Women's Service and Pathways across the Forensic Mental Health Estate

March 2019

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EXECUTIVE SUMMARY

Forensic Mental Health Services are specialist tertiary services that provide care and treatment for individuals who have a mental illness or learning disability and demonstrate offending behaviour or present a significant risk to others. Services offer multi-disciplinary assessment, consultation, care and treatment, which is proportionate to the situation, and underpinned by risk assessment and management and treatment of offending behaviour. The provision of such services across NHS Scotland varies, particularly for female patients. In areas where there are sparse forensic mental health service provisions, there can be blurred functions of wards and services, with patients being cared for in mixed purpose services, such as rehabilitation and forensic, and mixed gender settings. These mixed services are more prominent within low secure settings.

In Scotland, Forensic Mental Health inpatient services are divided across three levels of security; high, medium and low secure care (an overview of the forensic estate can be found in sections 2.1 & the female estate section 2.2). The differences between these levels of security extend to differences in the physical fabrication of the buildings, including entrance and egress procedures (environmental security), and differences in procedural and operational approaches (Forensic Network, 2004a). Relational security is an important aspect throughout all levels of security, however as an individual progresses throughout the security levels towards the community, the relational aspect of security proportionality increases as physical and operational security processes decrease (Forensic Network, 2004a).

According to the Forensic Network annual inpatient census from 2017, there are approximately 60 female forensic patients accessing secure forensic care across the Scottish estate (a full breakdown of patients, their locations and the numbers accessing out of area care can be found in section 2.3). At the time of the review, there were a further four patients identified as accessing care South of the Border (section 2.4 provides an overview of these patients). Although this is small population, female forensic inpatients cannot be thought of as a homogenous group (Culshaw, 2013) and due to differences from their male counterparts; it is not acceptable to try to fit women into a service primarily designed for men (Culshaw, 2010).

Female forensic patients are generally seen as having different and perhaps more complex needs, compared to their male counterparts (Culshaw, 2010). Though female patients are more likely to be admitted as transfers from other hospitals, following non-criminalised behavioural disorder, and often have fewer criminal convictions than their male counterparts, female patients are frequently among the more difficult patients to manage in services. Their behaviour can be chaotic and challenging, often including self-harm or problematic anger and aggression towards fellow patients and staff (Forensic Network, 2004b). In general, more aggressive incidents occur in female forensic units compared to male units and the length of stay for patients is often considerable (Culshaw, 2010). In this way, the experience and expertise of the workforce are crucial to safely managing this complex patient population. It has been stated that female forensic patients less frequently require the restrictions of physical security that their male counterparts require, with the most important aspect of security being

relational. In this way, the focus of security is often required to be on relational and internal security, rather than external perimeters and geographical isolation.

Background to Review

Following a National Estate Planning Workshop in December 2017 and the presentation of estate wide service developments at the NHS Boards Chief Executive Group meeting in January 2018, the Forensic Network were commissioned by NHS Chief Executives to establish a short life working group exploring pathways for women across the forensic estate.

The need for a major review of female forensic services has principally arisen as a result of challenges accessing high secure beds through the current pathway to Rampton Hospital and difficulties repatriating patients from this pathway. Additionally, at medium security there are problems accessing medium secure beds for North of Scotland patients and low provisions of single-sex accommodation. At low security, there is limited female service provision, which has resulted in a number of patients being cared for in independent healthcare out with their home NHS Board.

Limitations of the Review

The focus of this review was on pathways and services for female forensic patients. A definition of 'forensic' patients employed by the Forensic Network annual census was used throughout the review (Appendix 1) to determine patients that fell in to this population. There are limitations with this definition (see section 5.5) and despite the remit of this group being forensic patients, the review group were acutely aware that there are also a number of behaviourally challenging patients who have not been convicted of any offence but have been transferred into secure settings after being unmanageable in the open estate. These patients although not 'forensic' may benefit from care and treatment in secure settings. In some NHS Boards, these patents are managed in the same pathway, or are co-located, with forensic patients. It is at these boundaries between services and population types where there are increasing challenges, and although this review does not address these areas out with the Forensic Network, consideration of how the recommendations can support these populations at local NHS Board planning level should be made.

