will be actioned would need to be clarified in future years.

The Audit Committee agreed to approve the proposed Reserves Policy.

8. GOVERNANCE UPDATE

With reference to Article 7 of the minute of the previous meeting, there was submitted Report No IJB 23/17 by the Chief Finance Officer providing an update on a series of governance issues within the Integration Joint Board and making a series of general and specific recommendations.

The Report provided an overview of the current status of governance arrangements within the Integration Joint Board. The Appendices to the Report outlined the work under review and recommended that a further review of governance be undertaken in mid-2017.

Following discussion and having heard from the Chief Officer, Chief Finance Officer and Chief Internal Auditor in relation to the governance update, and also the issue in relation to the Corporate support, the Chief Officer agreed to consider whether the Corporate support issue required to be included in the Risk Register.

The Audit Committee agreed:-

(i) to note the provision of Audit Committee member development session in 2016/17 and to approve the proposal for annual development sessions in future years;

(ii) to endorse the proposal to increase the membership of the Audit Committee from 5 members to 6 members to increase the continuity of the Audit Committee, subject to the formal change being reflected in the IJB's overall governance review;

(iii) to note the planned re-scheduling of the review of the IJB's financial regulations;

(iv) to note the planned approach to the review of the role of the IJB's Chief Finance Officer in the context of CIPFA's Statement on the role of the Chief Finance Officer in Local Government;

(v) to note the "Follow up Actions" from the Annual Internal Audit report and to note the updates in Section 5 of the Report;

(vi) to note the updated response to the Audit Scotland self assessments and note the updates in Section 6 of the Report;

(vii) to also further develop hosted services relationships with other IJBs; and

(viii) to a further review of governance arrangements being undertaken in early 2017/2018.

9. 2016/17 INTERNAL AUDIT PLAN – PROGRESS REPORT

With reference to Article 6 of the minute of the previous meeting, there was submitted Report No IJB 24/17 by the Chief Finance Officer setting out progress towards delivery of the 2016/17 Internal Audit Plan.

Attached as Appendix 1 to the Report was the Angus Integration Joint Board's provisional Internal Auditor's progress report on the 2016/17 Internal Audit Plan. An equivalent report would be produced routinely for all Audit Committee meetings.

The Audit Committee agreed to note the provisional Internal Audit Progress Report.

10. DATE OF NEXT MEETING

To be confirmed.

As this was the last meeting before the Local Government Elections, Councillor Jim Houston intimated that he was not standing for re-election and expressed his thanks to officers and Audit Scotland. The Committee thereafter thanked Councillor Houston for his contribution and support to the Audit Committee.

AGENDA ITEM NO 6

REPORT NO. IJB 27/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

REVIEW OF STANDING ORDERS

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to review the Standing Orders of the Integration Joint Board.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

(i) note the current Standing Orders of the Integration Joint Board adopted at the Board's meeting on 6 October 2015;

(ii) consider whether the current Standing Orders remain fit for purpose; and

(iii) agree to adopt the amended Standing Order contained in Appendix 1 to this Report.

2. REPORT

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") obliges the Board to make standing orders for the regulation of its procedure and business, and all meetings of the Board or of a committee of the Board must be conducted in accordance with those standing orders. The Order also sets out certain matters that must be dealt with in the standing orders (such as the procedure for calling meetings, conflict of interests and the recording of decisions of the Board.

2.2 This Board, at its meeting on 6 October 2015, agreed to adopt Standing Orders. The Board is asked to note that Standing Order 19 provides that the operation of the Standing Orders will be monitored regularly and that any required amendments brought about by practice, legislation or policy will be presented to the Integration Board for approval.

2.3 The Board is invited to consider whether the Standing Orders remain fit for purpose or if any amendment would make the Board more effective, efficient or economic. The Board is asked to note that certain aspects of the Standing Orders cannot be amended (such as the maximum term of office of a Board member being three years).

2.4 Officers have considered the terms of the current Standing Orders and it is recommended that the Board adopt the amended Standing Orders attached as Appendix 1 (with tracked changes from the current Standing Orders). The main change is to provide for the establishment of the Board's Audit Committee.

3. CONCLUSIONS

The Board is legally obliged to adopt Standing Orders. It is considered prudent to regularly review the Board's Standing Orders to ensure that they remain current, legally compliant and permit the Board to conduct its business effectively, efficiently and economically.

REPORT AUTHOR: David Thompson
EMAIL DETAILS: ThompsonD@angus.gov.uk

June 2017

ITEM 6 APPENDIX 1

ANGUS HEALTH AND SOCIAL CARE

ANGUS INTEGRATION JOINT BOARD

STANDING ORDERS

1. General

1.1 These Standing Orders are made under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. These Standing Orders shall, as far as applicable be the rules and regulations for the proceedings of Committees and Sub-Committees and therefore reference to the term 'Board' in the said Standing Orders should be interpreted accordingly. The term 'Chairperson' shall also be deemed to include the Chairperson of any Committee or Sub-Committee but only in relation to such Committees or Sub-Committees.

1.2 In these Standing Orders "the Integration Board" shall mean the Angus Integration Joint Board established in terms of The Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015.

1.3 Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with these Standing Orders.

2. Membership

2.1 Voting membership of the Integration Board shall comprise three persons nominated by the NHS Board, and three persons appointed by the Council. Where the NHS Board is unable to fill its places with non-Executive Directors it can then nominate other appropriate people, who must be Members of the NHS Board to fill their spaces, but at least two must be non-executive Members.

2.2 Non-voting membership of the Integration Board shall comprise:

(a) the chief officer of the Integration Board;

(b) the chief social work officer of the local authority;

(c) the proper officer of the Integration Board appointed under section 95 of the Local Government (Scotland) Act 1973;

(d) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

(e) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract;

(f) a registered medical practitioner employed by the Health Board and not providing primary medical services;

(g) one member in respect of staff of each of the constituent authorities engaged in the provision of services provided under integration functions;

(h) one member in respect of third sector bodies carrying out activities related to health or social care in the area of the local authority;

(i) one member in respect of service users residing in the area of the local authority;

(j) one member in respect of persons providing unpaid care in the area of the local authority; ~~and~~

(k) The Clinical Director of the Integration Joint Board;

(l) one member in respect of commercial providers of social care; and

(k) such additional members as the Integration Board sees fit. Such a member may not be a councillor or a non-executive director of the Health Board.

The members appointed under paragraphs (d) to (f) must be determined by the Health Board.

2.3 A Member of the Integration Board in terms of 2.2 (a) to (c) will remain a Member for as long as they hold the office in respect of which they are appointed. Otherwise, the term of office of Members of the Integration Board shall be for three years. ~~or until the day of the next ordinary Elections for Local Government Councillors in Scotland, whichever is shorter.~~

2.4 Where a Member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Member they replace.

2.5 On expiry of a Member's term of appointment the Member shall be eligible for re-appointment provided that he/she remains eligible and is not otherwise disqualified from appointment in terms of Article 8 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

2.6 A voting Member appointed under paragraph 2.1 ceases to be a Member of the Integration Board if they cease to be either a Councillor or a non- executive Director of the NHS Board or an Appropriate Person in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

2.7 A Member of the Integration Board, other than those Members referred to in paragraph 2.2(a~~d~~) ~~and~~to (c~~e~~), may resign his/her membership at any time during their term of office by giving notice to the Integration Board in writing. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified. If this is a voting Member, the Integration Board must inform the constituent authority that made the nomination.

2.8 If a Member has not attended three consecutive Ordinary Meetings of the, Integration Board, and their absence was not due to illness or some other reasonable cause as determined by the Integration Board, the Integration Board may, by giving one month's notice in writing to that Member, remove that person from office.

2.9 If a Member acts in a way which brings the Integration Board into disrepute or in a way which is inconsistent with the proper performance of the functions of the Integration Board, the Integration Board may remove the Member from office with effect from such date as the Integration Board may specify in writing.

2.10 If a Member is disqualified under article 8 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 during a term of office they are to be removed from office immediately.

2.11 A constituent authority may remove a Member which it nominated by providing one month's notice in writing to the Member and the Integration Board.

2.12 Named Proxy Members for Members of the Integration Board may be appointed by the constituent authority which nominated the Member, as appropriate. The appointment of such Proxy Members will be subject to the same rules and procedures for Members. Proxy Members shall receive papers for Meetings of the Integration Board but shall be entitled to attend or vote at a Meeting only in the absence of the principal Member they represent. If the Chairperson or Vice Chairperson is unable to attend a meeting of the Integration Board, any Proxy Member attending the meeting may not preside over that meeting.

2.13 The acts, meetings or proceedings of the Integration Board shall not be invalidated by any defect in the appointment of any Member.

3. Chairperson and Vice Chairperson

3.1 The Chairperson and Vice Chairperson will be drawn from the NHS Board and the Council voting Members of the Integration Board. If a Council Member is to serve as Chairperson then the Vice Chairperson will be a Member nominated by the NHS Board and vice versa. The first Chair of the Integration Board will be appointed on the nomination of the Council.

3.2 The appointment to Chairperson and Vice Chairperson is time limited to a period not exceeding one year and carried out on a rotational basis between Council and NHS Board appointed Chairpersons. The term of office of the first Chairperson will be for a period of one year following the date of the formal establishment in law of the Integration Joint Board and yearly thereafter. The Council or NHS Board may change their appointee as Chairperson of Vice Chairperson during an appointing period.

3.3 The Vice-Chairperson may act in all respects as the Chairperson of the Integration Board if the Chair is absent or otherwise unable to perform his/her duties.

3.4 At every meeting of the Integration Board the Chairperson, if present, shall preside. If the Chairperson is absent from any meeting the Vice-Chairperson, if present, shall preside. If both the Chairperson and the Vice-Chairperson are absent, a Chairperson shall be appointed from within the voting Members present for that meeting. Any Proxy Member attending the meeting in terms of 2.12 may not preside over that meeting.

3.5 Powers, authority and duties of Chairperson and Vice-Chairperson.

The Chairperson shall amongst other things:-

(a) Preserve order and ensure that every Member has a fair Hearing;

(b) Decide on matters of relevancy, competency and order, and whether to have a recess during the Meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the Meeting;

(c) Determine the order in which speakers can be heard;

(d) Ensure that due and sufficient opportunity is given to Members who wish to speak to express their views on any subject under discussion;

(e) If requested by any Member ask the mover of a motion, or an amendment, to state its terms;

(f) Maintain order and at his/her discretion, order the exclusion of any Member of the public who is deemed to have caused disorder or misbehaved;

(g) The decision of the Chairperson on all matters within his/her jurisdiction shall be final;

(h) Deference shall at all times be paid to the authority of the Chairperson. When he/she speaks, the Chairperson shall be heard without interruption; and

(i) Members shall address the Chairperson while speaking.

4. Meetings

4.1 The first meeting of the Integration Board will be convened at a time and place to be determined by the Chairperson. Thereafter the Integration Board shall meet at such place and such frequency as may be agreed by the Integration Board.

4.2 The Chairperson may convene Special Meetings if it appears to him/her that there are items of urgent business to be considered. Such Meetings will be held at a time, date and venue as determined by the Chairperson. If the Office of Chairperson is vacant, or if the Chairperson is unable to act for any reason the Vice-Chairperson may at any time call such a meeting.

4.3 If the Chairperson refuses to call a meeting of the Integration Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least two thirds of the voting Members, has been presented to the Chairperson or if, without so refusing, the Chairperson does not call a meeting within seven days after such requisition has been presented, those Members who presented the requisition may forthwith call a Meeting provided no business shall be transacted at the Meeting other than specified in the requisition.

4.4 Adequate provision will be made to allow for Members to attend a meeting of the Integration Board or a committee of the Integration Board either by being present together with other Members in a specified place, or in any other way which enables Members to participate despite not being present with other Members in a specified place.

5. Notice of Meeting

5.1 Before every meeting of the Integration Board, or committee of the Integration Board, a notice of the meeting, specifying the time, place and business to be transacted, shall be delivered to every Member or sent by post to the usual place of residence of such Members or delivered by electronic means so as to be available to them at least five working days before the meeting. Members may opt in writing addressed to the Chief Officer to have notice of meetings delivered to an alternative

address. Such notice will remain valid until rescinded in writing. Lack of service of the notice on any Member shall not affect the validity of anything done at a meeting.

5.2 In the case of a meeting of the Integration Board called by Members in default of the Chairperson, the notice shall be signed by those Members who requisitioned the meeting.

5.3 At all Ordinary or Special Meetings of the Integration Board, no business other than that on the agenda shall be discussed or adopted except where by reason of special circumstances, which shall be specified in the minutes, the Chairperson is of the opinion that the item should be considered at the meeting as a matter of urgency.

6. Quorum

6.1 No business shall be transacted at a meeting of the Integration Board unless there are present, and entitled to vote both Council and NHS Board Members and at least one half of the voting Members of the Integration Board are present.

6.2 If within ten minutes after the time appointed for the commencement of a meeting of the Integration Board, a quorum is not present, the meeting will stand adjourned to such date and time as may be fixed.

7. Code of Conduct and Conflicts of Interest

7.1 Members of the Integration Board shall subscribe to and comply with the Standards in Public Life - Model Code of Conduct for Members of Devolved Public Bodies which is deemed to be incorporated into these Standing Orders. All Members who are not already bound by the terms of the Model Code shall be obliged before taking up membership, to agree in writing to be bound by the terms of the Model Code of Conduct for Members of Devolved Public Bodies.

7.2 If any Member has a financial or non-financial interest as defined in the Code of Conduct of Members of Devolved Public Bodies and is present at any meeting at which the matter is to be considered, he/she must as soon as practical, after the meeting starts, disclose that he/she has an interest and the nature of that interest and if he/she is precluded from taking part in consideration of that matter.

7.3 If a Member has any pecuniary or any other interest direct or indirect, in any contract or proposed contract or other matter and that Member is present at a meeting of the Integration Board, that Member shall disclose the fact and the nature of the relevant interest and shall not be entitled to vote on any question with respect to it. A Member shall not be treated as having any interest in any contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that Member on any question with respect to that contract or matter.

7.4 Where an interest is disclosed, the Member declaring the interest must determine whether that interest prohibits them from taking part in discussion of or voting on the item of business.

8. Adjournment of Meetings

8.1 A meeting of the Integration Board may be adjourned to another date, time or place by a motion, which shall be moved and seconded and put to the meeting without discussion. If such a motion is carried by a simple majority of those present and entitled to vote, the meeting shall be adjourned to the day, time and place specified in the motion.

9. Disclosure of Information

9.1 No Member or Officer shall disclose to any person any information which falls into the following categories:-

- Confidential information within the meaning of Section 50A(2) of the Local Government (Scotland) Act 1973.

- The full or any part of any document marked "not for publication by virtue of the appropriate paragraph of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973, unless and until the document has been made available to the public or press under section 50B of the said 1973 Act.

- Any information regarding proceedings of the Integration Board from which the public have been excluded unless or until disclosure has been authorised by the Integration Board or the information has been made available to the press or to the public under the terms of the relevant legislation.

9.2 Without prejudice to the foregoing no Member shall use or disclose to any person any confidential and/or exempt information coming to his/her knowledge by virtue of his/her office as a Member where such disclosure would be to the advantage of the Member or of anyone known to him/her or which would be to the disadvantage of the Integration Board.

10. Recording of Proceedings

10.1 No sound, film, video tape, digital or photographic recording of the proceedings of any Meeting shall be made without the prior written approval of the Integration Board.

11. Admission of Press and Public

11.1 Except in relation to items certified as exempt, meetings of the Integration Board shall be open to the public. The Chief Officer shall be responsible for giving public notice of the time and place of each meeting of the Integration Board not less than five days before the date of each meeting.

11.2 The Integration Board may by resolution at any meeting exclude the press and public therefrom during consideration of an item of business where it is likely in view of the nature of the business to be transacted or of the nature of the proceedings that if members of the press and public were present there would be a disclosure to them of exempt information as defined in Schedule 7(A) of the Local Government (Scotland) Act 1973 Act or it is likely that confidential information would be disclosed in breach of an obligation of confidence.

11.3 Every meeting of the Integration Board shall be open to the public but these provisions shall be without prejudice to the Integration Board's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The Integration Board may exclude or eject from a meeting a member or members of the press and public whose presence or conduct is impeding the work or proceedings of the Integration Board.

12. Alteration, Deletion and Revocation of Decisions of the Integration Board

12.1 Without prejudice to the terms of Standing Order 13, Except insofar as required by reason of illegality, no motion to alter, delete or revoke a decision of the Integration Board will be competent within six months from the decision, unless the Chairperson determines that a material change of circumstances has occurred to the extent that it is appropriate for the issue to be re-considered.

13. Suspension, Deletion or Amendment of Standing Orders

13.1 Subject to any statutory requirements, any one or more of the Standing Orders in the case of emergency as determined by the Chair upon motion may be suspended, amended or deleted at any Meeting so far as regards any business at such meeting provided that two thirds of the Members of the Integration Board present and voting shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Order(s) to be suspended.

14. Motions, Amendments and Debate

14.1 It will be competent for any voting Member of the Integration Board at a meeting of the Integration Board to move a motion or an amendment directly arising out of the business before the Meeting.

14.2 No Member, with the exception of the mover of the motion or amendment, will speak supporting the motion or amendment until the same will have been seconded by another voting Member.

14.3 Subject to the right of the mover of a motion, and the mover of an amendment, to reply, no Member will speak more than once on the same question at any meeting of the Integration Board except:-

- On a question of Order
- With the permission of the Chairperson
- On a point of clarification

In all of the above cases no new matter will be introduced.

14.4 The mover of an amendment and thereafter the mover of the original motion will have the right of reply for a period of not more than 5 minutes. He/she will introduce no new matter and once a reply is commenced, no other Member will speak on the subject of debate. Once these movers have replied, the discussion will be held closed and the Chairperson will call for the vote to be taken.

14.5 Amendments must be relevant to the motions to which they relate and no voting Member will be at liberty to move or second more than one amendment to any motion, unless the mover of an amendment has failed to have it seconded. The mover and seconder of the motion will not move an amendment or second an amendment, unless the mover of the motion has failed to have it seconded.

14.6 It will be competent for any voting Member who has not already spoken in a debate to move the closure of such debate. On such motion being seconded, the vote will be taken, and if a majority of the voting Members present vote for the motion, the debate will be closed. However, closure is subject to the right of the mover of the motion and of the amendment(s) to reply. Thereafter, a vote will be taken immediately on the subject of the debate.

14.7 Any Member may indicate his/her desire to ask a question or offer information immediately after a speech by another Member and it will be the option of the Chairperson to decline or accept the question or offer of information.

14.8 When a motion is under debate, no other motion or amendment will be moved except in the following circumstances:

- to adjourn the debate; or
- to close the debate in terms of Standing Order 14.6.

14.9 A motion or amendment once moved and seconded cannot be altered or withdrawn unless with the consent of the mover and seconder.

15. Voting

15.1 Every effort shall be made by Members to ensure that as many decisions as possible are made by consensus.

15.2 Only the three Members nominated by the NHS Board, and the three Members appointed by the Council shall be entitled to vote.

15.3 Every question at a meeting shall be determined by a majority of votes of the Members present and who are entitled to vote on the question. In the case of an equality of votes the Chairperson shall not have a second or casting vote.

15.4 Where a consensus cannot be reached at one meeting, the matter under discussion will be carried forward to a further meeting to be convened as soon as reasonably practicable by the Chair in terms of Standing Order 4.2 above to permit further discussion/resolution. If the voting Members do not agree such a method of breaking the deadlock then no decision will be taken and the status quo shall prevail. Standing Order 12 shall not preclude reconsideration of any such item within a 6 month period.

16. Minutes

16.1 The names of the Members present at a meeting shall be recorded in the minutes of the meeting.

16.2 The minutes of the proceedings of a meeting, including any decision or resolution made by that meeting, shall be drawn up and submitted to the next ensuing meeting for agreement, after which they will be signed by the person presiding at that meeting. A minute purporting to be so signed shall be received in evidence without further proof.

17. Committees, Sub-Committees and Working Groups

17.1 The Integration Board may establish any Committee, Sub Committee or Working Group as may be required from time to time but, with the exception of the Strategic Planning Group and the Audit Committee, each Committee, Sub Committee or Working Group shall have a limited time span as may be determined by the Integration Board.

17.2 The Membership, Chairperson, remit, powers and quorum of any Committee, Sub Committee or Working Groups will be determined by the Integration Board.

17.3 Agendas for consideration at a Committee, Sub Committee or Working Group will be issued to all Members no later than five working days prior to the date of the meeting.

17.4 The Integration Board has established an Audit Committee. The Audit Committee's membership, chairperson, remit, powers and quorum are set out in Appendix 1 to these Standing Orders.

18. Reports to the Integration Board

18.1 The Integration Board shall only consider reports through the office of the Chief Officer of the Integration Board. The following officers shall have the right to submit reports to the Integration Board which must be considered by the Integration Board:-

- The Chief Officer of the Integration Board
- The proper officer of the Integration Board appointed under section 95 of the Local Government (Scotland) Act 1973
- The Chief Social Work Officer of Angus Council
- The Clinical Director of NHS Tayside
- The Associate Nursing Director of NHS Tayside

19. Review of Standing Orders

19.1 The operation of these Standing Orders will be monitored regularly. Any required amendments brought about by practice, legislation or policy will be presented to the Integration Board for approval. In addition, these Standing Orders will be reviewed annually.

Appendix 1

ANGUS INTEGRATION JOINT BOARD

AUDIT COMMITTEE

CONSTITUTIONAL ARRANGEMENTS

1. Membership

1.1 The Audit Committee shall comprise of 6 members of the Integration Joint Board all of whom will be entitled to vote at the Audit Committee. The 6 members shall include:-

(i) two voting members of the Integration Joint Board (one each from the voting membership of Angus Council and NHS Tayside) (excluding the Chair and Vice Chair of the Integration Joint Board who cannot be members of the Audit Committee); and,

(ii) three non voting members of the Integration Joint Board (excluding the Chief Officer and Chief Financial Officer who cannot be members of the Audit Committee but who will be expected to attend).

1.2 the membership of the Audit Committee shall be reviewed, re-selected and re-approved by the Integration Joint Board in October 2018 and three yearly thereafter.

1.3 the Audit Committee should meet at least four times per year unless circumstances require additional meetings.

1.4 the Audit Committee shall appoint a Chair and Vice Chair of the Audit Committee (who need not be a voting member of the Integration Joint Board).

1.5 members of the Audit Committee will require to attend one development event a year in respect of their role as Audit Committee members.

2. Remit

2.1 the remit of the Audit Committee shall be:-

(i) to agree the Internal Audit Plan for the Integration Joint Board (without further reference to the Integration Joint Board),

(ii) to consider the terms of any external or internal Inspections, assessments or audits of the Integration Joint Board with a view to making recommendations to the Integration Joint Board in respect thereof (excepting therefrom external or internal inspections, assessments or audits in respect of clinical and/or care governance); and

(iii) to scrutinise the annual accounts and Governance Statements.

3. Quorum

3.1 No business shall be transacted at a meeting of the Audit Committee unless there are present at least one half of the voting Members of the Audit Committee.

Formatted: Font: Bold
Formatted: Right
Formatted: Centered
Formatted: Left
Formatted: Font: Bold
Formatted: Font: Not Bold
Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 1.27 cm + Indent at: 2.54 cm
Formatted: Indent: Left: 0 cm, First line: 0 cm
Formatted: Font: Bold
Formatted: Font: Not Bold
Formatted: Indent: Left: 1.27 cm
Formatted: Indent: First line: 0 cm
Formatted: Indent: Left: 1.27 cm
Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 1.27 cm + Indent at: 2.54 cm
Formatted: Indent: Left: 0 cm, First line: 0 cm
Formatted: Font: Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

AGENDA ITEM NO 8

REPORT NO IJB 28/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

FINANCE MONITORING REPORT

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

This report provides an update to the Angus Integration Joint Board (Angus IJB) regarding the financial performance of Angus IJB. Generally the Board will be asked to note the content of these reports and be asked to make specific decisions relating to the financial resources, financial management or the financial performance of the IJB.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) note the overall financial position of Angus IJB at the end of 2016/17 and the additional financial contribution made by NHS Tayside to reflect that position,

(ii) note the content of the report including the risks documented in the Financial Risk Assessment,

(iii) note and support the progressing of work associated with improving the IJB's Adult Services Financial Management, and

(iv) support the introduction of a revised budgetary framework for 2017/18.

2. BACKGROUND

This report is the final, year-end Finance Monitoring report for financial year 2016/17, the first year of the IJB having formal responsibility for the management of devolved services.

This report is structured in the following way:-

a) NHS devolved budgets.
b) Angus Council devolved budgets.
c) Partnership Funds
d) Financial Risk Assessment
e) Budget virements greater than £500k.

The Board will recall that the Angus IJB Integration Scheme set out that for 2016/17 and 2017/18, should the IJB ultimately overspend then that overspend would be attributed back to the Partner organisation in which the overspend was incurred. The implications of this agreement will be considered early in 2017/18 in advance of financial year 2018/19.

The IJB's detailed year end financial position for 2016/17 is set out in Appendix 1. All figures are still subject to External Audit review.

3. CURRENT POSITION

3.1 NHS DEVOLVED BUDGETS

Budgets devolved from NHS Tayside are described in a series of components as follows:-

- Local Hospital and Community Services
- Service Hosted in Angus on behalf of Tayside IJBs
- Services Hosted Elsewhere on Behalf of Angus IJB
- GP Prescribing
- General Medical Services and Family Health Services
- Large Hospital Services
- Overall Summary.

Local Hospital and Community Health Services

During the year a range of in year and recurring savings proposals have been approved by the IJB. These together with a series of other non-recurring under spends mean these budgets have, as anticipated, underspent. Some comments, many similar to those listed in the last update, regarding the main variances are noted below:-

- Psychiatry of Old Age – Significant short term underspends in advance of implementing service redesign.
- Community Nursing – Long term overspends due to underlying activity levels. This service is subject to an ongoing review including a review of Medicines Administration.
- IJB Management – Underspends relating to vacant posts, and funding associated with some posts being held in advance of confirmation of funding clarifications.
- General - There remain a number of other vacancy related underspends and underspends that exist in 2016/17 in advance of delivery of 2017/18 recurring savings.
- Recurring Savings – These services have made substantial progress in delivering recurring savings during 2016/17 and a number of savings measures were agreed for 2017/18 at previous Board meetings. Where practical these have been actioned during 2016/17 to ensure current budgets are best aligned to future planned levels.
- The overall underspending position for these budgets in 2016/17 should give the IJB a good opportunity to deliver on a number of the 2017/18 savings programmes.

Overall these budgets have collectively underspent this year by c£1.3m, slightly more than previous projections of a £1.2m underspend.

Service Hosted in Angus on Behalf of Tayside IJBs

While a number of savings proposals have been previously agreed, for these services there remains a shortfall of £153k regarding delivery of recurring savings targets. The further delivery of savings against services hosted in Angus will be considered further in conjunction with other local IJBs.

The main points to note regarding budgets for services hosted in Angus is as follows:-

- Tayside Forensic Medical Services – Medical staffing risks continued throughout 2016/17 as noted in Due Diligence process. The service continues to actively manage the issues and recent recruitment solutions suggest that overspends will reduce from c£700k to potentially nearer c£150k per annum from 2017/18 – though, of course residual risks remain.
- Tayside Out of Hours Services – Until the end of November this service had been underspending or breaking even on a month by month basis. From December there has been a material change in month on month variances and at the year end an overspend was reported. The changed pattern of variance was related to a number of factors including the number of shifts filled and the balance of salaried and sessionally engaged doctors changing (with a view to increasing the stability of the service). While these factors are still subject to continued review by Service Management and NHS Tayside Finance Department, it is likely that for 2017/18 pressures will continue until further interventions are agreed. The deterioration in the financial position during 2016/17 has

been shared with other IJBs with this deterioration presenting a new risk to all IJBs - one that will need to be monitored closely.

Services Hosted Elsewhere on Behalf of Angus IJB

As the Board will be aware a number of devolved services are managed by other IJBs on behalf of Angus IJB. Previously it has been noted that there had been some progress towards identifying savings associated with these services but that there were significant underlying risks of overspends. The year-end position is an overspend of c£510k, slightly better than previous expectations. Further financial information regarding this is set out in appendix 2. Issues such as the outcomes of reviews of Mental Health Services would be reflected in this set of information during 2017/18.

GP Prescribing

Previous reports have highlighted the risks regarding GP Prescribing budgets and the fact that Angus IJB is an outlier within Tayside and Scotland. While work is being taken forward at a Tayside level via the Prescribing Management Group and locally to address Prescribing overspends, the position remains one of ongoing overspend.

The year end position is that the Partnership is has a £2.7m overspend on a budget of c£21m. This results from a combination of historic spend levels, underlying volume growth being in excess of expectations, drug pricing being in excess of expectations and an under-delivery of savings targets. The year end position is marginally better than previously forecast. While the detail of this is still being considered within Prescribing Management Groups, this slight improvement is likely to be partially attributable to one-off factors (drug price rebates) and the early delivery of savings previously assumed to be delivered in 2017/18.

As noted this remains a major risk for the IJB. A separate Prescribing report was provided to the April 2017 Board meeting setting out the Prescribing Action Plan for 2017/18 and a follow up report will be provided in August 2017.

General Medical Services and Family Health Services

At the year end GMS budgets have underspent by c£103k. This includes allowing for a share of costs associated with the current arrangements at Brechin Health Centre. The provision of cost pressure funding from NHS Tayside in 2016/17 allowed recent growth in Enhanced Services and Premises costs to be contained. Longer term risks re further growth in these costs, the general uncertainties re General Practitioner recruitment and the introduction of a new GP contract from 2017 remain.

Budgets associated with other Family Health Services (FHS) have also marginally underspent this year (£15k).

Large Hospital Services

The Board will recall this is a budget that is devolved to the Partnership for Strategic Planning purposes but is operationally managed by the Acute Sector of NHS Tayside. In line with Scottish Government guidance, this budget is presented as breaking even in advance of further development of associated financial reporting and reflecting the risk sharing agreement for 2016/17.

As noted previously the Scottish Government are very keen that the Large Hospital Services issue is developed quickly in 2017/18. This presents both some opportunities to the IJB in terms of developing the overall strategic direction, but with that come risks regarding Acute Sector capacity. As this agenda develops further, so updates will be provided to future Board meetings through Budget Settlement papers.

Overall Position Regarding NHS Devolved Resources

The overall position is that NHS Services have reported an overspend position of c£2m. The offsetting variances, including large overspends re Prescribing, are described above. The IJB Executive Management Team and Senior Leadership team continue to look for opportunities to contribute to the longer term financial sustainability of the IJB. It is important to recognise that substantial progress has been made during 2016 in the identification of local NHS recurring savings.

Board members will be aware that the Integration Scheme contains a financial risk sharing agreement which means that the 2016/17 year end over-commitment for services delivered through NHS Tayside will revert to NHS Tayside at the financial year end for 2016/17. This will be addressed by NHS Tayside making an additional funding contribution to the IJB at the year end of £2.007m. While, in order to show the Partnership's underlying financial position, this additional contribution is not reflected in this report, the additional contribution of £2.007m from NHS Tayside for 2016/17 will be reflected in the IJB's formal Annual Accounts reported separately to the Audit Committee.

3.3 ANGUS COUNCIL DEVOLVED BUDGETS (Adult Services)

The year end financial position for Angus Council's devolved budgets shows an underspend of c£600k. This is an improvement against the near breakeven position previously projected. Some of this improvement is attributable to additional funding of £90k flowing from Delayed Discharge funds into Adult Services to support Homecare commitments. The balance of the improvement related to updated positions regarding likes of income out-turns (with income received generally being under-forecast in previous reports) and expenditure assumptions (with expenditure incurred generally being over-forecast in previous assumptions).

Year end underspends will be reflected in the IJB's annual accounts as year end reserves. This will be the first instance of the IJB having any reserves within its balance sheet.

The overall year end position has been supported by additional Scottish Government funding to support underlying cost pressures (c£800k – Social Care Funding (2016/17))and is reliant upon non-recurring underspends in a number of services. In particular there has been slippage on expected costs in both Mental Health (c£180k) and Learning Disability (£130k) that have helped support the bottom line on an in year only basis. The breakdown of the year end position, by service area, is included at Appendix.1. It should be noted that work to reconfigure the budget subheadings and to improve the quality of the report is still ongoing and therefore Appendix 1 is reported at service level rather than in more detail.

The ongoing strategic approach to delivering sustainable savings includes working with the Council's partner, Ernst & Young. This includes the Help to Live at Home project which continues to look at Care at Home with a view to changing the delivery model to achieve tangible savings in 2016/17 and 2017/18. Associated savings targets were reflected in the 2016/17 budget settlement between Angus Integration Joint Board and Angus Council. Beyond the strategic approach, the IJB Executive Management Team and Senior Leadership Team continue to look for opportunities to make both in year savings and for efficiencies to contribute to the longer term financial sustainability of the Partnership and these will be reported separately to the Board.

3.4 PARTNERSHIP FUNDS

A separate report regarding Partnership Funds is provided to this meeting. The 2016/17 allocation of Partnership Funds is reflected in this financial monitoring report.

3.5 FINANCIAL RISK ASSESSMENT

Appendix 3 sets out ongoing or emerging financial risks for the IJB. This risk register includes more detail than is held at a corporate level for Angus IJB's financial risks. As 2016/17 risks will have materialised in the year end position, so the risks are described in 2017/18 terms. Many of the risks are IJB-wide risks including examples such as future funding levels and the risks regarding delivery of savings. At this stage of the year, aside from important issues such as Prescribing, the clarification of 2017/18 budgets with Partners remains a risk.

The Finance support structure has previously been noted as a risk. This remains the case and, while the Chief Finance Officer has written to both Angus Council and NHS Tayside regarding this, much progress still needs to be made in terms of continuity and quality of that support. As separately reported to the Audit Committee, an Internal Audit report has been undertaken regarding the Financial Management of Adult Services within Angus IJB. This highlights historic weaknesses and sets out a series of Audit Recommendations to improve the position. The overall report rated the financial management support within Adult Services as "Inadequate". The Chief Finance Officer will work with the Finance support function provided by Angus Council to progress the Audit Recommendations and will report progress on this back through the Audit Committee during 2017/18.

