BOARD OF DIRECTORS MEETING

Date: 12th July 2017 **Item Ref:** 7

TITLE OF PAPER	**Longley Centre Phase 2 - Acute Bed Requirements**
TO BE PRESENTED BY	Clive Clarke – Deputy Chief Executive
ACTION REQUIRED	For collective decision to review paper and agree next steps
OUTCOME	Approval of paper
TIMETABLE FOR DECISION	
LINKS TO OTHER KEY REPORTS / DECISIONS	Longley Centre Development CQC action plan Clinical Strategy and Estates plan
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Decision needed to enable progression with next steps for the Longley Centre
CONSIDERATION OF LEGAL ISSUES	

Author of Report	Lisa Johnson, Deputy Service Director
Designation	Inpatient/ Acute Directorate
Date of Report	12th July 2017

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **12th July 2017**

Subject: **Acute Bed Requirements**

Presented by: **Clive Clarke Deputy Chief Executive**

Author: **Lisa Johnson Deputy Service Director, Giz Sangha Clinical Director, Richard Bulmer Service Director**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
	√				

2. Summary

The attached paper includes the following:

- Progress to date
- Analysis of the current system and service user profile
- Review and efficacy
- Clinical Strategy and Estates Requirements
- Future acute bed requirements

Analysis of bed use

Admissions only take place when alternatives have been considered and used where appropriate

- Alternatives to admission are vital to maintaining the bed numbers. This includes intensive home treatment (hospital at home), crisis house and step-down provision
- Low numbers of admissions and beds in Sheffield compared to the national picture
- No out of area acute bed use due to lack of capacity for 2 ½ years

Beds of care

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Total beds of care/ occupancy for whole age range acute in and out of city	141.8	127.8	116.1	104.7	84	68.5
Number of out of town bed nights	2939	1190	557	444	0 due to lack of capacity	0 due to lack of capacity

Bed Numbers
There has been good work across the pathways to reduce bed numbers, down from 90 to 49 acute beds, from 44 to 18 older adult beds. Modelling shows that with a length of stay of 31 days in acute care, 520 admissions can be managed in 49 beds with an occupancy of 91%. Modelling shows that with a length of stay of 70 days older adult acute, 70 admissions can be managed in 18 beds with an occupancy of 75% or 95% on a 14 bedded ward

Clinical Strategy and Estates

The purpose of this review was to

- Define the current and potential service re-design plans that had a direct or indirect impact on the use and utilisation of inpatient services across the Trust in general and the Longley Centre as a key site within the Trust's estate
- Consider the options available to support each of the service re-design plans
- Understand the broader and collective implications in respect of the Longley centre estate and the Trust's capital programme
- Reach a conclusion as to the best fit between the clinical strategies and estate strategy

Longley Centre services

- 3 acute wards
- Dovedale
- Endcliffe
- ECT
- Psychiatric Decision Support Unit
- 136 Suite
- Crisis Hub

3 Next Steps

- Maintenance and developments in ways of working of alternatives to admission including crisis house and step-down beds
- Maintain gatekeeping and capacity management (beds and community)_
- Reduce acute length of stay from 33 to 31 days
- Reduce older adult length of stay to 70 days
- Continue to manage and challenge delays to discharge and pathway blocks
- Support Psychiatric Decision Unit
- Maintain and develop crisis beds and step-down beds, continued effective contract management
- Reconfiguration of CMHTs and gaining accreditation for home treatment across the age range
- Home Treatment to work more as a 'hospital at home' model and the development work to support this.
- Proceed with Longley redesign and wider estates strategy

4 Actions

Review paper and agree next steps

5 Monitoring Arrangements

Inpatient, Community and Specialist Directorate SMT
EDG
Capital Board for estates elements

6 Contact Details

For further information please contact:
Lisa Johnson Deputy Director Inpatient Directorate

Acute Care Bed Capacity Requirements

4th July 2017

Lisa Johnson Deputy Service Director
Richard Bulmer Service Director
Giz Sangha Clinical Director

Contents

1. Introduction

The aim of Acute Care Reconfiguration has been to provide high quality acute care in the least restrictive environment and as close to home as possible.

Inpatient Directorate Mission Statement:

> The directorate has developed a high level mission statement that aims to outline the direction and principles that inform all developments and on-going service delivery.
>
> We provide an environment where people with mental and physical health problems requiring 24 hour care are supported in their recovery in an environment of respect, kindness and compassion.
>
> The environment will be orderly, tranquil and clean.
>
> Staff are confident, well -mannered and have high levels of expertise in providing evidence based assessments, investigations and recovery focussed care while supporting their own and others emotional wellbeing.
>
> Service users and their families are actively listened to and involved in the planning of interventions and care.

This paper defines the number of acute care beds required and the requirements for alternatives to admission. Alternatives to admission are vital to maintaining the bed numbers. This includes home treatment which is continuing to be developed, providing intensive interventions in the least restrictive way. This is known as 'hospital at home' or a 'ward in the community'. Crisis house beds and step-down provision are also essential elements of the acute care pathway.

The paper also summarises the Clinical Strategy and Estates work stream and aims to enable the next steps in finalising the Longley design for the centre of acute bed based care as well as the future crisis hub and psychiatric decision support unit. Reference is made to benchmarking information, current activity and predictions about future requirements.

The paper is organised under the following main headings:

- Progress to date
- Analysis of the current system and service user profile
- Review and efficacy
- Clinical Strategy and Estates Requirements
- Future acute bed requirements

2. Progress to date

2.1 Reducing ward bed numbers

During Acute Care Reconfiguration ward sizes have reduced from mostly 24 bedded wards across the age range down to a maximum of 18 mental health beds per ward. This is a significant quality and safety improvement. It is important to note that prior to acute care reconfiguration some of our 24 bedded acute wards were regularly running at up to 120% bed occupancy. Smaller wards with the same or enhanced staffing levels have improved the ratio of staff to service users. This improves the capacity to spend time 1:1 with service users and to support them on their journey of recovery. This has supported the reduction in length of stay for service users from 52 to 33 days.

2.2 Beds of Care

The table below shows how acute beds of care across the age range have reduced during acute care reconfiguration.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Total beds of care/ occupancy for whole age range acute in and out of city	141.8	127.8	116.1	104.7	84	68.5
Number of out of town bed nights due to lack of capacity	2939	1190	557	444	0	0

2.3 Elimination of Out of Area Bed Use

The lack of out of area bed use due to lack of capacity has reduced greatly over time and is being maintained. This is in a national context of most Trusts continuing to regularly place people out of town, some in large numbers every year. This is a great improvement in safety and quality for service users as well as a diversion of funding back into the NHS and the city.

SHSC is seen as an area of good practice with a number of trusts coming to learn from our acute care reconfiguration and SHSC won the Health Service Journal Redesign Award in 2016.

2.4 Providing fit for purpose, therapeutic and healing environments for the delivery of acute care

The first building to be designed and built as part of Acute Care Reconfiguration was our Psychiatric Intensive Care Unit Endcliffe. Our PICU environment was totally transformed and along with this staff have also developed new ways of working. Endcliffe has won three national design awards and the National Association of Intensive Care Units Team of the year award.

We are now designing the rest of the Longley Centre for provision of all of our acute care beds across the age range. These wards will be fit for purpose, EMSA compliant and provide safe, effective therapeutic environments. The location of acute care beds at the Longley Centre is in line with the Clinical and Estates Strategy (section 5).

3. Analysis

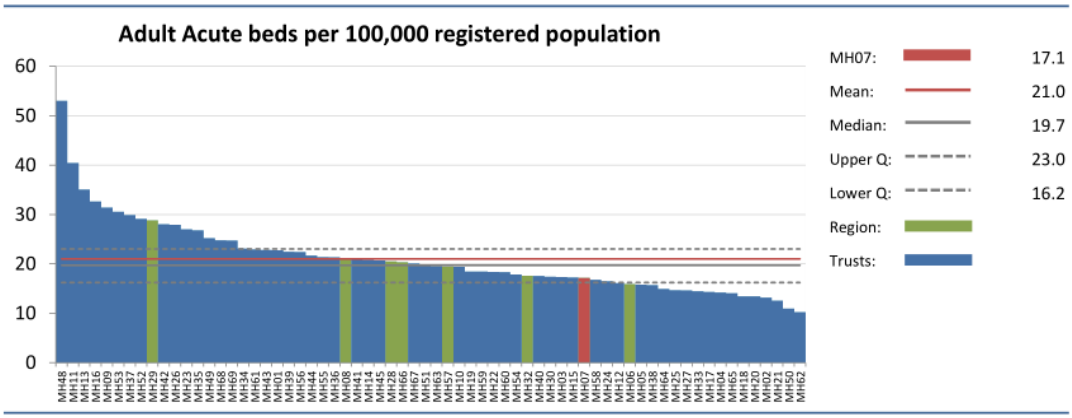
3a Analysis How the System Works

Benchmarking and current activity:

The NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking report was published in October 2016; considering the data presented within this, the below has been identified.