One of these problematic boundaries can be found with forensic intellectual disability services, with some services across the estate being managed under forensic directorates and others under intellectual disability directorates. Many of the patients in these units are on civil orders rather than criminal and therefore a proportion of patients do not meet the definition of forensic patients used for this review, however clinically these patients may be deemed to require secure inpatient care in forensic intellectual disability services. For this reason, there will be an underestimation of needs in these areas throughout the report.

Options Appraisal

The options appraisal process was conducted on the methodology outlined in section 4.1 and in line with HM Treasury guidelines (2018). An option of 'status quo' was included in all appraisals and affordability was not considered during the initial scoring of options, as per HM Treasury guidance (HM Treasury, 2018). The review group completed appraisals for high, medium and

low secure settings across six meetings, generating an initial list of possible options at each security level, outlining the pros and cons of each option, and shortlisting the options through group discussion based on option practicality and feasibility. A full list of options can be found in Appendix 2. All scoring was completed against the same set of benefit criteria, which were developed and agreed by the group (section 4.4.1).

All group members completed the option scoring for all three appraisals. Scores for the options appraisals were separated into three main groups; Care Providers separated by security level (high, medium, low), Professional Group Representatives, and Other (which included partner agencies such as; the Mental Welfare Commission, Scottish Government, National Services Division and Scottish Prison Service). The scores for individuals in each of these groups were combined and averaged to provide an overall group score. The totals of these groups' scores were then combined and averaged to give an overall result. This method allowed for an equal voice to be given to all stakeholders and avoided imbalance based on the number of people attending the review from a particular group. A full breakdown of scoring for each of the short listed options can be found in Appendix 3.

High Secure Outcome

The high secure short listed options consisted of: the status quo and maintenance of a pathway to the UK high secure facility at Rampton; development of a high secure service at The State Hospital (TSH); development of a co-located high secure unit with medium security; and development of an 'enhanced' medium secure pathway with continued use of the pathway to Rampton for highly complex cases.

A full list of the generated options and the pros and cons for each option can be found in Appendix 2. The table below overviews the shortlisted options and how these options were ranked by the review group.

Option	Description of Option	Weighted Score	Ranked
Status quo	Maintenance of pathways to Rampton for High Secure Care	318	4
Development of High Secure Female Unit at The State Hospital	Development of a bespoke women's service within the current high secure male service at The State Hospital (TSH)	607	2
Development of a Co-located National Women's Service offering Medium and High Secure Provision	Co-location of high and medium secure services. This would allow for flexibility in configuration when there are low base rate numbers of high secure patients, possibly through the creation of an annex.	621	1
Development of an 'Enhanced' Medium Secure Service with maintenance of the Rampton High Secure Pathway	Development of an 'enhanced' environment (see section 2.6.1.1 for further description), whilst maintaining a high secure pathway to Rampton. This Rampton Pathway would also include the newly developed 'outreach' service to support medium secure services caring for patients with complex and challenging behaviours	521	3

The highest scored option was co-location of a high secure service with medium service provision, this option would address the inequity in Scottish service provision between male and female services, whilst still allowing for the flexible use of resources as service demands fluctuate. The option maximises the recovery potential for medium secure transfer and due to the co-located nature of the service would support clear pathways for transitions to lower levels of security. Staff working across both security levels would ease transitions for patients.

In comparison to the current pathway to Rampton, this option would allow easier access to high secure beds and would support patients' rights in Scotland to appeal against excessive security conditions, while addressing current disparity in service provision for male and female patients.

The main drawbacks of the option are cost implications and the possible timescale for developing and delivering such a service. It is possible that the option would incur significantly higher running costs than the current pathway to Rampton, partially due to economies of scale for running a small service.

It was notable that there was significant divergence in views regarding the optimal arrangement for female high secure provision and that this remains the case for some stakeholders even after the options appraisal process.

Medium Secure Outcome

A full list of the options generated for medium secure services can be found in Appendix 2. The review group shortlisted options of status quo, development of single sex accommodation at the Orchard Clinic, and development of a female medium secure service at Rohallion to provide service provision for the North of Scotland. The table below outlines how these options were ranked by the review group.

