Part 1

The Strategic Case (1)

Appendix 2A	-	Programme Stakeholder & Consultation
Appendix 2B	-	Clinical Brief
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Appendix 2A

Programme Stakeholder and Consultation

Programme Stakeholders and Consultation

NHS Ayrshire & Arran has involved a broad range of stakeholders in respect of this programme and in the wider context of healthcare delivery in Ayrshire through Mind your health, the strategic review of mental health services in Ayrshire and Arran referred to above.

The Mind your health review was launched in December 2006 at a multi-stakeholder conference in Ayr attended by around 200 people. Following a participative approach involving eight multi-stakeholder workshops, two multi-stakeholder conferences and work by nine multi-stakeholder working groups, the Board endorsed an overall model of care at its meeting on 23 January 2008.The Board also ratified the proposed approach to planning inpatient mental health services to include an option appraisal and gave approval to a programme of informing and engaging with the wider community about the proposed community based services, from February to May 2008.

During February and March 2008, four reference groups; carers, service users, voluntary organisations and a fourth group comprising NHS staff, partner agency representatives and members of the public, carried out an option appraisal of a previously identified long list of options for the future location of acute mental health inpatient services. The option appraisal resulted in a short list of four options, plus the status quo. At the conclusion of the option appraisal and the period of informing and engaging, the NHS Board agreed at its meeting on 2 May 2008, to a plan for formal public consultation on the short list of options for the future location of acute mental health inpatient services.

The formal public consultation about the future location of acute mental health inpatient services began on 19 May 2008 and continued through to 12 September 2008 through several mechanisms:

- 14 community focus groups held throughout Ayrshire and Arran, each with up to ten people taking part in structured discussions. The focus groups were widely advertised in the local press, by posters at community and NHS locations and by invitation letters to over 700 community organisations;
- 19 targeted focus groups for specific organisations or community groupings, for example, young people, older people, BME communities and voluntary bodies
- Consultation with NHS staff and professional committees, this included attending 18 open staff meetings, 16 department meetings and 11 Professional Committees
- Consultation with MSPs, MPs, NHS Health Boards, Community Planning Partnerships and Local Authorities
- Attending meetings and events organised by other organisations throughout Ayrshire
- Poster information displays at twelve hospital sites throughout Ayrshire

This approach involved over 2,000 people in active participation and led to the overwhelming recommendation from all key stakeholder groups that future acute adult mental health inpatient services should be provided from the Ayrshire Central Hospital site at Irvine. A formal evaluation process

undertaken by an independent section of NHS Ayrshire & Arran and monitored by the Scottish Health Council, confirmed a very high level of customer satisfaction with the engagement processes used.

Following completion of the Mind your health review, consultation with stakeholders has continued as outlined below:

- A Mental Health Services Public Reference Group (PRG) was established in the spring of 2009, supported by the mental health directorate and comprising service users, carers and interested members of the public – a total active membership of around 25, with a total membership base of 48.

- The PRG meets approximately monthly, and is the main channel of dialogue between mental health services and service users & carers. Its activities cover the whole range of mental health services and include regular updates about the progress of the new build hospital project at Irvine.

- Two members of the PRG are nominated as members of the NACH Public Reference Group, and regularly report back to the PRG.

<u>NACH Public Reference Group</u>

- The NACH Public Reference Group was established in June 2009 to give an opportunity for the local community to comment and contribute to a range of aspects of service delivery within the site.

- To generate interest in a group, over 130 direct invitations were issued to the local community and voluntary organisations, service users, carers and the public who had already been in contact with NHS Ayrshire & Arran during the Mind your health consultation exercise. In addition to the invitations, a press release and a paid advert in the local press were used to raise awareness of the open meeting.

- The open meeting was held on 29 June 2009 and was attended by over 80 members of the public. At the meeting NHS Staff outlined the need for a public reference group, the role of the group, provided background information on the development and the current proposals for the Ayrshire Central site and then asked for attendees to “sign up” to get involved.

- 56 members of the public requested to be nominated for the Public Reference Group.

- It was recognised that there was a need to reflect a balance between individual, local residents and those representing voluntary/community groups on the Public Reference Group and from the list of 56, 20 members of the public were proposed. The remaining members are provided with updates on the development.

- Two representatives of the mental health services PRG attend, thus facilitating interaction. Video conferencing to a small number of the Island of Arran community is also provided.

- So far, the group have commented on the design statement, design, planning guidelines, benefits realisation, naming of the facility, etc.

- It is intended that the NACH Public Reference Group will continue to meet throughout the design, development and construction phases of the programme.

Staff

- Consultation with NHS Ayrshire & Arran staff has continued through the periodic issue of “Stop Press” bulletins, sent to all staff, and through the involvement of many staff in the organisational and operational decisions relating to the development.

Appendix 2B

Clinical Brief

North Ayrshire Community Hospital

Clinical Brief

Supported by:

BUCHAN ASSOCIATES LTD

Version OBC Final

November 2011

Contents

1. Strategic Context

a. NHS Ayrshire & Arran's Estate Strategy

The Estate Strategy for NHS Ayrshire and Arran and has been developed to reflect the changing demands on the estate. The Board is committed to constantly reviewing the services that are needed and planning for the future needs of the local population. This Estate Strategy sets out how the estate will be developed to meet those challenges to provide the most appropriate buildings and estate at the right time and to the right standard.

The benefit to the Board of having this Estate Strategy is an assurance that the quality of healthcare services will be supported by a safe, secure and an appropriately built environment.

The overall aim of this document is to provide a concise, user friendly working document containing information on the existing estate, whilst identifying the strategic changes that will have a direct impact on the shape and use of the Board's estate.

The Estates Strategy is dependent on effective clinical planning and engagement and as such this has been integral to its development.

Specifically the Estate Strategy provides:

- A clear, positive statement to public and staff on the Board's plans to maintain and improve services and facilities, in line with delivering its strategic objectives
- An assessment of the key drivers for change and alignment of the estate to support the Board's Service Strategy
- A strategic context for the forward investment of capital on the Board's estate
- A means by which the Board can identify capital projects and estate changes that will require formal approval
- A commitment to sustainable development, environmental targets and statutory requirements
- An assurance that risks are controlled and investment targeted to manage and reduce risk
- An assurance to staff that they will have an appropriate working environment

Fig.1. Ayrshire Central Hospital: Aerial View

This briefing document describes the clinical requirements of the new estate to be created that will form part of this important development and how this must relate to those buildings that it is planned to retain. It is consequently presented in a number of different sections that broadly relate to:

- The strategic context
- An overview of the facility, including service/design principles, concepts, relationships, etc
- More detailed descriptions of individual components as presented by key clinical and support staff (Presented as Appendices)
- The proposed schedule of accommodation (Presented in Appendix C)

It should be noted that this clinical brief relates mainly to clinical considerations around the new build element of the proposed scheme and the services being refurbished on Ailsa site. It should be noted that it is only one component of a wider suite of documents presented in the business case and should be read in conjunction with these.

b. Demography

The latest available statistics indicate that the estimated total population of Ayrshire and Arran as at 30 June 2010 was 366,860 a decrease of 0.5 per cent since 2000.
http://www.gro-scotland.gov.uk/statistics/theme/population/index.html

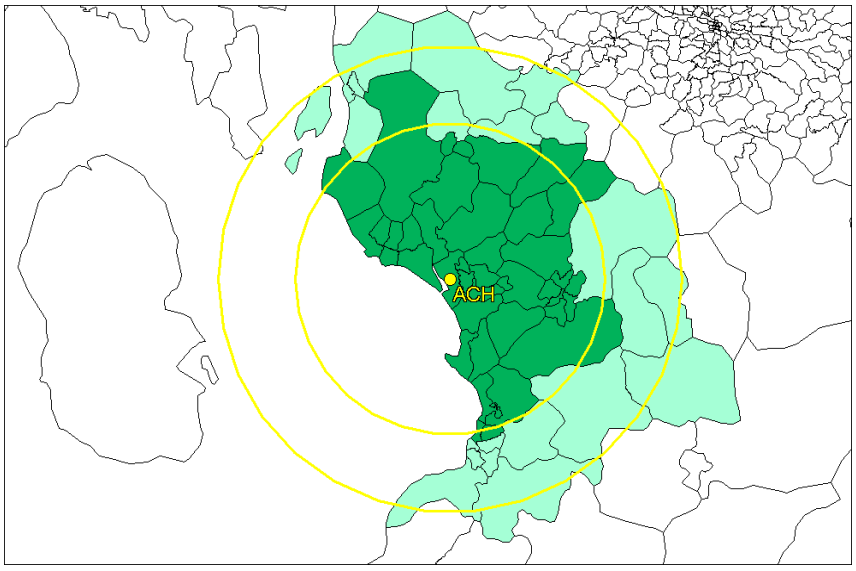


Figure 1 : Catchment Area for North Ayrshire Community Hospital

The table below shows the projected population change for each local authority. The decreases in the population within the younger age groups compared to the increases in the older age groups are very clear for each area.

- Projected population change for each local authority

Age (years)	East Ayrshire	North Ayrshire	South Ayrshire
Under 15	- 7.8%	- 15.3%	- 5.1%
15 - 64	- 6.6%	- 12%	- 9.1%
65 and over	+ 26.6%	+26.6%	+ 20.5%
Total	**0.0%**	**- 4.3%**	**- 1.2%**

Life Expectancy

The Table below presents data that shows the improvements in life expectancy between 1997-99 and 2007-09 at the national, health board and council area level. In Ayrshire and Arran, life expectancy at birth has increased by 1.8%, from 75.5 years to 77.2 years. This is lower than the Scottish average of 77.8 years. East and South Ayrshire show a similar percentage increase in life expectancy of 2.6 and 2.7 per cent respectively. North Ayrshire shows an increase of 1.9 per cent over the same period. South Ayrshire has the highest life expectancy, a significantly older population with fewer areas of multiple deprivation than East and North Ayrshire. NHS Ayrshire and Arran's rank position, compared with the 14 NHS Boards has dropped in the time period from 11 to 12. East Ayrshire's rank position compared to all other 32 local authorities remains the same however North Ayrshire has dropped four places to 26th and South Ayrshire has moved down two places to 17th.

Life expectancy at birth in Scotland 2007-2009 by administrative area, and comparison with 1997-1999 (persons)

	2007-09 Years	1997-99 Years	2007-09 Rank	1997-99 Rank	Difference in years	% change
Scotland	77.8	75.5	-	-	2.3	3.1
Ayrshire and Arran	77.2	75.5	12	11	1.8	2.4
East Ayrshire	76.7	74.8	25	25	1.9	2.6
North Ayrshire	76.7	75.3	26	22	1.4	1.9
South Ayrshire	78.4	76.4	17	15	2.1	2.7

Ref link http://www.gro-scotland.gov.uk/press/news2008/latest-life-expectancy-figures-announced.html

As the population gets older and the demand for NHS services increases, it is necessary to continue to consider and change how healthcare is provided in order to respond to the health needs of the population and new national policies. Services need to be developed to anticipate and manage long term illness, reduce the need for patients to attend an acute hospital and avoid unnecessary admissions.

This Clinical Brief takes account of all of the foregoing population and health issues and is critical to NHS Ayrshire and Arran being able to respond to these demands.

c. Health Strategy

NHS Ayrshire & Arran has developed a high level vision for the future direction of clinical services delivery.

This vision is based on shifting services from hospital to community based delivery (including community hospitals and community treatment centres) wherever safe and practical to do so and to accommodation fit for purpose. At the core of this is the national Quality Strategy. Those services that need to be on a major hospital site would be focused on the two acute sites in Ayrshire & Arran, with consequent clinical synergies, optimisation of expensive infrastructure and economies of scale.

This overall vision has now been developed into a number of new sites/developments including the provision of a new community hospital in Girvan plus extensive refurbishment and reconfiguration along with extensions to the main acute centres at Ayr and Crosshouse hospitals as well as the development of new community resource centres and primary care services such as dental centre.

Specifically, the evidence available identifies that the case for change related to healthcare delivery in and around North Ayrshire that is fundamental to the planning and creation of the proposed North Ayrshire Community Hospital can be summarised under a range of key headings including:

- Environmental Quality: Whilst clinical care is of the highest quality, further clinical development in North Ayrshire is currently constrained by the limitations of the existing built environment, for example, the majority of the buildings on the Ayrshire Central Hospital site where clinical care is provided are ageing, functionally unsuitable and in poor physical condition. Specifically, in the Board's Property Strategy, Ayrshire Central Hospital is listed as Estate Code category C (below acceptable standards) for functional suitability and category 3 (adequate) for space utilisation.
-
- The Need to Develop New Services & Models of Care: A Clinical Options Group, set up to ascertain current clinical activity and proposed services to be delivered from the new hospital has identified the need to expand the range of services currently on offer and to review the ways that these are delivered. Although much of this can be achieved through more detailed analysis of existing services and operational re-configuration, an element of new build is required to support future capacity requirements and approved

clinical strategies.

-
- Strategic Fit, including national and local strategy & policy: The development of services in North Ayrshire must be consistent with the proposals contained within a wide range of national and local strategic documents for example :-
    - The Quality Strategy
    - 'Developing Community Hospitals, A Strategy for Scotland',
    - NHS Ayrshire & Arran's Local Delivery Plan
    - Mental Health Local Strategy "Mind Your Health".
    - The Dementia Strategy.
    - Reshaping Care for Older People
    - Realising potential - An Action Plan for Allied Health Professionals -June 15th 2010. This three-year action plan reflects the focus of key policy initiatives providing support for the change agenda in mental Health.
-

In summary the new facility should support the Scottish Government stated purposes of:

-
- Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.
- Helping local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.
- Supporting teaching and training
- Rationalising the existing estate in order to improve operational efficiency, communication, accessibility, etc

d. Bed/Service Modelling

The range/volume of services specified/scheduled within this document are based on agreed service modelling data. This modelling data has been generated from a wide range of reviews including:

- Detailed current and future bed modelling related to all services
- A detailed analysis of all current and future outpatient activity as well as the services/locations available to support this
- A review of current and future office, meeting and administrative requirements in the context of new buildings and retained estate

All data collected/reviewed has been analysed in the context of existing local and national strategies on a single, service-wide health/social services perspective to ensure the provision of appropriately sized/configured areas that recognise current and future service delivery trends.

Although deemed to be robust, this data does not in any way negate the requirement for the new facility to be as flexible as possible to meet as yet unknown future care needs/trends.

Specific planning data/assumptions are included in the individual service templates presented as Appendices.

2. Facility Overview

a. Retained Estate

The new North Ayrshire Community Hospital facility will feature a significant new build element that is described within this document as well as an extensive retained estate. Services that will continue to be delivered from retained estate but will form the overall community hospital some examples include:

- Physical Rehabilitation (Including Pavilions 10 and 11 and the Douglas Grant Rehabilitation Unit)
- Sexual and Reproductive Health
- Community Dental Services
- Out of Hours Doctors
- Diagnostics
- General outpatients
- Administrative and meeting areas
- Offices, including clinical staff offices
- Support services, Training & Education Centre
- Kitchen and dining areas, including those associated with staff and patient meal preparation and staff dining areas

It is consequently noted that creating the optimal relationship between new and retained facilities is seen as a key design challenge associated with this project. Specifically, the whole facility must be seen and operate as a cohesive unit, with appropriate external links and FM routes identified with existing facilities . as represented in the adjacencies diagram. (Appendix B)

This challenge is made all the more difficult when recognising the wide range of different patient groups that will eventually be located on the site, many of whom have very different care/environmental needs.

It is further noted that a number of additional projects related to North Ayrshire Community Hospital have recently been undertaken and that the impact of these has been factored into all planning assumptions. These projects included (but are not restricted to); refurbishment of the existing “Horseshoe” Building, an extension to the existing General Out-patient Department (OPD), provision of a new Kitchen/Dining Room and development of an Out of Hours Treatment Facility/NHS 24 Satellite Control Centre within areas of the existing Horseshoe building.

The scheduling and implications of all of these developments must be taken into consideration during the planning and implementation of this project.

b. New Build Component

The new build component of the North Ayrshire Community Hospital, as identified in the attached Massing Diagram (Adjacencies Diagram B) and Schedule of Accommodation (Appendix C) will include:

- A main entrance with reception areas, waiting space, security/porters accommodation, café, small retail outlet, toilets, spiritual care area, and other supporting space as appropriate.

- An in-patient ambulance entrance to support the admission/transfer-in of patients on trolleys/chairs (avoiding main public thoroughfares).

- Outpatient clinic/consultation areas configured as a range of inter-connected but self-contained “modules” to support the full range of mental health and psychology-related OP/consulting activity on the site including Adult speciality area and a child & adolescent area. It is noted that “general out patient consulting” will continue to occur within the existing outpatient department although there will also be a cross-over in activity terms between the two areas.

- An ECT/Minor surgical/outpatient area, located close to elderly mental health wards and outpatient areas, with treatment and recovery spaces that would also be used as clinic accommodation for AHP services and as a minor surgical procedures area. (Functions changing on a sessional basis)

- A pharmacy/dispensary area

- A tribunal/ meeting area that is easily accessible from the main “core” of the facility that can be used as meeting rooms when not being utilised for tribunals

- In-patient ward areas arranged in 3 clinically appropriate “clusters” around shared re-enablement and rehabilitation areas including:

- Cluster 1; 60 Acute mental health beds in 3 x 20 bedded wards,
- Cluster 2; 30 Mental health beds forming a Rehabilitation Unit, 10 addictions beds with day case facility,
- Cluster 3; 30 elderly mental health beds in 2 wards, 30 long-term (continuing) care frail elderly beds and 30 frail elderly rehabilitation beds

- In addition self contained 8 bedded Intensive Psychiatric Care Unit (IPCU) and 8 Forensic Rehabilitation/ low secure beds which will use Cluster 1 rehabilitation and re-enablement accommodation if required on a planned basis to meet specific patient needs

It is noted, that in developing the operational model for the facility, a number of principles have been established that need to be recognised in the design, layout and configuration of the new estate and how it relates to existing/retained buildings. These include that:

- Wards should be configured in identified “clusters” in line with the massing diagram, with each cluster supported by a small range of local services and support accommodation.

- Although a number of wards have very similar scheduled accommodation – primarily to ensure optimum future flexibility – their preferred layouts, as described in the attached appendices generated by clinical services can be very different in recognition of specific clinical needs/considerations.

- All clinical (outpatient) consultations at the new North Ayrshire Community Hospital will take place in designated clinical consulting areas that will be separate from staff offices. These clinical consultation areas will include the existing general and specialist outpatient departments within the Horseshoe building, the new consultation areas specified within the schedules of accommodation for mental health/psychology/LDS/Etc, related services (including children’s services) and identified consulting space within wards and support “clusters”.

- All office accommodation, including the majority of meeting rooms, with the exception of a small number of clinical managerial offices within the scheduled new build, will be located within retained estate mainly within the Horseshoe Building.
- Staff will use the exisiting dining room and new café for all meals and breaks, with no local staff areas being provided out with this central “hub”.

- The new kitchen area will service all meal requirements throughout the site and is detailed in the FM Strategy.

- Staff Changing is based on a model that will see staff only having access to lockers for the period of a shift/duty in line with current thinking on this issue and to ensure optimal use of all areas. No other staff changing facility will be provided on site.

- The majority of support services functions will continue to be delivered from existing locations on the site. The only exception to this being the inclusion of a porter's area, security office, cashiers function and limited support areas in the new building.

- Control of infection issues remain extremely important considerations with Domestic Services Rooms (DSR or "Cleaners rooms"), linen areas, clean utility rooms and dirty utility rooms specified in all areas. Whilst efficient design may allow some appropriate sharing of these facilities, the design should always optimise the control and management of Hospital Acquired Infection in line with all relevant guidance on this matter, most notably in line with HAI SCRIBE.

- Future flexibility of all accommodation and, in particular, the ability of new spaces to be easily changed with time with regards to boundaries, layouts, patient groups using and clinical models employed is paramount.

- The overall design and layout of all areas should aim to reduce the risk of harm to patients and staff. Key elements of this risk reduction strategy should include, but not be restricted to:

    - Ligature points being avoided in all clinical/common areas through the selection of fittings and materials that reduce risk
    - Door handles must not have thumbscrews
    - The clinician should be positioned closest to the exit door of the room when consulting with or treating a patient
    - Wall mounted 'up and down' lighters should be used rather than angle-poise lamps for bed positions
    - Sharp edges should be avoided
    - Wall mounted items of equipment such as fire extinguishers should be recessed to prevent damage
    - Wall / door protectors should be used where there is risk of damage from e.g. bed / trolley movement

- In addition, it is noted that it should be possible for staff to lock-off en-suites, manually override any locks applied by patients and isolate utilities such as power or water from out with the room as appropriate

Overview: Entrances & Common Areas

The technological nature of hospital services may be an stressful experience for patients and their relatives. It is important, therefore, that when designing these facilities that the overall patient experience is taken into account together with that of their relatives, carers and visitors. The emphasis should be on providing a comfortable, pleasant but safe environment for patients and staff wherever possible, with particular emphasis on the wider therapeutic elements of the design and finishes. The ethos and philosophy is dominated by models for 'Recovery' 'Re-enablement' and 'Rehabilitation' as this is not a district General Hospital.

It is also essential to consider the needs of staff and the impact that the working environment has on job satisfaction, recruitment and retention.

Addressing gender, cultural and religious diversity is also a consideration as are the needs of relatives, carers and visitors whose opinions must be sought throughout the design process and taken into consideration.

Additionally, consideration should be given to alleviating fear and anxiety, maximizing security and safety, reducing boredom and creating a healing environment with the need for artwork, designed furniture, fittings, cabinetry, music and texture also a consideration.

Imaginative use of floor and wall finishes, colour and lighting will help to produce a warm, friendly environment. However, all must conform to infection control and other guidance, be seamless, easy to clean & resistant to damage.

Some patients, could stay in the hospital for a number of months or years and as such the environment of these areas should contrast significantly from acute clinical environments. These wards must also comply with health & safety and infection control but be firmly balanced with a sense of homeliness.

All accommodation must conform to the requirements of the Disability Discrimination Act 2005 including wheelchair access into rooms, provision for those who have hearing or visual impairments and for obese patients.

Attention is drawn to the design guidance contained in the following documents, which is not exhaustive:

- Way finding: effective way finding and signing systems – guidance for healthcare facilities (NHS Estates, 2005)
- Improving the Patient Experience (NHS Estates, 2003)
- Internal Environment: Evaluation of the King's Fund, Enhancing the Healing Environment Programme (NHS Estates, 2004)
- HTM 2045 Acoustics: Design Considerations
- Delivering Quality & Value, Institute for Modernisation & Improvement
- Lighting and colour for hospital design, Dalke et. Al. (NHS Estates, 2004)
- The Art of Good Health: using visual arts in healthcare (NHS Estates, 2002)
- Environmental Strategy for the NHS, (NHS Estates, 2005)
- The role of hospital design in the recruitment, retention and performance of NHS nurses in England, CABE, July 2004
- The Disability Discrimination Act 2005
- Health & Safety at Work etc. Act 1974
- COSHH regulations and recommendations
- Scottish waste management regulations, 2005
- Changing the culture (DHSSPS, 2006)
- Ward Sister's charter (DHSSPS, 2006)
- Protecting patients and staff (DHSSPS, 2005)
- HAI-SCRIBE (Health Estates, 2006)
- Royal College of Psychiatrists College Research Unit, Management of imminent violence: clinical practice guidelines to support mental health services, Occasional Paper OP41, London, 1998. http://www.rcpsych.ac.uk/publications/guidelines/ index.htm
- Scottish Health Planning Note 22

It is noted that all environmental and service requirements should correspond to the standards described in the relevant Scottish health Planning Notes and other technical guidance and the technical output specification for this project.

Overview: Outpatient Accommodation

Outpatient accommodation within the North Ayrshire Community Hospital facility has been developed as a series of self-contained areas that are as described in the Schedule of Accommodation. These include a range of support accommodation such as waiting and administrative areas as well as clinical support spaces.

Recognising the overview of accommodation provided previously it is noted that outpatient accommodation within the new build facility will primarily support mental health, psychological and therapy-related interventions. Rooms are included for group-type work as well as a number of specialised areas to meet the needs of particular clinical groups, e.g. Child and Adolescent Mental Health Services (CAMHS).

Regarding the latter group, it is important to reflect on all current regulations regarding the management of children in hospitals and in particular the need to identify dedicated facilities for children that prevent any mixing of paediatric and adult services. It is envisaged that the scheduling of an entire cluster for children's outpatient services may make this particular design challenge a little easier.

As in all clinical areas, consideration must be given to protecting the privacy and dignity of patients. Sound attenuation measures to ensure speech privacy in consult / exam, treatment, and other rooms where patients and clinicians have private discussions should be provided.

The design also needs to take account of the need to create a pleasant environment for the patients and staff by means of good design, locally controllable lighting and access to natural light and views.

Attention is drawn to the specific design guidance contained in:

- Outpatients Department (HBN 12, NHS Estates)
- Royal College of Psychiatrist Guidelines on consulting rooms has been considered (reference already provided)

Overview: In-patient Accommodation

As previously noted, the preferred configuration for the new facility is a "cluster" model that sees wards and other clinical areas distributed around shared/common areas that contain a range of supporting facilities/services as identified in the massing diagram and schedule of accommodation.

Leading from the entrance areas to the wards there should be sufficiently wide corridors to allow passage of varied numbers of staff, patients and visitors this should also support separation of facilities management (FM), visitor and patient routes.

This approach has a number of benefits:

- It restricts the crossing of patient, visitor, staff and FM flows and the associated risks
- It improves security by restricting the public to parts of the building and routes that are less sensitive.
- It improves privacy and dignity for patients who are being transferred to another ward/department, e.g. Diagnostics
- Transport of goods and services to a staff controlled area which can be well protected against physical damage

The inpatient wards at the new North Ayrshire Community Hospital – although specific in function and elements of configuration - will, as far as possible, comprise core generic elements in order that they may flex optimally over time. This flexibility is required in order to respond to clinical and demographic changes in the patient population without the need for major re-configuration. One key manifestation of this flexibility will be a design that allows individual ward boundaries to change in the future if required.

It should be noted that different fittings will be required in different wards/clinical areas and that individual clinical briefs (in Appendices) outlining how different patient groups have significantly different accommodation layout requirements. Notwithstanding this however a number of generic components of the clinical ward model can be identified including:

- 100% single rooms per ward - all with en-suite accommodation
- The majority of single rooms at 15.5m2 (including associated

family/clinical support space)

- Most ward areas having 1-2 rooms at a larger size (18m2) to provide additional functionality and flexibility. These larger rooms should normally be those located closest to observation areas and have overhead hoists where specified.
- All rooms should be planned with en-suite chamfered showers, WC's and Wash Hand Basins as per HBN 00-02 at 4.5m2.
- All rooms should be capable of using the global footprint available to support patient care as required both within the bedded and en-suite areas, i.e. Rooms should be designed in a manner that allows the en-suite and bedded component to at different times "borrow" space from the other.
- All rooms should optimise patient/staff observation and the volume of natural light entering the entire ward whilst minimising travel distances for staff and ensuring the maintenance of privacy and dignity.
- Ceiling mounted tracking hoists will be required in some rooms although this will vary by clinical specialty and should be referenced from the detailed element of the brief presented in the attached appendices.
- The rooms with tracking hoists should be located as close to key observation areas as possible and should be considered to be those rooms that will accommodate the patients who require the most care intervention and the closest observation. These will normally include the larger sized single rooms.
- All tracking should be kept as straight as possible to minimise travel distances and maintenance requirements.
- Tracking should allow patients to be moved between bed, bed-side chair, WC and shower without any requirement for manual handling intervention.
- IT is seen as fundamental to the efficient functioning of the new facility and should be considered at every stage of the design process. In particular the use of IT to reduce workload, repetition and errors is key. Specifically, it should be assumed that the new facility will be "paperless" and that consequently access to IT systems will be required everywhere clinical staff interact with patients. This will include at nursing stations, in offices, therapy areas, consulting rooms, "touch-down" bases, clinics, hot desk areas, etc.
- Specifically, the IT network should include an infrastructure for basic a range of wireless/PIR facilities for each ward supporting both IT and patient safety such as falls reduction.
-
- The move away from a single nursing station in many areas should be supported by the provision of informal desk space throughout the clinical area, e.g. "Touch down stations". These areas may at different times be used by all members of the multi-disciplinary team and should support the requirements of immediate documentation review/completion (ideally electronically and wireless) as well as

direct two-way observation.

- Many staff within the new facility will be moving from multi-bed ward areas with design and technology seen as crucial to supporting their clinical observation of patients within single rooms.
- Secure medicines lockers should be provided at each bedside for the storage of patients' own drugs and to facilitate patient self-administration of medications. (POD)
- Each room should have a coded safe with over-ride facility
- Rooms where Patients reside for longer periods need sufficient storage to accommodate more personal items and clothing
- The majority of offices will not be within the new facility but will instead be located within other parts of the retained estate. Key clinical offices are however scheduled where required.
- Public access to the wards should be controllable at all times with e.g. proximity card access/video-entry phone.
- A key feature of all wards is a "reception room" which it is envisaged may at different times be used to support patients, relatives and visiting staff as they enter/leave the clinical area. To this end, this room may be required to perform different functions in each ward area ranging from a traditional type "reception" to "air lock" type room or interview/family meeting space.
- Clean and dirty FM routes and patient / staff routes should be clearly identified and should be kept separate as far as possible.
- Although all beds will require bed head services that include nurse call systems, agreed entertainment systems, etc, piped gases are not a feature of any bedrooms within the facility.
-

In addition, attention is drawn to the design guidance contained in the following documents:

- SHPN 04, Inpatient Accommodation: Options for Choice (NHS Estates)
- HBN 04, Supplement 1, Isolation Facilities in acute settings (NHS Estates, February 2005)
- SHPN 08, Facilities For Rehabilitation Services
- SHPN 35, Accommodation for People With A Mental Illness
- SHPN 37, Facilities For Older People

Internal Ward Relationships

The Board recognises that the move from wards with multi-bed bays to 100% single rooms with en-suites will represent a significant change in practice for both staff and patients, with a key element of the successful design the ability to optimise the two-way visibility of staff and patients in both rooms and social spaces.

Whilst, as noted previously, the use of technological ways of achieving this should be explored, a number of design priorities should also be observed, as should the general principles of "lean management" and "the productive ward". Specific key elements of internal ward relationships worthy of note are:

Staff Bases

As noted previously, multiple staff bases are specified in some areas, particularly for night time use (touch-down bases), with a key general element of the design the requirement to observe as many patients as possible from each base.

En-suites

The position of the en-suites should not compromise the observation of bedrooms. Consideration, therefore, should be given to how good observation levels can be achieved from corridors and staff bases. In this context, the positioning of en-suites relative to beds is extremely important.

The preference of the clinical groups reviewing ward design is for "interlocking" and/or "in-board" en-suites as it is believed that these deliver the optimal combination of two-way observation, light ingress, travel distances and economy of the footprint.

Corridor/Door/Lift and Communication Area Sizes and Design

It is essential that beds can be manoeuvred in and out of bedrooms and clinical areas within wards as well as along corridors and out of the ward to all clinical and supporting areas, e.g. adjacent wards, diagnostics, the bed storage/repair area, etc. The maximum dimensions of beds (including attachments where necessary, e.g. Drip stands, pumps, monitoring equipment., traction, etc) should be taken into consideration in this regard. Similarly, bed lifts (if provided) must be able to take a bed and attachments along with up to 4 attendant personnel

Utility Rooms

The position of clean and dirty utility room(s) as well as other "common" areas must ensure that distances from bedrooms and other clinical areas are not excessive.

Socialisation Space

Socialisation space is a key component of all ward areas as in all wards patients/service users will spend the vast majority of the day period out with their bedrooms although it is noted that the preferred layout/configuration of

this space varies considerably by clinical area.

To ensure future medium/long term flexibility it is important that the design of all clinical areas facilitates a model whereby socialisation space can be used flexibly to meet the specific requirements of different patient groups this will include quiet and reflective time, entertainment and therapeutic activity. This requires to be balanced by maintaining an optimal relationship with bedroom and support/cluster accommodation.

Overview: External Areas

Many of the individual service templates attached focus on the essential requirement for exterior spaces and private gardens and terraces including on any upper floors as well as the more public spaces for walking or cycling

Where provided, these areas should also form part of the overall therapeutic environment and be subject to the same considerations and principles identified throughout this document.

Hours of Service & Work Patterns

Unless stated explicitly in detailed area briefs it should be assumed that:

- All wards will operate 24 hours/day, 365 days/year
- Outpatient areas will normally operate from 8-5 Monday to Friday and evenings. There may in the future be availability to provide weekend and out of hours appointments/sessions
- Administration areas will primarily operate between 8-5 Monday to Friday, although meeting rooms may be required to support evening/weekend events

As administrative areas are unlikely to be staffed out with office hours the implications of this should also be considered within the design. Specifically this should allow for these areas to be locked when un-staffed with a separate provision for out of hours visitors to make contact with ward/clinical staff before being allowed access to clinical areas.

Pathway & Patient Flows

Patients may be admitted to wards from a number of areas including:

- Home
- GP surgeries/ Health Centres
- Other clinical facilities such as community based clinics, District General hospitals or other hospitals
- Outpatient departments

These admissions may be either elective (planned) or unscheduled (un planned).

Separating scheduled care from unscheduled care is an important element in planning for the optimal utilisation of all resources and will be key to the overall model employed in the new hospital.

Scheduled patients will normally be admitted directly to a ward which they may access either via the clinical and consulting area, main entrance or In-patient (Ambulance) entrance should they be arriving by ambulance, hospital car or require to be dropped off close to an entrance for mobility or privacy reasons.

It is noted that the ambulance entrance must also facilitate discrete access to both IPCU and the Forensic Rehabilitation/low secure ward, either directly or via the adjacent support cluster, in order to admit patients to these areas under escort with the minimal of mixing with other patients and to facilitate privacy and dignity. (This may also be achieved through a direct entrance to these facilities at an entrance where vehicles can be parked safely if the design allows)

Outpatients will normally access clinical areas via the scheduled main entrance into the new building or via the existing entrance in the Horseshoe building for general outpatients, X-ray, etc. The fact that there will be two discrete outpatient areas within the facility may lead to confusion, emphasising the requirement for clear operational processes, an effective way-finding strategy and a design that optimally locates the new OP department as close to the existing area as possible. It is noted that whilst this would be a desirable element of the design there is no clinical reason to link both outpatient areas as they will be managing completely separate patient groups.

Once in the facility in-patients and out-patients may require to access, visit or go to a range of other areas to which clearly identified routes should be available including:

- Diagnostics – within the existing Horseshoe
- Therapy, in any one of a number of identified therapy areas in clusters
- Outpatients – even if they are an in-patient (When clinically appropriate)
- ECT/Minor Surgery area – primarily from elderly and adult mental health wards or from the inpatient areas elsewhere in South or East Ayrshire. Rarely people may attend as an out patient.
- Wards – primarily from entrance area
-

c. Service Continuity

It is essential that, during construction, all services are maintained on the hospital site within the existing operational buildings. This will present significant challenges in terms of care delivery, goods in and out, utility connections, etc.

Whilst many of these issues will be progressed through close working with technical staff and the established service continuity group, etc, it is important to recognise that Ayrshire Central Hospital is, and will remain throughout the build process a busy, functional clinical facility. The safety of everyone visiting or resident within the site must remain paramount at all times with regards to both the direct and indirect effects of the development process.

Specifically it is noted that careful planning will be required around the range of services supported by pavilions 1-3 as it is anticipated that these will be retained while construction work take place and 10 &11 at the other end of the site.

- In-patient accommodation will move to the new facility
- Mental health/psychology/CAMHS/Addictions related outpatient activity will move to the new build “consultation and interventional area”
- Administrative accommodation will move to retained accommodation within the Horseshoe

It is envisaged that significant car parking will be required to support the new facility both in its final format and throughout the build/development process and that this should be agreed in liaison with the North Ayrshire Council Local Authority and in conjunction with the development of a Green Travel Plan at a later stage.

3. Schedule of Accommodation

The current Schedule of Accommodation is attached as Appendix C.

All of the required rooms/spaces are identified within the attached Schedule of Accommodation with room details/specifications to be in line with the identified guidance.

It is important to note that:

- Every opportunity to appropriately rationalise scheduled areas through design should be identified
- Accommodation should be as flexible as possible
- Links to existing estate should be clearly identified
- A key design challenge will be making the whole facility (new build and existing estate) operate as one seamless clinical unit
-

To support an optimally efficient design, an adjacency matrix is presented as Appendix D, whilst Appendix E outlines those areas that must be located on the ground floor and those that could be located on upper floors.

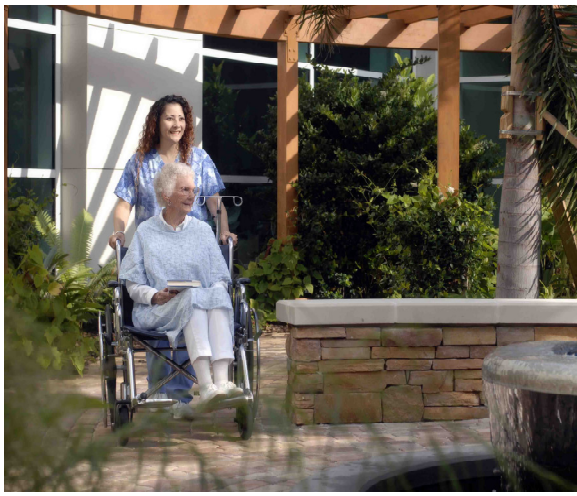
Appendices F to T present a more detailed operational overview of individual components which have been fundamental to the development of the Schedule of Accommodation, massing diagram and adjacency matrix.

Appendices

A Visual Clinical Specification
B New build Adjacency Diagram
C Schedule of Accommodation
D Adjacency Matrix
E Ground/Upper Floor Considerations
F Central (Walk-in entrance)
G “Ambulance” entrance
H Consultation & Interventional Area
I Multi-function ECT/Minor Surgery/Therapy Area
J Pharmacy/Dispensary
K Tribunal/Meeting Area
L Acute Mental Health Wards
M Intensive Psychiatric Care Unit (IPCU)
O Addictions Ward
P Rehabilitation unit (Adult Mental Health)
Q Elderly Mental Health Wards
R Rehabilitation Ward (General Health)
S Long Term Care (Continuing Care)
T Support Clusters

Appendix A – Visual Clinical Specification

- Outside space should be accessible from individual wards. Should include social and recreation areas and green space.



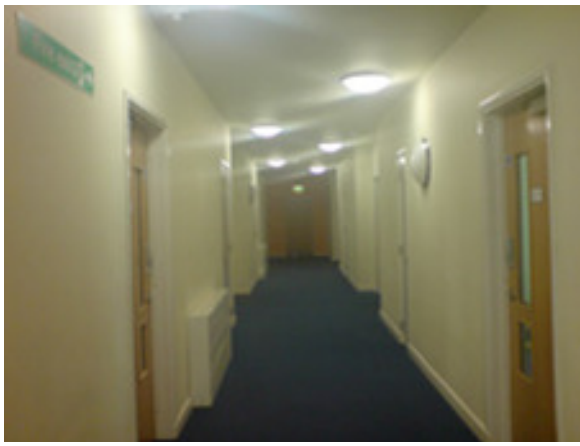
- Outside space may be used to increase the feeling of light and space indoors by, for example , the use of large windows.
- Outside space should be accessible to people with limited mobility.

Should not be overlooked, give the impression of being confined or cramped.


INTERNAL SPACES

- Public Spaces should maximise the use of natural light.
- Seating should be provided in corridors and public spaces.

- Reception Areas should be comfortable, welcoming and attractive.

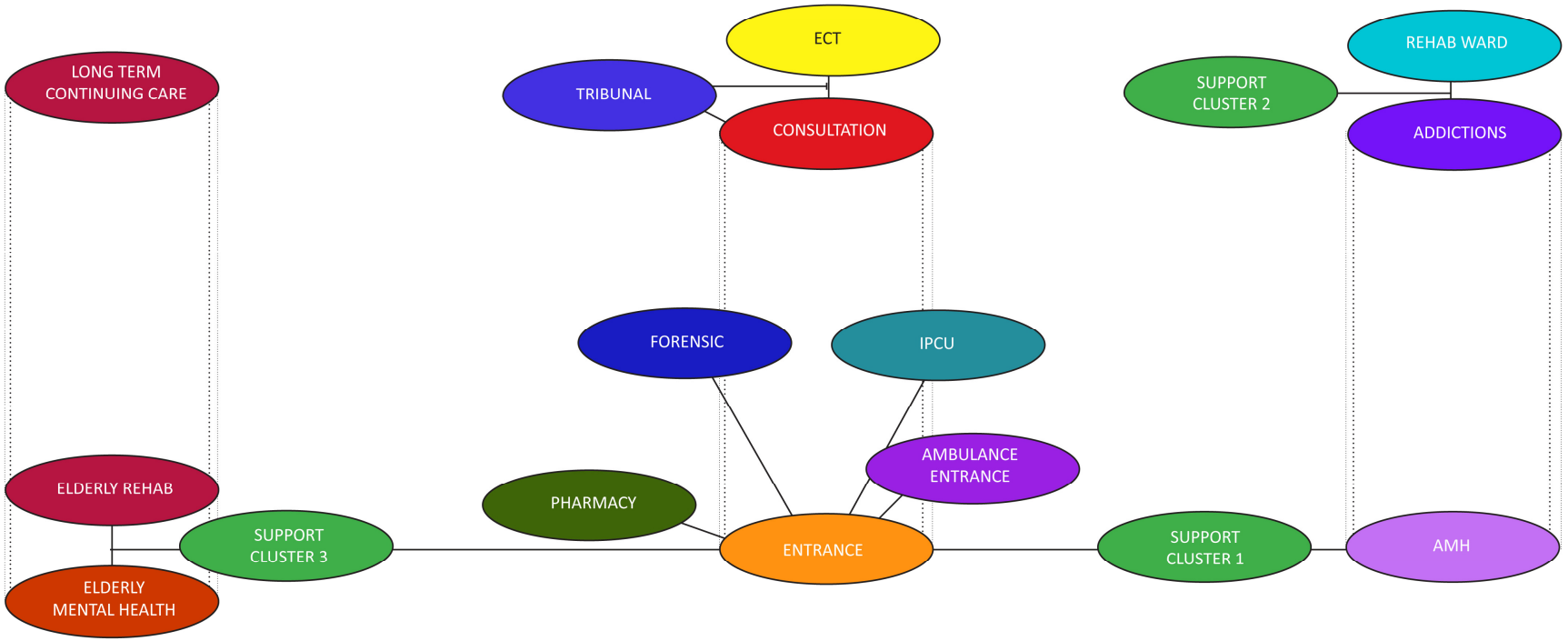


- Long dark corridors and unwelcoming reception areas must be avoided.

- Day Areas, including open-plan and smaller sitting areas retain impression of light and space.

Appendix B - New Build Adjacency Diagram

FIRST FLOOR



GROUND FLOOR

Appendix C – Schedule of Accommodation

BUCHAN ASSOCIATES LTD

Schedule of Accomodation

MASTER SHEET

Accommodation	Type	Net m2 m^2	Gross m^2	Comments
Central (Walk-in) Entrance	Admin	517	722.0	
Consultation & Inverventional Area	OP	521.5	744.7	
Ambulance Entrance	Admin/Circ	55.25	77.2	
20 Bed AMH Wards (MH)	Clinical		3027.7	3 x 20 bed wards
30 Bed Rehab' Unit (MH)	Clinical	1045.75	1526.3	1 x 30 bed unit
8 Bed Forensic Rehab' Unit (MH)	Clinical	464.25	677.6	1 x 8 bed ward
8 Bed IPCU (MH)	Clinical	444.25	657.7	1 x 8 bed ward
10 Bed Addictions Ward (MH)	Clinical	463.75	676.8	1 x 10 bed ward
15 Bed Elderly Wards (MH)	Clinical		1725.9	2 x 15 bed wards
ECT/AHP/Minor Surgery Suite	Clinical	183.25	255.9	
Support Cluster 1 (AMH)	Clinical/Admin	219.75	313.8	
Support Cluster 2 (Rehab)	Clinical/Admin	112	163.5	
Support Cluster 3 (Elderly)	Clinical/Admin	193.75	282.8	
30 Bed Elderly Rehab Ward	Clinical	985.75	1438.7	
30 Bed Long Term Care Ward	Clinical	985.75	1438.7	
Pharmacy	Admin/Clin	115.25	154.9	
Tribunal & Meeting Area	Admin	110.25	154.0	
Total			**14038.0**	

ADD PLANT	**737.0**
ADD COMMUNICATIONS	**1825.0**
TOTAL	**16600.0**

Approved on behalf of NHS Ayrshire & Arran

NAME

SIGNATURE

DATE

Version: OBC "As drawn" 1

N Sutherland

Appendix D – Adjacencies Matrix

North Ayrshire Community Hospital Adjacencies Matrix

	Acute Mental Health (AMH) Wards	Addictions Ward	"Ambulance" Entrance	Central (Walk-in) Entrance	Consultation & Interventional Area	ECT/Minor Surgery/Therapy Area	Elderly Mental Health Wards	Forensic Rehab' (8 bed, mental health)	IPCU	Long Term Care Ward (30 bed frail elderly	Pharmacy	Public Transport Pick Up/Drop Off	Rehabilitation Unit (30 bed, mental health)	Rehabilitation Ward (30 bed frail elderly ward)	Tribunal Suite/Meeting Area	Dining Room (Existing Facility)	Staff changing (In Horseshoe)	Spiritual Care Area	Existing general outpatients (In Horseshoe)
Acute Mental Health (AMH) Wards	-																		
Addictions Ward	E	-																	
"Ambulance" Entrance	D	D	-																
Central (Walk-in) Entrance	D	D		-															
Consultation & Interventional Area	D	D	D	E	-														
ECT/Minor Surgery/Therapy Area	D		E		D	-													
Elderly Mental Health Wards			D	D		D	-												
Forensic Rehab' (8 bed, mental health)			D					-											
IPCU	E		E					E	-										
Long Term Care Ward (30 bed frail elderly ward)			D	D			E			-									
Pharmacy	D	D	D		D						-								
Public Transport Pick Up/Drop Off	D	D		E	E		D	D	D	D		-							
Rehabilitation Unit (30 bed, mental health)			D					D				D	-						
Rehabilitation Ward (30 bed frail elderly ward)			D	D	D		E			E		D		-					
Tribunal Suite/Meeting Area	D		D		D			D	D			D	D		-				
Dining Room (Existing Facility)	D	D			D	D	D	D	D	D	D		D	D		-			
Staff changing (In Horseshoe)	D	D			D	D	D	D	D	D	D	D	D	D			-		
Spiritual Care Area				D														-	
Existing general outpatients (In Horseshoe)			D	D	D					D		D		D					-

Notes:

E = "Essential" adjacency. There is a definite clinical/operational rationale for these areas to be easily accessible from/between each other that must be a feature of the design

D = "Desirable" adjacency. Although not essential, there is a clear advantage associated with these areas being closely aligned if this can be achieved through the design

Appendix E – Ground/Upper Floor considerations

Services/ wards/ departments that definitely **could** be provided on the Upper floor	Services/ wards/ departments that could be provided on the Upper floor but would be a managed challenge/risk	Managed challenge/Risk if providing service on the Upper floor	Services/ wards/ departments that definitely **could not** be provided on the Upper floor
Central (walk-in) Entrance: Café Area/Coffee Shop/Retail	Support Cluster 1 Adult Mental Health	This Support Cluster must be easily accessible to the wards it is supporting – Adult Acute Mental Health, IPCU & Addictions	Central (walk-in) Entrance: Main Entrance
Central (walk-in) Entrance: Support facilities: sanitary	Support Cluster 2	This Support Cluster must be easily accessible to the wards it is supporting – Forensic rehabilitation/Low Secure, Rehabilitation unit and Addictions.	Ambulance Entrance
Central (walk-in) Entrance: Spiritual Care Area	Support Cluster 3 Elderly	This Support Cluster must be easily accessible to the wards it is supporting – Elderly Mental Health, Frail Elderly Long Term Care and Frail Elderly Rehabilitation Ward.	Mental Health Acute 20 Bed Wards x 3
Central (walk-in) Entrance: Hospital Admin/Support			Mental Health 15 Bed x 2 Wards – Elderly
Central (walk-in) Entrance: Mental Health Operational Management Team			Intensive Psychiatric Care Unit (IPCU)
Mental Health 30 bedded (3x10) Rehabilitation Unit			Forensic Rehabilitation/Low Secure
Consultation & Intervention Area			
Mental Health 15 Bed Ward - Addictions			Rehabilitation Wards (Frail Elderly)
	Frail Elderly Long Term Care Wards	Require easy access to safe outdoor space on the same level and access to outdoor space on ground level	Frail Elderly Rehabilitation in-patient Accommodation
ECT Suite/AHP Area/Minor Procedures Area			
Pharmacy/Dispensary			
Tribunal & Meeting Area			

Appendix F – Central (Walk-in) Entrance

Introduction and outline of services

Departmental Function

Our central walk-in entrance, reception and ancillary will provide:

- Main Entrance with reception area, records area, waiting area, porters and security offices;
- Café area/coffee shop/retail;
- Support facilities: sanitary;
- Spiritual care area; and
- Hospital admin/support including a cashiers office Mental Health Operational Management Team offices.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in common area and is described in the section entitled Main Entrance, Reception and Ancillary Accommodation in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The purpose of the Main Entrance, Reception and Ancillary Accommodation will be to provide an arrival point for patients (some arranged admissions transported by family; outpatients with or without carers; day patients with or without carers), visitors (to wards or attending meetings), staff and occasionally, goods. It will be an initial point of contact for individuals with enquiries.