3a.1. Adult Acute

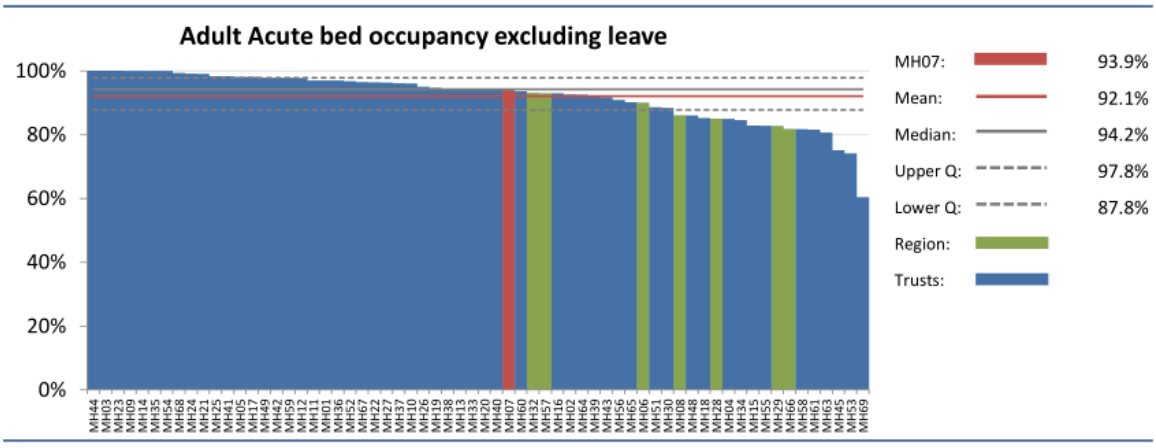
Adult Acute beds based on population:



In 2015/ 16 SHSC benchmarked well below the national average for the number of beds at 17.1 with the lowest Trust having 12 beds per 100,000 registered people. Since the data was produced for benchmarking SHSC have closed a 24 bedded acute ward and confirmed our wards as being a maximum of 18 beds.

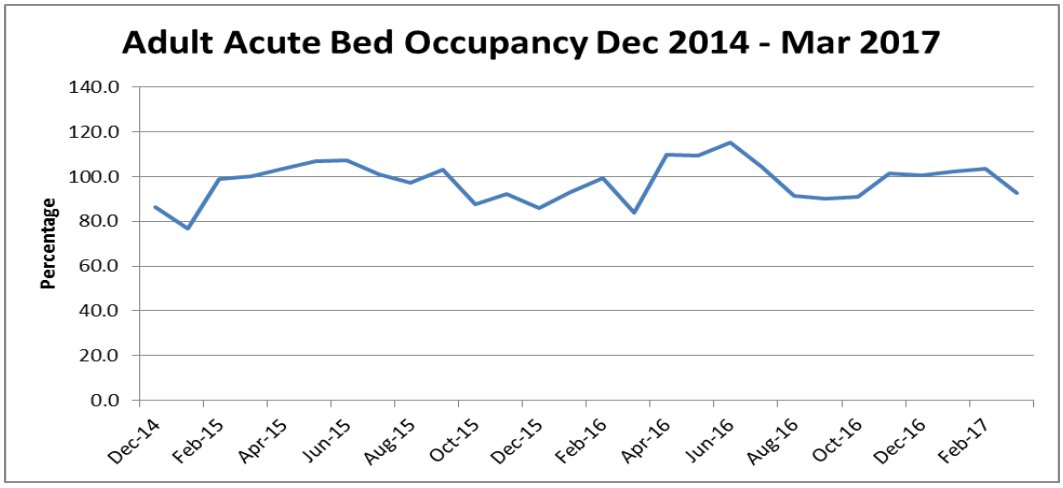
Our current bed numbers would give a figure of 12.5 acute beds per 100,000 population. This would be the lowest figure based on 2015/16 benchmarking and likely to benchmark as low compared to other Trusts. SHSC have been recognised by other trusts as an area of good practice and this has been nationally acknowledged.

Adult Acute Bed Occupancy exc. Leave:



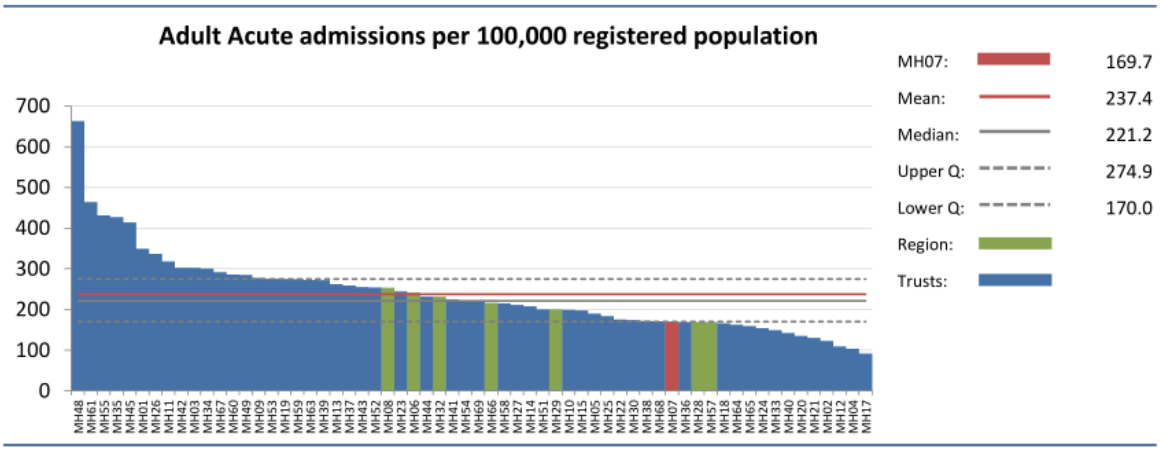
Adult acute occupancy for our organisation in 2015/16 was 93.9%, above the national average of 92.1%.

The chart below shows the bed occupancy of the Adult Acute wards over period December 2014 – March 2017. It is important to note that over this period the bed base has reduced.

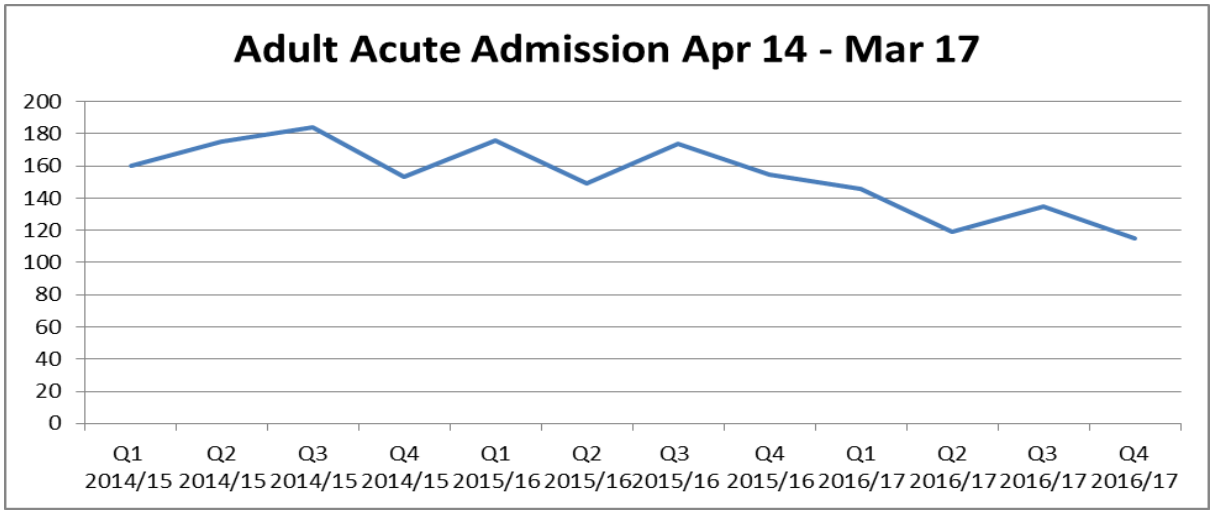


The table above shows our occupancy varies and there have been times when it has been over 100%Occupancy for May 2017 was 99%. Our aim is for occupancy of around 90%.

