GREATER GLASGOW HEALTH BOARD

MENTAL HEALTH STRATEGY

MODERNISING MENTAL HEALTH SERVICES
CONSULTATION PAPER

NOVEMBER 1999
SECTION 1: BACKGROUND

In September 1997 the Scottish Office issued a National Framework for Mental Health Services requiring health boards, in partnership with local authorities, to undertake a strategic review of mental health services and prepare a Joint Strategy covering a 6 year period.

At its May 1999 meeting, the Board approved a Joint Mental Health Strategy which set out the future direction for mental health services in Greater Glasgow (Board Paper 99/2 attached at Appendix1).

The Strategy recognised that further work was required to establish the precise configuration of services. It therefore committed the Board, working with the Greater Glasgow Primary Care NHS Trust and Local Authorities, to undertake a major review of mental health in-patient services with the aim of modernising the service. This review was set firmly in the context of planning future in-patient services within the comprehensive network of mental health provision and with the objective of addressing the balance between:

- hospital and community based services;
- health and social care services;
- different geographic sectors of Greater Glasgow.

SECTION 2: PURPOSE OF CONSULTATION PAPER

The purpose of this paper is to describe in detail significant proposals for change to the current pattern of mental health services and to seek a wide range of views on these proposed changes. The major proposals can be summarised as:

- a significant further development of the network of community based teams for adults and elderly. Establishing the teams as the co-ordinators of services for the severely mentally ill, linking into the rest of the system of care;
- reducing the role of the NHS in the provision of beds for continuing care and adopting a dispersed model of service, not based on hospital sites;
- revenue and capital investment in in-patient services, a reduction to the number of acute sites and the closure of Leverndale and Parkhead hospitals to be replaced by new facilities;
- the redevelopment of elderly mental health acute and assessment facilities and their co-location with general medical services for the elderly;
- addressing the balance between health and social care provision by investing considerable additional resources in social care services to better support and maintain people with mental health problems in the community;
- the development of a number of more specialist components of service, including addiction services, services for women with post-natal depression, services for younger people with dementia, eating disorders and alcohol related brain damage.
Why change?

The rationale for the changes in each component of service is detailed in Sections 4, 5 and 6. There are, however, a number of common issues underlying the proposals. These include:

- the poor quality of much of the existing mental health in-patient estate and the need to ensure that future acute admission services are provided in modern and purpose-built accommodation;
- a significant deficit in the quality and range of therapeutic interventions available in in-patient settings;
- major gaps in the services needed to move people from in-patient care to alternative places in the community and the need to develop a range of intermediary and community support facilities;
- the need for greater continuity of care management between in-patient and community based services and between health and social care services to promote more effective use of in-patient services.

The detailed proposals presented in this paper are a whole system response to these issues.

SECTION 3: PROCESS OF DEVELOPMENT OF THE PROPOSALS

The detailed proposals were developed during the summer of 1999 by a multi-disciplinary and multi-agency steering group involving the Health Board, the Greater Glasgow Primary Care NHS Trust and Glasgow City Council. The other local authorities were involved in aspects of the more detailed work around the proposed service models and kept appraised of progress through the Greater Glasgow Mental Health Steering Group. The work involved:

- a major review of the current in-patient services carried out by the Greater Glasgow Primary Care NHS Trust;
- an audit of all patients in acute admission (both adult and elderly);
- a comprehensive analysis of the functioning of community based mental health services, including the key functions of assertive outreach, support to primary care and crisis/out of hours services;
- the development of a proposed model for elderly mental health services by the Primary Care Trust setting out the functionality and key elements of service;
- a detailed audit of supported accommodation provision within Glasgow City Council;
- a review of future levels of NHS continuing care provision and alternative social care services;
- the specification of key elements of alternative services, including rehabilitation, step-down arrangements and enhanced day support.
The Steering Group commissioned a number of groups to focus on particular issues. The separate papers they produced which inform the final proposals and provide a platform for developing future detailed implementation plans are listed as Appendix 2. These combine a critical evaluation of existing data sources, major surveys relating to specific aspects of service, eg, current in-patients, community mental health teams and supported accommodation.

Three seminars with a North and South focus were held involving a wide range of stakeholders including Consultant Psychiatrists, nursing staff, local authorities, GPs and service users. The Scottish Centre for Mental Health Development and the Dementia Services Development Centre provided support and advice.

There are a number of points of detail concerning the proposals set out in the document which will be discussed further with local authorities during the consultation. These include:

- joint operational working;
- Social Work input into elderly CMHTs;
- intermediate care arrangements and rehabilitation;
- balances of care between adult and elderly mental health services and health and social care;
- capital provision for social care services.

**SECTION 4: ADULT MENTAL HEALTH SERVICES**

**4.1 Summary**

Current mental health service provision in Greater Glasgow reflects a combination of the historic, the opportunistic and recent attempts to develop a more integrated network of linked service provision. Despite the major strides taken during the 1990s towards a reduced emphasis on institutional models of care there remain significant problems or deficits in mental health service provision. These include:

- critical components of the integrated network of services either missing or inadequately developed which leads to people being inappropriately placed in various parts of the system;
- variation in services between different areas not related to need;
- the provision of services from six psychiatric hospital sites, most of which have significant problems with the estate with in-patient care provided generally in poor quality accommodation;
- very limited specialisation within mental health provision.

This section describes current services and a series of changes under the headings:

- Locality Based Community Networks;
- Out of Hours Services;
- Intensive Community Care;
• Intermediate Facilities;
• Intensive Day Support;
• Social Support and Supported Accommodation;
• Achieving Rehabilitation;
• In-patient Services;
• Specialist Services:
  - Addictions
  - Alcohol Related Brain Damage
  - Services for Women
  - Liaison Psychiatry;
  - Eating Disorders;
  - Adolescent Mental Health;
• Financial Summary;
• Service Configuration and Site Issues.

The proposed changes will involve the reconfiguration of services, enhancing existing services and developing a number of new services to fill identified gaps. In summary these developments include:

• substantial enhancement of community teams to strengthen their ability to co-ordinate care between all the components of the network;
• new services to support a more unwell group of patients in the community. These include partial hospitalisation, step-down facilities, out of hours crisis service, NHS day care;
• enhanced social care services;
• the reconfiguration of in-patient beds;
• the enhancement of addictions and alcohol related beds by 24 places;
• bed management teams linked to both the acute and rehabilitation services;
• enhanced staffing of in-patient services in smaller wards and the delivery of a wider range of therapeutic intervention;
• additional supported accommodation to accommodate the transfer of continuing care patients and new long-stay patients, including people transferring directly from acute in-patient beds.

These proposals are designed to improve the effectiveness of treatment and care and to ensure the transfer of individuals back into their homes in the community with the necessary support services in place.

4.2 Locality Based Community Networks

The network of community based mental health services constitute the core of the mental health system. At the heart of the community networks are multi-agency and disciplinary teams operating on the basis of common protocols and operational procedures.
Mental health in the 1990s in Greater Glasgow has been characterised by the development of a network of locality based mental health teams for the adult population. From 1993 to 1999 a total of 16 adult teams have been established, with total population coverage being achieved with the commissioning of the final four adult centres in 1999/2000. The teams are multi-disciplinary in nature and have established good networks in their communities, although a number of key aspects of their functionality and links with other agencies need to be developed further.

A major review of the functioning of the adult resource centres carried out during the summer of 1999 established that there is a considerable variation between the centres in the number of clients on caseloads, the types of client and the frequency with which they are seen. Overall, 27% of resource centre clients have mood disorders, 17% schizophrenia, 16% neurotic disorders, whilst 33% remain undiagnosed. It is perhaps significant that only 2% of clients being seen within the centres had a diagnosis related to substance misuse and mental ill health. The review found that there was a wide variation in the numbers of contacts per 1,000 population, ranging from 4.9 to 16.2, with the highest rates found in the east and parts of the south of the city. There was, however, a clear correlation between higher levels of contacts and deprivation.

The following recommendations were made by the review to improve and expand the service provided by the CMHT.

- The model of a single, locality based community mental health team should remain. The team should be multi-agency and disciplinary and include social work as an integral part of the team.

- The primary role of the CMHTs in the proposed reconfiguration of mental health services should be to act as the access point to other services, including hospital admission and as the co-ordinator of care.

- The role of the community team should be extended to include the following functions:
  - assessment and advice;
  - assertive outreach;
  - crisis response (in-hours);
  - rapid pick-up of discharge and out of hours patients;
  - prioritisation of patients with severe and enduring mental health problems;
  - long-term commitment to the management of patients with chronic serious mental health problems;
  - specialised therapeutic interventions for a range of clients;
  - support of the wider network, eg, primary care, in matters relating to mental disorders;
  - the roles of CPNs and psychologists should be developed to support the primary care team.

- Entrance and exit systems to the CMHTs require to be tightened and criteria put in place to ensure teams do not spend a disproportionate time in referral and assessment. Clients should be offered alternatives to specialised CMHT care where appropriate.
• Therapeutic intervention should be a key activity in teams with a range of explicit interventions provided by suitably trained and qualified staff.

• Clinical staff should be given responsibility to manage priorities within the team.

• In view of major variations across GGHB in terms of geography, clinical need, deprivation, other services available locally, the team model should have degrees of flexibility in terms of functional splits, opening hours.