Reception service may have to help individuals with particular problems, for example, mobility - finding a wheelchair, restlessness/anxiety. Help or escorting to a destination may be required, for example, cognitively impaired or sensory impaired patients/visitors. Staff in this area will need to have a detailed knowledge of the workings of the entire hospital in terms of who, where, how to, etc., failing that, speedy access to someone who does.

The Main Entrance, Reception and Ancillary Accommodation will be provided for 365 days, 7 days per week. The emphasis will be on being an initial point of contact for individuals arriving at the hospital and helping people to be in the right place at the right time.

A front desk reception to receive patients, relatives and NHS staff will be operational during Monday-Friday 9-5pm. “Welcomers” may man this desk. This area will allow one member of staff to greet the above people with a computer to access information. Directly behind this reception desk will be a room to house five staff and space for medical records for the hospital. Three of the staff will carry out the medial records function and two staff will complete the staff personnel function, recruitment, engagement and termination of staff. These staff would also manage the consultation and interventional area and support the reception area. The reception with associated medical records and admin function area would require to be on the ground floor. Healthy choice vending machines will be available at the main entrance.

The main entrance will require to be accessible 365 days, 7 days per week, 24 hours a day. To complement this accessibility as very few evening and overnight attendances are expected a form of ‘lock down’ permitted entrance is desirable rather than full open access at very low usage and low staffing times.

The café area /retail area will ideally open seven days a week and into the evening visiting. This area should be able to be secured when not in use.

Within the Management Team's area a room will be required to accommodate three people, to provide secretarial support to the Service Manager , the Senior Nurse, the Operations Co-ordinator and a secretary to support the procurement service and the Clinical Nurse Manager. This office could be placed on the upper floor. An office for the Psychiatry consultants who will be permanently based here (up to two WTE) could be located either with the Management Team or in an office in cluster for rehab. Ideally located with medical secretaries.

The spiritual care area will require to be accessible 365 days, 7 days per week, 24 hours a day and should be in a quiet area of the main entrance.

The main entrance area should:

- Be well signposted and easy to find, adequately sized, and offer level and unobstructed entry;
- Be well lit, staff and patient friendly and signed in such a way that patients and their escorts can find their way immediately. Ideally, patients accessing the main entrance should not have to pass the ambulances offload area;
- Create a calm and restful atmosphere and an environment which is non-threatening;
- Have an entrance with a canopy so that patients are offered protection from adverse weather conditions as they transfer from ambulances, taxis or private transport. The canopy should also be large enough to provide the same protection to cars unloading passengers/patients. The area should be well lit;
- A wheelchair bay should be provided adjacent to the main patient entrance lobby for immediate use;
- The provision of a drop-off zone close to this entrance for taxis or cars dropping off patients, which will include elderly or infirm;
- The provision of waste bins and salt bins should also be provided
- The entrance should be bright and easily identifiable from entrance roads, with good signage (see 'Wayfinding' NHSScotland);
- The entrance must provide adequate access for public transport vehicles, in particular for buses to manoeuvre in and out easily, taking account the length of buses;
- This entrance should have a suitable draught lobby, with two sets of automatic sliding doors adequately positioned far enough apart to ensure heat is retained within the building and that patients and staff are not subjected to draughts. It should not be possible to open both sets of doors at the same time unless in an emergency.
- The main patient entrance lobby is often a busy place. It will need to accommodate patients with a variety of conditions, including those using wheelchairs, those on foot but using walking aids, and those on foot but supported by escorts.
- It is essential that the lobby is large enough to permit easy movement of this traffic, and it should have a floor covering that will trap dirt carried by footwear or on wheels, and which can be easily cleaned. If

metal strips are used then designers should note that these can have an adverse effect on some people's vision. See also 'Welcoming entrances and reception areas' (NHS Estates, 2004);
- Afford no undue separation of staff from patients;
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Consider space and environment and recognise that this will be important from both the external and internal perspective;
- Be imaginative and creative use of space will be vital, for example, the avoidance of long corridors and the creation of attractive easily maintained/accessed landscaped gardens;
- It is essential for the service to be flexible to the changing needs of individuals and groups e.g. changes in conditions, gender, numbers, cultural needs etc.
- The physical environment will require to be responsive to such changes in demand;
- All therapeutic rooms should be designed to enable speech privacy; and
- Adequate provision of telephone access and IT infrastructure will be critical to effective communication, education and provision of evidence-based practice.
-
- This area has been described further in the exemplar design.

Role and Function

- The main function of the reception area is to meet and greet patients and direct patients and relatives. If a receptionist is concerned about a patient's condition, they should be able to summon help from clinical staff. "Welcomers" could provide this service which would provide a dual role, engaging with the community and encouraging volunteering and would also provide a cost effective service;
- Requires a hearing loop system at the main reception;
- There will be a focus on clinical and environmental safety and security for the patient, general public and staff within the service;
- The environment requires to lend itself to obtrusive and unobtrusive observation and in-keeping with Millan Principles;
- The environment must be pleasant, safe and the general ambience should promote mental and physical health well being; and
- It will continue to work closely and link with the community infrastructure.
-

Bed complement

- No beds will be provided in this area

-

Planned patient activity

- Not applicable
-

General principles of operation

- Not applicable

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be:

- Welcoming & homely;
- Well ventilated and spacious;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- All areas should be spacious, preventing those using our service feeling enclosed;
- The reception area should be located in an open space directly inside the entrance. The position of the reception area should allow reception staff to see all patients and escorts entering the department and have vision to the main waiting area;
- The design of the reception desk should be of a high quality and allow access for people with disabilities. It is appropriate to make the reception desk as friendly as possible; the inclusion of a hearing loop is a requirement. The inclusion of children's decor/mosaics should be considered. 'Friendly healthcare environments for children and young people' (NHS Estates, 2004) gives greater detail on designing a child-friendly environment. Care must always be taken to ensure that designs are suitable for all users; children, people with disabilities and disturbed patients. (www.fairforalldisability.org);
- The reception desk is the focal point of the waiting area. It requires to oversee the waiting area but care must be taken to ensure that those in the waiting area cannot overhear any discussions at reception. Computer facilities will be required for reception staff;
- The administration office should be provided behind the reception desk where access to photocopying, faxing, printing equipment and the disposal of confidential waste paper etc. will be required; and
- Security of the reception area should include the use of personal alarm transmitters.
- The waiting area will be required to accommodate some patients during very busy periods and for family and friends who accompany the patient to hospital. The general circulation area is the least easily

defined, as it has to provide a number of varying environments. From a design professional's viewpoint these are:

-
    - a waiting area for patients prior to their assessment;
    - a sitting area for friends and family, as some may elect to stay in the waiting area;
    - a designated, secure play and waiting area for children, possibly out of sight from the main adult waiting area but supervised by the staff at reception; and
    - an area for enquiries, information, and providing literature/notices of primary healthcare and local facilities.
-
- The design of the waiting area and all sub-waiting areas will include:
-
- circulation space for wheelchair users and pushchairs;
- space around seating for parking pushchairs and wheelchairs without impeding circulation areas;
- access to public or free phones for contacting friends, relatives, work etc;
- access to a text phone for those unable to use a public phone or a sign indicating that staff can make one available at reception or somewhere suitable;
- if TVs are provided, they should include text and locations must not interfere with any hearing loop systems;
- information boards (a sufficient number must be provided to prevent notices being stuck to walls, doors etc.);
- access to drinking water dispensers and possibly vending machines for healthy snacks, etc as some people arrive hungry or may have to wait for return transport.;
- the use of natural lighting where possible, although thought should be given to shade control;
- appropriate heating and ventilation;
- good, clear signage at appropriate height levels with maximum use of symbols or pictorial messages to assist those with poor reading or language difficulties in locating all services; and
- The seating layout should be considered carefully to prevent confrontational situations, for example, avoid seats directly opposite each other.
-

Corridors: Required features

- Corridor area should be kept to a minimum;
- Corridors should have no blind spots and allow maximum observation;
- Where corridors are not just to get from A to B they could have the opportunity for informal social contact, non institutional and natural light; and
- Corridors should provide seated areas for quiet contemplation and where possible views of shrubbery and gardens. Ward areas especially bedrooms and garden areas should not directly overlooked by any corridor.

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the unit must comply with current legislation

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Required adjacencies

External

- The Main Entrance, Reception and Ancillary Accommodation should have access to all ward areas without going outside; and
- Access to outpatient clinics in the consultation and intervention area and access to the ECT/minor surgery/therapy area without going outside.
-

Internal

- The café/area/coffee shop/retail should be located near the entrance;
- The spiritual care area should be in a quiet area located near the entrance;
- The hospital admin/support should be located behind the Reception/volunteer desk and in the ground floor;
- The Mental Health Operational Management Team offices should be located near to clinical services and could be located on the first floor; and
-

Storage facilities

The following storage facilities are required for:

- Porter's;
- Security;
- Community/Multipurpose/health Education Room (including HE store); and
- Wheelchairs.

Anticipated developments

- During the lifespan of the building a flexible approach to design will be required which takes into account changing models in delivery of care;
- The building should be able to meet the needs of future Information Technology developments; and
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

- All ages will access the Main Entrance
-

Admission Rates

- The main entrance should be open 365 days a year, 24 hours a day but will be securely closed after visiting (around 10pm) and reopened in the morning Monday - Sundayto maintain security and safety for patients and staff.

Diagnoses

- Patients admitted to the facility will have a varying range of mental health problems/illness and may some will experience issues re drug/alcohol misuse. They may be elderly and will be frail or possibly confused. Elderly patients are likely to have elderly relatives who may also be physically or mentally frail.
-

Anticipated illness-related behaviours

- The café and other entrance areas are likely to be a popular place for patients and visitors alike. Space and choice of seating areas will assist.

Anticipated clinical risks

Clients who are admitted to the facility may be at risk from the following:

- Harm to others;
- Poor motivation;
- Self neglect;
- Suicidal intention;
- Isolation in a community environment (social breakdown); and
- Institutionalisation.
- Physical dependency and immobility

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- Not applicable
-

Therapies

- Not applicable
-

Therapeutic facilities required

- Not applicable
-

Planned clinical meetings

- No clinical meetings will take place in this area

Other Meetings

- Not applicable
-

Clinical risk management principles

- Not applicable
-

Operational Procedures

Working day plans

- The main entrance will be open 365 days per year and 24 hours per day, but will closed after visiting Monday-Sunday. The café area/ coffee shop and retail will be closed after visiting hours.
- Security staff will be based in the main entrance 365days/24hrs, however the desk will not always be manned as security staff will require to undertake rounds throughout the site but will always be available on pager and 2way radio system.

Staffing arrangements and shift patterns

- The main entrance will be staffed 365 days per year and 24 hours per day.
-

Admission procedures

- Not applicable
-

Record-keeping storage

- In administrative areas, all clinical case records require to be stored within a lockable cabinet within a lockable room;
- Items of secure stationery require to be stored within a lockable cabinet;
- The administration office area will be located behind the reception desk with a medical records area adjacent; and
- The medical records area within the central walk in entrance will require to be extremely secure with access only by Administration and occasionally clinical in and out with office hours. This area must have appropriate medical records storage.
-

Visiting arrangements

- Visitor will enter via this area and there will be a varied but planned visiting time schedule. It is unlikely that visitors for the 206 patients would require to arrive at the one time although there will be peak

times.
-

Mealtimes/dining arrangements

- Facilities must promote the ambiance of the meal experience; and
- Cafe/coffee shop will be accessed by patients, visitors and staff.
-

Laundry facilities and linen management

- Not required in this area
-

Functional content

Number of Inpatient Beds/Treatment Spaces

- There will be no inpatient beds/treatment spaces in this area.

Investigative/Diagnostic/Treatment Capacity:

- Not applicable
-

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable
-

Specialist Technical Infrastructure Requirements

- Personal alarms;
- The reception area should be fitted with a discreet panic alarm system linked to security;
- Wall mounted alarms;
- Emergency Response Team (2222);
- Telephones for internal and external communications;
- Mobile phones for escort duties; and
- Emergency Response Pack.
- Secure Entry System - Security/Portering staff will be based in the main entrance to answer any queries
- Access to E-health and other IT systems from staffed areas.
- Announcements and health messages - what's on type visual

announcements may be provided by a technology based solution

-

Projected Future Activity

- Not applicable

Key Relationships with Other Departments

- Activities – retail and coffee shop (café area/coffee shop will be manned by either the Hospital Volunteers who will report to the manager responsible for volunteers throughout NHS Ayrshire & Arran or via directly provided services);
- Discreet Ambulance or Clinical taxis arrivals ;
- Chaplaincy;
- Internal support services – hotel services, portering, administration, IT, communications, finance, estates;
- Pharmacy;
- Service user groups/carer groups; and
- Voluntary sector see comment above re. hospital volunteers and other volunteer opportunities.
-

Future Service Delivery Risks

- Ageing population – more elderly patients and visitors and carers;
- Demographic changes;
- Activity levels will vary but predicted to be consistently high and
- Longer term future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need.

Appendix G – “Ambulance” Entrance

Introduction and outline of services

Departmental Function

Our Ambulance entrance will provide entrance, minimal waiting space

a bed equipment store area

Scope of Service/Specialist Services Provided

The accommodation is described in the section entitled ambulance entrance in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The purpose of the ambulance entrance is to provide a safe and discrete entrance to the unit.

All ambulance arrivals will be planned, the ambulance entrance will be accessible for 365 days, 7 days per week, 24 hours per day. A secure entry system will be operational with a buzzer ring to various named wards and to Porter. Visual identification of arrivals would provide an additional security feature especially in the Out of Hours periods.

The following will be crucial design considerations:

- Create a calm and restful atmosphere and an environment which is non-threatening;
- Should be able to accommodate patients subject to all levels of security;
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Area should be free from obstructions and should allow sufficient space to accommodate the need for immediate physical interventions;

- Be sensitive to the needs of physically disabled patients, visitors and staff; and
- Adequate provision of telephone access and access to immediate staff or emergency (2222) assistance.
- Easy and secure transfer of patients to the IPCU
-

Role and Function

The purpose of the ambulance entrance is to provide a safe and essentially, discrete and secure means of entrance to the hospital 24 hours a day 365 days a year.

Bed complement

- No beds will be provided in this area

Planned patient activity

The ambulance entrance will be used for planned in patient admissions and transfers from a range of sources described earlier.

Activity will be intermittent and may occur at anytime day or night. Doorways should be wide enough to allow a minimum of three persons abreast to enter. As with all entrances it should be able to accommodate the ambulant, non-ambulant and persons with a disability.

Within this ambulance entrance there will be a bed/equipment store . a seated area and space for wheelchairs

General principles of operation

- The area should be capable of being secured at all times and will by access in a planned way with authorised access system.

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be:

- Welcoming;
- Well ventilated and spacious;
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light;

- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Ligature points should be eliminated
- The Reception Area should have a panic alarm system for staff; and
- All areas should be spacious, preventing those using our service feeling enclosed.
-

Corridors: Required features

- Corridor area should be kept to a minimum; and
- Corridors should have no blind spots and allow maximum observation.

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the unit must comply with current legislation

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Required adjacencies

External

- The ambulance entrance should be covered / partially enclosed and centrally located to allow easy internal access to all wards especially IPCU

Internal

- The bed and equipment store should be located in a secure area accessible to the wards and in the utility area of the hospital close to the loading bay, a foul drain will be required; and

Storage facilities

The following storage facilities are required for:

- Bed/equipment store/test area

Anticipated developments

- During the lifespan of the building a flexible approach to design will be required which takes into account changing models in delivery of care;
- The building should be able to meet the needs of future Information Technology developments; and
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

- All ages and gender could access the ambulance entrance
-

Admission Rates

- The ambulance entrance will be accessible for 365 days, 7 days per week, 24 hours per day, however is designed to be used as a discreet entrance
-

Diagnoses

- Patients admitted through this entrance will have a varying range of mental health problems/illness.
- Patients may be transferred by Ambulance from the General Hospitals to the elderly mental health wards, rehab ward and long term (continuing care) wards and may have varying degrees of mobility and require wheelchair or trolley.
-

Anticipated illness-related behaviours

- Aggressive behaviour (verbal and physical);
- Aimless or ritualistic behaviours;
- Disinhibited behaviours;
- Lack of personal risk awareness;
- Suicide risk;
- Unpredictable and impulsive behaviours;
- Primary and Secondary physical disabilities/illnesses; and
- Fear and apprehension.
- Confusion or poor mobility

Anticipated clinical risks

- Clients who are admitted to the facility may be at risk from the following:
- Deliberate self harm;
- Harm to others;
- Poor motivation;
- Self neglect;

- Suicidal intention;
- Isolation in a community environment (social breakdown); and
- Institutionalisation
- Risk of falls

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- Not applicable

Therapies

- Not applicable

Therapeutic facilities required

- Not applicable

Planned clinical meetings

- No clinical meetings will take place in this area

Other Meetings

- Not applicable
-

Clinical risk management principles

- Risk management is important. Risk assessment should occur prior to arrival as part of the planned admission or transfer process and will be led by he clinical team from the receiving ward.

Operational Procedures

Working day plans

- The ambulance entrance will be accessible 365 days per year and 24 hours per day, with secure entry

Staffing arrangements and shift patterns

- The bed equipment store area will be operational during 9-5pm Monday to Friday and may be required for storage of broken beds at all times.
-

Admission procedures

- Not applicable
-

Record-keeping storage

- The Support Services Facilities Manager will be responsible for the admin function in relation to bed storage area.

Visiting arrangements

- Not applicable
-

Mealtimes/dining arrangements

- Not applicable
-

Laundry facilities and linen management

- Soiled linen (for example, disposable cloths and protective clothing) will be collected and stored in utility rooms in the hospital prior to transfer to the main soiled linen store; and
- Clean linen will be stored in cupboards/trolleys.

Functional content

Number of Inpatient Beds/Treatment Spaces

- There will be no inpatient beds/treatment spaces in this area.

Investigative/Diagnostic/Treatment Capacity:

- Not applicable

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable
-

Specialist Technical Infrastructure Requirements

- Personal alarm system and or Wall mounted alarms;
- Slow Door Systems (commended by MWC);
- Secure Entry System out of hours, proposed multi-way system buzzer ring to acute The security buzzer could be fitted with either buzzer or discrete flashing light at the entrance to the wards. When the operational policies are prepared this task could be assigned to security staff; and
- Telephones for internal and external communications.

Projected Future Activity

- Not applicable

Key Relationships with Other Departments

- Ambulance
- Chaplaincy
-

Future Service Delivery Risks

- It should be noted that patients may show signs of changes in diagnostic pattern within admission

Appendix H – Consultation & Interventional (Outpatients) Area

Introduction and outline of services

Departmental Function

Our consultation and interventional area will provide defined areas:

- Main consultation and intervention reception/support area with records area
- Supporting two sub outpatient areas for adults
-
- Outpatient clinic area (Child & Adolescent services) with reception

Consultation and interventional Area for adults x 2

The consultation and interventional area will be the main area for mental health outpatient activity. This area will have two clinic areas which will be accessed primarily by addiction services, learning disabilities, elderly, forensic, community mental health teams, primary care mental health teams eating disorders, forensic and the Clinical Psychology and Neuropsychology service. The consulting and therapy space will be booked in advance.

Addiction services will utilise the adult clinic area for outpatient appointments for new and return patients. Some patients attending will use the specimen/WC room for drug screen analysis.

It is also envisaged that Addiction services will use this area for evening and weekend work and would require appropriate security measures to ensure staff safety, for instance, secure entry.

Learning Disability Services will utilise the adult clinic area for new and return patients on single/multidisciplinary process initially on a Monday – Friday 9-5 basis. Patients may present with multiple physically disabilities. Patients may have to travel considerable distances and may require specialised transport. It is therefore imperative that consideration is given to toilet changing facilities, which can accommodate their needs and also refreshment facilities for them and their escorts.

Mental Health Elderly services will utilise the adult clinic area rooms for new and return patients Monday to Friday preferably after 11am to accommodate the client group. Patients may have difficulty in travelling distances and this should be taken into account in the location of this facility.

Primary Care Mental Health Teams will operate Monday to Friday, however their may be a requirement to offer evening sessions to this client group.

Eating disorders and forensic outpatients will use a range of clinics Monday-Friday with access required to the seminar room for group work and consulting space.

The Clinical Psychology and Neuropsychology service will be accessed by patients from General Medicine and Neurology including specific services to Acquired Brain Injury, Neuropsychology, Pain, Oncology and Palliative Care stroke, CHD and MS). These clinics will facilitate the "pooling" of resources across broad physical health groups (e.g. long term conditions) whilst ideally retaining membership of specialty teams as far as possible. There are also new arrangements developed in physical health to better support/bring psychological expertise to physical health care at a strategic level.

Provision within clinics includes individual neuropsychological and cognitive assessment as well as psychological assessment and treatment (individual or in groups) for functional disorders, health behaviours such as treatment compliance, and health symptom control. The service also provides advice, consultancy, supervision and training to health and social care staff who work with patients with physical health problems.

Child & Adolescent Clinic Area

The clinic area will be used by Child and Adolescent Mental Health Services (CAMHS) to improve the mental health and psychological well being of children and young people within North Ayrshire. This service will take in account the complexity and diversity of individual needs and should be informed by the views of children, young people, their families and carers.

- CAMHS offers assessment, intervention and support to children and young people up to the age of 18 who are in full time education and 16 to those who are not.
- CAMHS offers consultation and advice to a range of partner agencies.
- Provision of parenting groups
- Specialist clinics
- CAMHS will offer physical screening clinics, including venupuncture, physical screening, and physical examination, in relation to ADHD and Eating disorder pathways

The primary function of specialist child and adolescent mental health services (CAMHS) is:

- to develop and deliver services for those children and young people (and their families and carers) who are experiencing the most serious mental health problems. These services are provided directly by specialist CAMHS particularly to those children and young people whose difficulties are complex and severe.

As is clear throughout the Framework for Prevention, Promotion and Care (2005) specialist CAMHS staff also have an important role in supporting what the SNAP report called the "mental health capacity" of the wider network of children's services, namely services provided by other children's services around emotional well being and positive mental health. Specialist CAMHS play a significant role in supporting colleagues to deliver on this part of the framework requirements.

Scope of Service/Specialist Services Provided

The accommodation is described in the section entitled the Consultation & Intervention Area in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The purpose of the Consultation and Interventional Area is to improve health outcomes by working at several different levels.

Adult clinic area (2 required)

The majority of services with be Monday-Friday 9-5pm, along with evenings and weekends. Flexibility across morning and afternoon sessions will be required, for instance, elderly mental health services patients will access mid morning and early afternoon sessions.

The area should ensure:

- Direct assessment and therapeutic work with patients, individually or with families or groups;
- Working in teams, including supervision of work carried out by other professionals, staff support and joint clinical work with other professionals;
- Consultation about the care of patients; and
- Teaching and training in the application of principles to improve health care, e.g. application of cognitive-behavioural theory to practice, communication skills.

Outpatient clinic – Child and adolescent services

The purpose of the outpatient clinic area for child and adolescent services will be to provide an area where individuals are seen by a multi-professional dedicated team.

The area should:

- Create a calm and restful atmosphere and an environment which is non-threatening;
- Maximise therapeutic opportunities and the ability to relieve boredom;
- Afford no undue separation of staff from patients;
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Consider space and environment and recognise that this will be important from both the external and internal perspective;
- Be imaginative and creative use of space will be vital, for example, the avoidance of long corridors;
- It is essential for the service to be flexible to the changing needs of individuals and groups e.g. changes in conditions, gender, numbers, cultural needs etc. The physical environment will require to be responsive to such changes in demand;
- All therapeutic rooms should be designed to enable speech privacy and for CAMHS patients take into account varying ages between younger and older children;
- Therapy and observation rooms should have adequate storage space to ensure equipment is securely locked away;
- Adequate provision of telephone access and IT infrastructure will be critical to effective communication;
- The design of the reception admin support should be of a high quality and allow access for people with disabilities. It is appropriate to make the desk as friendly as possible; the inclusion of a hearing loop is a requirement. The inclusion of children's decor/mosaics should be considered. 'Friendly healthcare environments for children and young people' (NHS Estates, 2004) gives greater detail on designing a child-friendly environment. Care must always be taken to ensure that designs are suitable for all users; children, people with disabilities and disturbed patients. (www.fairforalldisability.org);
- The reception desk is the focal point of the waiting area. It requires to oversee the waiting area but care must be taken to ensure that those in the waiting area cannot overhear any discussions at reception. Computer facilities will be required to monitor occupation of the assessment rooms;

- Space should be provided behind the reception desk for photocopying, faxing, printing equipment and the disposal of confidential waste paper etc;
- The seminar room will be used for group work, for instance, for carers and education/supervision and consultancy for staff; and
- Security of the reception admin support area should include the use of personal alarm transmitters.

Role and Function

- There will be a focus on clinical/therapeutic and environmental safety and security for the patient, general public and staff within the service;
- Security will be provided at the least restrictive level, appropriate to the patients needs;
- The environment requires to lend itself to obtrusive and unobtrusive observation and in-keeping with Millan Principles;
- The environment must be pleasant, safe and the general ambience promotes mental and physical health well being;
- It will continue to work closely and link with the community infrastructure; and
- Within the three clinic areas cluster staff will be able to work with all age groups and across all specialties. They will provide neuropsychological and cognitive assessment (more sensitive than some neuro-imaging techniques in complex presentations) as well as psychological assessment and treatment for functional disorders. They will deal with health behaviours such as treatment compliance, and with health symptom control. Staff will work at all levels from individual to organisational.
-

Bed complement

- No beds will be provided in this area
-

Planned patient activity

Patients will access this area through planned, drop in (addiction services) and emergency appointments. There may be times when emergency outpatient appointments that may be required outwith appointment times but still within the working times of the department.

Some individuals will access this area from the islands and may have extended waits due to weather conditions or transport availability.

There will be a requirement for an area to be available to patients who arrive unannounced and will require interaction with staff, for instance, learning

disabilities.

-

General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group;
- Multi-disciplinary approach;
- Clinical interventions will be evidence based and reflect current best practice; and
- Intervention will be provided in keeping with an individual's care plan utilising a person centred approach.

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be:

Adult Clinics (2 required)

- Anti-ligature Standards;
- Through doors should have an appropriate viewing panel;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet storage services;
- Clinical areas that are non threatening and welcoming;
- All therapy rooms should be easily observable with no blind spots;
- Doorways should be wide enough to allow ease of access for disabled access;
- Calming features built into the fabric of the building; and
- Young people should be involved with the design.
-
- The waiting area will be required to accommodate some patients during very busy periods and for family and friends who accompany the patient to hospital. The general circulation area is the least easily defined, as it has to provide a number of varying environments. From a design professional's viewpoint these are:
-
- a waiting area for patients prior to their assessment;
- a sitting area for friends and family, as some may elect to stay in the waiting area; and
- an area for enquiries, information, and providing literature/notices of primary healthcare and local facilities
-
- The design of the waiting area and all sub-waiting areas will include:
-
- circulation space for wheelchair users and pushchairs;
- space around seating for parking pushchairs and wheelchairs without impeding circulation areas;

- access to public or free phones for contacting friends, relatives, work etc;
- access to a text phone for those unable to use a public phone or a sign indicating that staff can make one available at reception or somewhere suitable;
- if TVs are provided, they should include text and locations must not interfere with any hearing loop systems;
- information boards (a sufficient number must be provided to prevent notices being stuck to walls, doors etc.);
- access to drinking water dispensers and possibly vending machines for healthy snacks, etc as some people arrive hungry;
- the use of natural lighting where possible, although thought should be given to shade control;
- appropriate heating and ventilation;
- a secure environment;
- good, clear signage at appropriate height levels with maximum use of symbols or pictorial messages to assist those with poor reading or language difficulties in locating all services; and
- Evening and weekend use of this clinical area should have appropriate security for minimal staffing levels ie, rooms which are not in use may be locked

Clinic Area – Child & Adolescent Services

The main key design considerations for this area will be:

- There is a possibility of sharing some facilities with community paediatrics. These include clinical areas for physical examination, bloods, height and weights. Camhs will offer physical screening clinics, including venupuncture, physical screening, and physical examination, in relation to ADHD and Eating disorder pathways
- There are specific issues for many of the young people seen by CAMHS around body image, and therefore specific arrangements would need to be in place to accommodate the needs of these young people;
- It is identified that certain synergies do exist, it is also important CAMHS maintains its identity and status as a service within its own right. Similarly there are also shared synergies around transition to adult mental health services and learning disabilities;
- Dedicated area for CAMHS that is discreet for children, young people and families. Also allows young people and children the freedom to display particular types of behaviour without being stigmatised or chastised because other service users and/or professionals do not understand why they are behaving in such a way. A specific CAMHS base provides a safe environment for children, young people and families where they are understood and empathised with;
- Anti-ligature Standards;
- Through doors should have an appropriate viewing panel;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;

- Discreet storage services;
- Clinical areas that are non threatening and welcoming;
- All therapy rooms should be easily observable with no blind spots;
- Doorways should be wide enough to allow ease of access for disabled access;
- Calming features built into the fabric of the building; and
- Young people should be involved with the design.
-
- The waiting area will be required to accommodate some patients during very busy periods and for family and friends who accompany the patient to hospital. The general circulation area is the least easily defined, as it has to provide a number of varying environments. From a design professional's viewpoint these are:
-
- a waiting area for patients prior to their assessment;
- a sitting area for friends and family, as some may elect to stay in the waiting area;
- a designated, secure play and waiting area (sub reception) for children, possibly out of sight from the main adult waiting area; and
- an area for enquiries, information, and providing literature/notices of primary healthcare and local facilities will be provided in the sub reception.
-
- The design of the waiting area and all sub-waiting areas will include:
-
- circulation space for wheelchair users and pushchairs;
- space around seating for parking pushchairs and wheelchairs without impeding circulation areas;
- access to public or free phones for contacting friends, relatives, work etc;
- access to a text phone for those unable to use a public phone or a sign indicating that staff can make one available at reception or somewhere suitable;
- if TVs are provided, they should include text and locations must not interfere with any hearing loop systems;
- information boards (a sufficient number must be provided to prevent notices being stuck to walls, doors etc.);
- access to drinking water dispensers and possibly vending machines for snacks, chocolate etc as some people arrive hungry;
- the use of natural lighting where possible, although thought should be given to shade control;
- appropriate heating and ventilation;
- a secure environment;
- good, clear signage at appropriate height levels with maximum use of symbols or pictorial messages to assist those with poor reading or language difficulties in locating all services; and
- Evening and weekend use of this clinical area should have appropriate security for minimal staffing levels ie, rooms which are not in use may be locked.
-

Corridors: Required features

- Corridors should have no blind spots and allow maximum observation
- Long unbroken corridors should be avoided, with the maximum use of natural light and ventilation.
- Well signposted.
- Public access to upper corridors to wards should not be accessible by the public
-

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the unit must comply with current legislation

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Required adjacencies

External

- This consultation and intervention area should be located near or adjacent to the existing outpatients department; and
- The consultation and interventional area should be close to the main entrance.
-

Internal

- Therapy and observation rooms should be together within the CAMHS clinic area;
- There may be a requirement for Strathclyde Police to use the CAMHS observation room out of hours, a request for video recording has been asked for as this may change prior to FBC this will be confirmed.
- Ward areas infrequently but a patient could be admitted from outpatients; and
- Direct access to ambulance entrance for onward to transfer to district general hospital.
-

Storage facilities

The following storage facilities are required for:

- Storage for all items, for example, in the CAMHS clinic area (Medical and non medical equipment);
- Addictions service will require needle exchange locked storage facilities;
- Therapeutic equipment;
- Activities store; and
- Miscellaneous items.

Anticipated developments

- During the lifespan of the building a flexible approach to design will be required which takes into account changing models in delivery of care;
- The building should be able to meet the needs of future Information Technology developments;
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service; and

- It is anticipated that Elderly mental health services will require expansion in the future as services are developed to meet the increasing elderly population and the balance of care is shifted.
-

Client Group Characteristics

Age and Gender

- Adult mental health services will offer assessment, intervention and support of people aged 16-65 years of age;
- CAMHS will offer assessment, intervention and support to children and young people up to the age of 18 who are still in full time education;
- Elderly will offer assessment, intervention and support to people over 65 with people with a mental health problem or people of any age with dementia;
- Addictions will offer assessment, intervention and support to 16 years of age and over; and
- Learning disabilities will offer assessment, intervention and support to 16 years of age and over.
-

Admission Rates

- Not applicable

Diagnoses

- Not applicable

Anticipated illness-related behaviours

- On occasion, some of these clients who attend this department may show these behaviours:
- Aggressive behaviour (verbal and physical);
- Aimless or ritualistic behaviours;
- Disinhibited behaviours;
- Lack of personal risk awareness;
- Suicide risk;
- Unpredictable and impulsive behaviours;
- Secondary physical disabilities/illnesses;
- Fear and apprehension; and
- Illicit drug misuse.

Anticipated clinical risks

- On occasion, some of these clients who attend this department may be at risk from the following:
- Deliberate self harm;
- Harm to others;
- Suicidal intention;
- Patients arriving at the clinic facilities without an appointment.

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

The adult clinic arear and chld/adolescent clinic area will allow direct assessment and treatment for a variety of patient groups, including learning disabilities, elderly mental health, addictions, community mental health teams, primary care mental health teams, eating disorders, forensic patients. Psychological assessment and treatment for more complex psychological disorders will also take place including neuropsychological or cognitive assessment and advice regarding diagnosis, management, treatment and rehabilitation.

The outpatient clinic cluster for CAMHS will provide assessments and therapeutic intervention as required from a range of multi-disciplinary staff including Psychologists, Psychiatrists, OT, Psychotherapists, nurses etc.

-

Therapies

- Individual and group therapies will be provided in an appropriate setting within and out with the facility in accordance with an individualised care plan. On a planned and ad hoc basis;
- Therapies will enhance the care experience and will be focussed upon specific agreed interventions and outcomes;
- Therapy should be in keeping with recovery/Tidal Model and should be evidence based;
- Therapies should be provided by a wide range of multi disciplinary staff; and
- Therapy Examples – Anger management, Coping Skills, Anxiety management, ‘talking therapies’ & engagement.

Therapeutic facilities required

- Adequate space to provide therapeutic interventions as required within the units both as groups and 1-1; and
- Adequate storage space to contain therapeutic equipment will be required within the units.

Planned clinical meetings

- Adequate space is required to provide for a variety of clinical meetings which will take place on a regular basis:
-
- Multi-disciplinary meetings;
- Group activities;
- Consultant meeting;
- Junior Doctor reviews;
- Care Programme Approach(CPA) meetings;
- Case conferences
- Group activities; and
- clinical interventions.
-

Other Meetings

- Not applicable
-

Clinical risk management principles

- Each case is assessed on an individual basis in relation to good clinical risk management principles and an intervention plan devised;
- Risk management for this client group is important. The environment must be conducive to delivering the risk management plan;
- Based on a proactive approach to positive risk management (embedded within the service); and
- Formalised assessment tools will be utilised and process reviewed on an ongoing individualised basis.

Operational Procedures

Working day plans

- The adult clinic area will primarily operate Monday to Friday, 9am – 5pm although evening and weekend services will be required in the future, for instance, addiction services and primary care mental health teams.
-
- The CAMHS clinic area will operate Monday to Friday, 9am-5pm, although appointments do also accommodate children, young people and families after school. Clinicians operate from locality bases but also see clients in their own homes or other appropriate settings
-

Staffing arrangements and shift patterns

- The service operates as above, apart from public holidays

Admission procedures

- Not applicable
-

Record-keeping storage

- The service primarily makes use of the FACE system as an electronic patient record, but requires storage facilities for paper-based correspondence in relation to clients, and all historical records. All paper clinical case records require to be stored within a lockable cabinet within the records area; and
- Addiction services utilise the SAMS system through the IT system
-

Visiting arrangements

- Not applicable

Mealtimes/dining arrangements

- Not applicable

Laundry facilities and linen management

- Not applicable

Functional content

Investigative/Diagnostic/Treatment Capacity:

- An addictions testing area and phlebotomy areas required
-

Outpatient Service (Number of Sessions and specialist functions):

Each room will be used to maximum efficiency though robust and stringent operational systems.

Specialist Technical Infrastructure Requirements

-
- Projected direct/indirect impact of technology advances on all services delivered from the unit including:
-
- Access to FACE software package. The use of FACE by CAMHS clinicians has an impact on the use of admin to support them and free up time for clinical work;
- Ehealth - Health records CHI, GP – sci-gateway (single shared assessment, multi-agency, access referrals to services);
    - Tablets, PC and wireless computing units to access all standard and specialist clinical and operational systems
- Personal alarm system

Projected Future Activity

Within the **Adult clinic area** it is expected to have 1000 new referrals and 3000 return patients, along with carers group work sessions and staff training/supervision.

-

Within the **Child & Adolescent clinic area** the following applies:

- Over the past year we have had a 9% increase in referrals;
- Over the past year there has been a 5% increase in referrals in the North;
- HEAT targets;
- Commitments 10 and 11 – Delivering for Mental Health;
- Recovery approach;
- Tidal Model;
- 18 week RTT;
- Independent Assessment Framework (IAF);
- Partnership Forums;
- Referral rates over the past year have increased in the North locality by 5% from 479 to 518. This is expected to continue and increase. There will also be an increase in staff numbers. Within the next year the North Locality will have an additional 2 CAMHS clinicians. With the promise of increased funding it is anticipated that the team will continue to grow;
- Referral processes are being reviewed in the service. The age range will be broaden from 0-18, which will increase the number of referrals;
- Development of pathways for ADHD, eating disorders, psychosis; and
- Development of nurse prescribing, may increase clinic type work loads.

Key Relationships with Other Departments

- Appropriate Physical health services e.g. Douglas Grant Rehabilitation unit, Oncology, Stroke, etc
- Primary mental health link workers in schools
- Pan Ayrshire alcohol project
- Independent Assessment Forum
- Partnership forum
- Advocacy
- CAMHS
- Child protection
- Childcare services
- Community Mental Health Teams
- Education and universities
- GPs
- Hospital Social Work department
- Learning Disabilities
- Local Authorities Social Services, housing, benefits agency, tenancy support, job centre plus, citizens advice service, pet fostering etc
- Medical staff
- Others Allied Health Professionals
- Pharmacy
- Police
- Psychology
- Service user groups/carer groups
- Standby Social Work services
- Voluntary sector

Close to	Reason	Category*
Adult mental health services	Transition from CAMHS to adult services can be facilitated by closer proximity	important
Learning disabilities	Transition from CAMHS to adult services can be facilitated by closer proximity, some links already exist and need to be maintained	Important
Paediatrics	Some links already exist and need to be maintained	Important
Main entrance	To allow easy access for elderly mental health patients	Important
Central walk-in entrance	To allow patients, family and friends to access the café area/coffee shop/retail	Important

Future Service Delivery Risks

- Changes in practice;
- Changes in diagnostic pattern for admission eg personality disorders, challenging behaviour, Autistic Spectrum Disorder (ASD), brain injury, Alcohol Related Brain Damage (ARBD) and changes in diagnostic pattern for admission;
- Demographic changes;
- Integrated Care Pathways (ICP);
- HEAT targets – readmission rates, suicide prevention etc;
- Positive risk taking;
- Other services developing;
- Bed availability and bed blocking due to the lack of alternative community provision;
- Activity levels unpredictable;
- Future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need;
- Service Level Agreements (SLA) out of area no longer available for extra-contractual referrals therefore service would again have to adapt to that need;
- Patients arriving at the clinic facilities without an appointment; and
- People attending when intoxicated or under the influence of drugs.

Appendix I – Multi-function ECT/Minor Surgery/Therapy Area

Introduction and outline of services

Departmental Function

This area will have many multi-functional uses. In the first instance it will be an ECT suite for approximately two days/week, the description below describes the function of this service. When this area is not required for ECT purposes, it is proposed that this area could be used for a variety of uses, including a minor procedures area by GPs, AHP therapy area and by the addictions service to offer a tolerance testing.

All the above services are described below under separate departmental functions.

ECT Suite

The scope of the ECT department is to provide a safe, effective and progressive ECT facility, delivered by professionals who have experience and a specialised knowledge of the service.

ECT is effective in a wide range of psychiatric disorders but it is generally accepted as a first line treatment in severe or life threatening depression and treatment resistant depression.

The basic aim of ECT treatment is to induce a generalised cerebral seizure of a tonic–clonic or grand mal type, and to do so with an electrical dose that is sufficient to maximise the clinical efficacy of treatment, but not so high that it needlessly causes cognitive adverse effects of treatment.

The department function is:

- To provide effective, up to date and safe ECT treatment for the Ayrshire and Arran patient population;
- Maintain exemplary standards for service delivery through existing clinical governance structures;
- To provide an educational and training resource for junior doctors and nursing staff; and
- To encourage audit and research projects in ECT as well as contributing data to the Scottish national ECT audit project.

Minor procedures area

Within this area, minor lump, bump surgery may take place when rooms are available.

-
-

AHP Therapy Area

-

The shared space will be used by Allied Health Professionals to provide a rehabilitation and enablement service to inpatients. These services will include:

- Assess, diagnose, treat and refer patients to other services;
- Play a central role in promotion of health and wellbeing;
- Liaise with other clinicians and provide a specialist service;
- Teach, train and mentor other clinicians, students patients and carers; and
- Undertake research and development to improve clinical practice.
-

Addiction services

This area when available could be used by Addiction services for tolerance testing purposes. This would allow the service to bring patients in to a safe observation area to titrate prescribed methadone.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in Mental Health Services and is described in the section entitled ECT Suite/AHP Area/Minor Procedures Area in the Schedule of Accommodation.

Model of Care

Descriptive Overview

ECT

ECT is used as a treatment for a minority of patients with severe and/or treatment resistant mental illness. It is delivered to a high standard as a result of collaboration between ECT clinic staff, the anaesthetic department and the referring ward team. Service standards are subject to scrutiny from a number of outside agencies/bodies and this provides an incentive for ongoing audit, training and development of the service.

Therapy Area

The therapy area will provide a model of care that will be underpinned by the philosophy and principles in Co-ordinated, Integrated and Fit for Purpose: A Delivery Framework for Adult Rehabilitation in Scotland and the principles set out in AHPs as Integrators of Care.

- Access
- Dignity and the patient as a person
- Integrating care and partnership
- Choice and personal control

Addictions

This area when available could be used by Addiction services for tolerance testing purposes. This would allow the service to bring patients in to a safe observation area to titrate prescribed methadone.

Role and Function

ECT

- All areas should have a source of natural light;
- Preparation room must accommodate a trolley bed;
- Treatment room must be adequate;
- Space to allow a trolley bed to be wheeled in from the preparation room and out to the recovery room;
- Space to allow a minimum of 6 staff to work around the patient on the trolley bed;
- Space to accommodate the anaesthetic equipment, the ECT equipment used during the treatment session, emergency trolley plus supplies used in the course of a treatment session;
- Treatment Room - Separate room next to preparation room that will accommodate trolley bed and all necessary equipment;
- Piped in oxygen and suction, ECT machine and back up (EEG facility), Unilateral and bilateral probes, Anaesthetic machine (ventilator) (suction) to meet remote site requirements, Patient monitors (1 for each patient with ECG facility and 1 in treatment room), Suction points or machines (1 for each patient), Electronic thermometers x 4, Laryngoscopes x 3, Glucometer x 2, 12 lead ECG machine x 1, Emergency trolley x 1, Surgical trolleys x 6, First aid boxes x 1, Tilting trolleys that carry oxygen and have i/v stands x 8, Ambu-bag x 1, Automated defibrillator x 1, Theatre stools x 8, Clocks with second hand, Stop watch, All necessary sundries and

emergency supplies;

- Storage space, telephone, IT system. Moving and handling (wheelchair). Natural light. Theatre light, Infection control. Health & safety;
- Recovery Area should be a separate room next to treatment room that accommodates trolley beds for maximum through flow of patients. Storage space. Telephone. IT system. Natural light. Ability to adjust lighting levels for individual recovery bay areas. Piped in oxygen and suction. Infection Control. Manual Handling. Health & Safety. Observation;
- Recovery room size must fit 7 trolley beds plus monitors for each recovery patient, stool for nurse caring for each recovery patient, equipment as above;
- Small dedicated kitchen space for preparation of snacks;
- Dedicated office space; and
- ECT requires storage space for bulky sundries e.g tubing for anaesthetic machines, currently stacked in large boxes in recovery areas of existing clinics inappropriately. If treatment area is to be used for purposes other than ECT, as proposed, then the ECT machine and related ECT-specific equipment needs to be securely stored outwith the treatment room. When the recovery area is being used for non-ECT purposes, the monitors must be securely stored elsewhere and trolley beds may need to be moved elsewhere within the suite.