Adult Acute Admissions based on population

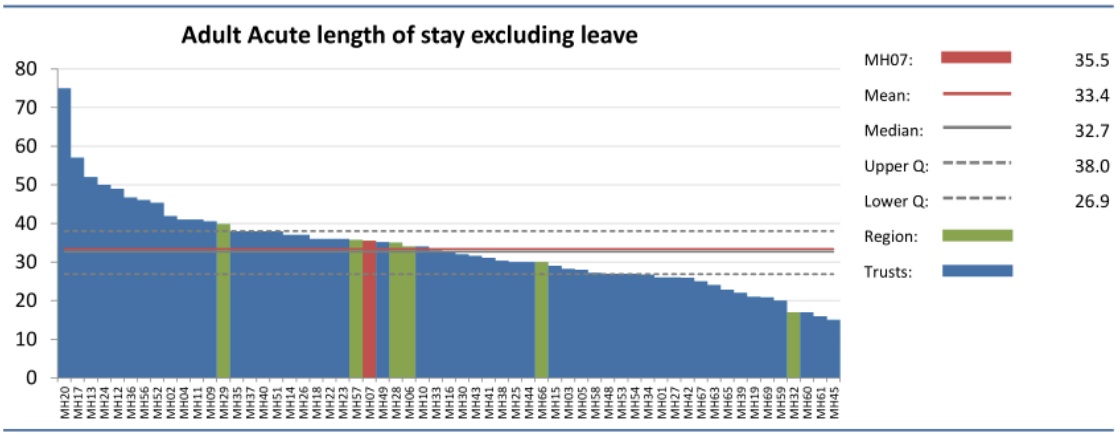


The number of adult acute admission is low and below the average at 169.7 and benchmarks well both regionally and nationally.

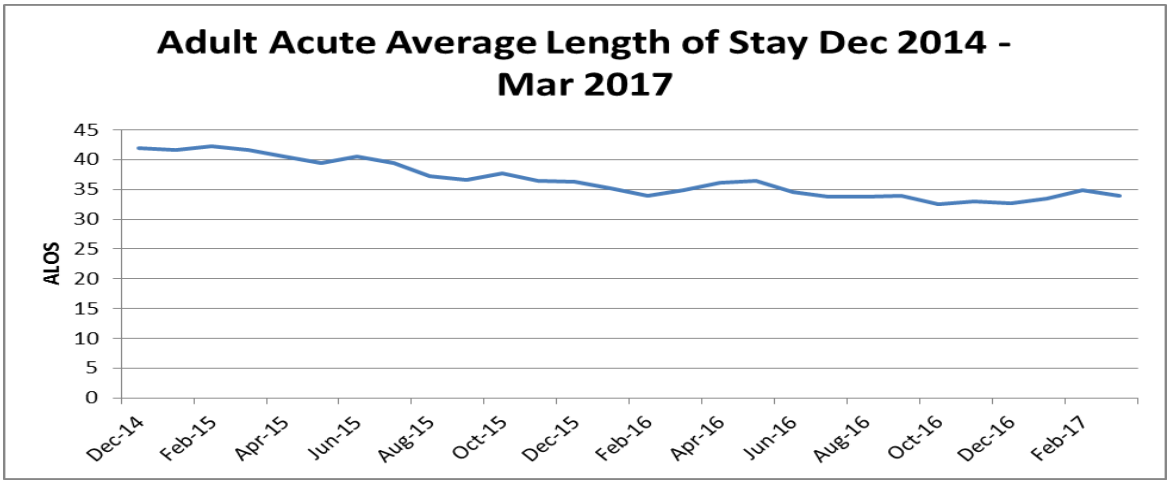


This shows that our admission numbers have fallen significantly due to reconfiguration and new ways of working. The admission rates are now fairly constant at around 45 per month.

Length of stay exc. Leave



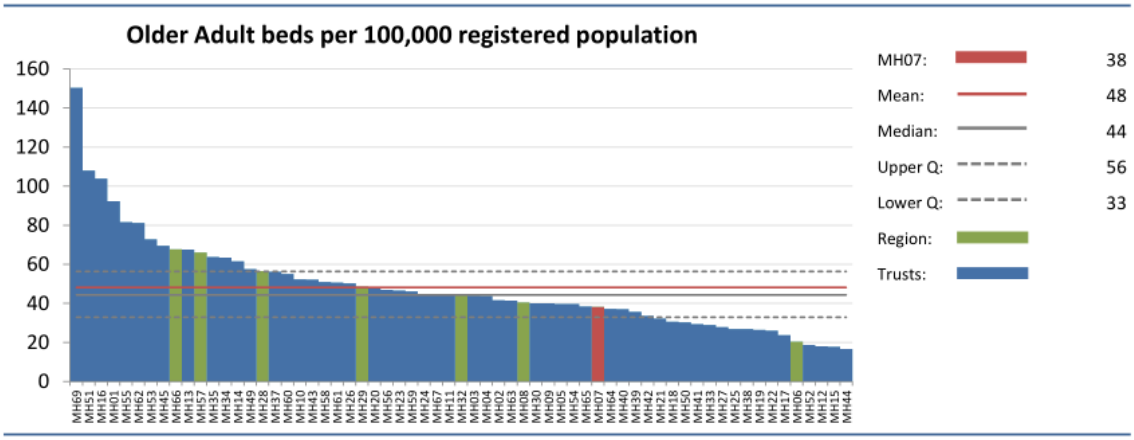
SHSC was slightly above average for acute length of stay in the 2015/16 benchmarking with a length of stay of 35.5days.



The inpatient directorate is continuing to work with clinical colleagues to aim to deliver an average length of stay of 31 days.

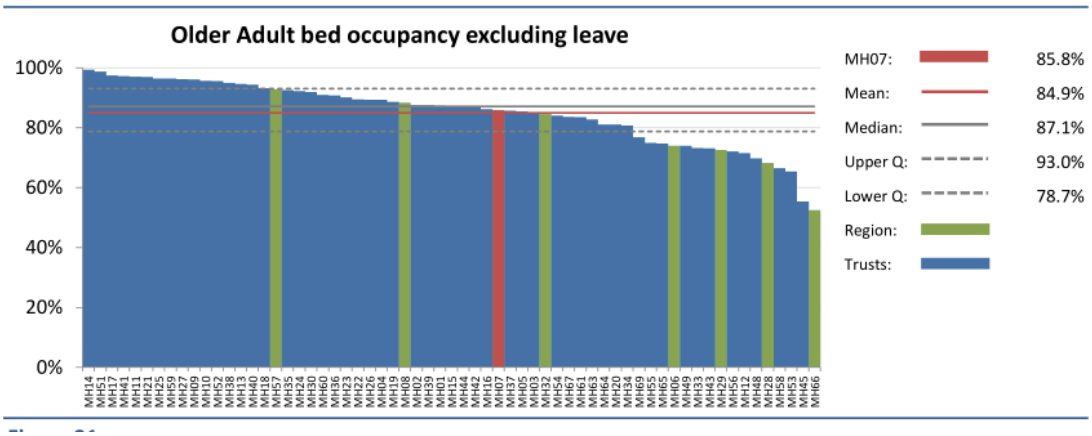
3a.2 Older Adult Acute

Older Adult beds based on population

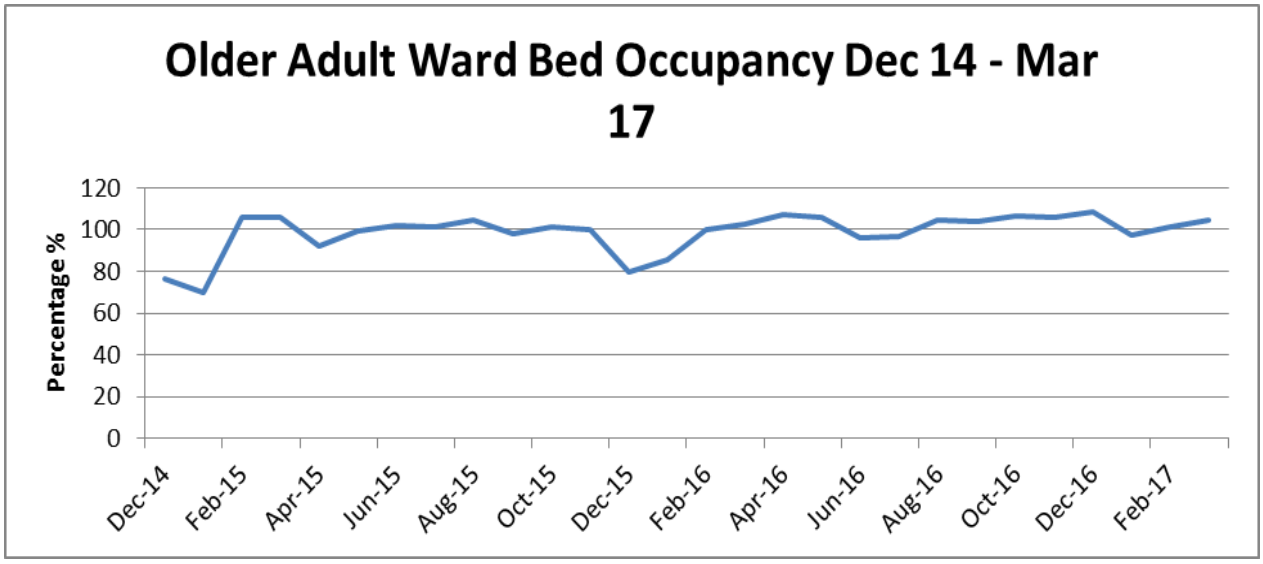


SHSC have a below average number of older adult beds at 38. This figure includes dementia and functional beds.