The Board are asked to note and support the progressing of work associated with improving the IJB's Adult Services Financial Management. This will include developing a more robust budgetary framework that will facilitate future financial planning (e.g. longer term financial planning) and financial reporting developments (e.g. Locality reporting).

3.6 BUDGET VIREMENTS GREATER THAN £500k

The December 2016 Board meeting agreed the granting of flexibility to the Chief Finance Officer to approve, in consultation with the Chief Officer, virements without further reference to the Board; noting any virements made above £500,000 would be in consultation with the Chair and Vice Chair and reported back to the next Board in future finance papers.

Virements Since the Last Board Meeting

While a number of significant budget adjustments are still required to improve and refresh the IJB's Adult Services budgetary framework, there have been no major virements processed since the last report to the Board. The process of refreshing the Adult Service's budgetary framework will now be actioned as part of the process of creating a revised budgetary framework for the opening budgets for 2017/18. IJB Board members are consequently asked to support the introduction of a new budgetary framework from the start of 2017/18 for all services. The revised budgetary framework will be reflected in the first financial monitoring reports for 2017/18.

4. SUMMARY

The main financial implications of this report are set out in the body of the report at section 3. The overall financial position of the IJB reflects year end underspends within Adult Services, underspends on local hospital and community health services, all offset by overspends within Prescribing. The overall financial position of the IJB, also reflected in budget settlement papers, does have a material impact on the way Angus IJB provides services in future. By making ongoing progress with delivery of efficiencies and cost reduction programmes alongside service redesign and modernisation, the IJB will be most able to deliver the services it requires to deliver to the local population on a sustainable basis.

REPORT AUTHOR: ALEXANDER BERRY, CHIEF FINANCE OFFICER
EMAIL DETAILS: hsciangus.tayside@nhs.net

June 2017

List of Appendices:

Appendix 1: Angus Health and Social Care Partnership Financial Monitoring Report 2016/17
Appendix 2: Hosted Services
Appendix 3: Angus Health and Social Care Partnership Financial Risk Register

Appendix 1

Angus Health & Social Care Partnership - Financial Monitoring Report 2016-17

	Adult Services		Angus NHS		Partnership Accounting	
	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)
	£,000	£,000	£,000	£,000	£,000	£,000
Older Peoples Services						
Psychiatry Of Old Age			4,953	-224	4,953	-224
Medicine For The Elderly			3,394	-24	3,394	-24
Community Hospitals			3,282	-24	3,282	-24
Minor Injuries / O.O.H			1,900	-2	1,900	-2
Community Nursing			3,620	177	3,620	177
Enhanced Community Support			669	-76	669	-76
Older Peoples Service	32,097	1,909	17,819	-174	49,916	1,735
Mental Health	2,457	-190	2,231	-55	4,687	-245
Learning Disabilities	13,066	654	476	-58	13,542	596
Physical Disabilities	1,827	-161	0	0	1,827	-161
Substance Misuse	438	-85	845	-60	1,284	-145
Community Services						
Physiotherapy			1,525	-51	1,525	-51
Occupational Therapy	811	-63	677	-52	1,488	-115
Anti-Coagulation			300	-26	300	-26
Primary Care			597	-39	597	-39
Health Improvement			50	-25	50	-25
Carers Strategy			117	0	117	0
Complex Care			159	9	159	9
Homelessness	830	-111			830	-111
Joint Community Loan Store	877	34	90	-8	967	25
Grants Voluntary Bodies Angus			69	0	69	0
Tayside Primary Care Services			149	0	149	0
Community Services	2,518	-141	3,733	-192	6,251	-333
Planning / Management Support						
Centrally Managed Budget	3,667	-2,606	619	-619	4,286	-3,224
Management / Strategy / Support Services	579	37	991	-137	1,570	-100
Planning / Management Support	4,247	-2,568	1,610	-756	5,857	-3,324
Local Hospital and Community Health Services			26,715	-1,295		
Services Hosted in Angus on Behalf of Tayside IJBs						
Forensic Service			741	698	741	698
Out of Hours			6,722	174	6,722	174
Speech Therapy (Tayside)			1,056	-40	1,056	-40
Locality Pharmacy			1,200	0	1,200	0
Tayside Continence Service			1,473	-33	1,473	-33
Unresolved Savings Associated with Hosted Services			-267	267	-267	267
Hosted Services Recharges to Other IJBs			-7,964	-777	-7,964	-777
Services Hosted in Angus on Behalf of Tayside IJBs	0	0	2,962	289	2,962	289
Services Hosted Elsewhere on Behalf of Angus IJB			13,028	509	13,028	509
GP Prescribing			20,861	2,622	20,861	2,622
General Medical Services			16,459	-103	16,459	-103
Family Health Services			11,426	-15	11,426	-15
Large Hospital Set Aside			11,759	0	11,759	0
Grand Total	**56,649**	**-582**	**103,209**	**2,007**	**159,858**	**1,425**

APPENDIX 2 – HOSTED SERVICES

SERVICES HOSTED IN ANGUS IJB ON BEHALF OF TAYSIDE IJBs			
	ANNUAL BUDGET	YEAR END VARIANCE	
	£	£	
ANGUS HOSTED SERVICES	10925000	1066000	
HOSTED SERVICES ATTRIBUTABLE TO DUNDEE & PERTH IJBs	7964000	777000	72.9%
BALANCE ATTRIBUTABLE TO ANGUS	2961000	289000	27.1%
SERVICES HOSTED IN DUNDEE & PERTH IJBs ON BEHALF OF ANGUS IJB			
	ANNUAL BUDGET	YEAR END VARIANCE	
	£	£	
ANGUS SHARE OF SERVICES HOSTED IN DUNDEE			
Palliative Care	5314078	136714	
Brain Injury	1591786	37196	
Dietetics (Tayside)	2841206	-153909	
Sexual & Reproductive Health	1961857	-70321	
Medical Advisory Service	149538	-31169	
Homeopathy	25567	1770	
Tayside Health Arts Trust	56723	0	
Psychology	4492367	-577696	
Eating Disorders	286737	-22956	
Psychotherapy (Tayside)	939697	-21735	
Learning Disability (Tay Ahp)	766782	-49285	
Keep Well	434669	-77320	
Balance of Savings Target	-594305	594305	
Grand Total	18266702	-234404	
Angus Share (27.1%)	4950000	-64000	
ANGUS SHARE OF SERVICES HOSTED IN PERTH & KINROSS			
General Adult Psychiatry	14856635	1021883	
Learning Disability (Tayside)	5774126	173697	
T.A.P.S.	632147	-30335	
Tayside Drug Problem Services	830841	-52285	
Prisoner Health Services	3701487	240598	
Public Dental Service	1995541	-23139	
Podiatry (Tayside)	2896882	-96749	
Balance of Savings Target	-880357	880357	
Grand Total	29807302	2114026	
Angus Share (27.1%)	8078000	573000	
TOTAL ANGUS SHARE OF SERVICES HOSTED ELSEWHERE	13028000	509000	

APPENDIX 3 – ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP FINANCIAL RISK REGISTER

Risks – Revenue	Risk Assessment		Risk Management/Comment
	Likelihood	Impact (£k)	
Savings Targets			
Progress to identify and deliver balance of 2016/17 recurring NHS savings target (Hosted Services), additional 2017/18 NHS targets and to release funding to support overspends elsewhere.	High	TBC (inc c£153k from 16/17) (2017/18)	IJB pursuing:- actions documented in Budget Settlement papers.
Progress to deliver 2016/17and beyond GP Prescribing Savings	High	c£2m (2017/18)	Progress being taken forward through combination of local working and the NHST-wide Prescribing Management Group. See report to April 2017 Board meeting.
Progress to deliver 2016/17 agreed Adult Services savings and additional 2017/18 requirements in context of overall financial position of Angus Council.	Medium High Medium	c£400k (Unmet 2016/17) c£300k (2017/18) c£820k (2017/18)	The IJB Senior Leadership Team continue to monitor delivery of 2016/17 planned savings and alternative measures described in February IJB Board papers. Further savings and cost containment required beyond that already identified or to be delivered through Transforming Angus. Require Help to Live at Home Savings – delays on timing of savings possible.
Cost Pressures			
Review of Nurse Staffing Levels by NHST Nursing Directorate may recommend increased staffing with consequent exposure to increased costs on basis of existing service configuration.	Increasing	Not known	Previous reviews from Nursing Directorate have stated that Nurse Staffing levels need to increase in some instances. This has not been matched by any funding commitment from NHS Tayside.
IJB is exposed to ongoing NHS overspends regarding Community Nursing, Forensic Medical Services (FMS) and Out of Hours.	High	c£1.0m (2017/18)	Comm. Nursing and FMS are continuing to review service delivery models. It is now expected that Forensic Medical Services overspends will fall in 2017/18. Out of Hours under review.
For 2016/17 IJB's Large Hospital Resources will be reported at breakeven. In the longer term this will be an increasing financial risk for the IJB.	Increasing	Not known	Potential risks from 2017/18 or 2018/19 noting Scottish Government intentions.
The IJB's Adult Services are likely to see significant underlying growth in demand and consequent cost in 2016/17. This is mainly as a result of demographic pressures.	High	c£1000k (Estimated Recurring)	The IJB continues to explore permanent resolution to underlying overspends.
The IJB has a number of significant impending (2017/18) cost pressures that did not feature as part of budget settlement discussions with Angus Council.	Low	c£0.5m	Rated medium due to the outcome of the budget settlement discussion with Angus Council and the likelihood of costs being incurred.
Other (including Funding)			
Impact of NHS Tayside overall financial position.	High	Not known	Scottish Government have introduced certain stipulations regarding the 2017/18 budget that limit the overall budgetary exposure. However risks remain regarding Prescribing and issues such as Complex care.
Resolution of Devolved Budgets to the IJB (current or emerging issues)	Medium	Not known (2017/18)	Some issues remain unresolved. NHS Tayside may consider the devolution of NHS funding to support Complex Care to IJBs. Angus currently consumes a high proportion of the Tayside funding for Complex Care.
Finance Support Structure	Medium	N/A	CFO continues to work with both Angus Council and NHS Tayside to ensure required support in place but currently there are areas of risk.

AGENDA ITEM NO 9

REPORT NO IJB 29/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

PARTNERSHIP FUNDS

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

The purpose of this report is to update the Board regarding the status of a series of Partnership Funds that are overseen by the Partnership's Strategic Planning Group (SPG) with routine management and review through the Partnership's Finance Monitoring Group (FMG).

1. RECOMMENDATIONS

It is recommended that the Board:-

(i) Notes the background information regarding Partnership Funds including the status of the funds described.

(ii) Reviews and supports the funding plans for utilisation of Delayed Discharge Funding as set out in the report (section 2.3).

(iii) Reviews and supports the funding plans for utilisation of Integrated Care Fund (ICF) funding as set out in the report (section 2.4).

(iv) Notes and supports the plans for utilisation of Social Care Funding (2016/17) as set out in the report (section 2.5).

(v) Notes and supports the plans for utilisation of Social Care Funding (2017/18) as set out in the report (section 2.6).

(vi) Notes the position regarding Technology Enabled Care Funding.

(vii) Requests that the Strategic Planning Group provide a further update to the IJB in 6 months regarding the status of Partnership Funds.

2. PARTNERSHIP FUNDS - BACKGROUND

2.1 In May 2016 (IJB paper IJB/46) it was agreed that the Angus HSCP Finance Monitoring Group (FMG) would continue to have the role of overseeing Partnership Funds on behalf of the Angus HSCP's Strategic Planning Group (SPG). It was agreed that the FMG would provide reports to the SPG regarding Partnership Funds and that, in turn, the SPG would provide a half-yearly report to the IJB regarding those funds. This report is the most recent half yearly report to the Board reflecting the work overseen by the SPG.

2.2 Ongoing Partnerships Funds have been previously listed as:

- Delayed Discharge Funding (from 2015/16)
- Integrated Care Fund (from 2015/16)
- Social Care Funding (from 2016/17)
- Technology Enabled Care Funding (from 2015/16).

Of these funds, Social Care Funding (2016/17) and Delayed Discharge have previously been confirmed as being permanent allocations, the Integrated Care Fund was previously assumed to be available until March 2018 only and the Technology Enabled Care Funding is time limited.

These funds are described in the sections below with future funding proposals set out for review and approval. Once funding streams are deemed to have become mainstream, then they will be monitored alongside core Angus HSCP resources and no longer subject to specific monitoring by the Finance Monitoring Group or Strategic Planning Group.

Key points of change since the last paper to the IJB are as follows:-

- An amendment to the previous assumption that Integrated Care Funds would be time limited to a confirmed (by Scottish Government) position that Integrated Care Funds will now be permanent.
- Addition of Social Care Funding (2017/18) reflecting the 2017/18 budget agreement between the Scottish Government, NHS Health Boards and Local Authorities and in turn reflected in the 2017/18 budget settlements between Angus HSCP and both NHS Tayside and Angus Council.
- An increased recognition that the allocation of Partnership Funds funding must be made in the context of the overall IJB's financial position.
- An increased focus on mainstreaming short term investments and removing planning uncertainty such that the monitoring of these resources is seen alongside other recurring commitments within the IJB's overall budgetary framework.

2.3 DELAYED DISCHARGE (£639k; recurring)

In 2015/16, Angus Partnership received £639k Delayed Discharge funding from the Scottish Government. The utilisation of this funding stream has been previously described (report IJB 87/16). The main intention of this permanent funding stream is to maximise performance regarding effective discharge planning and minimise number of unnecessary admissions.

Report 87/16 recognised the significant permanent planned investment in Enhanced Community Support. It is now proposed that the existing Angus performance on Delayed Discharge issues is consolidated by applying the balance of this funding on a permanent and mainstreamed basis to support Home care within Adult Services. In addition it is recommended that commitment to work streams: Clinical Pathways and Residential Care are also now treated as permanent and mainstreamed. The overall proposal is shown in table 1 below.

Angus Integration Joint Board - Delayed Discharge Summary **Table 1**

	2016/17	2017/18	2018/19	2019/20	2020/21	
	Plan	Plan	Plan	Plan	Plan	
Project/Work stream	**£k**	**£k**	**£k**	**£k**	**£k**	**Notes**
Develop Home Care Market Contracts	35	18	0	0	0	Temporary Funding
Residential Care	29	29	29	29	29	Convert to Permanent Commitment
Enhanced Community Support	68	344	344	344	344	Permanent Commitment - Per report 85/16
Project Implementation (ECS)	0	60	60	0	0	Temporary Funding
Working with Communities	38	20	20	20	20	Includes long term investment in Advocacy Services
Clinical Pathways	47	86	86	86	86	Convert to Permanent Commitment
Other	19	58	40	0	0	Temporary Funding
System Capacity (Tayside)	0	0	0	0	0	
System Capacity (NHS Tayside)	307	0	0	0	0	Support in 2016/17 only
Home Care	90	160	160	160	160	New Commitment
Movement Between Funds (ICF/Delayed Discharge)	29	-136	-100	0	0	To manage short term commitments
Total	**663**	**639**	**639**	**639**	**639**	
Brought Forward from Previous Year	**24**	**0**	**0**	**0**	**0**	
Scottish Government Funding	**639**	**639**	**639**	**639**	**639**	
Carried Forward to Next Year	**0**	**0**	**0**	**0**	**0**	

It is suggested flexibility remains with the Finance Monitoring Group to adjust allocations in line with this overall plan to better align specific costs with specific funding streams but generally the above table is recommended as the final apportionment of the IJB's Delayed Discharge investments.

Other points to note include:-

- Within the IJB's allocation of Social Care funding from 2016/17 there was an ear-mark of £100k re Delayed Discharge. For 2017/18 and recurrently it has previously been agreed this funding be used for Home Care. This will give a combined net increase of c£260k to Home Care resources to consolidate existing levels of service provision as described in IJB paper 16/17.This has become practical due to the revised assumptions regarding the Integrated Care Fund funding which in turn provides increased flexibility re Delayed Discharge funding.
- Once funding is mainstreamed, the financial monitoring of mainstreamed investments will shift from Finance Monitoring Group to mainstream financial monitoring. The intention is that at this point funding is therefore deemed to be permanent and no longer requires discrete reporting back to the IJB.
- For 2016/17 only, the IJB has utilised non-recurring under spends on this funding stream to contribute to overall NHS Tayside pressures regarding winter planning and Delayed Discharge – including pressures associated with Angus patients – and to support the Home care costs noted above. This is reflected in the table above for 2016/17 only.
- For 2017/18 and 2018/19 there are Delayed Discharge commitments in excess of Delayed Discharge funding. It remains the plan that this excess, as set out in previous papers, is supported by Integrated Care Fund funding. In 2017/18 it is possible there will be slippage in the first half year re the implementation of Enhanced Community Services. Any slippage of that type will reduce the support required from the ICF.

This plan has been discussed at the Finance Monitoring Group, Delayed Discharge Task & Finish Group and, most recently, the Strategic Planning Group.

While Angus HSCP is generally making progress with the management of Delayed Discharges, this remains an area of high priority for the Partnership and issues are not restricted to Older People's Services.

2.4 INTEGRATED CARE FUND (£2.13m; now recurring)

As noted in the Background section of this paper, it is now confirmed that this funding stream will be permanent. This is a helpful revision to the previous working assumption. On that basis, table 2 below now sets out a revised Integrated Care Fund plan.

It is now proposed that a majority of ongoing commitments, as described in table 2 below, are now treated as mainstreamed permanent commitments. The exact value of a number of these will be refined by the Finance Monitoring Group reflecting the most current information, some after consideration of refreshed business cases. As per Delayed Discharge funding above, once funding is confirmed as permanent, so the associated financial monitoring will shift from Finance Monitoring Group to mainstream financial monitoring.

A number of other investments will be short term or one year only and these will largely be funded by the flexibilities that exists within the budgetary framework.

The proposed revised plan is now set out in the table below:-

Angus Integration Joint Board - Integrated Care Fund Summary (ICF) **Table 2**

Project/Work stream	2015/16 Actual £k	2016/17 Plan £k	2017/18 Plan £k	2018/19 Plan £k	2019/20 Plan £k	2020/21 Plan £k	Notes
Enablement - Social Care Enablement Teams	195	0	120	0	0	0	Long term via Help to Live at Home
Physiotherapy & Generic Rehab & Falls	149	160	160	160	160	160	Convert to Permanent Commitment subject to FMG review of business case
Hospital Discharge Pathway	297	0	100	33	33	33	Long term partly via Help to Live at Home
Hospital Discharge Pathway (Care Managers)	0	0	137	137	137	137	Convert to Permanent Commitment
Dementia	101	112	112	112	112	112	Convert to Permanent Commitment
Supported Housing	75	0	0	0	0	0	
Organisational Development Support	224	190	351	297	258	258	Convert to Permanent Commitment
Supporting Self Directed Support	1	79	70	11	0	0	Temporary Funding
Data Sharing System	0	0	100	0	0	0	Temporary Funding
Carers Support	258	245	256	256	256	256	Convert to Permanent Commitment
Working with Communities	296	191	135	135	135	135	Convert to Permanent Commitment
Working with Communities II	0	410	400	300	300	300	Convert to Permanent Commitment
Joint Store	0	173	0	0	0	0	Temporary Funding
Keep Well	13	37	73	73	73	73	Subject to FMG review of business case
Locality Allocation	0	0	203	247	100	0	Temporary Funding
Glen Isla	62	60	62	0	0	0	Temporary Funding
Other	89	71	72	47	47	27	Convert to Permanent Commitment
Available Funds	0	0	639	639	639	639	Review in context of IJB's Financial Plans
Movement Between Funds (ICF/Delayed Discharge)	0	-29	136	100	0	0	To manage short term Delayed Discharge commitments
Total	**2060**	**1699**	**3126**	**2547**	**2250**	**2130**	
Brought Forward from Previous Year	**1124**	**1194**	**1625**	**629**	**212**	**93**	
Scottish Government Funding (Confirmed)	**2130**	**2130**	**2130**	**2130**	**2130**	**2130**	
Residual Shortfall	**0**	**0**	**0**	**0**	**0**	**0**	
Carried Forward to Next Year	**1194**	**1625**	**629**	**212**	**93**	**94**	

Regarding table 2, it is important to note the following:-

- Information regarding Integrated Care Fund commitments will be included in the Partnership's Annual Performance Report.
- After this round of consolidation recurring available funds will reduce to £639k. Given the financial challenges and uncertainly surrounding the IJB (e.g. unmet savings, savings proposals still being developed, a range of unfunded cost pressures), it is recommended that further investment of this funding continues to be overseen by the FMG, is used in a manner consistent with the IJB's overall strategic plan and priorities and investment is made in the context of the IJB's overall financial position and where proposed investments help contribute to the financial recovery of the IJB's overall financial position.

2.5 SOCIAL CARE FUNDING (2016/17) (£5.340m; permanent funding)

Much of this funding has already been described (87/16) as being utilised to support 2016/17 demographic pressures and issues related to the 2016/17 budgets setting process (e.g. implementation of Scottish Living Wage).

However as per 87/16, part of the funding had initially been set aside to sustain services originally funded via the Integrated Care Fund. With the confirmation that Integrated Care Fund funding is now to be permanent, so the previous assumptions re the utilisation of the recurring balance of this funding (£1.113m – per section 2.3 of report 87/16) can be revised.

The Board will be aware there are potential recurring over-commitments in the underlying IJB financial projections for Adult Services - noting that the 2016/17 financial position was supported by non-recurring funds, including c£800k of Social Care Funding (2016/17). As the full budget revision exercise is still ongoing, for now it is recommended that the majority of the available funding is allocated in line with the original expectations for this funding, that being to assist offset the cost of increased capacity demands. This allocation will therefore be applied through the budget refresh exercise with funds allocated across the breadth of Adult Services to support the cost of existing commitments reflecting capacity in the system at the start of 2017/18.

As this funding is intended only to support Adult Social care and has not previously been overseen by the Finance Monitoring Group, it is recommend that any balance of this funding still available after the budget refresh exercise be overseen by the Chief Officer with the intention being any funding is utilised, as per Integrated Care Funding, in line with the IJB's overall strategic plan and priorities and

investment is made in the context of the IJB's overall financial position and where proposed investments help contribute to the financial recovery of the IJB's overall financial position.

2.6 SOCIAL CARE FUNDING (2017/18) (£2.280m; permanent funding)

The receipt of this funding stream was noted at the February IJB meeting (paper 13/17, "Budget Settlement with Angus Council"). While this funding is new funding to be devolved to the IJB, it is entirely associated with specific commitments including likes of delivery of increased Scottish Living Wage, War Veteran charging issues and the implementation of Carers Act. As such, it is proposed that this funding is allocated in line with Scottish Government guidance, so the expectation is this funding will not require to be overseen via the Finance Monitoring Group, Strategic Planning Group or reported directly back to the IJB unless by exception.

2.7 TECHNOLOGY ENABLED FUNDING

While this funding is overseen by the Finance Monitoring Group, there is minimal local flexibility as to how the funding is applied as approved funding comes direct from the Scottish Government Technology Enabled Care Programme for specific developments. Angus has been awarded £155,000 payable over the financial years 2016/17 and 2017/18 to specifically enhance telecare. Angus has also been awarded £87,500 payable over the financial years 2016/17 and 2017/18 to host a Tayside wide telehealth initiative.

3. RESOURCE MANAGEMENT ISSUES

3.1 The remaining Integrated Care Fund resources not currently committed on a recurring or permanent basis will continue to be monitored through the Finance Monitoring Group and reported to the Strategic Planning Group and then the IJB.

Where the expression "permanent" or "recurring" or "mainstreamed" is used to describe an investment, this is permanent, recurring or mainstreamed on an ongoing basis but can still be amended by a future decision of the IJB.

4. CONCLUSIONS

4.1 The IJB should note the range of issues set out regarding Delayed Discharge Funding, Integrated Care Funding, Social Care Funding (2016/17 and 2017/18) and Technology Enabled Care Funding. As the HSCP develops it is increasingly important for these resources to be seen in the context of the overall Partnership, the Partnership's longer term financial planning and in the context of the financial pressures facing Angus HSCP and both Angus Council and NHS Tayside.

The recommendations set out for the IJB reflect this position.

REPORT AUTHOR: ALEXANDER BERRY
EMAIL DETAILS: hsciangus.tayside@nhs.net

6 June 2017

AGENDA ITEM NO 10

REPORT NO IJB 30/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

BUDGET SETTLEMENTS FOR 2017/18

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

The purpose of this report is to update the Integration Joint Board regarding the proposed Budget Settlements between Angus IJB and both Angus Council and NHS Tayside for 2017/18.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) Note the update provided regarding the Budget Settlement with Angus Council including the position regarding risk sharing, residual savings and cost containment balance and reserves.

(ii) Support and approve the ongoing work being undertaken to refresh the Adult Services budgetary framework as described in the report.

(iii) Regarding the proposed budget settlement with NHS Tayside:-

a. Note the ongoing work to clarify the budgets to be devolved regarding Local Services (including Partnership Allocations and Resources devolved to Adult Services).

b. Supports the process of continuing to seek clarification from Perth IJB regarding the adequacy of the budgets for Mental Health Services prior to otherwise accepting the proposed budget for Hosted Services.

c. Notes the update re Prescribing budgets.

d. Notes that an overall update re the 2017/18 budget settlement with NHS Tayside will be provided to the next Board meeting.

(iii) Note the Angus IJB Annual Financial Statement.

2. BUDGET SETTLEMENT WITH ANGUS COUNCIL – UPDATE

2.1 The Board considered the detail regarding the proposed devolved budget from Angus Council at the Board meeting on 22nd February 2017 and received an update at the April 2017 Board meeting. The following matters are covered within this update:-

- Risk Sharing arrangements regarding unfunded Investment bids.
- Residual Savings and Cost Containment Balance.
- Reserves.
- Budget refresh.

2.2 Risk Sharing

The issue of risk sharing arrangements relates to Investment Bids that were not reflected in the budget settlement with Angus Council. This includes issues associated with Learning Disability (Changes in Family Support), provision of Level 4 Mental Health Accommodation and issues regarding capacity on services such as Mental Health Officer and Adult with Incapacity.

Discussions have now concluded with Angus Council and the agreement is that for any financial risks that emerge during 2017/18, the IJB will seek to contain those financial risks where

practical. Otherwise, for 2017/18, any bottom line impact would be managed as part of the overall risk sharing agreements with Angus Council. For risks that stretch beyond 2017/18, these would be considered within the context of overall discussion between Angus Council and Angus IJB re future year budgets.

2.3 Residual Savings and Cost Containment Balance (£268k)

Board members will recall that the agreed budget settlement with Angus Council included a requirement to resolve a balance of £628k through further savings or cost containment measures. Options to partly address this balance were agreed at the April Board meeting, leaving a planning balance of £268k to resolve. At this point the expectation is that further reviews of 2017/18's forecast cost pressures regarding Learning Disability and Care Home activity will be undertaken in due course to seek to contain the forecast cost pressures.

It is expected that information regarding Learning Disability and Care Homes will be provided to a future Board meeting.

2.4 Reserves

At the start of 2017/18, Angus IJB will carry forward reserves derived from under spends within Adult Services in 2016/17. While the IJB does have a policy of seeking to create a prudent level of general reserves, reserves may also be required in 2017/18 to assist the IJB manage some significant changes what will happen with in Adult Services in 2017/18. That will include costs associated with the implementation of the 2017/18 phase of Help to Live at Home.

2.5 Budget Refresh

As has been noted in separate IJB reports (e.g. Finance Monitoring reports, including 14/17), a major exercise is required to refresh the budgetary framework for Adult Services. It had initially been anticipated that this refresh would happen in 2016/17 however it has now become necessary for it to be actioned at the start of 2017/18. Due to the status of a number of budgets and the very large variances within many budgets, a bottom up review of the overall framework has been undertaken. The Board are now asked to approve the process of revising the overall budgetary framework that will reflect at least the following principles:-

- Inflation type pressure for 2016/17 and 2017/18 (including implementation of Living Wage).
- Historic changes in activity levels and already-approved commitments..
- An increased alignment with current models of service delivery (e.g. Help to Live at Home).
- Savings delivered in period to March 2017.

Final budgets will be reflected through future Finance Monitoring Reports once the exercise is complete.

3. BUDGET SETTLEMENT WITH NHS TAYSIDE

3.1 A paper was (16/17) was submitted to the last IJB Board meeting describing the current status of the budget settlement with NHS Tayside. While this paper described the overall position it also noted that a number of issues remained unresolved. The following provides an update and is described reflecting the various components of budgets devolved from NHS Tayside are as follows:-

- Local Services (including Partnership Allocations and Resources devolved to Adult Services)
- Services Hosted in Angus on behalf of Tayside IJBs and Services Hosted Elsewhere on Behalf of Angus IJB
- Family Health Service Prescribing
- General Medical Services and Family Health Services
- Large Hospital Services.

3.2 Local Services (including Partnership Allocations and Resources devolved to Adult Services)

While previously the general recommendations has been that the IJB accept the proposed budget for devolved local services, there remain a small number of issues to be clarified with NHS Tayside. There are outstanding discussions to be concluded regarding a small number of cost pressures and, in particular, there is an outstanding matter to be concluded regarding clarifying responsibility for funding NHS shares of Complex care packages. This last point requires clarity regarding historic and future commitments.

These matters remain unresolved and are now the subject of ongoing discussion with NHS Tayside's Director of Finance. A further update will be provided to the August Board meeting.

Previously it has been noted that Alcohol and Drugs Partnership (ADP) funds will be devolved to IJBs. Work is developing to conclude this and in advance of that a proposal is described at 2.4 to modernise the way this funding is treated.

3.3 Services Hosted in Angus on behalf of Tayside IJBs and Services Hosted Elsewhere on Behalf of Angus IJB

The April budget Settlement paper (paper 16/17) notes that Angus IJB received confirmation from Perth & Kinross IJB (as service hosts) regarding the adequacy of Mental Health budgets before any final acceptance of the budges is confirmed to NHS Tayside. This matter remains outstanding and will be confirmed after further clarification regarding overall Mental Health plans.

3.4 Family Health Service Prescribing

Previous papers to the IJB Board have described the forecast shortfalls regarding Prescribing resources. While work continues to improve the IJB's Prescribing position, significant shortfalls remains. An update will be provided to the IJB Board in August 2017.

The overall financial planning framework is also subject to a series of revisions that includes reviews of previous assumptions of drug price rebates. These revised assumptions will include a deterioration in the assumed benefit re drug price rebates of up to £1.4m on a recurring basis. The timing and scale of the impact remain unclear. This has an effect of weakening the previously projected Angus prescribing forecast.

Board members may be aware that currently Prescribing resources devolved from NHS Tayside to IJBs are apportioned using formulae that reflect weighted populations. Recent re-workings of these formulae, via Information Services Division of Scottish Government, suggest potential future movements in apportionments within Tayside. The detail associated with these re-workings will be discussed through Tayside forums and the impact in short and longer term assessed in due course.

Much work continues regarding prescribing and the August board update will reflect the most recent budget forecasts.

The Board has previously request that the Chief Officer and Chief Finance Officer also explore with NHS Tayside options regarding extending the "risk sharing" agreement regarding Prescribing beyond the current end date of March 2018 until prescribing costs can be sustained in line with available budgets. This would assist with the transition into 2018/19 when the current risk sharing agreement will have expired. This is a matter that is of common interest to all IJBs in Tayside and discussion may be developed on a Tayside IJB wide basis.

3.5 General Medical Services and Family Health Services

There has been no change in planning assumptions regarding these budgets.

3.6 Large Hospital Services

Previously it has been recommended that the proposed budgets are accepted as a notional budget in advance of more detailed proposals describing a budget that reflects the underlying substance of the working agreement for 2017/18. This remains the position.

3.7 Summary

While progress continues to be made with resolving the outstanding issues regarding the budget settlement with NHS Tayside, there are a number of outstanding issues. An update on these matters will be provided to the next IJB meeting.

4. BUDGET SETTLEMENTS - FINANCIAL PLANNING RESPONSE

4.1 Angus HSCP's Budget Settlements with Angus Council and NHS Tayside both contain significant financial challenges. Updates regarding the progress and risks associated with addressing these challenges will be provided regularly to the IJB through this financial year. A brief update of progress to date is noted below.

4.2 Adult Services Update

Measure	Planned Outcome	Status
Help to Live at Home	£820k	See separate update to IJB (paper 33/17).
Review of Charges	£200k	Initial changes implemented, impact to be monitored.
Delayed Discharge Funding	£260k	Agreed and in place
Additional management efficiencies	£100k	Progress being monitored.
Balance	£268k	Initial response still being developed through Care Home and Learning Disability reviews.
Total	£1648k	

Further savings measures are required to assist address the shortfalls of £393k regarding 2016/17 savings targets. Separate work is being progressed within the IJB to address this issue and is reflected in the "Improvement and Change Programme" paper separately presented to the June IJB meeting.

4.3 NHS Services Update

The financial planning response to the NHS Budget Settlement was only confirmed at the April Board meeting. As such the process of taking the response forward is less progressed and therefore a full update is not provided here. However early indications are that some of the initiatives including progressing the savings associated with Medication Administration and identifying additional operational efficiencies are behind schedule. A more detailed update will be provided to the August Board meeting.

4.4 Prescribing

As previously agreed a full update on Prescribing will be provided to the August IJB meeting. While accepting the local challenge in particular is very significant, progress continues to be made at both a local and Tayside level. A number of difficult challenges continue to require to be addressed including considering how to support Prescribing work streams (including determining the scale of resource required to support Prescribing work streams), consideration of the merits of certain drug choices and ensuring we maintain maximum local General Practitioner engagement around an issue where Angus HSCP does face a significant financial challenge.

5. ANNUAL FINANCIAL STATEMENT

On an annual basis all IJBs are required to produce an Annual Financial Statement. Guidance has been issued by the Scottish Government regarding this and it notes..." All Integration Authorities (Partnerships) completed their Strategic Commissioning Plans by 1st April 2016 with varying levels of financial information included. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires that each Integration Authority (Partnership) must publish an Annual Financial Statement on the resources that it plans to spend in implementing the Strategic Commissioning Plan."