• There should be differential resource allocations based on need in each locality.
• The relationship with primary care should be strengthened and made more explicit.

To deliver this service model will require an additional net investment of £1,580K.

4.3 Out of Hours Crisis Service

A consistent theme from service users and carers, which emerged out of the consultation on the Joint Mental Health Strategy, was the need to improve the responsiveness and effectiveness of the out of hours service. This request has also been echoed by GPs. The value of the current emergency (duty doctor) system is recognised and the development of the out of hours crisis response will be in addition and complimentary to this service.

It is proposed that the crisis service be developed incrementally over a period of three years based on yearly review and evaluation. From 2000/01 the service will have the following key features:

• the service based on CPN input will be accessed through the primary care out of hours GEMS service and is open to all patients referred by their GP. Clients will be seen at their local GEMS centre.

• the team will have support from a number of disciplines (medical, social work, standby staff, housing staff);

• the team will provide assessment, support and treatment to clients and their families and arrange follow-up by the local CMHT or other relevant agencies on a next day basis if required;

• the service will offer admission through the duty doctor for patients who, on assessment, may require more intensive treatment;

• there will be user involvement in the planning and continuous development of the service over the next three years. The process of this involvement must be transparent.

To deliver this service model will require an additional net investment of £360K.

4.4 Intensive Community Care

Five NHS partial hospitalisation projects are proposed to provide intensive community based care. This service delivered through the community teams linked to the in-patient service
should offer intensive input to patients either as an alternative to admission to hospital or to reduce their length of stay and facilitate early discharge. The service will be targeted on individuals who develop acute symptoms and require more intensive treatment for a short period. Staffing ratios need to be high, the capacity to administer medicine should be available if required and the therapeutic nature of the input flexible to respond to patient need. The service will be provided both within the community resource centre and in the patient’s own home. It is envisaged due to the intensive nature of the work that not more than 6 places would be offered per partial hospitalisation project. The nature of this service may vary with the particular needs of each sector, eg, provision of informal overnight accommodation in the north and an attached project on the assessment for in-patient care at the point of referral in the south.

To deliver this service model will require an additional net investment of £700K.

4.5 Intermediate Facilities

A new model of community service is proposed for the east and south-east of Glasgow. In the east, the area is characterised by high levels of deprivation, high admission rates for schizophrenia and high levels of homelessness in the in-patient population. Therefore, the level of demand by people with serious mental problems is high. Similar problems exist in the south to a lesser degree coupled with limited move-on facilities and an in-patient unit (Leverndale) twelve miles away from a substantial proportion of its catchment area.

A step-down unit is proposed to facilitate timely discharge from NHS in-patient care for patients who no longer require the degree of nursing and medical care offered within an acute in-patient setting but require intensive interventions from social workers, housing workers, occupational therapists and activity nurses to facilitate their ability to function effectively in the community in appropriate living accommodation.

Whilst the major emphasis in an acute in-patient setting is on alleviating clinical symptoms, patients often have complex needs only one of which is the relief of acute clinical symptoms. Step-down will bring together a group of professionals and agencies to address those needs whilst encouraging and supporting the individual in the move back to their own home. It is envisaged that the maximum length of stay will be three to four months. The unit would allow for a greater degree of medical input than would be available from a CMHT. This service is not limited to specific diagnostic groups but individuals will be characterised by having severe psychiatric disorders, complex social and mental health care needs, a poor network of social care supports and poor social functioning. Although these patients may still require NHS clinical input, this will not be their major need. It is expected this would relieve some of the pressures on in-patient services.

The two units east and south-east would be jointly commissioned health and social care facilities of 10 places and would be accessed only from acute in-patient services.

To deliver this service model will require an additional net investment of £700K.

4.6 Intensive Day Support

There is a need for the development of more supportive day services for people who are acutely unwell and whose lifestyle often prohibits them from accessing structured or vocational projects. Key features of this proposed service would be:
• informality;
• choice;
• opportunity for social contacts;
• availability of low key therapeutic activities.

This model should be available on a fairly informal basis within CMHTs and combine social care with clinical and nursing support. The key area where such support is lacking is in the west Glasgow sector.

To deliver this service model will require an additional net investment of £150K.

4.7 Social Supports and Supported Accommodation

As the pattern of deinstitutionalisation, particularly around the north and east, developed during the 1990’s so an enhanced network of community based social care services was put in place to support people with serious mental health problems in the community. This involved the commissioning of around 360 supported accommodation places, enhanced dementia units, nursing and residential home accommodation places, community support projects ranging from employment schemes through to dementia day units and augmented home care packages. During the period of up to 2000 a total of £14 million has been transferred on a recurrent basis from health to social care to maintain and support the serious and chronically ill in the community.

Although the network of social support services has formed a vital element of the network of care required for people with mental health problems a number of issues require to be addressed as part of the current review and proposals for future configuration:

• the level and range of supported accommodation places, bearing in mind that most places were commissioned for people already in care leaving limited flexibility to meet new demand in the community. A total of 72 new supported accommodation places will be commissioned. Whilst some of these new places will provide accommodation for people being discharged from longer term NHS care, a number will be available for people to be moved through from acute in-patient care;

• the balance of social care support across GGHB recognising that the north and east infrastructure having been developed more intensively than in the south and west;

• the level of social work input into community based mental health services and the greater integration of care management processes;

• the need for day services in the south and west and support for adults with severe and enduring mental health problems as part of a co-ordinated rehabilitation and support function to minimise the number of hospital readmissions and to promote employment opportunities;

• support packages for adults who move from intensive supported accommodation to individual tenancies;

• an increased number of augmented care packages to enable people with severe mental health problems to maintain people in their own homes;
the establishment of home based respite care places across GGHB.

There are currently around 350 supported accommodation places commissioned by Social Work in Greater Glasgow. Supported accommodation is a vital component of the network of mental health services providing both homes for patients being resettled from long-term care as well as offering support in homely environments for people who due to their mental illness are unable to sustain their own homes.

As part of the review, Glasgow City Council Social Work Department undertook a major audit of the 291 supported accommodation places across 28 projects commissioned by the department. The audit found:
- that there was a very high occupancy rate in the projects (94%);
- 61% of clients had previously been in a long-stay hospital;
- 16% of clients had previously been in a short-stay hospital;
- 22% of clients have been in the accommodation for less than one year;
- 63% of clients have been in their accommodation for less than 5 years;
- 37% of clients have been in their accommodation for over 5 years;
- 31% of clients have high support needs;
- 39% of clients have medium support needs;
- 34% of clients have low support needs;
- 9% of clients have accommodation with support needs;
- 27% of clients were considered as having the capacity to move on within one year;
- a further 33% of clients were considered as being likely to be able to move on after 2 years.

The audit demonstrated that there is considerable flexibility within the current supported accommodation arrangements. Notwithstanding this, however, it is clear that there is a need for additional supported accommodation places, particularly with more intensive support. As part of the reconfiguration proposals it is recommended that an additional 72 supported accommodation places are commissioned across GGHB with an equitable spread. This level of new places, plus those places which are likely to become available as a result of existing clients moving on (potential of 175 within two years), will greatly facilitate the ability of the new configuration of services to manage more people with severe and enduring mental health problems in the community.

This programme of social care developments will require additional investment of £4,077K.

4.8 Achieving Rehabilitation

The model of rehabilitation proposed in Greater Glasgow in line with the Framework document will no longer be restricted to services provided within an in-patient setting pre-discharge. The model will be based on the principle of normalisation in which rehabilitation for individuals with severe and enduring mental illness is a continuous process. This will extend across agencies from hospital to community and focus on supporting people to function to the best of their ability within a community setting. This will be a consultant-led service and particular multi-agency and disciplinary specialist skills are required to deliver such a service.
Currently there are 34 hospital based rehabilitation places in Greater Glasgow which are primarily orientated towards resettlement of long-stay patients. Specialist rehabilitation services need to reorient themselves to people in the community, many in supported accommodation to prevent relapse resulting in hospital admission. A modern rehabilitation service should be:

- based in the community with a residential component;
- multi-agency;
- able to deliver a range of responses to meet complex health and social care needs;
- staffed with specially trained staff with a wide range of psychosocial and biomedical expertise.

It is proposed that there should be two specialist rehabilitation teams in Greater Glasgow within a single management system and linked to enhanced discharge teams and CMHTs. The teams will focus not only on supporting discharge but also on maintaining patients in a stable community environment, eg, supported accommodation and identifying relapse at an earlier stage when treatment in the community is possible. The teams would carry some long-term caseload, gatekeep NHS continuing care beds and be a jointly commissioned health and social care service with close links to the network of supported accommodation places. It is expected that the community rehabilitation services would provide support to around 40 people at any one time.

This configuration will result in a net additional investment of £228K.

4.9 **Acute Adult Admission**

Since the early 1990s concentrated efforts have been made to build up the community mental health infrastructure. This has achieved significant successes. The quality and effectiveness of in-patient care now needs to be addressed. This will be the priority focus during the first phases of the implementation of the proposals in this document.