Older Adult Bed Occupancy

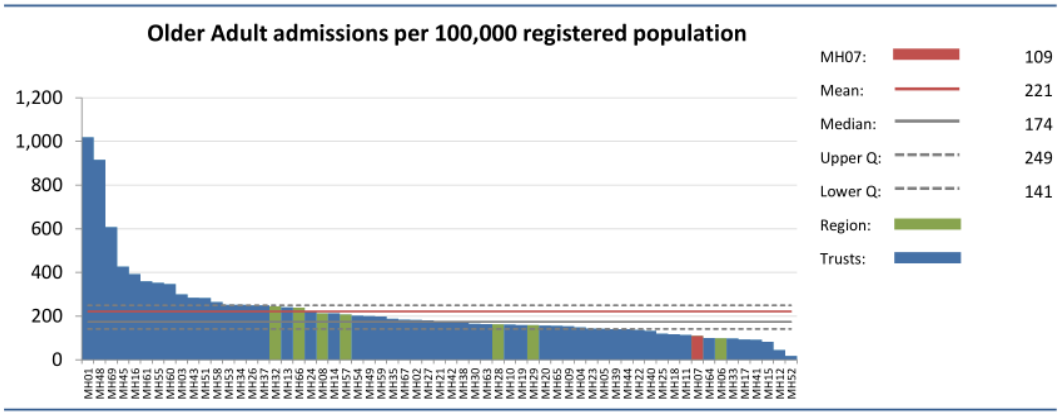


SHSC bed occupancy overall is just below average however the table below shows Dovedale occupancy is regularly running at just over 100 % bed occupancy.

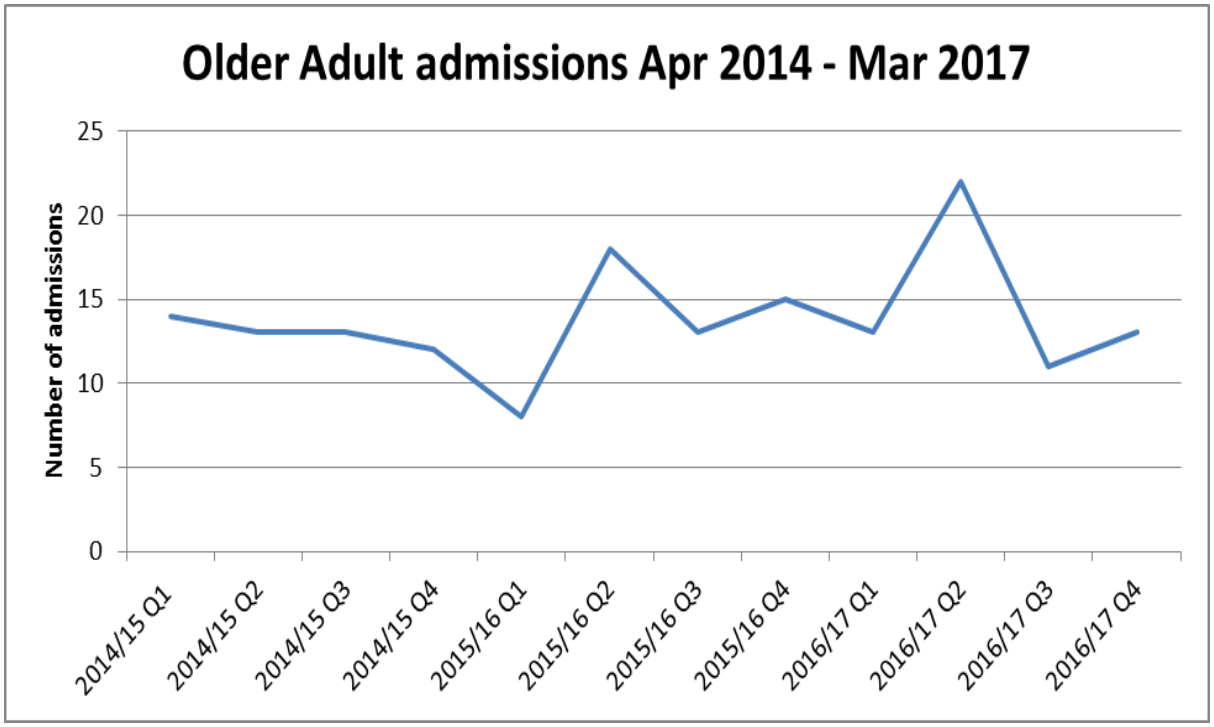


Microsystems work has commenced on Dovedale ward and ward staff are engaging with this process. The aim is to lower bed occupancy by reducing length of stay.

Older Adult admissions based on population

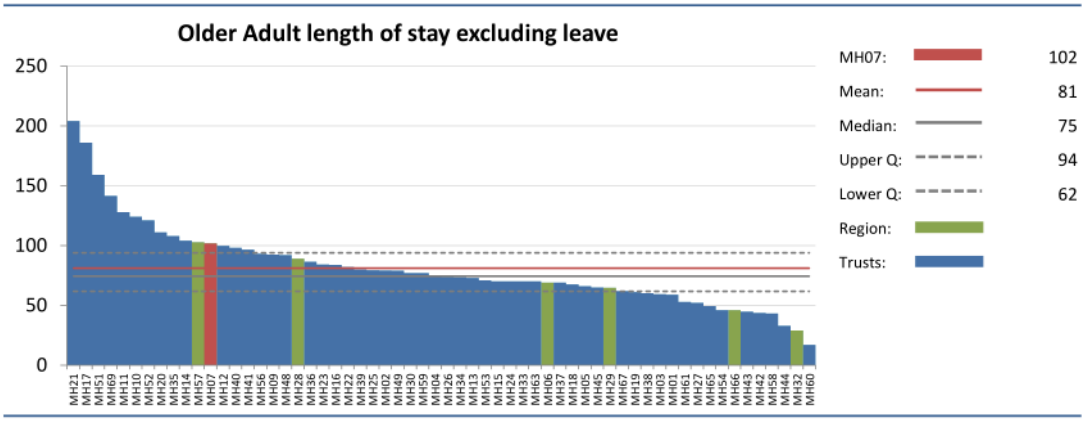


SHSC has a low admission rate for older adults, the table below shows admission over the past 3 years.

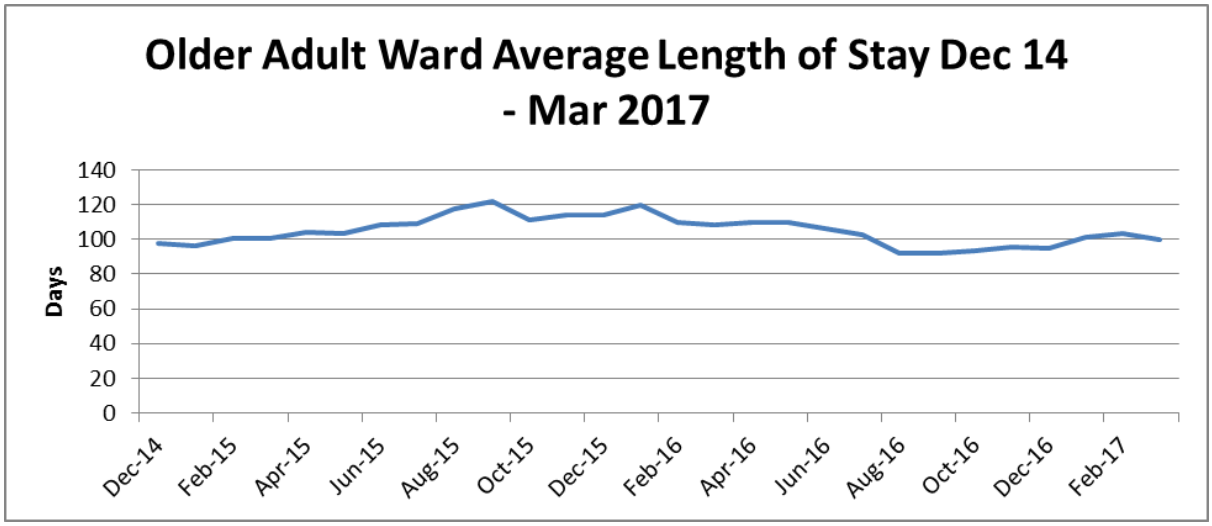


There is an average of 6 Dovedale admissions per month.

Older Adult Length of stay



SHSC older adult length of stay is 21 days higher than the national average. This is a key area of quality improvement focus for the directorate.