Through discussion at the national Chief Finance Officer network it has been accepted that early versions of the Annual Financial Statement will be limited in their content but that these statements should develop in time to be multi-year representations of financial planning assumptions. A format has been agreed nationally and the Angus version of the 2017/18 Annual Financial Statement is shown below.

	2017/18			2018/19 Indicative			2019/20 Indicative		
	Payment £m	Set Aside [2] £m	Total £m	Payment £m	Set Aside £m	Total £m	Payment £m	Set Aside £m	Total £m
Resource									
LA	44.169		**44.169**	44.169		**44.169**	44.169		**44.169**
Health Board	107.980	11.759	**119.739**	107.980	11.759	**119.739**	107.980	11.759	**119.739**
Total Income	**152.149**	**11.759**	**163.908**	**152.149**	**11.759**	**163.908**	**152.149**	**11.759**	**163.908**
Expenditure									
Hospital [1]	0.000	11.759	**11.759**	0.000	11.759	**11.759**	0.000	11.759	**11.759**
Community Healthcare	44.218		**44.218**	44.218		**44.218**	44.218		**44.218**
FHS & Prescribing	48.660		**48.660**	48.660		**48.660**	48.660		**48.660**
Social Care	59.272		**59.272**	59.272		**59.272**	59.272		**59.272**
Total Expenditure	**152.149**	**11.759**	**163.908**	**152.149**	**11.759**	**163.908**	**152.149**	**11.759**	**163.908**
Savings Target	3.075	0.000	3.075	TBC	TBC	TBC	TBC	TBC	TBC
Agreed Savings	2.288	0.000	2.288	TBC	TBC	TBC	TBC	TBC	TBC
Reserves			0			0			0

Notes

1. This figure is currently contained within "Community Healthcare". An agreed methodology to determine this figure is still under consideration

While 3 years of information require to be shown, years beyond 2017/18 are shown with nil change from 2017/18 reflecting the status of funding agreements locally and nationally and the status of longer term expenditure plans.

It is important to note that work still needs to be undertaken to clarify a “Hospital” planned expenditure figure from within the overall Community Healthcare figure. While this task may appear straightforward it is complicated by many health services, including those hosted elsewhere in Tayside, being services that span hospital and community health provision. This includes teams that work across these boundaries (for example Allied Health Profession teams) and staff groups that work across boundaries (for example medical and pharmacy staffing).

A revised version of the Annual Financial Statement will be issued once the “Hospital” figures have been clarified.

6. CONCLUSION

6.1 The above paper is intended to provide an update regarding the status of the Budget Settlement with Angus Council and the budget settlement proposal with NHS Tayside.

Further information will be shared with the Board in due course and at the August Board meeting in particular.

REPORT AUTHOR: Alexander Berry, Chief Finance Officer
EMAIL DETAILS: hsciangus.tayside@nhs.net

June 2017

AGENDA ITEM NO 11

REPORT NO IJB 31/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

IMPROVEMENT AND CHANGE PROGRAMME

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The HSCP identified a number of efficiency measures within Budget Settlement papers approved by the IJB on 22nd February 2017 (see report no 12/17). Applying learning derived from the Help to Live at Home programme, it is recognised that a programme management approach would have considerable benefits in terms of dealing in a coordinated way with the service user, human resource, contracts, financial benefits realisation and communications issues which will arise during implementation. The IJB is asked to note and approve the approach being taken to the delivery of the Improvement and Change Programme and to seek further progress reports through the Service Delivery Plan reporting schedule.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) notes the contents of this report;

(ii) approves the programme management approach being taken;

(iii) seeks progress reports through the Service Delivery Plan reporting schedule.

2. BACKGROUND

Strategic goals

Angus Health and Social Care Partnership (AHSCP) is committed to placing individuals and communities at the centre of service planning and delivery in order to deliver person-centred outcomes. The Partnership is focused upon improving the long term health of its population, providing timely health and social care interventions when needed and ensuring that such interventions give the best outcomes for our service users and their carers. The Angus Strategic Plan makes a commitment to shifting the balance of care from institution-based to care at home; it calls for health and social care to extend beyond the traditional setting of hospitals and care homes to reach more effectively onto a person's own home and community.

Challenges

There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and which helps to maintain their independence and the support of their own community.

There are a number of workforce challenges. We have witnessed a significant shift in the availability of the traditional health and social care workforce in Angus. We anticipate further change over the next few years, particularly in the nursing and medical workforce, which will

result in difficulties in recruiting and retaining staff in the numbers required in some areas of Angus. We cannot afford to ignore these early warning signs, and need to plan to provide care on a more sustainable basis, and to deploy the available workforce efficiently and effectively.

Resource management is becoming more challenging because of increasing levels of demand. Year on year we face a growing requirement to manage the resources of the IJB in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The strategic plan identifies a number of areas of efficiency, and the shift in the balance of care required.

The quality and suitability of our facilities is not always of the standard we would wish. We currently provide care from a number of facilities which are either no longer fit for purpose or which will require substantial investment, and which may not be sustainable in the future and/or may not be required in terms of new ways of providing care.

The introduction of Self Directed Support (SDS) has significantly changed the provision of social care services, giving more control to service users and their carers and driving the expansion of the independent and third sectors as care and support providers.

During 2016/17 the IJB identified shortfalls on its delivery of 2016/17 planned savings. Together with the need to develop responses to future financial challenges, this was a factor in the Board agreeing to a series of savings for adult social work services. Impact assessments have been completed for these measures and were originally considered by a sub group of voting members of the IJB and then shared with the full IJB membership.

Action

The proposed Improvement and Change Programme aims to improve the current operating model in a further range of social care services. These service changes cover several service user groups and share a common goal of achieving cost effective and sustainable service models which meet the outcomes required by service users. The projects have been identified through operational feedback where services are under-utilising resources and/or where the service model is no longer fit for purpose. Savings targets have been identified for each project.

A successful change programme will contribute to delivering the strategic direction of the Partnership and contribute towards Angus IJB developing a balanced long term financial plan, bearing in mind the financial challenges that the Partnership currently faces.

3. CURRENT POSITION

The purpose of the Improvement and Change Programme (ICP) will be to:

- Deliver improvements to services which also contribute to achieving efficiency savings or more effective use of resources which will deliver the best outcomes for the people of Angus.
- Coordinate service reviews and improvement project plans to deliver a coherent and strategic change programme
- Plan and deliver a programme of change which will achieve the desired configuration of services, within the budget plan and required timescales.

The programme scope includes projects for which identified savings have been agreed by the IJB and others which are in a more developmental stage. The former are:

1. Dementia Day care review
2. Review of Care and Assessment for Older People – management arrangements
3. Review of staffing model and commissioning options – supported housing for people under 65 with mental health problems
4. Review of supported housing – older people

5. Review of overnight support – learning disabilities accommodation

The Programme scope will also include in the latter category:

6. The Residential and Nursing Care Home Review implementation plan. A report regarding this review and an options appraisal will be submitted to the IJB in August 2017 for approval.
7. A review of the procurement arrangements for Community Meals to determine if these are the most efficient means of meeting the needs of our service user group.

There are also a number of other, large scale reviews for which similar programme management approaches are required. These include the review of minor injury and illness provision, the review of in-patient facilities, and the roll out of ECS. The scale of some of these reviews will inevitably mean that they remain as discrete reviews. However, close attention will be paid to connections between programmes and the impact of actions made by one on any other. Separately, over time, we may opt to add further projects into the new Improvement and Change Programme where these would benefit from a consolidated approach.

The ICP will deliver a change programme to manage the projects for the services identified for savings and improvement measures. The programme will be focused on achievable benefits, putting service users and their needs at the centre of the process. The change work will involve engagement with staff, service users, public, and all stakeholders which are currently involved in service provision or future service provision. The projects will be coordinated through a change programme team which will manage project progress, pooling and coordinating common themes to ensure a coherent strategic approach. The programme will report to a programme board, identified by the AHSCP Executive Management Team, and submit progress reports to the IJB at an agreed frequency. The programme is proposed to commence in July 2017.

4. NEXT STEPS

Our next steps will be to develop the programme for delivering the change programme. Early work will include:

1. Establishing data requirements for each project within the programme.
2. Develop stepped approach to change with a detailed timeline for each project, identifying peaks of activity, dependencies, risks and implications for capacity.
3. Preparation of business case for each project
4. Develop benefits realisation plans for monitoring financial benefits and performance outcomes.
5. Develop communications strategy for the programme with a focus on service-users, staff, IJB members, media and other stakeholders.
6. Review of contracts arrangements for each project, where relevant.
7. Develop risk assessment and risk management plans.

5. RISKS AND RISK MANAGEMENT

The Improvement and Change programme encompasses a number of savings measures which are necessary to achieve the approved 2017/18 budget plan. If these are not achieved the Partnership may need to identify savings in other areas. The programme management approach ensures a generic contribution to the overall financial planning of the IJB.

It should be noted that the programme has some risks to successful delivery, as is common with all change programmes at this stage of development. Foremost amongst these is capacity within the management team to deliver a broad range of changes at the same time as continuing to provide the day-to-day business of service delivery.

In recognition of this demand, the Programme Manager for Help to Live at Home will extend his remit to include the Improvement and Change Programme, and will identify the necessary resources to successfully deliver the programme within the required timescale.

A detailed risk assessment and risk management plan will be developed.

6. CONCLUSIONS

The IJB is asked to note the work being undertaken to develop the Improvement and Change Programme and to approve the approach outlined in this report so that it can progress to the next stage.

REPORT AUTHOR: George Bowie, Head of Community Health & Care Services (South Angus)
EMAIL DETAILS: BowieGS@angus.gov.uk

June 2017

AGENDA ITEM NO 12

REPORT NO. IJB 32/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

ANNUAL STRATEGIC PROGRESS AND PERFORMANCE REPORT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to update the Integration Joint Board (IJB) on the progress made in delivering the strategic plan and the effect of our activity on performance during 2016/17. This report builds on previous quarterly performance reports presented to the IJB. The report demonstrates the level of improvement activity being delivered across the partnership and shows how that is driving progress towards the delivery of the Partnership's vision, strategic shifts and planned outcomes for the people of Angus.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

(i) approve the 2016/17 Strategic Progress and Performance Report for Angus (Appendix 1);

(ii) recognises the progress that has been made by staff in delivering the aims of the strategic plan;

(iii) asks the Chief Officer to ensure that updated performance reports are provided to the IJB quarterly.

2. THE ANNUAL STRATEGIC PROGRESS AND PERFORMANCE REPORT

2.1 The IJB have agreed previous reports related to the development of the partnership's performance framework.

2.2 This 2016/17 Strategic Progress and Performance Report aims to set out the strategic level performance described in the partnership's performance framework. This includes the national core indicators which demonstrate progress against the national outcomes.

2.3 Strategic activity during 2016/17 and a number of additional local indicators have been developed to show progress and performance in relation to the four strategic priorities:

Priority 1	Improving health wellbeing and independence
Priority 2	Supporting care needs at home
Priority 3	Developing integrated and enhanced primary care and community responses
Priority 4	Improving integrated care pathways for priorities in care

2.4 The report also provides both progress and performance information on a further three performance areas:

Performance area 1	Clinical and care governance
Performance area 2	Staff
Performance area 3	Resources

2.5 2016/17 Strategic Progress and Performance Report (Appendix 1) provides evidence of progress in line with the requirements for the annual performance report set out in regulations.

2.6 In setting out strategic progress and performance the report highlights that:

- Angus performs well nationally in relation to most national core indicators. This good performance shows the progress the partnership has made in shifting the balance of care to more community based and responsive services and addressing the average length of stay in hospital following an emergency admission.
- Progress has been made in addressing hospital bed occupancy. Angus has seen a continuing decrease in the bed day rates although admissions continue to increase. Readmission rates have increased and have impacted on performance in relation to the overall rate of admission.
- Readmissions within 28 days of discharge have increased for Angus as a whole; this increasing readmission rate contributes to the increase in all emergency admissions. The largest increase in readmissions is in the South West locality. The North East has also seen increasing readmissions for the first time in 2016/17. The South East saw the most improvement through to quarter 3 but has lost ground in quarter 4 2016/17.
- Enhanced Community Support (ECS), managing timely discharge and increasing levels of personal care, has contributed to a reduction in bed days lost to delayed discharges for people aged 75+.
- There has been a 33% increase in the level of personal care being delivered within our localities. More people are being supported and more people are receiving higher levels of care.
- The North West locality has the lowest rate of total care home placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate but uses less personal care and other community services. The North East locality makes the most placements by population rate and also uses very high levels of personal care and other community based services. The South West locality makes few placements but also uses less personal care and other community based services. The South West was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localities saw an increase in the number of placements in 2016/17.
- A high proportion (89%) of users of care rate the services as excellent or good. Locally, information gathered by services also indicates high levels of satisfaction with those services.

2.7 During 2017/18 it is anticipated that further indicators will be developed as progress is made with the implementation of the performance framework, along with improvements in the availability of data and information from Angus Council, NHS Tayside and the Information Services Division (ISD) Source project.

REPORT AUTHORS: **Gail Smith, Head of Community Health & Care Services (North)**
George Bowie, Head of Community Health & Care Services (South)

EMAIL DETAILS: **hsciangus.tayside@nhs.net**

7 June 2017

Appendices

Appendix 1 – 2016/17 Strategic Progress and Performance Report

ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

STRATEGIC PROGRESS AND PERFORMANCE REPORT

April 2016 to March 2017

Published June 2017

Introduction

The purpose of this Annual Strategic Progress and Performance Report is to show progress against the four priorities set out in the Angus Health and Social Care Partnership's strategic plan and three performance areas. The four priorities of our strategic plan aim to deliver the nine national health and wellbeing outcomes. The relationship between our strategic priorities, the national outcomes and the national core indicators is set out in appendix 1. Our performance in relation to the national outcomes will be set out in relation to our four strategic priorities and three performance areas. These are:

The information included in this report aims to set out what has been achieved in relation to the delivery of the priorities set out in the strategic plan; what is to be delivered next and how the delivery of the strategic plan has impacted on the performance of Angus Health and Social Care Partnership. Throughout the report, performance is shown by locality, where possible, in order that locality improvement groups can focus on addressing variance in performance and continuous improvement. The emerging strategic delivery plan for 2017-19 is set out at appendix 2. The report does not cover hosted services. Discussions are ongoing with other Partnerships about how we create and deliver a shared approach to reporting on those services.

The total number of people over 65 living in Angus has not changed over the last 5 years. However, the number of people aged 75+ has increased by over 1,000 and the number of people between 65 and 74 has decreased by over 1,000. This, in part, contributes to some of the increase in hospital activity as a rate of the adult population. It has not been possible to adjust rates for 2016/17 to take account of demographic change as population figures are not yet published. Data has been constructed based on 2015 populations. Data is show using rolling years, this means:

- Quarter 1 16/17 (Q1) = 1 July 2015 to June 30 2016
- Quarter 2 16/17(Q2) = 1 October 2016 to 30 September 2016
- Quarter 3 16/17(Q3) = 1 January 2016 to December 31 2016
- Quarter 4 16/17(Q4) = 1 April 2016 to March 31 2017 (full year effect)

***Data explanatory note*:** where health information has been extracted from a different source other than the ISD Source team there are some minor discrepancies between the ISD published and non-ISD published health information. All non-published information, such as health information shown by localities, should therefore be treated with caution. Social care information has been extracted from Care First, there have been some data anomalies and data quality issues which are being addressed to improve the quality of the performance information. The national position for 2016/17 in relation to performance against the 23 national core indicators will not be published until September 2017 and therefore cannot be included in this report. The 2015/16 benchmark is offered to allow for some comparison.

Angus Performance Summary

Overall Locality Performance

- Angus performs well nationally in relation to most national core indicators (see Table 1) This good performance shows the progress the partnership has made in shifting the balance of care to more community based and responsive services and addressing the average length of stay in hospital following an emergency admission.

- Progress has been made in addressing hospital bed occupancy. Angus has seen a continuing decrease in the bed day rates although admissions continue to increase. Readmission rates have increased and have impacted on performance in relation to the overall rate of admission.

- Readmissions within 28 days of discharge have increased for Angus as a whole; this increasing readmission rate contributes to the increase in all emergency admissions. The largest increase in readmissions is in the South West locality. The North East has also seen increasing readmissions for the first time in 2016/17. The South East saw the most improvement through to quarter 3 but has lost ground in quarter 4 2016/17.

- Enhanced Community Support (ECS), managing timely discharge and increasing levels of personal care have contributed to a reduction in bed days lost to delayed discharges for people aged 75+.

- There has been a 33% increase in the level of personal care being delivered within our localities. More people are being supported and more people are receiving higher levels of care.

- The North West has the lowest rate of total care home placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate but uses less personal care and other community services. The North East makes the most placements by population rate and also uses very high levels of personal care and other community based services. The South West makes few placements but also uses less personal care and other community based service. The South West was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localities saw an increase in the number of placements in 2016/17.

- A high proportion (89%) of users of care, rate the services as excellent or good. Locally, information gathered by services also indicates high levels of satisfaction with those services.

- Only West Dunbartonshire, Renfrewshire and Clackmannanshire have a higher proportion than Angus of all its care services (Care Homes, Care at Home, Day Care etc) graded as good or better by the Care inspectorate in Scotland during 2015/16.

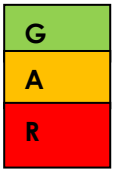
- Targets for further improvement have been established in relation to:

    - Attendance at A and E
    - Admissions from A and E
    - Hospital bed day rate
    - Rate of bed days lost due to delays in discharge

  These targets have been developed locally and will be refined over the next few months, particularly where the target for 2018 has already been achieved.

Angus Ranked Performance in 2015/16

The tables below show the summary of Angus 2016/17 performance in relation to the Scottish (2015/16) performance across a range of national indicators.



Angus is performing well against the Scottish average

Angus rate is similar to the Scottish average but there is room for improvement

Angus has greater room for improvement against the Scottish average

Table 1: Angus' Ranked Performance for national indicators

Biennial Outcome Indicators 2015/16					
	Indicator	**Title**	**Scotland 2015/16**	**Angus 2016/17**	**Ranking 2015/16**
Outcome indicators 2015/16 biennial survey	**NI - 1**	Percentage of adults able to look after their health very well or quite well	**94%**	**95%**	**13**
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**84%**	**89%**	**5**
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**79%**	**81%**	**11**
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**75%**	**81%**	**8**
	NI - 5	Total percentage of adults receiving any care or support who rated it as excellent or good	**81%**	**82%**	**19**
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	**87%**	**83%**	**29**
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**84%**	**84%**	**21**
	NI - 8	Total combine percentage of carers who feel supported to continue in their caring role	**41%**	**39%**	**25**
	NI - 9	Percentage of adults supported at home who agreed they felt safe	**84%**	**86%**	**12**
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	**NA**	**NA**	**–**
Quantitative Indicators – Angus 2016/17 Scotland and ranking as at 2015/16 (2016/17 information is not available)					
	Indicator	**Title**	**Scotland 2015/16**	**Angus 2016/17**	**Ranking 2015/16**
Data indicators 2015/16	**NI - 11**	Premature mortality rate per 100,000 persons	**441**	**391**	**8**
	NI - 12	Emergency admission rate (per 100,000 population)	**10480**	**10,913**	**12**
	NI - 13	Emergency bed day rate (per 100,000 population)	**106531**	**111,585**	**18**
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	**95**	**107**	**26**
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting.	**87%**	**90%**	**4**
	NI - 16	Falls rate per 1,000 population aged 65+	**21**	**20**	**8**
	NI - 17	Proportion of care services graded 'good' (4) or	**81**	**90% ***	**2**

		better in Care Inspectorate inspections (*2015/16)			
	NI - 18	Percentage of adults with intensive care needs receiving care at home *(2015/16)	**62**	**52%***	**31**
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**915**	**355**	**4**
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**21**	**26%**	**2**
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home		**NA**	**-**
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready		**NA**	**-**
	NI - 23	Expenditure on end of life care, cost in last 6 months per death		**NA**	**-**

Note: At the time of writing, 2016/17 national ranking information has not been published and therefore cannot be included in this report.

Locality Performance in 2016/17 against baseline year 2015/16

<-3%	2016/17 performance has improved against baseline 15/16 rate
>-3 to <3%	2016/17 performance is similar the baseline 15/16 rate (- figure is improving performance, +figure is declining performance)
>3%	2016/17 performance has declined against the baseline 15/16 rate

Table 2: Percentage change in 2016/17 against baseline year 2015/16

National Indicator	Angus	North East	North West	South East	South West
12.Emergency Admissions	**1.60%**	**1.50%**	**0.70%**	**0.50%**	**4.50%**
13.Emergency Bed Days	**-1.40%**	**-5.30%**	**-0.60%**	**0.40%**	**0.20%**
14. Re-admissions after 28 days	**2.60%**	**3.30%**	**5.10%**	**-9.20%**	**12.40%**
16. Falls ending in admission [1]	**9.00%**	**26.30%**	**18.70%**	**5.60%**	**-11.70%**
19. Delayed Discharges [2]	**2.70%**	**-18.30%**	**23.40%**	**78.70%**	**-36.70%**

Footnote:

[1] Admissions resulting from a fall represented 5% (535) of all emergency admissions in 2016/17. Wider variation is likely to be seen where small numbers exist (Ref. Table 1 NI 16)

[2] In the South East, delayed discharges increased from 17 in 2015/16 to 26 in 2016/17. Wider variation is likely to be seen where small numbers exist (Ref. Table 1 NI 19)

Priority 1: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's strategic plan is to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self-management of long term conditions. The health inequalities in Angus were identified in the Joint Strategic Needs Assessment. We are working with public health to determine appropriate measures which provide evidence in relation to health equity and the impact of services across Angus. This will include ensuring that data from primary providers is available in order to see performance in the most and least deprived areas of Angus against the Angus average performance. Addressing performance variation will go some way to begin to address health inequalities.

1.1 What we have achieved to date

- Delivered a programme to support self-management of long term conditions
- Developed peer support groups for long term conditions
- Progressed a review of out of hours services; this has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.
- Developed a primary care transformation programme
- Increased uptake of community alarm services and the range of peripherals available
- Supported Voluntary Action Angus and other third sector organisations financially to develop and deliver community based services to support adults with health and social care needs. Each locality has a voluntary sector single point of contact officer supporting and signposting communities. These officers also work within multi-disciplinary teams supporting options for social prescribing.
- Delivered support through Voluntary Action Angus to support people to get home and be at home through volunteer post-hospital support programmes
- Developed ALISS, a web based community information system. Progress has been made in making information available about the range of opportunities to access voluntary support in Angus. Information on most organisations can now be found on ALISS (a local information system for Scotland).
- Provided resources to Angus Carers Association to provide a carers support worker in each locality. This worker works within the multi-disciplinary teams to identify carers and provide advice and support. A range of supports can be put in place following an assessment of carers needs, this includes daytime short breaks and overnight breaks.
- The Angus Alcohol and Drug Partnership completed the pilot phase of the whole family approach and produced recommendations for the future.
- A needs assessment around "chemsex" was carried out in partnership with The Terrence Higgins Trust, which provided information relating to the use of substances and subsequent impact on sexual behaviour.
- Developed Independent Living Angus, a web based self-assessment and referral tool to support access to information and advice on equipment to support daily living. This is also used by the First Contact service to support individuals to access some equipment from the equipment store without the need for assessment by occupational therapy.
- Established a working group to progress the implementation of the new Carers (Scotland) Act 2016 which places new duties on local authorities from 1 April 2018.

1.2 What we plan to do next

- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.

- Further develop the application of Independent Living Angus as part of the review of First Contact arrangements. This will include consideration of how to provide advice and support for self-management of long term conditions through Independent Living Angus.

- Develop an improvement plan to address the falls admission rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and will incorporate a review of the Angus falls services.

- Continue to roll out programmes to support self-management of long term conditions

- Develop new arrangements for respite for people with learning disabilities

- A study of children affected by parental substance misuse to be carried out by the Angus Alcohol and Drug Partnership (ADP)

- Planned re-design of services, in response to national ADP funding reductions.

- Fully implement the Carers (Scotland) Act 2016 ensuring that a state of readiness evaluation is completed and eligibility criteria are developed in consultation with carers by 31 March 2018.

1.3 How we monitor progress

Progress is monitored through the following national and local performance measures:

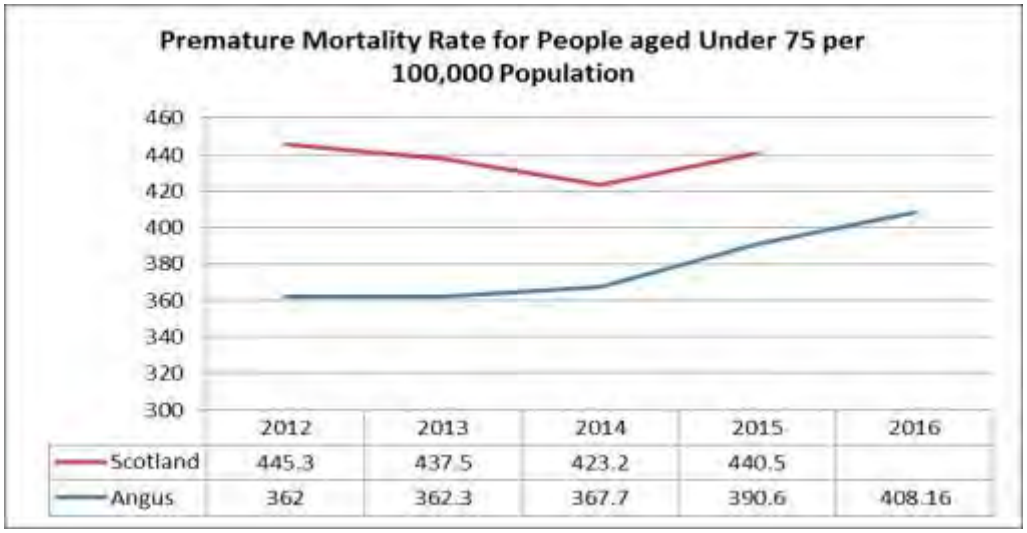
Angus continues to perform well (above the Scottish average) in relation to the proportion of individuals who are able to look after their own health (see table1)

Premature mortality

1.3.1 Angus is consistently below the Scottish average in relation to premature mortality rates. As at 2015, Angus is the 7th lowest ranked partnership for premature deaths with 391 per 100,000 population (ISD). National data tables for 2016 have not been published at the time of this report.

1.3.2 There has been an increase in premature mortality in Angus; this is a continued trend. There is variation between localities. The North East and South East have the highest premature mortality rates. These localities include areas of deprivation.

Graph 1: Management Information: Premature Mortality Rate for People aged Under 75 per 100,000 Population

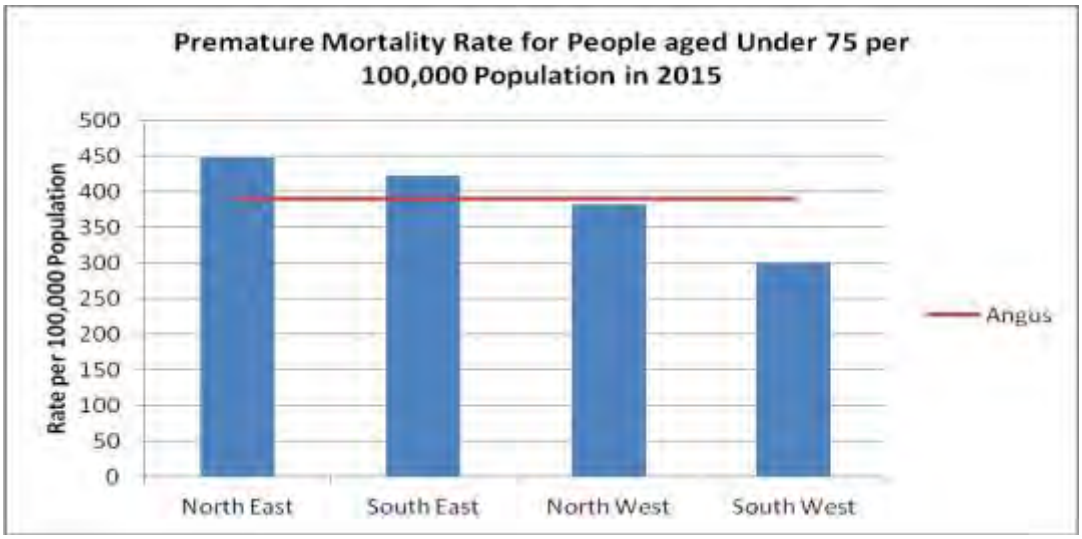


	2012	2013	2014	2015	2016
Scotland	445.3	437.5	423.2	440.5	
Angus	362	362.3	367.7	390.6	408.16

Source: National Record of Statistics (up to 2015)

Note: * 2016 rates are produced by ISD LIST and are provisional. They are not official National Records of Scotland (NRS) statistics. Official figures by NRS for 2016 will be released later in 2017.

Graph 2: Management Information at Locality Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population in 2015



Source: ISD LIST (not official NRS statistics)

Note: Premature mortality rates at locality level are calculated by the ISD LIST team in Angus and are these are not official National Records of Scotland statistics.

1.3.3 Angus Health and Social Care Partnership are working with Community Planning Partners to develop broader locality plans which address the causes of deprivation. Amongst that work is delivering different approaches to engage with people who do not usually use services.

Keep Well

Paul is a 63 year old man from a Keep Well targeted postcode area. He has had infrequent contact with his General Practice, but has attended previously in relation to muscular/joint pain and recent urinary symptoms. He has recently retired from oil related employment.

His Keep Well Health Check revealed a raised Total Cholesterol result of 6.55mmol/L. His Cardio-vascular Disease Risk Score was 23%. His GP prescribed cholesterol lowering medication, (Simvastatin). Paul expressed some ambivalence about this, which he discontinued after 3 days as he was experiencing unpleasant side effects.

He agreed to attend follow-up appointments with the Keep Well Outreach Nurse at 3 and 6 monthly intervals, adopting a House of Care approach, to monitor and review behaviour change strategies. These were identified and agreed, in relation to his aim of reducing his cardio-vascular risk and cholesterol levels. Goals included increasing his physical activity, following a Mediterranean style diet, and reducing his intake of sugars and animal fats. His cholesterol levels were repeated at the 3 monthly review appointment with the Keep Well Outreach Nurse in December 2016, which showed a reduction on his Total Cholesterol from 6.55mmol/L to 6.04mmol/L, which contributed towards a lower Cardio-vascular Disease Risk Score of 19%.

Paul advised that he felt positive and optimistic about his ability to manage and assume control over his health, and was motivated and confident in continuing to utilise the health behavioural change strategies he had identified.

The Third Sector and Volunteering

1.3.4 Angus continues to have high levels of volunteering. Voluntary Action Angus (VAA) are supporting the development of voluntary organisations and volunteering across Angus. The capacity of communities to care is a focus of the work. The biggest capacity issue for organisations is volunteer recruitment. VAA has recruited more than 1300 volunteers who are now engaged in community and voluntary organisations in a health or care context. They have provided minibus and transport services for older people and for 216 community / voluntary organisations to make journeys. More than 130,000 miles of volunteer driving have supported our communities. 216 new volunteers have been trained and supported into volunteering opportunities in 2016/17. New volunteer agreements and hand books have been developed and implemented to support all volunteering activity.

Warm and Well project by CAB

Margaret was referred by SCARF (Save Cash and Reduce Fuel) part of Home Energy Scotland. Margaret is in her 80s and has a large energy bill due to her supplier reducing the direct debit without consent. Margaret had been in touch with her energy supplier to advise they did not want the direct debit to reduce but the energy company decreased it anyway. Margaret's complaint had not been dealt with by the energy company. The Warm and Well Fuel Poverty Worker visited Margaret and contacted the energy company to raise a further complaint. As Margaret now had an outstanding balance which she could not afford to pay an application was successfully made to the energy company's trust fund and the outstanding balance of £900.44 was cleared.

Margaret is awaiting the energy company updating meter readings and to revert Margaret's payments back to the fixed tariff she was originally on. This was the first time Margaret had ever been in debt; she had been very stressed and anxious when she was referred to the project. Client was over the moon that this debt has been cleared and is now no longer suffering from stress.

Carers

1.3.5 Angus performance in relation to carers feeling supported to continue their caring role is marginally less than the Scottish average. There is an improvement in the number of carers that have been identified in Angus and the number of carers support plans that have been put in place. In 2016/17, Angus Carers have recorded:

- 1053 carers aged over 55 were registered with Angus Carers, an increase from 413 registered carers over 55 in 2015/16. The total number of carers registered of all ages is 2033.
- 4,672 hours of volunteer-led 'care free' respite were provided
- 269 new carer support plans were developed and 34 reviews undertaken with carers aged over 50 years old
- 363 support plans in place with carers aged over 50 years

Developing a carers support plan

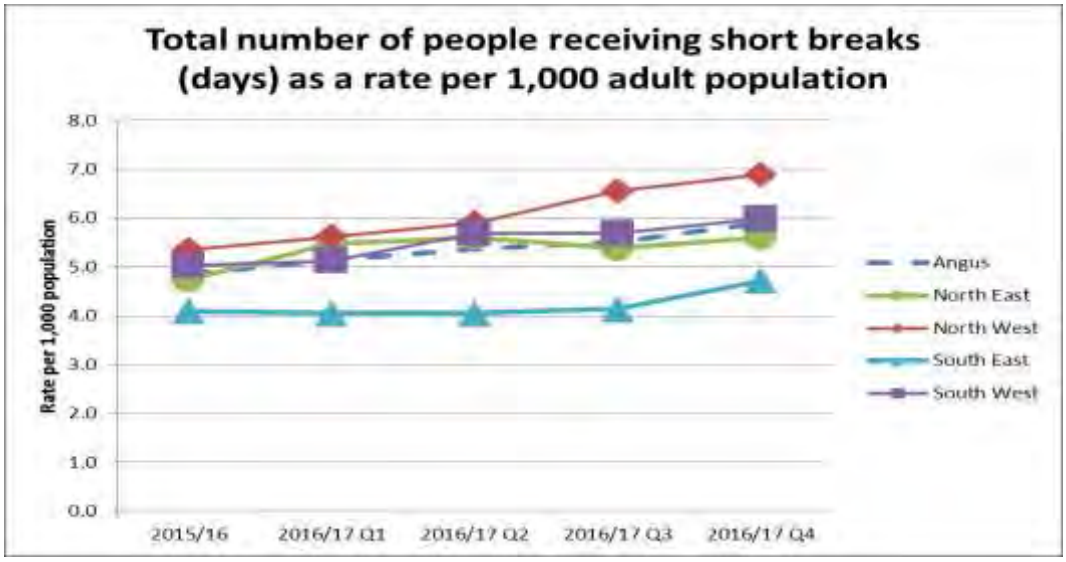
Walter is a 70 year old male who was referred to Angus Carers by an existing carer/volunteer. He had been caring for his wife for 5 years without any support and it was beginning to take its toll. Walter was reluctant to admit he was struggling initially but during the support conversation it became apparent that Walter and his wife, Susan, were finding things difficult; both were quite tearful and emotional. When I explained what kinds of support Angus Carers could offer they were both very open and admitted things had to change.