There are six psychiatric hospitals within Greater Glasgow. Recent years have seen a significant increase in the number of admissions to adult acute beds (including IPCU). Admissions to these beds rose from 3,272 in 1993/94 to 3,864 in 1998/99 or by 15.3%. Occupancy rates in the three year period 1996/97 to 1998/99 were consistent across all sectors at between 93 to 95%. During the same period average length of stay in all acute admission sites reduced considerably from around 34 days to the current average of 28 days. The proportion of patients admitted more than once in any given year has remained fairly constant at around 21% over the last five years. It is significant, however, that this group of “revolving door” patients account for around 40% of occupied bed days.

There is wide agreement between the planning partners that wherever practical and possible acute adult admission services should be sited on DGH sites to facilitate good and effective care with other clinical disciplines and to reduce the stigma often associated with dedicated mental health hospital locations.

The purpose of admission to in-patient care is to support and treat those patients whose illness is of such severity and/or whose behaviour is so disturbed they cannot be managed within a community setting.
An important piece of work defining the functionality of adult admission wards was undertaken as part of the review. This work reinforced the message of the national work undertaken by the Sainsbury Centre "Acute Problems" that admission wards were under severe pressure to deal with an ever increasing complexity of case mix and challenging behaviours to deal with, with minimal staffing levels that often afforded the opportunity only for stabilisation and basic care. Levels of therapeutic interventions and effective outcomes are seriously compromised under such conditions. The review, therefore, recommended the following:

- clear criteria and processes for admission and discharge linked into community teams;
- improved staffing ratios and skill mix, particularly for nursing and occupational therapy staff;
- enhanced staff skills and training;
- monitoring and evaluation of therapeutic interventions and evidence based practice;
- the provision of acute in-patient care in smaller ward sizes of 20 beds;
- a reduction of the use of constant observation with more therapies available on and off the ward;
- clear standards and targets for discharge planning;
- identification and implementation of appropriate outcome measures.

A survey of all patients in acute adult mental health beds was carried out by the Trust in August 1999. This survey revealed that out of 356 patients some 79 patients (22.2%) were considered as not requiring the level of care of an acute in-patient facility. This finding reinforces the intuitive sense that the current mental health system for adults does not have a flexible enough range of services between acute in-patients and the community. Another significant finding from the survey related to the fact that current bed management arrangements are extremely diverse with many entry points for admission to acute in-patient care. Significantly, only 100 out of the 356 patients analysed had been admitted with a local community mental health team and social work involvement, with a significant number (29%) being admitted with involvement of neither a CMHT or social work. A critical function of CMHTs (including social work) should relate to co-ordinating access to in-patient facilities, both in terms of managing admissions but also, more importantly, to facilitate earlier discharge. Similarly, the significant number of admissions directly from general hospital A&E departments and acute wards may be reduced by a liaison CPN service to these departments and a general hospital parasuicide service. The survey demonstrates that there is considerable room for improvement in overall bed management.

There is also a recognition that improvements to the functioning of community based services, eg, assertive outreach and the establishment of step-down units to facilitate earlier discharge, will impact on the overall number of acute adult admission beds required. Enhanced community based services and support, including a community based rehabilitation service and additional support team, will be used to target the group of
“revolving door” patients with the aim of reducing multiple admissions, thereby impacting on the overall bed days currently utilised by this group of patients.

The work of Professor John Wing (Epidemiological Based Needs Assessment: Review of Research on Psychiatric Disorder, London, 1991) has been used to establish a comparative benchmark for adult in-patient services. Wing estimates that for a population of 900,000 the following levels of NHS in-patient provision would be appropriate:

- IPCU - 36 places;
- Acute Care/Crisis - 360 places.

In his analysis, Wing includes elderly functional mental illness beds. The above compares to current services in GGHB which have the following bed numbers:

- IPCU - 35 places;
- (Adult and Elderly) Acute/Crisis/Rehab - 482 places.

The work done by the Primary Care Trust as part of the inner cities initiative supports the view that acute in-patient provision in Greater Glasgow is significantly above the average.

On the basis of the comparative evidence and the results of the recent survey there appears to be a case for proposing a small reduction in the overall level of acute admission beds. It is proposed that the number of intensive psychiatric beds be slightly increased from 35 to 36, but that the numbers of acute admission beds be reduced from 326 to 280. In addition, there will be around 100 elderly functional beds which need to be added to the 280 to get a true comparator on the basis of Wing’s analysis.

This configuration will result in a net additional investment of £2,610K.

### 4.10 Addiction Psychiatry Services

As well as those points relating to general adult services, the review identified a significant increase and morbidity in both drug and alcohol abuse and co-morbidity with other psychiatric disorders as well as a high level of people presenting to mental health services through general hospitals. Therefore, a number of more specialist and tertiary mental health services require to be developed to compliment the generic community and in-patient services. Proposed specialist services are described in the following sections.

An increasing issue for mental health services is the co-existing of substance misuse and mental illness. The spectrum of co-morbidity ranges from substance misuse secondary to mental illness to substance misuse resulting in mental illness. Whilst services exist at both ends of the spectrum, the vast majority of co-morbidity lies in between and suffers from a lack of comprehensive services.

At present, services in the city for the groups are scattered across ten sites and lack coherence. In-patient services are spread across four sites with, significantly, no specific drug service in South Glasgow. It is recognised that a more rational approach to this component of the service needs to be developed and the overall number of in-patient beds enhanced from the current 22 with the establishment of a 30 bed specialist unit on a general hospital site servicing the whole of Glasgow. Day services should be on the same site.
Two specialist drug/alcohol teams north/south in the community will work with this in-patient unit to provide an integrated service and link with existing social work services, specialist services in the voluntary and independent sector, local community mental health and forensic teams.

**To deliver this service model will require an additional investment of £322K in in-patient services and £300K in community teams.**

### 4.11 Alcohol Related Brain Damage

Proposals for people with alcohol related brain damage, including Korsakoff's Syndrome, were set out in the Joint Mental Health Strategy. It is proposed to establish two assessment and rehabilitation units, each of 8 beds, with linked day care services. Specialist residential home places will be commissioned by social work to provide longer-term care with a limited number of houses offering accommodation with support available in the community.

**To deliver this service model will require an additional net investment of £1M.**

### 4.12 Services for Women

Work during the preparation of the Joint Mental Health Strategy highlighted a major service gap in the provision of a specialist service for mothers with post-natal depression and their babies. It is proposed that this gap be filled in the future by the provision of one specially designed four-bedded unit in the city. Further work is being done to establish a post-natal disorders network across Glasgow involving health visitors and CPNs. There is also an increasing awareness of the particular needs of women, particularly from ethnic minority backgrounds, and the need to ensure the availability of single sex wards for women who require this facility. Again, the reconfiguration proposals must ensure as a minimum that the design of the new in-patient wards ensures separation of the sexes is possible in bedrooms, day areas and quiet areas.

**To deliver this service model will require an additional net investment of £240K.**

### 4.13 Liaison Psychiatry

Liaison psychiatry is the provision of psychiatric services to general hospital patients. All models of psychiatric liaison services advocate a comprehensive psychiatric team including liaison consultant, psychiatric trainee, CPNs, social worker and psychologist. The core components of such a service will include assessment and management of deliberate self-harm patients and management of patients with psychological problems in acute medical and surgical wards and the A&E departments. Key issues for liaison psychiatry include:

- services for particular clinical problems, such as unexplained physical symptoms;
- services linked to other specialist clinics, eg, pain management, chronic fatigue syndrome;
- liaison links to other major units, eg, transplant units, oncology, neuropsychiatry.

It is proposed to stage the development of liaison services with the first stage of development addressing service provision to A&E departments and parasuicide services. It is proposed to establish 2/3 CPN teams under consultant supervision with additional junior medical staff input, North and South of the river. The teams will deliver a parasuicide assessment service...
and also have input to local A&E departments. To provide out of hours cover the teams would link to the GEMs CPN service.

To deliver this service model will require an additional net investment of £200K.

4.14 Eating Disorder Services

The commissioning of specialist services for eating disorders in Scotland has been patchy and the range of services is widely divergent. The national framework document for mental health services highlights the need for a more co-ordinated approach to service provision.

The Audit Commission (1997) proposed that specialised services should be centrally planned and co-ordinated. They describe a hub and spoke mode with the centralised element providing very specialised in-patient care with feeder clinics providing “franchised” care from the centre. Different clinical services may experience different problems in delivering the service ranging from a lack of therapeutic skills to a lack of specialist beds.

The four tier model proposed in Glasgow consists of initial support providing by the primary care team which would receive training to improve early detection of eating disorders and their treatment. A second tier resource centre service would offer a generic service with specialist input from a nominated team member with a particular interest in this area. A third tier of the service would provide a more specialist input through daycare and optional overnight accommodation. The fourth tier of the service for the small numbers of patients with life threatening disorders would involve ECR referral to a specialist in-patient service.

To deliver this service model will require an additional net investment of £350K.

4.15 Adolescent Mental Health Services

The adolescent in-patient unit at Gartnavel Royal Hospital currently operates with ten staffed beds. The accommodation is in urgent need of upgrading and there has been agreement for a new building. The national strategy is clear that planning for adolescent in-patient provision should be on a regional basis. A process has been set up with all West of Scotland health boards (including clinical representation) to undertake this planning.

Decisions on the number of beds required for an enlarged adolescent unit will depend on a number of factors. The Dumfries Ladyfield adolescent unit is scheduled for closure and this will be taken into account in further plans. In addition, clinical opinion favours increasing the age cut-off to 18 years and this would increase the bed requirement. At least ten additional beds would be required for the new unit commissioned in partnership with other health boards.

