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# **Greater Glasgow Primary Care Division**

**Formerly  
Greater Glasgow Primary Care  
NHS Trust**

## **Local Forensic Psychiatric Unit**

**Full Business Case Submission to  
Scottish Executive Health Department**

**January 2005**

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**GREATER GLASGOW PRIMARY CARE NHS TRUST**  
**LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**  
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## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**

#### **SECTION 1: EXECUTIVE SUMMARY**

##### **1.1 Introduction**

- 1.1.1 The purpose of this full business case submission is to secure approval for the provision of a local forensic psychiatric unit (LFPU) which will serve the population of Greater Glasgow.

##### **1.2 Background**

- 1.2.1 The need to develop services for mentally disordered offenders is a national priority. NHS Greater Glasgow's strategy for developing services is:

- to establish a community outreach team, with close links to the police, the courts and the prison services;
- to establish adequate low and medium secure in-patient facilities within the Greater Glasgow area to complete the network of forensic psychiatry services by bridging the gap which currently exists between community based services and the high secure service provided by the State Hospital; and
- to establish support housing for a small number of mentally disordered offenders within a community setting.

- 1.2.2 The establishment of local services, in particular the provision of a forensic psychiatric unit, will enable the repatriation of Glasgow patients who are currently "entrapped" within the State Hospital at Carstairs and limit referrals to the State Hospital to patients who need to be cared for in conditions of high security. The provision of an LFPU will be instrumental in achieving this and is necessary to secure compliance with the requirements of the Mental Health (Care and Treatment)(Scotland) Act 2003 by enabling patients to be cared for in secure conditions which are appropriate to their level of assessed need. This will minimise exposure to the risk of judicial reviews and compensation claims, and limit the need for potentially very expensive placements in private facilities to achieve compliance with the Act.

- 1.2.3 The proposal to establish an LFPU within NHSGG is fully supported by the Forensic Managed Care Network Board, on which NHSGG has full representation, and is a key element of a plan to provide a network of forensic psychiatry inpatient services for NHS Scotland. The scale and configuration of the LFPU has been worked up in close consultation with colleagues at the State Hospital, to determine the number and mix of places required to support the service model.

##### **1.3 Service Model**

- 1.3.1 The care needs of mentally disordered offenders can be broadly categorised into 5 service levels. These are: 1) Assessment, 2) Ongoing support (community), 3) Low secure inpatient care (LFPU), 4) Medium secure inpatient care (LFPU) and 5) High secure inpatient care (State Hospital). To address these needs, it is necessary to ensure that there is adequate provision at each service level, and also that there is a balanced provision across all levels so that patients can move to the care package which is most appropriate to their assessed need at a particular point in time. This is achieved through a continuous process of review and assessment.

## **1.4 Summary of Preferred Option**

- 1.4.1 The preferred option for developing forensic psychiatry services to achieve the service model is to extend community services to include an outreach service, provide a new LFPU comprising low and medium secure facilities (the subject of this FBC), and to work with social services to establish support housing within a community setting (this is already planned as a separate joint project).
- 1.4.2 The requirement is for an LFPU of 74 places, comprising 30 low secure places and 44 medium secure places. Within the medium secure facility, a dedicated unit of 4 places will be established for people with a learning disability.
- 1.4.3 This will provide sufficient places to accommodate those patients who are currently cared for within an interim forensic psychiatric inpatient unit which is located at Leverndale Hospital (30 patients) and other patients who are currently accommodated within mainstream psychiatric hospitals within Greater Glasgow (up to 10 patients). It will also accommodate those Glasgow patients who are currently "entrapped" within the State Hospital (approximately 30 patients) and bring equilibrium to the movement of Glasgow patients into and out of the State Hospital.
- 1.4.4 It is recognised that the transfer of patients from the State Hospital will require to be carefully managed over a timescale of up to 2 years; accordingly the commissioning of the unit will be phased to accommodate this.
- 1.4.5 A forecast of how occupancy levels within the unit are anticipated to develop is provided within section 3.3.4 of the FBC. This shows that the forensic psychiatry service plans to operate both low and medium secure care inpatient facilities at an occupancy level of 90% on an ongoing basis. It is envisaged that this will provide the necessary flexibility to manage peaks in demand for places as these arise.

## **1.5 Location of LFPU**

- 1.5.1 The planned location for the LFPU is a greenfield site at Stobhill Hospital, on the basis that this provides the opportunity for maximum benefit in terms of clinical service provision.

## **1.6 Summary of Preferred Solution for Providing the LFPU**

### **1.6.1 Overview**

The preferred solution is for the LFPU to be provided by Canmore Balfour Beatty (CBB) to NHS Greater Glasgow under a private finance arrangement (PFI).

Under this arrangement, CBB will provide an LFPU facility for use by NHS Greater Glasgow during a contract period of 35 years.

The LFPU will comprise 74 places, all single bedrooms with ensuite facilities at ground floor level, together with day areas, therapy rooms and all other facilities consistent with the requirements incorporated within the requirements specification issued by NHSGG.

Under the terms of the contract, CBB will be responsible for the design, construction, and ongoing maintenance of the LFPU, and for its ongoing availability for use by NHSGG in line with agreed quality standards.

### **1.6.2 Timetable – Key Dates**

GGNHS Board approval of FBC                      20 April 2004

SE approval of FBC	31 May 2004
Financial Close	28 February 2005
Complete construction	1 April 2005 – 31 October 2006
Commission LFPU	1 December 2006

### 1.6.3 Financial Summary

- (i) The annual charge which will be made by CBB for providing the LFPU is £1.737M (2004/05 base cost). This is affordable, being within the funding level earmarked by GGNHSB for the project. NHSGG has also made provision within its financial plan for the full year additional cost associated with staffing the LFPU.
- (ii) The economic appraisal confirms that in terms of value for money the CBB proposal is more advantageous than the alternative of providing the LFPU using public funding. This is evident from a comparison of the net present values (NPV) of the costs of both options:

	<b>CBB – Pfi funding option</b>	<b>Public sector funding option</b>
	<b>£'000</b>	<b>£'000</b>
NPV	27,513	23,945
NPV of retained risks	4,337	8,022
Overall NPV	<b>31,850</b>	<b>31,967</b>
	=====	=====

Net Present Value (NPV) is calculated by converting every payment which would be made under either option over a period of 35 years into its present day value, then aggregating these to produce a total NPV for each option.

For both options, the level of risk which is retained by the NHS is assessed, again covering a 35 year period, with financial values attached to each risk based on assessment of its likelihood to occur. NPV of retained risks is calculated as described above.

The analysis shows that the CBB proposal is forecast to be less costly than the Public Sector funded option over a 35 year period by £117,000. This is attributable to the assessed value of risks which are transferred to CBB under the terms of the contract. These relate predominantly to the risk of costs overrunning on construction and maintenance of the LFPU facility over a 35 year period.

### 1.6.2 Key Contractual points

- (i) The Standard Form Contract documentation recommended by the Scottish Executive Health Department has been used in this PFI deal.
- (ii) A special purpose company will be established by Canmore Balfour Beatty to deliver the contract. This company will fund, build the facility and maintain it over the period of the contract, 35 years. The maintenance will include pre-planned maintenance to keep the building in good condition and routine maintenance to remedy daily failings and damage.
- (iii) The company will enter into two principal sub-contracts in order to deliver the project:
  - Design and build – Balfour Beatty
  - Maintenance – Parsons Brinckerhoff

The Trust will enter into direct agreements with both these sub-contractors and with the funder to the project. These agreements allow protection of respective interests in the event of any material default by the special purpose company.

- (iv) The contract contains standards which the building and the maintenance function are expected to meet. Provided these standards are met, the full unitary charge will be paid, monthly in arrears. Mechanisms are in place in which monitoring of standards is carried out. In the event of standards not being met, deductions will be made from payments in accordance with detailed criteria set out in the contract. The most significant deduction mechanisms concern availability of the facility. Unavailability of the facilities will trigger a graduated scale of deductions leading to complete withdrawal of payment in the event of unavailability of the entire facility, although this is considered as an extreme and an unlikely event.
- (v) In certain defined circumstances, e.g. repeated failure to achieve standards or make payments, either party may terminate the contract and step-in rights exist for the Trust and the funding bank in such an event. These step-in rights are intended to allow continuity of services and protection of financial interests.

## **1.7 Conclusions**

- (i) The provision of an LFPU within NHSGG is a national and local strategic priority and is necessary to comply with the requirements of the Mental Health (Care and Treatment)(Scotland) Act 2003.
- (ii) The solution proposed by CBB for the provision of an LFPU meets the requirements of NHSGG, is affordable and demonstrates value for money.
- (iii) The solution proposed by CBB will allow NHSGG to establish an operational LFPU by December 2006. The potential for securing the capital required to provide the LFPU using public funding within even the long term future (i.e. up to 10 years) is regarded as remote and so the CBB solution represents the only realistic option for providing the unit.

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**

#### **SECTION 2: STRATEGIC CONTEXT**

##### **2.1 Description of Trust and Statement of Objectives**

- 2.1.1 The Greater Glasgow Primary Care Trust provides health services to the population of the Greater Glasgow area, approximately 900,000 people. The Trust is responsible for the provision of mental health (including learning disability services), community and primary health care to the residents of Greater Glasgow. The Trust's annual income is approximately £503M and it currently employs 5,500 w.t.e. staff.
- 2.1.2 The objective of the Trust is to ensure that the healthcare which it provides to its resident population matches their needs. Accordingly, in developing its services, the Trust recognises the importance of working together with partner agencies including patients, patient representative groups and the public, to identify, plan and implement changes aimed at the improvement of the services which it provides. The Trust believes that this approach is fundamental to providing services which work in a truly integrated way, involving multi-disciplinary teams of clinical and non-clinical staff, both PCT and its partner agencies.
- 2.1.3 The project which is the subject of this business case is the establishment of a comprehensive service for mentally disordered offenders, located within the Trust's Mental Health Division, which matches the needs of this patient group within the Greater Glasgow area. The National resource at the State Hospital at Carstairs will continue to provide services for those requiring high secure care. The service aim is to provide packages of care which are appropriate to the needs of individual patients in appropriate settings within an environment which will provide an appropriate level of security.
- 2.1.4 From the patient perspective, the overall service aim is to maximise the opportunity for rehabilitation and a return to sustained independent living. To achieve this, a comprehensive approach is required, combining the provision of medium secure, low secure and outreach services into an integrated total service package.
- 2.1.5 The objective of the project is to ensure that this is achieved and that an appropriate balance is established between the different service elements which will maximise the opportunity for the service aim to be realised in practice.

##### **2.2 Description of strategic context, including description of strategic objectives**

- 2.2.1 The need to develop services for mentally disordered offenders has been identified as a national priority with particular emphasis on the need for a multi-agency approach, co-ordination between different service elements and public safety (MEL 1999/5) – "Health Social Work and Related Services for Mentally Disordered Offenders in Scotland". This states that:-

*"mentally disordered offenders should be cared for: -*

- with regard to quality of care and proper attention to the needs of individuals;*
- as far as possible in the community rather than in institutional settings;*

- *under conditions of no greater security than is justified than by the degree of danger that they present to themselves or others;*
- *in such a way as to maximise rehabilitation and their chances of sustaining an independent life; and*
- *as near as possible to their own homes or families if they have them.*

*Services for mentally disordered offenders should include careful assessment and management of risk in appropriate facilities".*

- 2.2.2 National Guidance in NHS HDL (2001)9 "Services, Care, Support and Accommodation for Mentally Disordered Offenders in Scotland: Care Pathway" recognises that an individual's illness will not be static and that their health and social needs will vary over time. This requires that the Trust establish a service able to meet these needs in a flexible way.
- 2.2.3 Greater Glasgow NHS Board's Local Health Plan identifies the development of services for mentally disordered offenders as a key priority within the framework established for the development of mental health services in the Greater Glasgow area. The main elements of Greater Glasgow NHS Board's strategy for developing services in this area are as follows:
- i. The establishment of a community outreach team, with close links to the police, the courts and the prison services.
  - ii. The establishment of adequate low and medium secure in-patient facilities within the Greater Glasgow area to complete the network of forensic psychiatry services by bridging the gap which currently exists between community based services and the high secure service provided by the State Hospital.
  - iii. The establishment of support housing for a small number of mentally disordered offenders within a community setting.
- 2.2.4 The Trust's proposal specifically addresses elements (i) and (ii) of Greater Glasgow NHS Board's service strategy. It envisages the strengthening of the community outreach team to provide a more rapid and flexible response to requests for assessment by the police, the court system and the prison services. It also envisages the provision of a new local forensic unit, housing an appropriate balance of low secure and medium secure care in-patient facilities. The third element of the strategy, the establishment of limited support housing in the community, is provided for within Greater Glasgow NHS Board's framework for the development of mental health services. The implementation of this strategic initiative is already planned as a separate joint project, working together with social services, and so does not form part of this proposal.
- 2.2.5 The essence of the proposal is to put in place a service network which actively encourages multi-agency working, particularly within the community element of the service; which enables patient needs to be matched at all levels of care by the provision of services appropriate to those needs; which supports a co-ordinated approach across the boundaries between the different levels; and which ensures an appropriate level of safety and security for patients at each service level, in line with the principles set out in MEL (1999/5) and HDL (2001)9.



- 2.2.6 On this basis, the Trust's proposal enables the achievement of Greater Glasgow NHS Board's strategic requirements.

### **2.3 Review of key assumptions**

- 2.3.1 From the patient's perspective, the chief aim of providing a local forensic psychiatric service is a reduction in offending behaviour, rehabilitation and a return to sustained independent living. It is assumed that the opportunity for achieving this will be significantly enhanced by the availability of a menu of packages of care at different levels of security appropriate to the patient's needs, at the point of entry to the service. Levels of service will range from community out-patient services at one end of the spectrum to a medium secure service at the other end. This will enable the patient to engage with the service at a level which best matches their need and allow an early start to the rehabilitation process. The introduction of a care unit comprising a combination of low secure and medium secure facilities fills a gap in the spectrum of care and enables a balanced portfolio of packages of care to be made available to mentally disordered offenders. The absence of a permanent facility of this nature at the present time creates an imbalance in the current forensic psychiatry service provided to Glasgow patients.
- 2.3.2 It is anticipated that, based on current patient statistics, the introduction of a Local Forensic Psychiatric Unit incorporating 74 in-patient beds, split between medium secure care and low secure care facilities, will meet the anticipated need and bring equilibrium to the movement of Glasgow patients into and out of the State Hospital.
- 2.3.3 At November 2002 there were around 80 Greater Glasgow patients in the State Hospital at Carstairs. The State Hospital's 1999 Special Review of forensic services, published in June 1999, indicated that the level of patients admitted from the Greater Glasgow area was excessive. The review found that over 50% of these patients required a lower level of secure care than that provided at Carstairs. This reinforced the finding of an earlier survey carried out by State Hospital consultants in 1994, that 53 % of patients admitted from the Greater Glasgow area required a lower level of secure care. Based on available audit data it is estimated that a further 40 forensic patients are accommodated within Glasgow psychiatric hospitals. The majority of these are cared for in interim low secure ward facilities.
- 2.3.4 Admissions to the State Hospital relating to Greater Glasgow residents have been running at about 22 per annum, with around 17 discharges per annum, a net admission rate of 5 patients per annum.

### **2.4 Description of present catchment population and present level of service activity**

- 2.4.1 The catchment population of the Greater Glasgow area is around 900,000. Greater Glasgow experiences a disproportionately high level of poverty relative to the rest of Scotland, concentrated in particular in its inner city areas. This almost certainly contributes to the relatively high crime rate experienced within the city and has had some bearing on the appreciable growth in substance abuse experienced in recent years.
- 2.4.2 With regard to service activity, the absence of accurate data measuring the ongoing prevalence of mental illness among offenders resident within the Glasgow area means that it is necessary to draw upon survey information to provide snapshots of current activity levels.

- 2.4.3 Patient statistics from the State Hospital records confirm that around 80 current in-patients typically come from the Greater Glasgow area. As explained in section 2.3, it is estimated that over 50% of these patients require a lesser level of secure care than that provided by Carstairs.
- 2.4.4 Patient activity In terms of community based services is generated largely by referrals from the police, the courts and the prison system. During the twelve months to October 2002, the community service received 1535 referrals.
- 2.4.5 It is worth noting that Glasgow accounts for around 35% of all High Court cases in Scotland. It is also worth highlighting the high level of substance abuse in the Glasgow area relative to other areas of Scotland. This is a growing problem in the Glasgow area and is significant in terms of forensic psychiatry services provision due to the close relationship which exists between substance abuse, crime and mental illness. These factors have contributed to a growth in demand for forensic psychiatry services across the full spectrum of care, ranging from requests for assessment received from the courts through to in-patient services.

## **2.5 Market Analysis**

### **2.5.1 Sources of referral to forensic psychiatry services include:-**

- Patients who have come into contact with the criminal justice system via prisons and courts.
- Existing patients within general psychiatry services who require forensic psychiatry care.
- Patients within the State Hospital who do not require care in high security.
- Patients in the community who require continuing care and support to reduce the risk of re-offending as a result of their mental illness.

2.5.2 This demonstrates the complexity of the patient group, displaying a range of needs for different levels of care to be provided within settings which provide varying degrees of protective security relevant to each category of need.

2.5.3 The patient population is small in size, but growing in number. This growth can be attributed to a combination of unmet need being identified, a demand for more rapid assessment from the courts and other agencies, and an underlying growth in volume.

2.5.4 For referrals which are received from the criminal justice system, the Trust operates a limited out-patient service based on a city centre site in Glasgow, limited to day services and an outreach service in the community.

2.5.5 For in-patient admissions, the Trust operates a limited forensic psychiatry facility within interim accommodation. This service is operated at the low secure end of the care spectrum.

2.5.6 Where in-patient admission is required above the low secure end of the care spectrum, the only recourse at present is admission to the State Hospital at Carstairs. Accordingly, the State Hospital, whose facilities are aligned to the needs of the high secure care end of the client group, may receive admissions requiring only medium secure care and indeed in some cases low secure care, on account of the absence of appropriate facilities within the Glasgow area to enable the relevant treatments and packages of care to be provided on a local basis.

2.5.7 Therefore, gaps exist in the range of services provided to meet the needs of the client group as described above. By extending the range of services provided to include a community outreach service and day services for patients who are resident within the community and by developing a new dedicated unit incorporating adequate levels of medium and low secure care in-patient facilities, these gaps in service provision will be addressed.

2.5.8 At present there are no private sector service providers engaged in the provision of services for adult mentally disordered offenders in Scotland and there are no other NHS providers capable of providing locally available services within the Greater Glasgow area for the volume of Greater Glasgow residents. The Trust has been encouraged by Greater Glasgow NHS Board to develop this proposal to meet the requirements of their strategy for the development of services for mentally disordered offenders into the longer term future. The Greater Glasgow NHS Board has set aside sufficient resources on a recurring basis to meet the recurring costs associated with the provision of this service, as calculated by the Trust.

## **2.6 Description of the size and scope of the project**

2.6.1 The project envisages the expansion of services provided within the community to include an outreach service and the provision of day services based on an existing city centre site. It also envisages the development of a Local Forensic Psychiatric Unit on the site of Stobhill Hospital, providing facilities for in-patient based care for patients within both a low secure and medium secure environment. Both elements of the project require that service development be taken forward on a joint basis, with the full involvement of social work services, the police, procurators' fiscal office and the prison service in shaping the way services are provided to ensure an integrated approach with the work of these other agencies. In addition, there will be close liaison with the State Hospital to ensure that the interface between the State Hospital and the new unit operates effectively and that both units function in a complementary way relative to each other.