Susan was a little reticent but agreed to consider the options for befriender. I supported Walter to apply for Attendance Allowance; this was successful at High Rate and he received backdated payment of over £500.00 coming just a few days before Christmas. Walter and Susan were £82.00 a week better off. I matched Susan with a volunteer who will accompany her days out giving Walter some much needed respite. I referred to the Short Breaks and 'Respitality' service where Walter could get more support to allow some time for golf/football.

Walter is thrilled that we are supporting them and says he could not have accessed this without our help

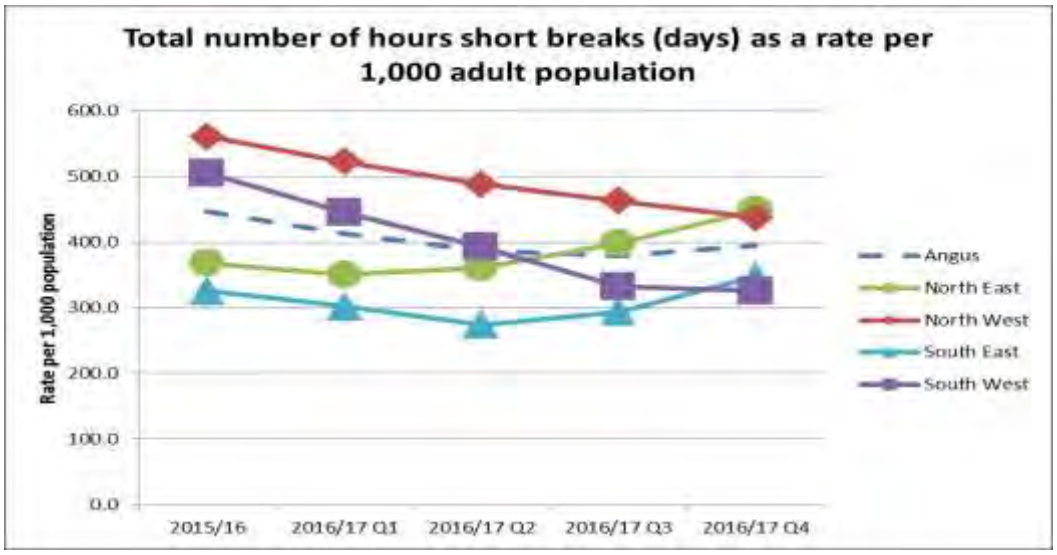
1.3.6 The number of carers accessing short breaks has risen from 454 in 2015/16 to 551 in 2016/17 (an increase of 21%). The carers assessment offers the self-directed support options, providing carers with greater flexibility about what types of services they choose and how they are delivered. Following the introduction of self-directed support there has been a shift away from the use of day care with carers using shorter breaks at home rather than day care to support their respite needs. Total day respite hours have reduced from 41810 in 2015/16 to 36961 in 2016/17 (a decrease of 11%). There is wide variation in day time respite between localities with the North West supporting the most people with day time respite and the most number of hours.

Graph 3: Management Information at Locality Level: Rate of people using short breaks



Source: Care First (Angus Council)

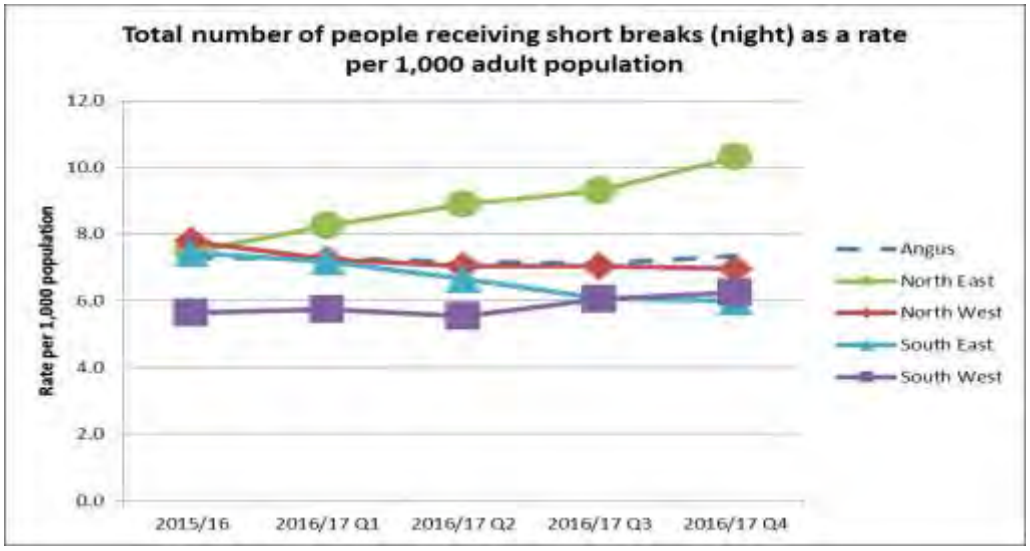
Graph 4: Management Information at Locality: Rate of short breaks (daytime hours)



Source: Care First (Angus Council)

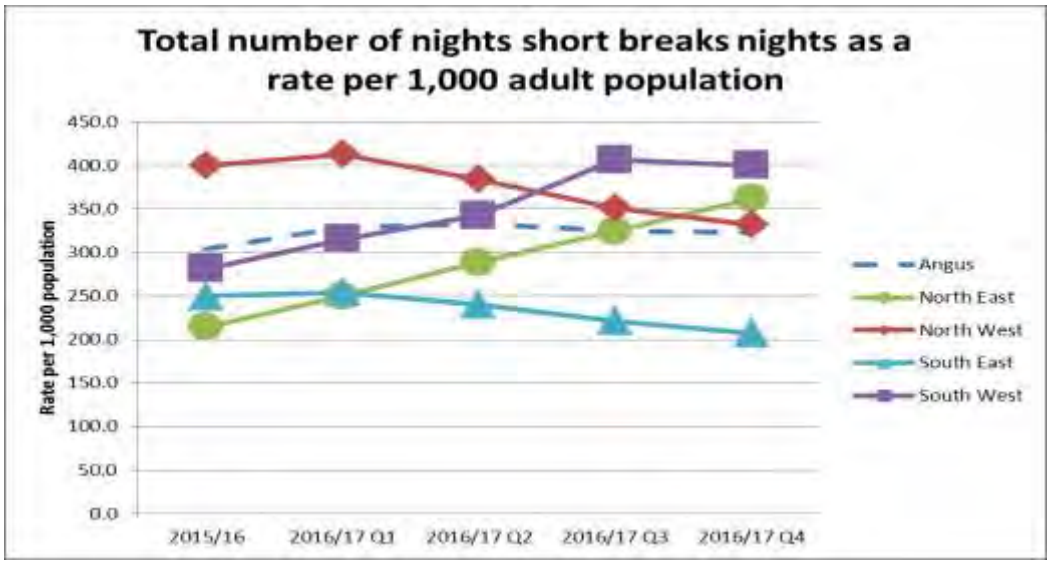
1.3.7 There continues to be a similar rate of provision for short break nights and the number of carers accessing this support. Variation between localities is increasing, with the North East locality supporting more people with respite and providing more overnight respite .

Graph 5: Management Information at Locality Level: Rate of people using short breaks (nights)



Source: Care First (Angus Council)

Graph 6: Management Information at Locality Level: Rate of short breaks nights

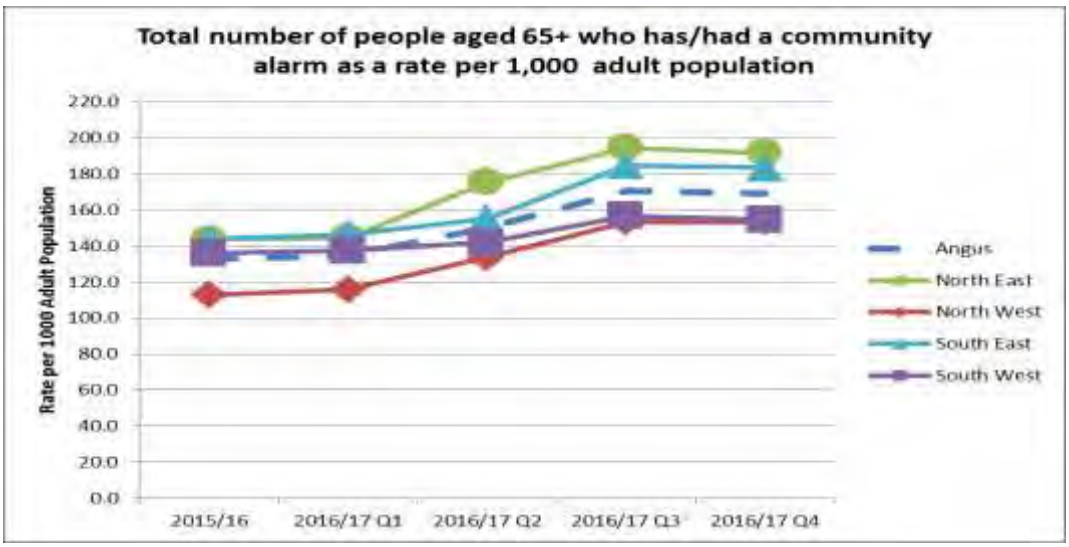


Source: Care First (Angus Council)

Community Alarm

1.3.8 Installation of community alarms has risen since 2015/16. Community alarm now support 4381 people across Angus. This is an increase from 3438 in 2015/16 (27% increase).This is in line with our aim to improve tele-enabled care. The range of available equipment and sensors has also increased e.g. GPS monitors, Tru-call, call blocking system. There is variation between Angus localities in the uptake of community alarm.

Graph 7: Management Information at Locality Level: Rate of community alarm use



Source: Care First (Angus Council)

Enablement

1.3.9 All new referrals for a social care service, where eligible needs exist, are supported by a period of enablement lasting between four to six weeks. Enablement services have been successful in returning individuals to full independence. In 2015/16 52% of people who were over 65 years required no further services following a period of enablement. Individuals using enablement in 2015/16 were much more likely to have had previous successful enablement contacts. Due to changes in operational procedures we are currently unable to show enablement performance for 2016/17.

Enabling Stuart and Alan

Stuart, an older gentleman was in Montrose Infirmary The nursing staff and the occupational therapist were unsure how this man would manage at home due to memory and mobility. They were concerned that he might go home only to fail.

Stuart was keen to go home so we agreed a discharge with 4 times daily visits from the enablement service. It took a few days for Stuart to find his feet but he became independent within four weeks. The only service he now requires is assistance once a week for 5 minutes to change a catheter leg bag.

Alan is an older gentleman who had poor mobility, poor appetite, a urinary catheter and a stoma in place

He was discharged from hospital with support from the enablement service 4 times a day. Alan took a week to settle back at home. He is now independent with making his own meals and his appetite has increased. He has also become fully independent with his personal care needs and manages well with bathing equipment supplied by the occupational therapist. Initially the only ongoing assistance he required was to change his catheter leg bag, but the catheter has now been removed. Alan no longer requires social care support. He has a community alarm, just in case he needs us.

Accident and Emergency

1.3.10 An Accident and Emergency Performance indicator is not included in the national core data set for integration therefore we have not developed locality information in this area. The Scottish Ministerial Group have asked for projected performance in this area. We do know that there has been a deceasing trend in the Angus population in relation to attendance at A & E. We expect this trend to continue. Following an attendance at A & E the proportion of people who require to be admitted is increasing; we expect this trend to continue as people use emergency departments and minor injuries and illness units (MIIUs). There is a planned approach to reviewing the future provision of MIIU services in Angus. An option appraisal will be developed in consultation with localities.

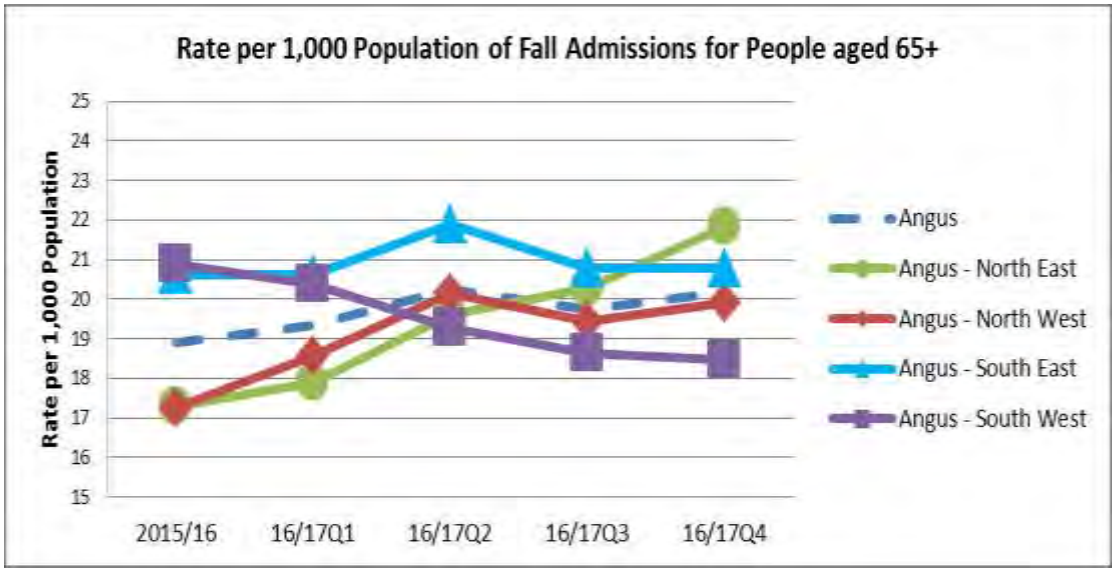
1.3.11 The aim is to continue to reduce A&E attendances in line with the current projection. This reduction is approximately 6% by 2018.

Admissions following a fall

1.3.12 In 2016/17 the rate of falls admissions in Angus is 20 per 1,000 population. This Angus falls rate is an increase on the 2015/16 level of 19.2 per 1,000 population. The Angus falls rate is just below the 2015/16 Scottish rate of 21 per 1,000 population. Angus was ranked 8 for this national indicator in 2015/16. The level of falls in our community does contribute to hospital admissions and places ongoing pressure on services as individuals are more likely to need ongoing health and social care support.

1.3.13 There is a continued upward trend in the rate of falls leading to an admission in Angus. This upward trend is most pronounced in the North East and North West localities. The South West saw the biggest decrease between 2015/16 and 2016/17. The reason for this recent improvement in the South West is unclear and requires to be investigated as part of the review of the falls pathway in order that any improvement opportunities can be shared across Angus. The increase in falls rate accounted for an additional 42 admissions due to falls in 2016/17 from 2015/16 admissions (an 8.5% increase).

Graph 8: Management Information at Locality Level: Rate of fall admissions per 1,000 population for people aged 65+



Source: ISD LIST management information (not official ISD statistics)

Note: * 2016 rates are provisional and are not official ISD statistics. Official figures for 2016 will be released later in 2017.

Priority 2: Supporting care needs at Home

The Joint Strategic Needs Assessment identifies that the population of Angus is growing older and that the population of Angus will continue to age for the next 20 years. It is anticipated that this change in demographics will place a further increase in demand on services if they continue to be delivered in the same way. The strategic plan aims to address demographic change by changing the way that services are provided. The focus of the strategic plan is to support care needs at home by enhancing opportunities for technology enabled care; further progressing self-directed support; and delivering change in care at home services through the Help to Live at Home project.

2.1 What we have achieved to date

- Delivered a range of new support through technology enabled care such as video active, a joint venture with Angus Alive; provided new types of equipment through community alarm such as call blockers to reduce nuisance calls and scams; GPS systems to support people with dementia when they are out and about; introduced Florence (FLO) a patient reminder system to support GP, nursing and allied health professional (AHP) interventions with patients.

Using technology to support people at home

Alistair is a gentleman who lives with his daughter. He has recently been diagnosed with Alzheimer's disease. Alistair has enjoyed walking all his life but has started to get confused whilst out walking and has become distressed when he has not been able find his way home. His daughter, Alison, became concerned about her father getting lost and started following him when he was out for his walks. We have provided Alistair with a GPS tracker which has allowed Alison to monitor his movements within the town without the need to follow him. The tracker provided Alistair with an easy way to get in touch with his family if he became disorientated. Alistair is very happy that he is able to get out of the house and that his daughter is reassured. He says 'I no longer feel like a prisoner in my own home being watched all the time'.

- One of the recorded reasons for delays in timely discharge has traditionally been the lack of capacity in personal care services. The Help to Live at Home project has made significant progress in addressing this. The programme has led to an improvement in availability of personal care with greater choice and control for individuals in how their support is delivered. More personal care is being delivered in our localities than ever before. Much more of that care is now being delivered by the independent sector.

- Intervention through Voluntary Action Angus to support people to get home and remain at home through volunteer post-hospital support programmes.

- Developed a 'next steps to home' project which supports people with enablement based respite while care at home arrangements are established.

- Integrated the health and social care occupational therapy teams delivering a locality based model.

- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.

Supporting people to get in and out of their house

Occupational therapists work with Angus Care and Repair to look at solutions for the provision of ramps quickly to support discharge or towards the end of life. Mr M had a long term progressive condition affecting his functional mobility. He required to use mobility aids both in and outwith the home environment and used a wheelchair for longer distances outdoors although his use of this will increase over time. Mr M was unable to manage the access steps to his home. He was residing wholly on the ground floor of his property and unable to get outside.

Mr M wanted to be able to enter/ exit his home independently and have more choice about when he can go into his garden/ community setting. The ramp was installed in July 2016 and removed in February 2017 following his death. The ramp improved his end of life care significantly.

Approximate cost of a permanent solution would have been £3400. Cost of temporary ramp and installation was £1712. The ramp has now been reused elsewhere.

- Developed a social enterprise model 'Care about Angus' which supports people living in sheltered accommodation.

Care About Angus is a social enterprise. It has grown considerable during 2016/2017 from an organisation employing 24 staff in April 2016 to 55 staff in March 2017. Our client base has also grown. Home Help Service April 2016 1417 hours service delivered, March 2017 1694 hours service delivered, a 19.5% increase.

The demand for Home Help services is growing with between 4 and 7 new enquiries received each week. It is not always possible to satisfy the demand immediately as there might not be available staff in the right area at the time; this situation is constantly reviewed by management and new staff recruited when possible. All staff are trained, PVG checked and are issued with a contract of employment.

Community Resource Worker service in Sheltered Housing - August 2016 330 clients, March 2017 362 clients, a 9.7% increase. The number of clients fell initially in 2016 due to some residents being excluded from the benefit system when SDS was implemented. We are also restricted in the number of new clients by the total number of housing units available in each Sheltered complex and the type of client being given accommodation.

Community Resource Workers are offering a much wider range of services to clients based on discussion with the client, their families or Care Managers and is person centred so they do not receive a stereo-type service but one based on individual needs. Staff also work closely with Community Alarm to ensure that if an emergency arises when they are on site then a rapid response is possible.

2.2 What we plan to do next

- Through the Help to Live at Home programme, deliver the redesigned enablement, early supported discharge and prevention of admission services.
- Embed ECS in practice in the North localities and review effectiveness in South localities in light of year end performance information.
- Although palliative care services are hosted by the Dundee Partnership we believe it important to develop a locally based approach to palliative care. Lippen Care has agreed to fund a project worker for a year to bring together local professionals and communities to agree our local approach to palliative and end of life care.
- Continue to improve on the number of anticipatory care plans in place.

- In line with the promises in the National Delivery Plan for Health and Social Care, the availability of Key Information Summaries will be increased and everyone will be offered one by 2021.

- Examine opportunities for greater application of telecare during night-times in residential care and supported accommodation.

- Address sleep-over arrangements in line with Scottish Living Wage and working time directives.

2.3 How we monitor progress

Progress is monitored through the following national and local performance measures:

Self-directed support

2.3.1 Access to long term support requires an assessment of need with an individual making choices about what services would meet their personal outcomes, how and when those supports will be delivered/accessed and who will provide them. Self-directed support is the mechanism by which these choices are provided. The options available are:

Option 1 - direct payment
Option 2 - person directs the available support
Option 3 - local authority arranges the support
Option 4 - mix of the above

1357 people now access self-directed support options; an increase of 12% on 2015/16. There has been a shift towards greater choice and control with a greater proportion of supported people accessing direct payments (option1) and directing the available support (option 2). Option 2 was not available before the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 and uptake continues to rise. Most people in Angus continue to access option 3, asking Partnership staff to organise support on their behalf although the proportion of people using option 3 has decreased. As yet there is very little shift from traditional models of support provision with most resources continuing to be spent on personal care. Table 3 below identifies the relative uptake of the self-directed support options.

Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16 Value	2016/17 Value
Percentage of people who access SDS (Option 1)	4%	8%
Percentage of people who access SDS (Option 2)	13%	15%
Percentage of people who access SDS (Option 3)	79%	73%
Percentage of people who access SDS (Option 4)	4%	4%

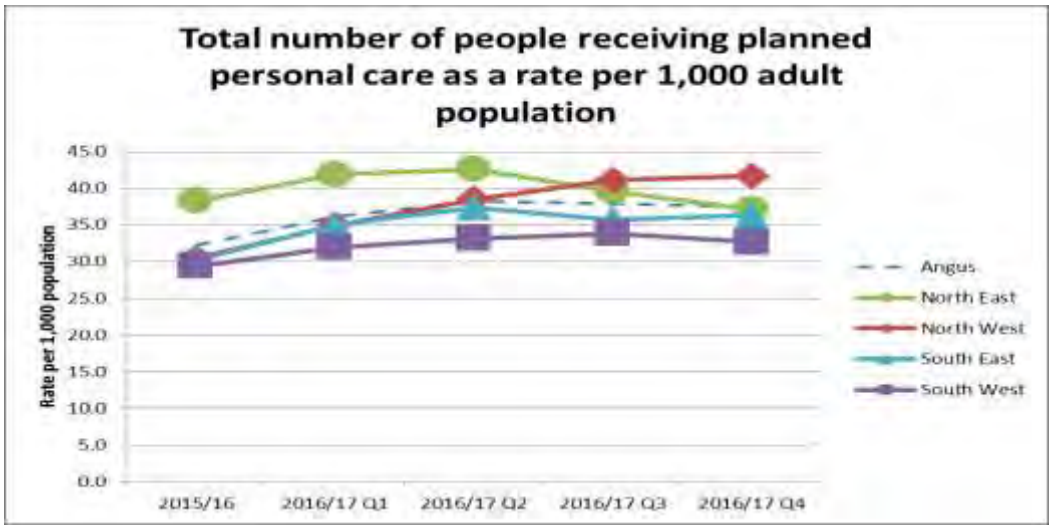
Source Care First (Angus Council)

Care at home including personal care

2.3.2 In 2015/16 Angus provided the lowest levels of intensive personal care support packages in Scotland with approximately 49% of those requiring personal care receiving 10 hours or more; the national average was 62%. Care home placement rates for people aged over 75 remain much higher than the Scottish average (paragraph 3.3.10). This suggests that the balance of social care provision in Angus requires to be addressed further.

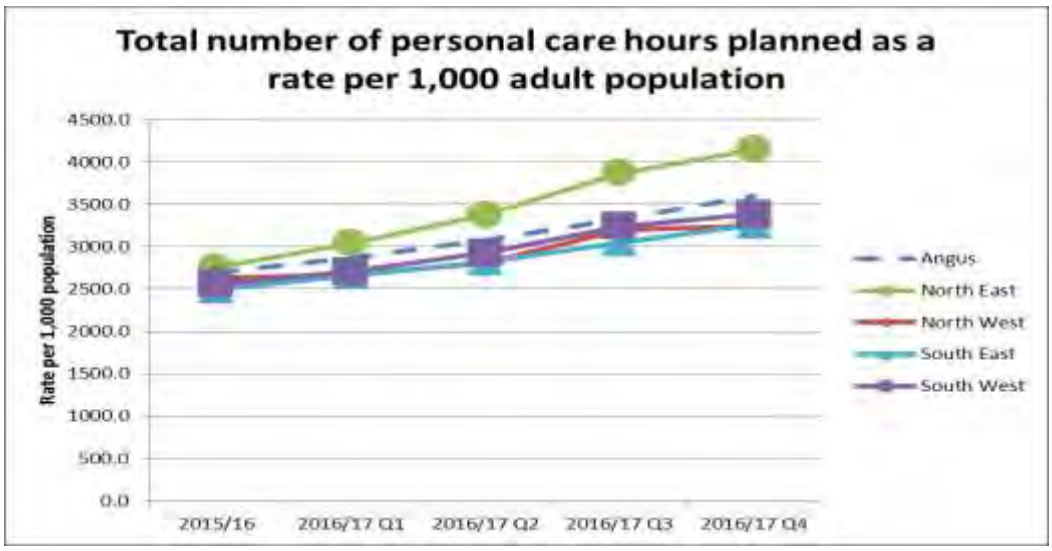
2.3.3 In 2016/17 both the number of people receiving personal care and the number of hours delivered has increased. In 2016/17 1307 people received personal care every week an increase of 5% on 2015/16. 336,000 hours of personal care were delivered in 2016/17, an increase of 33% (an additional 83,691 hours) on 2015/16.

Graph 9: Management Information at Locality level: Rate of Personal Care Hours



Source Care First (Angus Council)

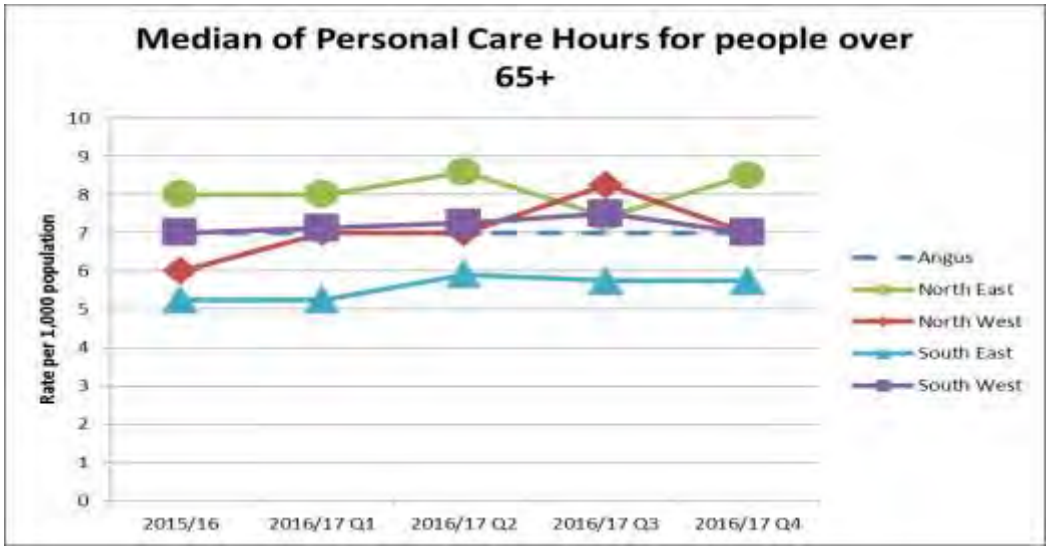
Graph 10: Management Information at Locality level: Rate of Personal Care Hours



Source: Care First (Angus Council)

2.3.4 In 2016/17 the most often offered (median) size of a personal care package in Angus was 7 hours. More people are receiving this level of personal care and this has contributed to the average (mean) personal care package increasing from 3.9 hours per week in 2015/16 to 4.9 hours per week in 2016/17.

Graph 11: Management Information at Locality level: Personal care support package per week (Hours)



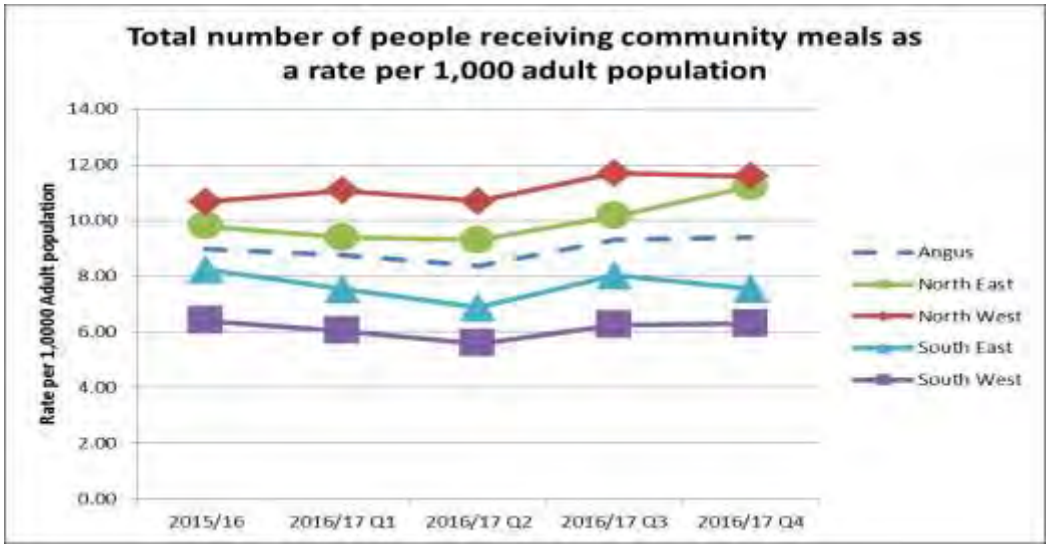
Source: Care First (Angus Council)

2.3.5 Social Care in Angus is not focused solely on personal care (2.3.2). There are a range of different types of supports available, including community meals, day care, community alarm, and volunteer arrangements for transport and befriending which combine with personal care provision to support people to live at home for as long as possible.

Community Meals

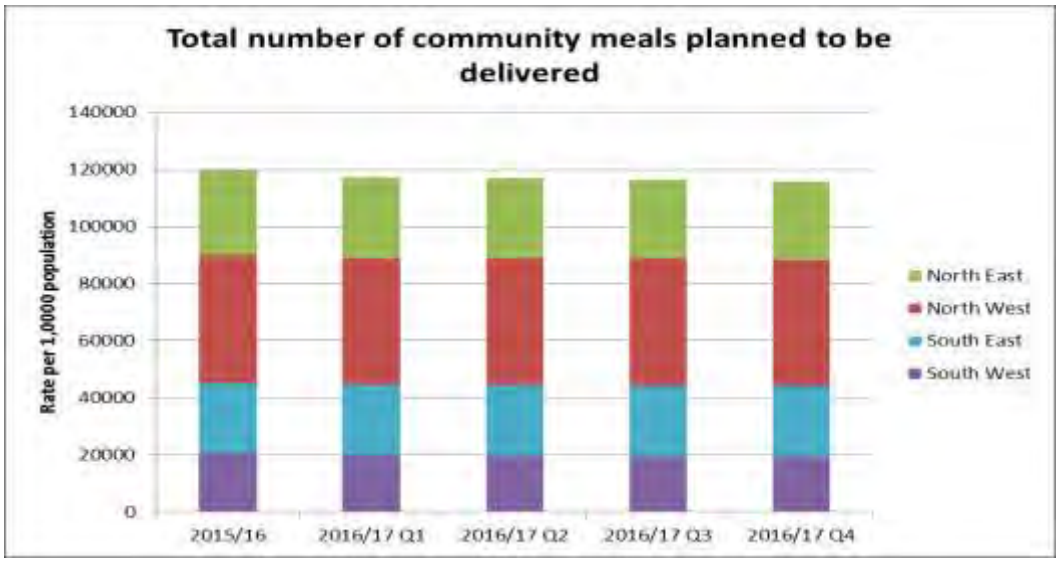
2.3.6 The number of people receiving community meals has increased from 839 in 2015/16 to 879 in 2016/17. The number of people using the tea time sandwich service, delivered along with a hot lunch, has declined. This appears as an overall reduction in the number of meals provided from 119662 to 115744.