Two options are currently being considered, a unit at Gartnavel or Stobhill. In view of the extent of capital work involved it is envisaged that the new development would not be in place for over two years. As the existing Dumfries unit will not be sustainable for that period, arrangements will therefore need to be made for an interim unit.

It is anticipated that the health boards will commission in-patient services as a consortium based on average occupied bed days.
It is assumed that the development of a West of Scotland in-patient services for adolescents will be cost neutral for Greater Glasgow.

4.16 Financial Summary

This section summarises the financial impact of the service proposals outlined in the above.

**Adult Mental Health Developments**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>£'000</th>
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<tbody>
<tr>
<td>Acute In-patient Investments (including Addictions, Alcohol and Services for Women)</td>
<td>4,172</td>
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<tr>
<td>Completion and Enhancement of CMHT Network</td>
<td>1,580</td>
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<td>Out of Hours/Crisis Service</td>
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<td>Intensive Community Care</td>
<td>700</td>
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<td>Intermediary Discharge Facilities x 2</td>
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<td>Intensive Day Support</td>
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<td>Rehabilitation Services</td>
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<tr>
<td>Community Drug/Alcohol Teams</td>
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<td>Liaison Psychiatry</td>
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<tr>
<td>Eating Disorders Service</td>
<td>350</td>
</tr>
<tr>
<td>Development of Social Care Services</td>
<td>4,077</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,817</strong></td>
</tr>
</tbody>
</table>

This assumes 20 bed newbuilt wards with enhanced in-patient nurse staffing and includes reinvestment in replacement long-stay services.

4.17 Service Configuration and Site Issues

The table below shows the current and proposed range and scale of services.

**Adult Mental Health Service Network**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Current</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admission/IPCU</td>
<td>361</td>
<td>316 beds (280 acute and 36 IPCU)</td>
</tr>
<tr>
<td>Drug/Alcohol</td>
<td>22</td>
<td>30 beds</td>
</tr>
<tr>
<td>Adult Continuing Care</td>
<td>206</td>
<td>150 beds (see section 6)</td>
</tr>
<tr>
<td>Younger People with Dementia</td>
<td>0</td>
<td>20 beds (see section 6)</td>
</tr>
<tr>
<td>Alcohol Related Brain Damage</td>
<td>0</td>
<td>16 beds</td>
</tr>
<tr>
<td>Intermediate Facilities - Discharge Units</td>
<td>0</td>
<td>20 beds</td>
</tr>
<tr>
<td>Intensive Community Care</td>
<td>0</td>
<td>30 places</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>34</td>
<td>Up to 40 places Community based service provided by 2 teams.</td>
</tr>
<tr>
<td>Adult CMHTs</td>
<td>16</td>
<td>16 locality based team across GGHB with integrated social work input.</td>
</tr>
<tr>
<td>Drug/Alcohol Teams</td>
<td>0</td>
<td>2 teams, north/south of the river.</td>
</tr>
<tr>
<td>Crisis/Out of Hours Team</td>
<td>-</td>
<td>Dedicated team linking the GEMS.</td>
</tr>
<tr>
<td>Supported Accommodation</td>
<td>358</td>
<td>430 places across GGHB</td>
</tr>
</tbody>
</table>
For a number of these services the geographic configuration is fairly clear. Deciding the future geographic configuration of adult acute beds is more difficult. Set out below for discussion are the tensions and choices described on a north and south basis.

Adult acute admission services, including IPCU and rehabilitation services, are currently provided from 6 sites. The current configuration is:

<table>
<thead>
<tr>
<th>Location</th>
<th>IPCU</th>
<th>Adult Admission</th>
<th>Drug/Alcohol</th>
<th>Rehab</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruchill</td>
<td>6</td>
<td>60</td>
<td></td>
<td></td>
<td>66</td>
</tr>
<tr>
<td>Woodilee/Stobhill*</td>
<td>5</td>
<td>60</td>
<td>8</td>
<td>8</td>
<td>87</td>
</tr>
<tr>
<td>Parkhead</td>
<td>12</td>
<td>80</td>
<td>8</td>
<td>12</td>
<td>112</td>
</tr>
<tr>
<td>Gartnavel</td>
<td>12</td>
<td>60</td>
<td></td>
<td>14</td>
<td>86</td>
</tr>
<tr>
<td>Leverndale</td>
<td>60</td>
<td>22</td>
<td></td>
<td></td>
<td>417</td>
</tr>
</tbody>
</table>

* A newly commissioned 66 bed unit, providing adult admission and IPCU services for north Glasgow, will open at Stobhill Hospital in early 2000. At this stage the 66 beds currently at Woodilee will relocate to Stobhill.

There are major problems with much of the existing estate in which acute in-patient services are provided.

- **Parkhead Hospital**: although only built in the late 1980s Parkhead is of a poor design, land-locked, overcrowded and on three storeys. It is universally considered inappropriate for providing high quality therapeutic psychiatric care.

- **Southern General Hospital**: the 2 adult acute admission wards at the Southern General are located in old, Victorian buildings in an extremely poor state of repair and are again totally unsuited to providing modern mental health services.

- **Gartnavel**: the accommodation at Gartnavel is generally poor, with IPCU and Rehabilitation services provided in old, Victorian buildings and admission facilities in poorly designed wards.

- **Leverndale**: the wards at Leverndale are relatively good but do not have the considerable clinical advantages of being co-located on a DGH site and are not of a standard which will be acceptable in the medium term.

**Options for Future Estate Configuration**

- **South Glasgow**
  - Beds are currently provided on 2 sites, in very poor accommodation at the Southern General and in reasonable accommodation at Leverndale. There is a consensus that a single admission site should serve the whole of the south. Within that framework, 2 endpoint options are possible:
• extend and redevelop the Leverndale site to include the current Southern beds. Results in closure of Southern and a non DGH based service;

• replace the beds on the Southern site, either in a single development to replace Leverndale, or a phased development, dealing first with the overriding priority to replace the sub-standard current facilities. Results in closure of Leverndale.

• Given that Leverndale would require capital investment to modernise its current facilities and to replace the Southern General beds and the benefit of co-location with a general hospital facility, it is the view of the Review Steering Group that:

• a capital plan should be developed to replace the current services at the Southern General and to replace the Leverndale services there, leading to the closure of Leverndale Hospital.

• North Glasgow

On the completion of the Stobhill development, replacing Woodilee, beds will be located on 3 sites:

• Gartnavel, in poor accommodation;
• Stobhill, in new, high quality accommodation;
• Parkhead, in poor and overcrowded accommodation.

There is a clear consensus that:

• Gartnavel needs to be redeveloped;
• Parkhead needs to be replaced.

Seeking views on the options for the replacement of Parkhead is a fundamental issue for consultation. There are essentially 2 options:

Relocate Parkhead services to:

A. a DGH site, Stobhill or the GRI are the obvious local choices;
B. develop a new psychiatric facility in east Glasgow.

The critical factors in weighing up these options are:

• how important is a locally accessible facility, particularly given the high morbidity in the east;
• where is the optimal site of an acute in-patient facility from a clinical and economic perspective;
• is it acceptable and clinically viable to develop a new mental health facility not co-located with a general hospital.
Option A has two distinct sub-options:

GRI Co-location: This would achieve a DGH siting but on a campus which is already intensively developed and is likely to face the same issues of lack of space and congestion which cause such problems at Parkhead. In addition, the economic and clinical issues of retaining a third site in north Glasgow would not be addressed.

Stobhill Co-location: This would achieve a DGH siting on a relatively uncongested site with existing modern mental health services. However, in discussions about the secure care development strong views have been expressed about further development of psychiatric services at Stobhill.

Option B - a rebuilt facility in the East End would resolve the issue of local access but would not deliver co-location. Given the particular benefits for elderly mentally ill patients of achieving co-location (outlined in Section 5.6) it is likely that such a service would be for adults only. This reinforces the issues about critical clinical mass and the economics of small, stand alone facilities.

An intermediate step might to be move elderly services from the current Parkhead site to address the issue of congestion. However, if that was for other than the very short term the financial implications of capital charges and overhead costs falling entirely on a reduced, adult service would be unacceptable.

The view of the Steering Group was that DGH co-location is essential and that 3 separate, adult admission sites for the North Glasgow population are probably not clinically or financially justifiable.
SECTION 5: ELDERLY MENTAL HEALTH SERVICES

5.1 Summary

The future pattern of elderly mental health services seeks to achieve the following 3 main aims:

- an improvement in the recognition, detection and assessment of mental health problems in older people, including dementia;
- an enhanced level of early intervention combined with more effective treatments for people suffering from functional mental illness with an increased ability of services to recognise and respond to adverse effects of treatment;
- an emphasis on the “function” that services perform and on outcomes with a redesign of the relationship between in-patient and community based services.

This section describes current issues and a series of changes under the headings:

- Primary Care Support;
- Locality Based Mental Health Teams;
- Acute In-patient Care;
- Financial Summary;
- Service Configuration and Site Issues.