2.6.2 The project will therefore be multi-disciplinary in nature, involving a multi-agency approach.

2.6.3 The project envisages the introduction of additional staff resources and facilities resulting in recurring costs of £8.7M per annum. The capital cost associated with building the new Local Forensic Unit is £17.9M, inclusive of VAT, professional fees, and equipment. Costs are stated at 2004/05 values. Costs quoted within the OBC, which was approved on 28th July 1999, were stated at 1997/98 values and were as follows:

- revenue costs: £ 5.7M per annum
- capital cost: £12.5M

2.6.4 The scope of services which will be provided on completion of the project is set out below. New service elements are marked thus \*

### **Community services**

#### *Assertive Outreach*

- Follow-up services to patients discharged to their own home \*
- Follow-up services to patients discharged to support accommodation \*

- Day service provision for work & social activities \*
- Out-patient appointment services
- On call provision from both community nursing and medical staff \*

#### *Services to Scottish Prisons*

- Assessment of patients referred for potential in-patient admission
- Therapeutic inputs to patients in prison \*
- Liaison with local services on discharge of prisoners

#### *Day Services*

- Specific services for offenders (Mental Health and Learning Disability) \*
- Links with existing services \*
- Mental Health assessment \*
- Assertive follow-up \*
- Treatment compliance \*

### **In-Patient Services**

#### 30 bed Low Secure Facilities

- Rehabilitation/Long stay facility – 24 places \*
- Female Unit – 6 places \*

(Within the Low Secure Facility there will be flexibility of 4 places between the two elements allowing for a range of 24 rehabilitation/long stay and 6 female unit places or 28 rehabilitation/long stay and 2 female unit places).

#### 44 bed Medium Secure Facilities

- Admission facility - 10 places \*
- Intensive Care facility - 6 places \*
- Rehabilitation/Long stay facility - 24 places
- Learning Disability facility - 4 places\*

Four places will exist within forensic medium security for people with a Learning Disability. To provide the bridge between forensic medium security and mainstream Learning Disability services, eight supervised places have been established and retained at Leverndale Hospital. These places were developed as a component of the re-provision of continuing care facilities following the closure of Lennox Castle Hospital. Delivered as an element of forensic services at its most locally secure, the four medium secure places complete the system and continuum of care for people with Learning Disability.

High Secure Facilities would be provided via the State Hospital.

## **2.7 Assessment of future service need**

- 2.7.1 The proposal for developing services for mentally disordered offenders which is contained within the project is driven by the requirement to meet the existing needs of patients who are resident within the Greater Glasgow area. It is consistent with the aims of Greater Glasgow NHS Board's Local Health Plan which has recognised the principles on which the national priority to develop services within this area has been based and applied these to identify the specific service needs for service development with the Greater Glasgow area. The proposal as set out in the FBC is in line with national and local priorities in addressing recognised patient needs.
- 2.7.2 The scale of the proposal reflects the relative needs of the Greater Glasgow area for local forensic psychiatric services, based on the size of the population and other factors such as the incidence of crime, including the prevalence of substance abuse, which are experienced within some of the more deprived inner city areas of Glasgow and have a bearing on the demand for forensic psychiatry services.
- 2.7.3 The project aims to establish a new service in response to an already identified need. It is reasonable to assume that the key factors influencing the flow of referrals will continue to feature into the long-term future and that the service provision envisaged within the project will therefore match a lasting need. The aim of the service development is the promotion of the rehabilitation of mentally disordered offenders. The logic of achieving this aim in practice dictates that over time the level of demand for elements of the secure care unit facilities may change. Accordingly, a flexible approach has been taken in designing the facilities to be incorporated within the unit to provide scope for adaptation in face of changing service demand with regard to in-patient facilities.
- 2.7.4 Greater Glasgow NHS Board sees the requirement to provide this service via the Trust as a long-term commitment and has confirmed its full support for this development on a continuing basis.

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**

#### **SECTION 3 – THE OUTLINE BUSINESS CASE**

##### **3.1 Summary of Outline Business Case**

- 3.1.1 The outline business case set out the Trust's preferred model for developing forensic psychiatric services for the Greater Glasgow NHS Board area. This was prepared and submitted on 28th May 1999 and was approved by the Scottish Executive on 28th July 1999.
- 3.1.2 The Trust's preferred model for developing forensic psychiatric services for the Greater Glasgow NHS Board area consists of two main initiatives:
  - (i) The extension of community services to include an outreach service.
  - (ii) The provision of a new Local Forensic Psychiatric Unit, comprising low secure and medium secure facilities.
- 3.1.3 The introduction of services in each of these areas is identified as necessary to bridge the gaps in existing care provision and enable a comprehensive service to be provided to mentally disordered offenders resident in the Greater Glasgow area. The aim is to put in place a spectrum of care which allows the movement of patients across the spectrum to the point most appropriate to their needs, ensuring that packages of care are made available which match their requirements. At present, patients are placed at points of the spectrum which do not necessarily match their needs. Patients who would benefit from receiving care and/or treatment in a medium secure or low secure environment are placed instead in a high secure environment (i.e. the State Hospital) due to the absence of suitable alternative facilities, potentially damaging the success of initiatives targeted at rehabilitation. Patients who would benefit from outreach services do not receive them, thereby increasing the likelihood of re-offending after discharge into the community.
- 3.1.4 The outline business case explained the sources of referrals to the forensic psychiatry service and highlighted the statistics which indicated a growth in demand for community based services, including the need for an outreach service. It explained the nature of the current provision of low secure care services within Glasgow's psychiatric hospitals and described the disproportionately high and inappropriate level of admission to the State Hospital on account of the absence of alternative medium secure facilities within the Greater Glasgow area. It identified the demand for the type of services which would be on offer from a Local Forensic Psychiatric Unit (sometimes referred to in earlier documents as a "Secure Care Centre"), as proposed in the OBC.
- 3.1.5 It identified the preferred site for the planned new Local Forensic Psychiatric Unit as Stobhill Hospital, on which the Trust already has a significant presence in terms of acute psychiatric in-patient beds.
- 3.1.6 Subsequent to approval of the OBC, the Trust and the Health Board reviewed its preferred option for location of the Local Forensic Psychiatric Unit in response to local community interests resulting a period of engagement which saw two series of events arranged to re-visit and reflect on the chosen site option. This process concluded that the Trust's chosen site option remained the preferred site for providing a Local Forensic Psychiatric Unit for the Greater Glasgow area.

3.1.7 Due to the time interval between OBC approval and FBC developments, it has been necessary to revise the original cost estimates for inflation. The OBC identified the costs associated with the development of the preferred option as being a capital cost of £12.5M, and incremental recurring costs of £5.7M, and confirmed that Greater Glasgow NHS Board fully supported the Trust's proposal and had set aside additional resources within its financial plan to fund the anticipated incremental revenue costs.

3.1.8 NHS continues to support the Trust's proposal at the following levels of cost ( 04/05 ):

- recurring costs                      £ 8.0M per annum
- capital cost                            £17.9M

## 3.2 Evaluation of Options

### (i) Introduction

3.2.1 The care needs of mentally disordered offenders are highly individualistic in nature. It is possible, however, to group these into categories representing different levels of service and approach the design of packages of care on this basis. This is shown in the table below:

	<u>Service Level</u>	<u>Service Location</u>	<u>Brief Description of Service Activity</u>
1.	Assessment (i) out-patient clinic (ii) outreach	Community	(i) Assessment of referrals from police, courts, prisons etc. (ii) Follow up of ex-offenders post discharge.
2.	Ongoing support	Community – (i) Home based (ii) Community unit	(i) Home visits by CPN. (ii) Ex-offenders attend day centre for advice support etc.
3.	Low secure in-patient care	Hospital based, low security environment	Short and long term stays, full range of acute services provision.
4.	Medium Secure in-patient care	Hospital based, medium security environment	Short and long term stays, full range of acute services provision.
5.	High secure in-patient care	Hospital based, high security environment	Longer term stays, full range of acute services provision.

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

3.2.3 On this basis, it follows that the alternative models of care which were assessed by the Trust were to a large extent variations on a single theme. These are described below:

**(ii) Assessment of Options and selection of preferred model of care**

3.2.4 The alternative models of care considered by the Trust are described below. Each option goes some way towards filling the gap(s) in service provision identified by Greater Glasgow NHS Board within its Local Health Plan.

<u>Options</u>	<u>Community Service</u>	<u>In-patient Service</u>
1.	No change to existing service	Retain interim ward provision for low secure service, and re-designate beds within existing IPCUs for limited medium secure services. Retain use of State Hospital facilities.
2.	Extend community service to provide outreach service(s)	As Option 1.
3.	Extend community service to provide outreach service(s)	Provide new unit with combined low secure and medium secure care facility on a single site. Retain appropriate use of State Hospital facilities.
4.	Extend community service to provide outreach service(s)	Provide new unit providing separate low secure care and medium secure care facilities on a single site. Retain appropriate use of State Hospital facilities.
5.	Extend community service to provide outreach service(s)	Provide 2 new units, one for Glasgow (North) and one for Glasgow (South), embracing low secure care and medium secure care facilities on 2 separate sites. Retain appropriate use of State Hospital facilities.



3.2.5 Each option was assessed against a range of different criteria to determine the preferred model of care. A summary of the assessment process is provided below:

	<b>Selection Criteria</b>	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>	<b>Option 4</b>	<b>Option 5</b>
1.	Scope for repatriation of inappropriate admissions from State Hospital	Limited	Limited	Improved	Yes	Yes
2.	Rapid response to demand for urgent assessment	No	Yes	Yes	Yes	Yes
3.	Adequacy of security arrangements at different levels of care	No	No	Improved	Yes	Yes
4.	Flexibility to cope with increase in referral rate from (a) courts (b) prison service	No No	Yes Yes	Yes Yes	Yes Yes	Yes Yes
5.	Best use made of available forensic psychiatry skills	No	No	Yes	Yes	Improved
6.	Adequate provision of low secure care facilities assured	Yes	Yes	Yes	Yes	Yes
7.	Adequate provision of medium secure care facilities assured	No	No	Yes	Yes	Yes
8.	Scope for flow of patients through levels of care maximised	No	No	Improved	Yes	Yes
9.	Affordability	Yes	Yes	Yes	Yes	No

3.2.6 The preferred model of care was Option 4. This met all key selection criteria and so provided the solution which offered the potential for achieving the desired balance of care provision for mentally disordered offenders.

3.2.7 The option assessment was conducted by a representative working group comprising:

Forensic Psychiatrists  
General Adult Psychiatrists  
Psychiatric Nurses from IPCU  
Adolescent Psychiatrists  
Learning Disability Psychiatrists  
General Psychiatric Occupational Therapists

3.2.8 This group was led by the Clinical Director for in-patient services. The remit of the group had been to review the provision of forensic psychiatric services within the

Trust and recommend a model to shape the future development of services. In carrying out its remit, the group reviewed existing service provision within the then Community and Mental Health Services Trust, conducted a literature review and reviewed service models adopted by other NHS Trusts within the UK. This was instrumental in identifying the criteria which were used to assess the viability of the different options for service development.

- 3.2.9 On completing its work, the Working Group issued a paper setting out the various options and recommendations which was circulated widely within the Trust and the Trust's clinical advisory groups. All groups supported Option 4 as the most appropriate model of care.

### 3.3 Preferred model of care – illustration of patient flows:

- 3.3.1 The model of care is designed to operate in such a way that patients are able to enter or be discharged at each level of care or move smoothly between levels of care, taking whichever route is most appropriate to their needs. This is demonstrated in the table below which illustrates the hierarchy of care:

	Level of care	Source of referral	Destination of referral
1.	Assessment service	Police, courts, prisons, general psychiatry service	Prisons, M.S.U, H.S.U, community outreach service
2.	High secure unit (State Hospital)	Assessment service, M.S.U	M.S.U, L.S.U, community outreach, day service.
3.	Medium secure unit	Assessment service, H.S.U	L.S.U, Community outreach, community day service
4.	Low secure unit	M.S.U, H.S.U	Community services (outreach, day service, support housing)
5.	Ongoing community services	Assessment service, L.S.U, M.S.U	Community services (outreach, day services support housing), L.S.U, M.S.U, H.S.U, prisons

Key                      L.S.U =              Low Secure Unit  
                              M.S.U =              Medium Secure Unit  
                              H.S.U =              High Secure Unit (State Hospital)

- 3.3.2 The table illustrates how a patient would be expected to move through the different levels of care, with the ultimate objective of being rehabilitated into a community setting where ongoing support would be provided from a menu of services according to the particular need of the individual. Initially there would be some flow between the medium and low secure facilities and the mainstream psychiatric in-patient service, but this would be expected to reduce significantly when the new service became established and so is not represented within the illustration. Clearly the objective of the service is lasting rehabilitation, however it is recognised that the possibility of re-offending exists. Accordingly, the potential flow of patients back into a medium level of secure care within the local facility or high security at the State Hospital is also reflected in the illustration. This adds a circular dimension to what would be expected to be a broadly linear process of care, but, reflects the reality of what may happen in individual cases where rehabilitation might be achieved on an iterative basis.

3.3.3 The length of stay within each level of care will be variable, again dependent on individual clinical need. Movements between individual levels of care will be subject to a process of extensive clinical evaluation.

3.3.4 A forecast of admissions to the LFPU has been prepared covering the initial five years after opening. The planned transfer of patients from the interim forensic facilities at Leverndale, together with State Hospital information on current patient numbers and admission / discharge rates, and local forensic service experience, has been used to project the anticipated flow of patients through the LFPU. A summary of this work is shown in the table on the following page.

The assumptions which underlie the figures in the table are summarised below:

#### **Medium Secure Facilities**

##### **Years 1-3**

- \* 10% of patients will be within the service for 3 months or less
- \* 30% of patients will be within the service for between 4 to 8 months
- \* 50% of patients will be within the service for 9 months to 2 years
- \* 10% of patients will be within the service for more than 2 years

##### **Years 4-5**

- \* 10% of patients will be within the service for 3 months or less
- \* 40% of patients will be within the service for between 4 to 8 months
- \* 40% of patients will be within the service for 9 months to 2 years
- \* 10 % of patients will be within the service for more than 2 years

The average lengths of stay, based on the figures above, are summarised in the table below:

<b>LFPU</b>	<b>Average Length of Stay in Days</b>
<b>Medium Secure Unit (38 beds excluding 6 ICU beds)</b>	
Years 1 – 3	320
Years 4 –5	273
Years 1 – 5	298
<b>ICU</b>	
Years 1 – 3	268
Years 4 –5	374
Years 1 – 5	330
<b>Low Secure Unit</b>	
Years 1 – 3	483
Years 4 –5	450
Years 1 – 5	467



### Medium Secure Facilities

- 3.3.5 It is reasonable to assume that, through the introduction of the service developments envisaged within the preferred model of care, it will be possible to achieve a reduction in the length of stay for longer stay patients and this is reflected in the assumptions set out above with effect from Year 4 onwards.

### Low Secure Facilities

- 3.3.6 The expected length of stay for this patient group is between 3 months to more than 5 years with a minority who may stay for their lifetime. The percentage split for in-patient stays is assumed to be the same as that for the medium secure accommodation. It is envisaged that movement within this patient group will occur over the 5 year period due to the development of the Outreach Support Teams, Supported Accommodation etc.

### Emergency Admissions

- 3.3.7 Planned occupancy levels are set below maximum capacity to provide for the flexibility needed to respond to peaks in service demands, including emergency admissions.
- 3.3.8 All admissions and discharges will be managed by following a strict system of admission and discharge protocols.
- 3.3.9 Within the LFPU itself there exist different levels of care packages which relate to different levels of patient need. The length of time spent in each section of the medium facilities will again vary dependent on the needs of individual patients. It can, however, be measured in broad terms as shown below:

Level of care		Estimated length of stay	
Intensive	}	Medium	Days / Weeks
Admission	}		Weeks / Months
Rehabilitation	}	Low	Months
	}		Months

- 3.3.10 Outreach services will be provided on an ongoing basis to patients who have been discharged into the community.
- 3.3.11 At present the community service consists of an assessment service which is provided from a base in Glasgow city centre. Referrals are received from the police, courts and prison services and are assessed from the city centre base. It is envisaged that the community part of the service will be expanded to provide an outreach service into the community and a day service provided from the current city centre base.
- 3.3.12 All patients discharged into the community will have undergone a programme of extensive risk assessment conducted by a multi-agency team. Care provided in the community will be managed through the Care Programme Approach (C.P.A) <sup>1</sup>.

- 3.3.13 The community outreach service will be co-ordinated from the city centre base and will introduce an assertive follow up service to patients who have been discharged to their own homes and to patients who have been discharged to supported accommodation.
- 3.3.14 This service will be provided by additional Community Psychiatric Nurses (CPNs) and social work resources, who will initiate contact with discharged patients, assess their care requirements and work with them to arrange a package of care and support appropriate to individual needs. Thereafter contact will be maintained on a regular basis to review progress and make necessary amendments to the programme of care.
- 3.3.15 The day service will be provided from the city centre base and will provide a facility for patients to drop in to discuss problems and receive support from nursing and medical staff.
- 3.3.16 The exact level of caseload which would come under the management of the outreach team is difficult to assess. The introduction of this service will pick up what is currently an unmet need. Initial referrals will come from the early discharge of patients currently managed within the in-patient service together with cross referrals from the current community psychiatric resource centre teams. It is estimated that the initial caseload can be expected to sit in the range of 60 to 110 patients.

#### **3.4 Configuration of Local Forensic Psychiatric Unit Facility**

- 3.4.1 The layout of the new secure care facility is planned to reflect the clinical model of care. The building design takes account of the different levels of health needs which will be met within the overall facility, separating the low secure facilities from the medium secure facilities. Within the medium secure facilities there will be separation of the different elements of care provided. The result is groupings of discrete facilities which reflect the needs of the different patient groups who will receive different packages of clinical care.
- 3.4.2 By organising the provision of care into groupings of discrete facilities, the clinical view is that this will provide an environment in which there will be improved care for all patient groups and will provide better quality of life and more appropriate opportunities for rehabilitation.
- 3.4.3 The Local Forensic Psychiatric Unit is designed to enable flexible use of rooms and bedroom accommodation. Wherever possible, rooms are multipurpose. For example, dining rooms are capable of being used as quiet areas outside of meal times, and activity areas can also be used as Clinical Conference Rooms.
- 3.4.4 The bedded areas are also configured to allow scope for flexible use where required:
- a) **Medium Secure (Intensive Care Area)**  
  
The 6 bed intensive care ward includes the facility for completely separate space for up to 2 females.
  - b) **Low Secure**  
  
A discrete ward in the low secure facilities is designated to accommodate up to 6 female patients. In the event of the demand for places being less than this, the design allows for up to 4 bedrooms to be allocated to the main area of one of the wards without the care requirements of female patients being compromised in any way.

3.4.5 The floor area of the Local Forensic Psychiatric Unit is planned to be approximately 6,600m<sup>2</sup>. In addition, outdoor activity areas adjacent to both the medium secure and low secure units cover a ground area of approximately 7800m<sup>2</sup>. The outdoor areas are planned to provide scope for operating a gardening project within the area adjacent to the medium secure accommodation.