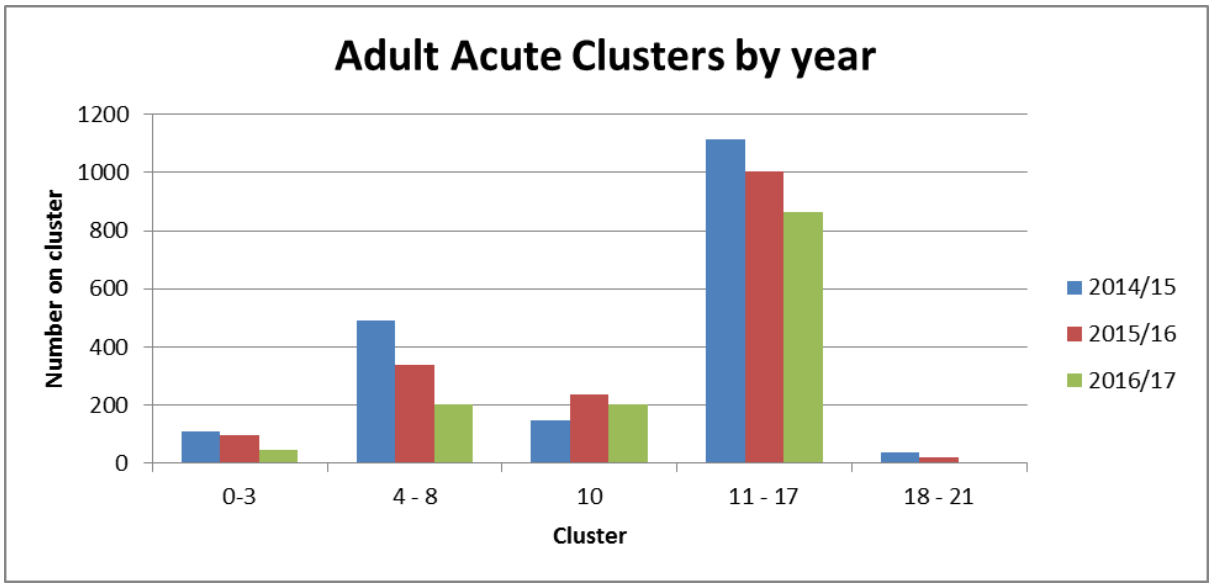
3a.3 Out of area placements

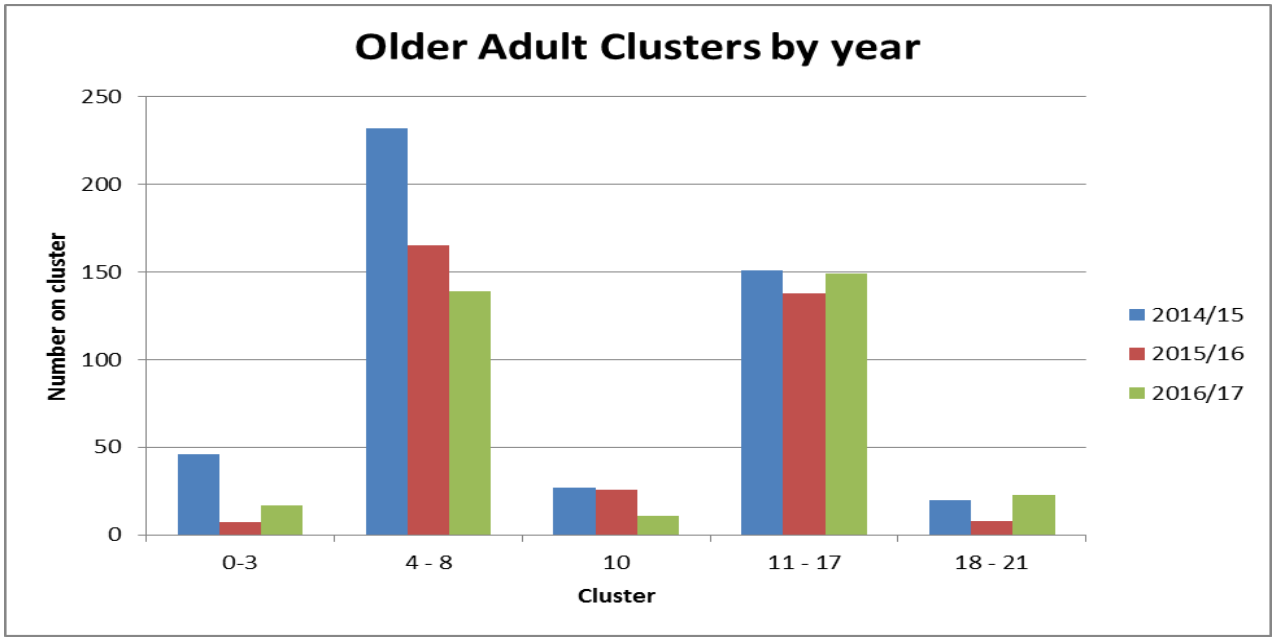
SHSC has not placed anyone out of town due to lack of bed capacity for two and a half years this is in a national context where many trusts continue to place people out of town for care.

3b Analysis - Service User Profile

Analysis of the service user profile on our acute wards across the age range has taken place and the headlines from this are summarised below.

3b.1 Clustering review



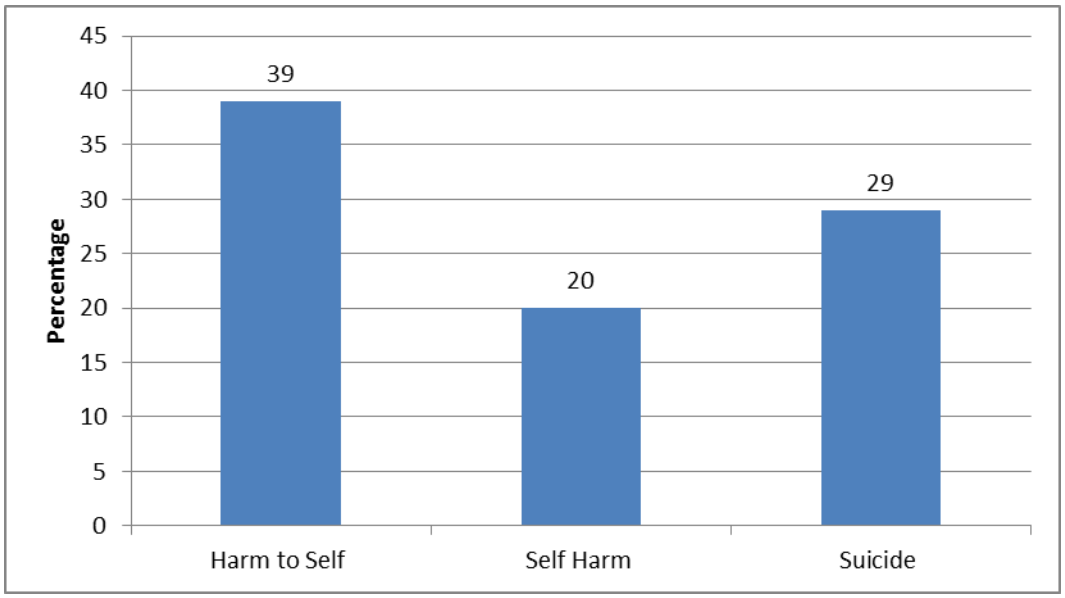


The clustering definitions can be found in appendix C. Detailed clustering information can be found in Appendix D. The clustering data shows that there has been a positive reduction in clusters 0-3. We are continuing to ensure clustering reviews show the most appropriate cluster.

3b.2 Risk and Vulnerability review

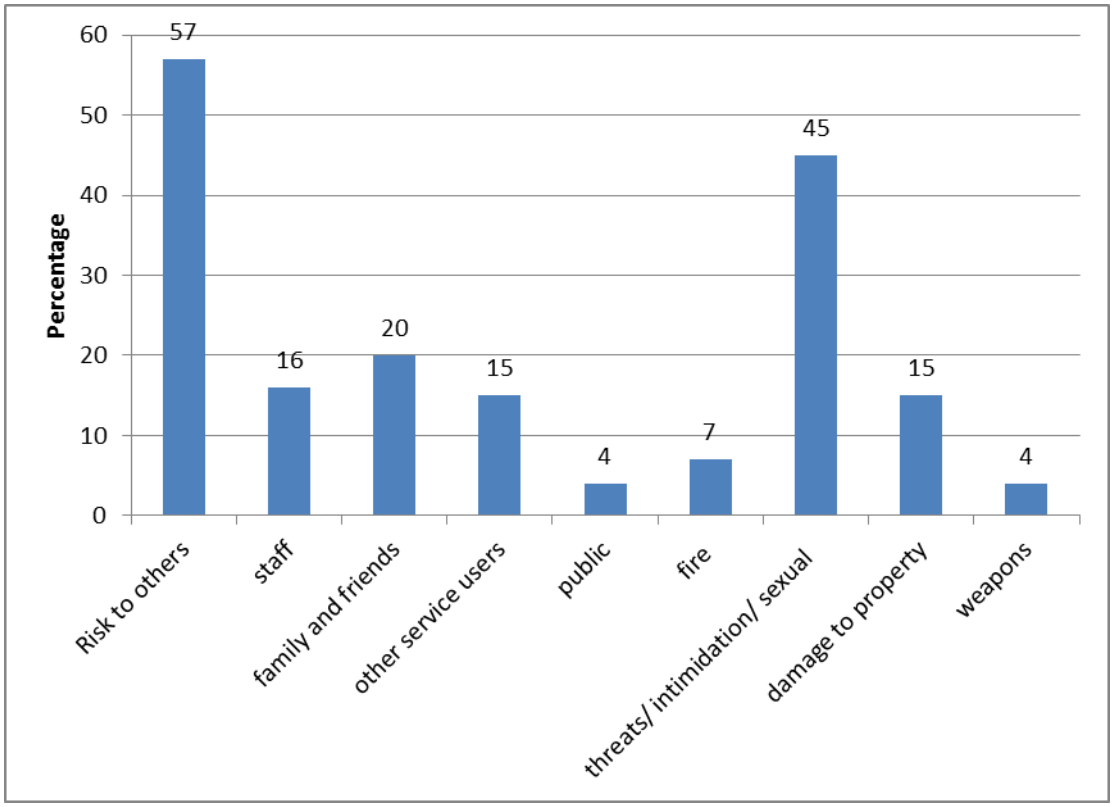
A snapshot review of vulnerability of the Inpatients in that day has been carried out using information from the detailed risk and management assessments (DRAM) – whole age range on 5th April 2017 excluding detox beds. This included current risk and anything over the previous 4-6 weeks. What the information does not capture is the risks posed by everyone at the point of admission. There are a number of people who have well managed risks or their risks have diminished as their mental health has improved. There are also a small number of individuals were the risks have increased due to being admitted and having access to more vulnerable people.