The proposals for elderly mental health services are based on a continuation of a trend towards community based services. The future pattern of service will be based on:

- a reduction of acute beds from 203 to 160;
- the continuation of the clear separation of functional and organic beds;
- the provision of future services in high quality accommodation in wards of 20 beds;
- higher staffing levels within the wards to promote enhanced therapeutic interventions and effective clinical care
- a strong preference to co-locate acute/assessment mental health beds on District General Hospital sites beside elderly admission services;
- the establishment of discharge co-ordinators and flexible home care services to facilitate discharge of people to community settings as soon as clinically appropriate;
- the enhancement of elderly community mental health teams, including social work posts, to improve links with primary care and assessment in the community.

5.2 Primary Care Support

The key elements of service that need to be enhanced in primary care in the future include the following:
• Enhancing the skills of primary care teams to increase their awareness and ability to detect, recognise and assess mental health problems in older people including dementia. The level at which this element needs to be provided is at Local Health Care Co-operative level in collaboration between the Primary Care Trust and Social Work.

• Improving the physical assessments provided in primary care - this needs to be achieved at the individual practice level and involves improving the abilities of primary care in the physical assessment of older people with mental health problems.

• The development of shared care protocols particularly in the areas of depression and dementia. This should be provided through an agreed template with LHCC protocols.

• The improved management in non-specialist care homes of people with mental health problems and people with dementia. This needs to occur at the practice level.

• An enhancement of prescribing advice to primary care.

The development of these elements within primary care will lead to an improved detection, recognition and assessment of both functional and organic mental illness within primary care settings. This will enable people to be more appropriately responded to within primary care settings and for those who require it referral on and access to more secondary levels of health and social care and support.

**To deliver this service model will require an additional net investment of £300K.**

### 5.3 Locality Based Mental Health Teams

There are four main key elements that need to be enhanced in secondary care locality based services. These are the following:

• An enhancement to the locality mental health teams for the elderly. Each of the 5 locality areas need to have enhanced staffing including:
  - an increase in the number of consultant psychiatrists;
  - an increase in the number of social workers;
  - an increase in the occupational therapy and psychology support in community mental health teams; and,
  - an increase in support working staff.

The functions of locality mental health teams for the elderly are in the following areas:

  - assessment;
  - treatments;
  - social care and support;
  - care plan and management;
  - long-term care and support;
  - emergency responses;
  - training and support to primary care.
There are different models for social work input into the elderly teams with a need to ensure appropriate links into Area Social Work Elderly services. Further discussion will take place with local authorities on the precise organisational relationships of social work provision into elderly mental health teams.

- A more targeted role for day hospitals. This will mean a reduction in the current level of provision and the appropriate redeployment to other day care services and the enhancement of staffing in both health and social work staff for the locality mental health teams for the elderly.

- Enhance the “outreach clinics” to achieve coverage across the whole of Greater Glasgow.

- Improvement in buildings to meet with the ideal of “one stop shops” particularly with improved facilities in the west and south-west.

These enhancements in locality secondary care will improve the following:

- an increase in early intervention response (assessment and services) for older people with mental health problems and dementia;

- an increase in effective treatments particularly for people with functional illness who will receive more effective treatments at more appropriate points in time with improved outcomes;

- an increase in the recognition and response to adverse effects of treatment and a reduction in risks and consequences of mental illness and dementia in the elderly population.

To deliver this service model will require an additional net investment of £350K.

Given the need to improve staffing levels on acute elderly wards and the costs of new capital investment it is proposed to enhance the current level of expenditure for 203 beds of £7.9 million for the 160 beds to be reprovided in the new service by £175K.

5.4 Financial Summary

This section summarises the financial input of the service proposals outlined above.

### Additional Elderly Mental Health Services Investment

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient Beds</td>
<td>175</td>
</tr>
<tr>
<td>CMHT Assessment/Primary Care</td>
<td>300</td>
</tr>
<tr>
<td>Social Work input CMHTs</td>
<td>200</td>
</tr>
<tr>
<td>Improved Discharge Arrangements</td>
<td>150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>825</strong></td>
</tr>
</tbody>
</table>

In addition to these investments, as part of the proposals to reconfigure continuing care services a further £2.8 million is earmarked for elderly mental health services.
5.5 Service Configuration and Site Issues

At present the 203 beds are spread across 4 hospital sites (Stobhill, Parkhead, Gartnavel Royal and Leverndale).

Given a strong clinical preference that elderly mental health admission beds are co-located with general medicine admission services for the elderly on DGH sites, options for the future configuration of acute in-patient services are limited. Pursuing this aim will mean a shift in service from both Parkhead and Leverndale hospitals. The Review Steering Group recommended the following:

- **South Glasgow**
  
  A single service on the site of the DGH for south Glasgow. This will involve the relocation of services from Leverndale Hospital.

- **North Glasgow**
  
  In the north, options revolve around a 2 or 3 site solution.

  The 2 site solution would see the proposed beds for north Glasgow split between Gartnavel and Stobhill hospitals.

  The 3 site option would entail either beds configured at Gartnavel, Stobhill and the GRI or at Gartnavel, Stobhill and a new (greenfield) stand-alone site in east Glasgow. This last option would not meet the objective of close alignment on a DGH site with general medicine services for the elderly.

The 2 site option north of the Clyde emerged as the preferred option for the Review Steering Group. The east would require an enhanced community health presence, allied to the proposed NHS continuing care facility located in a nursing home in this part of the City if this option is implemented.
SECTION 6: NHS CONTINUING CARE

6.1 Summary

In developing plans for the future NHS in-patient the function and number of long-stay places is highly significant because:

- the quality of accommodation in some of our continuing care is not acceptable;
- Glasgow has a high level of continuing care compared to the rest of the UK;
- continuing care beds are significantly more costly than equivalent social care provision and patients who are not discharged do not attract social security benefits;
- dependency studies indicate that the dependency levels of continuing care patients are similar to those of people in nursing and even residential homes;
- occupancy levels for continuing care are low;
- there is significant pressure to place patients in nursing homes, above the planned level of demand;

This section describes current issues and a series of changes under the headings:

- Purpose and Current Services;
- Proposed Services;
- Financial Framework.

The key proposals in respect of NHS continuing care are:

- to reduce the number of adult mental health NHS continuing care beds from 206 to 150;
- to reduce the number of elderly mental health NHS continuing care beds from 533 to 364;
- to provide the majority of future NHS continuing care provision for both adult and elderly people in partnership nursing homes spread across Greater Glasgow and not on hospital sites (with the exception of 90 beds in modern accommodation at Ruchill Hospital);
- to develop a further 72 supported accommodation places and 100 nursing/residential home places and a range of respite and home care services;
- to develop new services for younger people with dementia, including a 20 bed unit within the NHS;
- to ensure future arrangements for commissioning NHS continuing care are flexible and overall numbers are kept under review to allow further adjustments to the overall level in the future.

6.2 Purpose and Configuration of Current Services
The purpose of NHS continuing care is set out in NHS Circular MEL(1996)22. This states that following a clinical assessment by a Consultant Psychiatrist, in conjunction with the multi-disciplinary team, a decision will be taken on whether:

- the patient needs continuing in-patient care arranged and funded by the NHS because:
  - either he or she needs ongoing and regular specialist clinical supervision on account of: the complexity, nature or intensity of his or her health needs, ie, medical, nursing or other clinical needs taken together; or the need for frequent not easily predictable clinical interventions; or where he or she required routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or where he or she has a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision;
  - or offer acute treatment or in-patient palliative care in hospital or hospice his or her prognosis is such that he or she is likely to die in the very near future and discharge from NHS care would be inappropriate, including supported housing;
- the patient needs a period of rehabilitation or recovery arranged by the NHS to prevent discharge arrangements breaking down;
- the patient can be appropriately discharged from NHS care.

It is widely recognised that the majority of people with mental health problems who require continuing care can be met through nursing or residential home provision or by home based treatment and support services. There will, however, be a small number who require specialist nursing and medical treatment/care and/or high levels of support and supervision within an NHS facility.

The NHS contribution to continuing care must be based on a clear sense of therapeutic and/or care benefit and focused on the small group requiring intensive intervention and support. A recent SHRUGS Report (Scottish Human Resource Utilisation Group, Greater Glasgow Primary Care NHS Trust, August 1999) demonstrated that the dependency levels of many people in NHS continuing care provision did not have significant additional treatment and care needs from people in social care provision. This survey revealed that 38% of patients in elderly mental health continuing care beds had a low dependency.

At present the pattern of NHS continuing care provision is as follows:

<table>
<thead>
<tr>
<th>Sector</th>
<th>Adult</th>
<th>Elderly</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>60</td>
<td>124</td>
<td>184</td>
</tr>
<tr>
<td>East</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South</td>
<td>116</td>
<td>259</td>
<td>375</td>
</tr>
<tr>
<td>West</td>
<td>30</td>
<td>150</td>
<td>180</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>206</strong></td>
<td><strong>533</strong></td>
<td><strong>739</strong></td>
</tr>
</tbody>
</table>
Current NHS continuing care provision is spread across a number of sites and is of variable quality. Three broad categorizations of accommodation can be identified:

- good accommodation within private nursing homes commissioned on a partnership basis. This accounts for 289 beds (39%);
- 90 beds (12%) in relatively modern accommodation at Ruchill Hospital;
- 260 beds (49%) in psychiatric hospitals, generally in poor quality accommodation.