3.4.6 The following shows how the building area maps to the individual facilities:-

	Facility	Overview of accommodation					
		Beds	Clinic/ Interview Rooms	Therapeutic Rooms	Day Rooms	Staff Rooms	Floor Area m <sup>2</sup>
1.	Medium Secure Unit						
	(i) IPCU	6	3	2	4	1	372
	(ii) Admission Unit	10	4	2	3	1	443
	(iii) Rehabilitation Unit						
	- North	12	4	2	2	1	455
	- South	12	4	2	2	1	455
	(iv) Learning Disabilities Unit	4	2	2	2	1	300
2.	Low Secure Unit						
	- North	12	3	2	2	1	445
	- South	12	3	2	2	1	445
	- Female	6	3	2	2	1	327
3.	Indoor Recreational Facilities	Sports hall, gym, library and education centre, metal and wood workshop, art room, pottery room, games room and therapy rooms (music, kitchen) etc.					667
4.	Clinical offices and administrative support						572
5.	Reception area and doctors on-call						204
6.	Circulation space (35%)						1,640
7.	Other (Plant rooms etc)						240
8.	<b>Totals</b>	74	26	16	19	8	6,565

**The above information is provisional pending conclusion of the PFI process**

### 3.5 Assessment of site options for locating Local Forensic Psychiatric Unit

3.5.1 The process of evaluating the alternative models of care resulted in a preferred option consisting of two separate initiatives. These are as follows:

- (i) Introduction of community outreach service
- (ii) Introduction of new Local Forensic Psychiatric Unit comprising both low secure care and medium secure care accommodation.

3.5.2 A base already exists for the development of the community outreach services. This was not the case with regard to the potential location of a Local Forensic Psychiatric Unit and so it was necessary to identify alternatives and evaluate a number of potential options. Options assessed included a series of alternatives based on the Leverndale Hospital site, a split-site solution between the Stobhill Hospital and the Leverndale Hospital sites, a single solution on the Stobhill (greenfield) site and the Belvidere Hospital site.

3.5.3 Each option was assessed in terms of a range of benefits criteria which are shown below, together with their relative weightings:

➤ Clinical effectiveness and quality of service	19
➤ Safety of patients, staff and public	16
➤ Quality of the physical environment	15
➤ Accessibility for patients, families and staff	13
➤ Deliverability	9
➤ Flexibility for growth and change	6
➤ Acceptability to patients, families and staff	12
➤ Compatibility with national and local MH strategy	10
	<hr/>
	<b>100</b>
	<hr/>

3.5.4 The outcome of this process, as explained in detail in the OBC, was that the Stobhill (greenfield) site was identified as the option most likely to provide the maximum benefits in terms of clinical service provision.

3.5.5 As noted at paragraph 3.1.6 above two subsequent series of events were held:-

- (a) a revisit of the initial option appraisal conducted over four days in the period 29th January 2001 to 26th June 2001 with input from community interests representing the Stobhill area which was incomplete and resulted in the Health Board proposing and asking the Trust to take forward
- (b) a second appraisal event conducted over three days in the period 19th November 2001 to 14th December 2001 involving a wider community of interests across Greater Glasgow and which concluded that the Stobhill Greenfield site was the preferred option.

3.5.6 These exercises are documented in reports presented to the Health Board and Primary Care Trust in 29th January 2002 and 7th February 2002 respectively <sup>2</sup>.



### **3.6 Summary of main benefits**

- 3.6.1 The main objective of the project is the improvement of the quality of care provided to mentally disordered offenders.
- 3.6.2 A summary of the main benefits which will accrue to patients arising from the implementation of the project is provided below:
- (i) Local access to secure care service(s)
  - (ii) Provision of appropriate level of secure accommodation
  - (iii) Improved physical environment for provision of care
  - (iv) Improved prospect of successful rehabilitation
  - (v) Availability of ongoing specialised community based support.
- 3.6.3 Further to the above, the introduction of a balanced provision of care as envisaged by the project will ease pressure on the facilities of the State Hospital which currently accommodates a significant number of residents who require medium and/or low secure care, rather than high secure care.

### **3.7 Financial Summary**

- 3.7.1 The capital and revenue costs of the alternative site options for achieving the preferred model of care were calculated, taking into account:
- Capital costs
  - Staff Costs
  - Supplies and overheads costs
  - Capital charge costs
- 3.7.2 Capital costs for the preferred option, the Stobhill (green field) site, were the lowest.
- 3.7.3 The revenue costs associated with this option were also the lowest. Other options demonstrated incremental revenue costs of between £50,000 and £1.09M in 1997/98.
- 3.7.4 The OBC approval stands at £12.5M construction cost. Taking account of the impact of inflation since 1997/98, the capital cost of the preferred option is now £17.9M at 2004/05 cost values.
- 3.7.5 The total recurring revenue costs which will be incurred by the Trust in providing the enhanced service as envisaged by the project will be £8.7M (2004/05 base). The total amount of income currently received by the Trust from Greater Glasgow NHS Board with regard to the current provision of forensic psychiatry and associated services is £4.4M. This leaves a requirement for additional funding of £4.3M which is provided for within the envelope of funding identified by Greater Glasgow NHS Board for a comprehensive cross-agency service.

## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION

#### SECTION 4: THE PREFERRED SOLUTION

##### 4.1 The Preferred Solution

- 4.1.1 A description of the consortium and its members, including an evaluation of their strengths and qualities, follows:

The consortium comprises:

Lead Member	Canmore Partnership
Builder	Balfour Beatty
Banker	Dexia Group
Financial Advisor	Operis
Legal Advisor	Dundas and Wilson
Architect	Boswell Mitchell Johnston
Facilities	Parsons Brinckerhoff

- 4.1.2 The Lead member, Canmore Partnership, and the builder Balfour Beatty have had experience in schemes of this scale and have reflected an understanding of health requirements, both technical and day-to-day service issues, in their written submissions and in face-to-face dialogue.
- 4.1.3 They have NHS PFI experience at the Lochgilphead Health & Social Care Facility at Durham & Darlington Community Hospital. In addition, Balfour Beatty has a wide experience of public sector construction projects, ranging from Edinburgh Royal Infirmary to Barlinnie Prison.
- 4.1.4 Architects, Boswell Mitchell Johnson, were responsible for designing an 84 bed psychiatric hospital in Dundee and have brought this experience to bear on this project.
- 4.1.5 Whilst no party has designed a health service forensic facility, with its emphasis on security, the output specification provides a clear and comprehensive statement of requirements.
- 4.1.6 Parsons Brinckerhoff have experience of FM delivery at Royal Berkshire Hospital and the Office of Government Commerce.
- 4.1.7. In commercial terms, Balfour Beatty, who will bear significant risk on building, are rated as “minimal risk” by Dun & Bradstreet.

##### 4.2 Description of the PFI solution

- 4.2.1 The design consists of 74 single bedrooms with ensuite facilities arranged as:

- 2 x 12 bed low secure units
- a 6 bed female low secure unit
- a 4 bed medium secure learning disability unit
- a 10 bed medium secure admission unit
- a 6 bed medium secure intensive care unit
- 2 x 12 medium secure bed rehabilitation units

4.2.2 These are all provided at ground floor level, with day areas and therapy rooms. There is an indoor recreational facility and outdoor recreation areas (enclosed within the perimeter of the building). In addition to patient areas, there are reception and administration areas.

4.2.3 Key features of the building are:

- The design ensures security of patients, staff, property and public safety. There is strict control of movement of people and goods in and out of the building and within the building between compartments. In addition to technical security measures such as door entry and cameras, there is operational security delivered through the design and location of staffing points throughout the building.
- Compliance with patient charter standards. In addition to security measures, rooms and spaces allow for audio and visual privacy where appropriate.
- Designed for therapy. The patient experience is enhanced through optimal use of light, colour and space.
- Servicing of the building can take place without disrupting patient services.

4.2.4 The PFI solution offers a design which addresses all these requirements and makes available the accommodation required for delivery of forensic services. Construction is in timber frame, with facilities configured to achieve optimal use of available space while ensuring clinical and security requirements are met. The contract term for providing the facilities is 35 years.

4.2.5 The building will be constructed in an area designated for an LFPU at Stobhill Hospital. It satisfies the location requirement, which is to be collocated with mainstream acute and acute MH inpatient facilities.

#### **4.3 Timetable for securing outstanding planning permission and details of what happens if planning permission is not achieved**

4.3.1 The nature of the consultation process for the service required the Trust to submit a detailed planning application for an LFPU. (The building design was used to develop the Public Sector Comparator). The planning application was approved in October 2002.

4.3.2 The solution now proposed involves some minor changes to the design on which the planning application was based originally, with the main changes being:

- administration being on two floors instead of one
- the building floor space is slightly reduced from the Public Sector Comparator due to space efficiencies inherent in design.

4.3.3 Glasgow City Council has indicated that it intends to process these changes as amendments to the planning application accordingly and there is no requirement for Canmore Balfour Beatty (CBB) to resubmit a new planning application for approval.

4.3.4 At financial close, the Trust, CBB and the Council will exchange letters acknowledging transfer of planning permission from the Trust to CBB who will assume responsibility for the construction.

#### **4.4 Timetable from FBC to financial close and delivery of service**

##### **4.4.1 The timetable is:**

Greater Glasgow NHS Board approval of FBC	20th April 2004
Scottish Executive approval of FBC	31 May 2004
Financial Close	28 February 2005
Complete Construction	1 April 2005 – 31 October 2006
Service Commencement	1 December 2006

#### **4.5 Details of when the price quoted in the PFI bid is firm until**

- 4.5.1 A base date of 1<sup>st</sup> April 2004 is the date adopted for the price quoted in the PFI bid. The base date has been amended to 1<sup>st</sup> January 2005, following agreed changes to the bid specification and the public sector comparator, reflecting indexing and site conditions.

The unitary charge will be held firm until 28 February 2005.

#### **4.6 Details of the assumed interest rate on which the price of the scheme is based, including the interest rate buffer**

##### **4.6.1 The assumed interest rate on which the price of the scheme is based is:**

Senior Debt	5.24 %
Margin	1.0 %
MLA	0.03%
Credit Spread	0.15%
<b>Total</b>	<b>6.42%</b>

- 4.6.2 Interest rates may be subject to fluctuation in the period up to financial close. The Trust recognises the need to take account of any change in costs associated with changes in the rate of interest in its financial plan to meet the cost of operating the unit.

#### **4.7 Sensitivity analysis of the effect on the price of an increase or decrease in interest rates**

##### **4.7.1 The sensitivity of Unitary Charge to interest change is:**

	<b>£'000</b>
Standard Charge (before rates and energy supply) at interest rates stated above	1737
Increase in rates by 0.25%	1762
Increase in rates by 0.5%	1787
Decrease in rates by 0.25%	1712
Decrease in rates by 0.5%	1687

## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION

#### SECTION 5: THE PUBLIC SECTOR COMPARATOR (PSC)

##### 5.1 Description of how the PSC has been derived and updated from the preferred option in the OBC

- 5.1.1 The PSC is derived from the preferred option in the OBC. The preferred option was for the provision of a facility of 74 places, located on a Greenfield site at Stobhill Hospital. The basis of costing the different elements of the PSC was as follows:

Cost Element	Basis of Costing
Salaries – clinical and administration	Manpower plan (see Section 16, Appendix 1)
Building cleaning and maintenance	Experience of existing acute in-patient facilities within mental health, particularly intensive care units
Building cost and pre planned maintenance	Build cost guidelines, indexed to current values (BCIS cost index). Technical advice on building and infrastructure costs
Heat / light / power, rates	Current guidance on heating, rates costs as normally applied, scaled to building
Other costs (e.g. catering)	Support Services estimates, based on current experience
Land	The land is within the ownership of NHS Greater Glasgow and will transfer at existing cost and funding

- 5.1.2 The PSC has been updated to reflect: a) build and other cost inflation, indexed to take account of elapsed time, and b) changes to design agreed during process of exploring the scope for a PFI solution (see section 5.2). Indexing has been applied to capital build costs and to current salary scales where applicable:

	OBC Preferred Options Costings £k	Present PSC Costings £k
Capital build cost 1999/2000	12500	
2004/2005		19030
Revenue cost (capital charges, maintenance, heat/light/power, rates) 1999/2000	1380 p.a.	
2004/2005		2044 p.a.

**5.2      Explanation of any updates that have been made in order to place the PSC on the same basis as the PFI option**

- 5.2.1    When the OBC was prepared, a facility of 76 places was envisaged. This has been subsequently refined to 74 places with a small change to the balance of medium secure/low secure provision to reflect the need to provide a configuration which meets the requirement of single sex accommodation.
- 5.2.2    There have been no significant changes identified during the process of exploring PFI which would require adjustment to be made to the PSC excepting those changes identified above i.e., site conditions and indexation changes.

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION**

#### **SECTION 6: THE PPP/PFI PROCUREMENT PROCESS**

##### **6.1 Description of the procurement methodology undertaken**

- 6.1.1 The Trust used the PPP/PFI procurement process based on European Procurement Regulations Negotiated Procedure.

##### **6.2 Details of the advisers used by the Trust**

- |       |                    |   |
|-------|--------------------|---|
| 6.2.1 | Legal              | McClure Naismith, Queen Street, Edinburgh     |
|       | Finance            | Tribal Consulting, Birmingham                 |
|       | Technical          | Young & Gault, Speirs Wharf, Glasgow          |
|       | Project Management | Currie & Brown, West Campbell Street, Glasgow |

##### **6.3 Description of the pre-qualification process indicating the route by which the Trust arrived at the short list**

- 6.3.1 The Trust placed a notice in the Official Journal of the European Community (OJEC) on 2 September 1999 inviting interest in the design, construction, finance and operation of hard facilities for a Local Forensic Psychiatric Unit, or Secure Care Centre, as it was then called. The negotiated procedure would be applied.
- 6.3.2 Pre-qualification questionnaires were sent to 7 interested parties of which 5 were interviewed to assess their breadth of experience and depth of interest. Thereafter, 3 consortia were selected for invitation to negotiate:
- Melville Dundas
  - Grosvenor House Group
  - Balfour Beatty
- 6.3.3 Invitations to Negotiate were issued on 7 April 2000.
- 6.3.4 Subsequently, in June 2000, recognising the level of public concern regarding the proposed location for the Unit, it was decided to suspend the ITN process and initiate an extended period of public consultation regarding the siting of the Unit. The outcome of this process of consultation confirmed that the preferred location at Stobhill Hospital was the best option. Glasgow City Council approved a detailed planning application for this site in October 2002.
- 6.3.5 During this period, the Trust maintained contact with the Bidders who reiterated their interest in the project.
- 6.3.6 In November 2002, the Trust re-issued the ITN, updated to reflect current guidance and requirements.
- 6.3.7 Following re-issue of the ITN, Grosvenor House Group declined to submit a bid.

6.3.8 Dawn Construction Ltd took over Melville Dundas PFI interests during the bid process. The Trust accepted this on the basis of Dawn's track record and in particular its experience on the Stonehouse Hospital project.

#### **6.4 Brief Summary of the Invitation to Negotiate document including the evaluation process and criteria described for selecting a preferred bidder**

6.4.1 The Invitation to Negotiate included:

- *Volume 1* - The Trust's approach to the invitation process and the requirements from Bidders for submission of proposals.
- *Volume 2* - Draft Project Agreement describing the legal framework by which the Trust would enter into contract with a private sector partner.
- *Volume 3* - Output Specification detailing output requirements of the building and performance standards required by the Trust.
- *Operational Policies* - describing how the Trust would operate services in the new unit.

6.4.2 The evaluation process was based upon:

- evaluation of the design carried out under a disciplined process of questions and answers on proposed designs; all contributed to this process of evaluation - clinicians, managers and technical advisors;
- legal assessment carried out by the Legal Advisors;
- financial assessment carried out by the Financial Advisors;
- integrity assessment carried out by Legal Advisors; and
- technical assessment carried out by Technical Advisors

#### **6.5 Explanation of the choice of preferred private sector partner**

6.5.1 Both Bidders submitted proposals that complied with design outcome requirements where they scored closely. On FM services, CBB emerged with a slightly more thorough approach to these services. On other evaluations, the only area of significant difference was on affordability and value for money. CBB were close to the benchmark values while Dawn/Melville Dundas were further away. Intense dialogue and negotiation took place with both sets of Bidders to explore how closely they could bring proposals into line with PSC financial benchmarks without compromising outputs compliance, and it became evident that Canmore/Balfour Beatty were better placed to close the gap than Dawn (Melville Dundas). Therefore CBB were appointed Preferred Bidder.

6.5.2 A summary of the relative scores is provided below:

	<b>Canmore/Balfour Beatty</b>	<b>Dawn Group</b>
Technical Works	1.33	1.31
Technical Services	1.82	1.65
Legal	0.90	0.92
Integrity	0.62	0.66
Financial	1.51	1.24
<b>TOTAL</b>	<b>6.18</b>	<b>5.78</b>

#### **6.6 Copy of the original OJEC advertisement**

A copy of the original OJEC advertisement is attached as Section 6 Appendix A.



## APPENDIX A

### COPY OF ORIGINAL OJEC ADVERTISEMENT

1. **Awarding Authority** Greater Glasgow Primary Care NHS Trust  
Gartnavel Royal Hospital  
1055 Great Western Road  
GLASGOW  
G12 0XH
2. (a) **Award Procedure** Negotiated
- (b) **Contract Type** See 3B below
3. (a) **Site** A single site in Glasgow
- (b) **Service**

Design, construction, equipping, financing and maintenance of a 72 (sic) place single bedded en suite secure health care facility to provide a range of health care services to offenders with mental health problems.

The build will encompass all clinical and associated non-clinical departments.

Tenders are sought by the Trust for proposals from suitably experienced contractors or consortia of suitably qualified specialists.

A contract term of 30 years is anticipated.

#### **Preparation of Plans**

The Bidder will be required to draw up such plans, which should take cognisance of Good Practice Guidelines in design and layout for this specific client group – this should include reference to guidelines from:-

- Community Care
- Greater Glasgow Health Board's Health Improvement Programme
- National Government Priority to improve Mental Health
- Framework for Mental Health Services in Scotland
- Scottish Office Consultation Draft Paper "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland"

The Bidder will be required to receive such approvals and consents as are necessary to satisfy the requirements of the Trust; the Planning Authority, Building Regulations (Scotland); Environmental Health and any other statutory authority requirement.

#### 4. **Completion Deadline**

On appointment, the successful Bidder will be responsible for achieving the necessary planning and related consents. It is intended to have the facility ready for use by October 2002.

5. **Legal Form**

Anybody to whom a contract is awarded must be a body corporate where joint and several liability will apply for due performance of the contract. There must be appropriate security for all contractual obligations.

6. **Note**

- (a) Deadline for receipt of expressions of interest will be 12.00 midday 24 September 1999.
- (b) **Address** as a 1 : For the attention of the Chief Executive
- (c) **Contract Name** Jack Wilson Estates Capital Administrator (tel 0141 211 3765)
- (d) **Language** English

7. **Deposits and Guarantees**

A performance bond will be required for each contractor, firm or supplier, to be specified in the contract documentation.

8. **Financing and Payment**

The Trust is seeking innovative proposals from the private sector for the funding of this scheme ensuring risk transfer and value for money are identified.

9. **Qualification**

Each applicant (or each member of a consortium) must provide details as set out below:

These include:

- Copies of the last 3 years audited accounts
- Details of the experience and professional qualifications of candidate's staff who would hold key positions of responsibility for carrying out the project
- Details of major projects undertaken in the last three years, included in this must be examples of healthcare facilities, preferably involving secure care
- Details of referees for each member of the consortium and other professional, financial or technical information that will enable the Trust to assess the suitability and experience of the candidate

**Variants** Variant bids will be permissible, provided the contract authority agrees that the core requirements will be met.