39% of the acute ward population as of 5th April 2017 are a risk to themselves.



Risk to self / self harm / suicide. The risk to self includes behaviours that make the individual vulnerable including neglect, impaired decision making etc.

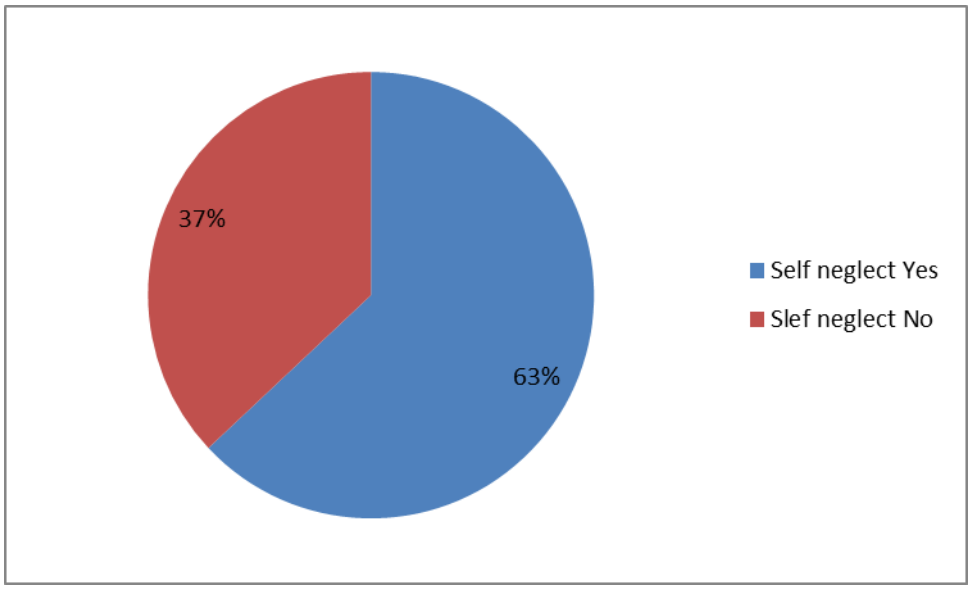
58% are a risk to others with family and friends the most likely to be affected.



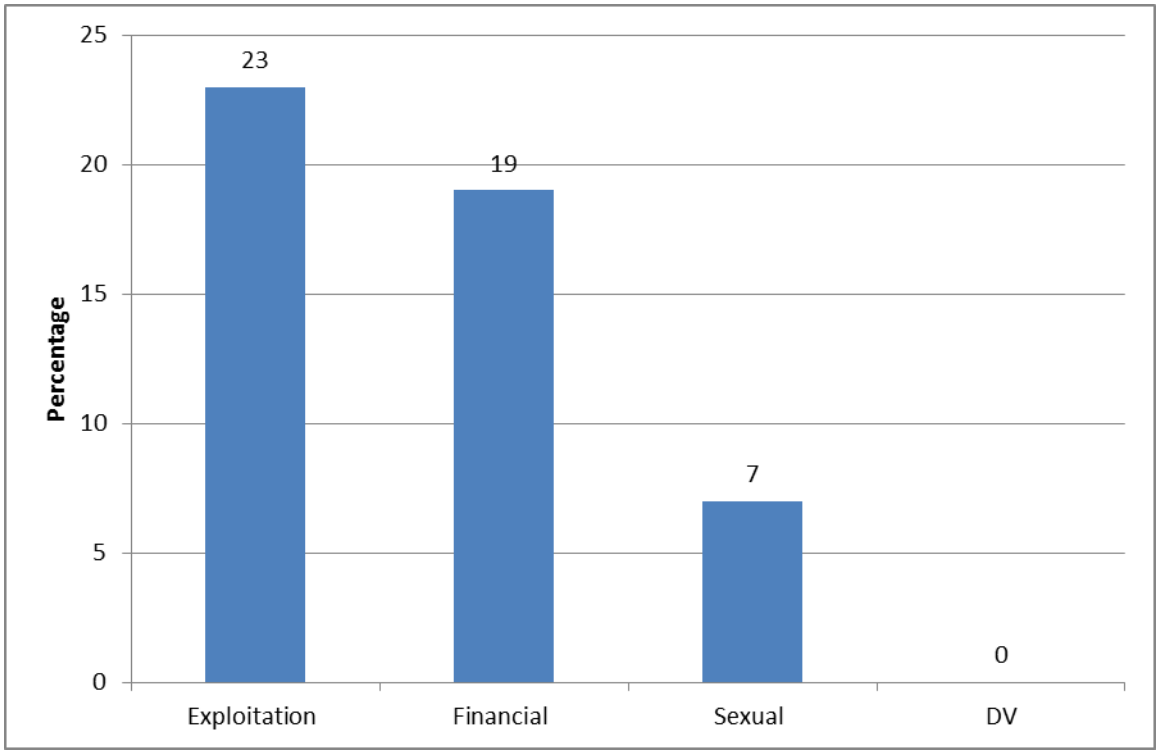
There are 5 people with a recent history of fire starting although there are others who have a historical risk of arson; actual or suspected.

Self neglect

64% of the population self-neglect. This jumps to 89% of the Dovedale population. There are more than come in with self-neglect but is not a current risk

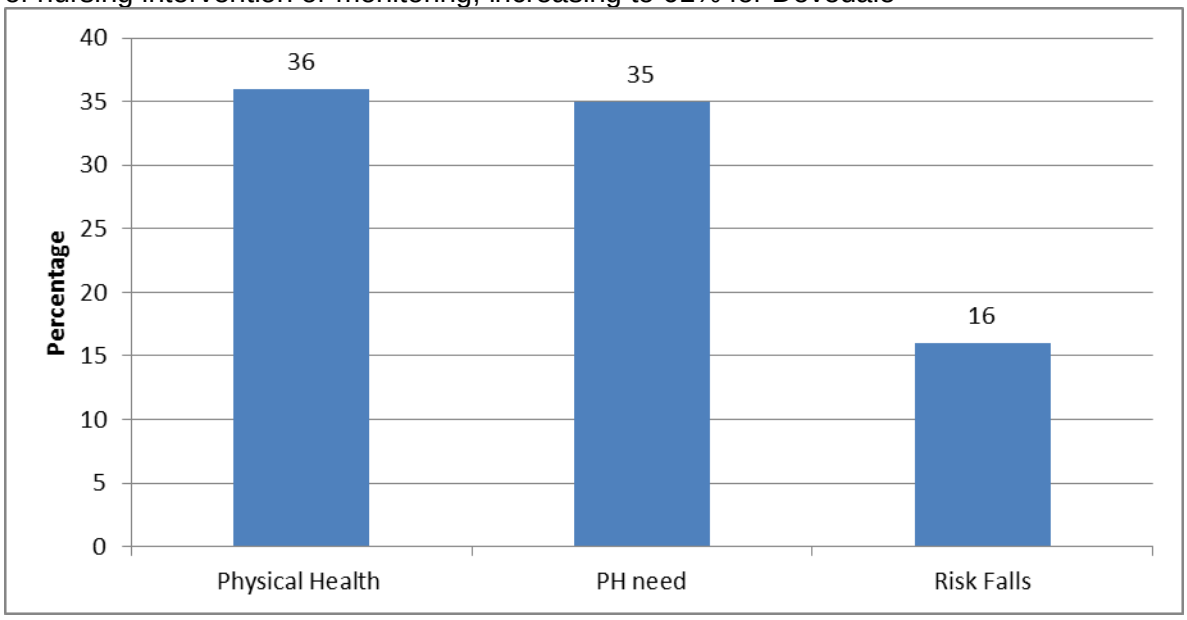


23% are at risk of exploitation with financial being by far the highest. This may not fully capture the vulnerability of our population as coming into hospital can resolve that but it might be an issue on discharge. There were no reported current Domestic Violence and only 1 historical reference