Graph 12: Management Information at Locality level: Rate of Community Meals provision



Source: Care First (Angus Council)

Graph 13: Management Information at locality level: Community Meals Delivered

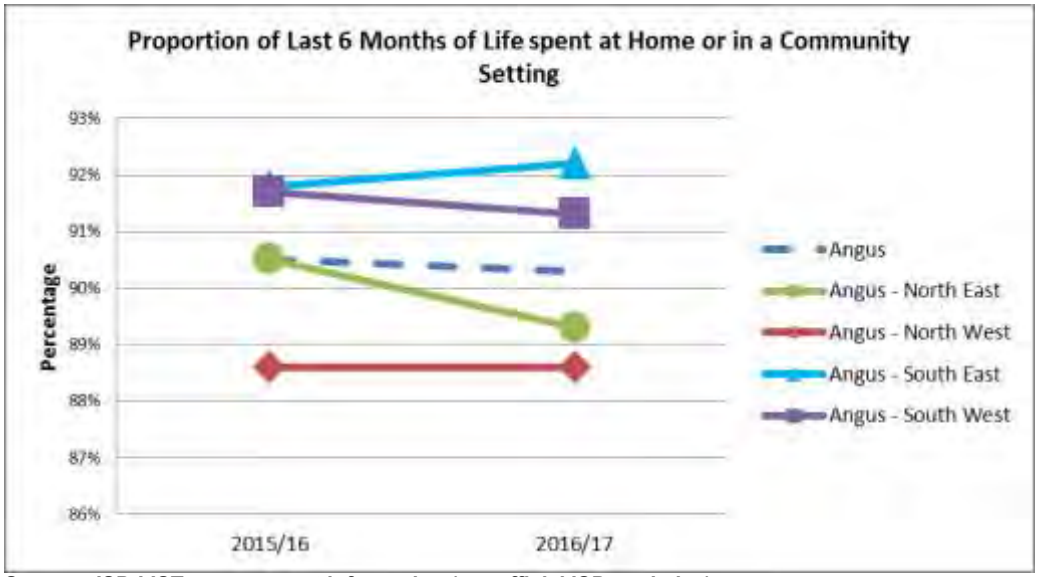


Source: Care First (Angus Council)

Last 6 months of life

2.3.7 Angus performs well in relation to end of life care. The percentage of time that people spend at home or in a community setting in the last 6 months of their life in Angus is 90%. Across Scotland as a whole 87% of people spend the last 6 months of life at home or in a community setting. There is variation across localities with the South localities supporting more people to live at home or in a community setting during the last 6 months of life than the north localities. It is anticipated that the roll out of enhanced community support in the north localities will support improvements in this area of performance.

Graph 14: Management Information at Locality Level: Proportion of Last 6 Months spent at Home or in a Community Setting



Source: ISD LIST management information (not official ISD statistics)

2.3.8 We know we need to develop locality based information on end of life care including gaining a greater understanding of place of death and the type of support that requires to be in place to continue to shift the balance from large hospital to community based supports. Once information is available this will be included in the quarterly performance report for the IJB.

Priority 3: Developing integrated and enhanced primary care and community responses

Over the next three years AHSCP aims to deliver performance that meets the aspirations of Angus communities. The aim is to support individuals to stay at home when appropriate; if a hospital admission is necessary then to ensure a timely discharge plan with relevant support available at home or in localities is important. In Priority 3 we consider the impact of improvements around our GP practices and in the community on the unplanned use of hospital beds.

3.1 What we have achieved to date

- The development of Enhanced Community Support (ECS) wraps responsive services around GP practices; proactively assessing older people with frailty that are at risk of an unplanned admission. ECS responds to escalations in health needs and it is delivered through the development of multi-disciplinary team. ECS has contributed to the success of supporting shorter hospital stays and thereby reducing bed day rates in the South localities. This service has not yet commenced in the North West and it is currently being implemented in the North East. Successfully supporting people at home who may otherwise have gone to hospital through ECS delivery in the South has led to the ability to close beds at Little Cairnie and also within Arbroath Infirmary.

Delivering ECS

My name is '**Mrs Mary Smith'**, I am 91 years old and until recently I have lived alone independently with support from my daughter 'Jennifer' and some carers who visit 3 days a week to help me have a shower.

My GP came to see me recently after I had a fall. I hurt my hip and I am still in pain and can't move about very well. To be honest I have had back pain for a while and was struggling a little bit but know I don't feel safe walking around and have just been staying in bed. I know that isn't good for me and the toilet is downstairs so that is a problem as well.

My GP has passed my details on to the people at something called Enhanced Community Support who will hopefully help me get around more.

The outcome of working together was that Mary:

- was assessed promptly by the primary care team and the efficient referral to the OT/ PT initiated a rapid response. This enabled her to safely stay in her own home with the equipment and support to facilitate this.
- decided it would be best to move her bed downstairs so she could live on one level without the need to risk using the stairs.
- made great progress with physiotherapy and OT and managed to return back to her previous level of mobility. This meant she could walk to the kitchen to make her own meals and drinks and this meant that the social care officers were no longer needed at meal times.
- is now able to administer her medications independently from the compliance aid.
- pain has improved and her painkillers have been reduced which has reduced the risk of side effects.
- now doesn't have to rely on carers to get her in and out of bed which continues to promote her independence and has not needed to use her community alarm since the equipment was installed.
- has met her befriender and is now enjoying a weekly visit or outing with her new friend. Jennifer is still thinking about contacting the Carers Centre.

- Increased the availability of personal care services through the Help to Live at Home programme.
- Embedded a planned date of discharge approach in discharge planning.
- Increased the number of anticipatory care plans in place.
- Located care management within community hospitals.

3.2 What we plan to do next

- Further opportunities for improving performance in this area need to be identified and implemented following further analysis of year-end figures, taking into account changes in performance information in the South localities, where ECS is the most well-established.

- Review reasons for re-admission to hospital within 28 days of discharge across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will continue to contribute to a reduction in re-admission to hospital.

- Review the effectiveness of social care packages which were in place for people who experienced a readmission within 28 days, and other factors which may have contributed.

- Fully implement ECS in the North localities with the expectation that this will lead to a requirement for a reduction in in-patient beds in keeping with the Scottish Government's Health and Social Care Delivery Plan (December 2016).

- A review of out of hours services is being progressed. This has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.

- Develop an improvement plan to address the increasing falls rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and this will incorporate a review of the Angus falls services.

- Address the variance in average length of stay in hospital following emergency admission between our localities through ECS.

- A review of the care home model in Angus is due to report to the IJB in September. Implement the recommendations of the care home review once approved by the IJB.

3.3 How we monitor progress

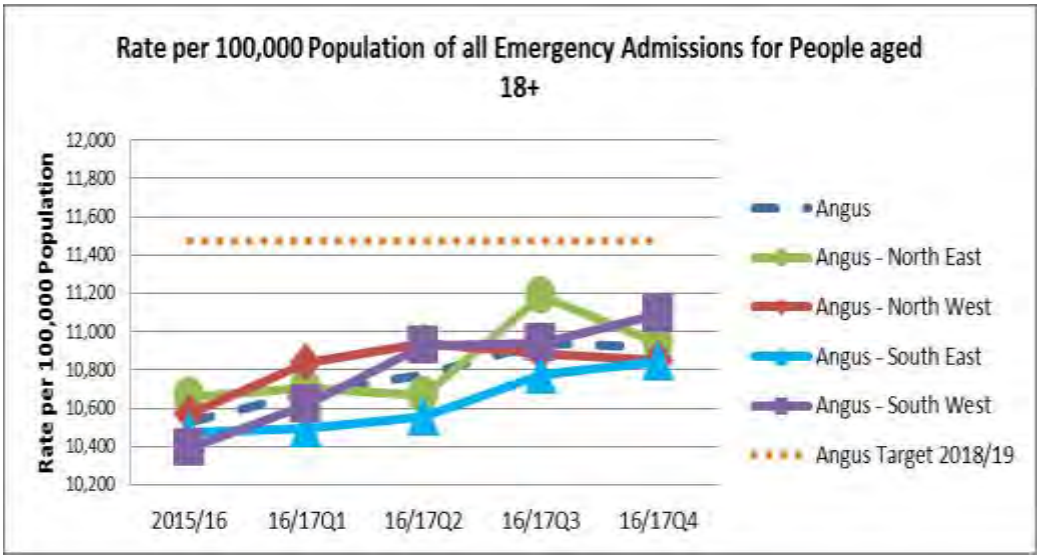
Progress is monitored through the following national and local performance measures:

Emergency admissions

3.3.1 Angus continues to perform well against the national picture and as at 2015/16 it is the 9th best performing partnership in Scotland.

3.3.2 Since 2015/16 all localities have seen an increase in emergency admission rates. There were 362 more admissions n 2016/17 than in 2015/16. In 2016/17, the South East has the lowest emergency admission rates and the South West has the highest emergency admission rates for people aged over 18 in Angus. The increase in the South West is driven by the increase in readmissions (see graph 20).

Graph 15: Management Information at Locality Level: Rate of Emergency Admissions for Adults



Source: ISD LIST management information (not official ISD statistics)

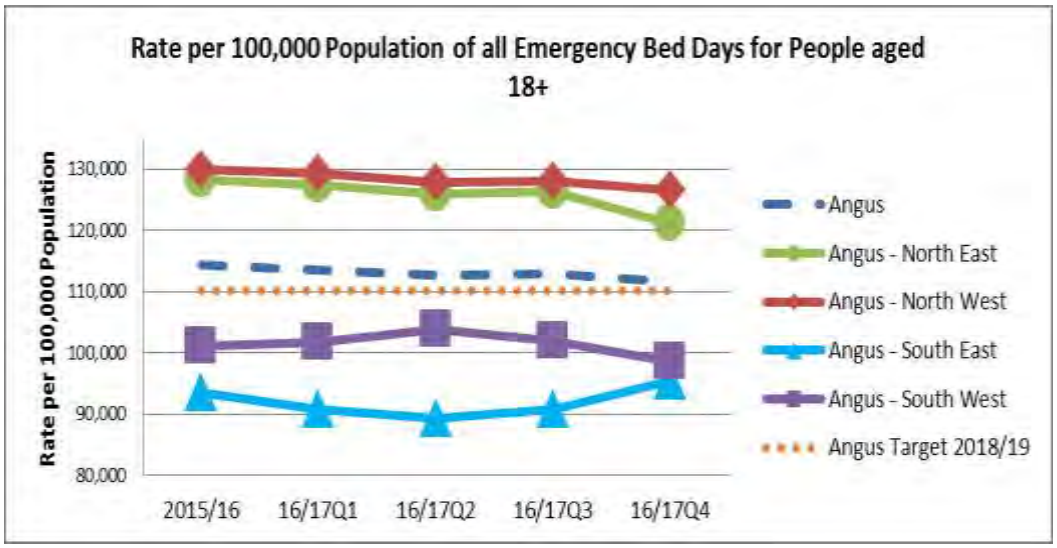
3.3.3 Although the rate of emergency admissions has increased, Angus continues to perform well against the national picture as admission rates are increasing across Scotland. Angus has continued to manage admission rates within the locally set target. This target had taken into account the national picture of increasing admissions and expected Angus admissions to increase in a similar way. Readmissions, which have increased in Angus, make a contribution to the overall picture of increasing admissions. It is anticipated that improvements in addressing readmission within our localities will lead to an improvement in overall admission rates.

Hospital Bed days used following an emergency admission

3.3.4 Angus had a higher emergency bed day rate (107,761) than the 2015/16 Scottish average at 106,531 per 100,000 population.

3.3.5 Although emergency admission rates have been increasing, emergency bed day rates in Angus have been steadily decreasing. The number of bed days used following an emergency admission in 2016/17 in Angus was 105,510 a decrease of 2.5% on the previous year. The lowest bed day rates are in the South East although there has been an increase in quarter 4 from improving South East performance earlier in the year.

Graph 16: Management Information at Locality Level: Rate of Emergency Bed Days for Adults



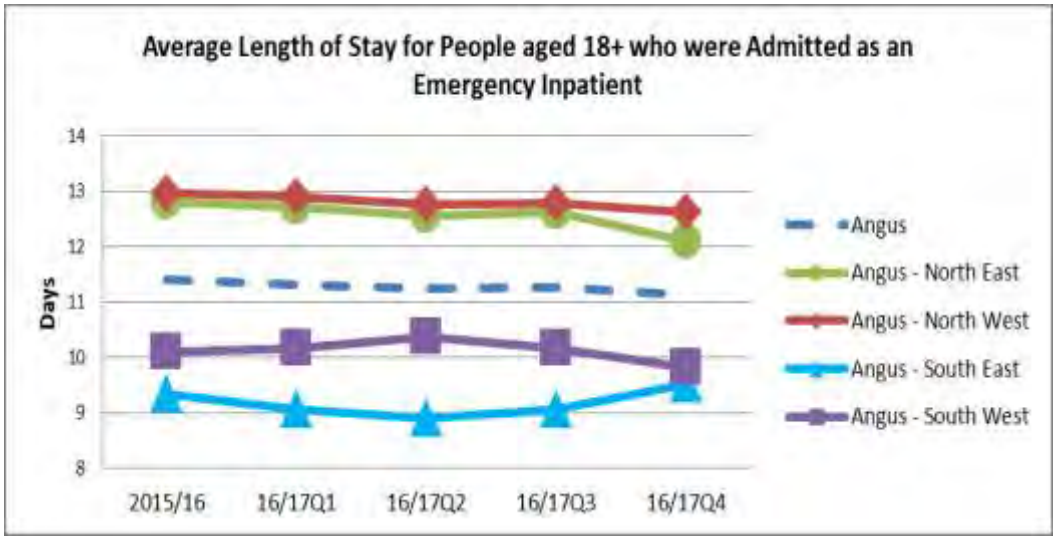
Source: NHS Tayside Business Unit (not official ISD statistics)

3.3.6 Following the implementation of ECS across all localities the variation in the bed day rate is expected to narrow. The target for improvement in bed days will be adjusted to reflect this.

Length of hospital stay following an emergency admission

3.3.7 The overall emergency bed day rate in Angus has improved due to reductions in average length of stay following an emergency admission. Average length of stay improved in all of the 4 localities. There is room for further improvement as there is a difference of almost 3 days between the North West and the South East localities.

Graph 17: Management Information at Locality Level: Average Length of Stay for Emergency Admissions for Adults



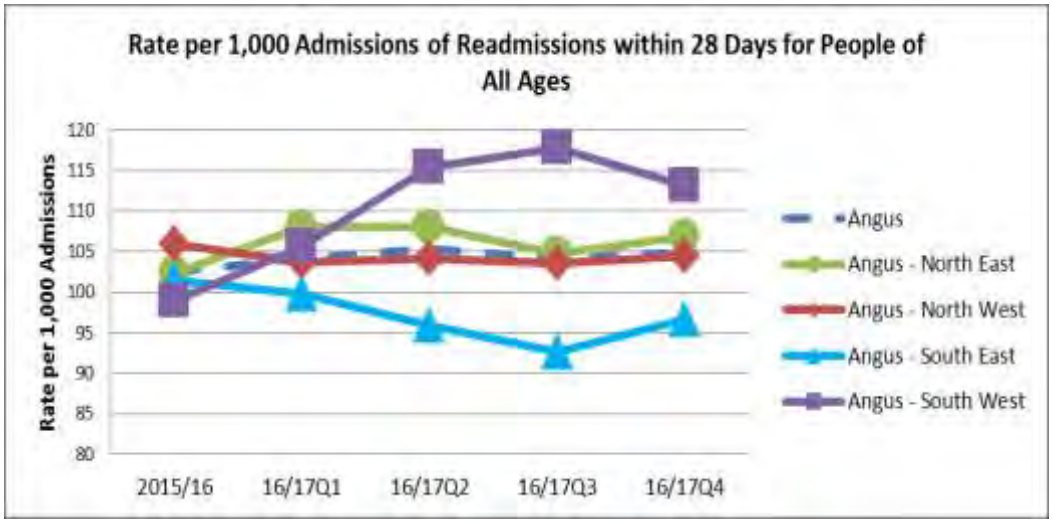
Source: ISD LIST management information (not official ISD statistics)

Readmissions to hospital

3.3.8 In 2015/16 the readmission rate for Angus was 104 per 1,000 admissions. This is above the Scottish readmission rate (96 readmissions per 1,000 admission) and ranked Angus as the 23rd performing partnership in Scotland.

3.3.9 Readmission rates in Angus in 2016/17 are higher than in 2015/16 at 107 readmissions per 1,000 admissions. The South West locality has seen the biggest increase in readmission rates between 2015/16 and 2016/17 but has begun to address this since the quarter 3 performance report. During 2016/17 the South East saw quarter on quarter improvements in readmission rates followed by an increase in quarter 4. A greater understanding of readmission data is required to understand how community responses might reduce readmissions to hospital.

Graph 18: Management Information at Locality Level: Emergency Readmission Rates within 28 days



Source: ISD LIST management information (not official ISD statistics)

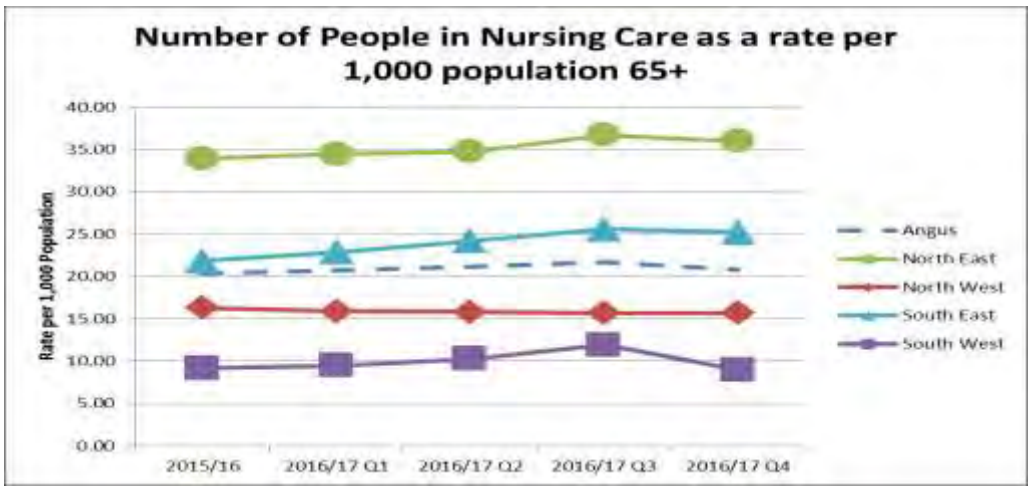
Residential and Nursing Care

3.3.10 The average age of a person placed in a care home in Angus is approximately 84.9 years, an increase from 84 years in 2015/16. The average length of stay has continued to decrease from 18 months in 2015/16 to 17.1 months in 2016/17. At any one time there are approximately 770 people placed in a care home. The total number of people in placements during 2016/17 was 1,985, an increase of 3.6% on 2015/16.

3.3.11 The North West has the lowest rate of total placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate. The North East make the most placements by population rate. The South West make the lowest number of placements. The South west was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localites saw an increase in the number of placements in 2016/17.

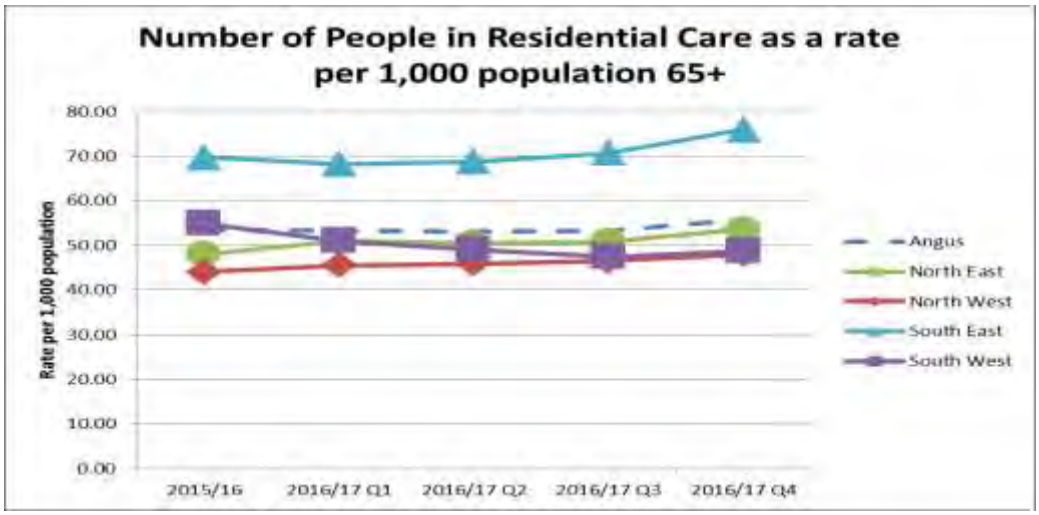
3.3.12 Patterns of care provision are inconsistent across Angus and the variation in the pattern of service uptake cannot be explained by variation in the proportion of over 85s in the population, the level of owner occupiers (who, anecdotally, are more reluctant to move into care) or older people living alone (who are more likely to be considered at risk and more likely to take up a care home placement). Commissioning of care home placements does relate more closely to the rate of bed provision within the locality.

Graph 19: Management Information at Locality Level: Nursing Care Placement Rate



Source: Care First (Angus Council)

Graph 20: Management Information at Locality Level: Residential Care Placement Rate



Source: Care First (Angus Council)

Priority 4: Improving integrated care pathways for priorities in care

Health and Social Care services are available to support all adults in need. There are some more complex needs that require additional support. This includes specialist needs such as mental health, learning disability and substance misuse. Services may wholly or in part be hosted by another Partnership. Angus Health & Social Care Partnership is working with other Partnerships and with Housing to develop responses to services in this area.

4.1 What we have achieved to date:

- Reviewed and implemented timely discharge processes including direct referral from discharge co-ordinators to early supported discharge and enablement teams.
- Provided additional resource for the discharge team at Ninewells.
- Provided access to social care IT systems for discharge staff working in Ninewells.
- A housing contribution statement has been agreed with Angus Council Housing services which sets out how specialist housing needs will be supported.
- Developed an accommodation overview and priorities for people with learning disabilities. Progressed three specific accommodation projects for people with learning disabilities.
- Increased the number of people with a power of attorney in place in Angus through our involvement in a campaign to improve uptake.
- An Angus Autism Strategy has been developed and approved. An implementation plan is being progressed.
- An older people's mental health strategy is being developed.
- The development of a Carers strategy is being progressed in line with the new Carers (Scotland) Act 2016. Commencement date for this new legislation is April 2018.
- A learning disability accommodation overview has been produced with three priorities agreed by the IJB.
- Progressed the delivery of new supported accommodation in Forfar for people with a learning disability.
- A strategy has been published by the Alcohol and Drugs Partnership and a delivery plan implemented.
- Worked with Perth and Kinross HSCP (host IJB) on issues facing in-patient adult mental health services.
- Successfully tested the delivery of mental health and wellbeing services within one GP practice.

4.2 What we plan to do next

- Work with Housing to ensure the availability of community based accommodation for people with mental ill health and learning disability.
- Replace The Gables Care Home with supported accommodation for the current residents.
- Conclude the review of hospital bed needs in Angus and implement the findings; this is due to report to the IJB later in 2017.
- Further develop discharge planning arrangements for adults with mental ill-health, learning disability, physical disability.
- Conclude the review of supported accommodation for older people and implement the findings.

- Undertake a review of supported accommodation for people with learning disabilities.
- Undertake a review of supported accommodation for people with adult mental health problems.

4.3 How we monitor progress

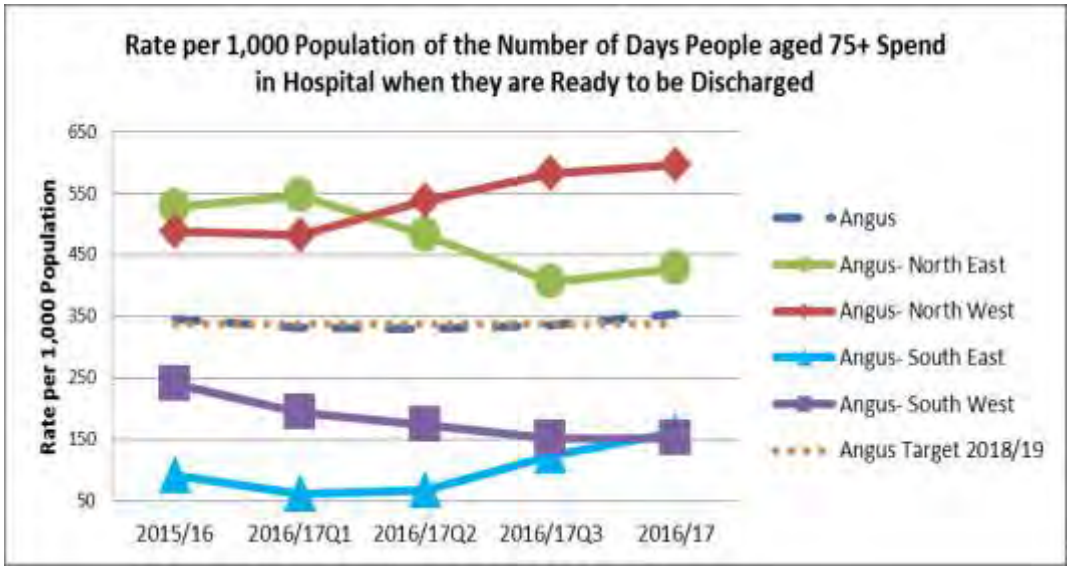
Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures. We measure pathways in and out of secondary care through our work on timely discharge.

Timely discharge

4.3.1 As at 2015/16 the number of days people spend in hospital when they are ready to be discharged as a rate per 1,000 population, is 355 (down from 368) per 1,000 in Angus. This is below the 2015/16 Scottish rate of 915 per 1,000 population. In 2015/16 Angus was the 4th best performing partnership in Scotland.

4.3.2 The rate of all bed days lost to delayed discharges for people aged 75+ has increased from 4042 in 2015/16 to 4153 in 2016/17 (a 2.7% increase). There has been a continued decline in bed days lost to delayed discharge in South West. The average length of a delay has increased from 14.2 days in 2015/16 to 17 days in 2016/17. The total number of people delayed has decreased from 284 to 245. Delays relate to 4% of all bed days associated with emergency admissions. The variance in bed days lost to delayed discharges between the northern and southern localities suggests that there is still room for improvement in the north. Our plans aim to reduce bed days lost to delayed discharge by 4% by 2018 (166 days).

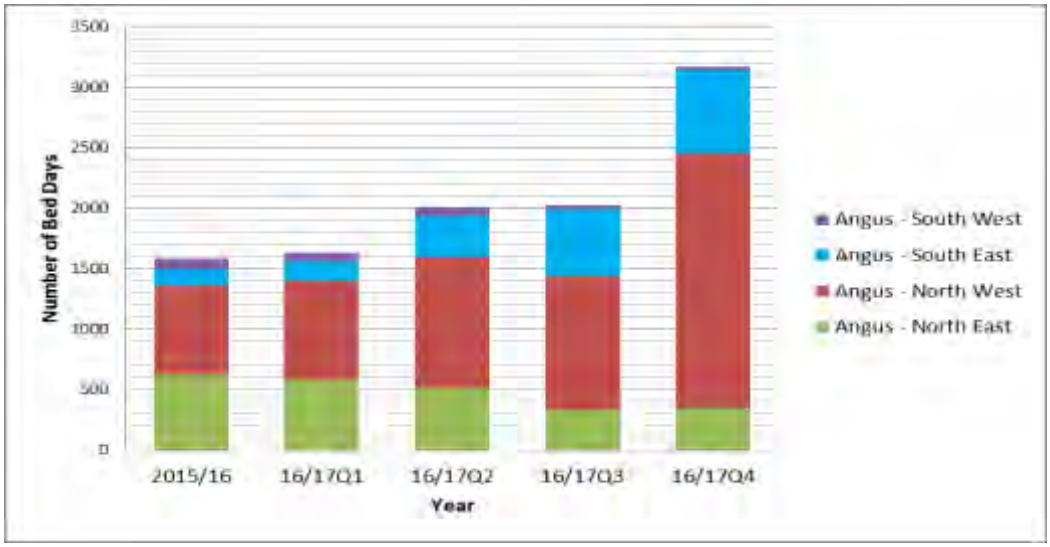
Graph 21: Management Information at Locality Level: Bed days lost to delays in discharge



Source: ISD LIST management information (not official ISD statistics)

4.3.3 The number of bed days lost to complex delayed discharge has doubled between 2015/16 and 2016/17. The main reason for delay is people awaiting legal process to be concluded for over 75s (guardianship). For under 75s, complex delays mostly relate to the provision of specialist accommodation to meet assessed needs.

Graph 22: Management Information at Locality Level: Bed days lost to complex delays in discharge



Source: ISD LIST management information (not official ISD statistics)

4.3.4 The roll out of ECS in North Angus and the continued development of Help to Live at Home is expected to have a reducing effect on patient delays in hospital. It is anticipated that these improvements being made in response to the strategic priorities will have a stabilising effect despite the increasing proportion of older people in Angus.

4.3.5 Campaigns to increase awareness and uptake of power of attorney are expected to have some effect on complex delays. The delivery of the learning disability accommodation priorities and work in mental health services with Housing is also expected to deliver improvements in complex delays. It is recognised that new build accommodation solutions take time.

Performance Area 1: Workforce

Angus Health & Social Care Partnership is working to improve the comparability of the workforce data and present information in a consistent way.

5.1 What we have achieved to date

The Angus Health and Social Care Partnership Staff Forum was established in June 2016 to ensure that the ethos of partnership working is embedded in practice. The forum's remit is to ensure the fair and consistent application of the employing authorities (NHS Tayside and Angus Council) staff governance standards within the Partnership. It addresses operational issues affecting staff and services and contributes to the development and implementation of strategy and policy.

In our Corporate Risk Register we have recorded that *'due to changing demographics affecting our staff and people who use our services there is a risk that Angus HSCP will be unable to develop and sustain its workforce to meet its objectives*,' We plan to mitigate this risk by:

1. Bringing together our health and social care staffing by creating opportunities to improve outcomes through increased efficiency and reduced duplication of effort.
2. Maximising our efficient recruitment and training opportunities to ensure our workforce can meet the services' strategic objectives.

Our Staffing Age Profile (Graph 23) illustrates this risk.

5.2 What we plan to do next

Performance reporting is already in place regarding workforce spend and sickness absence. We will develop an indicator measuring our vacancies and the length of time posts remain vacant.

We are developing a fully integrated workforce plan covering NHS Tayside, Angus Council, Third and Independent sector staff. This will include:

- joint training strategies,
- maximising modern apprenticeships,
- developing joint employer protocols which will permit flexible staffing arrangements to allow immediate staff shortage risks to be managed e.g. use of secondments, temporary contracts, etc.

iMatter, the Staff Experience Continuous Improvement Model will be rolled out across the majority of our services during the summer of 2017. This iMatter process begins with a staff questionnaire that gathers views on their experiences. These are aggregated and a team report is generated. The data in the report can then be used as the basis for the development work at team, service and organisational level, to enhance staff and patient / service user experience. It also offers an opportunity to understand where teams are currently (a baseline) in moving forward as new working arrangements become embedded in the Partnership.

5.3 How we monitor progress

Quantitative Data regarding staff sickness and vacancies will be complemented by qualitative feedback from the iMatter team action plans. These will be reviewed by the appropriate management groups. The progress of our improvement plans are dependent on having the right staff in the right place. Risks will be monitored and reported to the Strategic Planning Group.

Progress is monitored through the following national and local performance measures:

Angus as a good place to work

National Indicator 10 Percentage of staff who say they would recommend their workplace as a good place to work is still under development and therefore cannot be reported.

Sickness Absence

The percentage of sickness absence amongst Angus NHS staff decreased by 0.55% between 2015/16 and 2016/17.

There has been a improvement in the percentage sickness absence of Angus Council staff working in Angus Health and Social Care Partnership between quarter 3 2016/17 and quarter 4 2016/17.

Table 4: Management Information - Percentage Staff sickness absence of staff working within Angus Health and Social Care Partnership

Angus Health and Social Care Partnership	2015/16	2016/17
NHS staff	5.02	4.78
Angus Council staff	6.28	7.46

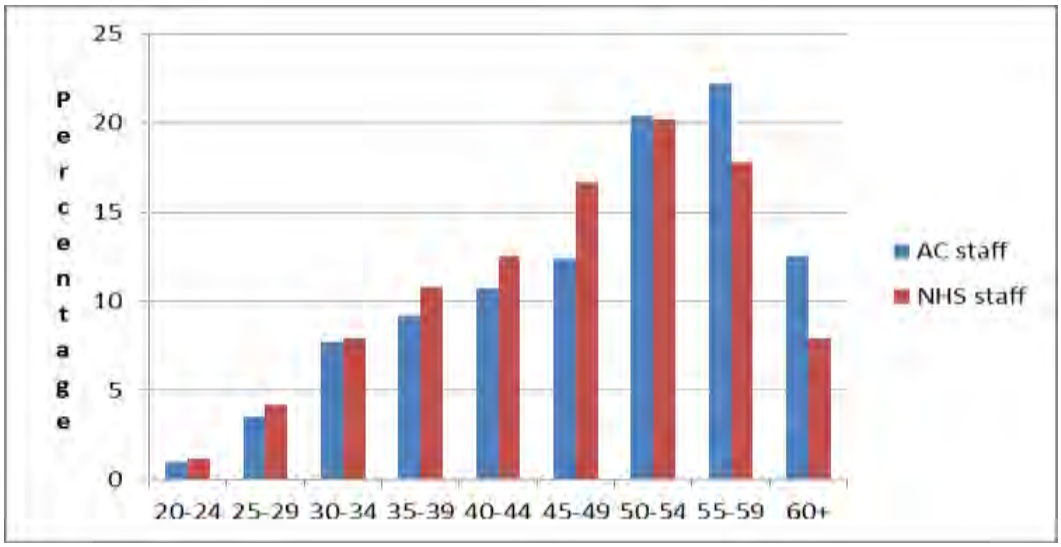
Source: Angus Council and NHST epayroll

We know that our staff are delivering services and care in an increasingly complex environment and that stress related illness is amongst the main causes of absence across Angus. The emerging workforce plan will ensure that appropriate support systems are in place to address sickness/absence.

Age profile

There are 833 NHS Tayside staff and 845 Angus Council staff working in AHSCP. The workforce is aging.

Graph 23 Management Information at Angus Level: Age profile of Angus Health and Social Care Workforce



Source: Angus Council and NHS Tayside

Performance Area 2: Clinical, Care and Professional Governance

Clinical, Care and Professional Governance is overseen through a governance group (R2) established under the agreed Clinical and Care Governance Framework which allows for multi-agency scrutiny. There is an exception reporting approach which reflects the 6 domains of assurance set out within the framework. A regular reporting calendar assures that services under the direct responsibility of the Angus IJB including hosted services, alongside voluntary reporting by the wider partnership members, occurs. The quality of performance is evaluated by regular production of performance data for consideration by the group. The risk register and any complaints are also considered. Some arrangements in relation to improving data availability and quality have still to be addressed however progress is being made. Areas for development are highlighted in each domain.