10 **Other Information**

This requirement may be suitable for the application of the Private Finance Initiative (PFI) or an alternative Public Private Partnership (PPP). Service providers who respond to this requirement will ultimately be required to make firm proposals for funding the project in accordance with this application. The contracting authority reserves the right not to award a contract.

## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION

#### SECTION 7: THE APPRAISAL PROCESS

##### 7a Financial Appraisal (Affordability Analysis)

##### 7a.1 Quantification of the revenue implications of the scheme for the PSC and the PFI option

- 7a.1 Costs have been quantified based on work carried out in preparation of the Public Sector Comparator and the financial models supplied by Canmore/Balfour Beatty. It is recognised that some minor changes may occur between completion of this version of the FBC and financial close. Details of these will be provided in the FBC – PPP/PFI Addendum to be submitted following financial close.

Costs base at 2004/05 prices.

##### Services within Scope of PFI

	<b>PSC £'000</b>	<b>As Provided Under PFI £'000</b>
Capital Charges	1418	-
Maintenance	293	-
Heat, Light & Power	82	82
Rates	251	251
Unitary Charge (Yr 1)	-	1737
<b>Total</b>	<b>2044</b>	<b>2070</b>

Whilst the total revenue cost of the PFI solution exceeds the cost of the PSC solution, the PFI cost is currently based on an excessive senior debt interest rate, likely to be considerably less at time of financial close. The actual interest rate applying is likely to reduce the charge by a sum in the region of £40k p.a., reducing the charge from £1737k to £1697k. The Board will not require to provide funding to run the scheme under a PFI provision.

##### 7a.2 Analysis of the impact of the proposals on the Trust's I & E A/C, Balance Sheet and cash flow

- 7a.2.1 The Trust's projected financial position is now incorporated within NHS Greater Glasgow's (NHSGG) financial projections, and is part of a unified NHS financial plan. The funding stream(s) required to pay for the operation of this unit are incorporated within NHSGG's financial plan. Planning also allows for the event of the property passing to the NHS at the end of the contract at a nil or nominal value and a residual interest in the asset accumulates over the life of the contract.

##### 7a.3 Description of assumptions made for the financial appraisal, including an explanation of the methodology used to project both income and expenditure

##### 7a.3.1 Key assumptions:

- Patient activity is consistent with occupancy assumptions. Patient activity is described in Section 3.3 of this case. The projected occupancy levels are

between 76% and 91% for the Medium Secure bed facilities and between 89% and 91% for Low Secure bed facilities. Occupancy levels are based on detailed forecasts of admissions and discharges. This will provide the necessary level of flexibility to manage the eventuality of occasional peaks in the admission rates.

In addition to the above, it is planned that the Unit will open on a phased basis:

*Phase 1* - first 6 months - open 2 medium secure wards and 2 low secure wards (40 beds)

*Phase 2* - second 6 months - open further 2 medium secure wards (16 beds)

*Phase 3* - after 18 months - open low secure ward and IPCU ward (18 beds)

A phased introduction of services is appropriate for a development of this scale and will enable staff recruitment, development and training activities to be scheduled within a realistic timescale.

- Staffing levels remain consistent with the workforce plan, and can be achieved through recruitment. The workforce plan is based on the preferred model of care, with different manpower levels at each level of care, from admission through to rehabilitation into the community as described in Section 3. Detail of the plan is set out in Section 16 and describes the skills, numbers and recruitment necessary to achieve the desired model of care.
- Indexation assumptions are robust. It is assumed that funding indexation and cost inflation are 2.5% p.a.
- The unitary payment is £1737k p.a. based on January 2005 price base and will be indexed annually to the RPI value. It will not fluctuate beyond this without explicit agreement of the Trust and in accordance with the project agreement.
- Lifecycle costs are borne by the Project Co for the duration of the agreement.
- The interest rate used as a discount factor in assessment is 6% p.a., as advised for economic assessments.
- Delivery of the PFI service will commence in the timescale planned, December 2006.
- VAT is excluded from the assessment, being assumed as reclaimable, where charged by the Project Co.
- Capital charges are omitted from the PFI solution assessment, an off-balance sheet treatment being assumed.
- Land continues in NHS ownership. A small capital charge will be incurred by the Trust. This has been excluded from the assessment.
- NHS Board funding streams are available as planned.

7a.3.2 No further service development beyond the establishment of the new unit is assumed. However, it is acknowledged that even with the most detailed approach to service planning, unforeseen changes will arise. A general assumption is made that these will be matched, as required, with additional revenue funding or realignment of resources.

#### 7a.3.3 PFI financial model assumptions:

- Concession period 35 years
- Debt : equity ratio - 90:10
- Senior debt - £17.9 M
- Year 1 unitary charge £1,737,000 at 2004/05 base
- Year 2 unitary charge £1,737,000 at 2004/05 base
- Overall interest rate 6.42% at time of drafting

#### 7a.3.4 Rate of Return

Green Book guidance revised the rate of return from 6% to 3.5% with effect from 1<sup>st</sup> April 2003.

In accordance with guidance on the conduct of PFI processes, as it applies to schemes which were at the stage this project had reached at 1 April 2003, 6% was used as the rate of return in the assessment of bids and the public sector comparator.

#### 7a.4 Description of income from other sources

- 7a.4.1 No income is assumed from other NHS Boards as the facility is planned to service the needs of NHS GG patients only.

#### 7a.5 Position on VAT treatment of the project, including details of clearance from C & E

- 7a.5.1 In accordance with regulations published by the Treasury, the Trust may claim and be refunded tax charged on supply of services and leased accommodation relating to health care facilities. It is anticipated that this direction will apply to the scheme.

#### 7a.6 Description of how land and buildings have been included in the deal

- 7a.6.1 Trust land will be used for construction of the facility and there will be a Head lease of the land to the Project Co, together with an Under lease of the land by the Project Co to the Trust. This arrangement terminates on termination of the deal or ending of the agreement period.

- 7a.6.2 No current buildings are included in the deal.

#### 7a.7 Details of writing off of any Trust assets

- 7a.7.1 No Trust assets will be written off on account of this scheme.

#### 7a.8 For building projects, forms FB 1 – 4 detailing capital costs

- 7a.8.1 Forms for the building costs of the PSC option are included as Section 7 Appendix A. The sum total of construction is shown as £17942k. This sum is amended to £19030k in accordance with an adjustment for additional cost of drainage for the site, of £378k and build cost indexation from April 04 to January 05 of £710k.

## **7b Economic Appraisal (Value for Money Analysis)**

### **7b.1 Net present value (NPV) comparison of the PSC and the PFI option**

7b.1.1 The results of the analysis are:

<b>Net present value over 35 years -</b>	<b>PSC</b>	<b>PFI</b>	<b>£'000</b>
NPV of cash flows	23945	27513	
NPV of retained risks	8022	4337	
Risk-adjusted NPV	31967	31850	

7b.1.2 The analysis shows that the PFI option has the lowest NPV and is therefore the best value for money over the contract period.

7b.1.3 In both cases, it is assumed that buildings have a 60 year life-span. The contract has a period of 35 years duration from date of signing and it is over this period that the comparison is measured.

### **7b.2 An explanation of the reasoning why the preferred option is better value for money**

7b.2.1 The preferred option is better value for money because for a lesser economic cost, it includes provision of the facility and removes from the Trust significant risk elements. The principal risk element is the potential of exposure to an excess cost of capital construction. This is shown in the assessment of risk which is presented in section 7c below. The main conclusions are that:

- the Trust is protected from the potential for additional cost arising from a capital cost overrun;
- it is less likely to suffer from construction time overrun, with consequential cost and service issues; and
- the standard of maintenance is explicit and enforceable, to the benefit of the environment and service.

### **7b.3 Description of assumptions made for the economic appraisal**

7b.3.1 Key assumptions are:

- Prices are based on 2004/05
- PSC capital, lifecycle and FM costs have been estimated using a combination of existing experience, current guidance on NHS building costs appropriately indexed to a common cost base date, and using advice of technical advisors on the validity of build costs
- Capital cost indexing estimates are reliable. A BCIS build cost index of 213 Forecast, 4th quarter 2004 is used for the PSC capital cost
- A discount rate of 6% has been used in assessments
- VAT is excluded from assessments

**7b.4 Details of how the PSC was calculated, including updated information from the OBC on how the capital expenditure schedules, lifecycle costs and other operating costs were calculated. Consideration should be given to environmental factors**

7b.4.1 Details of the PSC calculation and how it was updated are shown in Sections 5.1 and 5.2.

7b.4.2 With regard to environmental factors, the project's works output specification draws attention to sustainability and environmental issues, in particular seeking installation of a building management system (BMS) which ensures optimum usage of energy resources. This is incorporated within the PSC design and is also specified in direction to the Project Co.

7b.4.3 Clinical waste does not feature as an issue affecting this project.

**7b.5 Description of the quantification of costs and benefits included in the appraisal**

7b.5.1 The costs and benefits in the appraisal include the relevant cash flows for the project and money valuation of the risks assessed for the project. VAT and capital charges are excluded from the appraisal, representing cash transfers from one government department to another.

7b.5.2 Quantification of PSC costs is outlined in Section 5.1 and quantification of risks is outlined in Section 7c.

**7b.6 Description of the non-quantified costs or benefits in the scheme**

7b.6.1 Section 11 gives detailed descriptions of non-quantified benefits and Section 12 describes the risk management approach where non-quantified costs arise. These are similar for the PSC solution or the PFI solution. Therefore non-quantified costs or benefits do not feature in this appraisal.

7b.6.2 In view of the constraints on capital funding in Greater Glasgow for the foreseeable future, the prospect of developing this facility through capital funding is remote. Arguably, the most significant non-quantified benefit of the PFI option is that it will allow the facility to be available in a short period at no additional cost and at no reduction in value for money. Patients will benefit from this development at a much earlier time than would be the case with a public capital option. They will experience a significant improvement in their lives, including enhanced prospects for successful rehabilitation, on account of the provision of the new service.

**7b.7 Sensitivity analysis, and scenario modelling of the key assumptions behind the economic appraisal**

7b.7.1 The key assumption used in economic appraisal is the interest rate applying to senior debt in the PFI financial model.

Sensitivity outcome:

**NPV over 35 year life -**

	<b>Senior debt % interest rate</b>	<b>NPV £'000</b>	<b>UC Year 1 incl. Rates &amp; H/L/P £'000</b>
Present model (without risk adjustment)	5.24	27513	1737
Reduce rate 0.26% to	4.98	27167	1711

Increase rate 0.26% to	5.50	27859	1763
------------------------	------	-------	------

7b.7.2 The outcome of this sensitivity analysis is that the VFM would improve by NPV £346,000 for each 0.26% fall in interest rate on the senior debt and would rise by NPV £346,000 for each 0.26% rise in interest rate.

7b.7.3 The interest rate would require to rise by more than 0.01% before the PFI option was no longer economically justifiable, i.e. PFI NPV (risk adjusted) £31980k v. PSC (risk adjusted) NPV £31967k, after 0.01% increase in senior debt interest rate.

It is acknowledged that this reveals a very small advantage to the PFI solution. However, at time of drafting, the long term SWAP rate is around 4.7%, as opposed to 5.24% used in the PFI solution outlined here, a gain of 0.54%. If sustained, the VFM of the PFI solution would improve by £718k, giving an overall superiority of £835k NPV.

7b.7.4 Further testing of assumptions is illustrated below:

i) PSC capital cost over-estimated by 0.6%:

	<b>PSC NPV £k</b>	<b>PFI NPV £k</b>
Original (risk adjusted)	31967	31850
PSC capital cost -0.6%	31853	31850

The PSC capital cost would require to be over-estimated by 0.6% to bring the PSC NPV to the value of the PFI NPV. An over-estimate of this size is possible and would bring the PSC into comparability with the PFI solution. However, given the scale of the beneficial change in the interest rate described above, it is not considered that this over-estimate or other minor difference need be brought into account.

ii) Maintenance costs over-estimated

	<b>PSC NPV £k</b>	<b>PFI NPV £k</b>
Original	31967	31850
Maintenance costs -3.0%	31840	31850

Maintenance costs would require to be over-estimated by a factor of 3% or more to bring the PSC NPV to a value similar or better than the PFI NPV. This over-estimate is possible, but as noted above, the change in the base interest rate outweighs any likely over-estimate that might have occurred.



## **7c Risk Analysis**

### **7c.1 Risk allocation matrix showing which party is responsible for managing each risk.**

7c.1.1 The risk allocation matrix is attached as Section 7 Appendix B and groups risks into:

- Design risks
- Construction and development risks
- Performance risks
- Operating cost risks
- Variability of revenue risks
- Termination Risks
- Technology and obsolescence risks
- Control Risks
- Residual Value Risks
- Other project Risks

### **7c.2 A list of the key individual risks including an explanation of what each one means and how the values and probabilities of those risks occurring have been determined**

7c.2.1 The key individual risks are those substantial risks which transfer to the Project Co under the agreement. The key risks to be transferred and their quantification within the PSC are based on:

- Design - risk that the design is insufficiently specified or agreed and changes are required after planned sign off stage. Quantified using Trust experience on smaller scale projects completed to date and escalating to scale of the present project. The technical advisors support this approach.
- Construction and Development - risk that costs overrun. The Trust's experience is that construction costs do escalate and this is normally addressed by revising specifications. Green book guidance published 2003 was used in assisting to update and quantify this risk. This guidance describes an expenditure bias in the range 2% to 24% and a works duration bias in the range 1% to 4% for NHS projects. In view of the self-contained nature of this project and the confidence that exists on ground conditions as a result of research, and ready access to the site, bias in the capital expenditure estimate is taken at the lower end of these ranges.
- Performance - risk that defects or other causes make the building unsuitable or unavailable for use. Specification and supervision of construction are rigorous processes designed to eliminate this risk. However, it is acknowledged that unforeseen circumstances can arise which impact the efficient running of the building, if not extending to place part of it out of use. A prudent allowance is made for this risk.
- Operating cost - risk that cost of maintaining the building is exceeded. The Trust operates buildings of various ages and is aware that operating costs can escalate beyond those estimated. Again, an allowance is made for this, partly based on experience.

7c.2.2 Risks were initially identified and quantified by the Trust, and were thereafter reviewed by the Trust's Financial Advisors who were able to confirm the reasonableness of the Trust's approach by reference to comparative studies with other NHS schemes.

7c.2.3 Individual risks and their evaluation quantification can be found attached as Section 7 Appendix B.

**7c.3 An NPV analysis of the risks retained by the public sector under each of the options considered**

**NPV over 35 years:**

Risk category	Options	
	PSC £'000	PFI £'000
Design	1034	248
Construction and Development	1712	210
Performance	629	40
Operating cost	2930	2549
Other risks	1718	1290
<b>Total</b>	<b>8023</b>	<b>4337</b>
Risks transferred	-	3686
<b>Total</b>	<b>8023</b>	<b>8023</b>

**7c.4 An assessment of the total risks associated with the project, including those which are non-quantifiable**

7c.4.1 Risks which are quantifiable are described in the above sections.

7c.4.2 Risks which are non-quantifiable are described in Section 12: Risk Management. Due to the nature of the Unit, there is an overarching need to contain risk, especially that attaching to safety of patients, staff and public. There is an active risk containment process which seeks to manage this major feature of the service.

**7c.5 Sensitivity analysis of the key assumptions underlying the risk analysis**

Risks transferred would require to fall by more than £117k NPV to make the PSC option better value for money than the PFI option. For this to happen, reductions would be required across the transfer of key risks e.g. risk of construction. Whilst there is a possibility of risks reducing, it is not considered likely that they would reduce in sufficient size to outweigh the benefit arising from the reduced interest rate detailed above.

**7c.6 Sensitivity analysis on the impact of other purchasers altering purchasing behaviours**

7c.6.1 Not applicable.

## APPENDIX A

**COST FORM FB1**

PROJECT DIRECTOR: Anthony Curran

	Cost Exc VAT £	VAT £	Cost Inc. VAT £
1. Department Costs (from Form FB2	7,747,598	1,355,830	9,103,428
2. On-Costs (a) (from Form FB3) (61.4% Department Cost)	4,757,022	832,478	5,589,500
3. Works Cost Total (1+2) at .....FP/VOP* SPSBTP1 (Tender Price index level 2003 = 210 base)	12,504,620	2,188,308	14,692,928
4. Provisional location adjustment (if applicable) (5 %)	625,230	109,415	734,645
5. Sub Total (3+4):	13,129,850	2,297,723	15,427,573
6. Fees (c) (10 % of sub-total 5)	1,313,000	(d) xxxxxxxxxx	1,313,000
7. Non-Works Costs (from Form FB4) (c)			
L.A. Fees	80,760	xxxxxxxxxx	80,760
OTHER			
8. Equipment Cost (from Form FB2) (7.5 % of Department Cost)	581,070	101,687	682,757
9. Contingencies	373,330	65,333	438,663
10. TOTAL (for approval purposes)	15,478,010	2,464,743	17,942,753
11. Inflation Adjustments (f)			
12. FORECAST OUTTURN TAKEOVER BUSINESS CASE TOTAL	15,478,010	2,464,743	17,942,753

Cash Flow Year:	SOURCE			£
	EFL	OTHER GOVERNMENT	PRIVATE	
			Total Cost (as 10 above)	_____
				_____
				=====
				=

Authorised by: Anthony Curran - Project Director

**FULL BUSINESS CASE FOR PREFERRED OPTION****COST FORM FB2**

TRUST: Greater Glasgow Primary Care NHS Trust

SCHEME: Local Forensic Psychiatric Care Unit

PHASE: N/A

PROJECT DIRECTOR: Anthony Curran

**CAPITAL COSTS: DEPARTMENT COSTS AND EQUIPMENT COSTS**Functional Content  
Equipment

Functional Units/

N/A/C/ (2)

DCG Schedule

	Space Requirement (1)		Date.....	Cost
			£	£
Administration		N	666,000	
Reception		N	338,200	
Recreation		N	1,181,098	
Beds				
	Intensivecare	6		
	Admission	10		
	Rehabilitation	48		
	Learning Disability	4		
	Womens Low Secure	6		
	Beds	<u>74</u>	5,338,750	
Kitchen		N	33,800	
Stores		N	30,750	
Energy Centre		N	159,000	
				£
				581,070
Less abatement for Transferred equipment if applicable (.....%) (3)				
Department Costs and Equipment Costs to Summary			£7,747,598	£581,070
(Form FB1)				See Notes Overleaf

**FULL BUSINESS CASE FOR PREFERRED OPTION****COST FORM FB3**

TRUST: Greater Glasgow Primary Care NHS Trust  
 SCHEME: Local Forensic Psychiatric Unit  
 PHASE: N/A

**CAPITAL COSTS: ON-COSTS**

	Estimated Cost (exc VAT)	Percentage of Departmental Cost %
1. Communications a. Space b. Lifts	£	
2. 'External' Building Works (1) a. Drainage b. Roads, paths, parking c. Site layout, walls, fencing, gates d. Builders work for engineering services outside buildings	£	
3. 'External' Engineering Works (1) a. Steam, condensate, heating, hot water and gas supply mains b. Cold water mains and storage c. Electricity mains, sub-stations, stand-by generation plant d. Calorifiers and associated plant e. Miscellaneous services	£	61.40
4. Auxillary Buildings	£	
5. Other on-costs and abnormals (2) a. Building b. Engineering	£	
<b>Total On-Costs to Summary FB1</b>	<b>£4,757,022</b>	<b>61.40</b>

**Notes:** Must be based on scheme specific assessments/measurements; attach details to define scope of works as appropriate.