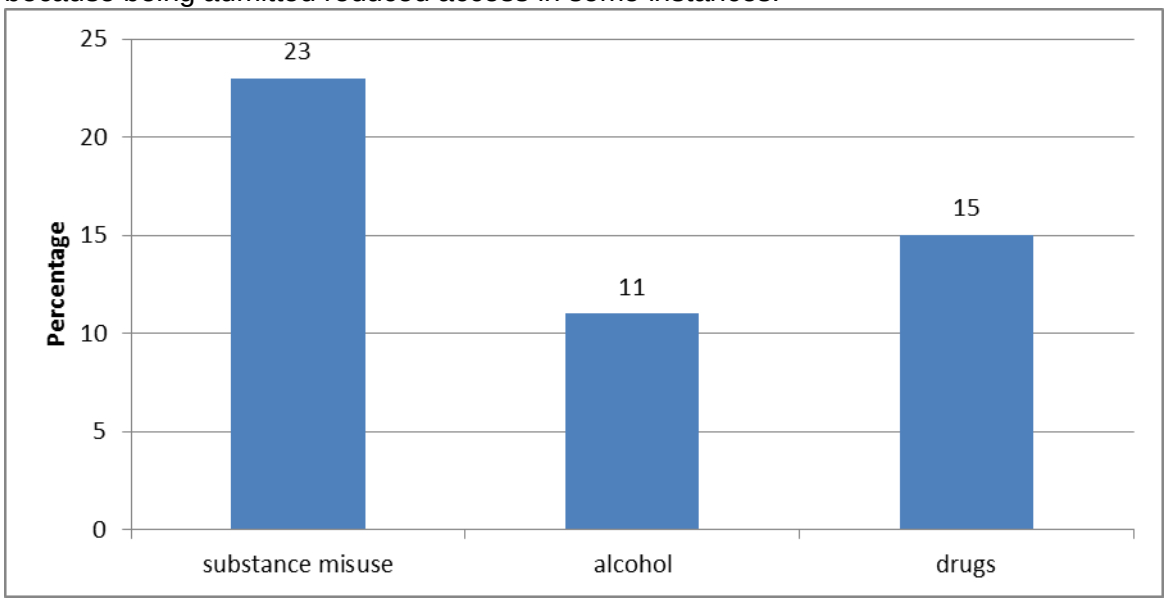
Physical Health needs

37% of the population had a physical care need – defined as those who required some form of nursing intervention or monitoring, increasing to 61% for Dovedale



Substance misuse

23% had substance misuse. It is noted that this may be under reported within the DRAM because being admitted reduced access in some instances.



17 (23%) were identified as being at risk of absconding.

There were 6 people who were disinhibited and/or wandered into other people's rooms

There were 3 (4%) who had no risks documented and 8 (11%) had 1 risk recorded. Everyone else (85%) had multiple current risk indicators

3b.3 Age

Admission data for the last 3 years shows that Dovedale admissions for those 64 and under are as follows:

2014/15	3
2015/16	4
2016/17	3

Admission data for the last 3 years shows that acute admissions for those 65 and over are as follows:

2014/15	22
2015/16	33
2016/17	21

The data shows that there continue to be fairly low numbers of older adults on the acute wards. The number of younger people on Dovedale rose in 2015 / 16 but has now returned to around 20 admissions per year – approximately 25% of admissions. This shows that older adults are not being increasingly placed on the acute wards due to there being less beds on Dovedale Ward.

3b.4 Review of Admissions

A review of the last 100 acute admissions was carried out by lead clinicians showed. This included detailed discussions as well as Insight review as well as confirmation of gatekeeping. This review showed that at the point of admission all service users required an acute hospital admission. Within the 100 people where there 3 who is possible with a more intensive package and earlier intervention was not have deteriorated to the point of admission being required.

The recorded diagnoses were as follows:
The diagnosis of the last hundred acute admissions (21.02.17) is broken down as follows
No diagnosis on Insight – 37%
Psychosis – 18%
Schizophrenia 15%
Depression 9%
Bipolar 7%
Personality disorder 6%
PTSD 5%
Delirium 1%
Alcohol 1%

Diagnosis recording is to be reviewed on an ongoing basis as agreed in the Inpatient Directorate Service Review

The diagnosis recorded are those which would be expected in acute care and there is a recognised reduction in the number of bed nights used by people with personality disorder this is in line with best practice.

4. Review and Efficacy of Acute Care System

The Acute Care System in Sheffield is working well and is supported by a wide range of services internal and external to the Trust. All service users go through effective gate keeping. Home treatment is considered for all service users across the age range. There are clear pathways into acute care from liaison services as well an increased and improved access to the 136 suite Place of Safety.

4.1 Community Developments Including Home Treatment

Home treatment is a fundamental part of the Acute Care Pathway and this remains an essential part of the Community Mental Health Team Reconfiguration. Home treatment is continuing to be developed, providing intensive interventions in the least restrictive way. This is known as 'hospital at home' or a 'ward in the community'. There are a range of changes being designed to the pathways of care. This will include the future introduction of a psychiatric decision support unit as well as further work on the Personality Disorder pathway. The CMHT reconfiguration will also improve the service user journey and the consistency of home treatment.

4.2 Crisis House Activity and next steps

The Crisis House opened on the 29th April 2013, the aim of this service is to provide short term accommodation for people experiencing a mental health crisis. There are 6 beds in total of which one is on the ground floor suitable for someone with mobility problems. The service is run and staffed by the Rethink mental health charity and commissioned by Sheffield Health and Social Care NHS Foundation Trust, the vision for this was for the service to act as admission avoidance. The Crisis House is well used and integrated into the home treatment pathway. Occupancy is running around 85% which is in line with the agreed performance indicator. The Crisis House continues to receive positive feedback from Service User and SHSC staff. The Crisis House is now making a positive impact on the number of admissions. This has been achieved by robust and effective contract management and joint action planning with Rethink.

Contracting status and next steps

The initial contract for this was agreed for 3 years plus 1, plus 1 and is currently in its second plus 1 extension. Following consultation with community and specialist directorate, it is the plan of the inpatient directorate to go out to tender for Crisis House provision as we all see the Crisis House as an essential alternative to hospital admission and a positive less restrictive environment to acute care. The directorate will work with colleague in other directorate to agree the required specification for Crisis House beds.

4.3 Step-down and Wainwright Crescent

Wainwright crescent (WWC) now provides and increased number of step down beds in order to support the acute care pathway. Step down provision is an essential part of maintaining service user flow. It has been agreed with EDG that a review of Wainwright Crescent use will be carried out in September 2017 and this will inform the required next steps. The inpatient directorate are considering all potential alternatives to admission including what bed based service are required.

4.4 Summary of Bed Use

All of the data and clinical knowledge reviewed has shown that all hospital admissions have been appropriate at the time of admission with appropriate gatekeeping having taken place. The admission numbers are low compared to the national benchmark. The length of stay could be reduced further, particularly for older adults.

5. Clinical Strategies and Estate Strategy Requirements

During February- April 2017 a review of current clinical strategies, and service transformation plans was undertaken alongside the Trust's Estate strategy.

The purpose of this review was to

- Define the current and potential service re-design plans that had a direct or indirect impact on the use and utilisation of inpatient services across the Trust in general and the Longley Centre as a key site within the Trust's estate
- Consider the options available to support each of the service re-design plans
- Understand the broader and collective implications in respect of the Longley Centre estate and the Trust's capital programme
- Reach a conclusion as to the best fit between the clinical strategies and estate strategy

The review was undertaken over four meetings involving service and clinical directors and assistant directors from the Inpatient, Specialist, Community and Learning Disability services along with senior input from the Facilities Directorate.

5.1 Defining the Clinical Strategies

The current and potential requirements in order to meet SHSC Clinical Strategies were reviewed. These included the following areas:

- Acute inpatient services
- Crisis Hub Model
- Dementia Pathway – Intermediate Care
- Location and provision of older adults care
- Firshill / Inpatient Learning disability provision
- Memory services

Detail regarding this can be found in Appendix 1a.

5.2 Estate implications and assumptions

To inform the review of options indicative cost assumptions were used to inform a view regarding financial impact and benefits. These were illustrative costs that drew upon previous costing work undertaken to inform current planning or alternative plans in previous years.

The cost assumptions supported the group to make relative decisions in terms of the benefit, or not, of various options. These included the acute ward numbers and Dovedale location. A summary of this can be found in Appendix 1b.

5.3 Conclusions from the Review

Firshill Rise should continue as a separate unit. The review concluded that there were no significant financial benefits of locating it within the Longley centre and the required space was not expected to be available.