6.1 Domain 1 - Information Governance

An adult care information governance group has been established in order to develop an internal information governance plan which complies with Angus Council policy. Data sharing agreements exist between Angus Council, Dundee City Council, Perth and Kinross Council and NHS Tayside. A SASPI data sharing agreement has also been put in place to support work between Angus Council, NHS Tayside and ISD. A review of data processing notices is underway to ensure that they continue to be compliant with how information is used.

There were 2 breaches in information governance in relation to adult care services. One involved a mis-addressed letter and the second a survey response. Remedial action was put in place to reduce the risk of further occurrence of similar breach.

Angus Council received 69 freedom of information act enquiries in relation to adult care services. The themes included:

- Uptake of self-directed support options
- A wider range of information in relation to home care services
- Charging and funding
- Procurement and contractual arrangements including contract values
- Occupational therapy, equipment provision and recycling
- Waiting lists and waiting times

Plans are being developed to expand open data in relation to health and social care. Freedom of information requests give a good indication of the type of data that should be included in the plans for improving open data.

6.2 Domain 2 - Professional Regulation and Workforce Development

Professional registration and revalidation

Systems are in place to assure that Angus Council and NHS Tayside staff working within Angus Health and Social Care Partnership maintain appropriate and up to date registration and complete any required revalidation process. All social care staff that require registration have the correct registration in place. No breaches in registration have been recorded in respect of health staff or social care staff working in the Partnership.

Since April 2016, all nurses and midwives in the U.K. need to follow a Revalidation process to maintain their registration with The Nursing and Midwifery Council (NMC). This new process replaces the previous (Prep) requirements, and all nurses and midwives will have to revalidate every three years to renew their registration.

Support, Supervision and Appraisal

It has been identified that stress related illness is a significant cause of absence within Angus. Ensuring good uptake of effective, high quality appraisal that discusses performance

and identifies support and development opportunities for staff will ensure staff are better supported.

The R2 group has responsibility for professional governance and will be looking to develop adequate data on support, supervision and appraisal. There are also plans to seek staff feedback on appraisal with a view to ensuring that appraisal within Angus HSCP is of a high standard.

eKSF for health staff is managed as a rolling programme. A snapshot of performance against this rolling programme is not a reliable measure of the quality and effectiveness of the appraisal and support arrangements that are in place.

Information on the proportion of adult care staff that have had an appraisal within the last 12 months is no longer collected centrally. New systems for collecting this information are being developed within services.

Risks

Two risks in relation to staff availability are highlighted as red risks on the register. This includes the inability to maintain sufficient levels of band 6 and 7 nurses within community nursing and a lack of experienced staff within minor injury units. Both risks are being addressed through the workforce plan (Performance area 2 Workforce).

6.3 Domain 3 - Patient, Service User and Staff Safety

Adult Protection

A full report on adult protection is published by the Angus Adult Protection Committee.

Adverse events

Adverse events are reported routinely by health staff and are typically anything that raises a concern. Approaches to care that encourage rehabilitation and enablement carry a greater risk of falls as greater mobilisation is part of the rehabilitation. This likely accounts for the higher levels of falls which are category 3 (green event/ negligible impact) and all falls in designated rehab facilities. The available information does not include the number of falls attributable to or recorded against one individual. One person may account for multiple recorded falls. Given the number of individuals who pass through premises each year, the falls rate is low. All falls are investigated and any required action is taken.

6.4 Domain 4 - Patient, Service User and Staff Experience

The national core outcome indicators are detailed in Table 1 at the beginning of this report. Outcome indicators relate to people's perception of their experience in using services. Angus performs relatively well against the national picture. The latest national indicator information available is from 2015/16:

89% of adults supported at home agreed that they are supported to live as independently as possible

82% of Angus adults receiving any care or support rated it as excellent or good.

There is opportunity for improvement across all outcome indicators most notably in relation to:

- people's experience of care provided by GP practice
- carers feeling supported to continue with their caring role.

(Source: Biennial Health and Care Experience Survey 2015/16).

Service Feedback

All services undertake experience surveys with people who use those services. Feedback is generally positive but services recognise that there continues to be more work to do. A summary of feedback during 2016/17 is contained in appendix 3.

6.5 Domain 5 - Regulation of Quality and Effectiveness of Care

Quality of registered social care services

In 2015/16 the proportion of care services graded good or better in Care Inspectorate inspections in Angus is 90% which is above the Scottish rate of 83%. 2016/17 data is not available at the time of writing. This ranks Angus as the 4th best performing partnership for this indicator. Care services include all registration categories: for example care home, day care, care at home.

Service inspections – Care Inspectorate

There are 76 registered social care services supporting adults in Angus. There have been 58 inspections in relation to care services provided within Angus in 2016/17.

There were 13 requirements made across all themes involving 6 homes

There were 123 recommendations across all themes involving 21 homes

Note: A **requirement** is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010 (the "Act"), its regulations, or orders made under the Act, or a condition of registration. Requirements are enforceable in law. Requirements are made where (a) there is evidence of poor outcomes for people using the service or (b) there is the potential for poor outcomes which would affect people's health, safety or welfare. A **recommendation** is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement. Recommendations are based on the National Care Standards, SSSC codes of practice and recognised good practice. These must also be outcomes-based and if the provider meets the recommendation this would improve outcomes for people receiving the service.

From inspection reports a number of issues are highlighted in requirements and recommendations.

Table 5 : Management Information – Themes of requirements and recommendations following inspections of care services in Angus.

Inspection Theme	Requirement themes	Recommendation themes
Care	medicines	care plans; medicines; skin management; activity; health monitoring; meal time experience
Staffing	recruitment and registration	recruitment; training; induction; supervision; registration
Management	audit	audit
Environment	N/A	signage; lighting; repairs

Source: Care Inspectorate data store

No enforcement action was taken by the Care Inspectorate in Angus during 2016/17.

Service Inspections – Healthcare Improvement Scotland (HIS)

An unannounced inspection of Stracathro Hospital in relation to older people in acute hospitals was undertaken on 21 - 22 February 2017.

Areas of Strength identified during the inspection

- All patients praised the care that they had received.
- DNACPR documentation was well completed.
- Good evidence of reassessments following transfer to Stracathro Hospital.

- Good mealtime management.

Areas for improvement identified during the inspection

- Documentation, such as care rounding sheets, fluid balance charts, food record charts and SSKIN bundles were not always accurately completed.

- The completion of person-centred care plans was variable. These should detail the interventions required to meet patients' identified care needs, but not all care plans reviewed did.

- There were some concerns around the completion of the assessment of capacity to consent and staff understanding of Adults with Incapacity documentation.

Complaints

In 2016/17, 53 complaints were received in respect of health services directed by the Angus Health and Social Care Partnership. The aim is to respond to 68% of complaints within 20 working days. In 2016/17 75% of complaints were responded to within the 20 working days.

The Care Inspectorate upheld 6 complaints in this time period – involving 5 homes. The issues raised in these complaints related to – record keeping: healthcare: staffing levels: adult protection.

6.6 Domain 6 - Promotion of Equality and Social Justice

The IJB approved a set of equality outcomes and mainstreaming report in May 2016. Indicators which show how services and outcomes vary between the most and least deprived communities in Angus are being developed. These are reported on separately.

Performance Area 3: Resources

One aim of our strategic plan is to evidence a shift in resources from health to social care provision and from institutional based care to community based services within our localities. We are working with Information Services Division (ISD) on the development of the Tableau health and social care dashboard. This is a system which matches health and social care data and generates information from spend on individuals to demonstrate the split between health and social care spend and between spend on institutional based care and community based services. We are working with ISD to improve the information we submit through their Source data collection system and working towards accessing the analysed data more quickly.

7.1 What we have achieved to date

- Introduced a new sheltered housing model.
- Developing community services including Enhance Community Support which support people to stay at home has resulted in less reliance on inpatient beds.
- Developing sustainable personal care through Help to Live at Home Programme
- Undertaken first phase of review on minor injury and illness services
- Delivered a series of operational, administrative and managerial efficiencies;
- The rate of use of care home beds has been reduced with commensurate improvements in the uptake and availability of care at home.

7.2 What we plan to do next

- Continue to move resources into the community through Enhanced Community Support as the roll out of our community based programmes become effective.
- Work with secondary care to better understand the higher costs in relation to emergency admissions and large hospital resources generally for Angus patients and to develop models of care which allow a shift in the balance of care with resource to the community.
- Further develop the Help to Live at Home Programme.
- Implement the changes to community nurse medicines administration.
- Progress the outcomes from the inpatient review.
- Further review minor injury and illness services.
- Seek to deliver a series of further operational, administrative and managerial efficiencies.
- We will work with Voluntary Action Angus to identify information on the contribution of the voluntary sector to our partnership.
- We will continue to work with the Source team at the Information Services Division (ISD) to improve the provision of social care information in order to develop measures relating to the balance of care between health and social care and the balance of care between community and institutional expenditure.
- Seek to develop locality reporting regarding resources.

7.3 How we monitor progress

Detailed reports on finance are submitted by the Chief Finance Officer separately. The IJB seeks to demonstrate best value through a comprehensive efficiency programme as described in Board papers and IJB financial monitoring reports.

Currently the availability of data within Tableau is dependent on our ability to upload our local data and on ISD's progress with the development of the dashboard. In respect of financial information the dashboard is currently providing information up to the year 14/15. We do not see this as relevant to the performance of the Partnership and wait for improved information in Tableau as the system is further developed.

Spend on hospital stays following emergency admission

7.3.1 Angus has one of the biggest percentages of total health and care spend on hospital stays where the patient was admitted as an emergency, at 26% against a Scottish average of 23%. This is not directly in the control of the IJB as most admissions are of an acute nature and are to Ninewells Hospital.

Appendix 1

Relationship between Angus Strategic Priorities, the National Wellbeing Outcomes and the National Core Performance Indicators

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core performance measures
Priority 1 **Improving health , wellbeing and independence**	**1. Healthier Living** People are able to look after and improve their own health and wellbeing and live in good health for longer. **5. Reduce Health Inequality** Health and social care services contribute to reducing health inequalities. **6. Carers are Supported** People who provide unpaid care are supported to look after their own health and wellbeing. This includes reducing any negative impact of their caring role on their own health and wellbeing.	Premature mortality rate. Falls rate per 1,000 population in over 65s.
Priority 2 **Supporting Care needs at Home** **Priority 3** **Developing integrated and enhanced primary care and community responses** **Priority 4** **Improving Integrated care pathways for priorities in care**	**2. Independent Living** People, including those with disabilities, long term, conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community. **3. Positive Experiences and Outcomes** People who use health and social care services have positive experiences of those services and have their dignity respected. **4. Quality of Life** Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.	**Priority 2** Percentage of adults with intensive needs receiving care at home. **Priority 3** Percentage of people with positive experience of care at their G.P. practice. Rate of emergency admissions for adults. Rate of emergency bed days for adults. Readmissions to hospital within 28 days of discharge. Proportion of last 6 months of life spent at home or in community setting. Number of days people spend in hospital when they are ready to be discharged. Percentage of people admitted from home to hospital during the year, who are discharged to a care home. Percentage of people who are discharged from hospital within 72 hours of being ready.

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core performance measures
Performance Area 1 **Clinical and Care Governance**	**7. People are Safe** People who use health and social care services are safe from harm.	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. Percentage of adults supported at home who agree that they are supported to live as independently as possible. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. Percentage of adults receiving any care or support who rate it as excellent or good. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. Percentage of adults supported at home who agree they felt safe. Percentage of adults able to look after their health very well or quite well. Percentage of carers who feel supported to continue in their caring role.
Performance Area 2 **Managing our workforce**	**8. Engaged Workforce** People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	Percentage of staff who say they would recommend their workplace as a good place to work.
Performance Area 3 **Managing our resources**	**9. Resources are used Efficiently and Effectively** To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. Expenditure on end of life care

Appendix 2

ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

STRATEGIC DELIVERY PLAN

2017-2019

April 2017

INTRODUCTION

The Angus Health and Social Care Partnership sets out the vision for change and improvement in its strategic plan. The plan set out four strategic priorities through which change and improvement would be delivered.

Angus Health and Social Care Partnership (AHSCP) is committed to placing individuals and communities at the centre of service planning and delivery in order to deliver person-centred outcomes. The Partnership is focused upon improving the long term health of its population, providing timely health and social care interventions when needed and ensuring that such interventions give the best outcomes for our service users and their carers. The Angus Strategic Plan makes a commitment to shifting the balance of care from institution-based to care at home; it calls for health and social care to extend beyond the traditional setting of hospitals and care homes to reach more effectively into a person's own home and community.

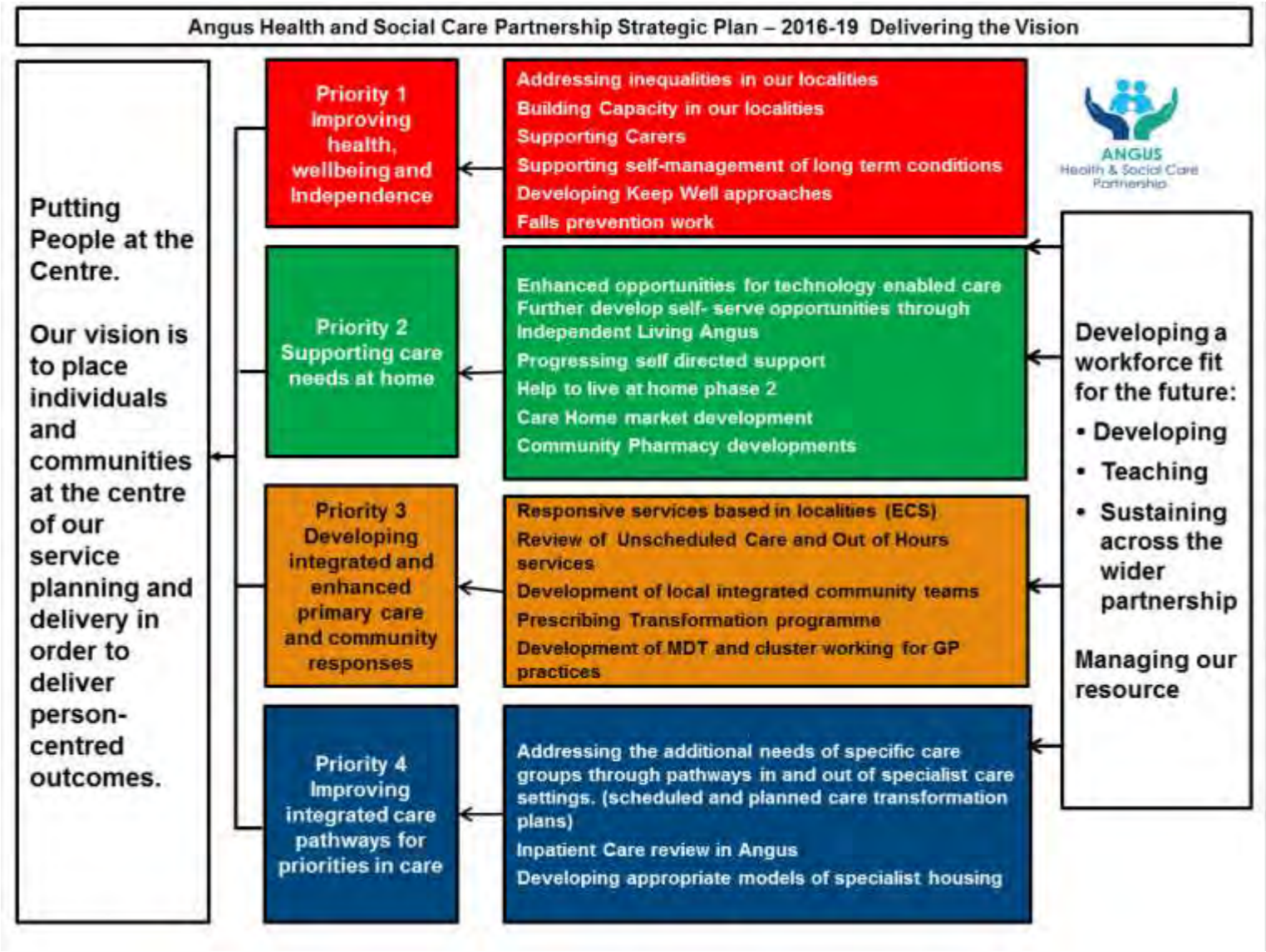
There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and which helps to maintain their independence and the support of their own community.

Resource management is becoming more challenging because of increasing levels of demand. Year on year we face a growing requirement to manage the resources of the IJB in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The strategic plan identifies a number of areas of efficiency, and the shift in the balance of care required.

The strategic plan will be progressed by the delivery of a range of improvement activity across services. This will include integrating teams, delivering services differently and developing new types of service models. Managing this range of developmental and change work is challenging. During the first year of the Partnership we have learned more about how to progress change in a challenging financial and strategic environment. This delivery plan is an iterative document which aims to set out how we will continue to progress our vision over the next 2 years. The delivery plan (table 1) will be updated every 6 months to provide further detail, taking into account the outcome of reviews which are currently underway and the completion of other work. Progress on the achievement of the delivery plan will be reported biannually through a Strategic Progress and Performance report.

Each locality has developed a locality improvement plan which includes an action plan showing how Angus wide improvement projects are impacting on that locality. These plans also identify a number of locality specific tests of change and improvements within localities supported by the locality improvement groups. It is anticipated that some of these tests of change will identify further improvement opportunities that can be rolled out across Angus and be included in a future version of the delivery plan.

Key Improvement Delivery Areas



Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
1	Supporting Carers	To ensure that Angus HSCP is fully prepared for implementation of the legislation on 1st April 2018. The Act furthers the rights of unpaid carers to ensure they are better supported and able to continue to care, if they wish to, and have a life alongside their caring role. To ensure that carers and their representative organisations are fully consulted in the development of the legislation. To create a benchmark of current provision and outcomes met in order to measure the impact of the new Act and track any increase in demand for services.	Identification of the scope and membership of workstreams	√			
			Collaboration and consultation with carers, their representative organisations and other stakeholders	√			
			Develop new Adult Carer Support Plan, Young Carers Statement and support plan	√			
			Local Eligibility Criteria for carers		√		
			Planning and delivery of changes to information systems, operational guidance,		√		
			Staff training		√		
			Publish public information		√		
	Technology Enabled care	Increase in number of people feel empowered to have greater choice and control to manage their own health, care and wellbeing through greater use of TEC. Staff feel more informed and confident to advise service users about TEC options.	Appoint Telehealth Project Manager to oversee implementation and evaluation of Tayside wide pilot of Florence (telehealth system)	√			
			Appoint Telecare Development Officer to increase awareness and uptake of telecare in Angus	√			
			Move from having TEC projects to developments at scale so that TEC shifts from being a desirable option to a core necessity.		√		√
	Falls prevention		Undertake a review of the falls pathway and identify further opportunity to improve falls prevention		√		

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
2	Self-directed Support	Deliver personalisation and improve choice and control in relation to social care services for supported people	Develop a Performance Framework	√			
			Develop a Finance Reporting Framework	√			
			Undertake a self-evaluation in relation to SDS	√			
			Implement Phase 3 (2016-2018) National Action Plan		√		
			Implement Service Delivery 2016-2018 Project Plan		√		
			Implement Learning and Development Plan	√			
2	Review of care Home provision in Angus	Care home provision in Angus that is fit for the future need and demand	Agree preferred option from appraisal of local authority care homes	√			
			Agree future preferred option from appraisal of care home market shape	√			
			Publish market facilitation plan		√		
			Deliver intentions from market facilitation plan			√	√
2	Help to Live at Home	To ensure that sufficient personal care and housing support is available in each locality and that supported people have choice and control over their support arrangements	Deliver Phase 2 development of new 'enablement services' including developing criteria and processes for the new service	√			
			Confirm the proposed changes to the service with the Care Inspectorate	√			
			Deliver new contract to replace existing personal care and housing support framework		√		
			Fully implement Care Monitoring		√		
2	Medicines administration	To ensure effective resource management in supporting medicines administration at home	Implement option 3 of the review of medicines administration. Band 3 health care assistants undertaking medication administration duties instead of Band 5/6 trained nurses.		√		
3	Enhanced Community support	Improve multidisciplinary working around GP practice to support timely discharge and support people at home when needs increase	Implement ECS model in North East Locality	√	√		
			Implement ECS model in North West Locality		√	√	
3	Drug, alcohol and substance misuse services	Access to a single service, one pathway, one multidisciplinary team and ultimately a single budget. Reduced duplication,	Integrated teams: Alcohol and Drug services - Angus Council Drug, Alcohol and Blood Borne Virus Team and Tayside Substance Misuse Service (Angus) will merge.	√			

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
		improved collaboration and integration of health and social care services					
3	Review of Care Management and District Nursing	To improve the effectiveness of care management and community nursing services. An improved understanding of how services are performing in a context of increasing complexity of care needs in the community & health and social care integration.	Produce a document for EMT outlining the learning from the review process and recommendations for further action		√		
3	Neighbourhood Care	Test approaches to integrated multi-service team in South Angus and at a later stage of potential for self - managing team	Project design revised in view of stakeholder feedback	√			
			Establish first pathfinder team in South West		√		
3	Prescribing	To ensure best value in the approach to Prescribing	Ongoing development, delivery and evaluation of Angus Prescribing Workplan.	√	√	√	√
			Enhanced outcome monitoring and reporting of current prescribing position and impact of programmes of activity within the Angus Prescribing Workplan	√	√	√	√
			Further develop our understanding regionally and locally of warranted variation	√			
			Ongoing development and prioritisation of additional initiatives to further reduce the overspend on FHS Prescribing	√			
			Enhanced horizon scanning to predict impact of changes to clinical pathways of care on prescribing locally as well as nationally.		√		
			Ongoing collaboration across the local community to maintain and develop ownership of the Angus Prescribing Workplan and promote ongoing locally identified tests of change related to prescribing.	√		√	

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
3	Adult Mental Health Home Treatment Team	Focus More Attention Upstream: Promotion, Prevention and Effective Intervention, Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services (NHWO 4) People who use health and social care services are safe from harm (NHWO 7) Resources are used effectively and efficiently in the provision of health and social care services (NHWO 9)	Identify team manager who will then oversee recruitment of staff for the new team	√			
			Implementation of operational guidelines	√			
3	Identify improvement opportunities from first year of statistical and performance analysis	Delivery of the Angus Health and Social Care Partnership vision	Review reason for increases in readmission rates and agree a further improvement plan within ECS and services		√		
			Review what social care packages were in place for people who experienced readmission and consider opportunities for improvement in social care packages		√		
3	Minor injury and illness services	To ensure appropriate service to meet the needs of the Angus population	Complete review and agree future plan for service model to be delivered in Angus		√		
4	Effective Discharge Planning	Following an emergency people are supported to leave hospital in a timely manner (within 72 hours of being ready for discharge) . Carers are involved in the discharge planning process	Improve recording of delays in discharge	√			
			'Next steps to home' test of change to be delivered	√			
			Understand and address reasons for increasing readmission rates	√			
			Public information leaflet	√			
4	Review of Inpatient services	To ensure appropriate levels of inpatient beds to meet the needs of the Angus population	Complete review and agree plan for future service model	√			

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
4	Delivering the Angus Autism strategy	To enable children, young people, and adults with Autism, and their families/carers, to receive the help they need.	Improving knowledge and understanding of autism by developing e-learning tool, other appropriate levels of staff training and promoting public awareness.		√		
			Improving support for children and families and adults by developing Social opportunities and activities for children, young people and adults with Autism to be further developed where possible in the local community. Autism friendly environments within mainstream and specialist services for adults to be developed. The number of Autism accredited specialist services for adults in Angus to be increased.		√		
			Improving learning opportunities for young adults. Information regarding suitable post school courses and links to agencies such as Skills Development Scotland to be made available to young people/adults with Autism. Links to be made with local businesses and colleges and universities with a view to promoting Autism awareness and necessary supports.		√		√
			Supporting adults with autism to live independently by Supported accommodation and mainstream tenancy availability to be increased for people with Autism.				√
4	Accommodation for people with learning disability	Adults with learning disability are supported to live independently.	Progress the replacement of the Gables Care Home				√
			Develop supported accommodation in South West locality				√
			Complete the redesign of Lilywynd in Forfar to support discharge from Strathmartine		√		
			Deliver replacement respite opportunities	√			
4	Palliative and end of life care	Adults feel supported at end of life	Develop an Angus palliative care strategy in conjunction with Lippen Care		√		

51

Appendix 3

Experience of services

1. What we have achieved to date

A&E and Inpatients

According to the most recent Inpatient Experience Survey 2016, the overall positive satisfaction was the greatest in relation to:

- How patients felt about the time waiting to be seen by a nurse or doctor in A&E (100%)
- In A&E patients had enough privacy when being examined or treated (100%)
- Patients were happy with the visiting hours (98%)
- The main ward or room patients stayed in was clean (97%)
- How patients felt about the time they waited to get to a ward (97%)

In-patients were, however, the least satisfied with the following aspect of their service:

- Patients knew which nurse was in charge of the ward (42%)
- Patients saw / received information on providing feedback / complaints about care received (45% positive response)
- Patients knew which nurse was in charge of their care (45%)
- Patients felt confident they could look after themselves after leaving hospital (52% positive response)
- Patients were not bothered by noise at night from other patients (52% positive response)

Between 2014 and 2016 Angus's inpatients' experience has improved in relation to the following:

- Patients saw / received information on providing feedback / complaints about care received (+12%)
- Prior to leaving hospital, patients felt confident that any help they needed had been arranged (+6%)
- Patients were involved in decisions about leaving hospital (+5%)
- Doctors discussed patients' condition and treatment with them in a way they could understand (+4%)
- If eligible, patients were happy with hospital transport arrangements for getting home (+4%)
- Nurses discussed patients' condition / treatment with them in a way they could understand (+3%)
- Staff took adequate care when carrying out physical procedures (+3%)
- Patients understood the possible side effects of their medicines (+3%)
- Patients had enough time with the people that matter to them (+2%)
- Doctors listened to patients if they had any questions or concerns (+2%)
- Staff took account of what matters to patients (+2%)
- How patients felt about the overall length of time they were in hospital (+2%)
- Staff treated patients with compassion and understanding (+1%)
- The hospital and ward's main ward or room patients stayed in was clean (+1%)
- The hospital and ward's bathrooms and toilets were clean (+1%)
- Patients felt people that matter to them were involved in decisions about their care / treatment (+1%)
- Nurses knew enough about patients' condition and treatment (+1%)

During the financial year 2016/17, there have been numerous improvements made to individual services provided across Angus with respect to patient/service user/carer and staff experience as well as promotion of equality and social justice, and ensuring equity in service provision.

Angus AHP Services

There has been a very positive status of seeking patient as well as carer experiences in Occupational Therapy (OT), Physiotherapy (PT) and Speech & Language Therapy (SLT) services, and of monitoring complaints/compliments and actioning and sharing complaints in OT, PT and SLT services in addition to a general promotion of evidence based practice, as evidenced by the status of data utilisation in service developments. The status of seeking staff experiences has all been well achieved in OT services.

Good performance has been evidenced with respect to seeking patient and carer experiences in SLT service as well as seeking staff experiences in PT and SLT services, and ensuring equity of service provision and targeting the greatest population needs in OT, PT and SLT services.

Older People and Physical Disability Service

There has been a very positive status of seeking patient and staff experiences as well as monitoring of complaints/compliments and sharing of the complaints findings in Assessment & Care Management (A&CM), OT, Glenloch and First Contact services. The same status has been evidenced in offering carers assessments and seeking carers views in these assessments in A&CM, OT and First Contact. All the sub-services also achieved standards in relation to ensuring equity of service provision across Angus. Early Supported Discharge/Prevention of Admission (ESD/POA) and Community Alarm services have achieved desired outcomes also in relation to ensuring equity of service provision across Angus. The Mainstream and SCO, Community Alarm and Accommodation services also had a well performing system in place for monitoring the demand per locality.

Learning Disability Services

There has been a very positive status of seeking service users and staff experiences as well as monitoring of complaints/compliments by Resource Centres, Care Management, Community Opportunities and The Gables services. The same status has been evidenced in relation to offering carers assessments by the Care Management Services. All services ensured equity of service provision across Angus and utilised data to inform service developments.

Accommodation and Home Care

There has been a very positive status of seeking regular service user feedback in Mainstream and SCO, ESD/POA, Community Alarm and Accommodation services as well as of carers in mainstream and SCO and Accommodation services. The same status has been evidenced for monitoring of complaints/compliments and actioning and sharing of complaints in Mainstream and SCO, ESD/POA, Community Alarm and Accommodation services.

The service performed well with further outcome/standard developments required with respect to seeking regular carer feedback in ESD/POA as well as ensuring equity of service provision across Angus by Mainstream and SCO, and Accommodation services. The same status has been observed with respect to monitoring of demand per locality by the ESD/POA service.

Angus Community Mental Health Services

The service achieved required outcomes/standard with respect to monitoring, actioning and sharing of complaints/compliments as well as lowering the number of delayed discharges.

The service performed well with further outcome/standard developments required with respect to seeking regular patient experiences.

Clinical Plan: Respiratory

There has been a very positive status of the seeking regular patient experiences as well as of monitoring, actioning and sharing of complaints/compliments. The service equally well utilised data to inform service developments as well as ensured that the greatest population needs are targeted (e.g. accessibility, inclusion).

The service performed well with further outcome/standard developments required with respect to seeking carer experiences.

2. What we plan to do next

Older People and Physical Disability

Further work is required to ensure that service user experiences are regularly sought in the First Contact services.

Accommodation and Home Care

Further work is required to ensure that regular service user feedback is sought by the Community Alarm service.

Angus Community Mental Health Services

Further work is required to ensure that regular carer experiences are sought by Angus Community Mental Health Services.

AGENDA ITEM NO 14

REPORT NO IJB 34/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

REVIEW OF INPATIENT CARE IN ANGUS

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This paper outlines the progress made to review inpatient care in Angus as requested by the IJB on 22 February 2017.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):-

(i) Notes the progress made and supports the continued progression of the review of inpatient care in Angus.

(ii) Notes that a further report will be submitted for consideration in October 2017.

2. BACKGROUND

People within Angus have access to a wide range of community-based services including five hospitals with inpatient beds at:

Arbroath Infirmary
Brechin Infirmary (non-operational since October 2015)
Montrose Royal Infirmary
Stracathro Hospital, by Brechin
Whitehills Health and Community Care Centre in Forfar.

There is growing evidence that healthcare needs to extend beyond the traditional setting of hospitals and reach more effectively into a person's own home and community. This means that care will be delivered by well led multi-disciplinary and multi-agency teams in community settings.

Shifting the Balance of Care (SBC) is a strategic objective for the Scottish Government, NHS and Local Authorities. Demographic pressures (particularly the projected rise in the number of older people); workforce issues; the need to improve health and social care outcomes, and the increasing cost care means that current ways of care delivery are not sustainable.

There are a range of challenges in providing inpatient care under the current operating model.

- **Growing demand for care.** People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to live in their own home for as long as it is safe to do so and when they need care this should be provided as close to home as possible.

- **Our workforce.** We are witnessing a significant shift in the availability of the traditional health and social care workforce in Angus. This is a situation which is also replicated nationally. We cannot afford to ignore this situation and need to plan to provide care on a more sustainable basis, and deploy the workforce available efficiently and effectively. We anticipate further significant change over the next few years, particularly in the nursing and medical workforce which will make it extremely challenging to recruit and retain staff in the numbers required to deliver the current model of care.

- **The condition of our estate.** We know that we currently provide care from a number of facilities which were appropriate for the delivery of models of care originally developed many years ago but which are not suitable to support the delivery of modern, more flexible health and social care models.

- **Resource management.** Year-on-year we face a growing requirement to manage the resources of the Integration Joint Board (IJB) in line with demand. Using the current resource framework as efficiently and effectively as possible is essential. The Strategic Plan identifies a number of areas of efficiency, and the shift required.

In order to respond to these challenges, we need to develop new clinical and care pathways that are likely to involve moving location and changing responsibilities.

From 2014/15 the Angus Community Health Partnership started to invest in Enhanced Community Support (ECS) in South Angus with the aim to move care away from assessment and care being provided in institutions to enabling more people to access the care they need in their own homes or in a homely setting. There are two key elements to delivering ECS. The move to working in this new model involves alignment of Medicine for the Elderly (MFE) and Old Age Psychiatry consultants with their corresponding teams to localities. Associated with this the multidisciplinary/multiagency teams are also designated to specific localities, including Community Nursing, Pharmacy, Allied Health Professionals, Voluntary Sector, Social Care and General Practice. The funding to support this was initially from Scottish Government short term funding sources, but from 2015/16 the funding was mainstreamed through reinvestment of part of the resources released from Little Cairnie Inpatient Services in Arbroath.

It was noted that in South Angus in 2015/16, the ECS approach was having a positive impact on hospital discharge and prevention of admission. Furthermore increasing levels of personal care had contributed to a significant (61%) reduction in bed days lost to delayed discharges for people aged over 75 years. This reduction continued into 2016/17 with a 37% reduction in bed days lost to delayed discharge in the first 6 months of the year. The ECS approach was showing a significant decrease in the use of and need for inpatient services in a community hospital setting We now provide more local care for people in there own homes, avoiding the reliance on unnecessary and lengthy hospital stays. In addition, there had been a 12% reduction in emergency bed day use by over 75 year olds from South Angus. There is a direct association between the implementation and effective application of ECS methods and hospital bed days used.

The Angus Strategic Plan makes a commitment to shift the balance of care. It calls for healthcare to extend beyond the traditional setting of hospitals and reach more effectively onto a person's own home and community. ECS is now firmly established across both South Localities and is being rolled out across the North with multiagency teams aligned to them. In December 2016 the Angus Integration Joint Board (IJB) reviewed the effectiveness of ECS and supported investment in extending this approach across Angus. Subsequently the IJB endorsed the consolidation of inpatient resources in line with current demand to support the shift in balance of care and to release the resource of non-operational inpatient facilities to support the spread of the ECS approach across Angus. On 22 February 2017 the IJB requested the submission of regular progress reports in the review of in-patient care.