\* Delete as appropriate

(1) 'External' to Departments

(2) Identify any enabling or preliminary works to prepare the site in advance e.g. demolitions; service diversions; decanting costs; site investigation and other exploratory works.

This form completed by: John Cameron Date: 16.02.04  
 Telephone No: 0141 211 3831

**FULL BUSINESS CASE FOR PREFERRED OPTION****COST FORM FB4**

TRUST: Greater Glasgow Primary Care NHS Trust

SCHEME: Local Forensic Psychiatric Unit

PHASE: N/A

**CAPITAL COSTS: FEES AND NON-WORKS COSTS**

		Percentage of Works Cost
<b>1. Fees (including 'in-house' resource costs)</b>		
a. Architects b. Structural Engineers c. Mechanical Engineers d. Electrical Engineers e. Quantity Surveyors f. Project Management g. Legal Fees h. Site Supervisor i. Others (specify)	1,313,000	10%
Planning Supervisor Expenses/contingency		
Total Fees to Summary (FB1)	<b><u>£1,313,000</u></b>	
<b>2. Non-Works Costs</b>		
		£
a. Land Purchase costs and associated legal fees		-
b. Statutory and Local Authority changes		-
c. Building Regulations and Planning Fees		80,760
d. Other (specify) e.g. decanting costs		-
Non-Works Costs to Summary (FB1)		<b><u>£80,760</u></b>

Notes:

\* Delete as appropriate

This form completed by: John Cameron      Date: 16.02.04

Telephone No: 0141 211 3831

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## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION

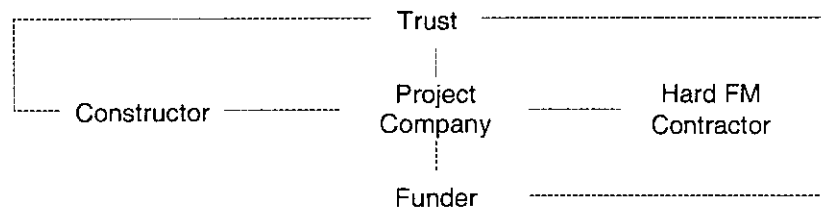
#### SECTION 8: THE SUMMARY OF THE CONTRACT STRUCTURE

##### 8.1 Description of the contractual framework of the PFI project

A contract has been drawn up for the purpose of setting out the terms and conditions upon which the Project Co will finance, design, construct and maintain services in connection with the operation of a Local Forensic Psychiatric Unit.

The project has used the Scottish Standard Form Project Agreement Version 1. The standard form Project Agreement forms the backbone of the framework and it is accompanied by ancillary agreements allowing for the lease of land, direct agreement with the funders, and collateral warranties between the Trust, the Project Co and Subcontractors.

##### 8.2 A diagram of the legal relationships between the various parties to the deal



##### 8.2.1 The agreements between the parties are:

- Trust with Project Co  
This is the main contract which, in return for a fee, the Project Co will finance, design, construct and service a building for 35 years, with which the Trust will deliver forensic services. The contract allows the Trust to withdraw payment of the fee in a staged manner in the event of failure to deliver on the part of the Project Co and allows the Trust to terminate the contract in the event of complete failure of delivery.
- Trust with Funder  
This agreement allows the Funder and the Trust to maintain a funding arrangement in the event that the main contract is terminated.
- Trust with Constructor  
This agreement allows the Trust step-in rights to the Project Co/Constructor agreement in the event of default on the Project Co's part.
- Trust with Hard FM Contractor  
This agreement allows the Trust step-in rights to the Project Co/FM Contractor agreement in the event of default on the Project Co's part.
- Project Co with Funder, Constructor and Hard FM Contractor  
The Project Co will hold agreements with the other three parties to fund, design and build, and maintain the facilities.

### **8.3 Summary of the main provisions of the contract agreement, the position reached on key issues and any points that are outstanding**

8.3.1 The Trust is entering into a single contract for the provision of services.

These services are:

- Design and construction of a building suitable for carrying out the services specified.
- Maintenance of this building.
- Energy and utilities management associated with the building.

8.3.2 The building to be provided is described in Section 4.2.

8.3.3 This contract is supported with agreements as outlined in 8.1 above.

8.3.4 Excepting those items detailed below in 8.3.5 to 8.3.9, the main provisions of the contract conform to the Standard Form Contract Documentation and these include:

- Payment mechanism, outlined below in 8.3.6.
- Step in rights to the Trust in the event of avoiding serious disruption to services, e.g. a significant health and safety issue arises.
- Termination of agreement in the event of default by the Project Co e.g. a material breach of contract is not remedied.
- Changes are allowed for in the provision of services that prescribe how they are initiated and which party will pay for them e.g. a change required under law in the housing of mentally disordered offenders would require to be paid for by the Trust.

8.3.5 Insurance. It is usual for ProjectCo to take responsibility for loss or damage to the building in a PFI agreement. However, in this scheme involving an unusual patient group, the Board has agreed to take responsibility for patient damage up to an identified limit. Thereafter, the ProjectCo take responsibility, bearing insurance for the purpose.

8.3.6 Land. The ProjectCo have requested exclusive access to the site, such that they can be assured that nothing will interrupt their building programme, something the standard agreement does not allow for. The licence allowing them to occupy the land has been amended to permit this.

8.3.7 Final Commissioning Programme. The standard agreement anticipates the Board providing this Programme, whereas it would be more appropriate for the ProjectCo to provide the programme, in consultation with the Board. The Agreement has been amended to show this preferred position.

8.3.8 Control of shares in the ProjectCo. The standard agreement seeks prohibition of holding of shares in the ProjectCo by bodies whose interests might conflict with health interests, unless approved by the Board. In view of the way in which share-holding can become diluted and remote, minority share-holding could arise without ready awareness by ProjectCo of the minority interests concerned. In these circumstances, shareholding may arise unnoticeably, breaching the agreement. For this reason, passive minority investment in ProjectCo shares is excluded from this provision.

8.3.9 Handback Bond. The standard agreement allows for a Bond to be procured by the ProjectCo for the value of putting the facility in good condition at handback to the NHS at

the end of the agreement period. In the current agreement, the Board has agreed to exercise retention of payments rather than resorting to use of a Bond.

8.3.10 Further specific items are addressed as described below:

- Energy costs will be passed through to the Trust for direct payment, subject to agreed savings targets.
- Rates will be passed through to the Trust for direct payment.
- Equipment will be provided by the Project Co only in the case of Group 1 equipment where it is installed as part of the building design and construction. The Trust will provide all other equipment.
- Hard FM only is to be provided by the Project Co and market testing is excluded in view of the scale of service provision.
- Provisions for TUPE and other employment matters are retained although it is not intended that Trust employees will transfer in this project.
- The base date for costs is April 2004 and indexing is allowed at RPI on each anniversary of this date.
- The length of the contract is 35 years and there are no break points in this period subject to satisfactory delivery of services by the Project Co.
- Composite Trader tax treatment is applied by the Bidder to their financial application.

8.3.11 Payment mechanism conforms to standard guidance providing for deductions in the event of failure in performance or availability. Clear criteria for these matters have been established within the Contract.

8.3.12 The basis of payment is 100% of the fee on availability for use of the whole building at the standards specified in the agreement. Failures on availability or on maintenance standards (which may not impact availability in the short term) will lead to a regime of deductions to this fee on scales explicitly laid out in the agreement, these deductions escalating to complete non-payment in the extreme event of complete unavailability of the premises to the Trust.

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## **SECTION 9: ACCOUNTING TREATMENT**

### **9.1 An assessment of the proposed accounting treatment**

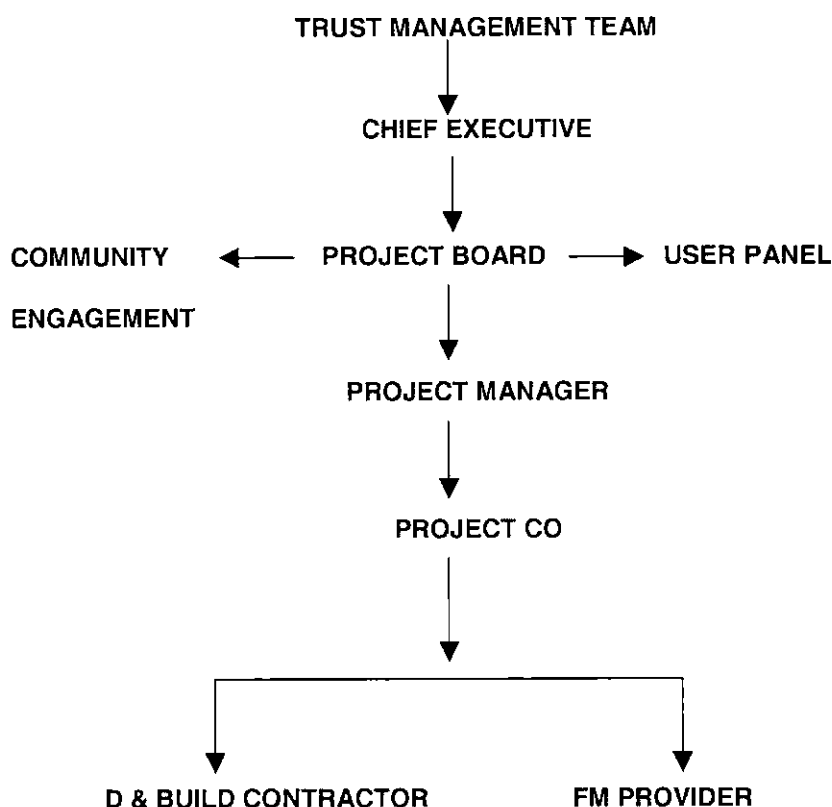
- 9.1.1 An assessment of the accounting treatment of the scheme has been carried out in accordance with the Treasury Taskforce Technical Note No.1.
- 9.1.2 In view of the unitary nature of the annual charge, FRS 5 applies and examination of the substance of the transaction leads to a conclusion that it is off balance sheet i.e., it is a revenue charge.
- 9.1.2 This is supported by the structure of the payment mechanism, the level of risk borne by the Project Co and the responsibility of the Project Co to decide how it builds and operates the building.

### **9.2 Written confirmation received from the Trust's external auditors indicates that they have no objection to the proposed accounting treatment of the project**

- 9.2.1 PriceWaterhouseCoopers have been consulted on the features of the project from which they would agree off-balance sheet treatment. It is considered that this project displays such features and their approval to this treatment will be sought by the time of financial close.

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**SECTION 10 – PROJECT MANAGEMENT ARRANGEMENTS**

- 10.1 The following management structure has been established for the project.



- 10.2 The Trust Management Team retains overall responsibility for all projects and will monitor costs and progress at regular intervals. It is responsible for ensuring that propriety is maintained in the planning and management of contracts.
- 10.3 The Trust Chief Executive takes full executive responsibility for the project, and for ensuring that it is managed in an appropriate manner. Lead responsibility for achieving the project is delegated to the Director of Finance who has executive responsibility for all Trust capital projects.
- 10.4 Because of the size and complexity of the project, a Project Board has been established to ensure an appropriate level of ownership of the project within the organisation. This Board comprises the Director of Finance, Head of Estates and Capital Investment, the Director of Nursing (as Divisional General Manager – Mental Health Division), the Clinical Director (lead Clinician) for Forensic Services, the Divisional General Manager for Directorates, the Nursing Services Manager (Forensic Directorate), the Project Manager, the Communications Manager and Trust Secretariat Manager with appropriate input from Finance, Human Resources and Support Services representatives when required. The Project Board is responsible for leading the project including the development of this business case, supported by external consultants as necessary.



- 10.5 The Head of Estates & Capital Investment will act as Project Manager and will be responsible for driving and managing the project on a day to day basis, coordinating the input of professional advisors across all functions and for the delivery of the project objectives.
- 10.6 A User Panel has been established comprising representatives of each of the relevant clinical and service departments, with delegated authority to confirm user service requirements and agree how these can be met. The User Panel includes representatives of external agencies able to represent patient interests in keeping with current philosophy in the Framework for Mental Health Services in Scotland. The User Panel also includes representatives from Finance, Estates, Human Resources and Support Services.
- 10.7 Throughout the construction phase the Trust will continue to ensure the local community around Stobhill, and other organisations and individuals with an interest in the LFPU, are kept updated on the development of the project. Where possible, communication will be developed on a joint basis with the North Glasgow University Hospitals NHS Trust to ensure that they reflect activity across the entire Stobhill site. This work will include the production of a joint Stobhill briefing update.
- 10.8 The Trust also plans to contact local groups and organisations before building work commences to offer to meet with them to provide an overview of the construction timetable, building design and service operation. In relation to user and carer involvement, the Forensic Directorate will develop plans to ensure that, where possible, the views of users and carers are sought.
- 10.9 **Control Arrangements during the Contract**
- 10.9.1 In accordance with "Public Private Partnerships in the National Health: The Private Finance Initiative – Good Practice" and the Project Agreement, the Trust has made arrangements to monitor the implementation of the contract following financial close.
- 10.9.2 The monitoring arrangements will:
- Measure the performance of the Project Co
  - Respond to change control requirements throughout the life of the contract
  - Provide information for monitoring the value for money of the services provided by the Project Co.
- 10.10 **Independent Certifier**
- 10.10.1 In compliance with the Project Agreement the Trust and the Project Co will jointly appoint a suitably qualified and experienced consultant to act as Independent Certifier.
- 10.10.2 The role of the Independent Certifier will be to safeguard the interests of the Trust and Project Co for the delivery of the capital works and start up the hard FM facilities management services; to manage the change control process up to the operating date of the LFPU and to broker the interests of all principal parties to the contract, minimising disputes and lengthy dispute resolution processes.
- 10.10.3 To comply with the above, the Independent Certifier will undertake the following functions:
- Design Compliance Check
  - Procedure Review

- Construction Review
- Reporting and Certification

#### **10.11 Trust Representative**

10.11.1 In accordance with the Project Agreement, the Trust has a right to appoint a Trust Representative who will have a entitlement to unrestricted access at all reasonable times to:-

- view the works on site
- visit any site or workshop where materials, plant or equipment are being manufactured, prepared or stored for use in the works.
- attend monthly progress meetings and site meetings
- monitor compliance with construction programme

10.11.2 The Trust Representative also has monitoring rights throughout the operational phase of the project, particularly approval of Maintenance Schedules and participation in Review Procedures.

10.11.3 The Trust Representative will report to the Project Manager.

#### **10.12 Control Arrangements during the Operational Phase**

10.12.1 The monitoring of the standard of the Service provided by the Project Co will involve a combination of the following:

- Project Co and/or Trust calls to the Helpdesk
- Project Co self monitoring (in accordance with the Performance Monitoring Procedures)
- User satisfaction surveys (Trust, staff, visitors and patients)
- Reviews/reports by statutory bodies
- Trust audit

10.12.2 The Project Co will provide the Trust with a draft Performance Monitoring Programme that will outline the actions the Project Co intends to undertake to monitor the performance of services provided to the Trust in accordance with the Project Agreement and the Services Specification. The Trust will agree the Performance Monitoring Programme prior to the delivery of services.

#### **10.13 The Role of External Advisers**

10.13.1 Throughout the procurement process for the LFPU project, the Trust has used the services of a number of external advisers in relation to financial, legal and technical issues.

10.13.2 Following financial close the requirement for external advisers will reduce however there will remain the need for their professional input through the construction, commissioning and operational stages up to post project evaluation.

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

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#### **SECTION 11: BENEFITS ASSESSMENT AND BENEFITS REALISATION PLAN**

##### **11.1 Description of the benefits to be delivered under the project**

11.1.1 The objective of the project is the establishment of a comprehensive service for mentally disordered offenders integrated with other agencies involved in the care, treatment and rehabilitation of this group. The State Hospital will continue to provide services for those requiring the provision of high secure care. The service aim is to provide packages of care, that are apropos to the needs of individual patients in appropriate settings within an environment that will provide the necessary levels of security.

11.1.2 The benefits to be delivered under the project are:

- ◆ Repatriation of inappropriate admissions from the State Hospital
- ◆ Appropriate risk assessment and containment for those in need of forensic psychiatric intervention
- ◆ Rapid response to demand for urgent assessment in a range of settings
- ◆ Maximisation of patient flow and rehabilitation through different levels of care
- ◆ Multi-agency care pathway for mentally disordered offenders
- ◆ Best use made of available forensic psychiatry skills targeting rehabilitation in a range of settings
- ◆ Flexibility to cope with increases in referral rates from Courts and prisons
- ◆ Packages of care for individual patients in appropriate security settings
- ◆ Appropriate security arrangements at different levels of care
- ◆ Increased availability of secure psychiatric facilities for patients needing to be transferred from police custody
- ◆ Provision of medium secure care facilities
- ◆ Provision of low secure facilities
- ◆ Outflow of patients into community settings

## 11.2 Benefits Assessment & Benefits Realization Plan

11.2.1 A plan summarising the benefits and how they will be achieved has been prepared and is presented in the table below:

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Repatriation of inappropriate admissions from the State Hospital	Enhanced potential for patient rehabilitation.	Establishment of local secure accommodation.	Head of Capital Planning & Investment	Provision of local facility	Chief Executive/ Director of Finance
	Re-alignment of resources at the State Hospital towards patients requiring high secure care.	Discharges from State Hospital to LFPU.	Clinical Director Forensic Psychiatry	Phased reduction of inappropriate admission of Glasgow patients assessed as not requiring full high security to the State Hospital, with the aim of reducing admissions to nil, within three – five years of opening the secure care unit.	Divisional Medical Director
	Local accessible service for Glasgow residents and increased retention of patient contact with home, family and friends.	Visits protocol for secure care services	Clinical Manager	Implementation of visits protocol increasing contact for a minimum of 50% of patients admitted from the State Hospital with home, family and friends.	Director of Nursing as Divisional General Manager
Rapid response to demand for urgent assessment	Patient needs assessed earlier, decreasing patient vulnerability and time spent in police custody, court and prison.	Development of community outreach team service including CPN court liaison service.	Clinical Manager	Reduction in the number of people detained/assessed who otherwise would remain overnight/weekend in police stations.	Divisional Medical Director
				Reduction in the number of people remanded into custody due to need for an assessment, to a maximum of 2 per month.	Clinical Director

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Scope for flow of patients through levels of care maximized.	Patient rehabilitation maintained. Potential for relapse minimised.	Establishment of Outreach Team and local secure facilities.	Clinical Director	Re-admission rate to the State hospital reduced. 100% compliance with established response target for Courts and Prisons.	Medical Director
	Admission to all levels of security available to all referral sources.	Protocols for patient movement between Community Outreach Team Service, local secure facilities and State Hospital High Security Service.	Clinical Manager	Discharge targets to Supported Accommodation and Community achieved. Reduced average length of stay for repatriated State Hospital patients not requiring high security.	Medical Director
	Inappropriate early discharge to next level of security avoided.			Reduced re-admission rate to GGHB services. Requests to the State Hospital for re-admission within 6 months of transfer to local services reduced to a maximum of 10% of total admissions per annum.	Medical Director

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Multi-agency network of services for mentally disordered offenders	Joint assessment of mentally disordered offenders.	Development of multi-agency joint assessment protocols	Clinical Director	Audit of agreed joint assessment protocols.	Divisional Medical Director
	Joint assessment for individuals appearing in Court.	Establishment of multi-agency Court Liaison Service including health and Social Work staff.		Audit of rota of attendance for Social Work and Health professionals.	
	Joint assessment for individuals in prisons.	Establishment of multi-agency Out-reach service to prisons including health and Social Work staff.		Audit of rota of attendance for Social Work and Health professionals.	
	Joint agency discharge planning	Agreed multi-agency in-patient discharge protocol	Clinical Director	100% compliance with the Care Programme Approach for Secure Care Services in-patient discharges.	
	Multi-agency health and Social Work sharing of information.	Develop multi-agency protocols and systems of work for sharing information and maintaining confidentiality.		Existence of centrally held information on mentally disordered offenders available to multi-agency services on demand.	
	Individual client access to appropriate adult representation	Develop training for volunteers and local protocol between police, Social Work, health and volunteers to undertake role.	Clinical Manager	Report to Multi-agency Steering Group on availability of Service  100% compliance with the Forensic Managed Care Network Board care pathway for mentally disordered offenders.	