AHP Therapy area

- Storage of trolleys and equipment will be required when facility not being used as ECT suite
- Most therapeutic activity will take place in the recovery room (stage 1), treatment room and recovery room (stage 2)
-

Addictions

If using this area by the addiction service, the following rooms would be required for patients:

- Preparation area (patients should be able to access this area to wait);
- Disposal/sluice/test area (this area will be used to undertake drugs screen urine analysis prior to commencement of treatment);
- Recovery room (stage 2) Treatment area (this area will be used to dispense and observe titration of prescribed medication – for up to 4 hours). It would be beneficial if there could be diversional activities available in this area, ie. flatscreen TV); and
- Office (access for Doctor and associated nursing staff – maximum of 3 staff at any one time).

Bed complement

- 7 treatment spaces

Planned patient activity

ECT Suite

Using data gathered for the last 5 years of clinic activity to estimate what the likely future activity of a single clinic would be, we note that there was a drop in total number of patients treated in 2008. Despite this, when looking at data over a three, four or five year timeframe, statistics remain consistent:

The future ECT clinic in Ayrshire would be expected to treat an average of 3.52 to 3.68 patients per day of operation, median number of patients = 3, mode = 2. There is a notable variation in the numbers of patients treated and if we use the 90^{th} percentile to estimate the maximum capacity of the clinic, this would be 7 patients using data for 3 or 5 years, or 6 patients using the 4 year data. Our preference would be for a clinic with 7 treatment spaces.

AHP Therapy area

This area would be utilised to conduct therapeutic group sessions such as anxiety management. May also be used for relaxation groups and health education groups.

Addictions

It is anticipated that in the future this service could use the rooms during two sessions, during the day and possibly into the evening in the future. There would be a maximum of 3 patients at any one time. Over the week there would be approximately 3 patients seen over the 2 sessions (twice over 2 days).

General principles of operation

Design Synopsis

ECT Suite

This area should have a discrete entrance.

In addition to the core design synopsis/critical features, unique features to this environment will be:

Waiting Area

To accommodate maximum through flow of patients and escorting staff. Comfortable, soft furnishings. Natural light, toilet area. Television, music system. Magazine storage.

Separate Kitchen Facility

To accommodate space for cutlery, crockery, kettle, toaster and the making of light snacks. To meet food and hygiene requirements Infection Control and Health and Safety.

Preparation Area

Separate room that will accommodate trolley bed storage space, telephone. Natural light. Hand-washing/moving and handling (wheelchair). IT system.

Treatment Area

Separate room next to preparation room that will accommodate trolley bed and all necessary equipment (see list). Storage space, telephone, IT system. Moving and handling (wheelchair). Natural light. Theatre light, Infection control. Health & safety.

Recovery Area

Separate room next to treatment room that accommodates trolley beds for maximum through flow of patients. Storage space. Telephone. IT system. Natural light. Ability to adjust lighting levels for individual recovery bay areas. Piped in oxygen and suction. Infection Control. Manual Handling. Health & Safety. Observation.

Office Space

Telephone. IT system. Filing cabinets. Desks. Chairs

ECT co-ordinator requires the use of this office throughout the working week as they deal with clinic related admin, enquiries, planning, etc outwith clinic sessions.

Storage Space

Separate room / Separate gas storage

Toilet Area

Disabled facility with shower.

Linen

Separate clean storage.

Storage room for:

- Equipment (medical)
- Piped in oxygen and suction
- ECT machine and back up (EEG facility)
- Unilateral and bilateral probes
- Anaesthetic machine (ventilator) (suction) to meet remote site requirements
- Patient monitors (1 for each patient with ECG facility and 1 in treatment room)
- Suction points or machines (1 for each patient)
- Electronic thermometers x 4
- Laryngoscopes x 3
- Glucometer x 2
- 12 lead ECG machine x 1
- Emergency trolley x 1
- Surgical trolleys x 7
- First aid boxes x 1
- Tilting trolleys that carry oxygen and have i/v stands x 8
- Ambu-bag x 1
- Automated defibrillator x 1
- Theatre stools x 8
- Clocks with second hand
- Stop watch
- All necessary sundries and emergency supplies

Equipment (manual handling)

- Pat slides
- Sliding sheets
- Hoist

Therapy Area

When the area is being used as a Therapy area the following equipment will require to be accessed from lockable cupboards:

- Mats for relaxation / mindfulness groups
- Resources for therapeutic group sessions – including relevant presentation materials, activities
-

Addiction service

-

If Addiction service uses this area, Addiction services will require a cupboard for the following items:

- Storage facility for controlled drugs
-

Corridors: Required features

- Corridors should have no blind spots and allow maximum observation
- Long unbroken corridors should be avoided, with the maximum use of natural light and ventilation.
- Well signposted

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the facility must comply with current legislation
- The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

ECT

- Clinical taxis – Occasionally utilised for transferring patients to and from the ECT suite for treatment;
- Private healthcare facilities – An Infrequent event which in the past has been provided through a service level agreement; and
- Scottish Ambulance Service – Ambulances are utilised regularly for transferring patients to and from ECT suites on the day of treatment.
-

Therapy area

- Not applicable
-

Addiction services

- Not applicable
-
-

Internal

ECT

- Elderly Mental Health wards and acute adult mental health wards;
- Ambulance bay;
- Taxi / drop off area;
- Pharmacy services – provide all drugs including anaesthetic agents therefore close links are essential; and
- Medical Physics and Estates – Close links required for Maintenance and calibration of equipment.

Therapy area

- Internal inpatient ward areas – who may be in the night attire; and
- Relatively close to outpatients entrance.
-

Addiction services

- Not applicable
-

Storage facilities

The following storage facilities for are required for:

ECT

- Separate Gas storage (oxygen and suction) (if piped not provided)
- Clean laundry storage space
- Waiting area – magazine storage
- Preparation Area - Separate room that will accommodate trolley bed storage space
- Recovery Area – storage space
- Linen – storage space

Therapy area

- Storage for mats (either mobile rack or cupboard space)
- storage for small pieces of gym equipment eg balls, hoops, bean bags
- storage for electrotherapy equipment eg ultrasound machines, interferential machines, TENS
- storage for walking aids (unless there will be central storage for large pieces of equipment)
- storage of materials for therapeutic group activities
- storage of audiovisual equipment
-

Addiction services

-
- Small cupboard for storage space to hold specimen bowls, latex gloves, drugs screens and clinical waste bin.

Anticipated developments

- Not applicable

Client Group Characteristics

Age and Gender

ECT

The service accepts referrals from working age and old age psychiatry services. Patients suffering from severe depression, or other mental illness for which ECT could be indicated. A medical assessment is completed and risk assessed and fit for anaesthesia.

Therapy Area

All patients over 16 years of age.

Addiction services

All patients over 16 years of age.

Admission Rates

The new site at ACH will be regarded as isolated for the purposes of anaesthetic input. Assessment of patients will be even more rigorous than in the past. Patients assessed as being of higher anaesthetic risk may need to receive their treatment in theatre space at the DGH site – probably Crosshouse. Some equivalent or borderline cases in the past would have had treatment in the Crosshouse clinic.

If more complex cases are treated in the community setting, we may see more outpatient ECT.

Diagnoses

ECT

- The majority of patients at ECT suffer from a depressive illness.

Anticipated illness-related behaviours

- Agitation and distress causing some disturbed behaviour before or after treatment with ECT e.g. post-ictal confusion.

- Patients may exhibit challenging behaviour and may be experiencing a degree of physical ill health.

Anticipated clinical risks

- Anaesthetic input to the ECT clinics is in accordance with the standards set by the AAGBI. Some anaesthetic pre-assessment of patients is required when potentially high-risk patients come for treatment from the psychiatric wards or the DGH wards. The outcome of that pre-assessment may be the involvement of other hospital specialists in optimising a patient's physical state prior to, and during a course of treatment.

Therapy Area

- No specific clinical risks

Addiction services

- Possible risk of overdose of contra-indication of prescribed medication with previous ingested substances.

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

ECT proposals

The psychiatric department have expressed their desire to have ECT facilities located in the new development at the Ayshire central site. Within Crosshouse context this will involve a significant change from current practice. At present ECT is carried out within the main hospital site on a Monday and Friday mornings. Anaesthesia for these sessions is currently covered by the duty anaesthetist for that day. In most instances this will be a consultant anaesthetist but occasionally an associate specialist or staff grade will provide the anaesthetic cover.

Moving to a distant site will involve changes in several areas.

Staffing

Pharmacy stock

Equipment supply and maintenance.

Emergency equipment.

Protocols for Contingencies.

1. Staffing.

The current compliment of staff required for a current ECT session within Crosshouse is an Anaesthetist, Consultant Psychiatrist, Anaesthetic nurse and 2-3 psychiatric nurses specialising in ECT. Recent documentation from national bodies had suggested that a fully trained recovery nurse should also be present to manage the transition of the patient from first stage recovery to second stage recovery.

Moving to the Ayrshire central site would not alter these requirements but the logistics would change significantly.

Anaesthetic cover.

As stated above the ECT sessions are currently covered by the duty

anaesthetist. Moving to the Ayrshire central site would necessitate the session itself, including travelling time, becoming a fixed clinical commitment of a consultant anaesthetist. Including travelling time to and from the bass hospital this would approximate to 1.5 PAs of direct clinical care. This clinical session would be required twice a week. The Ayrshire central site would be viewed as a distant site and as such should ideally be covered by a consultant. Clearly provision would need to be made for annual or sick leave and there may be instances when consultant cover could not be guaranteed. If no consultant cover could be supplied then an associate specialist could, under these circumstances, cover a distant site. However this would have to be assessed from a risk point of view before implementation. The source of funding for these consultant sessions would need to be discussed at management level.

Nursing cover., Anaesthetic Nurse, Recovery Nurse.

Minimum of 3 Psychiatric nurses skilled in the management of patients post ECT.

2. Pharmacy Stock.

Currently in Crosshouse the ECT suite has a well stocked albeit basic selection of drugs. This does not pose any major difficulty because of the proximity of the pharmacy department and theatres from which emergency drugs could be retrieved if required.

New site would require pharmacy stock similar to emergency theatres in Ayr and Crosshouse.

Special care and consideration would need to be given to rarely used expensive drugs such as Dantrolene and Sugamadex.

Inevitably there would be some waste from this stock because in most ECT sessions use of these drugs would be minimal.

3. Equipment Supply and maintenance.

The ECT suite should be fitted out to the current standard of an anaesthetic room. Piped gas should be present with cylinder back up.

The anaesthetic machine including mechanical ventilation and potential for volatile anaesthesia.

Machine regularly serviced and maintained by medical physics.

Failure of machine would necessitate cancelation of list.

Airway trolley to standard of emergency airway trolley in theatre 4 Crosshouse.

Discussion would be required about the need for airway rescue devices such as jet ventilation and a video laryngoscope.

The need for such equipment might be offset if difficult patients are given the first course of treatment within either Ayr or Crosshouse hospital.

A stock of central and arterial lines including the facility to monitor these should be in place.

2 infusion pumps would be required for emergency purposes.

A defibrillator with pacing options.

A selection of intravenous fluids.

Intraoperative and post operative monitoring should meet the minimum criteria as set out by the association of anaesthetists. Intraoperatively this would include capnography. Post op saturation, respiratory rate, heart rate and BP would require to be monitored.

4. Emergency equipment

The requirements for this are covered in the equipment section.

5. Protocols for Contingencies.

Staff involved in the delivery of ECT should be familiar with emergency contingencies for life threatening anaesthetic emergencies. This would include Advanced life support guidelines, treatment of malignant hyperpyrexia, treatment of anaphylaxis, emergency airway management in the can't intubate can't ventilate scenario and management of status epilepticus.

Regular training and assessment with logbooks of training should be kept for all staff involved.

As can be seen from the above moving to a distant site requires careful planning and consideration of the costs and benefits involved.

ECT suite should consist of connected rooms. The first area is a waiting-room, proposed number of waiting spaces 10 and a wheelchair bay where patients are received and welcomed into the unit. This is connected to a further room where patients are prepared for treatment, for example removing dentures and speaking in privacy to the anaesthetist and nurse,

without the presence of the equipment in the treatment room. Patients then move onto the third area, the treatment room, where ECT is administered, followed by the recovery room which is directly adjacent and connecting. This configuration is based on guidance from the Royal College of Psychiatrists.

-

Therapies

- Not applicable

Therapeutic facilities required

- Not applicable

Planned clinical meetings

- Not applicable

Other Meetings

ECT

- Developing a cognitive screening and rehabilitation role for the ECT clinic staff will result in some one-to-one sessions between staff and former patients. Anticipate patients will be offered follow-up at 3 and 6 months post ECT, but not all will take this up. Patients identified as having some difficulties will have sessions with staff to look at cognitive rehabilitation (e.g. six 30-60min sessions).

Therapy area

- Not applicable

Addiction services

- Not applicable

Clinical risk management principles

- Risk management for this client group is important. The environment must be conducive to delivering the risk management plan;
- Based on a proactive approach to positive risk management (embedded within the service);
- Formalised assessment tools will be utilised and process reviewed on an ongoing individualised basis;
- On admission each patient is assessed in accordance with a recognised risk assessment tool; and
- Based on this initial risk management plan is developed which will also determine the person' observation status.

Operational Procedures

Working day plans

ECT

We have specifically asked for treatment sessions to be on Tuesday and Friday mornings, for clinical reasons. This would need to change when a public holiday falls on a Tuesday or Friday, so some flexibility of use will be needed. If patient numbers increase and exceed our recovery capacity, we may need to have ECT on a third session during the working week.

The ECT co-ordinator would be working in the office at times outwith the ECT clinic treatment sessions.

Outpatients attending for ECT i.e. arriving on the morning of treatment and returning home with an escort later the same day, will need to spend longer in the department recovering before they go home. This may mean we use some parts of the unit e,g, the waiting area (recovery stage 2) after the treatment session has officially finished at 1300hrs.

Morning - 0930hrs - 1300hrs

Afternoon - 1330hrs – 1700hrs

Therapy area

- Dependent on availability of the room

Addiction services

- Access to rooms, two consecutive afternoons a week.

Staffing arrangements and shift patterns

ECT

In the new facility, the ECT team will consist of the nurse co-ordinator (a fulltime post) plus depute and a further 3 core staff with other ward staff drafted in when necessary.

Junior medical staff will attend the clinic to deliver treatment for training purposes. They will do this in blocks of 3 weeks. A consultant psychiatrist will be present at all treatment sessions in the new clinic facility.

The anaesthetic team will be present for the duration of the treatment session.

AHP Therapy Area

- Existing Mental Health OT staff would utilise the Therapy Area.

Addiction services

- Maximum of three staff, one medical and two nursing.

Admission procedures

ECT Admission Criteria for wards

- The ECT department only accepts referrals from secondary care mental health services. The decision for treatment is often complex and requires to be made by experienced mental health clinicians, usually the patient's own consultant psychiatrist and inpatient team. The service accepts referrals from working age and old age psychiatry services.

Therapy area

- Therapists accept referrals from working age and old age psychiatry services.

Addiction services

- Via planned appointment.

Record-keeping storage

- Not applicable

Visiting arrangements

- Not applicable

Mealtimes/dining arrangements

- Not applicable

Between meal snacks and access to beverages

ECT

Once patients have recovered from anaesthesia, they will have a snack and a drink e.g. tea and toast, prepared for them in the unit. Having consumed this and recovered a little further, they will mostly return to their ward for ongoing observation (note some patients are “outpatient”).

Laundry facilities and linen management

- Not applicable

Adult Recreational Facility

- Not applicable

Functional content

Number of Inpatient Beds/Treatment Spaces

ECT

-

Therapy area

- Floor space for 6 – 8 mats if used for relaxation
- Up to 12 people if seated for group work

Addiction services

Access to the following rooms:

- Preparation area (patients should be able to access this area to wait);
- Disposal/sluice/test area (this area will be used to undertake drugs screen urine analysis prior to commencement of treatment);
- Recovery room (stage 2) Treatment area (this area will be used to dispense and observe titration of prescribed medication – for up to 4 hours). It would be beneficial if there could be diversional activities available in this area, ie. flatscreen TV); and
- Office (access for Doctor and associated nursing staff – maximum of 3 people).

Investigative/Diagnostic/Treatment Capacity:

ECT

- The ECT service would not be possible without input from the Anaesthetic departments of both Crosshouse and Ayr Hospitals. In addition to providing a service on the day of treatment, the consultant anaesthetists provide advice and if necessary pre-anaesthetic assessment of patients who may be at higher risk of complications and the anaesthetic team also provide a service for the one or two patients each year who require treatment in a more acute setting e.g. emergency theatres.

Therapy Area

- Not applicable

Addiction Services

- Addiction services would require use of the Disposal/sluice/test area to undertake drugs screen urine analysis prior to commencement of treatment.

Outpatient Service (Number of Sessions and specialist functions):

ECT

- The first area is a waiting-room (waiting spaces for 10 people and wheelchair) where patients are received and welcomed into the unit. This is connected to a further room where patients are prepared for treatment, for example confirming identity, consent to treatment, attaching monitoring equipment, removing dentures and speaking in privacy to the anaesthetist and nurse, without the presence of the equipment in the treatment room. Patients then move onto the third area, the treatment room, where ECT is administered, followed by the recovery room which is directly adjacent and connecting. This configuration is based on guidance from the Royal College of Psychiatrists.

Therapy Area

- Not applicable

Addiction services

Access to the following rooms:

- Preparation area (patients should be able to access this area to wait);
- Disposal/sluice/test area (this area will be used to undertake drugs screen urine analysis prior to commencement of treatment);
- Recovery room (stage 2) Treatment area (this area will be used to dispense and observe titration of prescribed medication – for up to 4 hours). It would be beneficial if there could be diversional activities available in this area, ie. flatscreen TV); and
- Office (access for Doctor and associated nursing staff – maximum of 3 people).

Specialist Technical Infrastructure Requirements

- Piped in oxygen and suction required
- ECT suite should have access to a networked computer allowing laboratory and imaging results to be checked prior to treatment.
-

Therapy Area

- Not applicable
-

Addiction services

-
- Access to emergency equipment.
-

Projected Future Activity

ECT

Difficult to predict, as multiple factors at work – see below.

Although combined the Ayrshire and Arran ECT clinic forms the second largest clinic in Scotland we have seen a general decline in patient referrals over the last decade. This pattern is evident across the country and is partly due to considerable advances in antipsychotic and antidepressant medication. This fall has not been seen in the practice of old age psychiatry, which makes still disproportionately high use of the ECT service. There are several possible reasons for this. Older adults may be more likely to suffer from the sorts of illnesses which respond to ECT. Refusal to eat or drink, severe psychosis and stupor may be more common in older age groups. The greater speed of response to ECT may lead to it being used preferentially in people whose poor physical health accentuates the urgency of treatment. Additionally there may be differences among older patients in their attitudes towards, or acceptance of, ECT.

Our population is aging: it is estimated that the number of elderly people in Ayrshire will increase from 67000 to well over 80000 in the next ten years. Clearly the service requires to consider the potential increase in demand for ECT in this high usage group. It also generally accepted that elderly patients over a course of treatment require a greater number of treatments when compared to their younger counterparts, yet another factor that needs to be taken into account when considering the number of future treatment places.

Increasingly, we are seeing a preference for unilateral ECT treatment and a slow move away from bilateral stimulation, particularly in the elderly, in order

to minimise cognitive side effects. It is recognised that unilateral ECT often requires more treatments when compared to bilateral stimulation which again needs to be factored into future service capacity.

Patient numbers are declining throughout Scotland. Potentially this could be extrapolated to a point where the number of Ayrshire patients needing treatment was so small that even one clinic was no longer viable and patients would need to be sent elsewhere e.g. to Glasgow for treatment.

The proportion of elderly patients is increasing. The use of unilateral treatment as opposed to bilateral is being encouraged. Both of these will result in the smaller numbers of patients having slightly greater numbers of treatments per course of ECT.

Therapy Area

- Not applicable

Addiction services

- It is anticipated that in the future this service could use the rooms during two sessions, during the day and possibly into the evening. There would be a maximum of 3 patients at any one time. Over the week there would be approximately 3 patients seen over the 2 sessions (twice over 2 days).

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
EMH wards and acute adult wards	Ease of transfer of patients to and from treatment session	Desirable
Ambulance bay	Emergency transfer of critically ill patient to ITU	Important
Taxi / drop off area	Ease of transport of patients from Ailsa and any outpatients attending for treatment	Desirable

Hospital pharmacy	Speedy access to medications in emergency	Important

Future Service Delivery Risks

ECT

-
- The new site at ACH will be regarded as isolated for the purposes of anaesthetic input. Assessment of patients will be even more rigorous than in the past. Patients assessed as being of higher anaesthetic risk may need to receive their treatment in theatre space at the DGH site – probably Crosshouse. Some equivalent or borderline cases in the past would have had treatment in the Crosshouse clinic; and
- If more complex cases are treated in the community setting, we may see more outpatient ECT.

Therapy Area

- Not applicable

Addiction services

- Possible risk of overdose of contra-indication of prescribed medication with previous ingested substances.

Appendix J - Pharmacy/Dispensary

Introduction and outline of services

Departmental Function

- The Pharmacy Department will serve both mental health and community hospital services. It will provide clinical pharmacy services, dispensing and ad hoc supplies to both services. Bulk deliveries will be provided from Crosshouse Hospital Pharmacy Department direct to the wards. Estimated pharmacy staffing would not be expected to exceed 20, but is dependent on the pharmacy services required by the community hospital element. The Pharmacy requires a central location for access to all in-patient wards and also to the consultation and interventional area and outpatient clinics.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in Mental Health Services and is described in the section entitled Pharmacy/dispensary in the Schedule of Accommodation.

Model of Care

Descriptive Overview

Pharmacy cover two main elements of service provision:

- The provision of a clinical pharmacy service to patients and wards
- The supply of medicines to wards and to patients on pass and on discharge from hospital.

The level of service provision will be dependent on case mix. Current services do not necessarily reflect what will be required when the new community hospital is fully operational.

The main supply function will be managed from the central point at Crosshouse Hospital. The clinical and dispensing services can be provided in association with the mental health pharmacy arrangements subject to staffing and accommodation etc.

The new pharmacy department will support all patients on the North Ayrshire Community Hospital site.

Specialist clinical pharmacy services will be provided by the Mental Health Pharmacy Team (MHPT, currently based at Ailsa Hospital) to patients across NHS Ayrshire and Arran. Inpatient services are provided as part of the multidisciplinary team, with support to community services as appropriate. All aspects of mental health services will be supported:

- Adult inpatients and community services/IPCU/Low Secure/forensic
- Elderly mental health
- Addictions
- Learning Disabilities
- CAMHS

A dedicated area-wide clozapine pharmacy service is also provided by the MHPT, currently from Ailsa Hospital. This service will now be centrally provided from the new pharmacy at the NACH site.

The clinical pharmacy and dispensing requirements for the community hospital will be provided in association with the mental health pharmacy arrangements, subject to staffing and accommodation.

Role and Function

(1) Community Hospital element

At present all medicines utilised on the Ayrshire Central site are supplied from Crosshouse Hospital. This follows the upgrading of the pharmacy on the Crosshouse site and the closure of the pharmacy on the Ayrshire Central Hospital site. This is currently insufficient activity on the Ayrshire Central site to merit a pharmacy department.

A clinical pharmacy service is provided to the Ayrshire Central site from Crosshouse Hospital. A technician top-up service is also provided from Crosshouse.

(2) Mental Health Services

Dispensing and Medicine Supplies

The MHPT is based at Ailsa Hospital and provides all dispensing requirements (pass, discharge, outpatient prescriptions, self-medication supplies) to the Ailsa and Arrol Park sites. Ad hoc orders are also provided by Ailsa Hospital Pharmacy to these locations.

Pharmacy technicians from the MHPT provide a comprehensive ward top up service to MH services at Ailsa and East Ayrshire Community Hospital and also to Arrol Park. Bulk orders to Ailsa Hospital, Arrol Park and mental health beds at EACH are currently provided by Ayr Hospital Pharmacy, while Crosshouse Pharmacy provides bulk orders to MH beds at Crosshouse (1D and 1E) and Ayrshire Central Hospital (Pavilions 1 and 2).

Clozapine Service

The NHS Ayrshire and Arran centralised clozapine pharmacy service is also provided from a team based at Ailsa Hospital Pharmacy, supplying clozapine to approximately 230 outpatients throughout Ayrshire. Clozapine is also supplied by this team to inpatients at Ailsa and Arrol Park. In addition, clinical advice including specialist therapeutic drug monitoring is provided by the clozapine pharmacist and specialist clinical pharmacists.

Specialist Mental Health Clinical Pharmacy Services

Specialist mental health clinical pharmacy services are provided by pharmacists to all services within mental health. Each Senior Clinical Pharmacist has a specialist responsibility, e.g. Elderly Mental Health, Adult Mental Health, Learning Disabilities, etc. The pharmacists provide specialist advice and pharmaceutical care as members of the multidisciplinary teams. Mental health clinical pharmacy services are currently provided by the MHPT to Ailsa Hospital, Arrol Park, EACH, Ayrshire Central and Crosshouse sites, with input to CAMHS and forensic services.

With the new MH facility being provided at Ayrshire Central, it is important to note that a satellite clinical pharmacy service beds remaining on the Ailsa Campus will require to be retained with appropriate access to desk space/IT. There would be no requirement for separate dispensing/supply services to be provided at the Ailsa site and further discussion is required as to how these services will be delivered.

(3) Outpatient department

The hospital pharmacy department provides an outpatient dispensing service for patients requiring medication immediately as prescribed by psychiatrists at outpatient clinic. Location of the pharmacy relative to outpatient clinics would require to be considered, along with facilities for pharmacy staff to counsel patients about their medicines.

An additional consideration would be the future model for patients prescribed clozapine. One potential development would be the use of 'near patient testing' and 'one stop dispensing' where clozapine patients would have their blood taken, analysed immediately onsite and be given their medication in one visit, dependent on the result. Accommodation requirements and appropriateness of having of such a facility on the new NACH campus would need to be considered in consultation with nursing and medical colleagues.

Pharmacists also require appropriate accommodation to interview and counsel patients (separately from the prescription counselling service) and it would improve the current situation if outpatient accommodation could be utilised for this purpose.

(4) Medical gas provision

As expected, we are anticipating a mixed model, with MH wards using cylinders and the community hospital would be expected to utilise piped gases, in keeping with East Ayrshire Community Hospital and Girvan. We have discussed that ECT would preferably use piped gases, so it would be helpful to consider the siting of the ECT suite in relation to the community hospital facilities with respect to piping requirements. Additional consideration would need to be given to what gases would be required and anticipated usage as this would influence how the piped gases would be provided.

Bed complement

- Not applicable

Planned patient activity

- Medication usage will increase in the future;
- Potential remodelling of the clozapine service with near-patient testing/one stop dispensing; and
- Pharmacy activity in the community hospital (outpatient/clinical) will be determined by the range of specialties provided.

General principles of operation

Design Synopsis

The future development of mental health services will have an impact on the pharmacy accommodation and service needs of the site. A fully functioning pharmacy providing dispensing and clinical services will be required. The service needs of the new community hospital should be able to be provided from this pharmacy, although it is unclear what additional level of support will be required. It is however envisaged that bulk supplies would continue to be provided by Crosshouse pharmacy.

The clinical pharmacy service to the community hospital will require to utilise joint premises with mental health pharmacy.

The range and volume of services, will dictate the wider dispensing needs beyond mental health on the site and may require some resource transfer from Crosshouse.

Corridors: Required features

- Corridors should have no blind spots and allow maximum observation;
- Long unbroken corridors should be avoided, with the maximum use of natural light and ventilation; and
- Well signposted.

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the facility must comply with current legislation; and
- The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The Pharmacy Department requires to have secure road access and access point for deliveries.

Internal

- The Pharmacy Department requires a central location for access to both mental health and community hospital wards and also to outpatient clinics.

Storage facilities

- See under room detail description

Anticipated developments

Potential for further development of the area-wide clozapine service to include near-patient testing/one stop dispensing – potentially within outpatient facility.

Client Group Characteristics

Age and Gender

- Not applicable

Admission Rates

- Not applicable

Diagnoses

- Not applicable

Anticipated illness-related behaviours

- Not applicable

Anticipated clinical risks

- Pharmacy staff will be appropriately trained in terms of violence and aggression to minimise risk.

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- Clinical pharmacy services – providing pharmaceutical care to patients in community hospital and mental health facility

Therapies

- Not applicable

Therapeutic facilities required

Patient counselling room would require the following facilities:

- IT access/telephone point

- Secure doors to dispensary and waiting area (distinct from secure staff entry to dispensary)
- Panic alarm

Planned clinical meetings

- Pharmacists will require appropriate accommodation to interview and counsel patients (separately from the prescription counselling service) and it would improve the current situation if outpatient accommodation could be utilised for this purpose

Other Meetings

- Pharmacy staff will attend relevant clinical and management meetings as appropriate within NACH and offsite in relation to mental health and community hospital services.

Appendix K - Tribunal/Meeting Area

Introduction and outline of services

Departmental Function

Recognising that the tribunal process will be difficult and confusing for some patients and other parties, it is with this knowledge borne in mind that venues must be provided which fully meet the user's needs as well as supporting the requirements of legislation contained within the Act[1].

That is to say that all venues must allow for hearings to be conducted in privacy whilst allowing openness for sensitive discussions to take place. There is also a requirement for patient/counsel discussion to take place privately away from the main hearing room. Additionally, it must also be acknowledged that some patients participating in hearings may require taking some time out in a quiet area, becoming unwell or having to take medication at some point during the proceedings.

Scope of Service/Specialist Services Provided

The accommodation is described in the section entitled Tribunal/Meeting Area in the Schedule of Accommodation.

Model of Care

The Tribunal is a form of legal proceeding provided under mental health legislation[1] . Tribunal accommodation is required within both community and in patient settings. The tribunal is a formal proceeding, chaired by officers of the court, in attendance are solicitors, patients, advocate, family, Medical and nursing staff caring for the patient and Mental Health officer who are specialised social workers involved in the care of the patient

[1] Mental Health (Care and treatment) (Scotland) Act 2003

Descriptive Overview

The purpose of the Tribunal Suite is to facilitate Tribunals in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003,

These will be crucial design considerations. –

- The venue must meet all current legislation and regulations including; heating, lighting, ventilation, access, sanitation, Health and Safety and fire relating to the use or occupation of public access buildings.
- It must be easily accessible to the public, staff and tribunal members and not in an isolated or undesirable area. Reliable public transport services should be in operation.
- All accommodation must meet the requirements of the Disability Discrimination Act 1995.

The Tribunal Suite and meeting area should promote safety, dignity, comfort and privacy.

The area should:

- Create a calm and restful atmosphere and an environment which is non-threatening;
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Consider space and environment and recognise that this will be important from both the external and internal perspective;
- Adequate provision of telephone access and IT infrastructure will be critical to effective communication, education and provision of evidence-based practice; and
- Allow a quiet environment with good level of confidentiality for legal proceedings when those who are the subject of the tribunal can be anxious, distressed or present behavioural problems.
-

Role and Function

- The Tribunal fundamentally changes the way in which decisions will be made on the care and treatment of people in Scotland who have a mental health disorder. The Mental Health Tribunal for Scotland will

hear cases by means of a network of locally based tribunals across Scotland.

-

Bed complement

- No beds will be provided in this area

Planned patient activity

- Inpatients will access this Tribunal Suite

General principles of operation

- The three member tribunal panel plus clerk plus security staff arrive at 9a.m;
- The security presence is provided by the Tribunal and controls access to the tribunal rooms and calls for those present to move from the waiting area into the main hearing room; and
- From 9am, the tribunal panel spend time reviewing papers in the ante-room.

- The tribunal hearing begin at 10a.m. in the main hearing room. In the room will be:

- 3 member tribunal panel, plus tribunal clerk
- the mental health officer making the application for detention
- the responsible medical officer (consultant) for the patient
- the patient (with or without a nurse escort)
- patient's family member(s) and or named person
- patient's legal representative and or advocacy worker

- The panel hear the evidence submitted in the reports (2 medical, 1 MHO) and all three members can question the writers where available to establish that criteria for detention and treatment are met.

- The panel hears evidence from the patient and or their legal representative, again all three members asking questions as appropriate.

- Having heard the evidence, the panel then retire to their ante-room to consider their decision/ruling. While they do this, the other attendees return to a waiting room.

- All meet again in the main hearing room to hear the decision.

- If the decision is that the patient is to be detained, they return/go to an inpatient ward. At times this can require good patient management, If the decision is that the patient is not detained, they

may go to a ward voluntarily or leave completely.

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be:

- Intercom secure buzzer entrance;
- Security will be provided at the least restrictive level, appropriate to the patients needs;
- The environment especially waiting areas requires to lend itself to obtrusive and unobtrusive observation and in-keeping with Millan Principles;
- The environment must be pleasant, safe and the general ambience should promote mental and physical health well being. Water should be readily accessible;
- There should be one single point of entry to the Tribunal Suite and meeting area. Fire Egress routes can be planned but not for common use or access;
- Welcoming & homely;
- Well ventilated and spacious;
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Ligature points should be eliminated; and
- Areas are non threatening and welcome.

Corridors: Required features

- Corridor area should be kept to a minimum; and
- Corridors should have no blind spots and allow maximum observation.

Disabled access requirements

- The design of the unit must comply with current legislation.

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- Not applicable

Internal

- The Tribunal Suite should be in close proximity to the inpatient mental health wards – adjacent to the ambulance entrance.

Storage facilities

The following storage facilities are required for:

- Store for documents/information leaflets relating to the Mental Health (Care and Treatment) (Scotland) Act 2003, which will also be displayed and available in the waiting areas

Anticipated developments

- During the lifespan of the building a flexible approach to design will be required which takes into account changing models in delivery of care;
- The building should be able to meet the needs of future Information Technology developments; and
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

- 16 years of age and upwards will access the Tribunal Suite

Admission Rates

- The Tribunal Suite will be operational during working hours, Monday-Friday 9-5pm

Diagnoses

- Patients using the Tribunal Suite will have a varying range of mental health problems/illness and may experience issues re drug/alcohol misuse

Anticipated illness-related behaviours

- Aggressive behaviour (verbal and physical);
- Aimless or ritualistic behaviours;
- Disinhibited behaviours;
- Lack of personal risk awareness;
- Suicide risk;
- Unpredictable and impulsive behaviours;
- Secondary physical disabilities/illnesses; and
- Fear and apprehension.

Anticipated clinical risks

Clients who are attend to this department may be at risk from the following:

- Deliberate self harm;
- Harm to others;
- Poor motivation;
- Self neglect;
- Suicidal intention;
- Isolation in a community environment (social breakdown);
- Institutionalisation; and
- Displaying anxiety or range of other emotions.

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- There will be no direct clinical care taking place in the Tribunal Suite/Meeting Area although the patient may be escorted and observed by nursing staff.

Therapies

- There will be no therapies taking place in the Tribunal Suite/Meeting Area.

Therapeutic facilities required

- There will be no therapy facilities required in the Tribunal Suite/Meeting Area.

Planned clinical meetings

When the tribunal suite is not being used for a Tribunal the following meetings could take place and will require:

- Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis;
- Nursing handover reports;
- Multi-disciplinary meetings;
- Consultant meeting;
- Junior Doctor reviews;
- Care Programme Approach(CPA) meetings;
- Case conferences;
- 1-1 clinical interventions; and
- Adequate space to comply with Mental Health Act.

Other Meetings

- When not used as a Tribunal Suite, general meetings and recreational groups will access this area out with office hours or when available.

Clinical risk management principles

- Risk management for this client group is important. The environment must be conducive to delivering the risk management plan

Operational Procedures

Working day plans

- The Tribunal Suite will be accessible Monday – Friday, 9-5pm;
- When this area is used for general meetings access will be obtained by contacting the Mental Health Act administrator; and
- These legal proceedings can be called with short notice and booking would take precedence.

Staffing arrangements and shift patterns

- Not applicable

Admission procedures

- No admissions will take place in this area.

Record-keeping storage

- No records will require to be stored in this area. Although documents may required to be photocopied at short notice by the tribunal.

Visiting arrangements

- Not applicable

Mealtimes/dining arrangements

- Tribunals can be lengthy and it will be appropriate to provide tea and coffee and water fountain facilities for tribunal members, patient and other attendees to ensure hydration.

Laundry facilities and linen management

- Not applicable

Functional content

Number of Inpatient Beds/Treatment Spaces

- There will be no inpatient beds/treatment spaces in this area.

Investigative/Diagnostic/Treatment Capacity:

- Not applicable

Outpatient Service (Number of Sessions and specialist functions):

- Currently outpatient tribunals take place in another tribunal suite within the community in the main town of Irvine. It is unlikely this suite will be used but would be a contingency if significant premises issues made the other suite temporarily unavailable.

Specialist Technical Infrastructure Requirements

- Experience suggests that access to telephone conferencing facilities is helpful e.g. family member living at a distance or unable to travel;
- Intercom buzzer entrance for late attendees and to prevent intrusion to either waiting or tribunal areas; and
- Access to FACE to allow Medical Staff to confirm information requested by the panel members.

Projected Future Activity

Below is a breakdown of the number of hearings that have taken place from April 2008 to March 2009. The future activity for the Tribunal Suite at North Ayrshire Community Hospital will include all adult acute inpatients that are currently provided for at Ailsa and Crosshouse Hospitals.

It is likely we may need to retain access to the current tribunal suite at Ailsa for inpatient activity on the retained wards for Elderly Mental Health. These numbers are very low and will have minimal impact on the projections below.

The Millan Suite, 49 Bank Street, Irvine premises will continue to be used for community based patients and are organised by the Local Authority. This required to be retained as guided by the ACT[1]

	Hearings												
Venue	April 2008	May 2008	June 2008	July 2008	Aug 2008	Sept 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	Mar 2009	**Total**
Ailsa Hospital	10	10	9	10	8	10	5	7	9	11	13	15	**117**
Crosshouse Hospital	4	6	3	4	5	6	2	3	0	1	3	5	**42**
Millan Suite, 49 Bank St, Irvine	0	0	3	3	1	2	4	2	3	1	0	0	**19**
Total	14	16	15	17	14	18	11	12	12	13	16	20	**178**

	Hearings		
Venue	Male	Female	**Total**
Ailsa Hospital	67	50	**117**
Crosshouse Hospital	29	13	**42**
Millan Suite, 49 Bank St, Irvine	4	15	**19**
Total	100	78	**178**

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

- Solicitors/lawyers
- Advocacy
- Medical staff and nursing staff
- Activities – shop, canteen.
- Ambulance/clinical taxi transport for patients from other inpatient site
- CAMHS – adolescent tribunals have a potential to be required.
- Chaplaincy
- Clinical taxis
- Community Forensic Team
- Hospital Social Work department
- Internal support services – hotel services, portering, administration, IT, communications,
- Learning Disabilities clients very rarely may attend.
- Local Authorities Social Services
- Standby Social Work services
- Voluntary sector

Close to	Reason	Category*
Adult Mental Health inpatient wards	Patients access Tribunal Suite	Desirable, Essential within the inpatient building/new build/OP extension.

Future Service Delivery Risks

- It is anticipated that minor legislative changes to the Act will occur and it is unlikely they will have a major impact on the Tribunal function or suite;
- Nationally the formality of Tribunals will be reviewed, national patient groups have indicated the levels of stress experienced by patients is too high and report it still feels 'too like court'. Locally our existing suite is highly regarded as being one of the best. It is desirable to maintain and improve the facility being reprovided;
- Nationally the number of tribunals taking place are higher than desirable and a national review is expected with an aim to reduce rates;
- Out with this review, Local Activity levels could increase as it is expected that the future models of care are expecting a high ratio of detained patients to informal which could result in increased numbers of tribunals. The suite will have the capacity to accommodate this but

the alterative use as a general meeting room function would diminish; and

- Future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need.

Appendix L - Acute Mental Health Wards

Introduction and outline of services

Departmental Function

1 Teams and Links

Our Adult Mental Health Wards (AMH) are managed by nursing staff working within a patient/person-centred, multi-disciplinary and multi-agency framework in partnership with, physiotherapy, dietetics, occupational therapy, speech & language therapy, advocacy, social work, advanced nurse practitioners, psychology, medical staff and a range of visiting support services. There are links with the Community Mental Health Teams and where possible any other external agencies involved, prior to admission. This involves the aforementioned parties being invited to Multi-Disciplinary Meetings including Pre-Discharge Meetings. Further links exist with the University of West of Scotland (Nurse Training) and the Royal College of Psychiatrists (Medical Training).

At any given time there could be up to 6 nursing staff on duty (variable with clinical demand) , this could be supplemented by up to 2 student nurses. When the number of Medical (Consultants, Junior Doctors and Trainees), Allied Health Professionals and representatives of other agencies are added to this it is possible that up to 15 staff may be present and will require to be accommodated on the ward at peak times.

As part of the “Hospital at Night Service”, the development of the Advanced Nurse Practitioner role will provide cover at night which was previously provided by junior medical staff.

2

Service Users

Although this is an adult admission area, both the accommodation and delivery of care needs to be flexible enough to meet the needs of people of all ages including Children under the age of 16 and those who may have a physical disability and/or learning difficulties.

Patients will be admitted primarily as a result of a mental health problem however they may also have physical symptoms, which may be due to a co-morbidity of disease or because of dependence on drugs and/or alcohol.

3 The lifestyle choices made by some people with severe and enduring mental illnesses may also lead to a lack of social skills and self neglect with a subsequent and often significant deterioration in their state of physical wellbeing.

During the patients stay they may be regularly visited by family, relatives and friends who can also be involved in supporting the plan of care and participate in the person's recovery.

Therapies and Treatment.

The care team will assist the individual in taking an active role in their recovery by providing a range of therapeutic activity/interventions.

Activity, supported by a comprehensive ongoing assessment, may be scheduled or unscheduled, and will be co-ordinated and provided from a multi-disciplinary perspective which will directly involve the patient/carer as a key part of the team.

Activities will be designed to address a spectrum of health and social care needs which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.

Each person will be engaged with a care plan for each day of their stay, which reflects their needs, wishes and aspirations and is cognisant of their capabilities.

4 A key aim will be to provide a platform for social inclusion by re-integrating the patient into the community and local services. Working towards discharge will be the underpinning objective at all times to prevent inappropriate lengths of stay and promote independence. Effective integrated working and communication with community based health services and other agencies will be a key service element.

Some individual therapies including patient consultations, psychological therapies and advanced psychiatric assessments, will require private, confidential space (significant sound insulation whilst not compromising safety), allowing individuals the opportunity to express their emotions and personal issues.

There will be access to Electro-Convulsive Therapy (ECT) twice weekly. (more information on the ECT service is provided in the ECT/Minor Procedures area section)

Space and Observation.

5

The feeling of space plays a key role in promoting recovery and, as such, it is of the utmost importance that all patients have access to private and communal space both internally, in the form of small quiet areas and externally in the form of significant, safe therapeutic green space.

Some behaviours, for instance, behaviours associated with self harm, and elevated mood may compromise the patient's safety, increasing personal risk. Therefore there is a need to have a high level of awareness/supervision and observation of patients who are acutely unwell.

Legislation & Governance

We are governed by legislation which directs us to provide practical solutions for patient safety and also the principles under the Mental Health (Care and Treatment) (Scotland) Act 2003:

Non-discrimination - people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

Equality - all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

Respect for diversity - service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

Reciprocity - where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

Informal care - wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

Participation - service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

Respect for carers - those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

Least restrictive alternative - service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe, effective care, taking account where appropriate of the safety of others.

Benefit - any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

Child welfare - the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Schedule of Accommodation

The accommodation is scheduled in Mental Health Services and is described in the section entitled AMH Wards (Adult Mental Health) in the Schedule of Accommodation.

Model of Care

The philosophy of care will be explicitly user focused and supported by a robust systematic approach to clinical governance.

The objective of clinical services will be to provide a range of therapeutic interventions which are planned, co-ordinated and provided from multi-disciplinary and user/carer perspective, based on comprehensive ongoing assessment. A key aim will be to provide a platform for social inclusion.

Of the individual and group activities available, some will be generic, some

specialised and some will be onsite and some offsite. Activities will be designed to address a spectrum of health and social care needs which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.

Each person will be engaged with a programme of activity for each day of their stay, which reflects their needs, wishes and aspirations and is cognisant of their capabilities.

Working towards rehabilitation/discharge/recovery will be the underpinning objective at all times, preventing inappropriate lengths of stay and promoting independence and self reliance. Effective integrated working and communication with community based health services and other agencies will be a key service element.

Interventions will be evidenced-based or based on national consensus good practice and will be under-pinned by national standards and clinical guidelines.

The therapeutic environment will seek to fulfil the following functions:

- A ward timetable that is consistent and which relates to the organisation of time, space and patient activities;
- The involvement of patients as active participants in their care, contributing in a meaningful way to treatment decisions;
- Provision of an environment conducive to the containment and control of potentially dangerous behaviours through consistent staff practices that assist patients to moderate their behaviour and develop internal coping and control skills;
- A culture of support in which staff actively promote a sense of hope, well-being and self-esteem in their patients;
- Recognise that the therapeutic environment and ambience of the ward is a crucial element in how service users experience their in-patient stay and how they benefit from it and acknowledge that therapeutic interventions, social and recreational activities all play a part in the overall patient experience;
- The validation and affirmation of each patient's individuality supported by a structure of person-centred and recovery focused care planning
- The therapeutic environment plays an important part in positive treatment outcomes.

Descriptive Overview

The purpose of the inpatient service will be to provide an excellent standard of well co-ordinated assessment, treatment and care, in a safe and therapeutic setting for patients who are in the most acute and/or vulnerable stage of their illness. Such patients will typically present with serious and complex health and social care needs which cannot, at that time, be treated and supported safely and appropriately at home or in an alternative, less

restrictive, residential environment.

The Unit utilises a Recovery approach to enable the individual to achieve their maximum potential, which will include proactive discharge planning.

The inpatient service will be provided for 365 days, 7 days per week, 24 hours per day. The emphasis will be on the provision of a range of interventions and treatment plans which patients experience as being safe, humane and therapeutic. In this regard the inpatient facility will function as an essential core component of a whole system approach to mental health care in Ayrshire. Thereby, complimenting Primary Care Mental Health Teams (PCMHT), Community Mental Health Teams (CMHT) and Crisis Service. It is important that the new buildings and physical environment reflect positive vision of mental health services as a normal part of health service life and the life of the Ayrshire community they seek to serve.

The Royal College of Psychiatrist's Report '*Not just bricks and mortar' & 'Ten Standards for adult inpatient mental healthcare'*

recommend the need for new, smaller, inpatient psychiatric units which must reflect current practice and be of a standard likely to be acceptable to patients and staff well into the middle of the 21st century.

The inpatient service should promote safety, dignity, comfort and privacy as well as provide therapeutic opportunities for recovery and rehabilitation.