AHSCP will now undertake a comprehensive programme review of inpatient services in Angus and propose options later in the year for change. The review will be clinically focused, through Localities, putting patients and their needs at the centre of the process. The review will involve engagement with the public and stakeholders.

The programme will continue to focus on getting better value for the money that we spend on health and social care services. The programme will endeavour to ensure that it results in quality outcomes for people in Angus.

3. CURRENT POSITION

A Programme Team (PT) has been established composed of representatives of Angus Health and Social Care Partnership directly or indirectly involved in providing inpatient care in Angus. The PT will report to the AHSCP IPCR Programme Board (PB).

A Programme Initiation Document (PID) has been developed which sets out how the AHSCP will develop plans to implement the Angus IPCR.

The PID was approved by the PB on12 June 2017.

Purpose of Angus IPCR:

- Identify the inpatient resources which, together with other health and social care services, will deliver the best outcomes for the people of Angus.
- In the context of the IJB's overall financial position, we will prioritise our investment carefully to optimise the effectiveness of our services.
- Plan and deliver a programme of change which will achieve the desired configuration of services.

Aims of Angus IPCR:

Work with stakeholders to:

- Support the shift in balance of care and direct resources to support the ECS model, and the growth of multi disciplinary care for people in their own homes.
- Undertake a comprehensive review of inpatient care in Angus hospitals to ensure that they represent best value and are in line with current and projected demand, the AHSCP Strategic Plan, locality priorities, and best practice guidance, e.g. NHS Tayside Clinical Strategy, Chief Medical Officer's Annual Report – 2015/16: Realising Realistic Medicine.
- Identify options to consolidate inpatient resources and review the number of hospital sites in line with the demand to shift the balance of care.

Scope of Angus IPCR:

Inclusions:

- Current inpatient services undertaken at the five hospital sites. This includes all community service areas delegated to the Angus HSCP i.e. Medicine for the Elderly (MFE), Psychiatry of Old Age (POA), Community Inpatient Care, stroke rehabilitation and Palliative Care delivered across the following sites:
    - Arbroath Infirmary
    - Brechin Infirmary (non-operational since October 2015),
    - Montrose Royal Infirmary
    - Stracathro Hospital
    - Whitehills Health & Community Care Centre

Exclusions:

- In-patient facilities within B-Block at Stracathro Hospital which are the responsibility of the Acute Division, NHS Tayside. We note that within the context of reshaping surgical services in NHS Tayside, there may be further development of inpatient facilities. The Angus IPCR Programme will seek to align service plans and align with these developments.
- Maternity Services and General Adult Psychiatry (GAP) provided by NHS Tayside Acute Division and Perth and Kinross Health and Social Care Partnership respectively. We note that these areas of service are subject to reviews. The Angus IPCR Programme will seek to align service plans and coordinate with these reviews.

4. PROPOSALS

- Activity Review - The first step in the review process is to understand how inpatient care resources are being utilised in Angus. The activity review will focus on examination of each inpatient care facility within the scope.
- Outcome Review – The outcome review will give a clear picture of the effectiveness of the current inpatient care in Angus and will take into account future demand and our strategic commitment to shift the balance of care.
- Patient, staff and public engagement – There is a significant amount of interest in the in-patient care provided in Angus, therefore this will be a critical part of the review process. A sub-group will be established to inform, engage and consult.

5. TIMESCALES

IPCR Programme Board to consider PID to consolidate inpatient resources in Angus	June 2017
Inform, engage and consult with patients, staff and general public in localities about future options for inpatient care	June – November 2017
Consideration of the preferred option by the IJB	December 2017

6. FINANCIAL IMPLICATIONS

The IJB's financial position requires the delivery of significant levels of recurring savings (see IJB paper 78/16). The HSCP's Strategic Plan gave a commitment to work towards shifting the balance of care by investing in community services and reducing dependency on hospital beds.

7. OTHER IMPLICATIONS (IF APPLICABLE)

This review comes at a time when a number of other significant reviews are taking place in Angus which require input from a similar number of stakeholders. We must adapt our approach to informing, engaging and consulting accordingly to ensure appropriate representation and establish strategic links across all programmes.

REPORT AUTHORS: **Gail Smith, Head of Community Health and Care Services (North Angus) and IPCR Programme Sponsor**

Sally Wilson, Locality Integration Improvement Manager and IPCR Programme Manager

EMAIL DETAILS: **hsciangus.tayside@nhs.net**

June 2017

AGENDA ITEM NO 15

REPORT NO IJB 35/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

PRIMARY CARE UPDATE

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to provide Angus IJB with an update on Primary Care Service provision including an update and progress report on:-

- Primary Care Strategic Management and Transformation Board and Transformation Programme
- GP Recruitment and Retention
- Service delivery within Primary Care including 2c (NHS Tayside run) practices pan Tayside and Out of Hours
- Review of Minor Injury and Illness Service in Angus

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) note the current position locally and nationally regarding GP recruitment and retention;

(ii) note the progress to date in relation to the Review of the Minor Injury and Illness Service within Angus;

(iii) support the work undertaken to date to support the safe delivery of the services going forward;

(iv) support the ongoing work to improve the services and to develop a more integrated service between in and out of hours and multidisciplinary approach to delivering the service as part of the transformation programme.

2. BACKGROUND

Following the establishment of the Integration Authority, the Chief Officer has worked with stakeholders across NHS Tayside to review and revise the leadership framework for the management and development of primary care services. As such a Tayside Primary Care Strategic Management and Transformation Board and Tayside Primary Care Senior Management Group have both been established as part of the IJB infrastructure with an R3 Care and Clinical Governance Group for Primary Care, and reporting lines flowing through current hosting arrangements.

Primary Care including Out of Hours (OOH) continues to experience challenges particularly in relation to availability of General Practitioners (GPs) to cover services. These recruitment challenges are reflected across the GP practices in Tayside but are posing ongoing difficulties for the 2c (NHS Tayside run) practices. This is recognised locally within NHS Tayside and also nationally at Scottish Government level, with a number of strategies introduced to attempt to improve GP recruitment and retention.

Tayside GP OOH service is managed and coordinated by the Hub / Primary Care Emergency Centre (PCEC) in Kings Cross Health & Community Care Centre, Dundee, with 2 locality PCECs in Perth Royal Infirmary and Arbroath Infirmary. The service is staffed by teams of GPs, Senior Primary Care Nurses, Dispatchers, Receptionists, Drivers and admin staff.

The clinical model of OOH is comprised of a mix of salaried and sessional GPs and primary care nurses. There are a number of regular sessional GPs; GPs who pick up the occasional session and 85% of the shifts are salaried. The GPs are salaried to particular shifts rather than to the service in general.

3. CURRENT POSITION

Local Primary Care Update

GP Recruitment and Retention

NHS Tayside successfully appointed three career start GPs in 2016/17 who were placed in Edzell, Maryfield and Lochee.

A further round of recruitment is underway with active advertisement both locally to our NHS Tayside GP specialist registrar contingent; and also nationally with active engagement on social media and on the web. Interviews for these positions will be held over the next 6 weeks with a view to appointment in August. Any unfilled posts will remain open to applications thereafter.

Practice Update

There are 65 general medical practices in Tayside (which include two 17c (locally negotiated contract) Agreements – Edzell and Invergowrie & three 2c (NHS Tayside run) Arrangements – Brechin, Lochee and Whitfield).

There are currently fourteen GP vacancies in the Tayside Health Board area, with a further known 5 GP vacancies arising by 31 December 2017. Due to the challenges with recruitment of GPs as described above there is no guarantee the practices will be able to appoint to these vacancies. The majority of practices are enhancing multi disciplinary approaches to care within their practices to improve sustainability of services.

There are presently two GP practices in Dundee operating temporarily with closed lists.

2C Practice Update

- **Brechin**

  The current salaried medical team comprises 6 GPs. Three new part-time Salaried GPs took up appointment in April with one of the Salaried GPs increasing her commitment to the practice in June 2017, bringing the overall Salaried GP complement to 3.44 WTE. As the desired complement is 4.8 WTE, Brechin is being supported by regular locums whilst recruitment continues and multi-disciplinary approaches to care are being enhanced.

  With the support of the Primary Care Services Department, work will commence in the coming weeks to streamline the administrative structures and systems required to support clinical service delivery. The introduction of NHS Tayside's new telephony system over the summer will further support these developments.

- **Lochee**

  The existing medical team currently comprises 5 GPs, one of whom has recently handed in her notice. The overall medical complement is currently 2.8 WTE. Recruitment of a full-time replacement Salaried GP is underway with the appointment of an Advanced Nurse Practitioner also currently being explored.

  With the support of the Primary Care Services Department, work has commenced to streamline the administrative structures and systems required to support clinical service delivery. The introduction of NHS Tayside's new telephony system over the summer will support these developments.

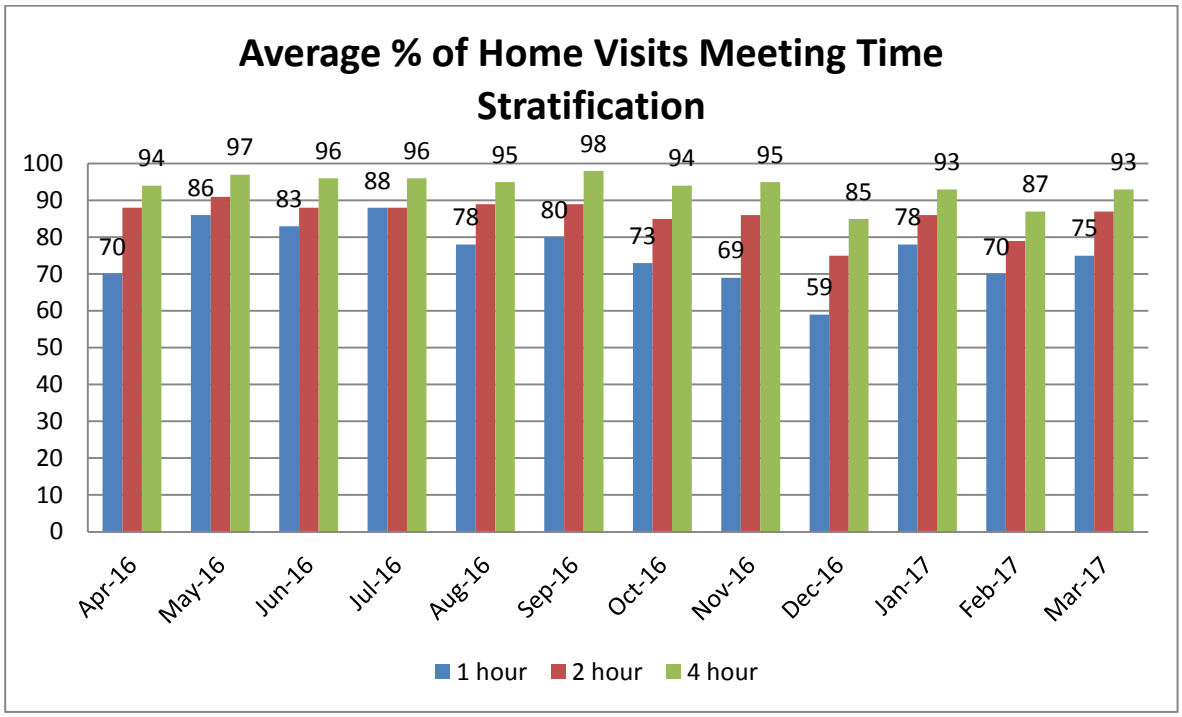
- **Whitfield**

  The current medical team comprises 3 GPs (1.6 WTE). The full-time Salaried GP has resigned to take up a partnership. Opportunities for the further development of the practice are currently being explored whilst advertisement of the vacancy which will arise mid August 2017 is progressed.

Out of Hours

The GP shift coverage has improved for the forthcoming summer months. There remain some challenges with covering some June and July shifts. There are a number of short shifts in August.

Despite ongoing challenges with shift coverage, the service has continued to perform well in relation to the time stratifications as demonstrated in graph below:



The service is also working with the wider multidisciplinary team to implement the recommendations from the National Out of Hours review, some examples of improvement work are detailed below :-

- Co-location of the OOH service and overnight district nursing teams in Dundee and Perth
- Closer working with paediatrics
- Co-location of a paramedic practitioner in Kings Cross during the OOH period
- Closer working with mental health and Police Scotland for community triage
- Successful implementation of NEWS and PEWS into the OOH
- Admitting rights for paramedics into Acute Medical Unit

Primary Care Transformation Programme

A Programme Manager for Primary Care has now been appointed and is working closely with the three Health and Social Care Partnerships and Out of Hours to progress developing and implementing multiagency models of care which meets the needs of the local population. An overarching programme plan has been developed in order to support this work. A scoping exercise aligned with the primary care strategy is also currently underway in partnership with the three Health and Social Care Partnerships including Out of Hours and NHS Tayside and an update will be provided at a future IJB meeting.

Review of Minor Injury and Illness Service in Angus

Following an initial review of minor injury and illness services across Tayside, recommendations were agreed by NHS Tayside Board, and each IJB was asked to identify opportunities to remodel services to meet the needs of the local populations, to ensure a safe and sustainable quality service.

A paper detailing options was presented to Angus Strategic Planning Group in December 2016 and subsequently agreed by the IJB. This paper established the concept of the locality hub model based on 'red, yellow, green' hubs depending on their purpose and function. Since then work has progressed to further redefine the hub models within Angus.

4. PROPOSALS

Primary Care Transformation Programme

The principles of a plan proposing the new model of service provision meeting the recommendations from Transforming Urgent Care and the Tayside Primary Care Strategic Framework are progressing.

A meeting with the Locality Improvement Leads and Chairs for Angus was held on 29 May 2017 to discuss potential site options. Following this each Locality Improvement Group will have the opportunity to review and a final list of options for the above model in Angus will be presented to the Strategic Planning Group for approval to proceed to Option Appraisal.

Work towards having similar multi-agency models of care across Tayside will be progressed and developed in line with the needs of the local population.

5. FINANCIAL IMPLICATIONS

Out of Hours

OOH has an annual budget of c£7m with end of year projections that the service will have achieved its savings targets and ended the year circa £174k overspent as a result of ongoing challenges in covering GP rotas and ensuring a safe level of care is provided across Tayside.

As hosted services, a process for financial risk sharing is in place.

Review of Minor Injury and Illness Service in Angus

Financial assessment of the proposed configuration of models will form part of the Option Appraisal. At the November 2016 Strategic Planning Group meeting it was agreed that £170k of recurring budgets should be released by the planned review of the minor injury and illness service to be offset against the Partnership's savings targets.

6. OTHER IMPLICATIONS (If Applicable)

RISK

Recent and current performance against this risk is highlighted in the table below.

Datix Ref	**Risk Title**	**Lead Director**	**Inherent Risk Exposure**	**Feb 2016**	**June 2016**	**Aug 2016**	**Dec 2016**	**April 2017**
353	Sustainable Primary Care Services	Chief Officer Angus HSCP	20 (5x4) Very High	12 (4x3) High	12 (4x3) High	12 (4x3) High	9 (3x3) High	12 (4x3) High

REPORT AUTHOR: **Jillian Galloway, Head of Prison Healthcare, Custody and Forensic Medical Services and Out of Hours**

EMAIL DETAILS: **hsciangus.tayside@nhs.net**

June 2017

AGENDA ITEM NO 16

REPORT NO IJB 36/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

ADULT SUPPORT AND PROTECTION IN ANGUS

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This report is to brief members of the IJB on progress on Adult Support and Protection in Angus.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) Note the content of this report;

(ii) Direct the Chairperson to bring a further report in 6 months addressing any particular issues identified by members.

2. BACKGROUND

Following a presentation to the IJB in 2016 by the newly appointed Independent Chair of the Angus Adult Support and Protection Committee, Ewen West, it was agreed that 6 monthly reports would be brought to the IJB highlighting areas of progress and risk in the area of ASP.

Adult Support and Protection is a general term covering the laws, policies and legislation in place in Scotland to protect and safeguard adults who meet the “three point test” under the terms of the Adult Support and Protection (Scotland) Act 2007. These are likely to be vulnerable adults known or suspected to be at risk of harm from a third party or from self harm or neglect. The law provides a range of powers and duties as part of the legal framework however adult protection is also about support and relies greatly on the judgement of health and social work professionals to understand the legal framework within which they operate and how best to use this to support adults to make choices, at the same time as protecting them from harm.

Adult Protection is therefore a balance between the rights of the adult and the duty to protect them which can in certain circumstances be conflicting. At times it is necessary to intervene to protect the adult and these decisions require to be made by the local authority who are the lead agency in such matters. However, adults also have the right to make decisions about their own lives which may increase their risk of harm. The adult must therefore remain at the centre of any adult protection intervention, their views must be taken into consideration at all times and there must be benefit to the adult as a result of the adult protection intervention.

3. CURRENT POSITION

In March 2017, the Angus Adult Protection Committee hosted a conference entitled **"Adult Protection - 10 Years On"**, a half day event held in St Andrews Church, Arbroath. In total, **89** members of staff were in attendance at the conference, including elected members, private sector representatives and other Local Authority area representatives. Invited speakers were Dr Ailsa Stewart, University of Strathclyde and Dr Roger A Blake, Lead Clinician General Adult Psychiatry, Angus Health and Social Care Partnership. Their presentations highlighted some of the challenges and successes of Adult Protection Practice at both a national and local level and preceded facilitated discussion sessions. Some of the key learning points from this event have assisted in the development of the 2017/18 ASP Business Plan.

Ensuring adults at risk are safe in all settings but particularly residential care is a key priority for the Committee. In 2017 significant progress has been made in engagement with and offering support to private/independent care providers in Angus. Four Locality based Improvement/Action Planning events have taken place and these will be followed up later in the year with the aim of ensuring that all staff providing care are aware of their duty to recognise harm/neglect and respond appropriately.

Financial Harm in Angus is the focus of the Financial Harm Sub Committee and the Financial Abuse Support Team (FAST). Their work has included engagement with community policing teams, Royal Mail staff, financial institutions, NHS staff and local community groups and remains a very important part of ASP work in Angus.

Future developments for the Committee include:

- Analysis of ASP referrals
- Developing a 2 year programme of self evaluation
- Developing the Protecting People Angus identity and joint working across other 'protection partnerships' including child protection, alcohol and drugs etc.

Members should also be aware that Scottish Government are developing a programme of Adult Support and Protection Inspection and supported self evaluation starting this year. Further information on this is awaited.

The Business Plan for 2017-18 is currently in draft form and will be presented to IJB members for information once finalised. The plan covers the areas outlined above, as well as other ongoing areas of work.

REPORT AUTHOR: **Ewen West, Independent Chair, Angus Adult Protection Committee**

EMAIL DETAILS: **For further information contact Evelyn Burnham, Acting Senior Planning Officer, Adult Protection. BurnhamE@angus.gov.uk or Wendy Hinnie, Workforce Development Officer, Adult and Child Protection. HinnieW@angus.gov.uk**

June 2017

AGENDA ITEM NO 17

REPORT NO IJB 37/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

THE CARERS (SCOTLAND) ACT 2016 IMPLEMENTATION

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

There are a number of changes being introduced by the Carers (Scotland) Act 2016 which are to be implemented from April 2018. The full impact of these changes is not known as the regulations which determine much of the detail of the Act have yet to be provided by the Scottish Government; however, it is anticipated that the Act will impose new demands on services in terms of operational delivery duties and financial support

1. RECOMMENDATION

It is recommended that the Integration Joint Board notes this update on implications for Angus Health and Social Care Partnership (AHSCP) of the Carers (Scotland) Act 2016.

2. BACKGROUND

The Carers (Scotland) Act 2016 is due to commence on 1 April 2018. The Act recognises the immense value of the unpaid care that is provided nationally by Scotland's estimated 759,000 carers (Scottish Health Survey 2013) and the impact that caring can have on individual carers. It furthers the rights of unpaid carers with the intention of ensuring they are better supported and able to continue to care, if they wish to, and have a life alongside their caring role.

Timescales for the introduction of the legislation reflect the significant preparation required in relation to regulation, statutory guidance and on-going monitoring and evaluation. Final decisions have still to be made on a number of regulation-making powers.

The Act has implications for both adult and young carers. This preparation work will be co-ordinated through the Carers Planning & Development Group, which also includes Angus Council's People Directorate, to ensure the regulations relating to young carers are implemented.

3. CURRENT POSITION

The key changes introduced by the Act are as follows:

a) The definition of an unpaid carer has been broadened to include people who intend to provide care as well as those already caring and also clarifies the position of parent carers. There is no longer a requirement that someone provides "substantial and regular" care, which has never had a legal definition.

b) The authority where an unpaid carer lives has a duty to prepare an Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS) for anyone identified, or identifying themselves, as an unpaid carer and willing and able to undertake this role. This duty is irrespective of whether they are deemed eligible for support. The ACSP will replace the current Carer's Assessment and signifies a change of culture as well as process/

terminology. The ACSP identifies personal outcomes and needs and aims to better support unpaid carers. It details the carer's personal circumstances; their ability and willingness to provide care; support that is generally available locally; any support that will specifically be provided to meet needs in accordance with the eligibility criteria; contingency plans; any assistance to be given to prepare an emergency or future plan if these are not in place; whether support should take the form of a short break from caring; and the circumstances in which the plan should be reviewed. Subsequent plans must record the extent to which outcomes have been met. Functions under this section of the Act must be exercised in a manner which encourages equal opportunities and takes account of protected characteristics under equality legislation.

c) The content of the ACSP including arrangements for emergency and/or future care is specified in the Act and there may be further regulation related to circumstances when the Plan will be reviewed.

d) In collaboration and consultation with unpaid carers and their representatives, local eligibility criteria must be established, published by 31 March 2018 and regularly reviewed. The criteria must include both the information/ indicators to be used to assess need, and the locally-defined threshold at which an unpaid carer is deemed eligible for support. These will be applied where needs and outcomes are identified in completing the ACSP/ YCS. The local authority has a duty to support carers who meet the eligible needs threshold and may provide support to meet carers' identified needs at a preventative/early intervention stage where these cannot be met by universal services. Regulation is expected on the process for review of eligibility criteria.

e) Where an unpaid carer does not meet the local eligibility criteria the authority must still detail how it plans to meet their needs and outcomes. The unpaid carer should still have access to preventative/early intervention support e.g. information and advice and universal and community-based services. Local authorities will have a power to provide support in these circumstances if they judge it appropriate. Health & Social Care Partnerships are responsible for adult social care, adult primary health care and unscheduled adult hospital care. It is not clear whether the duties extend to HSCPs.

f) Where there is a duty to provide support, consideration must be given to whether it should include a break from caring, on a regular, temporary or varying basis with authorities having due regard to the desirability of breaks being offered.

g) There is a duty to prepare a Short Break Statement which sets out how carers will be supported to access appropriate breaks from their caring role, with consideration also given to the cared for person and how care is provided to them.

h) Where unpaid carers are provided with support to meet their identified eligible needs this should be offered through the four Self-directed Support Options.

i) Scottish Ministers will provide guidance on time-scales for the preparation of the ACSP where the cared-for person is terminally ill.

j) With the cared-for person's consent, and where appropriate, unpaid carers must be involved in determining the cared-for person's need for support and services.

k) Unpaid carers must be involved in hospital discharge planning for the person they care, or intend to care for.

l) Unpaid carers must be involved in the planning, shaping and reviewing of services.

m) Under the Act a duty to prepare a 3 year local unpaid carers' strategy falls jointly to the local authority and health board. It is not yet clear where this leaves the HSCP which has responsibility for operational delivery. This strategy must set out a range of plans which include; the identification of carers; obtaining information about the extent of carers' needs, timescales for the development of ACSP/YPSP's and monitoring arrangements.

n) There is a duty to maintain an information and advice service for local unpaid carers which is accessible and proportionate to their needs, including those who have one or more protected characteristics.

In addition, the Scottish Government must produce a Carers Charter and is currently consulting on a new Carers Census which will be used to provide baseline data for 2017-18 ahead of implementation of the Carer Act. This will help to evidence the impact of the legislation.

Regulations are already in place to waive charges for support to unpaid carers and this policy will not be affected by the provisions of the Act.

An Angus Implementation Action Plan is in development and will note fuller details of the key changes, and action taken and anticipated in response to the legislation. It links with existing work by the Angus Carers Planning and Development Group, the work of the SDS Programme Board and other stakeholders.

4. PROPOSALS

In preparation for the introduction of the Act partnership work is on-going to:

1. Build a clearer picture of the situation in Angus and test out some of the assumptions that have been made, particularly in relation to the financial implications of the legislation. This involves analysis of the relationships between the preventative services and support provided by the third sector locally and referrals for statutory assessments. This should give a better picture of the actual cost of providing unpaid carers with support and inform development of eligibility criteria which do not exclude them from assistance which can make a difference to the longer term sustainability of care arrangements.

and to:

2. Establish local partnership work streams which reflect the themes of the national expert groups within the Carers (Scotland) Act National programme 2016 -2018, (which includes “regulations and guidance” and “creating the conditions for successful implementation”).

Unpaid carers make a huge contribution in Angus and are a vital resource for AHSCP. The Carers (Scotland) Act 2016 is an opportunity to ensure this vital contribution is valued and sustained.

The Scottish Government has introduced an optional “readiness self-assessment toolkit” to assist with implementation and to monitor progress against key milestones. We intend to apply the toolkit in Angus. This will ensure a planned approach to implementation and support our reporting to the IJB through the Service Delivery Plan reporting arrangements.

5. FINANCIAL IMPLICATIONS

There is £2 million funding in the 2017-18 Scottish Government Budget Bill to assist Integration Authorities and their partners to prepare for commencement of the Act on 1 April 2018. Around £40,000 has been allocated to Angus for building capacity. The Carers Planning and Development Group will decide how best to use the funds to support the implementation of the Act.

There is an expectation that increased awareness about the right to an assessment may increase the demand for both assessment and services at a statutory and preventative level. In its parliamentary evidence submissions at the Bill stage COSLA suggested that a new duty to support unpaid carers would place a significant financial burden on councils at a time when resources have reduced and demand continues to increase.

Carers cannot be charged for any support they receive.

6. OTHER IMPLICATIONS

The full impact of these changes is not known as the regulations which determine much of the detail of the Act have yet to be provided by the Scottish Government and will be co-produced with partners; however, it is anticipated that the Act will impose new demands on services in terms of operational delivery duties and financial support. Some of the main changes are:

- A carer is currently legally defined as someone providing “substantial and regular care”. In the new legislation the definition is much broader and is “an individual who provides or intends to provide care for another individual”. This will result in more people being included in the definition.

- The HSCP currently carry out an SDS carer’s assessment for those carers that we identify through working with service users. Under the new legislation, there is a duty to assess and prepare an adult support plan if a person identified as a carer accepts the offer of a support plan or if an adult meets the definition, that is the HSCP does not need to be involved with the cared-for person.

- In the new Act the responsible authority is the one where the carer lives even if the cared-for person lives elsewhere. This increases the duties for the area in which the carer is resident.

- In the new legislation the HSCP has a duty to provide support to carers in line with local eligibility criteria. The Government is to consult further and issue guidance on this. This is expected to encourage a preventative approach.

- The provision of short breaks from the caring role need to be considered and further guidance on this is to be developed. This could have significant financial implications for the Partnership.

In summary it is likely that more people will be identified or will identify themselves as carers and there will be a duty to provide support in line with local eligibility criteria. Further guidance is awaited from Ministers. It is anticipated that increased funding will be required to meet these legislative changes. Approximately £40,000 has been made available by the Scottish Government for the implementation phase.

It is anticipated that the Act will have implications on equalities and human rights in a positive sense; however, until the publication of the guidance and regulations to support the Act, it remains unclear what the impact will be at this time.

REPORT AUTHOR: Adrian McLaughlin, Principal Officer
EMAIL DETAILS: mclaughlina@angus.gov.uk

June 2017

AGENDA ITEM NO 18

REPORT NO IJB 38/17

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 28 JUNE 2017

COMPLAINTS HANDLING IN RELATION TO INTEGRATED SERVICES

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This report advises Board members of the requirement to have a Complaints Handling Procedure (CHP) in place in relation to Integrated Services.

1. RECOMMENDATION

It is recommended that the Integration Joint Board adopts the attached Complaints Handling Procedure for Integration Joint Boards (Appendix 1).

2. BACKGROUND

Work has been carried out to align the NHS and Social Work Complaints Handling Procedures (CHPs). This will provide clarity and consistency around how complaints which span integrated health and social care services should be handled. From 1 April 2017 both CHPs will have the same processes, with the limited exception of timescale extensions at the frontline stage.

3. CURRENT POSITION

The revised CHPs include guidance for staff around the handling of complaints about integrated services, as well as what to do should they receive a complaint which spans other services that remain the responsibility of the Health Board and Local Authority respectively. The Scottish Public Services Ombudsman (SPSO) published a model template CHP which covers complaints to the Integration Joint Board, for IJBs to adapt and adopt. Following adoption, the adapted template requires to be submitted to the SPSO's Complaints Standards Authority for a compliance check against the model CHP.

REPORT AUTHOR: **Gail Smith**
Head of Community Health & Care Services (North Angus)
EMAIL DETAILS: **hsciangus.tayside@nhs.net**

June 2017

List of Appendices:
Appendix 1 – Complaints Handling Procedure – Angus Integration Joint Board

ANGUS
Health & Social Care
Partnership

Complaints Handling Procedure

Angus Integration Joint Board

June 2017

Angus Integration Joint Board (IJB) Complaints Handling Procedure

Foreword

Our complaints handling procedure (CHP) reflects Angus IJB's commitment to welcoming all forms of feedback including complaints, and using them to improve our services. It seeks to resolve complaints as close as possible to the point of service delivery and to conduct thorough, impartial and fair investigations of complaints so that, where appropriate, we can make evidence-based decisions on the facts of the case.

The procedure introduces a standardised approach to handling complaints across integration authorities, which complies with the SPSO's guidance on a model complaints handling procedure. This procedure aims to help us 'get it right first time'. We want quicker, simpler and more streamlined complaints handling with local, early resolution by capable, well trained staff.

Complaints give us valuable information we can use to continually improve our services, whilst helping us to build positive relationships with people who use our service and rebuild trust when things go wrong.

Resolving complaints early saves time and resource and creates better relationships with people who use our service. Resolving them as close to the point of service delivery as possible means we can deal with them locally and effectively, so they are less likely to escalate to the next stage of the procedure.

The CHP will help us keep the public at the heart of the process, while enabling us to better understand how to improve our service for everyone.

What is a complaint?

Angus Integration Joint Board's (IJB) definition of a complaint is:

> 'An expression of dissatisfaction by one or more members of the public about Angus IJB's action or lack of action, or about the standard of service Angus IJB has provided in fulfilling its responsibilities as set out in the Integration Scheme'.

Issues that are not covered by this definition are likely to be covered by our other CHPs, relating to either our health or social work services.

A complaint may relate to dissatisfaction with:

- Angus IJB's policies
- Angus IJB's decisions
- the administrative or decision-making processes followed by Angus IJB in coming to a decision

This list does not cover everything.

A complaint is **not**:

- a first time request made to Angus IJB
- a request for compensation only
- issues that are in court or have already been heard by a court or a tribunal
- disagreement with a decision where a statutory right of appeal exists
- an attempt to reopen a previously concluded complaint or to have a complaint reconsidered where we have already given our final decision.

We will not treat these issues as complaints, but will instead direct the individual raising them to use the appropriate procedures.

Handling anonymous complaints

We value all complaints. This means we treat all complaints including anonymous complaints seriously and will take action to consider them further, wherever this is appropriate. We will consider anonymous complaints if there is enough information in the complaint to enable us to make further enquiries. If, however, an anonymous complaint does not provide enough information to enable us to take further action, we may decide that we are unable to complete the investigation. Any decision not to pursue an anonymous complaint must be authorised by a senior manager.

If an anonymous complaint makes serious allegations, it will be considered by a senior officer immediately.

If we pursue an anonymous complaint further, we will record the issues as an anonymous complaint on the complaints system. This will help to ensure the completeness of the complaints data we record and allow us to take corrective action where appropriate.

What if the individual does not want to complain?

If an individual has expressed dissatisfaction in line with our definition of a complaint but does not want to complain, tell them that we do consider all expressions of dissatisfaction, and that complaints offer us the opportunity to improve services where things have gone wrong. Encourage the individual raising the issue to submit their complaint and allow us to deal with it through the CHP. This will ensure that they are updated on the action taken and receive a response to their complaint.

If, however, the individual insists they do not wish to complain, we will record the issue as an anonymous complaint. This will ensure that their details are not recorded on the complaints database and that they receive no further contact about the matter. It will also help to ensure the completeness of the complaints data recorded and will still allow us to fully consider the matter and take corrective action where appropriate.

Who can make a complaint?

Anyone who is affected by the decisions made by Angus IJB can make a complaint. This is not restricted to people who receive services through Angus IJB and their relatives or representatives. Sometimes an individual may be unable or reluctant to make a complaint on their own. We will accept complaints brought by third parties as long as the individual has given their personal consent.

Complaints involving the Health & Social Care Partnership or more than one organisation

A complaint may relate to a decision that has been made by the IJB, as well as a service or activity provided by the HSCP. Initially, these complaints should all be handled in the same way. They must be logged as a complaint, and the content of the complaint must be considered, to identify which services are involved, which parts of the complaint we can respond to and which parts are appropriate for the HSCP to respond to. A decision must be taken as to who will be contributing and investigating each element of the complaint, and that all parties are clear about this decision. The final response must be a joint response, taking into account the input of all those involved.

Where a complaint relates to a decision made jointly by the IJB and the Health Board or Local Authority, the elements relating to the IJB should be handled through this CHP. Where possible, working together with relevant colleagues, a single response addressing all of the points raised should be issued.