Option	Description of Option	Weighted Score	Ranked
Status quo	Continued situation of two of the three medium secure services offering female beds. Only one of these (Rowanbank Clinic, West) has single sex accommodation for females, which can be required depending on the patients history and previous experiences (e.g. sexual abuse)	536	3
Female beds at Rowanbank Clinic and Orchard Clinic with both providing single sex accommodation	Development of single sex accommodation at the Orchard Clinic, NHS Lothian, and maintenance of the current service provision at two of three medium secure services	868	1
Development of medium secure female unit at Rohallion Clinic	Creation of a regional ward for the North that would admit female medium secure patients, increasing the number of beds across the estate at medium security and providing care for North of Scotland patients closer to home (at present North of Scotland patients access care in the Orchard Clinic or Rowanbank Clinic)	714	2

The highest scored option was continuing with the current bed configuration, with medium secure female beds at Rowanbank Clinic in the West and the Orchard Clinic in the South East, but with the development of single sex accommodation at the Orchard Clinic. Developing single sex accommodation in the South East without greatly altering bed configuration prevents the risk of over provision.

The development of single sex accommodation at the Orchard Clinic would broaden the range of patients that could be electively admitted and address the challenges faced by some medium secure patients who have transferred to England for care in single sex services. It would also bring forensic female medium secure provision in to line with Scottish Government and Department of Health guidance (Scottish Executive, 2000; Department of Health, 2007). The option would still provide no medium secure female provision north of the central belt, resulting in North of Scotland patients being cared for further away from their home localities, families and friends. There would remain a requirement to explore North of Scotland pathways to accessing secure services in the West and South East to ensure that the needs of these patients can be met timeously. At present, the beds provided in the West and South East are not regional provisions but NHS Board specific and this may be an area for further consideration by NHS Boards, in terms of developing regional agreement for access.

Low Secure Outcome

There were four shortlisted options at low security, though it was acknowledged that the detail of these options would require further discussions by regions and local NHS Boards.

Option	Description of Option	Weighted Score	Ranked
Status quo	Maintain the current estate configuration, with two purpose built female low secure services (NHS Greater Glasgow & Clyde and NHS Forth Valley) and other female patients being accommodated in mixed patient population and mixed sex wards (e.g. IPCU, Rehab) or independent care	425	4
Regional low secure services (2 or 3 - variable dependent on local general adult rehab provisions)	Creation of three regional low secure services that work with local areas to develop robust community links	604	3
Local female low secure services	Development of female low secure beds/services in all local NHS Boards	746	2
Hybrid model of regional and local secure services across Scotland	This model suggests a hybrid of regional and local services that work together to maximise local bed capacity and rehabilitation pathways to support patients transferring to community services. The exact configuration of services and pathways would be determined in regional partnership	789	1

At low secure, the highest scored option was the development of a hybrid model of regional and local secure services across Scotland. This option offers the greatest amount of flexibility for NHS Boards and can accommodate the needs of smaller NHS Boards by supporting bespoke

solutions between NHS Boards and regions. Regional units have previously been suggested in the Scottish Executive Health Directorate (2006) planning letter. Supporting patients to be cared for in localities closer to their home NHS Boards would also allow for the development of more efficient rehabilitation pathways, support community in reach working, and should enable smoother transitions to community placements. From a patient and carer perspective, this option also supports the opportunity to be cared for closer to home.

The success of a hybrid model would somewhat rely on services and NHS Boards working effectively and collaboratively regionally to ensure that there were not high amounts of service over-provision as a result of any new developments. It would also be important for NHS Boards to work nationally with the Forensic Network to ensure consistency in approach and ensure the principles of least restriction were consistently employed, as well as assuring some continuity in patient experience across the different services and NHS Boards. The boundaries between complex pathways of regional, local, and community care, as well as the demarcation of roles between regional and local units would require careful consideration.

Although this review process focused on the configuration of inpatient services, there would need to be extensive work at regional and local NHS Board level to determine effective community and rehabilitation pathways with low secure services to support patient flow and progression. In many areas, this would involve collaborative working with Integrated Joint Boards (IJBs).