The care environment should:

- Create a calm and restful atmosphere and an environment which is non-threatening;
- Maximise therapeutic opportunities and the ability to relieve boredom;
- Afford no undue separation of staff from patients;
- Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;
- Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;
- Provide opportunities for exercise, leisure and education;
- Be sensitive to the needs of physically disabled patients, visitors and staff;
- Consider space and environment and recognise that this will be important from both the external and internal perspective;
- Be imaginative and creative use of space will be vital, for example, the avoidance of long corridors and the creation of attractive easily maintained/accessed landscaped gardens;
- It is essential for the service to be flexible to the changing needs of individuals and groups e.g. changes in conditions, gender, numbers,

cultural needs etc. The physical environment will require to be responsive to such changes in demand;
- Individual bedrooms with en-suite facilities will be required for all patients to maximise opportunity for privacy and dignity;
- All therapeutic rooms should be designed to enable speech privacy;
- Adequate provision of telephone access and IT infrastructure will be critical to effective communication, education and provision of evidence-based practice;
- Dining arrangements for patients and adequate storage space for equipment and personal belongings will require careful thought to ensure adequacy and suitability for purpose; and
- Garden areas should be designed to provide contrasting textures and colours of plants, providing sensory stimulation and promoting sense of calm and relaxation. There should also be sheltered areas, suntraps and comfortable seating within the overall design.

Role and Function

Care will be patient centred:

- Psychiatric in-patient admission and assessment wards in single room accommodation;
- Services must respect the individual and recognise their full rights and responsibilities as a citizen;
- There will be a focus on clinical and environmental safety and security for the patient, general public and staff within the service;
- Services must balance the need for safety and security with the provision of a therapeutic environment;
- Security and observation will be provided at the least restrictive level, appropriate to the patients needs;
- Security will be provided by a range of approaches including: Informed clinical judgement, risk assessment, appropriate levels of staff, safe systems of work, environmental and physical security;
- The environment requires to lend itself to obtrusive and unobtrusive observation and in-keeping with Millan Principles;
- Environment needs to afford an opportunity to observe acutely unwell patients, but also facilitate privacy and dignity;
- The environment must be pleasant, safe and the general ambience promotes mental and physical health well being;
- The unit will be state-of-the-art offering modern, ground-breaking acute adult mental health inpatient facilities for the population NHS Ayrshire & Arran;
- It will continue to work closely and link with the community infrastructure;
- It will focus on discharge planning and minimal period of stay in-keeping with the shift in the *balance of care;*
- Patients will have access to information on the service and their care package, which will promote the greatest degree of self-determination, informed choice and equity;
- Provide innovative, evidence based treatment and care to individuals

and their families underpinned by a strong values base;
- Aligned with National drivers for example: QIS standards, ICP's and 'Acute Care Framework' ; and
- Each person will be seen as and treated as an individual.

Bed complement

- 60 beds over 3 wards
- Provided in single room accommodation with en-suite facilities;
- Each ward will be mixed sex but with flexibility to react to pressures of male/female demand;
- The service should be able to be developed and afford flexibility of beds for future potential service trends and changes; and
-

Planned patient activity

Admissions will be via Bed Managers from a variety of sources such as:

- Community Teams (Generic and Crisis)
- Intensive Psychiatric Care Unit (step down)
- Prisons
- Accident and Emergency
- Direct GP referral
- Outpatients
- Neighbouring NHS boards in time of crisis
- Primary Care Teams

Usual admissions to this area will represent clients who:

- Require assessment and treatment for an acute phase of their illness or who require assessment of their mental state
- Present risks that mean they are no longer able to be managed safely by Community Services
- Are subject to legislation that requires them to be admitted to hospital for assessment/treatment

General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group;
- Invasive clinical interventions such as restraint and rapid tranquilisation will be undertaken in a safe, non stimulating environment that respects the individual's privacy and dignity;
- Based on Millan Principles;
- Recovery focussed;
- 10 Essential Shared Capabilities (ESC)/Values Based Approach ;
- Multi-disciplinary approach;
- Clinical interventions will be evidence based and reflect current best practice; and
- Intervention will be provided in keeping with an individual's care plan utilising a person centred approach.

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be:

- The layout of wards should allow for discreet groupings i.e. hotel services, clinical & treatment, bedrooms;
- There should be one single point of entry to the ward;
- Welcoming & homely;
- Well ventilated and spacious;
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience;
- Clinical areas that are non threatening and welcoming;
- Bedroom areas should enhance the therapeutic experience and also provide privacy;
- All public areas within the ward should be easily observable with no blind spots;
- There should be one single point of entry to each ward
- Ligature points should be eliminated;
- As per smoking policy, outdoor smoking areas should be available & suitable for all seasons/weather conditions;
- All single rooms need to be observed by a nurses station which could be manned 24/7;
- All areas including bedrooms should be spacious, preventing those using our service feeling enclosed;
- Emphasis will be on day activity, engagement & treatments so sufficient space in day areas for 1-1 therapy and group work, not bed space; and
- There will be flexibility in approximately 10% of beds without

compromising mixed sex guidelines.

Corridors: Required features

- Corridor area should be kept to a minimum;
- Corridors should have no blind spots and allow maximum observation;
- Where corridors are not just to get from A to B they could have the opportunity for informal social contact, non institutional and natural light; and
- Corridors should provide seated areas for quiet contemplation.
-

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the unit must comply with current legislation

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Number and types of rooms

- 60 single, en-suite bedrooms with rooms configured into 3 wards
- Each ward will have 2 wings
- Waiting/Visiting area to be provided at the entrance to the ward
- 2 High Observation rooms per unit

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The wards should be adjacent to each other and connected by a common hub area
- Adult wards and IPCU grouped in close proximity to one another, allowing access to support cluster 1 and café area without going outside
- All should have access to discreet external and landscaped space that is designated specifically to each ward
- The units should have access to private communal safe, stimulating and landscaped and sheltered garden areas
- Close proximity to support cluster 1
- Co-located with ECT suite, IPCU, medical staffing, bed manager, gardening facilities, operational management staff, recreational facilities
- Should be in close proximity to the Tribunal Suite/Meeting Area

Internal

- Dining and day activities should be close to the entrance of the units and distant to the bedrooms
- Clean and dirty utility and linen room should be away from the main clinical areas
- Distressed patient (calming room) to be at the entrance to the bedroom area to ensure use both/day night in a quieter area
- The bedrooms should be distant from the clean and dirty utility room, linen room, reception/interview room, charge nurse office and dining room
- The Charge Nurses office should be at the main unit entrance
- The touchdown bases should be at the area of highest observation
- Store rooms, linen room, clean and dirty utility rooms, cleaners housekeeping room, WC should be clustered together and prevent access by non-clinical staff. This should be away from clinical area and bedrooms, and shared by the unit
- Patient's laundry should be distant to the bedrooms, reception/interview rooms and multi-disciplinary room.

- Reception/Interview room, Charge Nurse office and multidisciplinary room (Clinical Area) should be clustered together and distant from the bedrooms and hotel services area.
- Clean Utility should be close to the duty room
- The bedrooms should be distant from the hotel services and clinical areas.
- The sitting rooms should be sited in accordance with the mixed sex guidance.
- The social/activity/therapy area, sitting room and pantry should be sited in such a way that allows ease of access and use but distant from the hotel services area and dining room

Storage facilities

The following storage facilities are required for:

- Access to equipment store for all units as required
- Flat linen and towels
- Miscellaneous items
- Mobility aids as required
- Range of seasonal equipment (eg Christmas decorations)
- Spare duvets, pillows & mattresses
- Therapeutic equipment
- Secure lockers in each bed area
- Activities store

Anticipated developments

- During the lifespan of the building a flexible approach to design will be required which takes into account changing models in delivery of care
- The building should be able to meet the needs of future Information Technology developments
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service

Client Group Characteristics

Age and Gender

- Ideally 16 - 64 years male and female, some discretion at either end re Child and Adolescent mental health services (CAMHS) patients and those of an older age who may still have contact with ‘adult’ services

Admission Rates

- Admissions are accepted 365 days a year, 24 hours a day

Diagnoses

- Patients admitted to the facility will have a varying range of mental health problems/illness and may experience issues re drug/alcohol misuse

Anticipated illness-related behaviours

- Aggressive behaviour (verbal and physical)
- Aimless or ritualistic behaviours
- Disinhibited behaviours
- Lack of personal risk awareness
- Self Harm behaviours
- Suicide risk
- Unpredictable and impulsive behaviours
- Secondary physical disabilities/illnesses
- Fear and apprehension

Anticipated clinical risks

Clients who are admitted to this ward may be at risk from the following:

- Deliberate self harm
- Harm to others
- Poor motivation
- Self neglect
- Suicidal intention
- Isolation in a community environment (social breakdown)
- Institutionalisation

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

Inpatient care is one element of the care pathway. It offers time limited safety, support and therapy to people who are too unwell to be cared for in a non hospital setting. It is to improve the person's mental and physical health and functioning.

Usual admissions to these areas will represent clients who:

- Are deemed to be in crisis/vulnerable
- Require high levels of observation/intervention
- Require a place of safety for a short period
- Are at risk of harm to self or others

- Are at risk of severe neglect
- Behave in such a way that cannot be managed in other care settings
- Are at risk of suicide
- Who require short term mental health assessment and treatment
- Who require admission under the terms of the Mental Health Act
- To provide individualised care to people who are experiencing mental illness or distress who require in-patient care
- To assist individuals to improve their mental and physical health and functioning and social interaction.
- Maximising person's level of independence
- To provide a recovery based approach to care
- Should be underpinned by the Millan Principles and the 10 Essential Shared Capabilities (ESC's)
- Inpatient care is one element of the care pathway. It offers time limited safety, support and therapy to people who are too unwell to be cared for in a non hospital setting. It is to improve the person's mental and physical health and functioning

Therapies

- Individual and group therapies will be provided in an appropriate setting within and out with the facility in accordance with an individualised care plan. On a planned and ad hoc basis
- Therapies will enhance the care experience and will be focussed upon specific agreed interventions and outcomes
- Therapy should be in keeping with recovery/Tidal Model and should be evidence based
- Therapies should be provided by a wide range of multi disciplinary staff
- Therapy Examples – Anger management, Coping Skills, Anxiety management, 'talking therapies' & engagement

Therapeutic facilities required

- Adequate space to provide therapeutic interventions as required within the units both as groups and 1-1
- Adequate storage space to contain therapeutic equipment will be required within the units

Planned clinical meetings

- Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis
- Nursing handover reports
- Multi-disciplinary meetings
- Consultant meeting
- Junior Doctor reviews
- Care Programme Approach(CPA) meetings
- Case conferences
- 1-1 clinical interventions
- Adequate space to comply with Mental Health Act

Other Meetings

- Appraisal/supervision meetings
- Educational meetings
- Meetings with extended care team
- Meetings with relatives
- Team meetings
- Ward community meeting
- Group activities

Clinical risk management principles

- Risk management for this patient group is important. The environment must be conducive to delivering the risk management plan
- Based on a proactive approach to positive risk management (embedded within the service)
- Formalised assessment tools will be utilised and process reviewed on an ongoing individualised basis
- On admission each patient is assessed in accordance with a recognised risk assessment tool
- Based on this initial risk management plan is developed which will also determine the person' observation status

Operational Procedures

Working day plans

- The unit will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

- Multidisciplinary team handovers will take place at set times throughout the day as determined by the ward team.
- The unit will be staffed 365 days per year and 24 hours per day
- Staffing levels and shift patterns will be set out to achieve the optimum level of therapeutic care in a safe and secure setting

Admission procedures

- Admissions will be on an as required basis, criteria/process to be refined by the new model of care
- Admissions are accepted anytime

Record-keeping storage

- All clinical case records require to be stored within a lockable cabinet within a lockable room

- Items of secure stationery require to be stored within a lockable cabinet

Visiting arrangements

- Visiting arrangements will be as agreed with the unit team and may take place within the visitors room, dining room.
- If the patient's condition allows, visitors can take them to the café area in the main entrance or out with the unit area

Mealtimes/dining arrangements

- Facilities must promote the ambiance of the meal experience.
- Dining will be ward based and there will be three mealtimes per day
- Facilities must be available to permit the consumption of hot and cold drinks outwith recognised mealtimes

Laundry facilities and linen management

- A laundry room is required to provide for personal washing, drying and ironing of personal clothes
- Bed linen etc will be uplifted and sent to area laundry(discreet entry/exit)

Functional content

Number of Inpatient Beds/Treatment Spaces

- 60 single, en-suite bedrooms configured into 3 wards each with 2 x 10 bedded wings
- Comprising of two wings per unit for gender split

Investigative/Diagnostic/Treatment Capacity:

- Will require to be accessed at nearest General Hospital and other specialist services as required
- Access to ECT

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable

Specialist Technical Infrastructure Requirements

- Personal alarms
- Wall mounted alarms
- Nurse Call System
- Slow Door Systems (commended by MWC)
- Emergency Response Team (2222)
- Portable oxygen cylinders.
- Secure Entry System out of hours – intercom at entrance to wards.
- Telephones for internal and external communications.
- Mobile phones for escort duties
- Emergency Response Pack
- ECG machine
- Emergency Medication Box for escort duties
- Ward Safe
- All wards should be wireless enabled
- Patients should have access to internet based services in all clinical areas of the new hospital.
- Clinical meeting rooms should have access networked Pc's and to either large plasma screens or to projectors to facilitate team discussion of cases in clinical reviews of care.
- Smartboard technology could be used to facilitate replacements for whiteboards to manage bed states etc in ward areas. They should be connected to network pc's and bed management systems when they are available via new Patient Management systems.
- Meeting rooms could have access to teleconference facilities to facilitate multi-agency working and access to meetings for staff in rural and island areas.
- All clinical and admin staff use a PC on a daily basis, they will require access to networked PC's to carry out their duties.

Projected Future Activity

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

- Activities – shop, canteen, hair salon, gym
- Advocacy
- All services – General Hospital
- Ambulance
- Bed Managers
- CAMHS
- Chaplaincy
- Child protection
- Childcare services
- Clinical taxis
- Community Mental Health Teams

- CRISIS Teams
- Complementary therapies
- Dental services
- Education and universities
- Forensic Team
- GPs
- Hospital Social Work department
- Internal support services – hotel services, portering, administration, IT, communications, finance, estates
- Learning Disabilities
- Local Authorities Social Services, housing, benefits agency, tenancy support, job centre plus, citizens advice service, pet fostering etc
- Medical staff
- Others Allied Health Professionals
- Pharmacy
- Police
- Psychology
- Service user groups/carer groups
- Solicitors/lawyers
- Standby Social Work services
- Voluntary sector

Close to	Reason	Category*
IPCU	• Ease of transfer of patients • Safety • Staff assistance • Patients privacy	Essential
Tribunal Suite	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies	Desirable
Recreational Activities	• Ease of access to garden area	Desirable
Junior Staff on-call accommodation	• Immediate response – 24/7 • Safety	Important
ECT	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies • Accessible for emergency response	Desirable

Future Service Delivery Risks

- Changes in practice
- Changes in diagnostic pattern for admission eg personality disorders, challenging behaviour, Autistic Spectrum Disorder (ASD), brain injury, Alcohol Related Brain Damage (ARBD) and changes in diagnostic pattern for admission
- New Crisis service – unclear impact on bed need
- Ageing population – more elderly patients
- Demographic changes
- Integrated Care Pathways (ICP)
- HEAT targets – readmission rates, suicide prevention etc
- Positive risk taking
- Other services developing
- Bed availability and bed blocking due to the lack of alternative community provision
- Activity levels unpredictable
- Future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need
- Service Level Agreements (SLA) out of area no longer available for extra-contractual referrals therefore service would again have to adapt to that need
- All adult inpatient beds are now housed on one site, therefore contingency plans need to be considered in case of emergencies
- Accessibility to single site option

Appendix M - Intensive Psychiatric Care Unit (IPCU)

Introduction and outline of services

Departmental Function

1 Teams and Links

Our Intensive Psychiatric Care Unit (IPCU) is managed by nursing staff working within a patient/person-centred, multi-disciplinary and multi-agency framework in partnership with, physiotherapy, dietetics, occupational therapy, speech & language therapy, advocacy, social work, psychology, medical staff and a range of visiting support services. Strong working links are maintained with the Adult Admission Wards.

In addition assessment and treatment is undertaken for the Courts, under assessment or treatment orders.

At any given time there could be up to 6 nursing staff on duty (variable with clinical demand), this could be supplemented by up to 2 student nurses. When the number of Medical (Consultants, Junior Doctors and Trainees), Allied Health Professionals and representatives of other agencies are added to this it is possible that up to 14 staff may be present and will require to be accommodated on the ward at peak times.

2

Service Users

The accommodation and delivery of care needs to be flexible enough meet the needs of people of all ages and those who may have a physical disability and/or learning difficulties.

IPCU provides assessment and care for:

A) patients suffering from an acute psychiatric illness, the nature and degree of which is such that, in the interest of their own health and safety and/or for the protection of others, they require intensive nursing care in a secure ward setting, which cannot be provided in other acute mental health wards. Because of the above they may require to be detained under the terms of the Mental Health (care and Treatment) (Scotland) Act 2003.

B) Suspected mentally disordered offenders remanded by the Courts under the Criminal Procedures Act (1995) and who, because of their propensity for aggressive behaviour, cannot be adequately managed within other acute mental health wards

Patients will be admitted primarily as a result of a mental health problem that requires that they be nursed in a secure setting, however they may also have physical symptoms, which may be due to a co-morbidity of disease or because of dependence on drugs and/or alcohol.

3

The lifestyle choices made by some people with severe and enduring mental illnesses may also lead to a lack of social skills and self neglect with a subsequent and often significant deterioration in their state of physical wellbeing.

During the patients stay they may be regularly visited by family, relatives and friends who can also be involved in supporting the plan of care and participate in the person's recovery.

Therapies and Treatment

The care team will assist the individual in taking an active role in their recovery by providing a range of therapeutic activity/interventions.

Activity, supported by a comprehensive ongoing assessment, may be scheduled or unscheduled, and will be co-ordinated and provided from a multi-disciplinary perspective which will encourage involvement of the patient/carer as a key part of the team.

Activities will be designed to address a spectrum of health and social care needs which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.

Each person will be engaged with a care plan for each day of their stay, which reflects their needs, wishes and aspirations and is cognisant of their capabilities with due regard to any requirement for enhanced safety and security.

The service is recovery focussed, it provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation and security.

Working towards transfer to a less secure setting will be an underpinning

objective at all times to prevent inappropriate lengths of stay in IPCU

4

IPCU aims to provide a conducive therapeutic environment in which patient's illnesses can be assessed and treated and thereby improve their psychological (and physical) well being; control their aggression and reduce the risk of self harm. This is generally to ensure that further management can be carried out in a lesser secure ward setting. Many people with severe mental health problems still require intensive secure hospital treatment when they are most unwell.

- Some individual therapies including patient consultations, psychological therapies and advanced psychiatric assessments, will require private, confidential space (significant sound insulation whilst not compromising safety), allowing individuals the opportunity to express their emotions and personal issues.

5

- Space and Observation

The feeling of space plays a key role in reducing levels of anxiety and aggression and promoting recovery and, as such, it is of the utmost importance that all patients have access to private and communal space both internally, in the form of small quiet areas and externally in the form of significant, safe, secure therapeutic green space. Where patients are unable to leave a ward area as a result of their illness/behaviours the provision of space is increasingly important in promoting recovery.

- Some behaviours, for instance, behaviours associated with self harm and elevated mood may compromise the patient's safety, increasing personal risk. Therefore there is a need to have a high level of awareness/supervision and observation of patients in IPCU at all times.

Legislation & Governance

We are governed by legislation which directs us to provide practical solutions for patient safety and also the principles under the Mental Health (Care and Treatment) (Scotland) Act 2003:

Non-discrimination - people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

Equality - all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

Respect for diversity - service users should receive care, treatment and support in a manner that accords respect for their individual qualities,

abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

Reciprocity - where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

Informal care - wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

Participation - service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

Respect for carers - those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

Least restrictive alternative - service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe, effective care, taking account where appropriate of the safety of others.

Benefit - any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

Child welfare - the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Schedule of Accommodation

The accommodation is scheduled in Mental Health Services and is described in the section entitled IPCU in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The Intensive Psychiatric Care Unit has a clear and defined role in providing support to the local General Adult Wards and Forensic Services. The patients may have more complex and challenging illnesses and behaviours than those in General Psychiatric Wards, some of these may manifest themselves in increased levels of violence and aggression.

The ward environment needs to be conducive to enabling greater observation and control of patients than exists within the adult admission wards.

The 'special care area' within the ward will be used for particularly disturbed and aggressive patients requiring at times a non stimulating environment away from the main ward area and the overall environment within the ward should be conducive to providing care within a safe setting. This area should be en-suite to one bedroom and distant to day facilities.

The design should meet the national standards for an IPCU and in accordance with the NHS design audit tool.

The aim of the IPCU is to deliver the right care, at the right time, to the right patient. These aims should be delivered through a system of:

- Needs assessment
- Risk assessment
- Risk management
- Treatment planning and delivery

Each of these processes is conducted as part of a structure or system in order to realise a number of benefits including:

- All of the multi disciplinary team caring for the patient, the patient themselves and their carers should be able to share information regarding the identified needs, risks, objectives, interventions and treatments.
- Each should understand decisions that are being made and have reasonable expectations of what should be delivered and when
- The multidisciplinary team should be able to use the assessment and planning structure to avoid duplication in their work, identify any gaps and to prioritise the interventions, treatment and support they provide

Role and Function

IPCU is a ward whose function will be to essentially provide assessment, treatment and care for people who:-

- Suffer from acute psychiatric illnesses, the nature and degree of which is such that they require intensive nursing care in a secure ward setting, in the interest of their own health and safety, and/or for the protection of others.
- Because of the above, they may require to be detained in hospital under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2003.
- Are suspected mentally disordered offenders remanded by the courts under the Criminal Procedures Act 1995 and who because of their propensity for aggressive behaviour, cannot be adequately managed within the ordinary acute psychiatric ward setting, or are restricted due to being remanded back to hospital, therefore requiring a secure IPCU

- IPCU will operate with a consultant-led multi-disciplinary team of medical, nursing and other AHP (allied health professionals) staff.

- It is expected that the expertise of AHP staff like Psychology, Occupational Therapy and Physiotherapy can be called upon.

- Clinical responsibility for all patients, during their stay on the ward will primarily be that of the Ward Consultant and Nurse in Charge

- IPCU will work in close co-operation with the source of referral at all times.

- Care will be patient centred with their privacy and dignity being preserved at all times.

- The service must balance the need for safety and security with the provision of a therapeutic environment.

- The service must respect the individual.

Bed complement

- 8 beds provided in single room accommodation with en-suite facilities
- Special Care Area to comprise of sitting area, bedroom, WC and shower
- Bed provision will be in accordance with the mixed sex guidelines

Referral sources and reasons

Admissions will be accepted from a variety of sources such as:

- Prison services (short term assessment)
- Court services (short term assessment)
- Other secure hospitals
- Admission wards
- Continuing care wards

Usual admissions to this area will represent patients who cannot be safely managed in an open acute ward environment by virtue of:

- Requiring high levels of prolonged observation and high nurse patient ratio
- Presenting significant risk of harm to others
- Requiring to be in hospital as part of their compulsion under the terms of the Mental Health Act or Criminal procedures Act.

General principles of operation

- Millan Principles
- Recovery focussed
- Collaborative
- 10 Essential Shared Capabilities / Values Based Approach
- Multi-disciplinary approach
- Clinical interventions will be evidence based and reflect current best practice
- Intervention will be provided in keeping with an individual's care plan utilising a person centred approach
- Emphasis on day activity & engagement in broad range of social & therapeutic activities to support physical & mental wellbeing

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be;

- In keeping with IPCU Standards
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency situation
- Maximum use of natural and artificial light
- Maximum use of natural and artificial ventilation
- Discreet hotel and storage services
- Dining facilities that enhance the meal experience
- Clinical areas that are non threatening and welcoming
- Bedroom areas should enhance the therapeutic experience and also provide privacy at night
- There will need to be flexibility in approximately 10% of beds without compromising mixed sex guidelines
- All areas within the ward should be completely observable with no blind spots
- Ligature points should be eliminated
- As per smoking policy, outdoor smoking areas should be available for all seasons.
- Doorways should be wide enough to allow ease of access for a patient under physical restraint.
- Air Lock entrance to ward (Reception/Waiting area)
- Calming features built into the fabric of the building
- All bedrooms need to be observed by the staff base: 3 staff at night but could be manned 24/7
- The environment requires to lend itself to obtrusive and unobtrusive observation
- There will be an Special Care Area which will be a discrete, self contained living space, where those very disturbed patients, who are also very disturbing and disruptive to other patients, can be safely, humanely and effectively nursed separated from the rest of the ward. Almost like a mini apartment.

  This area should be:

  - Discrete, lockable and to one end of the ward to minimise noise disturbance
  - Self contained which contains living/day room, bedroom and toilet/shower
  - Safe with minimum furniture made from pre-cast foam

- Capable of having two staff in attendance at all times
- Designed to allow for the activities of daily living to be maintained in a humane environment
- Non stimulating

Corridors: Required features

- Corridors should have no blind spots and allow maximum observation
- Long unbroken corridors should be avoided, with the maximum use of natural light and ventilation.
- Corridors should be kept to a minimum.

Mixed gender requirements

The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

The design of the facility must comply with current legislation

The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The IPCU should be adjacent to the Acute Mental Health Wards and be connected by a common hub area
- The IPCU should have access to private safe, stimulating and landscaped garden areas
- Close proximity to Support Cluster 1
- Sheltered smoking area outside
- Close proximity to consultation and interventional area/outpatients department
- Car parking area

Internal

- The Duty Room should be in an area of high observation within the ward
- The open plan dining room and pantry should be close to the entrance of the ward and distant to the bedrooms
- Store room, linen room, clean and dirty room, cleaners' housekeeping room and staff WC should be clustered together and prevent access by non-clinical staff. This should be away from the clinical area and bedrooms.
- Patient's laundry should be distant to the bedrooms, interview rooms and multi-disciplinary room.
- Interview rooms, charge nurse office and fitness suite, social/activity/therapy area should be clustered together and distant from the bedrooms and hotel services area.
- Clean utility/treatment room should be close to the staff base for 3 staff
- The bedrooms should be distant from the hotel services and clinical areas.
- The sitting room should be sited in accordance with the mixed sex guidance.
- The social/activity/therapy area, sitting room and pantry should be sited in

such a way that allows ease of access and use

- The special care area should be distant to the hotel services, clinical areas

Storage facilities

The following storage facilities are required for:

- Specialist bathroom with suitable lifting aid (portable)
- Secure lockers x 8 in personal goods store for patient personal possessions that are not stored in their own room
- Flat linen and towels
- Spare duvets and pillows
- Activities store
- Storage room for miscellaneous items (quite large)
- Range of seasonal equipment (eg. Christmas decorations)

Anticipated developments

- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.
- The building should be able to meet the needs of future Information Technology developments

Patient Group Characteristics

Age and Gender

- 16 to 65 years old although sometimes exceptional circumstances will lead to some flexibility.
- Male and Female

Admission Rates

- Admissions are accepted 365 days per year, 24 hours per day.

Diagnoses

Patients admitted to the ward will have a varying range of mental illness diagnosis.

Anticipated illness-related behaviours

- Aggressive behaviour (verbal and physical)
- Aimless or ritualistic behaviours
- Disinhibited behaviours
- Lack of personal risk awareness
- Suicide risk
- Unpredictable and impulsive behaviours
- Secondary physical disabilities/illnesses
- Fear and apprehension
- Patients in an IPCU are more likely to have complex needs, including resistant psychotic illness, disadvantaged socioeconomic background and co-morbid substance abuse problems, compared with the patient population of general adult mental health services
- Serious assaultative behaviour

Anticipated clinical risks

Patients who are admitted to this ward will be at an increased risk from the following:

- Absconding with associated risks

- Deliberate self harm
- Harm to others
- Self neglect
- Challenging behaviour
- Suicidal intention
- Disinhibited behaviour

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- IPCU care is one element of the care pathway. It offers time limited safety, support and therapy to people in a secure environment who are too unwell to be cared for in open wards
- Is to improve the person's mental and physical health and functioning.
- Getting people well enough to return to main stream services, for instance, more open wards
- Completing assessments and appropriate transfer of patients
- Should be underpinned by Milan Principals and 10 ESC
- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the patient group.
- Clinical interventions will be evidence based and reflect current best practice.
- Invasive clinical interventions will be undertaken in a safe, non stimulating environment that respects the individuals privacy and dignity
- The IPCU is not to be respite from other elements of the care pathway

The IPCU will provide a stepping stone to inclusion, not a departure point for exclusion

Therapies

- Individual and group therapies will be provided within the facility in keeping with the care plan and models of care.
- Therapies should be in keeping with recovery/tidal model and be evidenced based
- Therapies will enhance the care experience and will be focussed upon

specific interventions and outcomes

Therapies should be provided by a wide range of multi-disciplinary staff

Therapeutic facilities required

- Adequate space throughout the day to provide therapeutic interventions as required within the ward
- Adequate storage space to contain therapeutic equipment will be required within the ward.
- Sufficient space for physical activities and exercise

Planned clinical meetings

- Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis
- Adequate space to comply with the new Mental Health (Scotland) Act
- Milan Suite

Other Meetings

- Appraisal/supervision meetings
- Educational meetings
- Meetings with extended care team
- Meetings with relatives
- Group Activities

Clinical risk management principles

- Based on this an initial risk management plan is developed.
- On admission each patient is assessed in accordance with the recognised risk assessment tool.
- One element of this plan is to determine the person's observation status.
- Risk management for this patient group is important. The environment must be conducive to delivering the risk management plan
- IPCU will have systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform

the treatment plan and enhanced Care Programme Approach.

Operational Procedures

Working day plans

- The ward will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

- Multi-disciplinary team 'safety briefs' & handovers will take place at set times throughout the day as determined by the ward team
- The wards will be staffed 365 days per year and 24hours per day
- Staffing levels and shift patterns will be set out to achieve the optimum level of therapeutic care in a safe and secure setting.

Admission procedures

- Admissions are accepted at anytime. Some are arranged on a planned basis most are emergency
- As far as possible admissions should be during normal office working hours and all requests for admission should be routed through the IPCU Consultant, Staff Grade or on call junior doctor.
- Admissions directly from the community should be exceptionally rare, as patients should be given the opportunity to be managed in an unlocked environment first.
- Informal patients should not be admitted to IPCU, unless it is the last available bed in Ayrshire. The patient must give informed consent to being admitted to a locked ward. The patient should be moved to a more appropriate setting at the earliest opportunity.
- Admissions from the courts or prison must be discussed and approved by the IPCU Consultant or deputy.

Record-keeping storage

- All clinical case records require to be stored within a lockable cabinet within a lockable room
- Items of secure stationery require to be stored within a lockable cabinet

Visiting arrangements

- Visitors are advised to contact the ward for advice regarding their visits before they come to the ward. Visiting is programmed.

- Children under school age are not allowed on the ward unless in exceptional circumstances.
- Infants of mothers with Puerperal illnesses may be brought in to visit provided permission is granted by the Charge nurse at least 24 hour before hand.

Mealtimes/dining arrangements

- Cafeteria arrangements should be flexible and provide healthy eating options and between meal snacks and access to beverages available
- Facilities must promote the ambiance of the meal experience.

Between meal snacks and access to beverages

- Cafeteria arrangements should be flexible and provide healthy eating options and between meal snacks and access to beverages available

Laundry facilities and linen management

- A room is required to provide for washing, drying and ironing of personal clothing.
- Patient's relatives may take items home for laundering purposes but this should be recorded by nursing staff in the appropriate manner.

Functional content

Number of Inpatient Beds/Treatment Spaces

- 8 single bedrooms with en-suite facilities
- 1 spacious clean utility/Treatment Room.
- 1 Activity area
- 1 fitness Suite

Investigative/Diagnostic/Treatment Capacity:

- This will be accessed via Crosshouse Hospital and other specialist services.

Outpatient Service (Number of Sessions and specialist functions):

- see clinical brief for outpatient department

Specialist Technical Infrastructure Requirements

- Portable oxygen cylinders
- Secure Entry System – intercom at entrance to wards.
- Telephones for internal and external communications.
- Personal alarms
- PIN point system alarms
- Nurse Call System
- Immediate response
- Mobile phones for escort duties
- Emergency Response Pack
- ECG machine
- Emergency Medication Box for escort duties.
- Suction
- PCs for patient use
- Wii games console

Projected Future Activity

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Admission Ward	• Ease of transfer • Safety alerts • Extra staff • Patient privacy	Essential
Forensic Rehabilitation/Low secure ward	• Ease of transfer • Safety alerts • Extra staff • Patient privacy • Decanting and contingency arrangements • Sharing of certain secure spaces	Essential

Consultation & Intervention Area and outpatients department	• Access • Co-located staff resulting in less driving time •	Desirable
Junior staff on-call accommodation	• Rapid response • 24 hours/day response •	Desirable
Close to car parking area	• Delivery of Ambulance Services • Reliance Vehicles	Essential
Support Cluster 1	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies	Desirable

Future Service Delivery Risks

- Changes in practice
- Changes in diagnostic pattern for admission eg personality disorders, challenging behaviour, ASD, brain injury, ARBD and changes in diagnostic pattern for admission
- New Crisis service – unclear impact on bed need
- Ageing population – more elderly patients
- Demographic changes
- Integrated Care Pathways (ICP)
- HEAT targets – readmission rates, suicide prevention etc
- Positive risk taking
- Other services

Appendix N - Addictions Ward

Introduction and outline of services

Departmental Function

1. Overview – Residential Addiction Unit

Addiction services provide a nurse led service to the population of Ayrshire and Arran which is approximately 375,000 and covers three local authority areas, of this population an estimated 50,000 experience problems with their use of alcohol and around 8,500 have severe drinking problems and severe drug problems.

The strategic leads for Ayrshire & Arran agreed a new model of service delivery which governs alcohol and drug interventions across Ayrshire. This Recovery Orientated System of Care (ROSC) was signed off in February 2011. The ROSC dictates that

'The strategic vision for Ayrshire & Arran is:-

- Recovery is possible and at the centre of all services we provide.
- People will own their own recovery and service staff will facilitate their recovery journey.
- People in recovery will support others along the path to recovery.'

This Residential Addiction Unit will combine the functions of alcohol detoxification (detox), drug detox, addiction assessment and a day programme within the North Ayrshire Community Hospital. This will comprise of a recovery orientated, 10 bedded unit used flexibly to enable the service to respond to rapidly changing population demands. All admissions to the unit will be planned. Duration of admission will be range between 4 days to 4 weeks maximum depending on purpose of admission.

Scottish Government defines recovery as "**a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society [and] is most effective when service users' needs and aspirations are placed at the centre of their care and treatment"**.

There is an increasing national evidence base for the use of residential beds as part of a recovery programmes and this direction is visibly supported by the Alcohol and Drug Strategies of the three Alcohol & Drug Partnerships (ADP) in Ayrshire and Arran.

This unit will allow the inpatient addiction assessment and interventions to focus on individuals with a greater complexity of need than is currently possible within existing arrangements. Residential programmes should not be stand alone intervention and in order for patients to progress throughout their recovery journey it is imperative that they are given a range of treatment options and choices as part of their overall integrated package of care to support them on their road to recovery.

The remit of the new Addiction Unit can be summed up as delivering the following functions:

- Pre-planned detox from alcohol and or other drugs;
- Elective specialist in-depth assessment;
- Structured day programmes for both in-patient and out-patients in order to prevent admission (step-up approach) or facilitate earlier discharge (step-down approach).

2.

Teams and Links

The 10 bedded Addictions Unit will be managed by nursing staff. The unit will operate 24 hours/day 365 days per year.
Staff will primarily work 12 hour shifts (day and night) on a rotational basis.

The Addiction Staffing complement will be:

- 1 x band 7 Charge Nurse
- 1 x band 6 depute Charge Nurse
- 8 x band 5 staff nurses
- 5 x band 2 nursing assistants

Total number of staff = 15 wte

Staff in this unit will work within a recovery orientated, person centered, multi-disciplinary and multi-agency framework in partnership with primarily Community Addiction Teams (CAT's) and Primary Care Addiction Teams (PCAT's) in North, South & East Ayrshire (6 teams in total).

All assessments, including risk assessment for in-patient residential programmes will be undertaken by CAT and or PCAT staff and will be updated on admission to this unit. All referrers will be in-reaching and remain involved in the patient's care at assessment, admission, up to and including discharge and aftercare arrangements. CAT and or PCAT along with in-patient staff and medical staff will consider appropriate options for clinical patient management including step-up arrangements to prevent admission to hospital or step-down arrangements to facilitate early discharge.

These programmes will vary in intensity and duration depending on assessment of need. The needs of the patients will direct the format of the programme e.g. one day per week or seven days per week, ADP commissioned services, and local recovery champions, will be integral partners in complementing this step-up and step-down approach.

Increased integration on a rotational basis of addiction community and in-patient staff will allow learning opportunities and promote an integrated Recovery Oriented System of Care (ROSC) as agreed by Alcohol and Drug Strategic Leads for Ayrshire & Arran in February 2011. This will ensure consistency of approach within the staff groups across community and in-patient services. The provision of this aspect of the ROSC to include a fluid and flexible model, of which group work is a core function, will enable the development of recovery communities and essential linkages to support the sustainability of goals for individuals. This provision within a discrete unit will allow greater integration between the various interventions and more efficient working practices.

The group programmes will be delivered in an environment conducive to patient learning and be complemented by ADP commissioned recovery services and recovery champions identified in each locality to offer support and learning.

A wide range of statutory, non-statutory partners and commissioned agencies may be engaged with patients throughout this process including social work, Dietetics, Pharmacy, Physiotherapy, Occupational Therapy, Dentistry, Podiatry, Tissue Viability, Continence Advisor, Hospital Chaplain, Advocacy, Mutual Aid, Careers Scotland, Volunteers, Ayrshire Council on Alcohol, Turning Point Scotland, Addaction, Strathclyde Fire and Rescue, Smoking Cessation, ex patients groups and identified recovery champions.

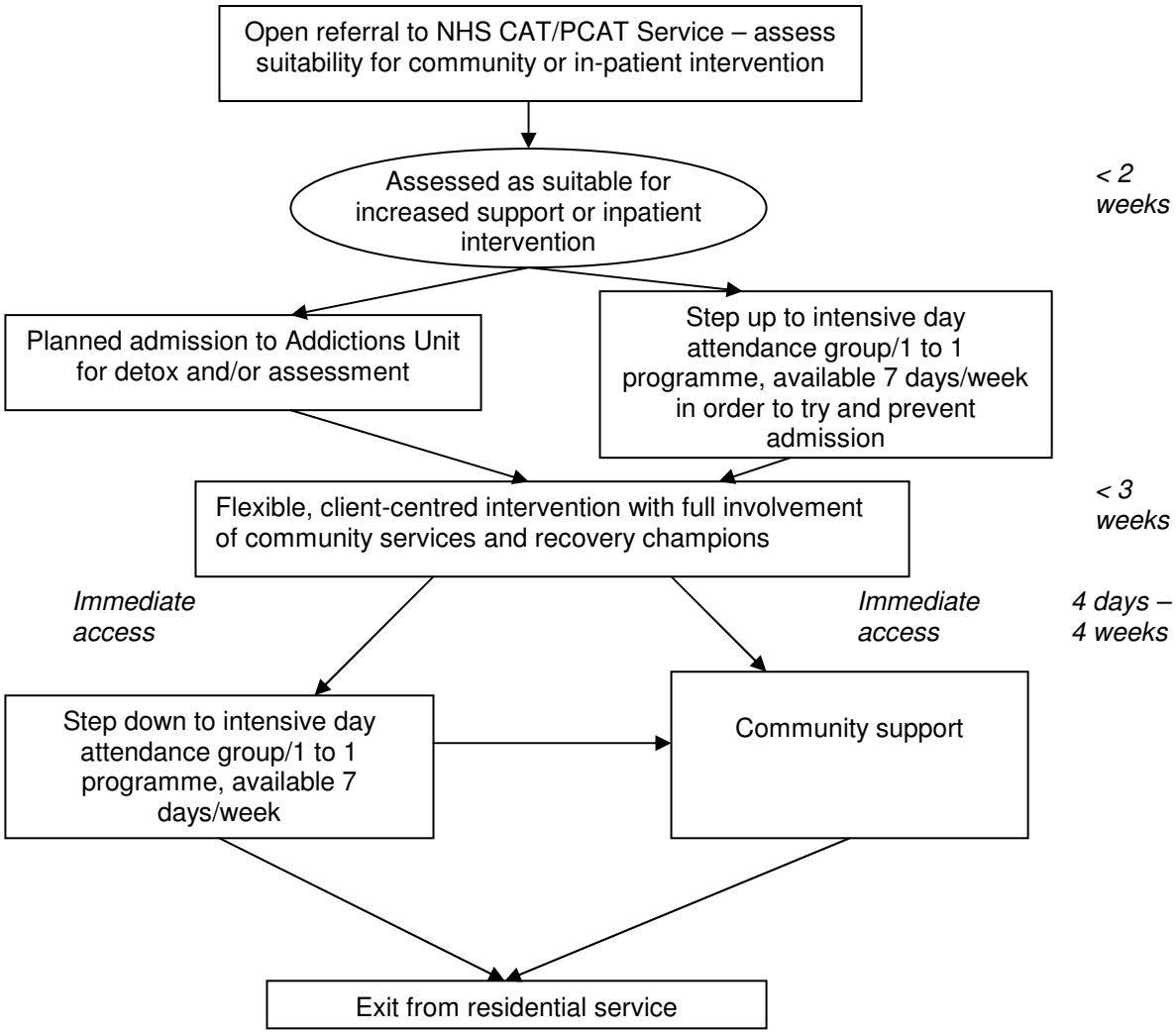
AHP input is envisaged to be required on a flexible, needs lead basis and the ability to respond to this should be reflected within individual AHP clinical briefs.

3. At any given time there could be up to 5 staff on duty within the unit and up to 14 patients (10 residential and 4 day attenders) at a time. These numbers may be supplemented by up to 2 student nurses, 1 member of medical staff and up to 4 Allied Health Professionals (AHP's), voluntary, statutory or commissioned agency staff members. The unit will therefore be required to accommodate approximately 10 staff members (including students, medical staff, AHP's, voluntary and statutory staff) and 14 patients at peak times, which is a total of 24 people.

Service Users

All assessments for in-patient residential programmes will be undertaken by CAT and/or PCAT staff. All referrers will be in-reaching and remain involved in the patient's care at assessment, pre-admission, admission, up to and including discharge and aftercare arrangements. Where agreed with the individual this will include relevant parties being invited to Multi-Disciplinary Meetings including MDT Reviews, Care Programme Approach meetings, Pre-Discharge Meetings, case conferences etc. This will streamline the admission and discharge process and lead to reduction of time spent in residential care and a reduction in the time from referral to discharge as outlined below. This process will also comply with the Scottish Government Drug and Alcohol waiting times as follows 'by March 2013, 90 per cent of

clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.'



Overall referral to discharge from residential services Between 6 - 9 weeks

Patients may continue to be supported through step down or community support arrangements.

Although this will be an adult admission area, both the accommodation and delivery of care needs to be flexible enough meet the needs of mixed sex groups with a range of ages and will include those who may have a physical disability and or mild learning difficulties. This area will also be required to meet the needs of out-patients attending for group work programmes

Patients will be admitted primarily as a result of complex addiction issues undertaking more specialist in-depth assessment for individuals with severe and complex alcohol and or drug and mental health related issues. A period of assessment (up to 4 weeks duration) will cover in detail the nature and extent of alcohol and drug use, physical and psychological health, personal and social skills, social and economic circumstances, impact of previous treatment episodes

and the assets and attributes of the individual.

Patients may also have physical symptoms, which may be due to: a co-morbidity of disease, because of dependence on drugs and/or alcohol or as a result of the lifestyle choices made by some people with mental illnesses leading to a lack of social skills and self neglect with a subsequent and often significant deterioration in their state of physical well-being.

During the individual's stay they will be encouraged to attend all therapeutic group programmes and maintain and foster relationships with recovery communities and family, relatives and friends who will also be encouraged to participate in and support the person's plan of care and participate in the person's recovery process.

4. Therapies and Treatment

The aim of the Addiction Services inpatient facility is to deliver the right care, at the right time, to the right patient.

Within this unit there will be dedicated space where group work sessions will be available to the patient group and also areas for out-patients attending group day programmes. These sessions may be delivered by a variety of staff such as Addiction Staff, statutory, non-statutory partners and commissioned agencies that individuals will incorporate into their individual recovery programmes in addition to one-to-one time spent with their key worker or group sessions. Dedicated and 'bookable' space will be required within the unit to allow the facilitation of activity programmes and the spaces will require to be flexible with the option to open up dividing walls/partitions to allow for larger groups should that be required or for social activity.

Meaningful activity will be vital within the Unit and this will require to be supported by a comprehensive ongoing assessment. Activity will largely be scheduled and will be co-ordinated and provided on a multi-disciplinary basis that will directly involve the individual service users.

Group activity will be designed to address addiction related issues and will also address the wider impact of addiction in relation to health and social care needs, which typically include physical, psychological, recreational, life-skills, cultural, spiritual and social elements.

Patients will be assisted by staff to take the lead in their own recovery plan and will identify an individualised activity plan that will form the basis of their recovery journey and will reflect their own personal needs, aspirations and attributes.

A key aim of this unit will be to provide an extension of community services to

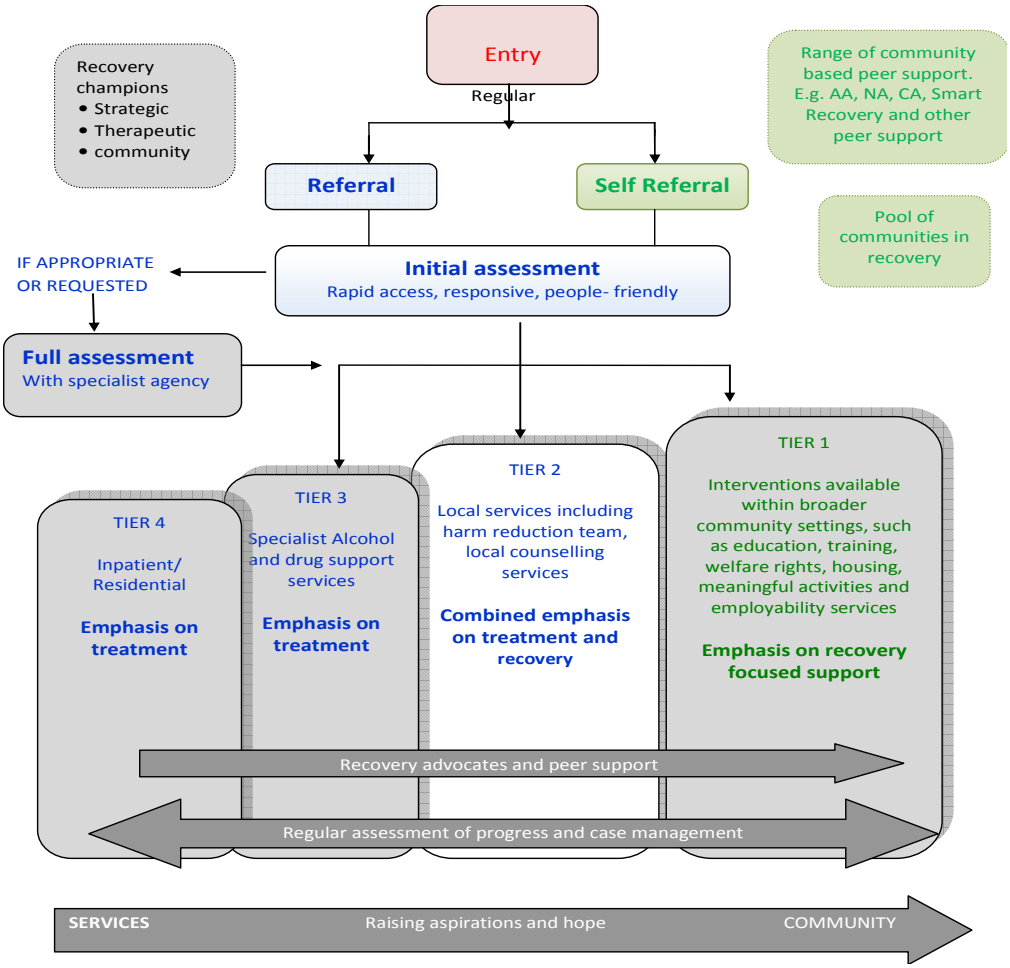
enable patients to access step-up or step-down levels of support and intervention as required and provide a platform for social inclusion by re-integrating the patient into their local community at the earliest possible stage of their journey. Working towards recovery and discharge will be the underpinning objective at all times.