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Best use made of available forensic psychiatry skills targeting rehabilitation in a range of settings	Improved care and rehabilitation for severe mentally disordered patients.	Professional development plans for secure care service staff.	Clinical Director	Improved balance of clinical inpatient and community sessions to meet service demands.	Divisional Medical Director
	Improved use of forensic staff skills.	Align forensic psychiatry to meet change in service provision.	Clinical Manager	100% compliance with completion of recorded risk assessment for all secure care service patients. Consultant Forensic Psychiatry supervision of community discharges.	Clinical Director
		Recruit additional staff resources.	Clinical Director	Annual review of clinical service and personal development plans.	Divisional Medical Director
Packages of care for individual patients	Individualised packages of care for patients integrating security of clinical patient care by staff with physical security of the building.	Named patient/nurse system, multi-disciplinary team care plan + CPA, and incident reporting system.	Forensic Nursing Services Manager	Annual review of operational risk assessment plan including individualised incident reporting, care plans, physical security, staff resources + training and building and equipment.	Divisional General Manager
	State Hospital facilities available for patients requiring care in conditions of high security.	Local low secure and medium secure accommodation.	Head of Capital Planning & Investment	Provision of local facility	Chief Executive
		Individual patient rehabilitation plans.	Professional Head of O.T.	Audit of patient rehabilitation plans.	Divisional General Manager
Appropriate security arrangements at different levels of care and rehabilitation		Admission and discharge protocols between service levels.	Consultant Forensic Psychiatrist	Multi-agency agreement on discharge and admission protocols between services.	Divisional Medical Director
	Enhanced potential for patient rehabilitation.	Care Programme Approach, + community treatment / supervision by Community Outreach Team for discharge patients.	Care Programme Approach Co-ordinator	100% compliance in completion of individual Patient CPA care plans	Divisional Medical Director
	Patients placed in secure accommodation appropriate to their needs.	Strengthened liaison arrangements with the State Hospital.	Clinical Director	State Hospital / local service agreed care plan for each transferring patient	Divisional Medical Director

Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Adequate provision of low secure care facilities assured.	Longer term low secure rehabilitation.	Establishment of low secure accommodation.	Head of Capital Planning & Investment	Provide low secure facility	Chief Executive
	Improved patient flow from medium security to low secure care.	Local low secure accommodation.	Clinical Manager	Increase no. of patients moving from medium security to low security.	Clinical Director
	Scope for more rapid access to improved rehabilitation.	Individual patient rehabilitation plans.	Clinical Manager	Phased reduction of inappropriate placements in the State Hospital, with the aim of reducing inappropriate placements to nil, within 3 – 5 years of opening the secure care unit.	Clinical Director
	Patients placed in secure accommodation appropriate to their needs.	Admission and discharge protocols between service levels.	Clinical Director	Audit of patient treatment plans. Multi-agency agreement on discharge and admission protocols between services.	Divisional Medical Director Divisional General Manager
Flexibility to cope with increase in referral rate from (a) courts (b) prison service.	Patient treatment begins earlier.	Development of community outreach team service including CPN court liaison.	Clinical Manager	Reduction in the number of people remanded into custody due to need for an assessment. Reduction in waiting time for assessment.	Clinical Director
	Improved Court and prison service access to assessment and treatment services.	Outreach Team assessment/treatment provision in prisons and at Court.	Clinical Director	Reduction in waiting time for initial assessment of Court and prison referrals. Reduction in the number of complaints from Courts and Prisons regarding availability of service response.	Divisional Medical Director
	Reduction in the number of mental health patients in prisons	Establish flexible working practices to meet peaks in demand in prisons and at Courts.	Clinical Manager	Agreed flexible working practices and new service agreements with prisons agreed within 24 months of new local service being established.	Director of Nursing as Divisional General Manager
	Flow of patients throughout the system of local secure care services.	Referral procedures between services.	Clinical Director	Multi-agency agreement on referral procedures between services.	Divisional Medical Director



Benefit Criteria	Benefit	Actions to achieve benefit	Responsibility	Measurement of achievement of benefit	Monitoring Responsibility
Adequate provision of medium secure care facilities assured.	Medium secure rehabilitation.	Establishment of medium secure accommodation	Head of Capital Planning & Investment	Provide medium secure facility	Chief Executive
	Improved patient flow from medium security to low secure care.	Local medium secure accommodation.	Clinical Manager	Increase no. of patients moving from medium security to low security. Reduced inappropriate referral to State Hospital	Clinical Director
	Scope for more rapid access to improved rehabilitation.	Individual patient rehabilitation plans.	Clinical Manager	Phased reduction of inappropriate placements in the State Hospital, with the aim of reducing inappropriate placements to nil, within three – five years of opening the secure care unit.	Clinical Director
	Patients placed in secure accommodation appropriate to their needs.	Admission and discharge protocols between service levels.	Clinical Director	Audit of patient rehabilitation plans. Multi-agency agreement on discharge and admission protocols between services.	Divisional Medical Director Divisional General Manager

- The benefits to be delivered under the project are the benefits deriving from the implementation of Trust plans in partnership with other agencies. The Trust's services will exist within a wider continuum of care that has been developed and agreed with local partner agencies in accordance with national and local strategy. The proposed pattern of multi-agency services is comprehensive, and will additionally comply with the developing Scottish Development Centre for Mental Health integrated care pathway for mentally disordered offenders. The wider continuum of care is set out in the following section.

### 11.3 Integrated Multi-Agency Care Pathway

11.3.1 The main elements of the strategy for developing services in this area are:

1.	The establishment of a community outreach team <i>including Social Work and health professionals</i> , with close links to the police, the courts and the prison services
2.	The establishment of adequate low secure and medium secure in-patient facilities, <i>with Social Work input</i> within the Glasgow area to complete the network of forensic psychiatry services by bridging the gap which currently exists between community based services and the high secure service provided by the State Hospital; and
3.	The establishment of support housing for a small number of mentally disordered offenders within a community setting.

11.3.2 The objective of the project is the establishment of a comprehensive service for mentally disordered offenders delivering an integrated care pathway with other agencies involved in the care, treatment and rehabilitation of this group.

11.3.3 The Trust's proposal specifically addresses elements 1. and 2. of the service strategy. It envisages a multi-agency health and Social Work community outreach team to provide a more rapid and flexible response to requests for assessment by the police, the court system and the prison services. It also envisages the provision of a new LFPU, housing an appropriate balance of low secure and medium secure care in-patient facilities.

11.3.4 The third element of the strategy, the establishment of limited support housing in the community, is also provided for within the locally agreed framework for the development of mental health services. The implementation of this strategic initiative is already planned as a separate joint project, working together with social services, and does not form part of this proposal. The Greater Glasgow Multi-Agency Steering Group has already commissioned an external consultancy for the initial stage of this element of the Strategy. The range, access criteria and organisation of supported accommodation will be subject to agreement. Over the previous four years (2000, 2001, 2002 and 2003) discharge to supported accommodation has been affected on 18 occasions, with the majority in the latter two years, 6 in 2002 and 5 in 2003.

11.3.5 The project envisages the expansion of services provided within the community to include an outreach service and the provision of day services based on an existing city centre site. It also envisages the development of a secure care unit on the site of Stobhill Hospital, providing facilities for in-patient based care for patients within both a low secure and medium secure environment. These elements of the project require that service development be taken forward on a joint basis, with the full involvement of social work services, the police, procurator fiscal's office and the prison service in shaping the way services are provided to ensure an integrated approach with the work of these other agencies. In addition, there will be close liaison with the State Hospital to ensure that the interface between the State Hospital and the new secure unit operates effectively and that both units function in a complementary way relative to each other.

11.3.6 Protocols for patient movement will link multi-agency services between service levels. Each patient will have an individualised care plan supported by multi-agency referral

protocols between service levels and multi-agency assessment and discharge protocols for patient movement. The service level receiving patients and the service level transferring patients will meet and discuss patient through care prior to patient movement, including to the community from in-patient care.

11.3.7 The services that will be provided on completion of the project will:

- ❖ Be co-ordinated and involve all the appropriate agencies – health boards, local authorities, including probation services and housing departments, NHS Trusts, the police, legal professions, the courts, prisons and voluntary organisations.
- ❖ Be led by highly qualified and experienced clinical staff.
- ❖ Be well integrated with mainstream mental health and learning disability services.
- ❖ Recognise the importance of promoting therapeutic interventions to stop an offence occurring/recurring.
- ❖ See long term, supervision and support as being as important as assessment and treatment.
- ❖ Meet the needs of State Hospital patients who no longer require high security.
- ❖ Meet the needs of patients treated in high cost settings in other parts of the country because there are no suitable facilities locally.
- ❖ Provide reasonable and sensible levels of security for the general public and staff.

11.3.8 These services will:

- ❖ Provide rehabilitation and health care for people who would otherwise be unnecessarily sent to prison.
- ❖ Provide added protection to the public and patients themselves when standard services alone in open mental health hospitals or community care are unlikely to contain risk satisfactorily.
- ❖ Provide a step-down facility for patients who no longer require the high level security of the State Hospital.

11.3.9 On this basis, the Trust's proposal enables the achievement of the NHS Board's strategic requirements.

11.3.10 A patient would be expected to move through the different levels of care, with the ultimate objective of being rehabilitated into a community setting where ongoing support would be provided from a menu of integrated multi-agency services according to the particular need of the individual.

#### 11.4 Benefits provided by PPP

11.4.1 The PPP model alters the relationship between the Trust and Facilities in that the Trust moves away from being the 'owner and operator' of buildings to becoming a "purchaser of services". This allows the Trust to manage the delivery of clinical services together

with supporting activities (catering, cleaning, etc) with private sector contractors and operators managing the construction and maintenance of the facilities.

- 11.4.2 The principal advantage being that any risk associated with the delivery of services is positioned with those best placed to manage them. This transfer of risk is a fundamental component of PPP and during the construction phase of the project the private sector contractors manage the risks associated with site conditions, contract costs and construction period. Further, during the operational period the risk associated with costs for maintaining the fabric of the building to agreed measurable standards is carried by the private sector.
- 11.4.3 In addition PPP assists in accelerating project delivery and increases the scope for innovation in the procurement of new facilities by fully utilising private sector experience and efficiencies in technical/legal/financial areas with clear advantages in value for money and affordability.
- 11.4.4 The PPP approach is aimed at providing a well designed building, maintained over its life, to predetermined standards, at an agreed cost with the private sector managing the risks associated with design, construction & development and operating costs.

## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION

#### SECTION 12: RISK MANAGEMENT

##### 12.1 Introduction

- 12.1.1 The project envisages the introduction of an expanded service within Greater Glasgow, which is adequate to meet the needs of mentally disordered offenders resident within the area. It involves the provision of care packages by multi-disciplinary teams in a number of different settings, working across inter-agency boundaries. The success of the project depends on the ability of the Trust, in partnership with other agencies, to operate the model of care which is described in section 3 in a way which is effective in meeting the needs of the patient groups.
- 12.1.2 The Trust's approach to managing the risks associated with operating its preferred model of care is explained below. This recognises the need to provide the general public with the necessary level of confidence that care is consistently being delivered in settings which provide for an appropriate level of security relative to the needs of individual patients.

##### 12.2 Risk Management Strategy

- 12.2.1 The risk management strategy reflects current national guidelines and is based on a process of risk assessment undertaken by the clinical team, the recommendations of expert practitioners in forensic services, the views of other service providers and the experience associated with the provision of the current interim service.
- 12.2.2 The strategy is founded on a methodical approach to the identification and analysis of risks. It comprises seven complementary areas of activity:
1. **Clinical Risk Management** – the systematic and rigorous application of methods to reduce clinical risks and maximise the clinical benefits to the individual patient.
  2. **Active Risk Containment** – the ongoing process of integrating the clinical risk management of individual patients within an environment where there is systematic focusing on all aspects of risk management.
  3. **Contingency Planning** – the development of fall back plans to contain risks arising from circumstances in which the normal function of the service is affected by adverse events.
  4. **Safe by Design** – the integration of the service model, the operational management and the care environment.
  5. **Physical Capacity** – the ongoing assessment of the demands relative to the capacity of the service.
  6. **Public Communications** – the strategy for communication and engagement with the public and media.
  7. **Residual Public Sector Financial Risk** - the identification and assessment of financial risks associated with resourcing the service.

## **12.3 Risk Identification and Analysis**

12.3.1 There are many identified risks arising from the care of Mentally Disordered Offenders; a client group that presents with an array of complex problems and needs. The approach to be adopted is described in more detail below.

### **(i) Clinical Risk Management**

12.3.2 Clinical decision making will be supported by use of an agreed set of risk management tools, including currently:-

- **HCR 20** – This is designed to identify the risk of violence and glean information upon which to base the plan of care, treatment and rehabilitation.
- **V-RAG** (Violence Risk Assessment Guide) – This is designed to predict the likelihood of violent offending.
- **SO-RAG** (Sexual Offence – Risk Assessment Guide) – This is designed to predict the likelihood of sexual offending.
- **B.S.I** (Behavioural Status Index) – This is designed to identify risk of a range of behaviours and glean information from which a plan of care, treatment and rehabilitation can be based.

12.3.3 The assessment, design and evaluation of each patient care package will be supported by contributions from all members of the multi-disciplinary team and repeated at regular intervals from admission through to care in the community. Risk assessment will be conducted regularly but as a safeguard a minimum frequency has been established providing that each patient must be assessed at a Case Review at least once every 3 months and more frequently if deemed clinically appropriate based on patients' changing mental state. Actions and interventions aimed at addressing problems and managing risk will be assigned a "key worker" who is identified and recorded within the patient's plan of care. The established minimum frequency for assessment of patients, who have been discharged, will continue to apply to those patients who are supported in the community by a multi-agency care plan.

12.3.4 Clinical Governance requires the implementation of multiple systems assuring and demonstrating the quality of services to patients and the community. This is supported by a Clinical Effectiveness programme, a vital adjunct to the management of risk that aims to improve the quality of patient care, inform education and training and maximise the use of available resources. This will put in place an additional level of scrutiny over the clinical decision making process, thereby further strengthening the approach to the management of clinical risk. This will include the implementation of the Caldicott recommendations.

12.3.5 Clinical risk management will also be secured through appropriate team building, developing communication skills amongst the clinical team and the process of risk management being open to valid information from any source to ensure a complete picture at all times.

### **(ii) Active Risk Containment**

12.3.6 The purpose of Active Risk Containment is to establish the means:

- to rapidly respond to events of unanticipated harm should they occur;
- to mitigate and ameliorate any harm arising;
- to create the opportunity to prevent harm through the collection and analysis of information relating to the causes or potential causes of harm; and

- to manage actively risks that threaten the provision of safe clinical care and the efficient use of clinical resources.

12.3.7 Key to this element will be the contribution which suitably trained and skilled staff can make to risk containment through working in a supportive framework in a building designed for purpose.

12.3.8 A combination of Clinical Incident Reporting and Investigation with Clinical Risk Analysis forms a framework of reporting and feedback. Information generated from this system is incorporated into the Risk Register. The system will be more effective if the experiences and views of the range of people involved in an incident are captured and this will be its aim.

### **(iii) Contingency Planning**

12.3.9 Service Contingency Plans are being developed and will provide the optimum management approach to ensure continued operation following any adverse incident. Service plans will be underpinned by the Trust Contingency Policy and will reflect the specific requirements of maintaining the integrity of safety and security systems in the event of service disruption. This will involve the communication of necessary information internally and externally to other agencies and the media. The plans will identify potential events and prospectively define the recognition alarm raising and immediate response to the occurrence. The service plans will be contained within the Policy and procedures that are to be made known to all staff through induction and on-going training programmes. All Trust contingency plans will be reviewed on a systematic basis and this will include the contingency plans for the continuous operation of Forensic services. These will also be reviewed by the Forensic Services Directorate.

### **(iv) Safe by Design**

#### Service Model

12.3.10 The model of care comprises three needs based service levels that are categorised by the level of security required by each care package, supported by a comprehensive assessment service. Progressive movement through each level will be controlled, placement being conditional on meeting acceptance criteria within a referral protocol. The referral/admission protocol will be strictly applied in all service areas including those relating to multi-agency settings. At each stage the care package will reflect individual needs and derive from a range of therapeutic interventions. If required, patients deemed to be in crisis can be rapidly reinstated to care within higher levels of security. Where patients are assessed as no longer requiring secure, residential accommodation for therapy they can begin a community based rehabilitation process, following consultation between disciplines and involvement of the individual as a partner in the process. Certain patients classified as "restricted" require the authorisation of the Adviser to the First Minister before beginning the rehabilitation community process.

#### Operational Management

12.3.11 Operational policies and procedures establish the management systems and standards relating to the control of risks in the Service. A range of management systems integrate physical and operational features including secure compartmentation and safety checks, to assure rapid activation and response where assistance may be required. All of the procedures contain a balanced approach to addressing the need to assure safety and security with the need to maintain a therapeutic environment.

#### Care Environment

12.3.12 The in-patient services will be provided from the 74-bed unit (see section 3.4). The plan for the unit is based on a design philosophy viewing the physical structure as an extension of operational procedures to provide security and effective therapeutic interventions. The design principles have been developed by involving architects and clinicians in the building designs and layouts and materials. In addition, there have been visits to other forensic units by the clinical and design teams, as well as discussions with individuals with expertise in the design of this type of unit. In particular, the Trust has involved the architectural liaison officer for Strathclyde Police. The design features reflect the need to guard against potential breaches of security. The features are described in detail within the design specification but include close circuit surveillance, alarms, controlled building entry, internal access controls and limiting functionality of areas relating to the use of perimeter rooms by patients. The facilities have also been designed to facilitate observation of patients by staff at all times. In developing the design brief, the need for external security was a key requirement. This has been achieved through the use of external walls of the building providing the external secure perimeter barrier.