Overall Pathway & Indicative Costs
The resultant pathway of highest scored options would be:

LEVEL OF SECURITY	HIGHEST SCORED OPTIONS
High	Co-location high and medium
Medium	Development of single sex female beds at the Orchard Clinic
Low	Hybrid model of regional and local secure services.

At this stage, there were no concrete proposals on which to base a sensitivity or risk analysis, and no firm outline for costs on which to base a financial analysis, as this would rely heavily on proposed developments in local NHS Board areas. Despite these limitations, a general financial analysis of options can be found in section 4.6. This section based all costing on general and standardised costs for refurbishment, which were provided by the NHS Greater Glasgow & Clyde Capital Team from a UK-wide benchmarking of Mental Health capital costs. It was determined that the cost of refurbishing a non-secure setting or general hospital building to a secure facility, would likely incur a similar costs to that of a new build, due to the upgrades required to the fabric of the building and surrounding land. The cost of refurbishing existing secure facilities to meet current standards is likely to be significantly less. The standard costs utilised in the financial analysis can be seen in the table below.

Cost Type	Cost per 1msq
New Build Construction Cost /m^2	**£3,080**
Refurbishment Cost General Hospital to Secure Facility /m^2	**£3,000**
Refurbishment Cost existing Secure Facility /m^2	**£1,500**

A standard meterage was used for the analysis, based on the size of the new Rowanbank Clinic extension for 18 medium secure beds, which will be approximately 1500m^2 (square metres). A generic staffing cost was also utilised throughout to provide indicative figures. This was based on staff profiles for two medium security wards; one six-bed female mental illness and one four-bed female intellectual disability ward. Both wards had a similar staffing profile and similar costs across a year, with staffing costing approximately £1m based on 1:1 nursing. It is likely that higher costs would be incurred for wards that had significant numbers of patients on 2:1 or 3:1 nursing ratios. Based on this methodology, the costings for the three highest scored options are outlined in the table below.

Indicative Costs (see section 4.6 for more detail)

Secure Level	Option	Costs
High	Development of a Co-located Women's Service offering Medium and High Secure Provision	This would likely incur structural changes to the design of medium secure unit to allow for a co-located annex that could make use of existing ward amenities and facilities. There would be additionally incurred staffing costs and possibly a need to accommodate changes to daily routines; however, the intention of co-location would be for female patients to combine with existing medium secure activities and facilities for female patients where possible. *Capital Costs* For a four-bed unit, the indicative costs would range from £501k for refurb of existing accommodation to £1.03m for a new build. *= £500k (refurb) to £1m (new build)* *Staffing Cost* Any final modelling should consider whether a single staff group could work across both high and medium secure female services to ensure best value and the ability to cope with fluctuations within patient numbers at each level of security. *= £1m for 1:1 nursing for 4 bed unit* *£1.5-£1.7m for a mix of 2:1 and 3:1 staffing, not including additional increased observation which may be required non-recurrently*
Medium	Female beds at Rowanbank Clinic and Orchard Clinic with both providing single sex accommodation	*Capital Cost* This would incur a capital cost at NHS Lothian for the development of single sex accommodation. It is anticipated that this would be refurb costs for approximately 7 beds or 583 m^2 (the number of female patients in the Orchard Clinic has not been above 6 in 2018) approximately £875,000. *= £875k (refurb)*

		Staffing Cost The beds at Orchard Clinic are already staffed, but further work would be required to determine the marginal additional costs of developing single-sex services.
Low	Hybrid model of regional and local secure services across Scotland	There are no clear ways to provide even indicative costs for low secure developments as many of these rely on regional and local NHS Board solutions, particularly in terms of bed numbers and size of services. *Capital Cost* New build regional inpatient low secure services (not taking into account existing configuration or existing local NHS Board beds) would incur costs of: North: £2.6m West: £3.85m South East: £3.6m *Staffing Cost* Staffing costs cannot be estimated at this stage. Low secure solutions are further complicated by the fact than many forensic ID patients are not managed under forensic service structures and may require separate provisions **Regional solutions should be discussed between local NHS Boards, considering local NHS Board provisions and requirements for effective and collaborative solutions**

Summary

The provisions for female forensic patients across the Scottish estate are varied, with some areas meeting need through mixed provisions (rehabilitation and IPCUs) and mixed sex accommodation, despite eradication of mixed sex accommodation in NHS Scotland being a target for Scottish Government since 2002 (Scottish Executive, 2000; Department of Health, 2007). The present pathway for high secure care to Rampton can create significant clinical and operational challenges, while at the other end of the spectrum low secure female provisions are sparse, with many vulnerable female patients often ending up in independent accommodation out with their home localities and away from family and friends.