Some individual therapies including patient consultations, psychological therapies and advanced psychiatric assessments, will require private, confidential space (significant sound insulation whilst not compromising safety), allowing individuals the opportunity to express their emotions and personal issues.

Wherever possible patients will be encouraged to self cater in some way, whether it is making a cup of tea and a snack through to fully self-catering all meals. Out-patients (day attenders) will not require mid-day or evening meals as the sessions will be split between morning and afternoon sessions which will negate the requirement for meals for this patient group.

5 Model of Care

Descriptive Overview



Model above adapted from design by Lanarkshire ADP and used with kind permission.

Approved at the Alcohol and Drug Strategic Leads meeting 18 February 2011

The Addiction Services inpatient facility will be a Tier 4 treatment focussed unit as outlined above in Ayrshire & Arran's ROSC.

Among those who seek and require help in dealing with their alcohol and or drug problem there will always be those who need the availability of an inpatient stay. This is recognised in all relevant national strategies and guidelines including "Inpatient detox followed by residential rehabilitation is the most effective way for drug users to become drug free, if they are motivated to be drug free and this is the agreed objective" (National Treatment Agency - NTA 2005).

The staff working is this unit will have specialist addiction expertise and skill and will focus on the major presenting issue of alcohol and drug problems. Central to the workings of the 'Addictions' facility will be the delivery of clearly defined, evidence based psychosocial interventions, delivered as part of an individuals recovery support plan. Each individual will be assisted to make changes in their alcohol and or drug using behaviour. Structured psychosocial interventions will be identified within a recovery support plan and these interventions can be delivered in an individual or group setting.

Examples of evidence based psychosocial interventions include:
- Cognitive behaviour therapy (CBT)
- Coping and social skills training
- Relapse prevention therapy

This unit will be abstinence based and have a clear and defined role which can be summed up as delivering the following functions;

- Pre-planned detox from alcohol and / or other drugs;
    - Alcohol Detox - expected duration of admission 4 -7 days.
    - Drug Detox – expected duration of admission 10 – 14 days.
    - Elective specialist in-depth assessment;
      Expected duration of admission, 4 weeks maximum.
    - Structured day programmes for day attenders in order to prevent

admission (step-up approach) or facilitate earlier discharge (step-down approach).
Day programme duration can be tailored to meet the individual need of the patients

The functions above this will be considered an extension of Addiction Services community service provision.

The community teams (CAT's & PCAT's) will assess patients whilst in the community and book the beds and facilitate admissions to this unit. Community staff will promote and ensure continuity of patient contact (via joint key worker sessions) whilst their patient is in the Addiction unit and will facilitate discharge planning and ensure follow up support is in place for all patients.

This patient group may have more complex and challenging mental illnesses and behaviours associated with chaotic drug and or alcohol misuse than those within the community environment. The facility environment will be conducive to providing a therapeutic atmosphere to enable recovery focused, patient centred care, encouraging behavioural change and relapse prevention through a range of psychological/psychosocial interventions and therapies.

Alcohol Detox

Detox refers to the planned withdrawal of a substance. Alcohol withdrawal carries risks and requires careful clinical management. Detox should be seen as part of the recovery pathway.

Appropriate treatment of alcohol withdrawal can relieve the patient's discomfort, prevent the development of more serious symptoms and forestall cumulative effects that might worsen future withdrawals. Hospital admission provides the safest setting for the treatment of alcohol withdrawals, although many patients with medication to moderate symptoms can be treated successfully via community and home detox (Myrick and Anton, Alcohol Health and Research World, Volume 22, No 1, 1998).

Signs and symptoms of alcohol withdrawal typically appear between 6 and 48 hours after heavy alcohol consumption decreases. Initial symptoms intensify and then diminish over 24 to 48 hours. Delirium tremens (DT's), the most intense and serious syndrome associated with alcohol withdrawal usually appears 2 to 4 days after the patients last use of alcohol.

Most individuals can detox safely and effectively in the community with intensive support and appropriate medication. In Ayrshire, this home/community detox is delivered by CAT/PCAT's in partnership with individual GPs.

However, some individuals require acute medical admission. This is usually indicated where there are co-existing medical conditions such as Delirium Tremens, pancreatitis, pneumonia or other infections. Other indicators of an

acute medical admission include severe undernourishment, severe on-going vomiting or diarrhoea or other acute physical illness.

For other individuals, where home/community detox is not safe or possible, pre-planned admission to the 'Addictions' facility would be available. Relative indicators for in-patient admission for alcohol detox include:

- History of severe withdrawal symptoms including alcohol withdrawal seizures;
- Multiple unsuccessful home/community detox interventions;
- Concomitant psychiatric illness
- Recent high levels of alcohol consumption
- Lack of reliable community/home support network
- Pregnant women – supported by Child Protection High Risk Pregnancy Protocol

Individuals requiring in-patient alcohol detox would be admitted for the minimal time possible. Discharge planning will be arranged as soon as withdrawal symptoms subside with the ongoing support from their local PCAT who will continue to monitor or administer medication related to alcohol withdrawal for the remainder of their detox regimen. This practice will maximise bed occupancy and continue to allow the service to respond to ever changing demands.

Other Drug Detox

In dependent drug users, detox is usually thought of as being a clearly defined process supporting safe and effective discontinuation of illicit substances while minimizing withdrawals. Increasingly individuals are using alcohol and 'cocktails' of other drugs. In-patient detox would normally only be considered for individuals who need a high level of nursing and medical support. Pre-planned admission to the new 'Addictions' facility for in-patient detox may be indicated for the following:

- have not benefited from previous formal community-based detox
- need medical and nursing care because of significant co-morbid physical or mental health problems requiring complex poly drug detox, for example concurrent detox from alcohol and or other substances
- are experiencing significant social problems that will limit the benefit of community-based detox
- Pregnant women – supported by Child Protection High Risk Pregnancy Protocol

However, some individuals require acute medical admission. This is usually indicated where there is a co-existing presentation of acute and complex physical conditions which may require a higher level of clinical management and treatment. This may result in a transfer of care to the addiction unit when deemed medically fit.

Staff will routinely offer a community based programme to all patients

considering drug detox. Individuals requiring in-patient drug detox would be admitted for the minimal time possible. Discharge planning will be arranged as soon as the optimum level of stability is achieved with the ongoing support from their local CAT/PCAT who will continue to monitor medication related to drug detox management for the remainder of their regimen. This practice will maximise bed occupancy and continue to allow the service to respond to ever changing demands.

Patients who do not successfully detoxify will be offered seamless access back into maintenance and/or other treatment programmes identified to meet their needs.

Elective specialist in-depth assessment

The 'Addictions' facility will also offer the availability of undertaking more specialist in-depth assessment for individuals with severe and complex alcohol and drug and mental health related issues. A period of assessment (up to 4 weeks duration) will cover in detail the nature and extent of alcohol and drug use, physical and psychological health, personal and social skills, social and economic circumstances, impact of previous treatment episodes and the assets and attributes of the individual.

Effective assessment is an ongoing process and seeks to identify the range and level of needs of the individual, not only the problems directly caused by substance misuse, but also the health, social and economic impact. A key feature of this assessment process is the exploration of the individual's attitudes and aspirations.

Structured day Programmes

The 'Addictions' facility will also offer the availability of some individuals attending a structured day programme. This intervention can also be incorporated into a step-up approach which is for individuals who may require a more intensive support package to prevent admission to the residential unit or a step-down approach following period of in-patient detox or specialist assessment which may facilitate earlier discharge.

The structured day programme will offer a range of interventions with availability of 8 x ½ day sessions each day (4 x full day sessions each day), 7 days per week (56 sessions per week). Regular key worker sessions are a key element of this structured day programme along with the ongoing development of individualised recovery support plans, which address alcohol and drug misuse, physical, mental health needs and associated behaviours and social functioning. The overall programme will include group work, psychosocial interventions, educational and life skills activities.

6 Role and Function

The Addictions inpatient facility provides assessment and an agreed plan of care via a flexible nurse led, person centred approach which is recovery focussed. The facility will offer evidence based interventions to service users within a group and/or individual setting to enhance skill base allowing healthy behavioural change to patients (as described in the descriptive overview).

The addiction inpatient facility will provide training, support, and consultancy to other organisations and workers. The service acts as a source of expertise, support and intervention to other professionals, patients and the community to provide a comprehensive range of prevention and treatment services across Ayrshire and Arran for alcohol and/or drugs.

The addiction inpatient facility will provide an inpatient, admission, assessment learning environment for the University of West of Scotland nursing students, each being supervised and supported by an experienced mentor. Further to this, we also provide learning opportunities to post graduate students, including nursing, medical, psychology and social work from a range of universities throughout Scotland.

7. Bed complement

The addiction inpatient bed numbers are:

- 10 inpatient beds

- Bed complement will also be DDA compliant
- All beds should be single room accommodation with en-suite facilities
- Bed provision will be in accordance with the mixed sex guidelines.

8. Planned patient length of stay

Patients will be admitted to this facility on a planned basis, with the approximate average length of stay being 4-7 days for alcohol detox or 10-14 days for other drug detox purposes.

Patients being admitted for residential specialist in-depth assessment will not exceed 4 weeks.

The day programme offers availability for 8 individuals attending for a ½ day session every day of for 4 individuals attending for a full day each. Therefore different people could attend at different times and for different duration.

9. General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the patient group
- Clinical interventions will be evidence based and reflect current best practice
- The addictions inpatient service will aim to provide a conducive therapeutic environment in which a patient's plan of recovery can be assessed and treated to improve their psychological and physical wellbeing and reduce the risk of relapse/self harm.

10. Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be;

- In keeping with anti-ligature and DDA and mixed sex accommodation standards;
- Single rooms with en-suite facilities;
- Doors, locks and windows should be of a design which enables access by staff in an emergency situation;
- Through doors should have an appropriate viewing panel;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet storage services;
- Dining facilities that enhance the meal experience;
- Clinical areas that are non threatening and welcoming;
- Social/Activity/Therapy area and sitting rooms should be therapeutic while

lending themselves to recovery;
- The provision of hot/cold drinks should be available in the pantry which should be en-suite to social/activity/therapy area;
- Bedroom areas should enhance the therapeutic experience and also provide privacy;
- All areas within the facility should be easily observable with no blind spots
- Ligature points should be eliminated;
- Outside smoking area should be well ventilated thereby preventing smoke pollution of adjacent areas, if legislation allows;
- Doorways should be wide enough to allow ease of access for disabled access;
- Calming features built into the fabric of the building.

11. Corridors: Required features

- Corridors should have no blind spots and allow maximum observation
- Long unbroken corridors should be avoided, with the maximum use of natural light and ventilation.
- Well signposted

12. Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

13. Disabled access requirements

- The design of the facility must comply with current legislation
- The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

14. Privacy and dignity requirements

- The design of the unit must comply with current legislation

15. Number and types of rooms

The schedule of Accommodation provides further information on rooms.

16 Required adjacencies

External

- Outdoor garden area should be safe and stimulating with a smoking shelter(legislation permitting);
- Sheltered outdoor activities area partially covered, allowing fresh air;

- The garden area should be landscaped and easily maintained;
- The addiction inpatient facility should be adjacent to the adult admission facility and connected by a common corridor;
- The facility should have easy access to Support Cluster 2 without having to go outside;
- The facility should be close to the recreational facility.

Internal

- The open plan dining room and pantry should not be next to the bathroom facilities;
- Staff base for 3 staff should be at the area of highest observation;
- Duty room should have a certain amount of observation;
- Store room, linen room, clean and dirty utility room, cleaners' housekeeping room, WC should be clustered together. This should be away from the clinical area and bedrooms;
- Patient's laundry should be distant to the bedrooms and social/activity/therapy area;
- Duty room and staff base for 2 places (hot desk with IT access) should be clustered together;
- The bedrooms should be distant from the social/activity and therapy area;
- The sitting room should be sited in accordance with the mixed sex guidance;
- The social/activity/therapy area, sitting room and pantry should be sited in such a way that allows ease of access and use but distant from the bedrooms.
-

17. Storage facilities

The following storage facilities are required for:

- Secure lockers for 15 staff;
- Flat linen and towels;
- Spare duvets and pillows;
- Activities store including seasonal decorations;
- Medical record storage space;
- Stationery cupboard;
- Central Storage room for miscellaneous items (large).

18. Anticipated developments

- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service;
- The building should be able to meet the needs of future Information Technology developments;
- Any future developments within all relevant guidelines and standards.

19. Client Group Characteristics

Age and Gender

- 16 to 65 years old although sometimes exceptional circumstances will lead to some flexibility.
- Male and Female

20. Admission Rates

- Facility will be open 365 days per year and admissions can be facilitated at any time.

21. Admission Criteria

- Pre-planned detox from alcohol and / or other drugs;
- Elective specialist in-depth assessment;
- Structured day programmes for both in-patient and out-patients in order to prevent admission (step-up approach) or facilitate earlier discharge (step-down approach).

Alcohol criteria

- History of severe withdrawal symptoms including alcohol withdrawal seizures;
- Multiple unsuccessful home/community detox interventions;
- Comorbid psychiatric illness
- Recent high levels of alcohol consumption
- Lack of reliable community/home support network
- Pregnant women – supported by High Risk Pregnancy Protocol

Drug criteria

- have not benefited from previous formal community-based detox
- need medical and nursing care because of significant co-morbid physical or mental health problems requiring complex poly drug detox, for example concurrent detox from alcohol and or other substances
- are experiencing significant social problems that will limit the benefit of community-based detox.
- Pregnant women – supported by High Risk Pregnancy Protocol

The presentation/admission requirements to access this service are as follows:

- Need for inpatient detox (criteria & procedures, as per protocols and guidelines for NHS Ayrshire and Arran inpatient detox, are well established)
- A requirement to deal with complex mix of significant alcohol and/or drugs and severe mental illness or mental health issues

Guiding principles which dictate admission is a complex issue however, the available national guidance stipulates that the requirements are;

- Individuals who are unable to achieve and maintain abstinence in a community setting;
- Those who express a desire to maintain abstinence and express a preference for admission addiction programmes or agree to enter this type of programme;
- Those who are likely to have substantial problems maintaining abstinence due to the severity of their substance dependence;
- Those requiring a programme of addiction support that is most suitably delivered in a residential environment;
- Those who are living in an environment characterised by social deprivation, including housing problems or instability, which represents a threat to relapse;
- Those who lack social support;
- Those whose social environment contains people (e.g. partners, friends) who are substance misusers and who are likely to hinder resolve or ability to maintain abstinence.

The proposed DDA compliant, single room accommodation will allow flexibility in admission presentation and allow the service to react and respond to local rapidly changing demand.

22. Anticipated illness-related behaviours

Patients who are admitted to this facility may display the following:

- Intoxification
- Disinhibited behaviours
- Unpredictable and impulsive behaviours
- Aimless or ritualistic behaviours
- Lack of personal risk awareness
- Patients in the facility are more likely to have complex needs as described in the appropriate sections of the ICD 10, Classification of Mental Health and Behaviour Disorders

23. Anticipated clinical risks

Patients who are admitted to this facility will be at an increased risk from the following:

- Absconding;
- Deliberate self harm
- Intoxication
- Illicit alcohol/drug use
- Inappropriate relationships/co-dependency with patients and staff
- Harm to others
- Self neglect

- Challenging behaviour
- Suicidal intention
- Disinhibited behaviour

24. Patient dependency characteristics

Principal aims of clinical care

Usual admissions to these areas will represent patients who undergo:

- Addiction assessment including assessment of risk, development of recovery plans and appropriate treatment interventions
- Timeous discharge planning supported by CAT's and PCAT's;
- Initial support, assessment identification of ARBD;
- Promote positive behaviour change related to the individuals psychological well being
- Integrated relapse prevention work based on Prochaska and Di Clementes Transtheroretical model of change and Marlatt's relapse prevention model
- Physical health screening and non-complex interventions
- Care and Treatment is underpinned by the Milan Principals and 10 Essential Shared Capabilities.
- The Therapeutic model within this unit is based on the tidal model of recovery
- Strategic drivers – Rights Relationship and Recovery, Road to Recovery, Closing the Gaps – Make a Difference: Commitment 13; Do the Right Thing – How to Judge a Good Ward
-

25. Therapies

- A range of addiction specific interventions will also be delivered, for instance, relapse prevention;
- Complementary therapies will be delivered as appropriate in line with new guidance emerging from the current review within the Mental Health Partnership and Professional Groups, for instance, Nursing & Midwifery Council (NMC);
- Individual and group therapies will be provided within the facility in keeping with the care plan and models of care;
- Therapies should be in keeping with recovery/tidal model and be evidenced based, for instance, CBT, motivational interviewing, family therapy, psychosocial interventions, solution focussed therapy etc; and
- Therapies will enhance the care experience and will be focussed upon specific interventions and outcomes.

26. Therapeutic facilities required

- Space to provide therapeutic interventions as required within the facility

- Storage space to contain therapeutic equipment will be required within the facility as previously described.

27. Planned clinical meetings

- Space is required to provide for a variety of clinical meetings which will take place on a daily basis
- Space to comply with the new Mental Health (Scotland) Act

28. Other Meetings

- Appraisal/supervision meetings
- Educational meetings
- Meetings with extended care team
- Meetings with relatives

29. Clinical risk management principles

- Based on this an initial risk management plan is developed;
- On admission each patient is assessed in accordance with the recognised risk assessment tool;
- One element of this plan is to determine the patient's observation status;
- Risk management for this patient group is important. The environment must be conducive to delivering the risk management plan;
- The Addictions facility will have systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform the treatment plan and enhanced Care Programme Approach.

30. Operational Procedures

Working day plans

- The facility will be open 365 days per year and 24 hours per day;
- The addiction inpatient facility will provide crisis intervention/support via telephone contact 24hours a day, 7 days a week.

Staffing arrangements and shift patterns

- Nursing handovers will take place in the duty room at set times throughout the day as determined by the facilities team;
- The facility will be staffed 365 days per year and 24 hours per day;

- Staffing levels and shift patterns will be set out to achieve the optimum level of therapeutic care in a safe and secure setting.

Admission procedures

- Admissions are accepted on a planned basis and will be facilitated to accommodate the individual presentations
- As far as possible admissions should be during normal office working hours and all requests for admission should be routed through the facilities staff;
- Admissions will be directly from CAT and /or PCAT staff;
- It is envisaged that the majority of admissions will be on an informal basis;
- At times patients could be detained under the Mental Health Care & Treatment (Act) (Scotland) 2003.

Record-keeping storage

- All clinical case records require to be stored within a lockable cabinet within a lockable room
- Secure IT systems for patient records
- Items of secure stationery require to be stored within a lockable cabinet

Visiting arrangements

- The intention is to have both timed and flexible arrangements for visitors, including children in line with the protected mealtime policy.

Mealtimes/dining arrangements

- Dining will be facility based and there will be three mealtimes per day;
- Facilities must promote the ambiance of the meal experience, and not be cramped;
- Facilities must be available to permit the consumption of hot and cold drinks out with recognised mealtimes;
- There will be a pantry area for patients to access these beverages.

Between meal snacks and access to beverages

- Facilities must be available to permit the consumption of hot and cold drinks out with recognised mealtimes
- There will be a pantry area for patients to access these beverages

Laundry facilities and linen management

- A room is required to provide for washing, drying and ironing of personal clothing.

Adult Recreational Facility

- Access to physical activities in the facility, for instance, treadmill, multi-gym, wii fit, table tennis, pool table;
- Sitting room (quiet room);
- Promotion of wellbeing, library, access to reading materials, interactive, board games as described with STAR Wards, further information on STAR Wards can be access by www.starwards.org.uk;
- Access to physical activities available at the leisure centre.

31. # Functional content

Number of Inpatient Beds/Treatment Spaces

- 10 in-patient beds with en-suite
- Treatment room, general and UVL both sides couch access for 1 patient
-

Investigative/Diagnostic/Treatment Capacity:

- A & E attendance/arranged appointments/transfer of patients to medical wards on occasions to treat physical conditions;
- EEGs and ECGs and CT scans are provided at Ayr or Crosshouse Hospital as appropriate;
- Medical staff and nursing staff carry out routine blood tests on admission, and any further blood tests as indicated; and
- Ability for nursing staff to access computer blood results.

Outpatient Service (Number of Sessions and specialist functions):

- Please see the Schedule of Accommodation for the consultation and interventional area for further details.

Specialist Technical Infrastructure Requirements

- Addiction educational resources, for instance leaflets, educational material, books;
- Mobile Phones for on call arrangements/emergencies;
- Pinpoint Alarm system;
- Portable Oxygen;
- Portable Suction;
- SAMS (Shared Addictions Management System) Addictions IT system.
- FACE (electronic patient record for Mental Health);

- Nurse call system;
- Telephones for internal and external communication;
- Security entry out of hours – intercom at entrance to ward

32. Projected Future Activity

- Demographic differentials for age (reducing) and gender (increasing incidence of women with problems);
- Increasing alcohol consumption is likely to increase problems by 20%;
- Nature of problems will change e.g. greater number of Alcohol Related Brain Damage at earlier age, increase physical health burden;
- New screening and Brief Intervention work will identify additional referrals;
- Previous drug prevalence studies (Scottish Government/Glasgow University) indicated a prevalence of 1.7% of the adult population in Ayrshire with a significant drug problem (awaiting release of updated study Summer 2009).

33. Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
CAT and PCAT (North Ayrshire) NHS and Local Authority	• Continuity of care	Essential
Admission Wards	• Ease of transfer • Safety alerts • Extra staff • Patient privacy	Essential
Outpatients department	• Access • Co-located staff resulting in less driving time •	Desirable
Medical staff (psychiatric)	• Rapid response • 24 hours/day response • •	Essential
Support Cluster 2	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies •	Desirable

34. Future Service Delivery Risks

- Activity levels unpredictable
- Activity/case mix change
- Affordability
- Commissioning plan
- Communication plan
- Consideration for smoking cessation - support to staff and patients
- Decanting of services
- Decommissioning plan
- Engagement with key stakeholders to create new model of care prior to transfer – transitional risk – preservation of good practice already established, change management
- Expectations of patients and staff, and the public
- Familiarisation with local facilities, town centre, parks, shops
- Full risk management plan
- Group dynamic within patients
- Impact on new service to statutory and non-statutory addiction services, localities, patient group
- Increase staff for increased number of patient
- Lead-in time for testing service/environment
- Ligature points
- Ongoing support from Emergency services and local police services, current A & E hospitals, social work,
- Patient security
- Settling in period may increase risks initially
- Snagging lists
- Staff Resources
- Stigma, sensationalism through media of patient group
- Sustainability
- Training and support for staff
- Transport – access and bus service for staff and visitors, carers and patients (timetables)
- Workforce – managing change for staff

Appendix O – Forensic Rehabilitation Unit (Low Secure)

Introduction and outline of services

Departmental Function

Context

The Forensic Rehabilitation Unit is a continuation of the development which took place on Ailsa campus providing an in-patient service for up to ten Mentally Disordered Offenders some of whom were receiving their care out-with NHS Ayrshire & Arran.

This was initially an interim arrangement as it was envisaged that a Low Secure Unit and Rehabilitation Unit would be built as part of the development on NACH. The current anticipated need would suggest that the Low Secure provision would be more financially viable by a Service Level Agreement with a Low Secure Unit as there would appear to be more of a requirement to provide rehabilitation beds in the immediate future.

There is a possibility however that the requirement for low secure provision may increase therefore the 8-bedded Forensic Rehabilitation Unit is being designed with the future option of being converted in use to a Low Secure Unit by being built to the same specifications and overall design as IPCU which meets the specification of a Low secure Unit.

1 Throughout the clinical brief the unit will be referred to as Forensic Rehabilitation Unit (FRU) but it is implicit that the unit may change function at a later date to become a Low Secure unit.

Key principles

The key principles for the development of integrated forensic mental health services should include:

Regard to quality of care and proper attention to the needs of the individual;

As far as possible in the community rather than in institutional settings;

Under conditions of no greater security than is justified by the degree of danger 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 as appropriate.

Consideration for service delivery should include;

2

Integration with Community Forensic Mental health services;

Clear care pathways from high to medium to low to community and vice versa;

Integration with forensic managed care network; and

Working definitions for the different categories of secure care.

Teams and Links

Our FRU will be Consultant led and managed by nursing staff working within a patient/person-centred, multi-disciplinary and multi-agency framework in partnership with, physiotherapy, dietetics, occupational therapy, speech & language therapy, advocacy, social work, psychology, medical staff, criminal justice team members and a range of visiting support services. Strong working links will be maintained with the Forensic Community Team.

3

At any given time there could be up to 6 nursing staff on duty (variable with clinical demand), this may be supplemented by 2 Student Nurses. When the number of Medical (Consultants, Junior Doctors and Trainees), Allied Health Professionals and representatives of other agencies are added to this it is possible that up to 16 staff may be present and will require to be accommodated on the ward at peak times. (These numbers would increase should the unit become a fully functioning Low Secure Unit).

Service Users

The accommodation and delivery of care must be flexible enough to meet the needs of people of all ages including those who may have a physical disability.

4

All clients will be subject to detention in hospital under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2003 or the Criminal Procedures Act (1995).

The patients will usually have more complex and challenging illnesses and behaviour, some of these may manifest themselves in increased levels of

violence and aggression, they may also have physical symptoms, which may be due to a co-morbidity of disease or because of dependence on drugs and/or alcohol.

Patients will receive assessment, treatment and rehabilitative care within the ward.

Therapies and Treatment

A key role of the ward will be to lead in the resettlement process of patients from secure facilities to a community setting.

The care team will assist the individual in taking an active role in their recovery by providing a range of therapeutic activity/interventions.

Activity, supported by a comprehensive ongoing needs and risk assessment, may be scheduled or unscheduled, and will be co-ordinated and provided from a multi-disciplinary perspective which will encourage involvement of the patient/carer as a key part of the team.

Activities will be designed to address a spectrum of health and social care needs which typically include physical, psychological, offence related, recreational, life-skill, cultural, spiritual and social elements.

5 Each person will be engaged with a care plan for each day of their stay, which reflects their needs, wishes and aspirations and is cognisant of their capabilities with due regard to any requirement for enhanced safety and security.

The service is recovery focused, it provides intensive treatment and interventions to patients who require an increased level of observation and security.

The FRU aims to provide a therapeutic environment in which patient's illnesses can be assessed and treated and thereby improve their psychological (and physical) well being and where their rehabilitation needs can be addressed, enabling better integration into the community on discharge.

Some individual therapies including patient consultations, psychological therapies and advanced psychiatric assessments, will require private, confidential space (significant sound insulation whilst not compromising safety), allowing individuals the opportunity to express their emotions and personal issues.

Space and Observation

Although an open ward access to and egress from the FRU will be strictly controlled and will require a high level of “perimeter” security (windows, doors, airlock entry etc). To ensure safety security and observation is optimised all ward facilities should be on a single level. These security provisions will be designed into the building when being constructed but systems such as the airlock entry will not be utilised as such unless the unit does adopt the Low Secure function.

The feeling of space plays a key role in reducing levels of anxiety and aggression and promoting recovery and, as such, it is of the utmost importance that all patients have access to private and communal space both internally, in the form of small quiet areas and externally in the form of significant, safe, secure therapeutic green space. Where patients are unable to leave a ward area as a result of their illness/behaviours the provision of space is increasingly important in promoting recovery.

6

Within the FRU emphasis has been placed on encouraging social / community activity.

Division of clients by function (assessment, treatment and rehabilitation) and gender (male, female) will be an operational issue and will require a flexible arrangement of room functions, e.g. bedrooms need not be in separate wings but all eight rooms should not be next door to each other perhaps in smaller groups (4- 4) separated by sitting areas/multifunction rooms.

Some clients may have to spend extensive periods (18 months to 2 years in FRU function and longer if Low Secure) within the unit and as such will not be able to access external recreational, educational and community services. In keeping with the Millan principle of Reciprocity it is imperative that a significant provision of common / activity space is made within the unit to offset the impact of these restrictions.

During the patients stay they may be regularly visited by family, relatives and friends who can also be involved in supporting the plan of care and participate in the person’s recovery. These visits will be on a planned basis.

Legislation & Governance

We are governed by legislation which directs us to provide practical solutions for patient/public safety and security (Criminal Procedures Act 1995)and also the principles under the Mental Health (Care and Treatment) (Scotland) Act 2003:

Non-discrimination - people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

Equality - all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

Respect for diversity - service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

Reciprocity - where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

Informal care - wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

Participation - service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

Respect for carers - those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

Least restrictive alternative - service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe, effective care, taking account where appropriate of the safety of others.

Benefit - any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

Child welfare - the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Schedule of Accommodation

The accommodation is scheduled in Mental Health Services and is described in the section entitled Low Secure in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The FRU will have a clear and defined role in providing support to Mentally Disorder Offenders. The patients will usually have more complex and challenging illnesses and behaviour; some of these may manifest themselves in increased levels of violence and aggression. The ward environment will be conducive to enabling greater observation, security and support to patients that exist within the open wards and to similar level of that within IPCU.

The aim of the FRU is to deliver the right care, at the right time, to the right patient. These aims should be delivered through a system of:

needs assessment;

risk assessment;

risk management; and

treatment planning and delivery.

Each of these processes will be conducted as part of a structure or system in order to realise a number of benefits including:

All of the multi disciplinary team caring for the patient, the patient themselves and their carers should be able to share information regarding the identified needs, risks, objectives, interventions and treatments;

Each should understand decisions that are being made and have reasonable expectations of what should be delivered and when; and

The multidisciplinary team should be able to use the assessment and planning structure to avoid duplication in their work, identify any gaps and to prioritise the interventions, treatment and support they provide.

The overall environment within the ward should be conducive to providing care within a safe setting that promotes the recovery process.

As a minimum standard the environment will comply with the Department of Health Document “Mental health policy implementation guide: National minimum standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments” which can be downloaded using the following link.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010439

Role and Function

The FRU operates as a specialist service located within adult mental health in-patient services but also works very closely with the Community Forensic Mental Health Team.

The FRU’s function will be to essentially provide assessment and care for people who:-

Suffer from mental disorder, the nature and degree of which is such that they require assessment and / or treatment in a secure ward setting, in the interest of their own health and safety, and/or for the protection of others;

Because of above they require to be detained in hospital under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2003 or the Criminal Procedures Act (1995);

(If become a Low Secure Unit) Are suspected mentally disordered offenders remanded by the courts under the Criminal Procedures Act 1995 and who because of their propensity for aggressive behaviour, cannot be adequately managed within the ordinary acute psychiatric ward setting, or are restricted due to being remanded back to hospital, therefore requiring a secure forensic low secure unit;

FRU will operate with a consultant-led multi-disciplinary team of medical, nursing and other AHP (allied health professionals) staff;

It is expected that the expertise of AHP staff like psychology, occupational therapy and physiotherapy will be integral components of the service;

Clinical responsibility for all patients, during their stay on the ward is primarily

that of the ward consultant;

FRU will work in close co-operation with the source of referral at all times; and

Care will be patient centred with their privacy and dignity being preserved at all times.

The service must balance the need for safety and security with the provision of a therapeutic environment.

Care will be patient centred;

Services must respect the individual;

Services must offer privacy and dignity;

Services must balance the need for safety and security with the provision of a therapeutic environment;

The environment requires to lend itself to obtrusive and unobtrusive observation; and

The environment must be pleasant, safe and the general ambience promotes mental health well being.

Bed complement

6 rehabilitation en-suite bedrooms, one with an en-suite ‘special care’ area

2 larger sized en-suite bedrooms to cater for mobility impaired or bariatric patients

Planned patient activity

Admissions will be accepted from a variety of sources such as:

Low/Medium Secure Units

IPCU/Admission wards

Rehabilitation wards

Usual admissions to this area will represent clients who cannot be safely managed in an open acute ward environment by virtue of:

requiring high levels of prolonged observation and high nurse patient ratio;

presenting a significant risk of harm to others; and

requiring to be in hospital as part of their compulsion under the terms of the Mental Health Act or Criminal Procedures Scotland Act require secure accommodation.

General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group;
- Clinical interventions will be evidence based and reflect current best practice;
- Invasive clinical interventions such as restraint and rapid tranquilisation will be undertaken in a safe, non stimulating environment that respects the individual's privacy and dignity; and
- The FRU will aim to provide a therapeutic environment in which patient's illnesses can be assessed and treated and thereby improve their psychological and physical wellbeing; control their aggression and reduce the risk of self harm.
- The Unit will aim to support individuals to work towards a discharge within 18 – 24 months from admission to the Unit
- All individuals in the FRU should be supported towards being fully self-catering as quickly as is possible

Design Synopsis

- In addition to the core design synopsis/critical features, unique features to this environment will be;
- In keeping with IPCU care standards (matrix of security);
- Where possible, it would be preferable to have a single sex facilities/bedroom areas;
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency situation;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet storage services and sufficient storage (within and outwith bedrooms) for personal belongings;
- Dining facilities that enhance the meal experience including an ADL kitchen and dining room;
- Clinical areas that are non threatening and welcoming;
- Common sitting and activity areas should lend themselves to recovery;
- The provision of hot*/cold drinks should be available in the common sitting/activity areas (*With the provision to be secured and accessible only when supervised by staff dependent on risk);
- Bedroom areas should enhance the therapeutic experience and also provide privacy;
- There will need to be flexibility for 1 bedroom to be 'switched' without

compromising mixed sex guidelines;

- All areas within the ward should be easily observable with no blind spots;
- Ligature points should be eliminated;
- Designated smoking area should be outside;
- Garden areas should provide colours of plants and sensory stimulation, sheltered areas, suntraps and comfortable seating;
- Doorways and corridors should be wide enough to allow ease of access for a patient under physical restraint;
- Air Lock entrance to ward.(Reception/Waiting area) This entrance (two sets of double doors) are an important security measure and must be retained although may not be utilised in the initial time whilst functioning as an FRU;
- Windows should only open if external area is secure (to prevent unauthorised items being passed into unit); and
- Calming features built into the fabric of the building.

The design synopsis should include the following aspects :

Forensic Rehabilitation Unit (Low Secure)

ENVIRONMENTAL SECURITY

DESIGN AND CONSTRUCTION

Secure outside area;

Secure external windows;

Double locked doors (will be unlocked when FRU);

Specifically designed to deter escape;

Window restrictors / reinforced windows;

Doors opening outward (interview room and bedroom), window restrictors / reinforced windows; and

Pinpoint type alarm system.

EQUIPMENT

Hand held metal detector; and

Limited to specific locations.

PROCEDURAL SECURITY

COMMUNICATIONS

Patients phone calls - No restriction except in “exceptional circumstances”;

Patients letters - Can be monitored under mental health legislation; and

Patients electronic mail / access to the internet - Supervised access on site unsupervised off site.

ITEMS – RESTRICTED (or prohibited)

Searching patients - On admission including possessions and as warranted by individual risk assessment - random searches following length of stay;

Drug access/screening - Urinary drug screening on basis of clinical need and on admission & random screening; and

Alcohol access/screening - Access to alcohol on leave approved by MDT. Alcometer available.

ITEMS – Daily living equipment

Sharp Kitchen knives – counted after use (will require supervised use if Low Secure)

Cutlery – (if Low Secure) Restricted metal cutlery - counted after use, supervised meals;

ADL kitchen – (If Low Secure - MDT approval); and

Fire setting materials (e.g. cigarette lighters) – (If Low Secure) Controlled/ limited access, no fire setting material with patients.

ITEMS - Access to money, valuables and belongings

Access to belongings - At MDT discretion;

Access to money/valuables - Dependant on individual assessment of capacity. Will be restricted; and

Patients should have small safes or lockable drawers in their bedrooms.

PROCEDURAL SECURITY

PEOPLE- Child Visitors - approved by MDT

Child visiting policy - approved by MDT; and

Visiting arrangements procedure - Specified visiting areas (other restrictions dependant on risk present at time).

PEOPLE- Internal Movement between clinical areas in a psychiatric facility

Patients - may be escorted;

Visitors / official visitors – Escorted; and

Provision of recreations/therapies – Range.

PEOPLE- Patient absence from the hospital

Routine pass (e.g. “testing out”) - Unit policies including individual risk assessment; and

Exceptional LOA (e.g. court, hospital) - Unit policies including individual risk assessment.

Miscellaneous

Contingency planning - Multi-agency planning for evacuation, escape and absconsion;

Window / door security - Standard hospital specifications; and

Furniture design - standard hospital furniture.

EQUIPMENT

X-ray / metal detector / ion detector - None routinely used;

Personal alarm systems – PinPoint alarm system;

Physical restraints - None used; and

Availability of additional special care area for behaviourally disturbed patients.

In addition to the core design synopsis/critical features, unique features to this environment will be:

- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience, ADL kitchen and dining room;
- Clinical areas that are non threatening and welcoming;
- Common social/activity/therapy areas should be domestic while lending itself to recovery;
- The provision of hot/cold drinks, controllable by staff, should be available in the pantry;
- Bedroom areas should enhance the therapeutic experience and also provide privacy;
- There will need to be flexibility in 1 of beds without compromising mixed sex guidelines;
- All areas within the ward should be easily observable with no blind spots;
- There should be one single point of entry to the ward;

- Ligature points should be eliminated;
- Designated smoking area should be outside;
- Doorways should comply with management of aggression guidelines;
- Airlock entrance to ward is essential; and
- 1 Special care area comprising of living area en-suite to1 bedroom.

The special care area is a discrete, self contained living space, where those very disturbed patients, who are also very disturbing and disruptive to other patients, can be safely, humanely and effectively nursed separated from the rest of the ward.

The special care area should be:

- Discrete, lockable and to one end of the ward to minimise noise disturbance;
- Self contained with a living area en-suite to 1 bedroom;
- Safe with minimum furniture made from pre-cast foam;
- Capable of having a minimum of 2 staff in attendance at all times;
- Designed to allow for the activities of daily living to be maintained in a humane environment; and
- Non stimulating.

Corridors: Required features

Corridor design is an important feature within the ward and should not just be seen as a means of getting from A to B

Should be kept to a minimum

Corridors should provide seated areas for quiet contemplation

Corridors should have no blind spots and allow maximum observation

Mixed gender requirements

The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

The design of the facility must comply with current legislation

The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The FRU should be adjacent to the IPCU and connected by a common corridor;
- The FRU should be adjacent to the AMH Rehabilitation Unit and as such have easy access to Support Cluster 2 without having to go outside; and
- The unit should have access to enclosed, secure, safe and stimulating garden areas.

Internal

- The open plan dining area and pantry should be close to the entrance of the ward and distant to the bedrooms;
- The base for 3 staff should be in the centre of the ward to maximise observation;
- Store rooms, linen room, clean and dirty utility rooms, cleaner's (housekeeping) room, staff WC should be clustered together and prevent access by patients. This should be away from the clinical area and bedrooms;
- Personal goods store should be accessible to patients and adjacent to bed areas;
- Patient's laundry should be distant to the bedrooms, interview rooms and social/activity/therapy area;
- Clean Utility, interview rooms, Charge Nurse office and social/activity/therapy area should be clustered together and distant from the bedrooms and hotel services area;
- The bedrooms should be distant from the hotel services and clinical areas; and
- The female only day room should be sited in accordance with the mixed sex guidance.
- Fitness Suite clustered with day areas and distant to bedrooms

Storage facilities

The following storage facilities are required for:

- Clinical equipment such as moving and handling equipment;
- Patient personal possessions that are not stored in their own room;
- Flat linen and towels;
- Spare duvets, pillows and mattresses; and
- Miscellaneous items.

Anticipated developments

As already described the building is being designed with the ability to become a Low Secure Unit should that become the prevalent need;

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service; and

The building should be able to meet the needs of future Information Technology developments.

Client Group Characteristics

Age and Gender

18 to 64 years old, male and female

Admission Rates

Admissions are accepted 365 days per year, 24 hours per day, following assessment, but will be infrequent and planned

Diagnoses

Clients admitted to the ward suffer from an identifiable mental disorder

Anticipated illness-related behaviours

Clients who are admitted to this ward may display the following;

Disinhibited behaviours;

Unpredictable and impulsive behaviours;

Aimless or ritualistic behaviours;

Lack of personal risk awareness;

Determined attempts to abscond; and

Drug / Alcohol seeking behaviour.

Anticipated clinical risks

Clients who are admitted to this ward may be at risk from the following:

Deliberate self harm;

Harm to others;

Self neglect;

Suicidal intention;

Poor mobility;

Poor motivation;

Absconding;

Drug / Alcohol use;

- Isolation in a community environment (social breakdown); and
- Institutionalisation

Patient dependency characteristics

Therapeutic Intent

Principal aims of clinical care

- In-patient care is one element of the care pathway. It offers time limited safety, support and therapy to people who are too unwell to be cared for in less secure surroundings;
- Offer systematically organised, personally tailored collaborative help, treatment and care in an atmosphere of hope and optimism.
- To provide individualised care to people experiencing mental illness who require a period of rehabilitation to facilitate a return to independent or supported community living;
- To work collaboratively with the individual to improve their mental and physical health and functioning and social interaction;
- Is not to be respite from other elements of the care pathway; and
- Is to provide a stepping stone to inclusion, not a departure point for exclusion.

Therapies

- A collaborative approach to care will be embraced in that the care team will encourage the individual to take an active role (and preferably lead) in their recovery by encouraging them to agree their activity programme from the range of therapeutic activities/interventions available to them within the Unit, the wider hospital setting and as quickly as possible in their local communities.
- Individual and group therapies will be provided in an appropriate setting within and out-with the facility in accordance with an individualised care plan;
- Activities will be designed to address a spectrum of health and social care needs, which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.
- Therapies will enhance the care experience and will be focussed upon specific agreed interventions and outcomes;
- A key aim will be to provide a platform for social inclusion by re-integrating the patient into what will be their local community on discharge and local services. Working towards independence and discharge will be the underpinning objective at all times;
- Wherever possible service users will be encouraged to self cater in some way, whether it is making a cup of tea and a snack through to fully self-catering all meals; and
- Therapies should be in keeping with the Recovery/Tidal model and be evidence based.

Therapeutic facilities required

Adequate space to provide therapeutic interventions as required within the ward and Support Cluster 2; and

Adequate storage space to contain therapeutic equipment will be required within the ward, recreational facility and Support Cluster 2.

Planned clinical meetings

Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis

Nursing handover reports

Multi-disciplinary meetings

Consultant Meeting

Junior Doctor Reviews

CPA Meetings

Case Conferences

One to one clinical interventions

Group Treatment

Other Meetings

Meetings with relatives

Meetings with extended care team

Educational meetings

Appraisal meetings

Staff meetings

Ward community meetings

Clinical risk management principles

- Robust risk assessment on admission to include period of time with no unescorted time off of ward;
- Based on a proactive approach to positive risk management (embedded within the service);
- Approach to care will be collaborative and will attempt to support the individual to retain control over their actions and treatment plan wherever possible;
- Unit will be an open Unit (when FRU) and individuals will be individually managed to minimise impact on fellows should there be restrictions to their movement as per risk assessment and management plan;
- Be cognisant of Memorandum of Procedure (MOP) with regards to Management of Restricted Patients and notifiable events http://scotland.gov.uk/Publications/2010/06/04095331/0
- Formalised assessment tools within FACE will be utilised and process reviewed on an ongoing individualised basis;
- Additional formalised tools such as CHR20 and START will be utilised to assist in risk assessment;
- Environment will be anti-ligature in nature; and
- Admissions will be planned in nature and subject to meeting acceptance criteria and potential risk issues being manageable within the Unit

Operational Procedures

Working day plans

The wards will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

- The wards will be staffed 365 days per year and 24 hours per day
- Staffing levels and shift patterns will be set out to achieve the optimum level of therapeutic care in a safe and secure setting
- Wherever possible individuals will be supported to undertake rehabilitative activity in their local community which may place a demand on the staff group if travelling to Ayr for example

Admission procedures

Admissions and transfers will be on a planned basis.

Record-keeping storage

A paper light system will be utilised but all clinical case records require to be stored within a lockable cabinet within a lockable room – electronic record keeping will minimise the requirement for stored records

Items of secure stationery require to be stored within a lockable cabinet

Visiting arrangements

Patients will receive visitors in an interview room on a planned basis

Children may only visit the Unit with explicit approval of RMO

Visiting must not interfere with planned programmes of care and will be planned as part of the activity programme for an individual.

If the patients condition and parole status allows, they can accompany visitors to the café area in the main entrance

Mealtimes/dining arrangements

- Dining arrangements will require to be flexible and provide healthy eating options and between meal snacks and access to beverages available
- Facilities must promote the ambiance of the meal experience
- It is hoped that the majority of individuals will self cater with the majority fully self-catering, the requirement for a large ADL kitchen reflecting this (will not be the case if Low Secure and this area will require to be locked off) & a dining room with sit down provision of meals will be needed

Between meal snacks and access to beverages

Facilities will be available within the pantry area to allow between meal snacks and access to beverages

Laundry facilities and linen management

A room is required to provide for washing, drying and ironing of personal clothing which should be accessible to patients.

Functional content

Number of Inpatient Beds/Treatment Spaces

- 8 beds (in patients)
- Access to interview rooms and meeting rooms
- Two social/activity/therapy areas which can be opened up to larger area

In the future there would be a distinct advantage if the community forensic team, remaining at Ailsa Hospital at this time, could be provided for at North Ayrshire Community Hospital. It would be preferable for this accommodation to be located as close to the forensic rehabilitation unit, given their joint working arrangements, with the intention of strengthening the relationships of all the relevant care teams and strengthen the integrated care pathway and links between health and Criminal Justice System.

Investigative/Diagnostic/Treatment Capacity:

Will require to be accessed at nearest General Hospital and other specialist services as required.

Outpatient Service (Number of Sessions and specialist functions):

- Will provide outreach service to some individuals on discharge for a time.