G1 will remain at Grenoside and the rest of the site will be utilised more effectively. There was not the space to accommodate it within the Longley centre therefore it had to remain there as other options to re-locate it would not have supported the broader Estate strategy direction.

The Longley centre, going forward, will consist of the following services

- Endcliffe Psychiatric Intensive Care Unit
- Four acute wards (three adult, one older adult). The review concluded that future capacity is not expected to reduce and have an impact on future ward requirements.
- Crisis Hub services co-located adjacent to each other on the Longley site. This will support effective management and clinical responses across the separate components of the model and make best use of shared space and accommodation.
- ECT service
- The Memory Service relocated to a modernised Longley Meadows site. This was considered the best option in respect of utilisation of the main site. There is a business case for the relocation of a primary IT data centre and one option is the Longley Meadows site. If that is progressed the potential to return Longley meadows to Clinical use will be lost.

5.4 Estate Strategy and Plans – Next steps as a result of the above

The next step from the above is to produce the outline business case for the Longley Centre that supports the above service configurations.

This work is being directed and progressed through the Trust's Capital Board in respect of developing and producing the internal outline business case through to the full business case for approvals by the Board. The governance process and approval through NHS I will be co-ordinated between to Trust's Finance and Capital Development teams via Capital Board. The scheduling of this development work is being finalised.

The outline business case is scheduled for review in September 2017.

6. Future Acute Bed Numbers

The Inpatient Directorate, in collaboration with Specialist and Community colleagues are recommending the following model for future bed based provision:

6.1 Acute Beds

The review of admissions and discussion of service user stories / case vignettes shows that only the most unwell people are admitted to hospital. The reasons people cannot be supported at home are due to their level of risk to themselves or others.

The current system needs to have capacity for an average of 45 admissions per month, with a length of stay of 31 days this would mean 46 occupied beds – 94% occupancy of the current 49 beds. Occupancy is currently higher due to the length of stay being around 33 days. In order to achieve occupancy of 85 – 90% a further reduction in admissions would be needed, down to 43 per month.

The Inpatient Directorate recommend that there are 3 acute wards for adults with a maximum of 18 beds on each. As more work takes place to reduce length of stay and admissions it is anticipated that a lower occupancy can be sustained. This will improve the quality and safety of the service and improve SHSC's benchmarking position.

6.2 Dovedale Beds

Admissions to Dovedale take place for the most acutely unwell service users. It is the Dovedale length of stay which is an outlier nationally. The average Dovedale admissions are 5 per month. It the length of stay was 70 days this could be managed in 14 beds. This is a focus for quality improvement across inpatient and community services. The Inpatient Directorate recommend a long term plan for a 14 bedded ward but an interim position of 17-18 beds dependent on the EMSA estates option.

6.3 Location of Wards

A decision has been made to locate acute beds at the Longley Centre and design work is progressing for this. As part of the review of plans an options appraisal for the location of Dovedale ward was carried. The outcome of this is that it is preferable for Dovedale to have new facilities on site at Longley. This provides improved links with STH, equal access to improved environments, easy access to shared spaces e.g. tribunal, activity space, ECT and on the occasions required easy transfer between wards. This has been confirmed through the Clinical Strategies and Estates work stream (see section 5)

7. Next steps

The Directorate would like to progress with design of the future wards keeping the current acute bed numbers and working towards 14 beds for Dovedale Ward. This will be possible by continued provision of high quality alternatives to admission including intensive home treatment across the age range, crisis house and step down beds. The required actions to further reduce length of stay will include reviewing how all alternatives to admission are working and what else can be done. This is in addition to the ongoing focus on ensuring most effective lengths of stay.

The specific actions to be taken to support pathway development, management and acute care flow include:

- Maintaining gatekeeping and bed management
- Reduce length of stay from 33 to 31 days on acute wards
- Reduce length of stay on Dovedale to 70 days
- Continue to manage and challenge delays to discharge and pathway blocks
- Support Psychiatric Decision Unit
- Maintaining and developing crisis beds and step-down beds by continued review, effective contract management and contracting
- Reconfiguration of Community Mental Health Teams and gaining accreditation for home treatment across the age range
- Proceeding with Longley redesign and wider estates strategy

8. Governance and Accountability

- Approval via EDG and Trust Board
- Monitoring through EDG, TOG and Inpatient Directorate SMT
- Estates work through Capital Board

Appendix 1
Clinical and Estates Strategy

1a. Clinical Requirements

Service development	Issues and focus of review
Acute inpatient services – required capacity	• To review current usage and determine expected future requirements in respect of bed numbers. • To determine if future requirements would continue to consist of 4 acute wards (adult and older adult). • Review undertaken through case review of 100 admissions to determine if alternatives to inpatient admission were appropriate. <u>Conclusion</u> • Review concluded the vast majority of admissions were appropriate and necessary and no evident service solution to reduce demands through alternative options. • Some bed reductions expected on older adult ward, but no further reductions expected on the three adult wards.
Crisis Hub model	• To review the component parts of the Crisis Hub model in respect of PDU, Place of Safety, Out of Hours, city wide Home Treatment, Single Point of Access, Liaison interface. • To consider anticipated service demand, volume of on-site patient activity, workforce numbers. • To consider if each of the above component parts of the Crisis Hub model need to be co-located or if the could operate separately either across the Longley site or more generally. <u>Conclusion</u> • Conclusion was that services within the Crisis Hub model need to be adjoining/ together to support patient and staff flow as different elements of the service work collaboratively in response to service demand and client need.
Dementia pathway – intermediate care	• As part of the city wide mental health transformation programme the future option of new/ additional 'intermediate care beds' is being explored and progressed. • This would result in a need to accommodate the additional service/ capacity in the future. • Need to determine if this would be accommodated within the Trust estate and if so which option would best suit in respect of Longley or Grenoside or other options. <u>Conclusion</u> • The transformation plan would intend to locate any future bed based capacity within a more appropriate community based setting. • Therefore additional inpatient capacity is not expected to be a requirement of this transformation plan.

Co-location of older adult wards – move G1 to Longley or Dovedale to Grenoside	• To consider the option to co-locate the two older peoples wards (G1 and Dovedale) on the same site to improve pathways and contribute to cost effective estate plans. <u>Conclusion</u> • From an estate and cost consideration this was not viable. There was not the space on the Longley site to accommodate G1 and the future expected bed requirements for the acute wards would not change this. The additional cost of building extra elsewhere on Longley would not be met from Grenoside savings. • Relocating Dovedale to Grenoside would add costs of renovating West Wing that would be more than the savings from not having Dovedale at Longley. Moving Firshill into the vacated Dovedale space would still result in an increased capital cost and does not align with the medium / longer term plans to consider disposal of the Michael Carlisle Centre site.
Firshill & ISS service model	• To consider if the current Firshill Rise service could be accommodated within the future Longley Centre to support a more affordable service model. • Future planned provision for Sheffield residents is set at four beds which aren't financially sustainable as a stand alone unit. • To review and consider if and how care for four people could be provided from within the broader Longley site and a shared care model with the mental health wards. <u>Conclusion</u> • The review concluded that this wasn't viable. The estate footprint requirements to accommodate and support four inpatient beds for people with moderate learning disabilities could not be achieved without reductions in c.15-16 mental health beds to free up the required space. • These beds reductions are not planned for nor expected. • The unit cost would not be significantly cheaper compared to the current stand alone option. • This review is supported by a separate business case reviewed and approved by Business Planning Group and EDG in May 2017.
Memory Services	• Currently accommodated within the Longley centre. • To review and consider if it needs to remain on the Longley centre. <u>Conclusion</u> • Due to links to STH services the Memory Service should continue on the Longley site, however its location does not need to be within the main building and could be accommodated elsewhere.
Other issues	The review confirmed that there were no other service plans or potential transformation plans that would have an impact on • utilisation of the Longley Centre, both currently and in the future • changes to inpatient requirements and expected capacity across the four Directorates.

Appendix 1b Estate Options / Costs

Estate option	Considerations
Longley Centre – current plans and option of having three acute wards instead of four	If the conclusion from the clinical strategy work suggested that only 3 acute wards would be required instead of the current four then the capital saving would only be c£1.9m. as the space would be used for something else and require modernisation. <u>Considerations</u> • Service plans do not involve a further ward closure. • Relocating a ward (eg Dovedale to Grenoside) would result in additional cost of c£2.5m, more than the assumed savings. (see below)
West Wing – reuse currently vacant ward space	The estimated cost to refurbish West Wing to the required ward standard would be c£2.5m. <u>Considerations</u> • The dementia pathway/ transformation plans suggest any future additional bed based capacity would be developed in a community setting rather than a hospital setting. • Relocating a ward into this space (see above) would result in a higher capital cost • It was also considered that West Wing is small in size compared to the new ward provision and wouldn't be able to accommodate an 18 bedded ward to the required standards.
Longley Meadows	Refurbishment costs would range up to c£1.3m if a major refurbishment was required.