Should a member of staff who represents the HSCP receive a complaint in relation to the IJB, and they have the relevant and appropriate information to resolve it, they should attempt to do so. If the staff member feels unable to offer a response, the complaint should be passed to the IJB team as early as possible for them to resolve.

If a person complains to Angus IJB about services of another agency or public service provider, but Angus IJB has no involvement in the issue, they will be advised to contact the appropriate organisation directly.

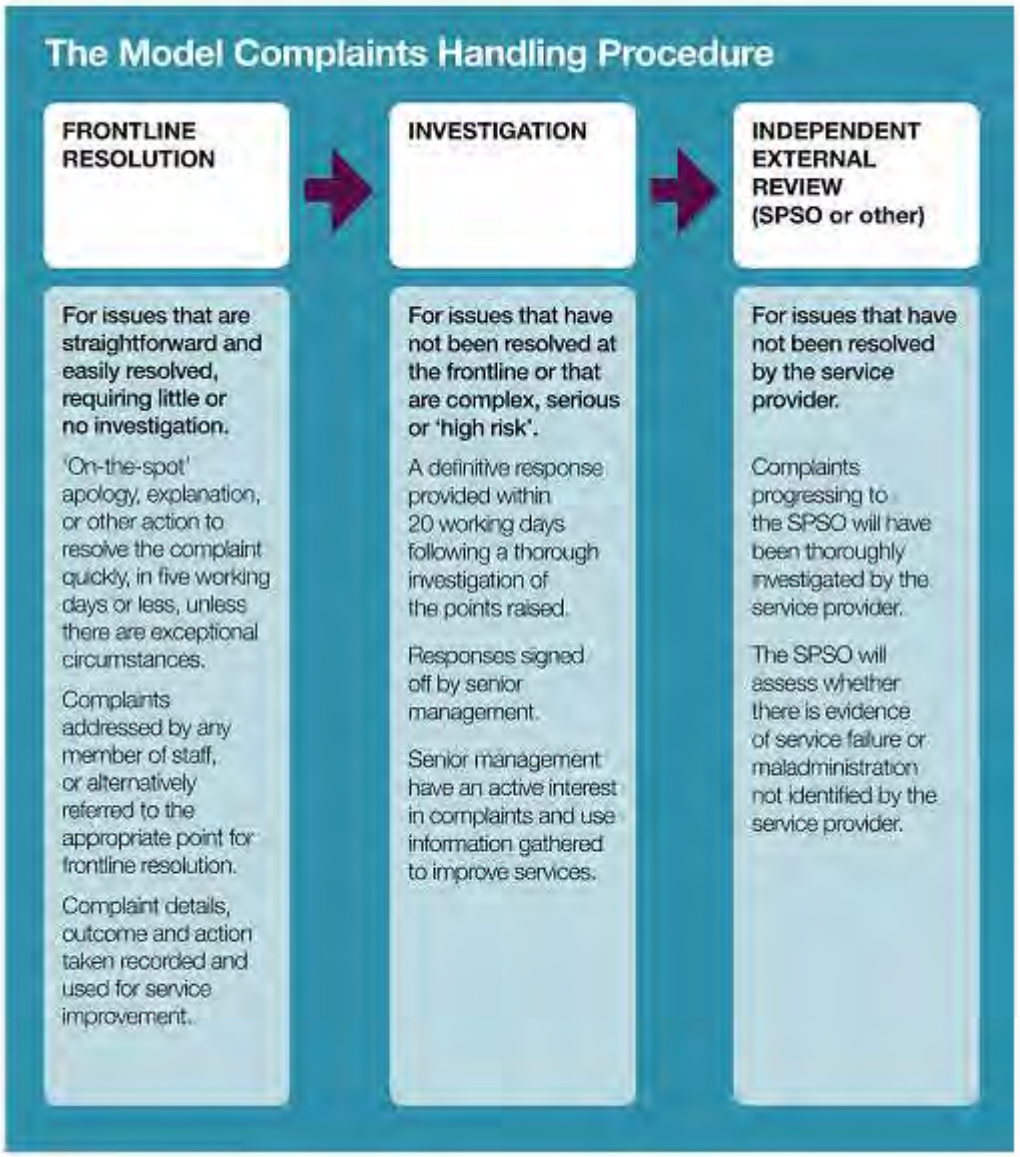
If we need to make enquiries to an outside agency in relation to a complaint we will always take account of data protection legislation and SPSO guidance on handling an individual's personal information. The Information Commissioner has detailed guidance on data sharing and has issued a data sharing code of practice.

The complaints handling process

The CHP aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff.

Our complaints process provides two opportunities to resolve complaints internally:

- **frontline resolution**, and
- **investigation**.



For clarity, the term 'frontline resolution' refers to the first stage of the complaints process. It does not reflect any job description within Angus IJB but means seeking to resolve complaints at the initial point of contact where possible.

Stage one: frontline resolution

Frontline resolution aims to quickly resolve straightforward complaints that require little or no investigation. Any member of staff may deal with complaints at this stage; if the member of staff receiving the complaint is not able to provide a response, then it should be referred on to a more appropriate member of staff.

The main principle is to seek early resolution, resolving complaints at the earliest opportunity. This may mean a face-to-face discussion.

Whoever responds to the complaint, it may be settled by providing an on-the-spot apology where appropriate, or explaining why the issue occurred and, where possible, what will be done to stop this happening again. They may also explain that, as an organisation that values complaints, we may use the information given when we review policies and processes in the future.

A individual can make a complaint in writing, in person, by telephone, by email or online, or by having someone complain on their behalf. Frontline resolution will always be considered, regardless of how the complaint has been received.

What we will do when we receive a complaint

1 On receiving a complaint, we will first decide whether the issue can indeed be defined as a complaint. The individual may express dissatisfaction about more than one issue. This may mean we treat one element as a complaint, while directing them to pursue another element through an alternative route.

2 If we have received and identified a complaint, we will record the details on our complaints system.

3 Next, we will decide whether or not the complaint is suitable for frontline resolution. Some complaints will need to be fully investigated before we can give the complainant a suitable response. A senior officer will escalate these complaints immediately to the investigation stage.

4 Where we consider frontline resolution to be appropriate, we will consider four key questions:

- What exactly is the complaint (or complaints)?
- What does the complainant want to achieve by complaining?
- Can I achieve this, or explain why not?
- If I cannot resolve this, who can help with frontline resolution?

What exactly is the complaint (or complaints)? It is important to be clear about exactly what the individual is complaining about. Staff may need to ask the supplementary questions to get a full picture.
What does the complainant want to achieve by complaining? At the outset, staff will seek to clarify the outcome the complainant wants. Of course, they may not be clear about this, so there may be a need to probe further to find out what they expect and whether they can be satisfied.
Can I achieve this, or explain why not? If staff can achieve the expected outcome by providing an on-the-spot apology or explain why they cannot achieve it, they will do so. If they consider an apology is suitable, they may wish to follow the SPSO's guidance on the subject, which can be found on the SPSO website (https://www.spso.org.uk/). The individual may expect more than we can provide. If their expectations appear to exceed what the organisation can reasonably provide, the officer will tell them as soon as possible in order to manage expectations about possible outcomes. Decisions at this stage may be conveyed face to face or on the telephone or via e-mail. In those instances, you are not required to write to the individual as well, although you may choose to do so. A full and accurate record of the decision reached must be kept, including the information provided to the individual.

If I can't resolve this, who can help with frontline resolution?
If the complaint raises issues which you cannot respond to in full because, for example, it relates to an issue or area of service you are unfamiliar with, pass details of the complaint to more senior staff who will try to resolve it.

Timelines

Frontline resolution must be completed within **five working days** of Angus IJB receiving the complaint, although in practice we would often expect to resolve the complaint much sooner.

Staff may need to get more information or seek advice to resolve the complaint at this stage. However, they will respond to the complainant within five working days, either resolving the matter or explaining that Angus IJB will investigate their complaint.

Extension to the timeline

In exceptional circumstances, where there are clear and justifiable reasons for doing so, senior management may agree an extension of no more than five working days with the complainant. This must only happen when an extension will make it more likely that the complaint will be resolved at the frontline resolution stage.

If, however, the issues are so complex that they cannot be resolved in five days, it will be appropriate to escalate the complaint straight to the investigation stage.

If the individual does not agree to an extension but it is unavoidable and reasonable, a senior manager can still decide upon an extension. In those circumstances, they will then tell the complainant about the delay and explain the reason for the decision to grant the extension.

Such extensions will not be the norm, though, and the timeline at the frontline resolution stage will be extended only rarely. All attempts to resolve the complaint at this stage will take no longer than **ten working days** from the date Angus IJB received the complaint.

The proportion of complaints that exceed the five-day limit will be evident from reported statistics. These statistics will be presented to Angus IJB on a quarterly basis.

Appendix 1 provides further information on timelines.

Closing the complaint at the frontline resolution stage

When staff have informed the individual of the outcome, they are not obliged to write to the individual, although they may choose to do so. The response to the complaint must address all areas that we are responsible for and must explain the reasons for our decision. Staff will keep a full and accurate record of the decision reached. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the frontline stage will be reported to the Angus IJB on a quarterly basis.

When to escalate to the investigation stage

Angus IJB will escalate a complaint to the investigation stage when:

- frontline resolution has been attempted but the individual remains dissatisfied and requests an investigation. This may happen immediately when the decision at the frontline stage is communicated, or some time later
- the individual refuses to take part in frontline resolution
- the issues raised are complex and require detailed investigation
- the complaint relates to serious, high-risk or high-profile issues.

When a previously closed complaint is escalated from the frontline resolution stage, the complaint should be reopened on the complaints system.

We will take particular care to identify complaints that might be considered serious, high risk or high profile. The SPSO defines potential high-risk or high-profile complaints as those that may:

- involve a death or terminal illness
- involve serious service failure, for example major delays in providing, or repeated failures to provide, a service
- generate significant and ongoing press interest
- pose a serious risk to an organisation's operations
- present issues of a highly sensitive nature, for example concerning:
  - a particularly vulnerable person
  - child protection.

Stage two: investigation

Not all complaints are suitable for frontline resolution and not all complaints will be satisfactorily resolved at that stage. Complaints handled at the investigation stage of the complaints handling procedure are typically complex or require a detailed examination before we can state our position. These complaints may already have been considered at the frontline resolution stage, or they may have been identified from the start as needing immediate investigation.

An investigation aims to establish all the facts relevant to the points made in the complaint and to give the complainant a full, objective and proportionate response that represents our final position.

What we will do when we receive a complaint for investigation

It is important to be clear from the start of the investigation stage exactly what is being investigated, and to ensure that all involved – including the individual - understand the investigation's scope. It may be helpful for an investigating officer to discuss and confirm these points with the individual at the outset, to establish why they are dissatisfied and whether the outcome they are looking for sounds realistic.

In discussing the complaint with the individual, the investigating officer will consider three key questions:

1. What specifically is the complaint or complaints?
2. What does the complainant want to achieve by complaining?
3. Are the complainant's expectations realistic and achievable?

It may be that the individual expects more than we can provide. If so, our staff will make this clear to them as soon as possible.

Where possible we will also clarify what additional information we will need to investigate the complaint. The individual may need to provide more evidence to help us reach a decision.

Details of the complaint must be recorded on the system for recording complaints. Where appropriate, this will be done as a continuation of frontline resolution. The details must be updated when the investigation ends.

If the investigation stage follows attempted frontline resolution, staff will ensure that all relevant information will be passed to the officer responsible for the investigation, and record that they have done so.

Timelines

The following deadlines are appropriate to cases at the investigation stage:

- complaints must be acknowledged within **three working days**
- Angus IJB will provide a full response to the complaint as soon as possible but not later than **20 working days** from the time they received the complaint for investigation.

Extension to the timeline

Not all investigations will be able to meet this deadline. For example, some complaints are so complex that they require careful consideration and detailed investigation beyond the 20-day limit. However, these would be the exception and we will always try to deliver a final response to a complaint within 20 working days.

If there are clear and justifiable reasons for extending the timescale, senior management will set time limits on any extended investigation, as long as the complainant agrees. They will keep the individual updated on the reason for the delay and give them a revised timescale for completion. If the individual does not agree to an extension but it is unavoidable and reasonable, then senior management can consider and confirm the extension. The reasons for an extension might include the following:

- Essential accounts or statements, crucial to establishing the circumstances of the case, are needed from staff, individuals or others but they cannot help because of long-term sickness or leave.
- Further essential information cannot be obtained within normal timescales.
- Operations are disrupted by unforeseen or unavoidable operational circumstances, for example industrial action or severe weather conditions.
- The individual has agreed to mediation as a potential route for resolution.

These are only a few examples, and senior management will judge the matter in relation to each complaint. However, an extension would be the exception and we will always try to deliver a final response to the complaint within 20 working days.

As with complaints considered at the frontline stage, the proportion of complaints that exceed the 20-day limit will be evident from reported statistics. These statistics will be presented to Angus IJB on a quarterly basis.

Appendix 1 provides further information on timelines.

Mediation

Some complex complaints, or complaints where individuals and other interested parties have become entrenched in their position, may require a different approach to resolving the complaint. Where appropriate, we may consider using services such as mediation or conciliation using suitably trained and qualified mediators to try to resolve the matter and to reduce the risk of the complaint escalating further.

Mediation will help both parties to understand what has caused the complaint, and so is more likely to lead to mutually satisfactory solutions.

If Angus IJB and the individual agree to mediation, revised timescales will need to be agreed.

Closing the complaint at the investigation stage

We will inform the individual of the outcome of the investigation, in writing or by their preferred method of contact. This response to the complaint will address all areas that we are responsible for and explain the reasons for the decision. We will record the decision, and details of how it was communicated to the individual, on the system for recording complaints. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the investigation stage will be reported to the Angus IJB on a quarterly basis.

In responding to the individual, we will make clear:

- their right to ask SPSO to consider the complaint

- the time limit for doing so, and
- how to contact the SPSO.

Independent external review

Once the investigation stage has been completed, the individual has the right to approach the SPSO if they remain dissatisfied. The SPSO considers complaints from people who remain dissatisfied at the conclusion of our complaints procedure. The SPSO looks at issues such as service failures and maladministration (administrative fault), as well as the way we have handled the complaint.

We will use the wording below to inform individuals of their right to ask SPSO to consider the complaint. The SPSO provides further information for organisations on the Valuing Complaints website. This includes details about how and when to signpost individuals to the SPSO.

Information about the SPSO

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. This includes complaints about the Scottish Government, NDPBs, agencies and other government sponsored organisations. If you remain dissatisfied with an organisation after its complaints process, you can ask the SPSO to look at your complaint. The SPSO cannot normally look at complaints:

- where you have not gone all the way through the organisation's complaints handling procedure
- more than 12 months after you became aware of the matter you want to complain about, or
- that have been or are being considered in court.

The SPSO's contact details are:

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Freepost SPSO

Freephone: **0800 377 7330**
Online contact **www.spso.org.uk/contact-us**
Website: **www.spso.org.uk**

Governance of the Complaints Handling Procedure

Roles and responsibilities

As per the Public Bodies (Joint Working) Act and as specified within the integration authority's Integration Scheme, the Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the integration authority. In line with this, overall responsibility and accountability for the management of complaints lies with the Chief Officer.

Our final position on a complaint must be signed off by an appropriate senior officer and we will confirm that this is our final response. This ensures that our senior management own and are accountable for the decision. It also reassures the individual that their concerns have been taken seriously.

Chief Officer:

The Chief Officer provides leadership and direction in ways that guide and enable us to perform effectively across all services. This includes ensuring that there is an effective complaints handling procedure, with a robust investigation process that demonstrates how we learn from the complaints we receive. The Chief Officer may take a personal interest in all or some complaints, or may delegate responsibility for the CHP to appropriate members of the Executive Management Team of the Health & Social Care Partnership. Regular management reports assure the integration authority of the quality of complaints performance.

Members of the Executive Management Team:

Members of the Executive Management Team of the Health & Social Care Partnership may be responsible for:

- managing complaints and the way we learn from them
- overseeing the implementation of actions required as a result of a complaint
- investigating complaints
- deputising for the Chief Officer on occasion.

However, members of the Executive Management Team may decide to delegate some elements of complaints handling (such as investigations and the drafting of response letters) to other senior staff. Where this happens, senior management should retain ownership and accountability for the management and reporting of complaints. They may also be responsible for preparing and signing decision letters to individuals, so they should be satisfied that the investigation is complete and their response addresses all aspects of the complaint.

Heads of Service:

Heads of Service may be involved in the operational investigation and management of complaints handling. As senior officers they may be responsible for preparing and signing decision letters to individuals, so they should be satisfied that the investigation is complete and their response addresses all aspects of the complaint.

Complaints investigator:

The complaints investigator is responsible and accountable for the management of the investigation. They may work in a service delivery team or as part of a centralised service team, and will be involved in the investigation and in co-ordinating all aspects of the response to the individual. This may include preparing a comprehensive written report, including details of any procedural changes in service delivery that could result in wider opportunities for learning across the organisation.

All staff:

A complaint may be made to any member of staff in Angus IJB. So all staff must be aware of this CHP and how to handle and record IJB complaints at the frontline stage. They should also be aware of who to refer a complaint to, in case they are not able to personally handle the matter. We encourage all staff to try to

resolve complaints early, as close to the point of service delivery as possible, and quickly to prevent escalation.

Angus IJB's SPSO liaison officer:

Our SPSO liaison officer's role may include providing complaints information in an orderly, structured way within requested timescales, providing comments on factual accuracy on our behalf in response to SPSO reports, and confirming and verifying that recommendations have been implemented.

Complaints about senior staff

Complaints about senior staff can be difficult to handle, as there may be a conflict of interest for the staff investigating the complaint. When serious complaints are raised against senior staff, it is particularly important that the investigation is conducted by an individual who is independent of the situation. We must ensure we have strong governance arrangements in place that set out clear procedures for handling such complaints, including the handling of complaints about the Chief Officer.

Recording, reporting, learning and publicising

Complaints provide valuable feedback. One of the aims of the complaints handling procedure is to identify opportunities to improve services across Angus IJB. We must record all complaints in a systematic way so that we can use the complaints data for analysis and management reporting. By recording and using complaints information in this way, we can identify and address the causes of complaints and, where appropriate, identify opportunities for improvements.

Recording complaints

To collect suitable data it is essential to record all complaints in line with SPSO minimum requirements, as follows:

- the complainant's name and address
- the date the complaint was received
- the nature of the complaint
- how the complaint was received
- the date the complaint was closed at the frontline resolution stage (where appropriate)
- the date the complaint was escalated to the investigation stage (where appropriate)
- action taken at the investigation stage (where appropriate)
- the date the complaint was closed at the investigation stage (where appropriate)
- the outcome of the complaint at each stage
- the underlying cause of the complaint and any remedial action taken.

We have structured systems for recording complaints, their outcomes and any resulting action.

Reporting of complaints

Complaints details are analysed for trend information to ensure we identify procedural failures and take appropriate action. Regularly reporting the analysis of complaints information helps to inform improvement actions.

We publish on a quarterly basis the outcome of complaints and the actions we have taken in response. This demonstrates the improvements resulting from complaints and shows that complaints can influence our processes. It also helps ensure transparency in our complaints handling service and will help the public to see that we value their complaints.

We must:

- publicise on a quarterly basis complaints outcomes, trends and actions taken

- where and when possible, use case studies and examples to demonstrate how complaints have led to improvements.

This information should be reported regularly (and at least quarterly) to the integration authority.

Learning from complaints

At the earliest opportunity after the closure of the complaint, officers involved in handling the complaint will make sure that the individual and relevant staff in the integration authority understand the findings of the investigation and any recommendations made.

Senior management will review the information gathered from complaints regularly and consider whether processes could be improved or internal policies and procedures updated.

As a minimum, we must:

- use complaints data to identify the root cause of complaints
- take action to reduce the risk of recurrence
- record the details of corrective action in the complaints file, and
- systematically review complaints performance reports to improve processes.

Where we have identified the need for improvement:

- the action needed to improve services must be agreed by the integration authority
- senior management will designate the 'owner' of the issue, with responsibility for ensuring the action is taken
- a target date must be set for the action to be taken
- the designated individual must follow up to ensure that the action is taken within the agreed timescale
- where appropriate, performance should be monitored to ensure that the issue has been resolved
- we must ensure that the integration authority learns from complaints.

Processes to ensure that actions are undertaken following learning from complaints or investigations and a follow-up review to assess their effectiveness needs to be in place. This will be addressed through R3/R2 Governance Groups.

Publicising complaints performance information

We also report on our performance in handling complaints annually in line with SPSO requirements. This includes performance statistics showing the volumes and types of complaints and key performance details, for example on the time taken and the stage at which complaints were resolved.

Maintaining confidentiality

Confidentiality is important in complaints handling. It includes maintaining the complainant's confidentiality and explaining to them the importance of confidentiality generally. We must always bear in mind legal requirements, for example, data protection legislation, as well as internal policies on confidentiality and the use of individual's information.

Managing unacceptable behaviour

People may act out of character in times of trouble or distress. The circumstances leading to a complaint may result in the complainant acting in an unacceptable way. Individuals who have a history of challenging or inappropriate behaviour, or have difficulty expressing themselves, may still have a legitimate grievance.

An individual's reasons for complaining may contribute to the way in which they present their complaint. Regardless of this, we must treat all complaints seriously and properly assess them. However, we also recognise that the actions of individuals who are angry, demanding or persistent may result in unreasonable demands on time and resources or unacceptable behaviour towards our staff. We will, therefore, work with the Health Board and the Council to apply the relevant organisational policies and procedures to protect staff from unacceptable behaviour such as unreasonable persistence, threats or offensive behaviour. Where a decision is made to restrict access to an individual under the terms of an unacceptable actions policy, the relevant procedure will be followed to communicate that decision, notify the individual of a right of appeal, and review any decision to restrict contact with us. This will allow the individual to demonstrate a more reasonable approach later.

Supporting the complainant

All members of the community have the right to equal access to our complaints handling procedure. Individuals who do not have English as a first language may need help with interpretation and translation services, and other individuals may have specific needs that we will seek to address to ensure easy access to the complaints handling procedure.

We must always take into account our commitment and responsibilities to equality. This includes making reasonable adjustments to our processes to help the individual where appropriate.

Several support and advocacy groups are available to support individuals in pursuing a complaint and individuals should be signposted to these as appropriate.

Time limit for making complaints

This complaints handling procedure sets a time limit of six months from when the individual first knew of the problem, within which time they may ask us to consider the complaint, unless there are special circumstances for considering complaints beyond this time.

We will apply this time limit with discretion. In decision making we will take account of the Scottish Public Services Ombudsman Act 2002 (Section 10(1)), which sets out the time limit within which a member of the public can normally ask the SPSO to consider complaints. The limit is one year from when the person first knew of the problem they are complaining about, unless there are special circumstances for considering complaints beyond this time.

If it is clear that a decision not to investigate a complaint will lead to a request for external review of the matter, we may decide that this satisfies the special circumstances criteria. This will enable us to consider the complaint and try to resolve it.

Appendix 1 - Timelines

General

References to timelines throughout the complaints handling procedure relate to working days. When measuring performance against the required timelines, we do not count non-working days, for example weekends, public holidays and days of industrial action where our service has been interrupted.

Timelines at frontline resolution

We will aim to achieve frontline resolution within five working days. The day the Chief Officer receives the complaint is day 1. Where they receive it on a non-working day, for example at the weekend or on a public holiday, day 1 will be the next working day.

Day 1	Day 2	Day 3	Day 4	Day 5

Day 1: Day Angus IJB receives the complaint, or next working date if date of receipt is a non-working day.		**Day 5:** Frontline resolution achieved or complaint escalated to the investigation stage.

[*The date of receipt will be determined by the organisation's usual arrangements for receiving and dating of mail and other correspondence.]*

Extension to the five-day timeline

If Angus IJB has extended the timeline at the frontline resolution stage in line with the procedure, the revised timetable for the response will take no longer than 10 working days from the date of receiving the complaint.

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10

Day 1: Day Angus IJB receives the complaint, or next working date if date of receipt is a non-working day.		In a few cases where it is clearly essential to achieve early resolution, Angus IJB may authorise an extension within five working days from when the complaint was received. They must conclude the frontline resolution stage within 10 working days from the date of receipt, either by resolving the complaint or by escalating it to the investigation stage.		**Day 10:** Frontline resolution achieved or complaint escalated to the investigation stage.

Transferring cases from frontline resolution to investigation

If it is clear that frontline resolution has not resolved the matter, and the complainant wants to escalate the complaint to the investigation stage, the case must be passed for investigation without delay. In practice this will mean on the same day that the complainant is told this will happen.

Timelines at investigation

Angus IJB may consider a complaint at the investigation stage either:

- after attempted frontline resolution, or
- immediately on receipt if they believe the matter to be sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Acknowledgement

All complaints considered at the investigation stage must be acknowledged within **three working days** of receipt. The date of receipt is:

- the day the case is transferred from the frontline stage to the investigation stage, where it is clear that the case requires investigation, or
- the day the complainant asks for an investigation after a decision at the frontline resolution stage. It is important to note that a complainant may not ask for an investigation immediately after attempts at frontline resolution, or
- the date Angus IJB receives the complaint, if it is sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Investigation

Angus IJB will respond in full to the complaint within **20 working days** of receiving it at the investigation stage.

The 20-working day limit allows time for a thorough, proportionate and consistent investigation to arrive at a decision that is objective, evidence-based and fair. We have 20 working days to investigate the complaint, regardless of any time taken to consider it at the frontline resolution stage.

Day 1	Day 5	Day 10	Day 15	Day 20

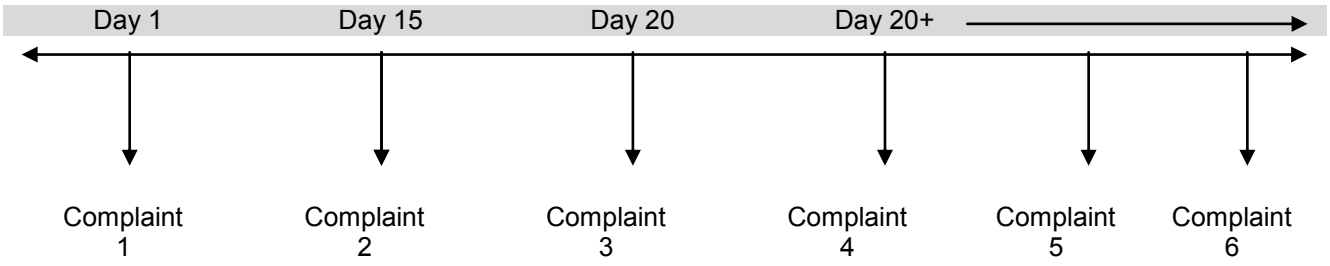
Day 1: Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.		**Day 20:** The decision issued to complainant or agreement reached with them to extend deadline

Exceptionally you may need longer than the 20-day limit for a full response. If so, the Chief Officer (or relevant Head of Service) will explain the reasons to the complainant, and agree with them a revised timescale.

Day 1	Day 5	Day 10	Day 15	Day 20+

Day 1: Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.		**By Day 20:** In agreement with the complainant where possible, decide a revised timescale for bringing the investigation to a conclusion.	**By agreed date:** Issue our final decision on the complaint

Timeline examples
The following illustration provides examples of the point at which we conclude our consideration of a complaint. It is intended to show the different stages and times at which a complaint may be resolved.



The circumstances of each complaint are explained below:

Complaint 1

Complaint 1 is a straightforward issue that may be resolved by an on-the-spot explanation and, where appropriate, an apology. Such a complaint can be resolved on day 1.

Complaint 2

Complaint 2 is also a straightforward matter requiring little or no investigation. In this example, resolution is reached at day three of the frontline resolution stage.

Complaint 3

Complaint 3 refers to a complaint that we considered appropriate for frontline resolution. We did not resolve it in the required timeline of five working days. However, we authorised an extension on a clear and demonstrable expectation that the complaint would be satisfactorily resolved within a further five days. We resolved the complaint at the frontline resolution stage in a total of eight days.

Complaint 4

Complaint 4 was suitably complex or serious enough to pass to the investigation stage from the outset. We did not try frontline resolution; rather we investigated the case immediately. We issued a final decision to the complainant within the 20-day limit.

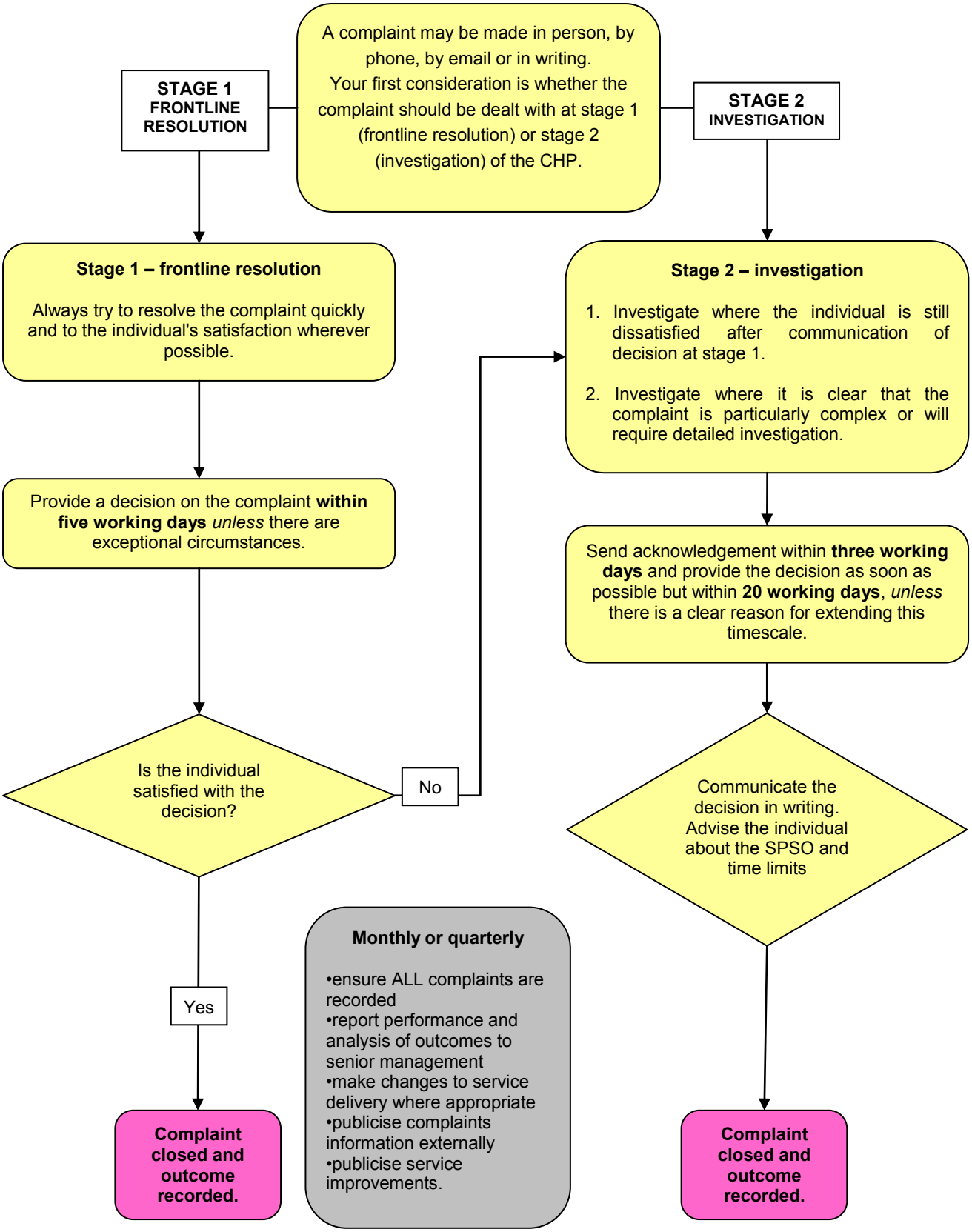
Complaint 5

We considered complaint 5 at the frontline resolution stage, where an extension of five days was authorised. At the end of the frontline stage the complainant was still dissatisfied. At their request, we conducted an investigation and issued our final response within 20 working days. Although the end-to-end timeline was 30 working days we still met the combined time targets for frontline resolution and investigation.

Complaint 6

Complaint 6 was considered at both the frontline resolution stage and the investigation stage. We did not complete the investigation within the 20-day limit, so we agreed a revised timescale with the individual for concluding the investigation beyond the 20-day limit.

Appendix 2 - The complaints handling procedure



Annex 1

Who your complaint should be directed to:

1. <u>If your complaint is in relation to Angus Integration Joint Board</u>: e.g.

- Angus IJB's policies
- Angus IJB's decisions
- The administrative or decision-making processes followed by Angus IJB in coming to a decision

You should contact:

Complaints Team
Angus IJB
St. Margaret's House
Orchardbank Business Park
Forfar
DD8 1WS
Telephone: 01307 474842
Email: hsciangus.tayside@nhs.net

2. <u>If your complaint is in relation to Health Services:</u> e.g.

- your care and/or treatment
- delays
- a failure to provide a service
- an inadequate standard of service
- a lack of information and clarity about appointments
- difficulty in making contact with us for appointments or queries
- treatment by or attitude of a member of staff
- scheduled or unscheduled ambulance care
- transport concerns, either to, from or within the healthcare environment
- environmental or domestic issues
- operational and procedural issues
- our failure to follow the appropriate processes
- your dissatisfaction with our policy

You should contact:

NHS Tayside Complaints and Feedback Team
Ninewells Hospital
Dundee
DD1 9SY
Telephone: 0800 027 5507
Email: feedback.tayside@nhs.net

3. <u>If your complaint is in relation to Social Care Services</u>:

To make a complaint about a social work service, please speak to the person you normally deal with in social work, or to their manager. You can also complete an online form.

Anyone can make a complaint to us, including the representative of someone who is dissatisfied with our service. We can take complaints from a friend, relative, or an advocate, if you have given us your written consent.

If you are not happy with how your complaint has been dealt with, you can have it recorded and investigated independently. This is called a stage two complaint. You can do this by writing to us at:

Chief Executive
Angus House
Orchardbank Business Park
Forfar
DD8 1BX.