Specialist Technical Infrastructure Requirements

Telephones for internal and external communications;

IT Systems for recording patient information electronically e.g. FACE;

System that have PC Pens and Tablets for utilisation by service users to participate in care planning etc;

PIN point system alarms;

Nurse Call System;

Slow Door Systems;

Emergency alerts for Immediate Response Team;

Mobile phones for escort duties;

Portable oxygen cylinders;

Security Entry out of hours – intercom at entrance to wards;

ECG machine

Projected Future Activity

The service will work to:

- The principles outlined in the Mental Health (Care and Treatment) (Scotland) Act 2003
- Other appropriate legislation and Scottish Executive guidance.
- These can be summarised as:
- Participation of the patient in the process;
- Respect for carers including consideration of their views and needs;
- The use of informal care wherever possible;
- The use of the least restrictive alternative;
- The need to provide the maximum benefit to the patient;
- Non-discrimination against a mentally disordered person;
- Respect for diversity regardless of a patient's abilities, background and characteristics;
- Reciprocity in terms of service provision for those subject to the Act;
- The welfare for any child with a mental disorder being considered paramount; and
- Equality.

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Rehabilitation Unit	• Accessing group activity programme in their area. • Staff support	Essential
IPCU	• Ease of transfer • Safety alerts • Extra staff • Patient privacy	Essential
• Acute Admission Wards	Staff support.	Desirable
Community Mental Health Team (Forensic)	• To facilitate communication re discharge planning. • Minimise travel time.	Essential
Access to ANP staff	• Rapid response • 24 hours/day response •	Essential
Close to ambulance entrance	• Delivery of Ambulance Services • Reliance Vehicles	Essential
Support Cluster 2	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies	Essential

Future Service Delivery Risks

Future client requirements & activity unclear and unpredictable;

Initial staffing numbers would require to be significantly enhanced if to

become Low Secure Unit with associated costs;

May be temptation to accept clients with higher risk issues rather than place in private sector Low Secure provision to keep within NHS Ayrshire & Arran;

Delayed discharges due to tenancy issues or options available within Local Authority to support discharge;

Stagnation due to lack of community services to move people on to (especially re Housing requirements);

'Split' of client group may change with more disturbed individuals requiring greater support and intervention by staff with impact on staffing resource and challenge to maintain programmes of activity;

- Implication of unknown long term drug abuse;
- Continuity & sustainability.
- Changing nature of clientele and therefore need to become Low Secure Unit within existing environment.
- Fit with integrated care pathways.
- Health & Safety (anti-ligature)
- Recreation, diversion/rehab activities
- Resources
- Throughput activity/case mix change
- Proximity of local resources re rehabilitation of patients

Appendix P - Rehabilitation Unit (Adult Mental Health)

Introduction and outline of services

Departmental Function

Overview

To provide an environment and culture that supports the provision of individualised rehabilitative programmes of care to individuals experiencing and recovering from a mental illness. This mental illness will typically have had an impact in their ability to function independently in the community and to cope with the requirements of everyday living. They may have become de-skilled as a result of prolonged mental ill-health, extended hospital stay, self neglect, lack of support or ability to cope with the activities of daily living.

The Unit will cater for a variety of individuals – supporting individuals who are perhaps treatment resistant and who require a longer period of care than can be facilitated in an acute admissions setting with active positive symptoms through to individuals whose illness may be very well controlled but who require to develop confidence in skills in undertaking daily living skills such as budgeting, maintaining a home, shopping, cooking. In the initial term the Unit may also have to cater for individuals who are in fact unlikely to be discharged from NHS 24 hour care and who will require to be supported in most tasks by staff – it is anticipated that the majority of these individuals will be supported on Ailsa campus however as they will have been a patient in Ailsa for a protracted period of time.

The Unit as a whole will embrace a Recovery Approach, 'recovery' defined by William Anthony as being

'a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of a new purpose and meaning in one's life as one grows beyond the catastrophic effects of mental illness'. *Anthony, W.A. (1993)*

In order to better describe how the different broad needs of clients within the Rehabilitation Unit will be met these needs can be broadly described in three sub-divided streams:

Stream 1: Those individuals with enduring needs who may require a slower paced programme of care designed to maximize their potential whilst acknowledging the likelihood that they will require prolonged support either in a hospital setting or in an intensively supported community setting.

Stream 2: Those individuals with ongoing needs and skills deficits who have been identified as being likely to respond to a medium paced rehabilitation programme designed to maximize their ability to function with a degree of independence with moderate support within a care or community setting.

Stream 3: Those patients with clearly identified needs likely to respond to an intensive fast-paced rehabilitation programme aimed at supporting them to develop their skills to a level where they can function within the general
1 community either independently or with minimum support.

Individuals will be able to move up and down streams dependent on their needs. There will also be a level of flexibility allowing patients who fall predominately within one stream to access components of other streams. This level of flexibility will be reflected in the physical structure of the ward.

-
- Teams and Links
-

The Rehabilitation Unit will be managed by nursing staff working within a person-centred, multi-disciplinary and multi-agency framework in partnership with, physiotherapy, dietetics, occupational therapy, speech & language therapy, advocacy, social work, advanced nurse practitioners, psychology, medical staff and a range of visiting support services. Efforts will be made, wherever possible, to engage with all agencies involved with an individual prior to transfer/admission to the Unit to ensure a holistic approach to care, avoid duplication of effort and ensure engagement with the significant others of an individual.

Where agreed with the individual this will include relevant parties being invited to Multi-Disciplinary Meetings including MDT Reviews, Care Programme Approach meetings, Pre-Discharge Meetings, case conferences etc. Further links exist with the University of West of Scotland (Nurse Training) and the Royal College of Psychiatrists (Medical Training).

At any given time there could be up to 12 nursing staff on duty across the Unit working within the ‘wings’ and the larger therapeutic area (variable with
2 clinical demand), this could be supplemented by up to 4 student nurses. When the number of Medical staff (Consultants, Junior Doctors and Trainees), Allied Health Professionals and representatives of other agencies are added to this it is possible that up to 20 staff may be present and will require to be accommodated on the Unit at peak times.

As part of the “Hospital at Night Service”, the development of the Advanced Nurse Practitioner role will provide cover at night which was previously provided by junior medical staff.

Service Users

Although this is an adult admission area, both the accommodation and delivery of care needs to be flexible enough meet the needs of people with a range of ages and can include those who may have a physical disability and/or mild learning difficulties.

Admissions will be accepted from a variety of sources including Acute admission wards, Forensic Rehabilitation Unit, and Community referrals.

Patients will be admitted primarily as a result of a mental health problem which has prevented them achieving and/or led to a deficit in their ability to maintain a safe, independent lifestyle in the community.

There are also a small group of patients who need ongoing longer term NHS continuing health care. These patients need ongoing and regular specialist clinical supervision as a result of the complexity, nature or intensity of their health needs. They require frequent, not easily predictable, clinical interventions which can be as a result of rapidly degenerating or unstable condition which requires specialist medical and nursing supervision. It is anticipated the majority of such patients will be supported on Ailsa campus.

3

They may also have physical symptoms, which may be due to:

a co-morbidity of disease , because of dependence on drugs and/or alcohol or

as a result of the lifestyle choices made by some people with severe and enduring mental illnesses leading to a lack of social skills and self neglect with a subsequent and often significant deterioration in their state of physical well-being.

During the individual's stay they will be encouraged to maintain and foster relationships with significant others in the community and as such may be regularly visited by family, relatives and friends who will also be encouraged to participate in and support the person's plan of care and participate in the person's recovery process.

Therapies and Treatment.

A collaborative approach to care will be embraced in that the care team will encourage the individual to take an active role (and preferably lead) in their recovery by encouraging them to agree their activity programme from the range of therapeutic activities/interventions available to them within the Unit,

the wider hospital setting and in their local communities.

Elements from the 'Treatment Mall' model (Bopp, Riddle, Cassidy, & Markoff, 1996) commonly utilised in America will be adopted – namely that there will be a dedicated space within the Unit where specific sessions will be available to the patient group (also to those not within the Rehabilitation Unit) that will be delivered by a variety of staff such as Pharmacists, AHPs, Psychologists, external Lecturers, Nursing Staff, Addiction Services staff etc and that individuals will incorporate into their individual activity programme in addition to one-to-one time spent with their key worker or closed group sessions within their sub-units. Dedicated and 'bookable' space will be required within the unit to allow the facilitation of this programme of activity and the spaces will require to be flexible with the option to open up dividing walls/partitions to allow for larger groups should that be required or social activity.

Meaningful activity will be vital within the Unit and this will require to be supported by a comprehensive ongoing assessment. Activity will largely be scheduled and will be co-ordinated and provided on a multi-disciplinary basis that will directly involve the individual and their carer as a key part of the team.

Activities will be designed to address a spectrum of health and social care needs, which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.

4 Each person will be engaged in the creation of an individualised activity plan that will be the keystone to their journey of recovery and will reflect their needs, wishes and aspirations and is cognisant of their capabilities.

A key aim will be to provide a platform for social inclusion by re-integrating the patient into what will be their local community on discharge and local services. Working towards independence and discharge will be the underpinning objective at all times.

Effective integrated working and communication with community based health services and other agencies will be a key service element.

Some individual therapies including patient consultations, psychological therapies and advanced psychiatric assessments, will require private, confidential space (significant sound insulation whilst not compromising safety), allowing individuals the opportunity to express their emotions and personal issues.

Wherever possible service users will be encouraged to self cater in some way, whether it is making a cup of tea and a snack through to fully self-

catering all meals.

Space and Observation.

The feeling of space plays a key role in promoting recovery and, as such, it is of the utmost importance that all residents have access to private and communal space both internally, in the form of small quiet areas and externally in the form of significant, safe therapeutic green space. Within the 30-bedded unit there should be sub-units that allows individuals the opportunity to spend time in areas that are potentially only occupied by 8-10 but no greater than 15 people and therefore are quieter and allow an individual to take time out from others and have an area other than their bedroom that they perceive as theirs.

Some behaviours, for instance behaviours associated with self harm, and elevated mood may compromise an individual's safety, increasing personal risk. Therefore there is a requirement to have the ability to facilitate a high level of awareness/supervision and observation of patients who are acutely unwell, in an appropriate environment i.e. in a sub-unit of the larger overall unit.

5

Individuals will be encouraged to not spend large amounts of time in their bedroom during the day but be in day spaces or out in the grounds or community engaged in meaningful activity as per their individual programme, thereby reducing the requirement for staff to be able to observe the unit as a whole at all times. Similarly at night the residents will be encouraged to be in their sub units, each of which will have sitting rooms and a snack kitchen which will allow staff to not be required to observe the larger day/therapy area as it will be locked off and unoccupied.

The preferred layout for the unit would be 3x10-bedded sub-units within the overall unit, by design it would be useful if these 3 bedroom areas could be observed from 2 staff bases overnight, thereby reducing the number of staff required to facilitate adequate supervision overnight

It is envisaged that on any given day a number of individuals will be engaged in therapeutic activity out-with the Unit and Hospital setting, accessing therapies and services within their local Community. This will reduce the number of people in the Unit but will have a requirement that staff are able to be released to support activity out with the Unit setting whilst maintaining reasonable numbers in the Unit to facilitate activity and ensure a safe environment.

Legislation & Governance

We are governed by legislation which directs us to provide practical solutions

for patient safety and also the principles under the Mental Health (Care and Treatment) (Scotland) Act 2003:

Non-discrimination - people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

Equality - all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

Respect for diversity - service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

Reciprocity - where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

Informal care - wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

Participation - service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

Respect for carers - those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

Least restrictive alternative - service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe, effective care, taking account where appropriate of the safety of others.

Benefit - any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

Child welfare - the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Schedule of Accommodation

The accommodation is scheduled in Mental Health Services and is described in the section rehabilitation in-patient accommodation in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The objective of this rehabilitative clinical service will be to provide and/or facilitate access to a range of therapeutic and social interventions, which are planned, co-ordinated and provide a multi-disciplinary and user/carer perspective, based on comprehensive ongoing assessment. A key aim will be to provide a platform for social inclusion, not a stepping stone to exclusion. The Unit will aim to offer systematically organised, personally tailored collaborative help, treatment and care in an atmosphere of hope and optimism.

Whilst the Unit as a whole will encompass thirty beds an individual's bed location will not define their programme of care, rather the configuration of the accommodation will allow the opportunity for some separation dependent on diagnosis, identified risk and potentially to some extent by at which stage in a programme of care the individual is. This would allow potentially vulnerable females to be managed in separate areas from a disinhibited male for example.

It is widely accepted that the recovery process is non-linear (Strauss and colleagues 1985) but that there are stages of change, Davidson, Roe, Andres-Hyman and Ridgway (2010) describe in their 'Transtheoretical Model' five stages of change –

Precontemplation (or pre-recovery)

Contemplation

Preparation

Action

Living beyond Disability (formerly described as maintenance)

There will therefore require to be a real flexibility around the programme of activity and engagement and that the bedroom and sub-unit an individual sleeps in does not define what activities and therapies they can engage in as they may move up and down through these stages.

Each person will be engaged in the creation of an individualised activity plan that will be the keystone to their journey of recovery and will reflect their needs, wishes and aspirations and is cognisant of their capabilities.

A key aim will be to provide a platform for social inclusion by re-integrating the patient into what will be their local community on discharge and local services. Working towards independence and discharge will be the underpinning objective at all times.

Effective integrated working and communication with community based health services and other agencies will be a key service element.

The care environment should:

Create a calm and restful atmosphere and an environment which is non-threatening;

Allow the support and observation of clients who may still be quite acutely unwell or suffering from a relapse of their condition in an appropriate environment whilst protecting their dignity and well-being;

Maximise therapeutic opportunities and the ability to relieve boredom;

Afford no undue separation of staff from patients;

Be attractive, uplifting and interesting in terms of décor, fabric, furnishings and interior and exterior design, as well as the use of natural materials, colour and textures;

Create a feeling of well ventilated space, maximising the use of natural light and minimising the reliance on artificial light;

Garden areas should be designed to provide contrasting textures and colours of plants, providing sensory stimulation and promoting sense of calm and relaxation. There should also be sheltered areas, suntraps and comfortable seating within the overall design.

Provide opportunities for exercise, leisure and education; and

Be sensitive to the needs of physically disabled patients, visitors and staff.

The overall environment within the Unit should be conducive to providing individualised care within a safe, therapeutic setting to enable recovery focussed, person centred care. The emphasis will be on programmes of care

that support activities of daily living and promotion of independent living. Access to and utilisation of green spaces will be vital.

Certain parts of the programmes of activity/therapy facilitated within the Unit will not be exclusively for those resident in the unit, for instance, if a Pharmacist was delivering a session on medications, their effects and side-effects then this should also be available to individuals in the acute setting.

The use of the facilitates within the support cluster will be vital also – Fitness Suite, ADL kitchen, Consulting Rooms that will be used to facilitate groups.

A key element will be to support and enhance social interaction and self care. There will be a need to maintain or develop close links near to the person's own or future tenancy and community as part of the rehabilitative and discharge process. Ensuring integration within community support networks through employment, enablement and recreational/leisure near to their area of residence on discharge.

Role and Function

Care will be person centred and collaborative in nature;

Informed by an understanding of the psychological principles governing how people can learn to change;

Services must respect the individual;

Services must offer privacy and dignity;

Activity will not be solely within the Unit but much will be community based in supporting and guiding people to access their local services on discharge;

The Unit will offer access to a resource in addition to those individuals resident in the unit;

Services must balance the need for safety and security with the provision of a therapeutic environment;

The environment requires to lend itself to obtrusive and unobtrusive observation; and

The environment must be pleasant, safe and the general ambience promote mental health well being.

Bed complement

30 beds provided in single room accommodation with en-suite facilities – these single bedrooms should be preferably be configured in 3 separate wings or sub-units. Each sub-unit should have the ability to be reasonably self-contained in having sitting areas, snack kitchen, interview rooms etc but

utilise the larger communal space for the bulk of planned activity

The service should be able to be developed and flexibility of beds for future service trends is vital which having the ability to sub-divide would facilitate

If 3 x 10-bedded wings then bed provision will likely be gender specific in two of the sub-units and possibly mixed sex in the third dependent on the needs at any given time.

Planned patient activity

Admissions will be accepted from a variety of sources such as;

- Acute wards
- Forensic Rehabilitation Unit
- Community referrals

Usual admissions to this area will represent clients whose needs include;

- Social integration needs to be developed;
- Mental disorder has led to the breakdown of their social infrastructure/support;
- Complexity, nature or intensity of their mental health needs (overall medical, nursing and other clinical needs) require NHS 24 hour care beyond that which can normally be met in the acute setting;
- Mental health needs require frequent, not easily predictable, clinical interventions;
- Require a focussed programme of rehabilitative skilling and/or re-skilling to address deficits in activities of daily living;
- Have potentially become institutionalised due to lengthy in-patient episode of care
- Require assistance to develop skills to maintain/obtain tenancy;
- Require assessment to identify/secure appropriate package of support to facilitate discharge;
- Meet physical well-being requirements and access to physical exercise etc; and
- Build up social, community networks and support to maintain independence and have the best chance of succeeding.

General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the service user group and should become community based as quickly as possible;
- Clinical interventions will be evidence based and reflect current best practice;
- Intervention will be provided in keeping with an individual's collaboratively developed care plan, utilising a person centred

approach;
- The focus will be on meaningful and therapeutic activity based on holistic assessment both within and out-with the Unit, and
- The longer duration of stay should be reflected in the investment in the environment and facilities

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be;

- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience;
- Significant facilities that facilitate self-catering activity;
- Clinical areas that are non threatening and welcoming;
- Bedroom areas should enhance the therapeutic experience and also provide privacy, each bedroom to have a safe or lockable drawer to allow safe storage for self-medication;
- There should be the ability to observe as many of the bedrooms as possible from one point overnight
- All public areas within the ward should be easily observable with no blind spots;
- Significant dedicated outside space accessed from public areas of the Unit;
- Therapy/activity rooms within the main public area of the unit that are utilised in the delivery of programmes of activity;
- There should be one single point of entry to the larger unit, with the ability to close off sub-units at night and if required at other times;
- Ligature points should be eliminated;
- Appropriate access to sheltered designated smoking area - out of doors; and
- Emphasis on space requirement should be on day areas rather than bedrooms.

Corridors: Required features

Corridor area should be kept to a minimum;

Corridors should have no blind spots and allow maximum observation;

Where corridors are not just to get from A to B they should have the opportunity for informal social contact, non institutional and natural light; and

Corridors should provide seated areas for quiet contemplation.

Mixed gender requirements

The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

The design of the facility must comply with current legislation

The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The unit should be self-contained but adjacent to other adult in-patient areas and connected by Support Cluster 2;
- The unit should have access to private communal safe, stimulating and landscaped and sheltered garden areas to gain access to fresh air without compromising safety, privacy or dignity; and
- Close proximity to Support Cluster 2 (link corridor/walkway undercover);

Internal

- The larger public and therapy rooms should be the hub of the Unit off which the sub-units radiate and these should be largely self-contained, the bedrooms being distal to the hub
- Clean and Dirty utility rooms and store room should be away from the main clinical areas;
- Consultation and therapy rooms should be distant from the

bedrooms;

- The bedrooms should be distant from the clean and dirty utility room, store room, interview room, staff base and open plan areas;
- Individual patient bedrooms should be lockable using locks that can be over-ridden by staff;
- The staff base for 3 staff should be at the main unit entrance; and
- The Charge Nurse office should not be at the main entrance to the ward but ideally within the main 'hub'.

Storage facilities

The following storage facilities are required for:

Access to equipment store for all apartments as required

Flat linen and towels

Miscellaneous items

Mobility aids as required

Central patient personal possessions that are not stored in their own room

Range of seasonal equipment (e.g. Christmas decorations)

Spare duvets, pillows and mattresses

Therapeutic equipment

Miscellaneous items

Anticipated developments

The building should be able to meet the needs of future Information Technology developments;

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service; and

Utilisation of smart technologies and alarm systems should be integrated from outset.

Client Group Characteristics

Age and Gender

18 - 64 years male and female although there will be some discretion re those of an older age who may still have contact with 'adult' services

Admission Rates

Admissions will be via planned transfer and following assessment and acceptance criteria being met

Diagnoses

Clients admitted to the Unit will have a varying range of mental health problems/illness and may experience issues re drug/alcohol misuse

Anticipated illness-related behaviours

Clients who are admitted to the Unit may display the following:

- Aggressive behaviour (verbal and physical)
- Aimless or ritualistic behaviours
- Disinhibited behaviours
- Lack of personal risk awareness
- Engage in challenging behaviours – deliberate self harm, absconding, use of alcohol or non-prescribed substances
- Unpredictable and impulsive behaviours due to active psychotic symptoms
- Behaviours associated with negative symptoms of longer term mental illness – lacking in motivation and confidence

Anticipated clinical risks

Clients who are admitted to this ward may be at risk from the following

- Deliberate self harm
- Harm to others
- Absconding
- Poor mobility
- Poor motivation
- Self neglect
- Suicidal intention
- Isolation in a community environment (social breakdown)

Institutionalisation

Patient dependency characteristics

- Poor physical health and associated mobility problems;
- Institutionalisation;
- Negative symptoms associated with enduring, longer term mental illness;
- Level of functioning and ability to do everyday tasks reduced (self-help compromised);
- Treatment resistant; and

- Communication issues.

Therapeutic Intent

Principal aims of clinical care

- Offer systematically organised, personally tailored collaborative help, treatment and care in an atmosphere of hope and optimism.
- To provide individualised care to people experiencing mental illness who require a period of rehabilitation to facilitate a return to independent or supported community living;
- To work collaboratively with the individual to improve their mental and physical health and functioning and social interaction;
- Maximising person's level of independence; and
- To minimise the time spent in the in-patient setting by providing a comprehensive outreach function to assist in returning individual to the community more rapidly.

Therapies

- A collaborative approach to care will be embraced in that the care team will encourage the individual to take an active role (and preferably lead) in their recovery by encouraging them to agree their activity programme from the range of therapeutic activities/interventions available to them within the Unit, the wider hospital setting and in their local communities.
- Individual and group therapies will be provided in an appropriate setting within and out with the facility in accordance with an individualised care plan;
- Activities will be designed to address a spectrum of health and social care needs, which typically include physical, psychological, recreational, life-skill, cultural, spiritual and social elements.
- Therapies will enhance the care experience and will be focussed upon specific agreed interventions and outcomes;
- A key aim will be to provide a platform for social inclusion by re-integrating the patient into what will be their local community on discharge and local services. Working towards independence and discharge will be the underpinning objective at all times;
- Wherever possible service users will be encouraged to self cater in some way, whether it is making a cup of tea and a snack through to fully self-catering all meals; and
- Therapies should be in keeping with the Recovery/Tidal model and be evidence based.

Therapeutic facilities required

- Adequate space to provide therapeutic interventions as described within the 'Numbers and Types of Rooms' and within the schedule of accommodation, due to the function of the Unit these areas are the focus of the environment
- Adequate storage space to contain therapeutic equipment will be required within the units.

Planned clinical meetings

- Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis
- Access to Tribunal accommodation to comply with Mental Health Act
- Nursing handover reports
- Multi-disciplinary meetings
- Consultant meeting
- Junior Doctor reviews
- CPA meetings
- Case conferences
- Clinical interventions

Other Meetings

- There will require to be the facility for community meetings which may include potentially all 30 residents or be within the sub-units. The open plan hub area should be able to accommodate such a meeting.

Clinical risk management principles

- Based on a proactive approach to positive risk management (embedded within the service);
- Approach to care will be collaborative and will attempt to support the individual to retain control over their actions and treatment plan wherever possible;
- Unit will be an open Unit and individual's will be individually managed to minimise impact on fellows should there be restrictions to their movement as per risk assessment and management plan;
- Close adjacencies to other AMH wards and IPCU will provide support for staff in case of emergency situations and allow transfer of an individual should the identified risk require this;
- Formalised assessment tools within FACE will be utilised and process reviewed on an ongoing individualised basis;
- Environment will be anti-ligature in nature; and

- Admissions will be planned in nature and subject to meeting acceptance criteria and potential risk issues being manageable within the Unit

Operational Procedures

Working day plans

The unit will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

- Multidisciplinary team handovers will take place at set times throughout the day as determined by the ward team;
- The unit will be staffed 365 days per year and 24 hours per day and will provide an outreach service to those in process of phased discharge;
- Unit will assist in assessment/advice of individuals in other care settings with regards to rehabilitative opportunities and offer the ability for individuals from other areas to attend and participate in activities within the unit; and
- Staffing levels and shift patterns will be set out to achieve the optimum level of therapeutic care in a safe and secure setting.

Admission procedures

Admissions will be via planned transfer and following assessment and satisfaction that admission criteria are met

Record-keeping storage

- A paper light system will be utilised but all clinical case records require to be stored within a lockable cabinet within a lockable room – electronic record keeping will minimise the requirement for stored records
- Items of secure stationery require to be stored within a lockable cabinet
- Visiting arrangements
- Visiting arrangements will be as agreed with the unit team and may take place within the dining area or consultation rooms within the Unit or out with. Visiting should not interfere with planned programmes of care and ideally should be planned as part of the activity programme for an individual.
- Children visiting should be planned in advance and in agreed areas of the Unit.

Mealtimes/dining arrangements

Dining arrangements will require to be flexible and provide healthy eating options and between meal snacks and access to beverages available

Facilities must promote the ambiance of the meal experience

It is hoped that the majority of individuals will self cater in some way with the hope that those nearing discharge will be fully self-catering, the requirement for a number of ADL kitchens and sitting areas reflecting this

Between meal snacks and access to beverages

There will be a larger ADL kitchen in the hub with snack and beverage preparation areas in each of the sub-units.

Laundry facilities and linen management

There will be a personal laundry facility in each sub unit to allow individuals to launder and iron their clothes.

Bed linen will be provided from hospital stock and laundered by NHS facilities

Functional content

Number of Inpatient Beds/Treatment Spaces

30 in total, 27 single bedrooms, 3 larger bedrooms, one in each sub-unit.

Investigative/Diagnostic/Treatment Capacity:

If not available onsite will require to be accessed at nearest General Hospital and other specialist services as required.

Outpatient Service (Number of Sessions and specialist functions):

Will provide outreach support for a time on discharge to ease transition.

Individuals non-resident in the Unit will be afforded the opportunity to participate in planned activity.therapy sessions as agreed appropriate with their care team.

Specialist Technical Infrastructure Requirements

- Telephones for internal and external communications;
- IT Systems for recording patient information electronically e.g. FACE;
- System that have PC Pens and Tablets for utilisation by service users to participate in care planning etc;
- PIN point system alarms;
- Nurse Call System;
- Slow Door Systems;
- Emergency alerts for Immediate Response Team;
- Mobile phones for escort duties;
- Portable oxygen cylinders;
- Security Entry out of hours – intercom at entrance to wards;
- ECG machine; and
- Emergency Medication Box for escort duties.

Projected Future Activity

By encompassing the historical 'non-acute' function with the intensive rehabilitative model then it is anticipated that the unit should run at approaching 100% occupancy.

The model of care will be reviewed and updated to reflect modern mental health approaches to rehabilitation services and current evidence based practices and latest research

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Pharmacy	• Advice, supplies and education	Essential
Therapies service	• Ease of access • Engagement	Essential
Public transport	• Mobility and rehabilitation	Essential
Leisure and social facilities	• Part of daily living programme, social inclusion	Essential
Acute Wards	• Source of referral, staff support. Access if requiring to transfer disturbed individual.	Essential
IPCU	• Access if requiring to transfer disturbed individual.	Essential
Community Mental Health Teams	• To facilitate communication re discharge planning	Desirable
Support Cluster 2	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies •	Essential

Future Service Delivery Risks

- Future client requirements & activity unclear and unpredictable;
- Delayed discharges due to tenancy issues or options available within Local Authority to support discharge;
- Stagnation due to lack of community services to move people on to (especially re Housing requirements);
- 'Split' of client group may change with more disturbed individuals requiring greater support and intervention by staff with impact on staffing resource and challenge to maintain programmes of activity;
- Implication of unknown long term drug abuse;
- Organic dementia in younger population -changes in practice;
- Changes in diagnostic pattern for admission e.g. personality disorders, challenging behaviour, ASD, brain injury, ARBD;
- Ageing population – more elderly patients;
- Demographic changes;
- Integrated Care Pathways (ICP);
- HEAT targets – readmission rates, suicide prevention etc;
- Positive risk taking;
- Other services and community based agencies developing;
- Bed availability and bed blocking due to the lack of alternative community provision;
- Future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need;
- All services being on one site will increase expectation of rehabilitation unit helping out other areas at times of increased demand with knock-on effect on programme within ward;
- All adult inpatient beds are now housed on one site, therefore contingency plans need to be considered in case of emergencies;

Appendix Q - Elderly Mental Health Wards

Introduction and outline of services

Departmental Function

The current purpose of the elderly mental health service is to offer an integrated, comprehensive and flexible service for people aged 65 and over with functional mental health problems; for all adults with a diagnosis of dementia and their respective carers.

The service is provided through a combination of community, day care and inpatient services working across Ayrshire and Arran. There is a significant degree of partnership working with Local Authority community care older people's services both operationally and in the strategic planning of services, which will be further developed based on identified best practice.

This template is in two sections, the elderly functional admission ward and elderly organic admission ward.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in Mental Health Services and is described in the section entitled MH 15 Bed Wards - Elderly in the Schedule of Accommodation.

The total bed complement for Elderly Mental Health Services will be 30, initially divided into two 15 bed wards. The Elderly Mental Health unit should be designed with enough flexibility to allow a change from 2 x 15 bed wards to another configuration i.e. 1x 12 bed and 1 x 18 bed to meet changing demands.

Model of Care – Elderly Functional Admission Ward

Descriptive Overview

The elderly functional admission ward will be suitable for the delivery and receiving of therapeutic psychiatric care. The environment should be conducive to providing care in a safe, homely type setting. The design should be in accordance with the NHS Design Audit Tool.

Role and Function

The ward will provide assessment and treatment for older people with mental health problems. The assessment will be part of a multi disciplinary team approach and a formulation of a plan of care based on this assessment will be implemented for each patient and a comprehensive discharge plan agreed.

Usual admissions to this area will represent clients who:

- Are deemed to be in crisis and have an identifiable psychiatric illness;
- Require high levels of nursing observation;
- Are at risk of harm to self or others;
- Are at risk of severe self neglect; and
- Require to be in hospital under terms of the Mental Health Act.

The ward function will ensure that the following principles are met:

Care will be patient centred;

Services must respect the individual;

Services must offer privacy and dignity;

Services must balance the need for safety and security with the provision of a therapeutic environment;

The environment requires to lend itself to obtrusive and unobtrusive observation; and

The environment must be pleasant, safe and the general ambience promotes mental health well being.

Bed complement

15 beds provided in single room accommodation with en-suite facilities

The Elderly Mental Health unit should be designed with enough flexibility to allow a change from 2 x 15 bed wards to another configuration i.e. 1x 12 bed and 1 x 18 bed to meet changing demands.

Bed provision will be in accordance with mixed sex guidance

Planned patient activity

Admissions will be accepted from a variety of sources such as:

Community Mental Health Teams

General Practitioners

Other hospitals

Care Homes

The average length of stay will be four to six weeks.

General principles of operation

All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group;

Clinical interventions will be evidence based and reflect current best practice; and

Invasive clinical interventions such as restraint, rapid tranquilisation, venepuncture and assistance with personal hygiene tasks will be undertaken in a safe, non stimulating environment that respects the individual's privacy and dignity, preferably in a patients own bedroom (one of the 2 larger ones).

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be;

- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency;
- Maximum use of natural and artificial light – daylight should be used whenever possible as it delivers good colour rendition;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience;

- Clinical areas that are non threatening and welcoming; and
- Common sitting and activity areas should be homely and domestic while lending themselves to recovery.

Bedroom areas should enhance the therapeutic experience and also provide privacy

There will need to be flexibility in approximately 10% of beds without compromising mixed sex guidelines;

Adequate signage should be provided within ward areas;

All areas within the ward should be easily observable with no blind spots;

There should be one single point of entry to the ward;

Should be a ligature free environment; and

Outside designated smoking area should be well ventilated thereby preventing smoke pollution of adjacent areas (currently a review of smoke free premises).

Corridors: Required features

Corridor design is an important feature within the ward and should not just be seen as a means of getting from A to B;

Corridors should provide seated areas for quiet contemplation;

Corridors should have no blind spots and allow maximum observation; and

Handrails should be fitted in accordance with Dementia Services Development Design Guidelines.

Mixed gender requirements

The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the facility must comply with current legislation
- The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

- The design of the unit must comply with current legislation

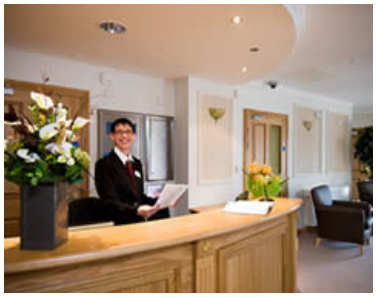
Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

The wards should have a shared reception/interview area



The elderly admission wards should be adjacent to each other and connected by a common corridor; and

The wards should each have access to their own enclosed, safe, stimulating and raised garden areas. The garden area should be secure and be enclosed by a timber fence which will be bordered by shrubs.

The wards should have ease of access to the store rooms, cleaners' (housekeeping) room, WC, patients laundry room, interview room and social/activity/therapy area and be in close proximity to them;

The wards should have easy access to Support Cluster 3 without having to go outside; and

The wards should have access to spiritual care area.

Internal

The open plan dining area and pantry should be close to the entrance of the ward and distant to the bedrooms

Clean and dirty utility rooms and linen room should be away from the main clinical areas;

Reception/Interview rooms should be distant from the bedrooms;

The bedrooms should be distant from the clean and dirty utility rooms, linen room, interview room and open plan dining area;

The charge nurses office should be close to the office for 2 people but not at the main entrance of the ward; and

The treatment room, bath, WC and wash : assisted, sitting room, office for 2 staff, disabled WC's and pantry should be sited in such a way that allows ease of access and use but distant from the dining room.

Storage facilities

The following storage facilities are required for:

Are required for

- Clinical equipment such as moving and handling equipment
- Flat linen and towels
- Incontinence equipment
- Miscellaneous items
- Mobility aids
- Patient personal possessions that are not stored in their own room
- Range of seasonal equipment (eg Christmas decorations)
- Spare duvets, pillows and mattresses
- Therapeutic equipment
- Wheelchairs
- Hoists (portable ones)

Anticipated developments

The building should be able to meet the needs of future Information technology developments

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

65 years and over, male and female

Admission Rates

Admissions are accepted 365 days per year, 24 hours per day

Diagnoses

Clients admitted to the ward suffer from an identifiable mental disorder

Anticipated illness-related behaviours

Aggressive behaviour (verbal and physical);
Aimless or ritualistic behaviours;
Clients who are admitted to this ward may display the following;
Disinhibited behaviours;
Lack of personal risk awareness;
Suicide risk; and
Unpredictable and impulsive behaviours.

Anticipated clinical risks

Clients who are admitted to this ward may be at risk from the following:
Deliberate self harm;
Harm to others;
Poor mobility;
Poor motivation;
Self neglect; and
Suicidal intention.

Patient dependency characteristics

Poor physical health and associated mobility problems

Therapeutic Intent

Principal aims of clinical care

In-patient care is one element of the care pathway. It offers time limited safety, support, therapy and treatment to people who are too unwell to be cared for in a non hospital setting.;

Is not to be respite from other elements of the care pathway;

Is to improve the person's mental and physical health and functioning; and

Is to provide a stepping stone to inclusion, not a departure point for exclusion.

Therapies

Individual and group therapies will be provided within the facility on a planned and ad-hoc basis; and

Therapies will enhance the care experience and will be focussed upon specific interventions and outcomes.

Therapeutic facilities required

Adequate space to provide therapeutic interventions as required within the ward;

Adequate space for physical activities; and

Adequate storage space to contain therapeutic equipment will be required within the ward.

Planned clinical meetings

Adequate space is required for approximately 12 people to provide for a variety of clinical meetings which will take place on a daily basis;

Case Conferences;

Consultant Meeting;

CPA Meetings;

Junior Doctor Reviews;

Multi-disciplinary meetings;

Nursing handover reports; and

One to one clinical interventions.

Other Meetings

Appraisal/supervision meetings;

Meetings with extended care team;

Meetings with relatives; and

Training and development and educational events for staff and relatives.

Clinical risk management principles

Based on this an initial risk management plan is developed;

On admission each patient is assessed in accordance with the recognised risk assessment tool;

One element of this plan is to determine the person's observation status; and

Risk management for this client group is important. The environment must be conducive to delivering the risk management plan.

Operational Procedures

Working day plans

The wards will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

Nursing handovers will take place a minimum of three times per day, mainly morning, afternoon and evening.

The wards will be staffed 365 days per year and 24 hours per day

Admission procedures

Admissions are accepted at anytime. Some are arranged on a planned basis, others are emergency

Record-keeping storage

All clinical case records require to be stored within a lockable cabinet within a lockable room, office – electronic record keeping has been implemented and records are stored as per record keeping guidelines in the admission wards .

Items of secure stationery require to be stored within a lockable cabinet

Visiting arrangements

Facilities should be made available for visits of personal pets;

If the patients condition allows, visitors can take them to the café area in the main entrance;

Visiting arrangements will be as agreed with ward team and may take place within the visitors room or out with the ward area; and

A small sitting room will be available within the ward.

Mealtimes/dining arrangements

Dining will be ward based and there will be three mealtimes per day; and

Facilities must promote the ambiance of the meal experience.

Between meal snacks and access to beverages

Facilities should be available within the pantry area to permit the making of hot and cold drinks and snacks out with recognised mealtimes

Laundry facilities and linen management

washing, drying, ironing and labelling of personal clothing will be carried out in the central laundry on site

Model of Care – Elderly Organic Admission Ward

Descriptive Overview

The elderly organic admission ward will be suitable for the delivery and receiving of therapeutic psychiatric care. The environment should be conducive to providing care in a safe, homely type setting. The design should be dementia friendly and in accordance with the Dementia Services Development Centre, NHS Design Audit Tool.

The fundamental design principle is that of being able to find your way easily from room to room in the course of normal daily activities.

Role and Function

The ward will provide assessment and treatment for older people with mental health problems. The assessment will be part of a multi disciplinary team approach and a formulation of a plan of care based on this assessment will be implemented for each patient and a comprehensive discharge plan agreed.

Usual admissions to this area will represent clients who:

- Are deemed to be in crisis and have an identifiable psychiatric illness;
- Require high levels of nursing observation;
- Are at risk of harm to self or others;
- Are at risk of severe self neglect; and
- Require to be in hospital under terms of the Mental Health Act.

The ward function will ensure that the following principles are met:

- Care will be patient centred;
- Services must respect the individual;
- Services must offer privacy and dignity;
- Services must balance the need for safety and security with the provision of a therapeutic environment;
- The environment requires to lend itself to obtrusive and unobtrusive observation; and
- The environment must be pleasant, safe and the general ambience promotes mental health well being.

Bed complement

15 beds provided in single room accommodation with en-suite facilities

The Elderly Mental Health unit should be designed with enough flexibility to allow a change from 2 x 15 bed wards to another configuration i.e. 1x 12 bed and 1 x 18 bed to meet changing demands.

Bed provision will be in accordance with mixed sex guidance

Planned patient activity

Admissions will be accepted from a variety of sources such

Community Mental Health Teams;

General Practitioners;

Other hospitals; and

Care Homes.

General principles of operation

- All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group;
- Clinical interventions will be evidence based and reflect current best practice; and
- Invasive clinical interventions such as restraint, rapid tranquilisation, venepuncture and assistance with personal hygiene tasks will be undertaken in a safe, non stimulating environment that respects the individual's privacy and dignity, preferably in a patients own bedroom (one of the 2 larger ones).

Design Synopsis

In addition to the core design synopsis/critical features, unique features to this environment will be;

- All areas within the ward should be easily observable with no blind spots
- Bedroom areas should enhance the therapeutic experience and also provide privacy

Bedrooms

- Toilet visible from bed-head position;
- Bed accessible from both sides;
- Space for monitoring equipment; and
- Dado rail to assist mobility.

- Clinical areas that are non threatening and welcoming;
- Common sitting and activity areas should be homely and domestic while lending themselves to recovery and should not be open plan. All sitting areas and activity areas should have natural daylight and a pleasant outlook;
- Outside designated smoking area should be well ventilated thereby preventing smoke pollution of adjacent areas;
- Dining facilities that enhance the meal experience;
- Discreet hotel and storage services;
- Doors, locks and windows should be of a design which is anti-barricade and enables access by staff in an emergency; and
- Appropriates colours and signage should be used.

- Ligature points should be eliminated;

- Maximum use of natural and artificial light;
- Maximum use of natural and artificial ventilation;
- The provision of hot/cold drinks should be available in the common sitting/activity areas;
- There should be no stepped areas within the ward; and
- There should be one single point of entry to the ward.

Corridors: Required features

- Corridor design is an important feature within the ward and should not just be seen as a means of getting from A to B. Dementia Services Development Design Guidelines (DSDC) guidelines should be considered;
- Corridors should have no blind spots and allow maximum observation;
- Corridors should provide seated areas for quiet contemplation; and
- Handrails to be provided in corridors of elderly mental health services.

Mixed gender requirements

- The design of the unit must comply with current mixed sex guidance legislation

Disabled access requirements

- The design of the facility must comply with current legislation
- The building should be sensitive to the needs of physical and sensory disabled patients, staff and visitors.

Privacy and dignity requirements

- The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The elderly admission wards should be adjacent to each other and connected by a common corridor;
- The wards should have access to enclosed, safe, stimulating and raised garden areas; the garden should be designed using Dementia Services Development Centre's design principles. The garden should be secured by the use of a timber fence which will be bordered by shrubs.
- The wards should have ease of access to store rooms, cleaners' (housekeeping) room, WC, patients laundry room, interview room and social/activity/therapy room and be in close proximity to them;
- The wards should have easy access to Support Cluster 3 without having to go outside; and
- The wards should have access to the spiritual care area.

Internal

- Clean and dirty utility room and linen room should be away from the main clinical areas;
- Reception/Interview room should be distant from the bedrooms;
- The bedrooms should be distant from the clean and dirty utility room, linen room, interview room [check name], charge nurse office and open dining area;
- The charge nurse office should be at the main ward entrance;
- The open dining area and servery should be close to the entrance of the ward and distant to the bedrooms; and
- The treatment room, bath, WC and wash (assisted), social/activity/therapy area, sitting room, office for 2 staff, WC dual access and hand-wash, accessible, wheelchair assisted and pantry should be sited in such a way that allows ease of access and use.

Storage facilities

The following storage facilities are required for:

- Clinical equipment such as moving and handling equipment;
- Flat linen and towels;
- Incontinence garments;
- Miscellaneous items;
- Mobility aids;
- Patient personal possessions that are not stored in their own room;
- Range of seasonal equipment (eg Christmas decorations);
- Spare duvets, pillows and mattresses;
- Therapeutic equipment; and
- Wheelchairs.

Anticipated developments

The building should be able to meet the needs of future Information Technology developments; and

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

Generally 65 years and over, however the ward will accommodate younger people with dementia at times.

male and female

Admission Rates

Admissions are accepted 365 days per year, 24 hours per day.

Diagnoses

Clients admitted to the ward suffer from an identifiable organic mental disorder

Anticipated illness-related behaviours

Clients who are admitted to this ward may display the following;

- Aggressive behaviour (verbal and physical);
- Aimless or ritualistic behaviours;
- Disinhibited behaviours;
- Lack of personal risk awareness;
- Resistiveness to care interventions;
- Unpredictable and impulsive behaviours; and
- Wandering behaviour.

Anticipated clinical risks

- Clients who are admitted to this ward may be at risk from the following:
- Falls;
- Harm to others;
- Poor mobility;
- Poor motivation;
- Poor nutrition; and
- Self neglect.

Patient dependency characteristics

- Incontinence;
- Other neuropsychiatric symptoms;
- Poor mobility problems;
- Poor physical health;
- Significant cognitive impairment; and
- Tissue viability problems.

Therapeutic Intent

Principal aims of clinical care

- Assessment of a person's future care and needs and how they can be safely met;
- In-patient care is one element of the care pathway. It offers time limited safety, support, therapy and treatment to people who are too unwell to be cared for in a non hospital setting;
- Is not to be respite from other elements of the care pathway; and
- Is to improve the person's mental and physical health and

functioning.

Therapies

Individual and group therapies will be provided within the facility on a planned or ad-hoc basis; and

Therapies will enhance the care experience and will be focussed upon specific interventions and outcomes.

Therapeutic facilities required

Adequate space to provide therapeutic interventions as required within the ward; and

Adequate storage space to contain therapeutic equipment will be required within the ward.

Planned clinical meetings

- Adequate space is required to provide for a variety of clinical meetings which will take place on a daily basis;
- Case Conferences;
- Consultant Meeting;
- CPA Meetings;
- Junior Doctor Reviews;
- Multi-disciplinary meetings;
- Nursing handover reports; and
- One to one clinical interventions.

Other Meetings

- Appraisal/supervision meetings;
- Meetings with extended care team;
- Meetings with relatives; and
- Training, development and educational venues.

Clinical risk management principles

- Based on this an initial risk management plan is developed;
- On admission each patient is assessed in accordance with the

recognised risk assessment tool;
- One element of this plan is to determine the person's observation status; and
- Risk management for this client group is important. The environment must be conducive to delivering the risk management plan.

Operational Procedures

Working day plans

The wards will be open 365 days per year and 24 hours per day

Staffing arrangements and shift patterns

Nursing handovers will take place a minimum of three times per day, mainly morning, afternoon and evening; and

The wards will be staffed 365 days per year and 24 hours per day.

Admission procedures

- Admissions are accepted at anytime. Some are arranged on a planned basis, others are emergency.

Record-keeping storage

All clinical case records require to be stored within a lockable cabinet within a lockable room. E-records are implemented within admission wards and are stored under record keeping guidelines; and

Items of secure stationery require to be stored within a lockable cabinet.

Visiting arrangements

Access facility for the visiting of personal pets;

If the patients condition allows, visitors can take them to the café area in the main entrance; and

Visiting arrangements will be as agreed with ward team and may take place within the visitors room or outwith the ward area.

Mealtimes/dining arrangements

Dining areas will require to be of varying sizes to accommodate people with severe dementia and/or with wandering behaviour ;

Dining will be ward based and there will be three mealtimes per day; and

Facilities must promote the ambiance of the meal experience.

Between meal snacks and access to beverages

Facilities should be provided within the pantry area to allow for the making of hot and cold drinks and snacks out with the recognised mealtimes.

Laundry facilities and linen management

A room is required to provide for the washing, drying, ironing and labelling of personal clothing.

Functional content

Number of Inpatient Beds/Treatment Spaces

30 beds, 15 functional and 15 organic beds

Investigative/Diagnostic/Treatment Capacity:

Access to labs and imaging will be required

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable

Specialist Technical Infrastructure Requirements

2222 (emergency response)

ECT

Gas cylinder storage

Intercom

IT systems

O2

Personal alarm systems

Radio comms, pagers

Satellite communications

Security entry – slow doors

Suction

Telemedicine/teleconferencing (tele-education)

Projected Future Activity

Increase in number of older people which will impact on the potential number of people with dementia and other mental illness. Increased demands on community mental health teams in respect of assessment, interventions and delivery of appropriate support packages both for person with dementia and other mental illness, their families and carers.