During the summer of 1999 the Primary Care Trust undertook a survey of the environment of NHS continuing care beds outwith nursing home partnerships. The key findings were:

- the majority of accommodation was found to be unsatisfactory, with poor accommodation at Leverndale and Gartnavel Royal;
- very few wards had single room accommodation;
- virtually all wards had an absence of space for visitors;
- few wards had space for therapeutic activities;
- the Ruchill wards represented the best accommodation for NHS continuing care in the Trust.

Social work services provide a range of home care and residential care for people with a variety of mental health problems, including dementia. In recent years, around 350 supported accommodation places for adults with mental health problems across Greater Glasgow. In 1998, there were a total of 1900 nursing home places and 440 places in residential homes for people with dementia (Greater Glasgow Joint Mental Health Strategy, May 1999).

It is important to reiterate the significant cost premium in providing NHS continuing care places and, therefore, the opportunity cost for other mental health services.

Since 1993 there has been a sizeable reduction in the number of NHS mental health continuing care beds. Despite this, in both comparative terms and set against nationally accepted bed norms the current level of continuing care beds in Greater Glasgow remains high.

A major benchmarking exercise (May 1998) involving 27 inner city mental health Trusts across the UK indicated that Greater Glasgow had over double the average number of adult continuing care beds and nearly three times the average elderly continuing care beds for mental health.

A recent comparison with Liverpool Health Authority again confirmed a significantly higher level of mental health NHS continuing care provision. For a population of 450,000, Liverpool has 123 continuing care beds covering both the adult and elderly populations. This compares to Greater Glasgow’s 769 for a population of 900,000.
Meltzer (D Meltzer et al, Epidemiologically Based Needs Assessment: Dementia, London, 1992), in his work on elderly mental health bed norms, suggested that a population of 900,000 would require between 276 to 414 NHS continuing care places (including dementia) with an average provision of 345 places.

A joint report from the Royal College of Psychiatrists and Physicians (1996) emphasised the importance of a level of NHS continuing care for older people with mental health problems to ensure direct consultation supervision of this group. The College estimated that for a population of 250,000 a range between 75 and 112 beds (including respite beds) should be available. This would equate to 403 elderly continuing care beds for GGHB at the top of the range and 270 at the lower end.

6.3 Proposed Service

This section describes in more detail the proposed level and arrangements for continuing NHS care.

- **Adult Continuing Care**

  At present, there are 206 adult continuing care beds in the NHS in Greater Glasgow. In terms of predicting future levels of provision. It is proposed to plan future levels of NHS continuing care for adults with mental health problems at 150 places. This is in addition to the proposed supported accommodation places of around 430 places across GGHB.

- **Elderly Continuing Care**

  NHS continuing care provision for elderly people with mental health problems should adhere to a split between organic and functional patients. Single room accommodation is generally preferable.

  Clinical advice indicates that there is no requirement for continuing care to be provided on a DGH site as it is more important that a network of more locally based facilities outwith hospital campuses are available to provide relative ease of access to relatives and friends who wish to visit. Local access is important as people will be staying in these units for a considerable time. This is a particular need in East Glasgow.

  It is important to ensure that NHS continuing care beds are reserved for patients with high dependency needs particularly those with concurrent behavioural problems.

  The “expert” opinion of Meltzer and his colleagues and the work carried out by the Royal College of Psychiatrists indicated that for the GGHB projected elderly population around 350 NHS continuing care places. This compares to the current level of provision of 563 beds. It is proposed to reduce the levels of NHS continuing care for elderly people with mental health problems from 563 to 364.

- **Services for Younger People with Dementia**

  It is increasingly recognised that there is a need to develop a specialist service for younger people with dementia. At present, this group is scattered in an
uncoordinated manner across a range of services without any sense of real care management. At present, the Primary Care Trust and Social Work are working to prepare a detailed service specification for this small but very vulnerable group. The outline of the service is expected to include a 20 place NHS assessment and treatment facility supported by a dedicated specialist social work team to provide enhanced care and support to people in their own homes and in nursing or residential homes.

To deliver this service model will require an additional net investment of £660K.

It is important to recognise that as clinical practice and alternatives to NHS care develop there may be a future need to review the proposed level of provision. To this end the Board will seek to ensure that newly commissioned places in private nursing homes are jointly commissioned with local authorities with the flexibility to be redesignated and transferred to social care if this is considered appropriate.

It is proposed that the 289 beds in private nursing homes be retained and a further 155 commissioned in the East, West and South sectors including 20 beds for younger people with dementia. The 90 bed provision in the good purpose-built accommodation at Ruchill Hospital should be retained. The current provision at Leverndale (180 beds) and Gartnavel Royal (180 beds) should be closed. The proposed future pattern of NHS continuing care is set out below.

### Proposed NHS Continuing Care

<table>
<thead>
<tr>
<th>Sector</th>
<th>Adult</th>
<th>Elderly</th>
<th>Beds</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>North and East</td>
<td>60</td>
<td>124</td>
<td>Ruchill</td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>30</td>
<td>60</td>
<td>Birdston</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>30</td>
<td>30</td>
<td>Moshen Nursing Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>150</td>
<td>30</td>
<td>NHS Partnerships (Rutherglen/Darnley)</td>
<td></td>
</tr>
<tr>
<td>Younger people</td>
<td>20</td>
<td></td>
<td>New Nursing Home/Partnership</td>
<td></td>
</tr>
<tr>
<td>with dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and challenging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total 534 beds

Included as part of this network of service, a 20 bed unit for men who exhibit disturbed and sexually disinhibited behaviour should be established.

- **Continuing Care without Beds**

  Additionally, as part of the NHS service a network of consultant-led outreach clinics will be established. This innovative service will involve consultant-led multi-disciplinary teams outreaching into nursing and residential homes, day care centres and other facilities used by significant numbers of older people to provide specialist clinical treatment, advice and support. These teams will provide a comprehensive home assessment and treatment service targeted at people who are unable to attend clinic or day facilities and play a critical role in preventing the breakdown of community placements either in people’s own homes or in nursing or residential care.
The proposals set out above would result in a reduction of 205 NHS continuing care places or 27% of existing provision of 739 beds. Discussion with local authorities has identified the range of alternative social care facilities to be commissioned to replace these beds. These include:

- 72 supported accommodation places;
- 40 places in dementia care beds;
- 60 dementia places in standard nursing/residential homes.
- enhanced social day care services;
- an increased number of augmented care packages to support people in their own homes;
- recruitment of "discharge co-ordinators" to assist people to return to their own homes after episodes of care;
- specially designed support packages for adults to enable them to move on from supported accommodation.

### 6.4 Financial Framework

The current costs of NHS continuing care for patients within GGHB is as follows:

**Current Revenue Costs of NHS Continuing Care**

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>£'000</th>
<th>Unit Cost £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>206</td>
<td>5,996</td>
<td>29,110</td>
</tr>
<tr>
<td>Elderly</td>
<td>533</td>
<td>14,013</td>
<td>26,298</td>
</tr>
<tr>
<td>Total</td>
<td>739</td>
<td>20,009</td>
<td>27,075</td>
</tr>
</tbody>
</table>

Based on the service pattern set out above, future costs for NHS continuing care will be:

**Proposed Revenue Costs of NHS Continuing Care**

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>£'000</th>
<th>Unit Cost £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>150</td>
<td>4,622</td>
<td>30,810</td>
</tr>
<tr>
<td>Elderly</td>
<td>364</td>
<td>9,842</td>
<td>27,040</td>
</tr>
<tr>
<td>Younger People with Dementia</td>
<td>20</td>
<td>660</td>
<td>33,000</td>
</tr>
<tr>
<td>Total</td>
<td>534</td>
<td>15,124</td>
<td>28,340</td>
</tr>
</tbody>
</table>

In addition, £200,000 will be invested in developing the elderly outreach clinics into nursing and other residential settings.

The reduction in NHS continuing care beds releases £4,685K for investment in alternative social services. The proposed network of alternative social care services has been costed as follows.

**Alternative Social Care Provision**

<table>
<thead>
<tr>
<th>Service</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>72 Supported Accommodation places</td>
<td>2,977</td>
</tr>
<tr>
<td>40 Dementia Care Unit places</td>
<td>1,065</td>
</tr>
<tr>
<td>60 Standard Nursing and Residential Home places</td>
<td>646</td>
</tr>
<tr>
<td>16 Home Based Respite</td>
<td>400</td>
</tr>
</tbody>
</table>
The need to provide a further 72 supported accommodation places will entail the identification of capital. Discussions with local authorities and Scottish Homes to agree the sources of this sum are underway.

SECTION 7: FINANCIAL SUMMARY

7.1 Summary

The scale of the proposed changes set out in the consultation paper for adult, elderly and continuing care mental health services are significant. This section presents financial implications of the changes under the following headings:

- Funding Sources, Change Costs and Balance of Care;
- Phasing and Prioritisation of Proposals;
- Capital Costs.

The key financial issues are:

- the funding sources for the proposed changes and the recurring costs of the service changes/developments;
- the balance of re-investment across health and social care services;
- the phasing and prioritisation of service change/development;
- the capital requirements for the modernisation of the mental health estate.

7.2 Funding Sources, Change Costs and Balance of Care

The table plus supporting comments below shows the total recurring resource that has been identified to finance the proposed network of services identified in the previous chapters. There are primarily two sources of funds proposed at this time:

1. New funds to a value of £8.3 million that will add to the current spend on mental health services within the GGHB area.