**(v) Capacity**

12.3.13 The scale of the proposal reflects the relative needs of the Greater Glasgow area for local forensic psychiatric services. Certain factors which apply to Greater Glasgow, in particular the incidence of crime combined with prevalence of substance abuse; make it unlikely that the demand for use of the planned unit will fall short of the available capacity. The greater risk in the longer term is that the demand for services will exceed the capacity of the unit to meet that need. The Trust's strategy for managing this risk is summarised below:

- a) The facility has been deliberately configured in a way which leads to maximum flexibility of the use of the accommodation, where this is possible and appropriate.
- b) The objective of the expanded service is to promote rehabilitation of patients. The assumptions which underlie the projected patient flows for the following five years are shown in section 3.3. These envisage that a reduction in the average length of stay for patients using the medium secure facility can be achieved over the five-year period. This will have the effect of freeing up additional spaces which will be available to meet a potential increase in demand for services.
- c) The Trust's plan, as described in section 3, is to manage the totality of its in-patient forensic service to ensure that care is always provided at an appropriate level relative to the needs of the individual patient, and in so doing to reduce the scope for bottlenecks to arise at particular points in patient care pathways. The development of community based services at an appropriate stage of the rehabilitation process will also reduce the demands on in-patient provision. This approach should ensure that there continues to be scope for admitting emergency referrals.

12.3.14 The unit described which is the subject of the business case is part of a continuum service which also embraces an outreach team, day services and outpatients comprising 16 clinicians. The objective of the expanded service is to promote the rehabilitation of offenders. The assumptions which underlie the projected patient flows for the following 5 years are shown in Section 3. These envisage that a reduction in the average length of stay for patients using the services can be achieved over the 5 year period. This will have the effect of freeing up additional space which will be available to meet a potential increase in demand for services.

12.3.15 The Trust's plan as described in Section 3 is to manage the totality of its secure care services to ensure that care is always provided at an appropriate level relative to the needs of the individual patient and in so doing to minimise the scope for bottlenecks



to arise at particular points patient care pathway. This should ensure that there continues to be scope for admitting emergency referrals.

12.3.16 The service also relates closely to the services of Social Work, Housing, the police and the State Hospital and it is expected that the question of a surge in need would impact on all these, requiring a joint approach to its management. Links with other services are established already and will be further strengthened by full implementation of the services described in Section 2.

12.3.17 It is more likely that short-term service demands will impact on particular elements of the service e.g. on medium secure capacity etc. but as described the unit has been deliberately configured in a way which leads to flexible use in the face of variation in demand.

**(vi) Public Communications**

12.3.18 The Trust has sought to adopt a positive approach to generating public engagement and participation of user groups with the aim of reducing the barriers between the service, its patients and the local community. This has been achieved through regular communication with community groups and representatives and by meeting community representatives about the establishment of the Unit. The Trust Communications Manager has responsibility for co-ordinating media relations. Protocols will be in place for providing appropriate notification of any incidents arising within the unit to partner organisations i.e. the Police, the Scottish Executive Health Department, the Mental Welfare Commission for Scotland, social work services, the local community and the media .

**(vii) Residual Public Sector Financial Risk**

12.3.19 Section 7C describes financial risk and risk transferred to the Project Company. Some risk remains with the Trust, described as residual risk, and the risks are outlined in Schedule A attached to this Section.

12.3.20 Risks have been considered under four main headings – Design, Construction and Development, Performance and Operating Cost, reflecting the financial dimensions of the project.

12.3.21 Significant risks are passed to the Project Company in respect of building construction and maintenance. The Trust retains financial risk in respect of operation which is described in Schedule A on the following page. The risks described are usual to all the Trust's services and being substantially operational and unconnected to the business case, they are described only and not evaluated here.

SCHEDULE A (Page 1 of 3)

SECTION 12  
LOCAL FORENSIC PSYCHIATRIC UNIT  
RESIDUAL PUBLIC SECTOR FINANCIAL RISK

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER TRUST'S CONTROL
		Impact	Probability		
1.	<u>Design changes</u> Design Changes	Medium	Low	The Trust will continue to be responsive to public safety concerns, to clinical care developments and to technological changes. Design changes would be effected if required in response to these but it is considered that changes with particular cost consequences to design are unlikely to happen.	The design brief has been based upon the clinicians and other users' specifications and has been signed off by them. Necessary security features have been incorporated. This has been a detailed process leaving no part of the building unexamined.
2.	<u>Construction and Development</u>				
2.1	Building cost index exceeds RPI	High	High	Project Co. bears risk	
2.2	Building tenders exceed cost	High	High	Project Co. bears risk.	
3.	<u>Performance</u> Failure of facilities resulting in repairs and unavailability costs	High	Low	Project Co. bears risk : margin retained by Trust in event of Trust changes.	

**SCHEDULE A (Page 2 of 3)**

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER TRUST'S CONTROL
		Impact	Probability		
4.	<u>Operating cost and variability of revenue</u>				
4.1	Inflation	High	Low	Inflation remains low. NHS funding contains allowance for inflation year by year.	Inflation control does not lie with the Trust. In the event that inflation is now low and/or annual funding does not accommodate an allowance for it, the service for mentally disordered offenders would be included within the review of all the Trust's services by Trust Management for prioritising delivery in these circumstances.
4.2	Excess patient demand	Medium	Medium	Patient activity remains within planned activity and design of unit.	Exercise of agreed protocols. Examination of capacity for flexibility : refer to features set out in Section 13 – Post Project Evaluation. Exercise of normal cost control measures established for a patient services unit. This involves budget setting, monthly cost monitoring and review/discussion/action at a senior level within management and financial functions. Budget responsibility at senior level is identified.

**SCHEDULE A (Page 3 of 3)**

	MAIN RISKS	RISK ASSESSMENT		KEY ASSUMPTIONS	RISK CONTROL IF UNDER TRUST'S CONTROL
		Impact	Probability		
4.3	Staff Costs	Low	Low	Staff numbers and costs remain within those planned.	Workforce planned within a wide-ranging multi-function context. Full costing and affordability within allowed funding has been examined. Staff recruitment control (refer Section 16 Personnel Issues) and cost control measures adopted, as for any other service.
4.4	Energy Costs	Low	Low	Energy costs controlled by Project Co.	Energy targets incorporated in contract with Project Co.
4.5	Maintenance Costs	Medium	Low	Project Co. bears risk.	Exercise of normal control measures highlighted in 4.2 above.
4.6	Other non-staff costs	Low	Low	Costs will be similar to those within current experience.	
4.7	Regulation Changes	Low	Low	No material regulation changes will occur e.g. staffing, safety, causing cost difficulties.	The unit management will be alert to any proposals in law or regulation which might impact the service, seeking to influence proposals appropriately before adoption. Any resulting impact on cost would require to be followed through in funding discussions or in reprioritising services.
4.8	Litigation Costs	Medium	Low	Standards of care will make these unlikely.	The impact of clinical governance in the Trust is to maintain and improve standards of care in addition to changing care regimes. In addition there is a programme of staff training and a budget supporting this, within the unit, which should lessen likelihood of this risk. Refer also to adoption of clinical and administrative tools in Section 13 Post Project Evaluation.

**GREATER GLASGOW PRIMARY CARE NHS TRUST**  
**LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**  
**SECTION 13: POST PROJECT EVALUATION PLAN**

13.1 The main objectives of the project are as follows:

- to ensure appropriate security arrangements exist at all levels of care;
- to provide for a rapid response to demands for urgent assessment;
- to provide for admissions from the State Hospital to local facilities;
- to build in sufficient flexibility to cope with increased referral rates from courts and the prison service;
- to make best use of available forensic psychiatry skills; and
- to provide an appropriate balance between low secure and medium secure care; to facilitate the smooth flow of patients through the different levels of care as their needs change.

13.2 The post project evaluation plan describes those measures which will be used to assess whether the clinical services and facilities which will be established by the project are operating in the way described within the business case submission.

13.3 The post project evaluation plan is set out below. This seeks to evaluate the success of the project in achieving its objectives by addressing the following questions:

**1. Have actual admissions to the in-patient facilities since full opening of the planned service included the anticipated level of admissions from the State Hospital to local secure facilities?**

Admissions to the State Hospital related to Glasgow residents have been running at about 22 per annum, with around 17 discharges per annum, a net admission rate of five patients per annum.

Based on current patient statistics the introduction of a secure care centre, incorporating 70-80 in-patient beds split evenly between medium secure care and low secure care facilities, will bring equilibrium to the movement of Glasgow patients into and out of the State Hospital by reducing the level of admissions to the State Hospital. The Greater Glasgow Multi-agency Steering Group will use the audit of the State Hospital population and Trust audit of in-patient population to monitor the movement of Glasgow patients into and out of the State Hospital.

**2. Have requests for urgent assessment resulted in a more rapid initial assessment taking place since the expanded service within the Community Outreach and C.P.N. Court Liaison Service became operational?**

Data will be collected routinely via individual care plans for in-patients to measure time between request for assessment to first contact.

3. **Are sufficient staffing and facilities in place to provide the planned level of secure care within each of the following:**

- (i) **24 male beds in a low secure environment?**
- (ii) **6 female beds in a low secure environment?**
- (iii) **10 admission beds in a medium secure environment?**
- (iv) **24 rehabilitation / long stay beds in a medium secure environment?**
- (v) **6 intensive care beds in a medium secure environment?**
- (vi) **4 learning disability beds in a medium secure environment**
- (vii) **supported accommodation ?**
- (viii) **in the community ?**

4. **Is there sufficient staffing flexibility to increase the number of initial assessments provided to the courts and to the prison service in the event of an increase in the referral rate?**

Data will be collected routinely via an annual audit and user survey.

5. **Is efficient use being made of available forensic skills through:-**

- (i) **an appropriate balance of clinical in-patient and community sessions?**
- (ii) **every patient having a recorded risk assessment?**
- (iii) **all discharges to the community being supervised by a Consultant Forensic Psychiatrist?**

This will be assessed via individual appraisals and audit of activity. 100% compliance with CPA and annual audit of recorded risk assessments.

6. Level of Care	Source of referral	Destination of referral
Assessment service	Police, Procurator Fiscal, courts, prisons, general psychiatry service	Prisons, medium secure, high secure, community outreach service
High secure (State Hospital)	Assessment service, medium secure	Medium secure, low secure, community outreach, day service
Medium secure	Assessment service, high secure	Low secure, community outreach, community day service
Low secure	Medium secure, high secure	Community service (outreach, day service, support housing)
Ongoing community services	Assessment service, low secure, medium secure	Community services (outreach, day services, support housing), low secure, medium secure, high secure, prisons

7. (i) **Is the volume and mix of patient numbers in line with expectations?**  
(ii) **Are occupancy levels in line with expectations?**  
(iii) **How do demand levels compare with available capacity?**

Actual patient admissions and discharges will be compared with initial plans and assumptions (as detailed at Section 3.3.4).

8. **Does the staffing regime which has been put in place support rehabilitation as an aim for patients by use of:**

- (i) Multi-disciplinary assessment including Social Work staff
- (ii) Case conferences for each patient about their needs and treatment
- (iii) Care Programme Approach for each patient being considered for discharge
- (iv) Standardised assessment tools and validated psychometric assessment
- (v) Feedback from an established monthly patient council
- (vi) A staffing appraisal system
- (vii) A schedule of external review including S.H.A.S., the Mental Welfare Commission and the Local Health Council
- (viii) A clinical audit plan and
- (ix) A clinical supervision system monitoring the implementation of clinical service protocols
- (x) An adequate range of skills and competencies being available or readily accessible to meet individual patient's rehabilitation requirements

**9. Is there a reduction in the re-offending rate of discharged in-patients?**

To be assessed by annual audit of readmissions related to offending.

- 13.5 The Trust has established a Project Board and developed a plan to oversee the completion of the project. The project plan, set out below, is overseen by the Project Board set up by the Trust for this purpose.

Action	Date for Completion
<b>Interim In-patient</b>	
• Enhanced continuing care in-patient staffing recruitment	January 2000
• Enhanced continuing care in-patient staffing start-up training	February 2000
• Interim continuing care in-patient facilities complete	March 2000
• Transfer of patients from existing Woodilee Hospital to interim facilities	March 2000
• Woodilee Secure Care Facilities Close	March 2000
• Interim Facilities at Leverndale Hospital Open	March 2000
• Interim Facilities at Leverndale Hospital Close	March 2006
<b>Multi-agency Outreach Team</b>	
• Out-reach Team Service Start-up	April 1998
• Out-reach Team Service Fully Functioning	March 2003
• Out-reach Team Start-up Recruitment	April 1998
• Out-reach Team Recruitment Completed	January 2002
• Out-reach Team Start-up Training	April 1998
• Out-reach Team New Starters Training Completed	March 2002

<b>Day Services</b>	
• day service facilities pilot	November 2000
• day service facilities complete	March 2006
• day service start-up recruitment commences	August 2000
• day service recruitment completed	February 2002
• day service start-up training	February 2002
• day service new starters training completed	March 2002

<b>LFPU</b>	
• construction of unit completed	March 2006
• partial in-patient staffing recruited and trained: wards opened – Admission, Rehabilitation 1 Medium Secure, Rehabilitation 1 Low Secure, Women's Low Secure	April 2006
• Partial in-patient staffing recruited and trained: wards opened – Rehabilitation 2 Medium Secure and LD Medium Secure	October 2006
• Complete in-patient staffing recruited and trained: wards opened – Rehabilitation 2 Low Secure & IPCU	October 2007
Note: Training includes multi-agency work and familiarisation with agreed protocols and procedures, as well as the maintenance and confirmation of therapeutic skills and security systems.	
Appointment of Project Manager.	October 2004
Equipment Procurement	March 2006

### Care Pathway

- 13.6 The development of the Scottish Development Centre (SDC) led Care Pathway is in two stages and is overseen locally by the Multi-agency Steering Group:

<b>First Stage</b>	
• information collection from health, social work and criminal justice agencies completed	March 2000 – April 2000
• site visits by SDC	March 2000 – June 2000
• multi-agency conference to contribute to second stage	June 2000



<p><b>Second Stage</b></p> <p>CP development. Elements which should be present at each stage of need including:</p> <ul style="list-style-type: none"> <li>• local policy development</li> <li>• operational structures and training</li> <li>• protocols and service agreements</li> <li>• advocacy services, user/carer groups + support for victims of crime</li> <li>• people who come to the attention of the police</li> <li>• prosecution + court proceedings</li> <li>• health care</li> <li>• aftercare and through-care</li> <li>• special needs groups</li> </ul>	<p>June 2000 – September 2000</p>
<p><b>The Trust will support the Multi-agency Steering Group implementation of the development of the Care Pathway through the following:</b></p> <ul style="list-style-type: none"> <li>• admissions from the State Hospital</li> <li>• rapid response to demand for urgent assessment in a range of settings</li> <li>• maximisation of patient flow and rehabilitation through different levels of care</li> <li>• multi-agency care pathway for mentally disordered offenders</li> <li>• best use made of available forensic psychiatry skills targeting rehabilitation in a range of settings</li> <li>• flexibility to cope with increases in referral rates from courts and prisons</li> <li>• packages of care for individual patients in appropriate security settings</li> <li>• appropriate security arrangements at different levels of care</li> <li>• increased availability of secure psychiatric facilities for patients needing to be transferred from police custody</li> <li>• provision of low secure facilities</li> <li>• provision of medium secure care facilities</li> </ul>	<p>June 2006</p>

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION**

#### **SECTION 14 : INFORMATION MANAGEMENT AND TECHNOLOGY STRATEGY**

- 14.1 A Description of the Trust's IM&T Strategy and how it relates to the project under consideration.**
- 14.1.1 The Trust's IM&T strategy is to establish access to relevant patient information via both manual and computerised systems. Staff will work both individually and in multi-disciplinary teams.
- 14.1.2 Any relevant information systems in use in the Trust will be made available to both clinical and administrative staff in the Local Forensic Unit to support the delivery of care.
- 14.1.3 The Trust's IM&T strategy recognises the need for information exchange and sharing between individual practitioners involved in the process of patient care, including the care of mentally disordered offenders, it also recognises the need to ensure where that information is shared or exchanged, both inside its own organisation and externally with other organisations, it remains secure and confidential through use of agreed protocols and systems. The Trust will continue to work with partner agencies involved in the Forensic Managed Clinical Network to ensure that data models are compatible and support the sharing of information between systems. Information sharing processes will use national software and communication solutions where these are appropriate.
- 14.1.4 Patient identifiable information will be shared between organisations only after appropriate consultation has taken place. Protocols are being developed between the organisations involved to ensure that a formal decision making process is adopted and followed. These involve all the agencies contributing to care and rehabilitation to ensure compliance with current legislation including the Data Protection Act 1998, the Mental Health (Scotland) Act 1984, the Human Rights Act 1998 and Caldicott Principles.
- 14.1.5 The Trust has put in place a communications network infrastructure in accordance with the NHSiS communications strategy. This enables staff to communicate internally and externally, and to access relevant Trust applications programs. The Trust's private network restricts access to internal staff. In addition, the Trust has a connection to the NHSnet enabling communication between other NHSiS organisations and out to the Internet via a secure firewall.
- 14.1.6 The Forensic Service is currently examining its IM&T requirements in the context of development of multi-agency working and the imperative to maintain high levels of data security within the Directorate. These developments will be taken forward across the Directorate and be ready for transfer to the new LFPU when commissioned. Included in the principles to be adopted will be:-
- active involvement by clinical staff in the development of systems which facilitate good quality data and through this improved patient care;
  - accurate recording of therapeutic interventions and the professional specialties responsible in the context of a co-ordinated package of care;
  - full compliance with relevant legislation and clinical governance standards recorded so as to ensure that the needs of the service and external accreditation and monitoring organisations are met; and
  - secure messaging within the Directorate and limited external links to preserve the security of patient data.

14.1.7 IT systems and technical support will be provided through a combination of in-house arrangements and external facilities management contracts and will reflect the security considerations of the LFPU.

**14.2 If a major redevelopment does not include a specific IM&T component, outline how the IM&T strategy will be delivered including any affordability implications.**

14.2.1 The scope of the procurement will include the provision of:-

- Internal infrastructure to support connectivity for voice and data services for a minimum of two hundred physical locations at a data speed of at least 100 mpbs.
- Internal network links and inter building network links within the Secure Unit will be at minimum speed 1000 mpbs.
- External data network connectivity to the Trust/NHS Glasgow network will be at minimum speed 100 mpbs.
- All telecommunications must be integrated with NHS Glasgow network.

14.2.3 The procurement excludes the provision of hubs, routers and other associated communications networking equipment. The procurement also excludes the provision of desktop hardware and software and clinical and non clinical applications. These items are included within the Trust's Strategic IM&T implementation plans. IM&T developments are prioritised by the Trust IM&T Steering Group and funded through the annual capital and revenue budget IM&T allocations. The developments detailed in paragraph 11.1 will be processed via this bidding process.

## GREATER GLASGOW PRIMARY CARE NHS TRUST

### LOCAL FORENSIC PSYCHIATRIC UNIT - FULL BUSINESS CASE SUBMISSION

#### SECTION 15 – EQUIPMENT

**15.1 An explanation of how equipment will be provided for the project, and what equipment is in the PPP/PFI contract.**

15.1.1 The Project Company will provide for the purchase, installation and commissioning of all Group 1 equipment. Group 1 equipment is all equipment installed into rooms such as heaters, cookers, fixed lifting equipment

15.1.2 Room data sheets are provided by the Trust specifying the Group 1 equipment required room by room, and specifying the standard expected for the items of equipment.

15.1.3 The model of care for assessment, treatment and rehabilitation is based upon clinician to patient interactions. Equipment requirements are of a minor scale compared with the building quality needed for security, living and care activity.

**15.2 A summary of how equipment within a PPP/PFI contract is handled**

15.2.1 The Project Company will be responsible for all equipment within the contract and will be responsible for training in its use, in addition to maintenance and replacement.