The projected increase in the elderly population will invariably impact on the demand for inpatient beds.

The key projected demographic change that will impact on mental health services in the medium term will be a significant increase in the proportion of older people within Ayrshire and Arran.(General Register Office for Scotland, 2007, Projected Population of Scotland (2006 based)

Currently 18.2% of the Ayrshire and Arran population is aged over 65 years (up from 17% in 2004). There is a projected rise in the 65-74 population in Ayrshire between 2006 and 2021, of 14%, from 36,851 to 42,124. Between the Local Authority areas, North Ayrshire is projected to increase by 16%, East Ayrshire by 11% and South Ayrshire by 13%. (The Social Work Services Inspectorate for Scotland, 1996: Population Needs Assessment in Community Care. Handbook for Planners and Practitioners)

More significantly, the over 75 population is projected to rise by 44%, from 29,995 to 43,192. The increase in the over 75 population is projected to vary between Local Authority areas with rises of 41% in East Ayrshire, 50% in North Ayrshire and 41% in South Ayrshire. [2]

The rates of dementia are also likely to rise commensurately: an estimated 5% of those aged 60-80 and 20% of those aged 80+ will have a form of

dementia

The overall age distribution of the Ayrshire population is as shown in Table 1 below:

Table 1

(General Register Office for Scotland mid-year estimates, 2007.)

Area	Under 15 years	15-64 years	65+	Total
Ayrshire	60,483	239,591	66,946	367,020
	16.5%	65.3%	18.2%	100%
North	23,144	88,639	23,977	135,760
	17%	65.3%	17.7%	37%
East	20,060	79,317	20,193	119,570
	16.8%	66.3%	16.9%	32.6%
South	17,279	71,635	22,776	111,690
	15.5%	64.1%	20.4%	30.4%

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Adult mental health	Professional development Ease of transition	Essential
Geriatric medicine	Ease of transition	Essential
Local Authority social work staff	Facilitate timely discharge and establish appropriate care packages	Essential
Primary care colleagues	Establishment of seamless care	Essential
Other healthcare professionals	Maintenance of effectiveness of multi-disciplinary working	Essential
Universities (Glasgow and West of Scotland)	Continuing development	Essential
Voluntary sector	Collaborative working	Essential
Leisure and recreational facilities	Improved physical health and mental wellbeing	Important
Patient focus public involvement	Engaging service users and carers to ensure establishment of appropriate quality services	Essential
Closer links with local community	to minimise stigma	Desirable
Support Cluster 3	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies	Desirable

* Category: Essential/Important/Desirable

Future Service Delivery Risks

Failure to secure appropriate decant facilities if required for the current Pavilion 1 and Pavilion 2 patients.

Observation of disturbed patients

Unable to attract appropriately qualified staff, including medical and nursing staff.

Financial resources

Current service risks

Isolated from rest of elderly mental health inpatient areas

Lack of appropriate daily living space

Lack of single rooms

Professional isolation due to standalone nature of elderly mental health unit

Accommodation – not fit for purpose

Patient mix – gender

Limited private space for visitors and family members

Poor access for disabled and hotel services and staff/patients, no pavements

Long walk from bus stop to ward areas and clinic

Isolated out of hours and staff backup

Observation of disturbed patients

Unable to predict demand for inpatient beds

Male/female mix segregation

Appendix R - Rehabilitation Ward (General Health)

Introduction and outline of services

Departmental Function

The care of the elderly directorate provides a range of inpatient, outpatient and day hospital Rehabilitation services on the Ayrshire Central site.

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Scope of Service/Specialist Services Provided

The accommodation is scheduled in the Community Hospital and is described in the section entitled Rehabilitation ward in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The principal policy goal of the Reshaping Care for Older People Programme is to “optimize independence and wellbeing for older people at home or in a homely setting”. The vision for the future delivery of Services for Older People on the new Ayrshire Central site reflects this overarching goal and is based on an integrated pathway approach that encourages multi-disciplinary and multi-agency working model across health and social care and which allows the patient a seamless journey between primary care, secondary care and the community.

This vision reflects NHS Ayrshire and Arran’s commitment to Reshaping Care for Older People and is an integral part of North Ayrshire CHP’s local Reshaping Care for Older People strategy. The North Ayrshire Joint Commissioning Strategy 2009-12 has been developed with input from key stakeholders, including older people and carers, to support the following key priority areas:

Delivering a Joint Commissioning Strategy for older people

Establishing an integrated model of rehabilitation and enablement services that includes Local Authority, Health, Voluntary and Independent sectors.

Reducing emergency admissions amongst people over 75 years

Reducing delayed discharges from a maximum of 6 weeks to 4 weeks

Shifting the balance from hospital based to community based intensive support services for older people. This will include development of Housing options that support independence for people with long term health conditions.

Developing services which sustain independence and promote self management amongst older people reducing Care Home placements

Developing informal social networks which promote the health and wellbeing of older people

Reducing hospital bed days experienced by older people due to delayed discharges and emergency admissions

Implementing the national Dementia Strategy

Implementing the Housing Options Strategy for Older People

In order that patients can be cared for in the most appropriate setting for their needs a range of in-patient, out-patient, day hospital and community services for older people will be provided. Access to the Ayrshire Central Hospital will be through a multidisciplinary Team who will be responsible for the patients care whilst in Ayrshire Central and also responsible for ensuring a smooth and supported discharge to allow patients to return to the community at the earliest opportunity.

A range of services for older people are currently being developed through our Reshaping Care Programme supported by the Change Fund aimed at preventing avoidable hospital admission and/or facilitating early discharge by offering more care in the community and increased levels of community rehabilitation. Work is ongoing to redesign the model of care currently provided in our Day Hospitals and to develop a more community based geriatric service. This will enable patients to be admitted to Ayrshire Central directly from the community where appropriate thus avoiding the need to be admitted to Crosshouse. This will ease the patient journey and reduce the overall length of stay.

Our vision will be supported by the development of an integrated health and social care model which will bring together a wide range of services. These integrated hubs will have a Single Point of Contact and will potentially include:

- Intermediate Care and enablement services
- Home from hospital services,
- Public Health Services
- Community Nurses
- Social Work and home care staff
- Allied Health Professionals
- Community Ward staff

- Community based Geriatrics service
- Community based elderly mental health services

The integration and potential co-location of these staff will promote a multi-disciplinary, multi-sectoral approach to services for older people, breadth of skills and expertise across the team, promote flexibility and help the team to develop a collective understanding of the needs of the local population and maintain long-term sustainability of services.

The vision also recognizes that frail older patients deemed ready for discharge are a dynamic groups whose care plan and support needs may change and local pathways will ensure optimal opportunity for individuals with complex need to exhibit late and often unexpected potential for a home based discharge.

The new hospital facilities will enable a range of planned care services to be developed locally ensuring the hospital is seen as a local community resources centre providing a bridge between home and acute hospital care.

Although there will be an increasing emphasis on community based rehabilitation a number of specialist wards and services will continue to provide rehabilitation services for those who need them. It is anticipated that changes in service delivery will mitigate against increased activity as a result of demographic changes. This will comprise of:

30 assessment and rehabilitation beds for patients transferring from the wards at Crosshouse

Outpatient services including a daily geriatric immediate access clinic (Mon – Fri 1.00-3.30pm) which will help to prevent avoidable hospital admissions as well as allow direct admission to the new community hospital where appropriate.

12 day hospital places

In partnership with the three Local Authorities the Rapid Response Service has been transformed over the last eighteen months from a hospital based service into an integrated locality based intermediate Care and Enablement Service. The skill mix within the team has been strengthened and the team now comprises of staff from across the all the allied health professions, community pharmacy, nursing and social care as well as input from Consultant Geriatricians and advanced Rehabilitation Nurse Practitioners.

This Intermediate Care Team is also integral to the development of a new Falls Pathway. This redesign work will allow more complex rehabilitation to

be undertaken in the community and will contribute to a reduction in admissions and a reduction in length of stay for older people.

The Care of the Elderly vision also anticipates a physical adjacency with the Elderly Mental Health wards would provide the potential for developing flexible services and for sharing knowledge, training & experience. There is also a potential for shared space between the two specialties.

The Care of the Elderly Directorate will work with the Diagnostics Directorate to ensure that there are appropriate services on the Ayrshire Central site and where this is not possible that services at Crosshouse are scheduled to ensure that the patient pathway is streamlined to ensure that patient can be transferred to Ayrshire Central without delay or unnecessary increases in length of stay.

Role and Function

A range of in-patient, out-patient, day hospital and community services for older people will be provided.

Although there will be an increasing emphasis on community based rehabilitation a number of specialist wards and services will continue to provide in-patient services for those who need them.

Bed complement

- 30 inpatient General Rehabilitation beds

General principles of operation

Design Synopsis

- Windows should be of a height that allows patients to see out of them when seated
- Maximise use of natural light;
- Disability Discrimination Act compliant;
- Occasional seating in corridors for patients to rest;
- Seated areas for quiet contemplation;
- Link with current dementia/visual impairment services to seek advice on design and decoration;
- Look at Palliative Care specific area/suit to include relative overnight facilities. Should there be consideration of a couple of rooms being two bedded to allow for management for partner admissions, management of challenging behaviour, depression/social isolation;
- At least one bathroom per ward to have overhead tracking hoists;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience;
- Clinical areas that are non threatening and welcoming;
- Common sitting and activity areas should be homely and domestic while lending themselves to recovery and should not be open plan;
- Bedroom areas should enhance the therapeutic experience and also provide privacy;
- Adequate signage should be provided within ward areas;
- All areas within the ward should be easily observable with no blind spots;
- There should be one single point of entry to the ward;
- Should be a ligature free environment; and
- Consideration should be given to the distance that carers would have to walk taking into account their mobility, this should kept to a minimum.

Corridors: Required features

- Maximise use of natural light;
- DDA compliant;
- Hand Rails required;
- occasional seating required for patients to rest;
- Link with current dementia/visual impairment services to seek advice on design and decoration; and
- Wide capacity – to take 2 way traffic.

Mixed gender requirements

- The design must comply with current guidance and legislation;

- Double room for partner admissions; and
- Alternative sitting areas – specifically television areas and sitting areas.

Disabled access requirements

- Must be DDA compliant, including loop system;
- All rooms/en-suites must be large enough to accommodate the use of patient hoists;
- Specific one bedroom per ward to facilitate bariatric patients; and
- Comfortable door width for ease of access/movement of beds.

Privacy and dignity requirements

- All rooms to be en-suite;
- Separate male/female toilets in shared areas; and
- The design of the unit must comply with current legislation.

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The rehabilitation ward should be located beside the long term care ward and elderly mental health wards;
- The ward should have access to enclosed, safe, stimulating and raised gardens;
- The ward should have ease of access to the store room, cleaners' (housekeeping) room, patients laundry room, interview room, duty room and multi-disciplinary room and be in close proximity to them;
- The ward should have easy access to the main entrance without having to go outside;
- Patients should have access to the spiritual care area;
- Ambulance/undertaker access bay;
- Ease of access within the hospital grounds for patients and visitors; and
- Parking facilities adjacent to front door to allow ease of transferring equipment into van for transporting to patients homes.

Internal

- Dining rooms and servery should be close to the entrance of the ward and distant to the bedrooms;
- Clean and Dirty utility room and store room should be away from the main clinical areas;
- Interview room should be distant from the bedroom;
- Second sitting room should be sited in accordance with the mixed sex guidance;
- The bedrooms should be distant from the clean and dirty utility rooms, store room, interview room, charge nurse office and dining rooms;
- The charge nurses office should not be at the main ward entrance ;
- The treatment room, bath, WC and wash assisted room, sitting rooms, duty room, disabled WCs and pantry should be sited in such a way that allows ease of access and use but distant from the dining room; and
- The wards should be close to:
    - Support cluster 3
    - Diagnostic dept.
    - Day hospital, provided in Douglas Grant Rehab Centre
    - Central walk-in entrance.

Storage facilities

The following storage facilities are required for:

- Stores for bulky disposable items, eg. Hoists + slings + drip stands + infusion devices;
- Stores –large bulky items such as continence supplies/urinals, bedpans;
- The treatment room should contain a lockable storage cupboard (0.8m x 0.5m for podiatry clinical instruments);
- continence supplies/urinals, bedpans;
- Spare duvets, pillows and mattresses;
- Wheelchairs; and
- RRS equipment – OT aids, Physiotherapy aids, nursing aids.

Anticipated developments

- The building should be able to meet the needs of future Information Technology developments
- The building should be flexible in design to meet the challenges of an ever changing and improving Health Service

Client Group Characteristics

Age and Gender

- 65 years of age and over
- Male and female

Admission Rates

- Admissions are accepted 365 days per year

Diagnoses

- General geriatric medical conditions

Anticipated illness-related behaviours

- Confusion;
- Aimless behaviour;
- Wandering;
- Aggressive behaviour, both verbal and/or physical; and
- Disinhibited Behaviour.
-

Anticipated clinical risks

- Poor physical health and related physical dependency;
- Poor mobility;
- Risk of falling;
- Poor motivation
- Mild to moderate dementia
- Depression

Patient dependency characteristics

Therapeutic Intent

For most patients in-patient care is part of the care pathway. It offers assessment, treatment and rehabilitation and support to people who cannot be cared for in a non-hospital setting.

Principal aims of clinical care

Therapies

- Individual and group therapies will be provided on a planned and ad-hoc basis; and
- Therapies will enhance the care experience and be focussed on specific interventions and outcomes.

Therapeutic facilities required

- Therapeutic facilities will be provided for in Support Cluster 3.

Planned clinical meetings

- Weekly multidisciplinary meetings;
- Ward Rounds;
- Case conferences; and
- Nursing handover reports.

Other Meetings

- Ward staff meetings;
- Meetings with discharge coordinator/social workers;
- Appraisal/supervision meeting;
- Meetings with relatives; and
- Training and development.

Clinical risk management principles

- Each patient will be assessed on admission using recognised risk assessment tools and a risk management plan put in place.

Operational Procedures

Working day plans

- 24 hours a day/365 days per year
- Day services

Staffing arrangements and shift patterns

- Mix of long/short shifts (5 hr – 11.5 hr)
-

Admission procedures

- Established admission protocols in place

Record-keeping storage

- Lockable storage facility
- IT infrastructure and full range of appropriate systems

Visiting arrangements

- Limited but flexible in rehabilitation wards

Mealtimes/dining arrangements

- Separate from sitting areas

Between meal snacks and access to beverages

- Should be available throughout the day

Laundry facilities and linen management

- On site

Adult Recreational Facility

- TV areas, quiet areas, activity areas;
- Hairdressing/barber facility;
- Also large social gathering area for large functions for example, concerts/bingo/bowls/teas; and
- Patient computer/internet/e-mail access should be available as increasing number of patients computer literate.

Functional content

Number of Inpatient Beds/Treatment Spaces

- 30 rehab inpatient beds

Investigative/Diagnostic/Treatment Capacity:

- Access to x-ray, pharmacy and labs required with ECG Technician, x-ray and ultrasound on site;
- CT, SPECT, MRI, Video fluoroscopy, Pulmonary Function & Cardiology testing provided at Crosshouse Hospital; and
- Electronic access to laboratory results.

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable

Specialist Technical Infrastructure Requirements

- 2222 (emergency response);
- Gas cylinder storage;
- O2;
- Suction; and
- Hoist tracking systems.

Projected Future Activity

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Elderly Mental Health	• Shared knowledge, training & experience. • Potential for developing flexible services	Essential
Central (Walk-in) Entrance	• Ease for patients	Desirable
Ambulance Entrance	• Transfers from & attendance at General Hospitals • Access for Undertakers	Essential
Multidisciplinary Team ++	• MDT Working	Essential
MS Specialist Nurses	• MDT Working	Essential
Wheelchair Service	• MDT Working	Essential
Consultant in Rehabilitation Medicine	• MDT Working	Essential
Local Authorities	• Partnership Working	Important
Voluntary Sector	• Partnership Working	Desirable
Long Term Care Ward	• Shared knowledge, training & experience. • Potential for developing flexible services	Essential
Parking	• to allow ease of transferring equipment into van for transporting patients homes	Desirable
Support Cluster 3	• Ease of access for inpatients • Safety • Staff assistance	Essential

Horizontal adjacency to Elderly Continuing Care ward	• Accessible for visiting agencies • • Access to shared staff resources	

* Category: Essential/Important/Desirable

++ Dietetics, Speech & Language Therapy, Physiotherapy, OT, Psychology, Podiatry

Close to	Reason	Category
Local Authority – NAC Home care services	To promote joint working and sharing of information across both Health and Social Services	essential

Future Service Delivery Risks

- Access to essential supporting services/facilities/people;
- Fit with integrated care pathways;
- Health & Safety (anti-ligature);
- Prevention of falls, observation areas and high observation areas;
- Recreation, diversion/rehab activities;
- Throughput activity/case mix change; and
- Patients with dementias/behavioural problems in same units as general elderly patients and palliative care patients.
-

Appendix S – Long Term Care (continuing care)

Introduction and outline of services

Departmental Function

Patients over 65 years of age may be admitted to a continuing care ward when the Hospital Consultant, in conjunction with the multi-disciplinary team from the discharging area, has decided that the patient requires ongoing and regular specialist clinical care or where the patient requires to undergo a period of further assessment to determine how their long term care needs can best be met.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in the Community Hospital and is described in the section entitled Long term care (continuing care) in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The vision for the future delivery of Care of the Elderly Services on the new Ayrshire Central site is based on an integrated pathway approach that encourages multi-disciplinary and multi-agency working model across health and social care and which allows the patient a seamless journey between primary care, secondary care and the community.

This vision is based on the view that patients should be cared for in the most appropriate setting for their needs. A range of in-patient, out-patient, day hospital and community services for older people will be therefore be provided

The principal policy goal of the Reshaping Care for Older People Programme is to “optimize independence and wellbeing for older people at home or in a homely setting”.

Following a multi-disciplinary assessment the Hospital Consultant, in

conjunction with the multi-disciplinary team, may decide that the patient requires ongoing and regular specialist clinical care on an in-patient basis due to the complex nature or intensity of his or her health care needs. Our vision, therefore, is to provide homely environment within our continuing care wards that meets the mental, physical, emotional and spiritual needs of this small group of patients who require ongoing hospital care.

Our long stay wards also act as a bridge between acute hospital care and the community for those patients whose needs can best be met in their own home.

In line with Reshaping Care for Older People it is our aspiration that older people should not be admitted directly to a care home from an acute hospital and we want our long-stay wards to provide an intermediate care setting where patient's community care assessments can be carried out.

Our long stay ward will also provide a homely, supportive environment for patients requiring respite care and for palliative care patients whose needs can best be met in a hospital setting

The vision also recognizes that frail older patients deemed ready for discharge are a dynamic groups whose care plan and support needs may change and local pathways will ensure optimal opportunity for individuals with complex need to exhibit late and often unexpected potential for a home based discharge.

A key goal in our Joint Reshaping Care for Older People Strategy is to reduce the maximum time for patients undergoing Single Shared Assessments from six weeks to four weeks and to reduce the number of bed days lost to delayed discharges. We anticipate that changes in service delivery will mitigate against increased activity as a result of demographic changes. Consequently we will reduce our current complement of continuing care beds from sixty to thirty prior to the opening of the new North Ayrshire Community Hospital which s will comprise of:

30 continuing care beds for those patients requiring NHS continuing care or who are undergoing assessment prior to discharge home or to a nursing home (a 30 bed reduction)

The Care of the Elderly vision also anticipates a horizontal adjacency with the Elderly Mental Health wards would provide the potential for developing flexible services and for sharing knowledge, training & experience. There is also a potential for shared space between the two specialties.

Role and Function

A range of in-patient, out-patient, day hospital and community services for older people will be therefore be provided

Although there will be an increasing emphasis on community based rehabilitation a number of specialist wards and services will continue to provide in-patient services for those who need them

Bed complement

30 long term (continuing care) beds

Planned patient activity

General principles of operation

Design Synopsis

- The ward requires to be on the ground floor
- Windows should be of a height that allows patients to see out of them when seated
- Maximise use of natural light;
- Disability Discrimination Act compliant;
- Occasional seating in corridors for patients to rest;
- Seated areas for quiet contemplation;
- Link with current dementia/visual impairment services to seek advice on design and decoration;
- Relatives overnight accommodation to allow family members to stay when required, should be situated near to Elderly Services wards.
- At least one bathroom per ward to have overhead tracking hoists;
- Maximum use of natural and artificial ventilation;
- Discreet hotel and storage services;
- Dining facilities that enhance the meal experience;
- Clinical areas that are non threatening and welcoming;
- Common sitting and activity areas should be homely and domestic while lending themselves to recovery and should not be open plan;
- Bedroom areas should enhance the therapeutic experience and also provide privacy;

- Adequate signage should be provided within ward areas;
- All areas within the ward should be easily observable with no blind spots;
- There should be one single point of entry to the ward; and
- Should be a ligature free environment.

Corridors: Required features

- Maximise use of natural light;
- DDA compliant;
- Hand Rails required;
- occasional seating required for patients to rest;
- Link with current dementia/visual impairment services to seek advice on design and decoration; and
- Wide capacity – to take 2 way traffic.

Mixed gender requirements

The design must comply with current guidance and legislation;

Alternative sitting areas – specifically television areas and sitting areas.

Disabled access requirements

Must be DDA compliant, including loop system;

All rooms/en-suites must be large enough to accommodate the use of patient hoists;

Specific one bedroom per ward to facilitate bariatric patients; and

Comfortable door width for ease of access/movement of beds.

Privacy and dignity requirements

All rooms to be en-suite;

Separate male/female toilets in shared areas; and

The design of the unit must comply with current legislation.

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

- The continuing care ward should be located beside the rehabilitation ward and elderly mental health wards to allow sharing of facilities and to encourage integrated working;
- The ward should have access to enclosed, safe, stimulating and raised gardens with adequate wandering and walking spaces;
- The ward should have ease of access to the store room, cleaners' (housekeeping) room, patients laundry room, interview room, duty room and multi-disciplinary room and be in close proximity to them;
- The ward should have easy access to the main entrance without having to go outside;
- Patients should have access to the spiritual care area;
- Ambulance/undertaker access bay;
- Ease of access within the hospital grounds for patients and visitors;
- The rehabilitation ward should be adjacent to the Elderly Mental Health wards to allow sharing of facilities and to encourage integrated working;

Internal

- Dining rooms and servery should be close to the entrance of the ward and distant to the bedrooms;
- Clean and Dirty utility room and store room should be away from the main clinical areas;
- Interview room should be distant from the bedroom;
- Second sitting room should be sited in accordance with the mixed sex guidance;
- The bedrooms should be distant from the clean and dirty utility rooms, store room, interview room, charge nurse office and dining rooms;
- The charge nurses office should not be at the main ward entrance;
- The treatment room, bath, WC and wash assisted room, sitting rooms, duty room, disabled WCs and pantry should be sited in such a way that allows ease of access and use but distant from the dining room; and
- The wards should be close to:
- Support cluster 3

- Central walk-in entrance.

Storage facilities

The following storage facilities are required for:

- Stores for bulky disposable items, eg. Hoists + slings + drip stands + infusion devices
- Stores –large bulky items such as continence supplies/urinals, bedpans continence supplies/urinals, bedpans, spare duvets, pillows and mattresses
- Wheelchairs

Anticipated developments

The building should be able to meet the needs of future Information Technology developments; and

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service.

Client Group Characteristics

Age and Gender

65 and over

Male and female

Admission Rates

- Admissions are accepted 365 days per year

Diagnoses

- Wide range of general medical conditions
- Mild to moderate dementia

Anticipated illness-related behaviours

Confusion;

Aimless behaviour;

Wandering;

Aggressive behaviour, both verbal and/or physical; and

Disinhibited Behaviour.

Anticipated clinical risks

Poor physical health and related physical dependency;

Poor mobility;

Risk of falling;

Poor motivation

Mild to moderate dementia

Depression

Patient dependency characteristics

Therapeutic Intent

For most patients in-patient care is part of the care pathway. It offers assessment and treatment and support to people who cannot be cared for in a non-hospital setting; and

For some patients requiring long-term continuing care the ward is their permanent home.

Principal aims of clinical care

Therapies

Individual and group therapies will be provided on a planned and ad-hoc basis; and

Therapies will enhance the care experience and be focussed on specific interventions and outcomes.

Therapeutic facilities required

- Therapeutic facilities will be provided for in Support Cluster 3.

Planned clinical meetings

Weekly multidisciplinary meetings;

Ward Rounds;

Case conferences; and

Nursing handover reports.

Other Meetings

Ward staff meetings;

Meetings with discharge coordinator/social workers;

Appraisal/supervision meeting;

Meetings with relatives; and

Training and development.

Clinical risk management principles

Each patient will be assessed on admission using recognised risk assessment tools and a risk management plan put in place.

Operational Procedures

Working day plans

- 24 hours a day/365 days per year

Staffing arrangements and shift patterns

Mix of long/short shifts (5hr – 11.5hr)

Admission procedures

Established admission protocols in place

Record-keeping storage

Lockable storage facility

IT infrastructure and full range of appropriate systems

Visiting arrangements

Open visiting to continuing care

Mealtimes/dining arrangements

Separate from sitting areas

Between meal snacks and access to beverages

Should be available throughout the day

Laundry facilities and linen management

On site

Adult Recreational Facility

- TV areas, quiet areas, activity areas,
- Hairdressing/barber facility.
- Also large social gathering area for large functions eg concerts/bingo/bowls/teas
- Patient computer/internet/e-mail access should be available as increasing number of patients computer literate

Functional content

Number of Inpatient Beds/Treatment Spaces

- 30 long term care (continuing care) inpatient beds

Investigative/Diagnostic/Treatment Capacity:

- Access to x-ray, pharmacy and labs required with ECG Technician, x-ray and ultrasound on site;
- CT, SPECT, MRI, Video fluoroscopy, Pulmonary Function & Cardiology testing provided at Crosshouse Hospital; and
- Electronic access to laboratory results.

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable

Specialist Technical Infrastructure Requirements

- 2222(emergency response);
- Gas cylinder storage;
- O2 - piped to at least 4 beds per area;
- Suction; and
- Hoist tracking systems.

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

Close to	Reason	Category*
Elderly Mental Health	• Shared knowledge, training & experience. • Potential for developing flexible services	Essential
Central (Walk-in) Entrance	• Ease for patients	Desirable
Ambulance Entrance	• Transfers from & attendance at General Hospitals • Access for Undertakers	Essential
	•	
Local Authorities	• Partnership Working	Important
Voluntary Sector	• Partnership Working	Desirable
Support Cluster 3 Horizontal adjacency close to Elderly Rehab ward	• Ease of access for inpatients • Safety • Staff assistance • Accessible for visiting agencies • Access to shared staff resources	Essential

* Category: Essential/Important/Desirable

++ Dietetics, Speech & Language Therapy, Podiatry

Close to	Reason	Category
Local Authority – NAC	To promote joint working and sharing of information	essential

Home care services	across both Health and Social Services	

Future Service Delivery Risks

- Access to essential supporting services/facilities/people;
- Fit with integrated care pathways;
- Health & Safety (anti-ligature);
- Prevention of falls, observation areas and high observation areas;
- Recreation, diversion/rehab activities;
- Throughput activity/case mix change; and
- Patients with dementias/behavioural problems in same units as general elderly patients and palliative care patients.

Appendix T - Support Clusters

Introduction and outline of services

Departmental Function

Within North Ayrshire Community Hospital there will be three support clusters associated with 3 separate areas, namely:

Support Cluster 1

Support Cluster 1 will provide therapy space for Adult Acute Mental Health inpatient Wards and occasionally the Intensive Psychiatric Care Unit. This support cluster will be accessed by up to 68 beds.

The support cluster will allow patients to access mainly AHP led therapies in a safe environment closely linked with their ward area.

Support Cluster 2

Support Cluster 2 will provide therapy space for Adult Mental Health Rehabilitation Unit, addiction ward and the Forensic Rehabilitation/low secure ward. The support cluster will be access by up to 48 beds.

Support Cluster 3

Support Cluster 3 will provide therapy space for Elderly mental health wards, frail elderly continuing care ward and frail elderly rehabilitation ward. The support cluster will be access by up to 90 beds.

Scope of Service/Specialist Services Provided

The accommodation is scheduled in the Mental Health section and is described in the section entitled Support Cluster 1 (AMH), Support Cluster 2 (MH), Support Cluster 3 (Elderly) in the Schedule of Accommodation.

Model of Care

Descriptive Overview

The vision for the support cluster is to provide therapy, recovery and exercise to patients using the facility. Each patient will have a designated support cluster which will be adjacent to their ward area. We have scheduled this area with three clusters, however a design would be considered as long as the area scheduled is the same or more.

Role and Function

The role of the support cluster will be to provide therapy, recovery and exercise to patients using the facility.

Bed complement

There will be no inpatient beds associated with any support clusters

Planned patient activity

Patients will have access to multi-purpose group/therapy areas to participate in a range of therapies. For instance:

Dietetics

- Access to support cluster areas for one-to-one consultations 3-4 times per week
- Access larger rooms to conduct group sessions. X3 per week in clusters
- Access to patient kitchen such as ADL Kitchen areas for provision of community food work service x1 per month.

Occupational Therapy

- Access to outdoor area for horticulture
- Access to larger rooms to conduct therapeutic group sessions with option of partitioning this to enable separate group sessions to take place
- Access to ADL kitchen for assessment and individual and group treatments (ensuring there is sufficient space for dining)
- Access to consulting room/quiet rooms for individual OT assessments within designated ward area/cluster recognising some areas are restricted with locked door
-

Physiotherapy

- Access to fitness suite and group room for exercise programmes (individual or group). Daily if possible. 1-2 hours
- Access to consulting room 2-3 x weekly 1 hour
- Some groups eg relaxation/mindfulness could be delivered either in a room in one of the clusters or ECT suite when available.

General principles of operation

Design Synopsis

Maximise use of natural light.

Disability Discrimination Act compliant

Occasional seating in corridors for patients to rest.

Seated areas for quiet contemplation

Link with Adult mental Health Wards (AMH) and Intensive Psychiatric Care Unit (IPCU) wards

Maximum use of natural and artificial ventilation

Clinical areas that are non threatening and welcoming

Common sitting and activity areas should be homely and domestic while lending themselves to recovery and should not be open plan

Adequate signage should be provided from the ward area to the support clusters

All areas within the support clusters should be easily observable with no blind spots

There should be one single point of entry to the support cluster, access procedure – depending on patient group (open and closed environments)

Should be a ligature free environment

Corridors: Required features

Maximise use of natural light.

DDA compliant

- Hand Rails required, for individuals with reduced mobility Definitely required in Elderly areas and rehab

occasional seating required for patients to rest .

Wide capacity – to take 2 way traffic, for instance, wheelchairs/walking aids/supervise those with reduced mobility

Mixed gender requirements

The design must comply with current guidance and legislation

Disabled access requirements

Must be DDA compliant, including loop system.

Privacy and dignity requirements

The design of the unit must comply with current legislation

Number and types of rooms

The schedule of Accommodation provides further information on rooms.

Required adjacencies

External

All support clusters should be adjacent to the wards that will be accessing the facilities.

The support cluster should be an enclosed, safe and stimulating space

Internal

Clean and Dirty utility room and store room should be away from the main therapy area

Storage facilities

The following storage facilities are required for:

- Equipment used in the group/therapy area

Anticipated developments

The building should be able to meet the needs of future Information Technology developments

The building should be flexible in design to meet the challenges of an ever changing and improving Health Service

Client Group Characteristics

Age and Gender

Support Cluster 1 – 16 to 65 years of age

Support Cluster 2 – 16 to 65 years of age

Support Cluster 3 – 65 years and over

Male and female

Admission Rates

Not applicable

Diagnoses

Support Cluster 1

- Patients accessing this cluster will have a varying range of mental health problems/illness and may experience issues re drug/alcohol misuse

Support Cluster 2

- Patients accessing this support cluster will suffer from an identifiable mental disorder, have a varying range of mental health problems/illness and may experience issues with drug/alcohol misuse

Support Cluster 3

- Patients accessing this cluster will have been diagnosed with an identifiable mental disorder and have general geriatric medical conditions

Anticipated illness-related behaviours

Support Cluster 1

- Aggressive behaviour (verbal and physical)
- Aimless or ritualistic behaviours
- Disinhibited behaviours
- Lack of personal risk awareness
- Suicide risk
- Unpredictable and impulsive behaviours
- Secondary physical disabilities/illnesses
- Fear and apprehension
- Patients from the IPCU ward are more likely to have complex needs, including resistant psychotic illness, disadvantaged socioeconomic background and co-morbid substance abuse problems, compared with the patient population of general adult mental health services
- Serious assaultative behaviour

Support Cluster 2

- Relapse and breakthrough symptoms

Support Cluster 3

- Confusion
- Aimless behaviour
- Wandering
- Aggressive behaviour, both verbal and/or physical
- Disinhibited Behaviour
- Physical inactivity
- Withdrawn
- Suicidal
- Lack of self confidence
- Secondary physical disabilities/illnesses – malnourished
- Unsteady gait - Risk of falling
- Anxious
- Paranoid/suspicious

Anticipated clinical risks

Patients who access these support clusters may be at risk from the following:

Support Cluster 1

- Deliberate self harm
- Harm to others
- Poor motivation
- Self neglect
- Suicidal intention
- Isolation in a community environment (social breakdown)
- Institutionalisation
- Absconding with associated risks
- Challenging behaviour
- Disinhibited behaviour

Support Cluster 2

- All of the above
- Obesity
- Inactivity

Support Cluster 3

- Poor physical health and related physical dependency
- Poor mobility
- Risk of falling
- Poor motivation
- Delayed discharge
- Reduced ability to self care
- Isolation/institutionalisation

Patient dependency characteristics

Therapeutic Intent

Inpatient care is one element of the care pathway. It offers time limited safety, support and therapy to people who are too unwell to be cared for in a non hospital setting. It is to improve the person's mental and physical health and functioning.

All clinical, therapeutic and social care will be provided at the least restrictive level appropriate to the needs of the client group.

For some patients requiring long-term continuing care the ward is their home.

Principal aims of clinical care

Therapies

- Individual and group therapies will be provided in the support cluster on a planned and ad hoc basis
- Therapies will enhance the care experience and will be focussed upon specific agreed interventions and outcomes
- Therapy should be in keeping with recovery/Tidal Model and should be evidence based
- Therapies should be provided by a wide range of multi disciplinary staff and other agreed partners
- Therapy Examples – Anger management, Coping Skills, Anxiety management, 'talking therapies' & engagement, ADL skills
- Individual and group therapies will be provided on a planned and ad-hoc basis
- Therapies will enhance the care experience and be focussed on specific interventions and outcomes

Therapeutic facilities required

- Adequate space to provide therapeutic interventions as required within the units both as groups and 1-1
- Adequate storage space to contain therapeutic equipment will be required within the units
- Sufficient space for physical activities and exercise

- Suitable furniture/fixtures and fittings to support activities (including facilities for the art group)

Planned clinical meetings

- It is not anticipated that clinical meetings will take place within the support clusters.

Other Meetings

It is not anticipated that any other meetings will take place within the support clusters.

Clinical risk management principles

- Risk management for this client group is important. The environment must be conducive to delivering the risk management plan
- Based on a proactive approach to positive risk management (embedded within the service)
- Formalised assessment tools will be utilised and process reviewed on an ongoing individualised basis
- On admission each patient is assessed in accordance with a recognised risk assessment tool
- Based on this initial risk management plan is developed which will also determine the person' observation status
- The IPCU ward will have systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform the treatment plan and enhanced Care Programme Approach.

Operational Procedures

Working day plans

- It is anticipated that each cluster should be accessible as required and into the evenings, 7 days/week
- On occasion there may be a requirement for access to the multi-purpose group therapy area for evening social events.
- On occasion there may be a requirement for access to ADL kitchen for breakfast and early evening activities

Staffing arrangements and shift patterns

Patients will in the majority of cases be accompanied by members of staff when using the support clusters.

Admission procedures

Not applicable

Record-keeping storage

Lockable storage facility

IT infrastructure and full range of appropriate systems

Visiting arrangements

- Not applicable

Mealtimes/dining arrangements

- Support Cluster 3 has a pantry associated with the multi-purpose group/therapy area.
- The other support clusters do not have any provision for mealtimes/dining arrangements.

Between meal snacks and access to beverages

Support Cluster 3 will provide meals snacks or beverages throughout the day

Support Clusters 1 and 2 have no provision for meal snacks or beverages

Laundry facilities and linen management

Not applicable

Recreational Facility

- TV areas, quiet areas, activity areas,
- The multi-purpose group/therapy area will be used as a large social gathering area for large functions eg concerts/bingo/bowls/teas
- Patient computer/internet/e-mail access could be available in this cluster as increasing number of patients will be computer literate

Functional content

Number of Inpatient Beds/Treatment Spaces

- No inpatient beds are provided in any support cluster.

Investigative/Diagnostic/Treatment Capacity:

- Not applicable

Outpatient Service (Number of Sessions and specialist functions):

- Not applicable

Specialist Technical Infrastructure Requirements

- No specialist technical infrastructure will be required in the support clusters

Projected Future Activity

- Not applicable

Key Relationships with Other Departments/NHS Ayrshire and Arran /Social Services/Social Work/Local Authority Services

- Not applicable

Future Service Delivery Risks

- Access to essential supporting services/facilities/people;
- Health & Safety (anti-ligature);
- Throughput activity/case mix change;
- Changes in practice;
- Ageing population – more elderly patients;
- Demographic changes;
- Activity levels unpredictable; and
- Future service demand is uncertain. This new provision needs to reflect change in trends and be adaptable to future need.

Appendix 2C

Environmental Quality Report

ENVIRONMENTAL QUALITY

1. Background

The built environment that this business case relates to includes accommodation that is currently delivered from three separate hospital sites. These are:

- Large components of the Ayrshire Central Hospital (ACH) Site. (By far the largest component of this business case.
- Retained clinical components of the Ailsa Hospital site (Primarily a refurbishment of elderly ward areas to bring them to a similar level of clinical functionality as the new build at ACH but also to extend the lifespan of their services
- The relocation of Wards 1d and 1e (Acute mental health wards) and Clinic K, Crosshouse Hospital will support NHS Ayrshire & Arran's "Building For Better Care" project.

Relevant elements of these facilities is now considered in more detail.

2. Ayrshire Central Hospital: Relevant Site Overview

Ayrshire Central Hospital (ACH) is located on the Western outskirts of Irvine in North Ayrshire. Although originally constructed in 1941, the site layout has changed very little thereafter.

Originally the Hospital provided in-patient care for infectious diseases and maternity services for the whole of Ayrshire and was split into North and South sections.

Historically, the nine pavilions to the North of the site (See Figure 1) provided 276 beds for infectious diseases, with the Southern end of the site providing a further 160 beds for maternity and post natal care.

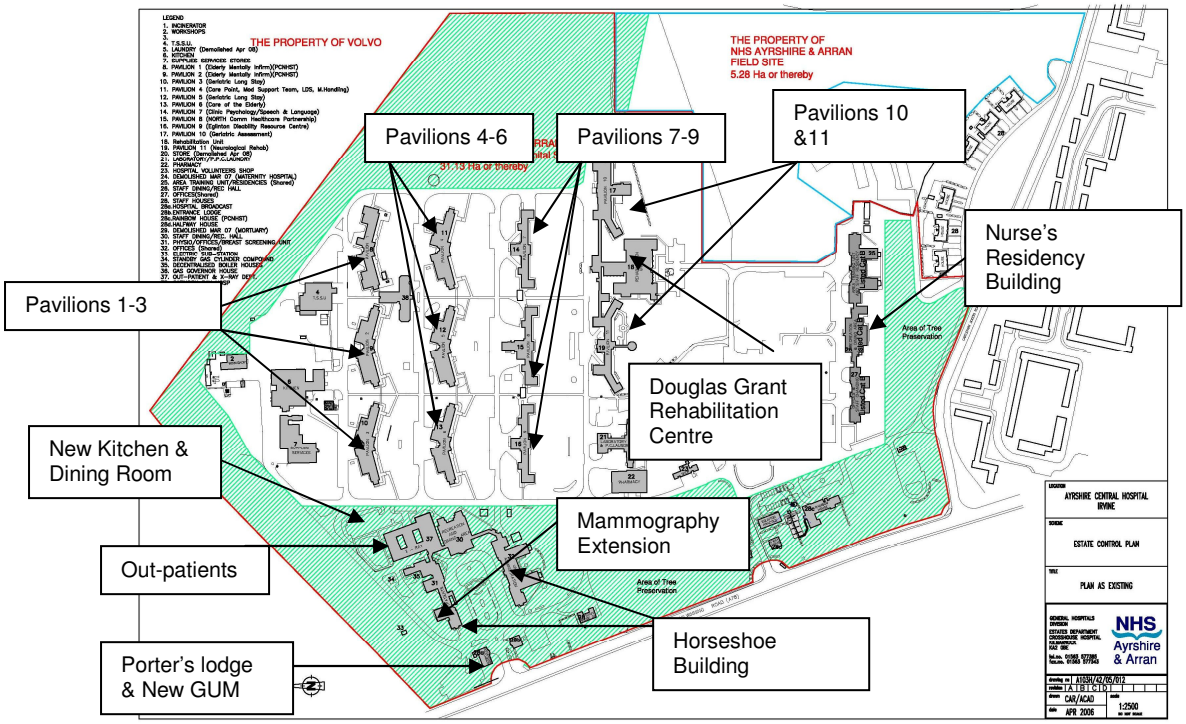
Following a region wide review of clinical service delivery, maternity moved from the Ayrshire Central site to Crosshouse Hospital in August 2006, leading to the demolition of the old maternity building in early 2007 and the subsequent closure of the nurse's residency building, which was no longer required.

Over a period of time these changes have led to a situation where the ACH site has been impacted upon by a wide range of service-related decisions that have primarily seen services move away, in turn this has led to a situation where the existing facility has suffered from a lack of overarching strategic direction/planning with a subsequent reduction in investment and co-ordination.

At present, the majority of clinical accommodation is still delivered from a combination of the original 1941 non-linked “pavilions”, supplemented by some non-linked 1970’s/80’s accommodation, e.g. Garnock Day Hospital.

Each inpatient pavilion features between 18 and 30 beds. All of this is in mixed sex wards that are divided into separate male and female multi-bed rooms. These bedded areas are supported by day space and minimal therapy areas within each individual building.

Figure 1: Existing Ayrshire Central site



Specifically, existing inpatient services (including short stay rehabilitation and continuing care beds) are delivered from five pavilions as follows:

Pavilion 1 18 short stay rehabilitation beds
Pavilion 2 18 short stay rehabilitation beds
Pavilion 3 25 short stay rehabilitation beds and 4 respite beds
Pavilion 5 30 continuing care beds
Pavilion 6 30 continuing care beds

The remaining 4 pavilions which are due to be demolished to make way for the new hospital, provide a variety services for the site and the surrounding locality:

Pavilion 4 - Learning Disability Service & Child and Adolescent Mental Health, plus a local authority day service (Carepoint).
Pavilion 7 - Community Clinical Psychology Service and Speech & Language Service.
Pavilion 8 - North Ayrshire Community Health Partnership.

Pavilion 9 currently accommodates a number of Local Authority and voluntary services, including Ayrshire Independent Living Network, Specialist Huntington's Disease Ayrshire Service and Momentum Scotland's Pathways Ayrshire programme.

Other accommodation/services currently delivered from the ACH site include:

Within the Horseshoe building:

- General outpatients include 6 consulting rooms and 5 interview rooms (these have recently been refurbished to meet clinical psychology and community mental health standards), nail surgery and podiatry.
- A new outpatient department extension – linked to the existing OP department provides 6 further consulting rooms, an additional minor operations room, treatment room, quiet room and interview room.
- A diagnostic department includes 2 x-ray rooms with associated accommodation i.e. waiting room, reception, process/viewing room and film chemical store.
- Mammography, including 2 mammography rooms and associated accommodation.
- Community dental, including 6 community dental surgeries and 1 x special needs dental surgery.
- A range of further supporting clinical accommodation on the ground floor, including AHP treatment, gymnasium areas and Ayrshire Doctors On-Call (ADOC) clinical consulting and support accommodation.
- A range of administrative and meeting areas on the first floor, providing a mixture of non-clinical office and service spaces.

Within the Douglas Grant Rehabilitation Facility and associated Pavilions (10 and11):

- Stroke rehabilitation in-patient services
- neuro-rehabilitation in-patient services

- NHSA&A outpatient and day case centre for neuro-rehabilitation services

Within the new kitchen development:

- The production kitchen (servicing the meal requirements for the entire site) which has been sized to accommodate future requirements associated with this development.
- The main staff and public dining areas

Within the new Clinical Decontamination Unit:

- TSSU services for all of NHS Ayrshire & Arran and surrounding Board areas

A range of smaller buildings that do not feature substantially within this business case but that are significant to the site include:

- Eglinton GP Practice
- New GUM (Genito-Urinary Medicine Clinic/Sexual Health) clinic facility
- Patient's personal laundry facility
- Procurement offices/delivery area

3. Ailsa Hospital Campus: Relevant Site Overview

It is currently anticipated that much of the existing estate will be retained at Ailsa Hospital; however this business case only covers investment in the clinical (ward) areas being retained. (The remaining clinical accommodation will be transferred to the new NACH facility). Figure 2 provides a site plan of Ailsa Hospital.

Clinical areas being retained that will be invested in include:

- Lewis, a 9 bed dementia care ward
- Iona, a 12 bed dementia care ward
- Jura, a 21 bed dementia care ward
- Dunure, a 22 bed organic assessment ward
- Clonbeith, a 16 bed continuing care (functional) ward
- Croy, a 14 bed functional assessment ward
- Croy day hospital

Lewis, Iona and Jura are configured as one wing of a single building complex with Dunure and Clonbeith forming the other wing. These two wings currently share a central gym/therapy area that it is not anticipated will change physically as a result of any new proposals for the Ailsa Campus.