2. The realignment of existing health resources that can be redirected to alternative services or locations consistent with strategic proposals. In line with this principle, resources that are currently deployed to services that cannot be released as part of this process have been ignored. Also the totality of resource attributable to existing services has been identified for redeployment and, as a consequence, when costs are proposed for new developments full costs have been used. This should make the process transparent.

Recurring Funding Sources

<table>
<thead>
<tr>
<th>Service</th>
<th>£K</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Support and Daycare</td>
<td>1,050</td>
<td></td>
</tr>
<tr>
<td>Enhanced Daycare Services</td>
<td>540</td>
<td></td>
</tr>
<tr>
<td>Services for Younger People with Dementia</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Services for Older People with Dementia</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,278</strong></td>
<td></td>
</tr>
</tbody>
</table>

The key financial issues are:

- the funding sources for the proposed changes and the recurring costs of the service changes/developments;
- the balance of re-investment across health and social care services;
- the phasing and prioritisation of service change/development;
- the capital requirements for the modernisation of the mental health estate.
### Realignment of Existing Resources

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Adult Community Services</td>
<td>500</td>
</tr>
<tr>
<td>Day Hospital Reconfiguration - Phase 1</td>
<td>297</td>
</tr>
<tr>
<td>Day Hospital Reconfiguration - Auchinlea</td>
<td></td>
</tr>
<tr>
<td>Release of Existing Out of Hours Service Funding</td>
<td>80</td>
</tr>
<tr>
<td>XBF Retraction Renfrewshire HC - Acute Services</td>
<td>400</td>
</tr>
<tr>
<td>GGHB XBF Retraction - Long-stay Patients</td>
<td>1,685</td>
</tr>
<tr>
<td>HIP Elderly Bed Reduction</td>
<td>500</td>
</tr>
<tr>
<td>Realignment of In-patient Services - Adolescent Services</td>
<td>505</td>
</tr>
<tr>
<td>Realignment of In-patient Services - Acute Services</td>
<td>27,618</td>
</tr>
<tr>
<td>Realignment of In-patient Services - Long-stay Beds</td>
<td>20,009</td>
</tr>
<tr>
<td><strong>Total Release of Existing Resource</strong></td>
<td><strong>51,594</strong></td>
</tr>
</tbody>
</table>

### Additional Proposed Funding

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>JCCP Capital Finance Provision</td>
<td>200</td>
</tr>
<tr>
<td>Modernising Community Care</td>
<td>100</td>
</tr>
<tr>
<td>1999/00 HIP Mental Health Development Provision</td>
<td>4,000</td>
</tr>
<tr>
<td>200/01 HIP Draft Financial Framework</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Total New Mental Health Funding</strong></td>
<td><strong>8,300</strong></td>
</tr>
</tbody>
</table>

**Total Available Resource**: **59,894**

---

**Notes:**

1. It has been assumed that the totality of services commissioned by GGHB with non-Glasgow Trusts can be released over the life of the framework. This will result in £2.085M of resources being available for investment locally.

2. The full cost of existing mental health in-patient services has been identified for reinvestment subject to an adjustment in respect of existing services included within the Strategy for Mentally Disordered Offenders which have been excluded.

3. The additional funding identified in the draft HIP 2000/01 financial framework has not yet been considered and agreed by the Health Board.

The application of funds are set out in the two tables below.
Reinvestment Profile

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost (£K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient Services (including Liaison Psychiatry)</td>
<td>46,521</td>
</tr>
<tr>
<td>Community Mental Health Services (Adult and Elderly) including rehab</td>
<td>5,702</td>
</tr>
<tr>
<td>Jointly Commissioned Discharge Services</td>
<td>850</td>
</tr>
<tr>
<td>Social Care Support Services (Adult and Elderly)</td>
<td>7,927</td>
</tr>
<tr>
<td>User Involvement</td>
<td>100</td>
</tr>
<tr>
<td>Out of Hours/Crisis Service</td>
<td>400</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>1,000</td>
</tr>
<tr>
<td>HIP Investment Health</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62,750</strong></td>
</tr>
</tbody>
</table>

The above package results in reinvestment in direct social care services of £7,927K. This would equate to a resource transfer of £26K for proposed bed closure. The detail of the proposed social care investment is set out in Table 16 below.

Proposed Development of Social Care Services

<table>
<thead>
<tr>
<th>Social Care Developments</th>
<th>£K</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient Review - Reconfiguration of Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>40 Dementia Care Units</td>
<td>1,065</td>
</tr>
<tr>
<td>60 Standard Dementia Nursing Home Places</td>
<td>646</td>
</tr>
<tr>
<td>36 High Supported Accommodation Places</td>
<td>1,758</td>
</tr>
<tr>
<td>36 Medium Supported Accommodation Places</td>
<td>1,219</td>
</tr>
<tr>
<td>Home Based Respite</td>
<td>200</td>
</tr>
<tr>
<td>Home Support and Daycare</td>
<td>800</td>
</tr>
<tr>
<td>Support to Resource Centres</td>
<td>400</td>
</tr>
<tr>
<td><strong>Total Investment</strong></td>
<td><strong>6,088</strong></td>
</tr>
</tbody>
</table>

Existing Service Gaps - Mental Health Strategy

<table>
<thead>
<tr>
<th>Social Care Developments</th>
<th>£K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Day Services</td>
<td>500</td>
</tr>
<tr>
<td>Services for Younger People with Dementia</td>
<td>200</td>
</tr>
<tr>
<td>Services for Older People with Dementia</td>
<td>400</td>
</tr>
<tr>
<td>Home Based Respite</td>
<td>200</td>
</tr>
<tr>
<td>Alzheimer’s Project</td>
<td>40</td>
</tr>
<tr>
<td>Home Support and Daycare</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total Investment</strong></td>
<td><strong>1,590</strong></td>
</tr>
</tbody>
</table>

Closure of Acute Beds - Health Improvement Plan

<table>
<thead>
<tr>
<th>Social Care Developments</th>
<th>£K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Social Care Services</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total Investment</strong></td>
<td><strong>7,927</strong></td>
</tr>
</tbody>
</table>

The above social care investment requires further work in relation to:

- detailed joint specifications of services between social work and health; and,
- agreement between the six local authorities within GGHB an allocation of resources for each authority.

The investment profile described above changes the balance of care:
The costs of the various service changes and service developments set out in the consultation paper and supporting documentation have been identified and result in a total proposed investment of £62,750K. As indicated above, the proposed funding sources to finance the service changes/developments total £59,894K. This leaves a funding gap of £2,856K. This needs to be discussed between the Board and its planning partners to agree what further sources of money can be applied including modernising community care funds. In addition, there may be opportunities to attract mental health development funds to ‘pump-prime’ investment proposals. An important part of this consultation is to seek views on the planned investment, its level of direction and how the financial gap might be closed.

7.3 Phasing and Prioritisation of Proposals

Phasing and timescales for implementation of much of the proposed change agenda will be heavily influenced by the availability of the considerable sums of capital required to modernise mental health in-patient services. Following the consultation on the reconfigured services set out in this paper, the Primary Care Trust will complete both an Outline and Full Business Case to access the capital required for the Scottish Office. At this stage, a 5 year implementation timescale, consistent with the Joint Mental Health Strategy should be assumed.

In year one of the proposed programme of change (2000/01) a total of £4,440K is expected to be available for reinvestment/service developments.

It is proposed that in year one the following services are developed reflecting current priorities and pressures in the mental health system.

### Proposed Investment Priorities for 2000/01

<table>
<thead>
<tr>
<th>Service</th>
<th>£’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Children/Young People</td>
<td>400</td>
</tr>
<tr>
<td>Adult Community Mental Health Teams</td>
<td>1,400</td>
</tr>
<tr>
<td>Improved Crisis Services</td>
<td>200</td>
</tr>
<tr>
<td>New Supported Accommodation Places (24 places/part-year)</td>
<td>750</td>
</tr>
<tr>
<td>Home Based Respite (8 places/½ year)</td>
<td>100</td>
</tr>
<tr>
<td>User Involvement</td>
<td>130</td>
</tr>
<tr>
<td>Elderly Outreach Team (Roving Clinic)</td>
<td>100</td>
</tr>
<tr>
<td>Younger People with Dementia</td>
<td>200</td>
</tr>
<tr>
<td>Dementia Social Care</td>
<td>250</td>
</tr>
<tr>
<td>Enhanced In-patient Staffing</td>
<td>545</td>
</tr>
<tr>
<td>Tackling Stigma</td>
<td>40</td>
</tr>
<tr>
<td>Strategy Development/Implementation</td>
<td>75</td>
</tr>
<tr>
<td>Health Investment - HIP Bed Closure</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,440</strong></td>
</tr>
</tbody>
</table>
This investment profile is based on the assumption of no bed closures. There is an ongoing piece of work to identify the phasing of bed closures and the reprovision of services. Given the issues around continuing NHS care outlined in Section 6, an early programme for closure should be developed.