**15.3 Details of how equipment not in the PPP/PFI contract will be provided.**

15.3.1 The Trust will provide for all Group 2, 3 and 4 equipment, i.e. that which is moveable and not part of a room's installation. Equipment to be procured includes:

- Therapeutic activities – tables, working platforms
- Exercise – gymnasium equipment
- Domestic – kitchen, cleaning
- Living areas – tables, chairs, beds etc.
- Reception / offices – office equipment

New equipment is expected to cost £520,000 in total and will be incorporated in Trust equipment spending plans for years 05/06 and 06/07.

15.3.2 Equipment from interim accommodation will also transfer to the new unit, in categories Group 2, 3 and 4. Any other surplus equipment in good condition within the Trust will also be transferred to the unit.

15.3.3 Agreed revenue funding includes an allowance for equipment repair and renewal in respect of Trust provided equipment.

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

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#### **SECTION 16 – PERSONNEL ISSUES**

##### **16.1 Context**

- 16.1.1 The project involves the development of services not currently provided within Greater Glasgow and will involve significant change to numbers and mix of staff employed and increased multi-disciplinary and multi-agency working. The following paragraphs provide relevant details and form part of the human resource change management plan.

##### **16.2 Developing the Current Service**

- 16.2.1 The Greater Glasgow Primary Care NHS Trust recognises that the success of the forensic psychiatry service is dependent on employing and retaining the appropriate number of staff with the right skills, working in a multidisciplinary and multi-agency way to engender the correct culture, foster rehabilitation of patients and prevent institutionalisation.
- 16.2.2 To establish fully the final service, it will be necessary to substantially increase staff numbers from the current staffing level of 132 WTE staff to the end point of 251.3 for the inpatient service. This overall increase of 119 WTE staff will be achieved using a combination of internal recruitment, redeployment of staff from general psychiatry and external recruitment.

##### **16.3 Workforce Planning Process**

- 16.3.1 The success criteria, as defined in Section 11, helped to shape the workforce profile required for the service in terms of numbers and skills. A multi disciplinary approach, involving all clinical and support services, was taken to agree the workforce profile. In the spirit of partnership working, the trade unions were also engaged in this process.
- 16.3.2 Each staff group working as part of a multi disciplinary team plays a critical role in providing a safe, secure and flexible patient focussed service. Although the physical aspects of security and risk management are important, employing sufficiently skilled and competent staff is equally important in working with this challenging client group to ensure early detection of problems and to prevent individuals from exposing themselves or others to accountable risk.

##### **16.4 Recruitment Strategy**

- 16.4.1 The end point workforce profile for the unit is shown at Appendix 1. All new posts in medical, psychology and occupational therapy will require to be externally recruited.
- 16.4.2 Of the new nursing posts required 60% to 70% will be recruited externally and 30% to 40% will be recruited internally to Greater Glasgow Primary Care NHS Trust. This process will involve an internal programme of retraining.

###### **(i) Medical**

- 16.4.3 Medical staffing will consist of Consultant Forensic Psychiatrists and doctors in training. Consultants will have experience in the treatment of mental illness, dealing with offending behaviour, risk assessment and rehabilitation of mentally disordered offenders (MDOs). The need for additional expertise in the areas of learning disabilities, adolescent psychiatry and drug and alcohol problems will be addressed in the medical recruitment plan as will the intention to recruit a forensic psychotherapist.

###### **(ii) Psychology**

16.4.4 Psychological assessment and intervention are central to the treatment and management of MDOs. Reducing offending behaviour must be a key element in the overall care plan of forensic patients. There is overwhelming evidence to demonstrate that psychological therapies are the treatments of choice for reducing recidivism and effectively rehabilitating offending behaviour. The clinical psychology service has 5 core roles to fulfil:

- assessing and modifying the disturbed behaviour, thoughts and emotions of offenders and victims; and the assessment and management of learning disabled offenders
- applying psychological principles to the management of institutional problems
- staff training in how to apply psychological principles
- providing systematic risk assessment and risk management
- systematic evaluation of individual treatment programmes.

**(iii) Nursing**

16.4.5 Nursing staff are responsible for the day to day care to patients over a 24-hour period, 7 days a week. By implication they represent the biggest element of the workforce. Nurses play a key role in facilitating change within the client group by providing skilled interventions that reduce risk, promote rehabilitation and reduce the chances of further offending behaviour. In the fully developed service, a range of skills and expertise will be developed in order to assess risk, provide a level of security and provide individualised care to patients.

16.4.6 The range of skills and expertise include those identified by the UKCC scoping study of forensic nursing and the Royal College of Nursing.

16.4.7 Specific skills include:

- |   |   |
|---|---|
| • Cognitive therapy                                   | • Working within the legal framework (Mental Health and Criminal) |
| • Psychosocial interventions                          | • Care Programme Approach   |
| • Prevention and management of aggression             | • Multi-agency Working  |
| • Anxiety management/relaxation                       | • Clinical Supervision  |
| • Psychotherapeutic approaches to care                | • Record Keeping  |
| • Management of female offenders                      | • Security  |
| • Offence specific work (sex offender, arson etc)     | • Research & audit  |
| • Management of patients with Personality Disorder    | • Induction programmes  |
| • Management of relationship boundaries with patients |   |

16.4.8 Within the nursing team there will be flexibility and movement between clinical areas, to ensure on-going development. This will also guard against the potential for an insular culture to develop.

**(iv) Therapies**

- 16.4.9 The workforce profile recognises the key role which therapies, such as psychotherapy and particularly occupational therapy, will play in maximising normal life functioning and occupational performance which is essential in rehabilitating individuals back into society, breaking the cycle of re-offending and providing the opportunity to heal psychological scars. The Therapist, in conjunction with the patient's key worker, will ensure each patient is given a specific individual programme of activity, which is directed to the maintenance or improvement of function. The Therapist will analyse the physical, cognitive, interpersonal, social, behaviour and emotional components of the activity and identify the aspects which are most appropriate for the individual's needs.

**(v) Administration**

- 16.4.10 The Admin Team will provide a 24-hour, 7 day per week service, across the following:

- secretarial
- reception, liaising with relatives, patients, staff and visitors
- telephone services
- data management
- medical record management
- general administration.

**(vi) Support Services**

- 16.4.11 An integrated model of support services will provide domestic, catering, portering, security, transport and grounds maintenance services and will play an essential role in the functioning of the service. Given the type of service and the specific challenges associated with the client group, fully integrating site services staff into the Unit is essential, particularly relating to security.
- 16.4.12 On account of the nature and scale of this development, soft FM Services are excluded from the package of services which bidders have been asked to tender for. This means that from the perspective of fully integrating the services there will be no significant associated TUPE issues or early retiral/redundancy costs associated with the current support services functions.

**16.5 Analysis of Workforce Profile and Benchmarking with Other Services**

- 16.5.1 The planned service and associated workforce profile has been benchmarked against a number of English MSUs which contain medium secure beds. Given that nursing represents the greatest element of the workforce, the comparison with other services will concentrate on this staff group. Analysis provided at Appendix 4.

- 16.5.2 Comparison for nursing skill mix and nurse ratio is shown in Appendices 2 and 3. Overall the nursing skill mix for the total Glasgow in-patient service is 63% / 37%. The Glasgow Unit nursing skill mix is richer than the other Units shown, however, this is offset by a slightly lower nurse to patient ratio.

	Skill Mix	Nurse to patient ratio
<b>Medium Secure - 44 Beds</b>		
Admission 10 beds	70 / 30	3 : 1
IPCU 6 beds	65 / 35	4 : 1
Rehabilitation 2 x 12 beds	61 / 39	1.9 : 1
Learning Disabilities 4 beds	63 / 37	4 : 1
<b>Low Secure - 30 beds</b>		
Women's Service 6 beds	64 / 36	4 : 1
Rehabilitation 2 x 12 beds	57 / 43	1.9 : 1
<b>Overall</b>	<b>63 / 37</b>	<b>2.6 : 1</b>

- 16.5.3 The total Glasgow nurse to patient ratio is 2.6:1 and again the Glasgow Unit is not the highest nurse to patient ratio. As can be seen from Appendix 4, the Glasgow Unit is also not one of the highest cost rates per day.
- 16.5.4 Key to implementing services for mentally disordered offenders is ensuring recruitment is completed prior to the service being put in place. This will enable effective induction, and training and development of new staff.

## 16.6 Retention Strategy

- 16.6.1 A key factor in recruiting and retaining staff will be the pay and conditions of service provided by the Trust. The Trust follows Whitley Council Pay & Conditions of service for all staff groups. In recognition of the challenging client group, all nursing, psychology and therapy staff working in the service will receive the forensic lead allowance when the full service is in operation. This reward package will bring the Trust into line with other medium secure services.
- 16.6.2 The pattern of working adopted by staff is also relevant to retaining staff once appointed. The service has been planned on a continental 3 shift system, which requires a higher staffing level than the less expensive long day 2 shift system. Given the demanding nature of the client group, the opportunity for therapeutic interaction in working 12 hours per day would be severely reduced. In addition, the Trust is working towards complying with the working time regulations and it is inappropriate to plan the creation of new services which conflict with current employment legislation.
- 16.6.3 Forensic psychiatry is perceived to be a challenging area of work. For the recruitment and retention strategy to be effective, the service should be as attractive as possible to prospective and current employees. The provision of educational opportunities for staff is being developed and the Directorate is strengthening links with the educational establishments. A commitment is being made to training and developing the workforce within the context of the National Education, Training and Lifelong Learning Strategy for the NHS in Scotland, leading to a clear programme of staff career development



## **16.7 Leadership**

- 16.7.1 The service will be led by a Clinical Director supported by a Clinical Manager who will work with Senior Clinical Staff across all disciplines to ensure that the highest standards of clinical care are delivered, and developed. The Clinical Staff already working in this area are nationally respected and the Trust will build on this to ensure that effective leadership of the service is sustained.

## **16.8 Training Commitments**

- 16.8.1 The Unit is seen as developing as a Centre of Excellence for Scotland and beyond. There is likely to be substantial training requirement for attached and seconded staff. This and the supervision requirements of existing staff will need to be addressed in the Workforce Plan for the Unit and will need to be taken into account in the time commitments of senior staff from the various professions.

## **16.9 Recruitment Difficulties**

- 16.9.1 Severe recruitment difficulties exist in England for nursing posts, but particularly in relation to psychiatry and psychology posts. Based on real successes in consultant psychiatry and psychology recruitment, despite national shortages, the Trust is confident that it can recruit the right staff with the right skills. The plan is to attract staff from English, Welsh and Scottish forensic units, and develop opportunities for internal recruitment of staff from within the Trust.

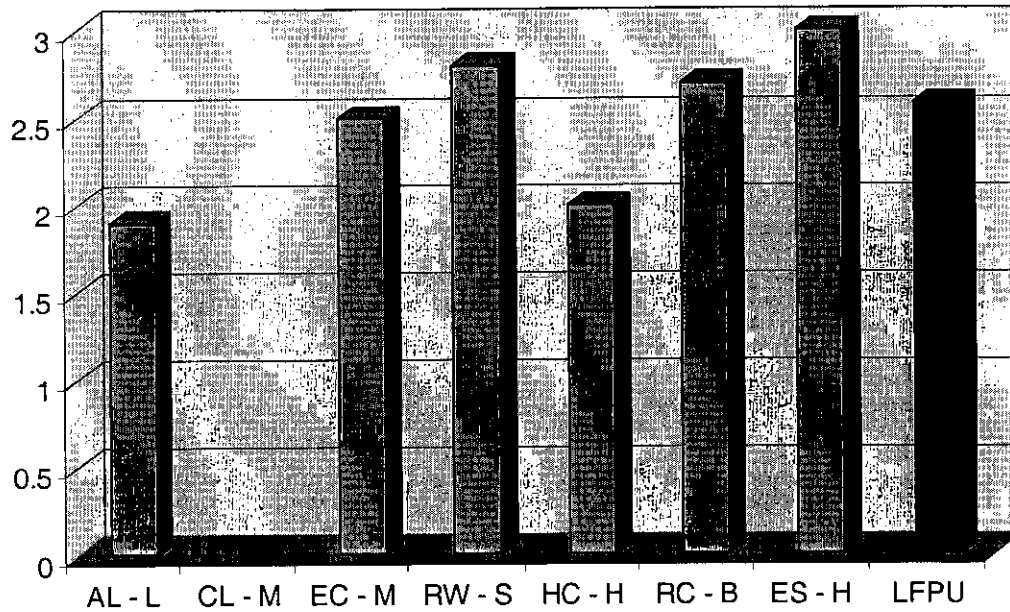
## **16.10 Annual Recruitment Plan**

- 16.10.1 A Trust workforce plan is updated annually to both recruit required skills and develop them in existing staff. Identified needs are in the provision of therapeutic interventions to patients for both broad and specific needs. This is supported by a process of appraisal and also clinical supervision. These skills will be developed at a range of levels and competencies and delivered informally in-house as well as through formal accredited training.

## **16.11 Value for Money**

- 16.11.1 Staffing, and in particular Nursing staffing, constitutes the main cost of a Forensic Inpatient Unit. A charge would be based on cost. A number of Units in the UK were surveyed to determine their daily charges and they are listed at Appendix 4. They average £380 per day per patient. The charge for the Trust's proposed Unit would be £340 per day. On this basis, the Unit will be value for money.

## Staff / Patient Ratio - Nursing



Arnold Lodge Leicester (AL – L)  
 Camlet Lodge Middlesex (CL – M)  
 Edenfield Centre Manchester (EC – M)  
 Ravenswood House Southampton (RW – S)

\*\* Humber Centre Hull (HC – H)  
 Raeside Clinic Birmingham (RC – B)  
 Eric Sheppard Unit Hertfordshire (ES – H)  
 Local Forensic Psychiatric Unit (LFPU)

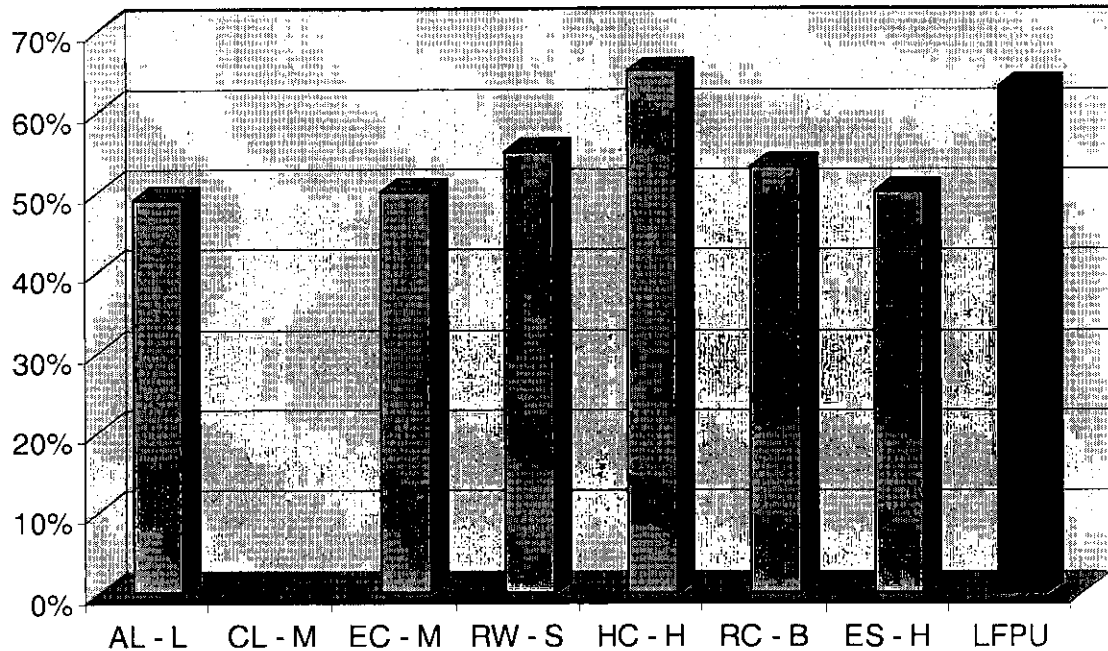
\*\* Please note Humber Centre have increased their beds in the last week by 16 from 32 to 48. however their skill mix and Staff bed Ratio remain the same

LOCAL FORENSIC PSYCHIATRIC HOSPITAL

WORKFORCE PLAN

		<b>w.t.e.</b>
Medical		
	Forensic Psychiatrist	4.2
	General Practitioner	0.3
	SHO Rotation	<u>2</u>
		<u>6.5</u>
Nursing		
	Grade H	2.9
	Grade G	8
	Grade F	9
	Grade E	47
	Grade D	54.3
	Grade B	25.6
	Grade A	<u>44</u>
		<u>190.8</u>
Allied Health Professional		
	O/T Head II	1
	O/T Senior I	3.5
	O/T Senior II	0.6
	Basic Grade	1
	Technical Instructor	2.9
	Psychologist B	2.5
	Psychologist A	<u>1</u>
		<u>12.5</u>
Business Services		
	Clinical Services Manager	0.8
	Business Services Manager	1
	Administrator Grade 6	0.9
	Admin. Assistant Grade 4	1
	Medical Secretary Grade 3	7
	Admin. Assistant Grade 3	2
	Receptionist Grade 2	<u>6.5</u>
		<u>19.2</u>
Site Services		
	Domestic	12
	Catering	5.7
	Portering	<u>4.6</u>
		<u>22.3</u>
Total		<u>251.3</u>

## Percentage Qualified Nursing



Arnold Lodge Leicester (AL – L)  
 Camlet Lodge Middlesex (CL – M)  
 Edenfield Centre Manchester (EC – M)  
 Ravenswood House Southampton (RW – S)

\*\* Humber Centre Hull (HC – H)  
 Raeside Clinic Birmingham (RC – B)  
 Eric Sheppard Unit Hertfordshire (ES – H)  
 Local Forensic Psychiatric Unit (LFPU)

\*\* Please note Humber Centre have increased their beds in the last week by 16 from 32 to 48. however their skill mix and Staff bed Ratio remain the same

**NHS FORENSIC FACILITIES  
COMPARISON OF CHARGES**

**Section 16  
Appendix 4**

<b>Facility</b>	<b>Beds</b>		<b>£ rate per day 03/04</b>
Arnold Lodge, Leicester	56	MH mixed	359
Camlet Lodge, Middlesex	49	MH mixed	356
	20	LD	371
Edenfield Centre, Manchester	73	MH mixed	394
Humber Centre, Hull	32	MH mixed	325
Ravenswood House, Southampton	58	MH mixed	445
Reaside Clinic, Birmingham	92	MH mixed	370
Eric Sheppard Unit, Hertfordshire	30	LD med. Sec.	428
			Average 380
Glasgow Forensic Unit annual cost @ 03/04 base = £8750k	74	mixed	340

## **GREATER GLASGOW PRIMARY CARE NHS TRUST**

### **LOCAL FORENSIC PSYCHIATRIC UNIT – FULL BUSINESS CASE SUBMISSION**

#### **SECTION 17: CONCLUSION**

##### **17 Conclusion**

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

17.2 The solution proposed by CBB for the provision of an LFPU meets the requirements of NHSGG, is affordable and demonstrates value for money.

The only significant building outstanding issue concerns site drainage and this will be resolved, the possible financial consequence capable of being absorbed within project funding.

17.3 The solution proposed by CBB will allow NHSGG to establish an operational LFPU by April 2006. The potential for securing the capital required to provide the LFPU using public funding within even the long term future (i.e. up to 10 years) is regarded as remote and so the CBB solution represents the only realistic option for providing the unit.