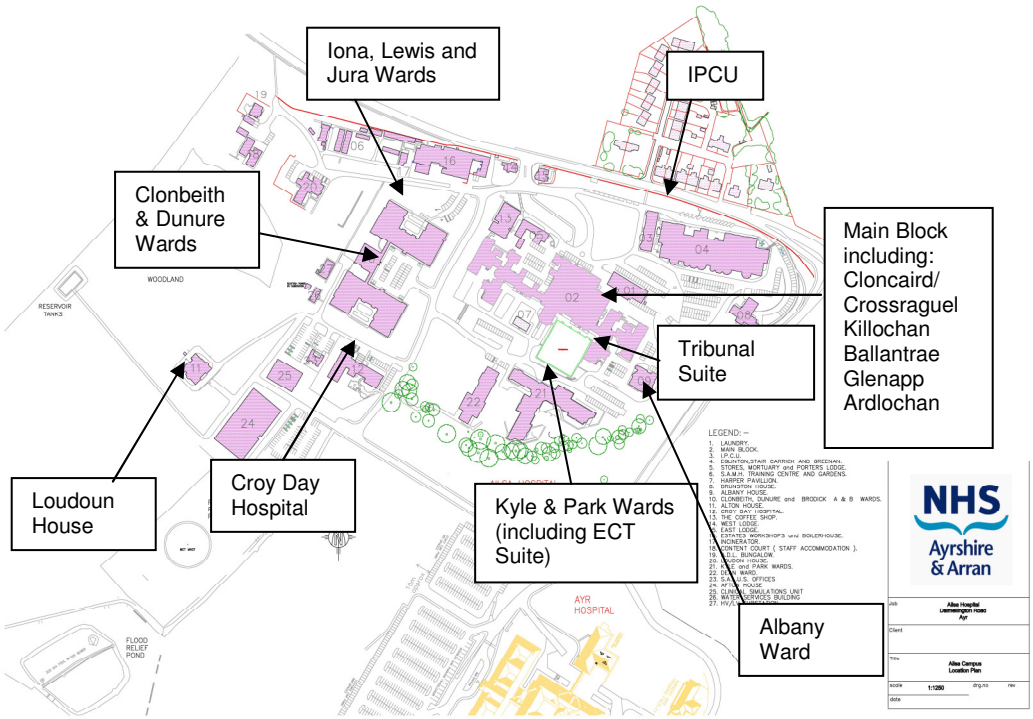
Croy is located in a separate but adjacent building which features a day hospital area that will not be affected physically by any new proposals for the Ailsa campus.

It should be recognised that these wards are already physically remote from other buildings on the site and that their relationship will not change with the remainder of the retained estate.

Other clinical areas that will transfer from the main hospital block at Ailsa to the new NACH facility include:

- Albany ward, a 8 bedded non acute mental health ward
- Cloncaird ward, a 8 bedded ward
- Killochan ward, a 12 bedded ward
- Ballantrae ward a 10 bedded ward
- Glenapp ward a 12 bedded rehab ward
- Ardlochan ward, independent living facilities

Figure 2: Ailsa Hospital, site plan



4. Crosshouse Hospital Campus & Kilmarnock Area: Relevant Site Overview

Located just to the east of the East Ayrshire village of Crosshouse and 1¼ miles (2 km) west of Kilmarnock, Crosshouse Hospital is the principal general hospital in North and East Ayrshire. Crosshouse was officially opened by the Secretary of State for Scotland, George Younger (1979-1986) on 2nd June 1984.

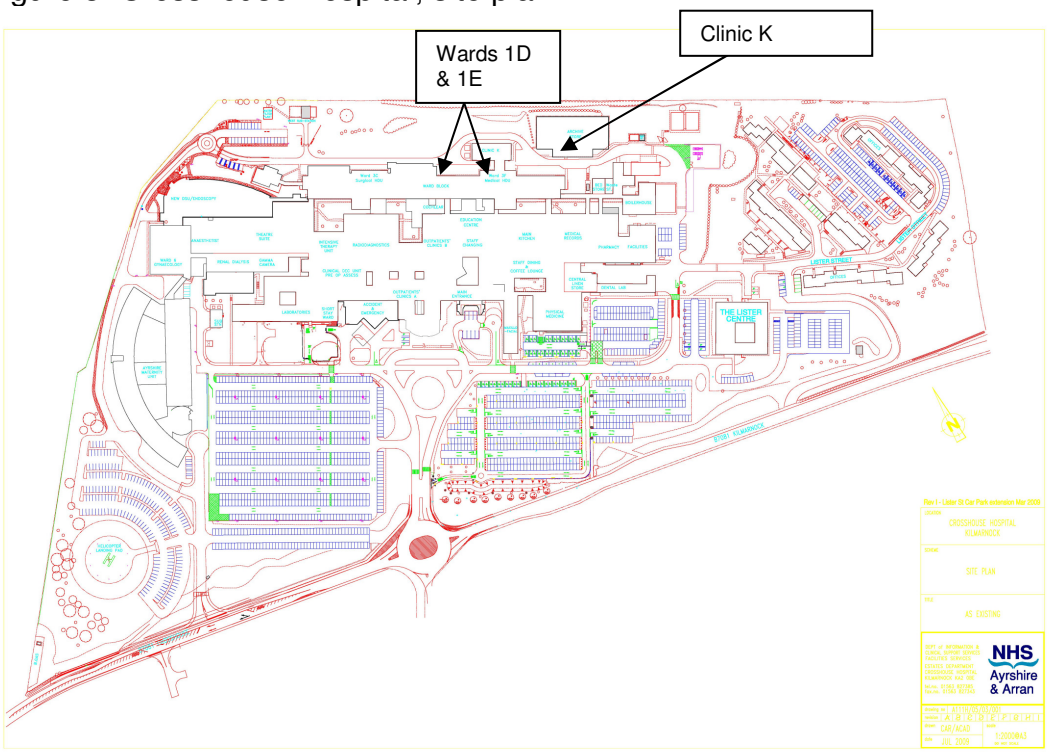
The hospital has 636 beds and includes accident and emergency facilities and Adult general psychiatric in-patient services (46 beds) that are provided in two wards in Crosshouse Hospital 1D and 1E.

Current Mental Health accommodation at Crosshouse Hospital that is relevant to this business case includes:

- Ward 1D, -23 bedded acute mental health admission ward
- Ward 1E, -23 bedded acute mental health admission ward
- Clinic K

It is planned that all of the above will transfer to the new facility at Ayrshire Central Hospital, see Figure 3 showing Crosshouse site plan.

Figure 3: Crosshouse Hospital, site plan



5. Environmental Considerations (6 Dimensions of Quality)

In considering the accommodation impacted upon by this business case, its overall performance has been assessed against the six dimensions of quality outlined in *Better Health, Better Care* and subsequently cited in the recently launched *National Quality Strategy. These dimensions are:*

Patient centred	Its ability to provide care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions
Safe	How it supports the avoidance of injuries to patients from care that is intended to help them
Effective	How it provides services that are evidence-based
Efficient	How it avoids waste, including waste of equipment, supplies, ideas, and energy
Equitable	How it supports care delivery that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
Timely	How it can reduce waits and sometimes harmful delays for both those who receive care and those who give care

A summary of this assessment follows that highlights current environmental quality issues that impact on service delivery as well as how they will be addressed by the investment proposed within the business case.

5.1 "Patient Centred" Issues Current

NHS Ayrshire & Arran's commitment to patient centred care which is respectful, compassionate and responsive to individual patient preferences is well documented in its annual service review assessments. It is very challenging to meet this commitment through the quality of our built environment.

Ayrshire Central Hospital

The ward and building configuration of the pavilions does not promote patient choice, patient observation or patient engagement. Ill patients often have to share six bedded dormitories and such single rooms as exist are often in cramped conditions that fall significantly short of current space standards.

Of the 125 beds within the 5 pavilions, only 8 are single room with en suite - just over 6% of the overall bed compliment. This is well below current Scottish Government guidelines and lower than the overall 32.5% single bed provision for NHS Ayrshire & Arran as a whole.

The current guidance outlined in CEL 27 (2010) for the provision of single room accommodation and bed spacing states that the minimum required bed space should "not be less than 3.6m wide x 3.7m deep".

Figure 4: Ayrshire Central ward and toilet layout

Of the 8 single bedrooms in Ayrshire Central hospital none meet the current guidelines with an average single bedroom size of 3.4m wide x 3 m deep or less.

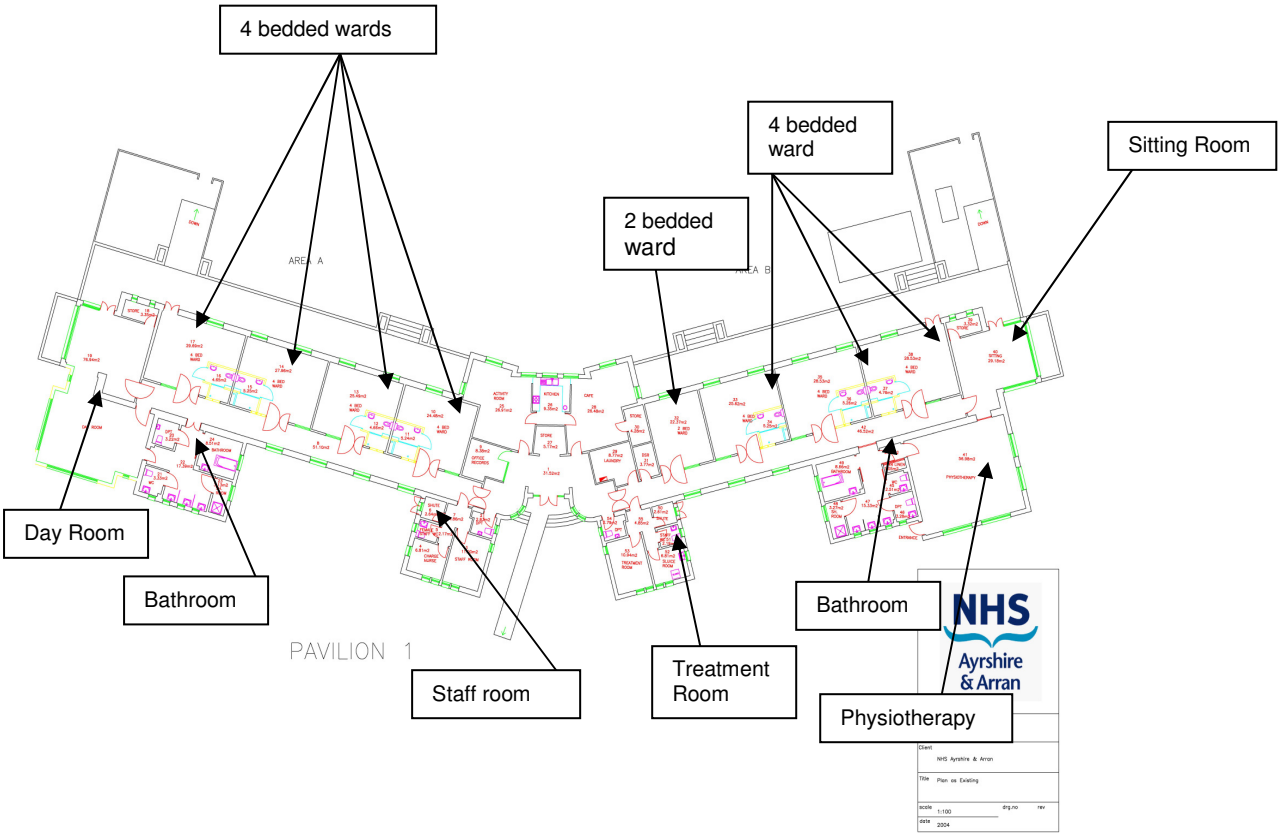
In summary, the site currently has zero single bed accommodation that meets minimum current standards.

All of the in patient ward accommodation at ACH is mixed sex although individual ward rooms are single sex. Figure 5 shows Pavilion 1 layout This issue is closely aligned to the privacy and dignity of the patient (Department of Health, 2007). Other issues of concern with the current environment include:

- The difficulty associated with keeping the facility clean, and appearing clean to patients and visitors, in reflection of the poor state of much of the environment as highlighted by the National Cleaning Standards published relating to the site;
- The requirement to use commodes because of the inaccessibility of many ward toilets (including en-suites);
- The difficulties associated with conducting clinical conversations in private;
- The requirement for male and female patients to share support facilities/areas, e.g. Day spaces, toilets, shower areas, etc;
- Having access to private toilet/washing facilities;

- The ability to entertain visitors in private areas/bedrooms when appropriate; and
- Having a degree of autonomy and control over environmental conditions, for example. being able to close blinds, shut doors, alter temperatures, etc.

Within the pavilions it is very difficult for patients to access private space as the communal space at either end of the pavilions is large and difficult to supervise.



Ailsa Campus

The majority of Acute Mental Health Wards (AMH) in Ailsa Hospital are situated within the main block which was constructed in the early 1868 of sandstone block and has very similar issues to those at the existing ACH.

The AMH wards include Albany, Cloncaird, Killochan, Ballantrae, Glenapp and Ardlochan which is the Independent living assessment area. With the exception of Albany these clinical areas are situated within the main block. Albany and Ardlochan wards are the only ward areas that are solely ground floor accommodation – providing an additional challenge to effective patient-centred care delivery.

The accommodation is mixed sex single bed accommodation that varies in size from 6.5m² to 19.1m² with no en-suite provision. The same issues apply to Ailsa as exist at ACH

Within the AMH wards there is poor lines of sight and, although all bedrooms are single, there is very little scope to adjust the current built environment to meet an individual's needs.

Elderly ward areas at Ailsa include Lewis, Iona, Jura, Dunure and Clonbeith.

Lewis, Iona and Jura are configured as one wing of a single building complex with Dunure and Clonbeith the other wing. These two wings currently share a central gym/therapy area that it is not anticipated will change physically as a result of any new proposals for the Ailsa Campus.

Within the elderly mental health ward areas day space areas and bedroom sizes are acceptable, although en-suite accommodation is configured such that dual assistance is difficult to realise – meaning that all patients who require dual assistance are currently taken to the appropriate assisted bathroom. (The shower is a separate cubicle with curtain and wall rather than the more modern style "wet room" type facility),

Storage space is highly limited in all ward areas with the result that not all rooms can be used for their primary function effectively because of the volume of inappropriately stored goods/materials they contain. E.g. dirty utility rooms are full of items because there is no space to store them elsewhere).

In addition, Lewis and Iona wards were previously a single clinical unit that has been separated to provide segregated facilities for different patient groups with particular care needs. Consequently these wards do not have access to all of the areas that they would ideally; most notably the existing single dirty utility and assisted bathroom is shared between the two which is deemed to be unacceptable.

Being of a very deep plan form, the central component of the ward areas – which includes the day spaces where patients spend most of their time, has only limited access to natural light. Although these central core areas do have "skylights", some of which have been enlarged to try and improve this situation, they are far from ideal and more natural light in day spaces is highly desirable. (Not least as it is an aid to orientation for the patients who reside here)

The Intensive Psychiatric Care Unit (IPCU) is located on Ailsa campus in a building which was formerly office accommodation for Consultant Psychiatrists and Medical Records. Although this area provides all single bedded accommodation (7 beds) it is a very confined area and there are many challenges in maintaining a safe environment due to its layout, for instance:

- Increased levels of observations to ensure safety;
- Very limited access to public and recreational space, which constrains recreational and therapeutic activities;
- There is a very limited 'garden space'. What is provided is a concrete courtyard with some raised flower beds to try and afford some green space;
- The entrance to the building is dark and unwelcoming and the interior of the building is ageing with little natural light; and
- There are blind spots within the bedrooms and general areas of the ward which pose a risk to the safe running of the Unit.

The IPCU building is located at the other end of the site from Kyle/Park and individuals who require to be transferred to IPCU have to be escorted through the grounds. This does not preserve the individual's privacy and dignity, particularly if requiring physical restraint. The situation is made worse for those patients being transferred from 1D/1E at Crosshouse as this necessitates a 19 mile ambulance journey with the associated risks for patients and staff.

Kyle and Park at Ailsa is a 23 bedded acute adult admission ward that was designed and opened in the late 1980's. The bed complement comprises of 5 single en-suite rooms and 3 x 6 bedded dormitories.

The entrance to Kyle/Park can be quite busy as it is also co-located with out-patient clinics and the ECT clinic. There is no dedicated space for admissions and therefore there can be a lack of privacy individuals being admitted and their families/friends.

Crosshouse Hospital & Kilmarnock

The AMH wards within Crosshouse General Hospital (wards 1d and 1e) were originally designed to meet the needs of a physically unwell client group rather than those with mental health issues and consequently the layout does not lend itself to the safe observation of individuals with thoughts of self-harm, this in turn leads to a requirement for increased staffing levels to ensure the safety of the patient with the associated restrictions and perceived intrusion.

Both 1D & 1E are 23 bedded wards - only 5 beds in each ward are single en-suite rooms, the other 18 beds in each ward are 6 bedded dormitories, there are no gender specific public areas. There is no designated outside space on Crosshouse Campus for individuals from 1D/1E and there is a high volume of traffic on the site. Those being cared for within 1D/1E can feel very constrained, in wards that are not designed to meet their needs and with little access to green space. In addition they find themselves located within the centre of a busy acute general hospital facility that is frequently not in keeping with their care requirements.

Patient Centred Considerations: Proposed

NHS Ayrshire & Arran's vision for the future direction of clinical services delivery was approved by the NHS Board in November 2008, and updated in December 2009 when the Board approved the Primary Care Your Health Strategy.
This vision is based on shifting the balance of care from hospital to community based delivery (including community hospitals and community treatment centres) wherever safe and practical to do so. The new facility will enable a range of planned care services to be developed locally, ensuring that it is seen as a local community resource centre providing a bridge between home and acute hospital care.

The new build component of the NACH will include:

- A main (outpatient) entrance with reception areas, waiting space, security/porters accommodation, café, small retail outlet, toilets, spiritual care area and changing facilities;

- An in-patient entrance to support the admission/transfer-in of patients on trolleys/chairs (avoiding main public thoroughfares);

- Outpatient clinic/consultation areas configured as a range of inter-connected but self-contained "modules" to support the full range of mental health, psychology-related and Learning Disabilities Service OP/consulting activity on the site including 2 "counselling clusters" and a "Child and Adolescent counselling cluster" – each with circa 6 consulting rooms per cluster. It is noted that "general out patient consulting" will continue to occur within the existing and extended outpatient department although there will also be a "cross-over" in activity terms between the two areas;

- An ECT/Minor surgical/outpatient area (re-located from Ailsa Hospital), located close to elderly mental health wards and outpatient areas, with treatment and recovery spaces that would also be used as clinic accommodation for AHP services and as a minor surgical procedures area. (Functions changing on a sessional basis);

- A pharmacy/dispensary area; and

- A meeting/tribunal area which will relocate from Crosshouse and Ailsa Hospitals that is easily accessible from the main “core” of the facility that can be used as meeting rooms when not being utilised for tribunals.

In-patient ward areas arranged in 3 clinically appropriate “clusters” around shared support areas including:

- Cluster 1; 88 Acute mental health beds in 3 wards and an 8 bedded Intensive Psychiatric Care Unit (IPCU) & 10 low secure beds
- Cluster 2; 30 Non acute mental health beds, 15 addictions beds, 12 rehab in-patient beds,
- Cluster 3; 30 elderly mental health beds in 2 wards, 30 long-term (continuing) care beds and 30 rehabilitation beds

It is noted, that in developing the operational model for the facility, a number of principles have been established that will be recognised in the design, layout and configuration of the new estate and how it relates to existing/retained buildings. These include that:

- Wards will be configured in identified “clusters” in line with the massing diagram, each cluster supports a small range of local services and accommodation.
- All 254 in-patient bedrooms will comply with the current CEL 27 (2010) guideline and address the whole patient experience at ACH, by a 100% improvement of issues such as privacy and dignity.

An essential part of the development of the ACH site is access to safe external landscapes and as such key landscape elements of the site will include

- Provision of a landscape led unifying framework and structure for the development proposals to ensure a consistent and cohesive approach to the site and to ensure an appropriate therapeutic and healing landscape suitable for the sites role as a mental health and community hospital
- Taking cognisance of the existing landscape and built environment and protect and augment them in the new proposal
- Creating a high quality, attractive and diverse hard and soft landscape treatment that reflects the status of the development complements the architecture of the building and strengthens the existing landscape character.
- Provision of a hierarchy of public and private spaces and their appropriate landscape treatment.
- Provision of a rich and inspirational environment, with seasonal interest and attractive usable spaces for all users including hospital staff, patients and the community
- The soft landscape design and choice of species that will be sympathetic to the character of the existing landscape and enhance the existing woodlands without affecting the long term integrity of the same.
- Access to Private Courtyards from ward areas

- The Woodland Belt and Public Open Space
- Car Parking and Vehicular Movement Zones

All clinical consultations at the new NACH will take place in designated consulting areas that will be separate from staff offices and support the 3 tier AHP model that has been proposed:

- 1st tier – the ability to support patients in their own room;
- 2nd tier – the ability to support patients in a therapy/communal space within the ward; and
- 3rd tier – the ability to support patients in scheduled space within the clusters or externally.

Further clinical consultation areas will include the existing general and diagnostic outpatient departments within the Horseshoe building, the new consultation areas specified within the schedules of accommodation for mental health/psychology/LDS/Etc, related services (including children's services) and identified consulting space within wards and support "clusters".

Staff will use the new dining room that has recently been constructed for all meals and breaks.

The new kitchen area will service all meal requirements throughout the site.

Ailsa Campus

Relocating the adult acute admission accommodation will realise the vision for shifting the balance of care from hospital to community based delivery.

Currently the bed configuration is stretched across the length of the building which is not conducive to good levels of observation. There are various blind spots which present dangers to both staff and patients in the buildings. Corridors are dark and only allow limited natural light to enter the building. There is one very small Treatment Room which is not fit for purpose. There is no green area for patients to access, instead there is a patio area that receives very little light and is very claustrophobic.

The new build IPCU will be design specifically for the purpose it was meant to serve and in doing so will address the majority if not all the issues previously discussed. In addition it will provide accommodation that is light, airy and afford far greater opportunity regarding access to green space, therapeutic activities, space for families to visit etc. It would be co-located with the adult acute admission wards and will allow discrete access.

The proposed model for the new-build non-acute accommodation is to have a 30 bedded 'Slow Stream Rehabilitation Unit' provided on a single en-suite room basis. The Unit would be sub-divided into smaller 'pods' that would allow gender and condition specific adaptation to ensure the provision of individualised person-centred care.

The 'Fast Track' Rehabilitation Unit will have 12 beds, again all single and en-suite but 3 of these beds will be within single self-contained bed-sit type accommodation to allow individuals to practice independent living skills prior to discharge.

Crosshouse

Wards 1d and 1e (Acute mental health wards), Clinic K, the ECT suite and tribunal accommodation at Crosshouse Hospital will be transferred to the new build at ACH – freeing up space for the redesign of "front door services" under NHS Ayrshire & Arran's "Building For Better Care" project.

Safety Issues Current

There are a number of issues that pertain to the safe environmental quality of all three Hospital sites, these can be summarised as follows:

- Observing and engaging with patients is hampered by the design and layout of the wards;
- Inadequate space in all ward areas to provide quiet areas for patients;
- Ageing accommodation and site layout creates increasing health & safety concerns for patients and staff;
- Current accommodation does not allow for ward and therapy areas to be closely connected;
- Service Users have to walk through busy corridors or be transferred by ambulance through the grounds to access services or therapies – exposing them to the risk of foot and road traffic; and
- The nature of the existing estate makes extensive works regarding anti-ligature issues financially unviable with the associated risks.

Ayrshire Central

It is crucial to have an environment which supports the very highest control of infection standards. With an efficient design, the management of Healthcare Acquired Infection policies can be optimised. The table below illustrates the number of ward closures and incidences of HCAI over all three hospital sites.(see Figure 6 Source:- *NHS Ayrshire & Arran's Control of infection Team)*

Figure 6: Infection Control instances [March 2009 – March 2010

Ayrshire Central Hospital	Ward Closure	Incidences of HAI
Pavilion 1	3	8
Pavilion 2	0	1
Pavilion 3	2	108
Pavilion 5	3	50
Pavilion6	3	27
Total	11	94
Ailsa Campus		
Clonbieth	1	1
Dunure	2	16
Brodick A	1	5
Brodick B	1	2
Croy	0	6
Total	5	30
Crosshouse Hospital		
1 D		1
1 E		3
Total		4

Ailsa Campus

Fire Risk Assessment

• A recent fire risk assessment carried out at Ailsa Hospital found the general fire precautions within Clonbeith & Dunure, Iona, Lewis, Jura Wards and Croy ward and Croy Day Hospital were found to be adequate and in general all the ward areas were assessed as being level 9, which is low risk, although the report identified a number of operational issues which are being addressed.

Estate constraints

Throughout the adult acute admission and IPCU setting there are challenges with regard to safe observations, ligature risk and generally an environment in which staff have to work extremely hard to overcome the challenges of the environment rather than having it assist them in the safe and effective delivery of care.

The current non-acute estate is of mixed quality, outdated, and no longer suits current modern nursing approaches and practice. The Victorian estate offers no flexibility in re-configuration, and the physical spread of wards does not support an integrated approach to care delivery. As already mentioned the bulk of the accommodation is over more than one floor and this poses challenges regarding those individuals with physical mobility issues or sensory impairment.

The nature of the existing estate makes extensive works re anti-ligature issues financially unviable with the associated risks.

Safety Considerations Proposed

The general principals and considerations of safety outlined within this section will be expected within the new facility. For instance:

- The overall design and layout of all areas will aim to reduce the risk of harm to patients and staff and provide a safe environment. Key elements of this risk reduction strategy will include, but not be restricted to:
    - Ligature points being avoided in all clinical/common areas through the selection of fittings and materials that reduce risk;
    - Door handles must not have thumbscrews;
    - The clinician should be positioned closest to the exit door of the room when consulting with or treating a patient;
    - Consideration will be given to lighting at bed positions;
    - Sharp edges will be avoided;
    - Wall mounted items of equipment such as fire extinguishers will be recessed to prevent damage;
    - Wall / door protectors will be used where there is risk of damage from e.g. bed / trolley movement;
    - In addition, it will be possible for staff to lock-off en-suites and manually override any locks applied by patients as appropriate;
    - Control of infection issues remain extremely important considerations with Domestic Services Rooms (DSR or “Cleaners rooms”), linen areas, clean utility rooms and dirty utility rooms specified in all areas. Whilst efficient design may allow some appropriate sharing of these facilities, the design will always optimise the control and management of Healthcare Acquired Infection in line with all relevant guidance on this matter, most notably in line with HAI SCRIBE; and
    - Staff will continue to change in a range of established changing areas throughout the site although additional changing facilities have also been scheduled into the new build. All changing is based on a model that will see staff only having access to lockers for the period of a shift/duty in

line with current thinking on this issue and to ensure optimal use of all areas.

The new facility will address a number of issues and criticisms of the current accommodation, such as:

- Safe levels of medical cover 24 hours a day, seven days a week;
- Purpose built facilities that will ensure a high level of safety measures incorporated into the build, including good observation and engagement features;
- New build accommodation will allow for ward and therapy areas to be interconnected;
- Appropriate accommodation will ensure ample quiet areas to help reduce tension for individuals and groups;
- Improved safety at night for patients and staff;
- More staff available to call upon in emergency situations; and
- Location in North Ayrshire means the majority of emergency admissions having less distance to travel from North and East Ayrshire.

Effective Current Estate

Ayrshire Central

A recent inspection of the Mental Health Welfare Commission commented about the Pavilions at Ayrshire Central:

- "Despite some refurbishment, these wards remain unfit for the care of people with dementia and there is no clear reprovision plan".

- "The physical environment is poor and unfit for purpose. The ward has a mix of people with differing needs and we thought the staff numbers, skills, training and supervision were not adequate to provide proper care".

- Physical Health Care: "Regular physical health reviews and provision of appropriate documentation of incapacity need to improve".

- Activity: "Availability of activity was variable. The service needs to ensure that all people have access to appropriate stimulation and useful activity".

In conclusion the team stated that "The accommodation is not fit for purpose and there are issues about the mixing of young physically disabled patients and continuing care patients. The pavilions also have very large day/dining rooms, lack of storage space and inadequate space between the beds. This hospital requires major refurbishment to bring the accommodation up to modern standards".

Ailsa

The current accommodation is out-dated and is no longer fit for purpose given numerous recent changes and future anticipated changes;

- Recent and projected increase in forensic and dual diagnosis in population;
- Personality disorder with challenging behaviours, ARBD population;
- Impact of Mental Health (Care & Treatment)(Scotland) Act 2003 and Section 26 re Social Inclusion and associated responsibilities;
- Emphasis on Recovery agenda and focus on rehabilitation;
- Healthy living lifestyle, physical health and activity;
- Condition management;
- Ageing population – more elderly patients, demographics; and
- Move away from ethos of 'Continuing Care' to 'non-acute', always looking to individual moving on from in-patient care.

Staff currently strive to provide the best clinical care in environments that do not lend themselves to individual, therapeutic rehabilitative function thereby reducing their effectiveness.

Effective Considerations Proposed

The general principals and considerations of effectiveness outlined within this section will apply to the new development:

- the new development will develop new services and models of care. A Clinical Options Group, set up to ascertain current clinical activity and proposed services to be delivered from the new hospital has identified the need to expand the range of services currently on offer and to review the ways that these are delivered effectively. Although much of this can be achieved through more detailed analysis of existing services and operational re-configuration, an element of new build is required to support future capacity requirements and approved clinical strategies, such as:
    - Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care;
    - Helping local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life;
    - Supporting teaching and training; and
    - Rationalising the existing estate in order to improve operational efficiency, communication, accessibility, etc.

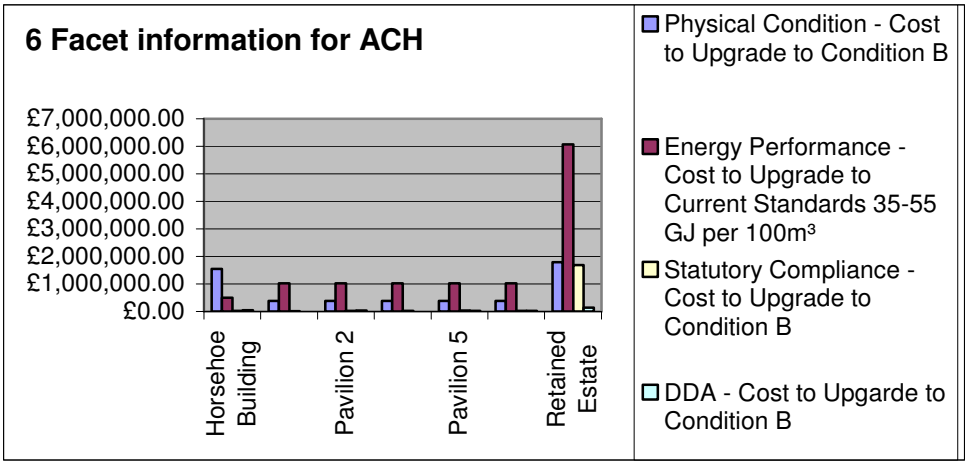
The proposed accommodation for the new facility will be more flexible, support individualised therapeutic activity, optimise the effectiveness of staff interventions and have a greater impact on the quality of care delivered in order that staff time and effort can be utilised more effectively to overcome the shortcomings of the built environment.

Efficient Current

Ayrshire Central

As already stated, most buildings on the Ayrshire Central site are ageing, functionally unsuitable and in poor physical condition, constraining the ability for further clinical development. Specifically, in the Board's current 6 facet survey, Ayrshire Central Hospital is listed as Estate Code category C (below acceptable standards) for functional suitability and category 3 (adequate) for space utilisation. Figure 7 shows further detail on the 6 facet report.

Figure 7: 6 Facet information for Ayrshire Central

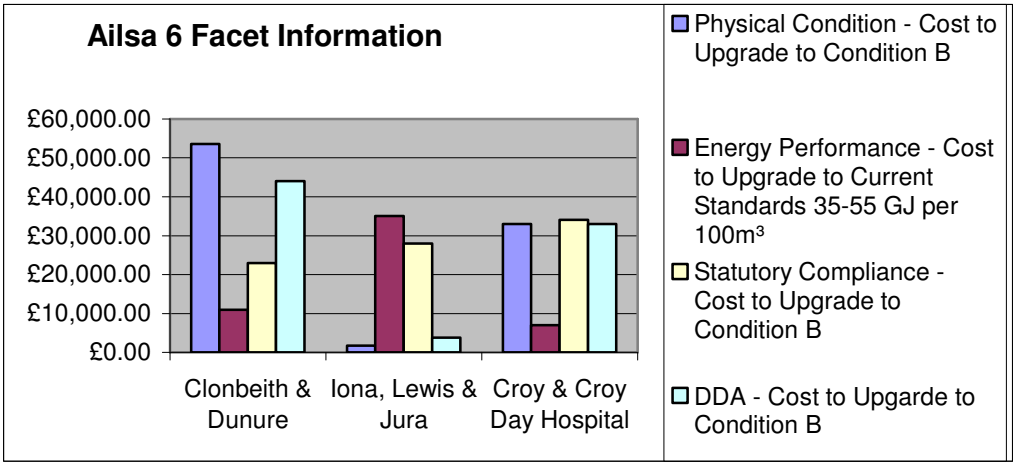


If the programme does not proceed, capital investment of approximately £19M will be needed to clear all the backlog maintenance and to bring the accommodation on the Ayrshire Central site to an acceptable standard.

Ailsa campus

Whilst clinical care on the Ailsa campus is of the highest quality, further mental health clinical development in South Ayrshire is currently constrained by the limitations of the existing built environment, for example, the majority of the buildings on the Ailsa Hospital campus where clinical care is provided are ageing, functionally unsuitable and in poor physical condition. Specifically, in the Board's current 6 facet survey, Ailsa Hospital is listed as Estate Code category C (below acceptable standards) for functional suitability and category 3 (adequate) for space utilisation. Figure 8 shows more information on the Ailsa 6 facet report.

Figure 8: 6 Facet for Ailsa campus



Although there have been considerable attempts to ensure the interior environment of the in-patient areas within the non-acute wards is of high standard, there are increasing challenges with regard to providing modern insulation, plumbing, drainage, heating and waste disposal.

All of these would be addressed by provision of purpose built, modern accommodation.

Efficient and Sustainable Considerations Proposed

NHS Ayrshire & Arran will embrace and comply with the energy and carbon reduction principles set out in the current edition of the Scottish NHS Encode/DoH SHTM 07-02. It is however recognised that the units used for benchmarking are changing to align with central government policy and Technical Standards requirements, and that kWh and kG of carbon emissions per metre squared, will replace benchmark references to GJ/100m3. NHS Ayrshire & Arran will produce suitable Technical Reports to illustrate and substantiate the appropriate design and energy management decisions taken for the programme. In particular NHS Ayrshire & Arran is investigating the use of renewable energy sources (solar thermal, solar Photo Voltaic, biomass, ground source heating and cooling), and low carbon solutions, including combined heat and power/tri-generation plant, heat recovery techniques, and industry standard energy efficiency measures.

The current proposals will facilitate the application of an Environment Management System. This is in accordance with the mandatory requirements set out within the Environment Management Policy for NHS Scotland (HDL (2006)21) and NHS Ayrshire & Arran's own Environmental Management Policy and Sustainable Development Statement. NHS Ayrshire & Arran will also take cognisance of NHS Scotland's Sustainable Development Strategy document CEL 15 (2009).

NHS Ayrshire & Arran will promote sustainable development and demonstrate an integrated approach to the social, environmental and economic factors including any local strategies supported by North Ayrshire Council.

The facilities will deliver benefits to the environment, such as:

- Demonstrate that climate change issues have been addressed through the proposed design;
- Demonstrate the use of recycled products within design specifications;
- Provision of an energy efficient design that takes account of the need for energy management and maintenance costs, and whole life cycle needs;
- Provide projections for energy performance and whole life cycle running costs;
- Propose innovative options delivering further efficiencies, highlighting their benefits;
- Produce good documentation, which clearly defines the design;
- Produce robust risk management throughout the design, construction and handover phases of the project that embrace the aims of the Sustainable Development ethos;
- Adopt hierarchical energy efficiency and waste management strategy – reduce, re-use and recycle waste during construction and operation;
- Implementation of an Environmental Management System (EMS / Corporate Greencode) for accreditation with ISO 14001;
- Contribute to minimising ozone depletion, global warming, air and water pollution and non-renewable resource depletion;
- Respect the local landscape and protect natural habitat and species taking due account of the UK Biodiversity Action Plan and the Nature Conservation (Scotland) Act 2004;
- Avoid sources of ionising and electromagnetic radiation and any design features associated with sick building syndrome;
- Maximise efficient and effective removal and transportation of all forms of waste;
- Advise NHS A&A in adopting maintenance regimes which maintain optimum performance;
- Avoid the use of harmful building products and processes; and
- Maximise natural daylight, natural ventilation and passive solar energy;

Through these measures we aspire to achive a BREEAM “Excellent” rating. (currently assessed as 70.3%)

In addition NHS Ayrshire & Arran will explore the use of prefabricated elements to achieve good quality control, ease and speed of installation and flexibility for future use.

The design of the new development will promote NHS Ayrshire & Arran's commitment to providing a sustainable estate that meets the needs of the present without compromising the ability of future generations to meet their needs in all of its activities.

Sustainability will be further discussed and articulated in Section 2 - Sustainability.

Equitable Issues Current

Transport

NHS Ayrshire & Arran is committed to addressing transport and access planning in line with national, regional and local transport policies and planning controls which require the need to offer realistic alternatives to the use of the private car for some journeys.

Ayrshire Central Hospital is located within North Ayrshire at the northern end of Irvine, approximately two miles from Irvine town centre adjacent to the A737 Kilwinning Road which is the main north-south arterial route between Irvine town centre and the A78. Ayrshire Central Hospital can be accessed in a number of ways depending on how far patients, visitors and staff have to travel, this section details ways to access the site.

Pedestrian Access
Ayrshire Central Hospital site is a large site which is presently not conducive to walking within the site due to varying standards of walking paths provided.

Pedestrian access within Ayrshire Central Hospital grounds is of varying standards. Some areas of the site particularly at the South end of the site have little or no pedestrian footways leading to the buildings with pedestrians required to walk along the roadways to door entrances.

Figure 9 shows the 1600m walking catchment area for acceptable travel distances to services and facilities from Ayrshire Central Hospital.

Cycle access
On road and off road cycle path/lane provision to Ayrshire Central Hospital and within its grounds is poor. Figure 9 shows the 2500m cycling catchment area for acceptable cycle travel distances to services and facilities from Ayrshire Central Hospital.

There are no cycle lanes along the A737 and no road cycle lane provision between Irvine Town Centre and Ayrshire Central Hospital. Access can be obtained via the National Cycle Network Route 7/73 approximately 1km from the hospital as illustrated in the map provide by North Ayrshire Council, (see Figure 9). No marked cycle lanes are provided within the main access to the hospital.

Public transport information

Public transport information including bus and rail timetables is available at Ayrshire Central Hospital from the following reception areas:

- Mammography unit
- Outpatients/x-ray
- Central administration building (horseshoe)

An Infopoint telephone travel and information help point is located within the hospital at the outpatients/x-ray entrance area providing free phone access to travel line and the local taxi company.

Vehicular access and current traffic flows

There are two main entrance access points for Ayrshire Central Hospital from the A737 Kilmarnock Road serving the north and south sides of the hospital site. The hospital site access roads are 7.2m wide and have 'STOP' signs and markings for exiting traffic.

An additional road access to the hospital site is available via the narrow gated access from Castlepark Road at the south end of the hospital site. This entrance is approximately 100m along Castlepark Road, east of Kilwinning Road. This access road is available for general access but is mainly used by staff.

Parking

Ayrshire Central Hospital currently has 430 parking spaces this will increase to 630 in the new development including an appropriate number of parent and child and disabled parking places.

The current total of 430 car parking spaces is broken down as follows:

Total Car parking spaces: 430
Marked Car Parking Spaces: 380
Disabled Car parking Spaces: 50
% of disabled spaces: 11.63%

Car parking within the hospital is uncontrolled and operates on a first come first served basis with no restrictions on duration of stay. Parking is also evident outwith defined parking bays, designated car park areas, on yellow lined areas and within restricted areas around the site. The hospital site currently has no legal status with associated Traffic Regulation Order to enforced parking restrictions on yellow lines.

Equitable Considerations Proposed

Transport

Vehicular access and circulation will be from controlled junctions on the A737 Kilwinning to Irvine Road. The aim is to separate delivery vehicles and other vehicles as early as possible on entering the site and options will be considered for a separate service road potentially using the existing access to the hospital.

It is intended that the existing perimeter drive is retained and becomes part of the circulation system but the aim is to separate and minimise conflict where possible between staff, visitor, delivery and FM vehicles as they enter, move around the site and access the building.

The main entrance hub to the new hospital will be highlighted with a shared plaza and would allow for bus access and include turning circles and designated drop off place only.

Emergency vehicles and visitors setting down patients/ staff and disabled access and car parking would be able to access the Plaza. Staff and visitors arriving by car will be directed to a distributor road linking all car parks.

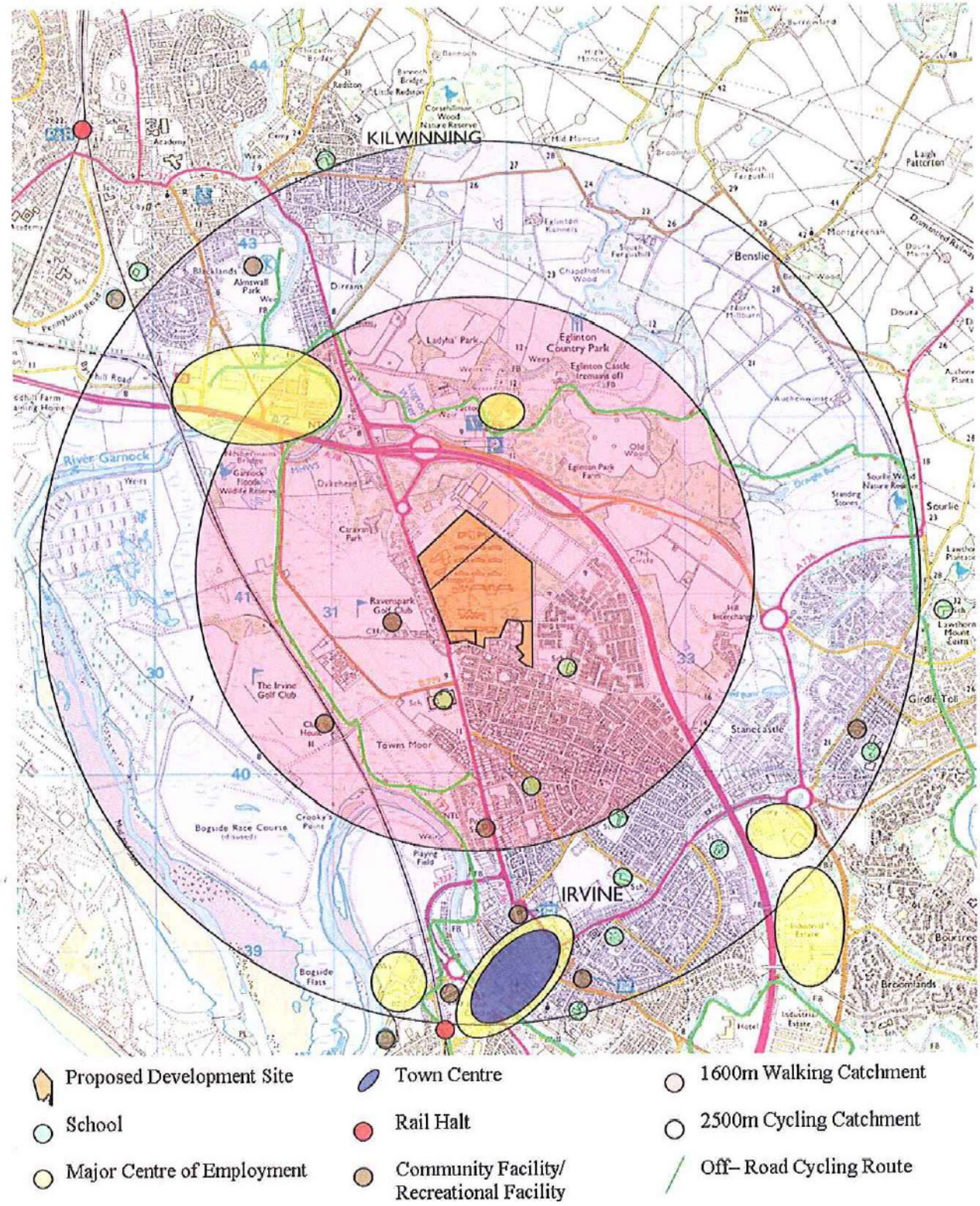
Pedestrian and Cycle Access

The aim is to segregate where possible pedestrian access and circulation including cyclists from vehicular movement.

Shared Pedestrian/ cycle paths entering the site from the A737 to either side of the Main Entrance Drive.

Pedestrian paths within car parks orientated in a north/ south alignment feed into east/ west distributor paths.

Figure 9: Ayrshire Central Hospital catchment area



An entrance plaza is proposed at the hub as an entrance to the new hospital and will provide a welcoming arrival experience. The entrance area would consist predominantly of hard landscaping and include signage, street furniture and lighting. The aim will also to be to avoid cluttering the entrance area

Parking

Under the current proposals car parking provision will reflect the guidance stated within SHTM 07-03, which will result in an overall increase of 200 car parking spaces i.e. from 430 to 630. A suitable car parking management strategy that reflects NHS Ayrshire & Arran's policies on transport will be implemented before the new facility is operational.

A hierarchy of landscape treatments will be introduced to structure parking and movement zones. Structure landscaping will be introduced to compartmentalise the new development and screen the areas of car parking. Tree avenues and tree rows would assist in identifying pedestrian circulation routes to the Main Entrance from the Car Parks. Where there is insufficient space to introduce trees, hedge lines will be used.

Timely Issues Current

Acute mental health and IPCU is currently located on the Ailsa campus, which is a large disparate site. Transfer of patients is neither timely nor dignified at the moment due to the disparate nature of the Ailsa Campus. In addition those patients being transferred from 1D/1E at Crosshouse Hospital are required to undertake a 19 mile ambulance journey with the associated risks for patients and staff.

Within the current estate accommodation constraints mean there is little opportunity to cater for specific diagnosis or presentation in any area with associated impact on most efficient care delivery and patient experience leading to longer episodes of care than may be achievable. Often admitting patients to wards that have concerns regarding anti-ligature provision and the ability to observe 'at risk' patient's leads to delays in admission as additional staffing is required. This in turn often leads to individuals having to remain in the acute care setting for longer periods or requiring to be transferred to the Acute Admissions or IPCU setting if their presentation is no longer felt manageable within the non-acute setting.

Constraints regarding gender and presentation mix can lead to delays in accepting individuals for transfer also until the 'right bed' becomes available.

Flexible, condition appropriate accommodation will address both these issues and optimise the ability to respond to referrals on a timely basis and increase access to this service.

Timely Considerations Proposed

Acute Admissions/IPCU

The co-location of the new adult acute admissions service and IPCU will mean there is ready access to each other's service and reduce the time it takes to effect a transfer.

The new build IPCU will be design specifically for the purpose it was meant to serve and in doing so will address the issue of patient transfer. It will be co-located with the adult acute admission wards and will therefore allow discrete access.

The proposed model for the new-build non-acute accommodation is to have a 30 bedded 'Slow Stream Rehabilitation Unit' provided on a single en-suite room basis. The Unit would be sub-divided into smaller 'pods' that would allow gender and condition specific adaptation to ensure the provision of individualised person-centred care.

The 'Fast Track' Rehabilitation Unit will have 12 beds, again all single and en-suite but 3 of these beds will be within single self-contained bed-sit type accommodation to allow individuals to practice independent living skills prior to discharge.

Both these rehabilitation wards will be purpose built and will address all of the issues regarding observation and timely admissions.