7.4 Capital Costs

The Greater Glasgow Primary Care NHS Trust has carried out preliminary modelling around a number of site options for the proposed future configuration of mental health services. This modelling has been based on the following assumptions:

- the proposed bed numbers by category set out above;
- ward sizes of 20 beds for adult and elderly admission in single room accommodation;
- the co-location of all elderly mental health admission services on DGH sites with services for the elderly;
- the preferred location of adult admission beds on DGH sites;
- no new capital investment in NHS continuing care facilities;
- a requirement to develop community based early discharge facilities and rehabilitation services;
- improved community elderly mental health team bases and one-stop clinics;
- the provision of 72 supported accommodation places in specially commissioned accommodation in the community.

The overall capital costs of the proposals set out below.

<table>
<thead>
<tr>
<th>Estimated Capital Costs of Reconfiguration Proposals</th>
<th>£M</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient North Glasgow (reprovision of 256 beds)</td>
<td>20.1</td>
</tr>
<tr>
<td>In-patient South Glasgow (reprovision of 180 beds)</td>
<td>16.4</td>
</tr>
<tr>
<td>Intermediate Facilities (20 places)</td>
<td>1.5</td>
</tr>
<tr>
<td>Community Based Rehabilitation Services (40 places)</td>
<td>2.7</td>
</tr>
<tr>
<td>Elderly Community Mental Health Locations x 2</td>
<td>1.0</td>
</tr>
<tr>
<td>Supported Accommodation Places (72 places)</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total Capital Investment</strong></td>
<td><strong>43.2</strong></td>
</tr>
</tbody>
</table>

The revenue consequences of the capital investment have been reflected in the costings of the proposed new configuration of services. The preferred model results in a capital charge increase of £850K over current facilities.
MENTAL HEALTH STRATEGY

Recommendation

The Board is asked to approve the Greater Glasgow Joint Mental Health Strategy.

1. Introduction

This paper sets out:

- the background to the Strategy;
- the financial framework;
- year 1 priorities;
- implementation and planning mechanisms.

2. Background

The Scottish Office issued the Framework for Mental Health Services in Scotland in September 1997. This required health boards, in partnership with local authorities, to undertake a strategic review of mental health services and produce a six year plan for change. It reaffirmed mental health as a national priority and set out a systematic framework to develop a shared approach between health, social work, housing, the voluntary sector, users and carers to arrive at an integrated and effective mental health service.

In October 1998, the Board received a draft Strategic Review and Implementation Plan and endorsed this for wide debate and discussion. The Review and Implementation Plan were the products of extensive discussion and consultation with the broad range of interests involved in mental health services.

At its February 1999 meeting, the Board received an update on the Strategic Review which set out the key issues arising from the period of wider discussion. The final Strategy reflects those issues. Main areas of redrafting are:

- Mental Health Therapies (Chapter 9);
- Services for Children and Young People (Chapter 3);
- Adult Mental Health Services (Chapter 4), particularly regarding social care provision and liaison psychiatry.
3. **Financial Framework**

Since the February meeting, considerable further work has been done on the overall financial framework for the Mental Health Strategy, closely related to the finalisation of the Board’s revenue planning set out in the Health Improvement Programme.

This results in additional Health Board investment of £4 million in mental health over the period of the Strategy, allowing the Strategy to be in balance in years 1 and 2 and at the end point. Further work is still required on the detailed phasing of developments and funding sources in years 3 and 4 to bring the programme into overall balance.

Tables 1 and 2 set out in summary form service development within the Strategy and funding sources.

**Table 1: Service Developments**

<table>
<thead>
<tr>
<th>Proposed Developments</th>
<th>Programme Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>20</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>300</td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>1217</td>
</tr>
<tr>
<td>Services for Mentally Disordered Offenders</td>
<td>2725</td>
</tr>
<tr>
<td>Older People and People with Dementia</td>
<td>650</td>
</tr>
<tr>
<td>User Development</td>
<td>90</td>
</tr>
<tr>
<td>Total Annual Developments</td>
<td>5002</td>
</tr>
</tbody>
</table>

**Table 2: Funding Sources**

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Programme Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Release of Existing Resource</td>
<td>2169</td>
</tr>
<tr>
<td>MDO Development Funding</td>
<td>2168</td>
</tr>
<tr>
<td>Modernising Community Care</td>
<td>100</td>
</tr>
<tr>
<td>HIP Mental Health Provision</td>
<td>565</td>
</tr>
<tr>
<td>Total Available Resource</td>
<td>5002</td>
</tr>
</tbody>
</table>

Details of the financial framework are set out in Chapter 12 of the Strategy.

The financial framework reflects current assumptions and it is recognised that this will change in the light of continuing work on future in-patient configuration and the balance of care. A number of continuing cost pressures, including anti-psychotic drugs and in-patient staffing levels, will necessitate close monitoring of the framework and a rigorous process of regular review. This will entail:
• annual review of priorities for spend;
• phasing of in-year developments to reflect availability of funding;
• future potential allocations to mental health as part of the Board’s revenue planning;
• further discussion on potential increased investment from local authorities in mental health services.

4. **Year 1 Priorities**

As a result of the joint discussions with local authorities and the Primary Care Trust a number of key priorities have been identified for year 1 of the Strategy. These form the basis of year 1 implementation.

- Review of mental health in-patient services to establish key balances of care on a geographic, general/specialist, agency, hospital and community basis.
- Complete the network of Community Mental Health Teams by establishing 4 new teams and agree the core functions to be delivered by CMHTs across Greater Glasgow.
- Agree and implement revised crisis services linked to GEMS and Social Work Standby.
- Develop improved service responses for people with mental health problems who also abuse drugs and alcohol.
- Continue to develop services for mentally disordered offenders in line with the Board's Strategy and to manage the continuing pressures from patients referred from the State Hospital and the Criminal Justice System.
- Establish coherent systems between the Board, the Primary Care Trust and GPs on the management of external mental health referrals.
- Agree multi-agency protocol for managing people with personality disorders.
- Introduce clinical procedures for the management of new anti-psychotic drugs.
- Carry out an audit of supported accommodation and develop an Accommodation Strategy for mental health.
- Enhance community services for children and young people with mental health problems and develop a managed care network for this group.
- Ensure mental health issues are addressed as part of the Board’s work on Social Inclusion.
- Develop a detailed Mental Health Promotion Framework to complement the Mental Health Strategy.
- Develop integrated care pathways for women with post-natal depression and on the psychosocial management for people with schizophrenia.
• Develop effective mechanisms for user involvement in mental health policy issues.

5. **Implementation and Planning Mechanisms**

In the preparation of the Joint Strategy, a number of effective planning groups have been established. It is proposed that these groups be continued as Planning and Implementation Groups. These groups include:

- Greater Glasgow Mental Health Strategy Group comprising GGHB, Primary Care Trust, local authorities, GPs and Trade Unions.
- Local Authority Planning and Implementation Groups involving the Board, local authority Social Work and Housing, Primary Care Trust and GPs.

These groups will develop detailed implementation plans and monitor progress against developments/service changes.

Key elements of the mental health changes relating to the delivery of services provided by the Primary Care Trust will be monitored and reviewed through performance management arrangements.

Separate Joint Commissioning Groups have been established to oversee developments in mental health for children and young people, mentally disordered offenders and services for people with early onset dementia.

An annual review and update of the Mental Health Strategy concurrent with the HIP process will be reported to the Board.

6. **Conclusion**

This Strategy and the detailed work plans and financial framework which underpins it, set a clear strategic direction for change to mental health services in Greater Glasgow.
**APPENDIX 2**

**LIST OF SUPPORTING PAPERS PREPARED AS PART OF MENTAL HEALTH SERVICES REVIEW**

*Note: these papers are no longer available.*

<table>
<thead>
<tr>
<th>Paper</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper 1</td>
<td>Modernising Mental Health Services: Key Paper</td>
</tr>
<tr>
<td>Paper 2</td>
<td>Community Mental Health Networks</td>
</tr>
<tr>
<td>Paper 3</td>
<td>Assertive Outreach</td>
</tr>
<tr>
<td>Paper 4</td>
<td>Out of Hours Crisis Response</td>
</tr>
<tr>
<td>Paper 5</td>
<td>Role and Functions of and Adult In-patient Unit</td>
</tr>
<tr>
<td>Paper 6</td>
<td>Mental Health In-patient Nursing Service</td>
</tr>
<tr>
<td>Paper 7</td>
<td>In-patient Snapshot Survey</td>
</tr>
<tr>
<td>Paper 8</td>
<td>Linkage Data Analysis of Admission to Psychiatric Units</td>
</tr>
<tr>
<td>Paper 9</td>
<td>Services for Patients with Perinatal Disorders</td>
</tr>
<tr>
<td>Paper 10</td>
<td>Elderly Mental Health Services</td>
</tr>
<tr>
<td>Paper 11</td>
<td>Audit of Supported Accommodation</td>
</tr>
<tr>
<td>Paper 12</td>
<td>NHS Continuing Care Beds</td>
</tr>
<tr>
<td>Paper 13</td>
<td>Admission, Discharge and Rehabilitation Services</td>
</tr>
<tr>
<td>Paper 14</td>
<td>Development of a User Network</td>
</tr>
<tr>
<td>Paper 15</td>
<td>Addiction Services</td>
</tr>
<tr>
<td>Paper 16</td>
<td>Adolescent Psychiatry</td>
</tr>
<tr>
<td>Paper 17</td>
<td>Social Care Services</td>
</tr>
</tbody>
</table>