The highest scored options in all three options appraisals would begin to address the challenges in service provision for female forensic patients.

- The development of a co-located high secure female service within medium security, would provide equity of service with male patients and preventing the need for Scottish patients to travel South of the Border for care. The co-location with medium

security allows for economies of scale and resource during periods of significant demand fluctuation.

- The development of single sex medium secure accommodation at the Orchard Clinic, NHS Lothian, would support complex and vulnerable patients to access care in a suitable environment and reduce the number of patients having to access care South of the Border to obtain single sex medium secure care.
- The development of a hybrid model of regional and local secure services would limit the amount of patients placed out of area in independent healthcare provisions away from their communities, families and friends. This would also provide equitable services to male patients.

Effective solutions across all levels of secure care rely on a coordinated regional approach with support from Health and Social Care Partnership and Integrated Joint Boards.

Recommendations

Recommendation 1:

National and Local Planning – NHS Boards that have medium secure female provision should explore the possibility of a co-located high secure development. This should be done in conjunction with national planning and National Services Division

Recommendation 2:

Regional and Local Planning - NHS Lothian and the South East Region should progress single sex accommodation in the Orchard Clinic

Recommendation 3:

Regional and Local Planning – NHS Boards should work regionally to determine best solution based on need for female low secure provision in areas. This will need to incorporate local NHS Board facilities and provision to protect against risks of over-provision. In some areas, solutions may be bespoke, particularly for small forensic intellectual disability populations. To meet these needs effectively, services should define clear pathways for low secure provision, with clear rehabilitation pathways and outlined step-down to the community.

Recommendation 4:

Local Planning – Closer planning between intellectual disability and forensic directorates should be undertaken by NHS Boards to ensure local and regional solutions meet patients' needs.

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1. INTRODUCTION

1.1 Background to the Review

Following a National Estate Planning Workshop in December 2017 and the presentation of estate wide service developments at the NHS Board Chief Executive Group meeting in January 2018, the Forensic Network were commissioned to establish a short life working group exploring pathways for women across the forensic estate.

The need for a major review of female forensic services has principally arisen as a result of challenges accessing high secure beds through the current pathway to Rampton Hospital, difficulties accessing medium secure beds for North of Scotland patients, and limited female low secure provision which has resulted in a number of patients being cared for in independent healthcare out with their home NHS Board.

1.2 Aims and Objectives

The review group were tasked with:

1) Exploring pathways for women through criminal justice and the forensic estate (high, medium, low and community), addressing any requirements for high security considering the size of the potential population in Scotland
2) Identifying the needs of women requiring care in forensic mental health services and forensic intellectual disability services, determining the most effective ways of meeting these needs, addressing whether traditional services and the current estate configuration (including geographical location of services) is currently able to respond to these needs
3) Establishing the size of the population (including those currently placed South of the Border) and exploring the proportion of the population that are forensic in nature. This should also involve establishing any demand pressures in England and whether developments in the Scottish estate would impact on these
4) Considering how these services fit into the current national planning assumptions for Scotland and how any proposals or recommendations from this work support evidence based best practice with this population
5) Identifying viable options for improvements to meet the needs of women in the forensic estate and to consider the impact of recommendations and proposals on patient pathways, estate planning, and any financial impacts where possible.

1.3 Review Scope

1.3.1 In scope:

The primary priorities for the working group were pathways across the forensic estate, with specific consideration of the small population size and fluctuations in numbers at the different levels of security. It was determined from the outset that there would be a need for flexible services to manage base rate fluctuations and changing service level requirements.

1.3.2 Out of scope:
The scope of the report extended only to the forensic estate. The review group were acutely aware of the different definitions used to determine 'forensic' patients and the challenges faced with over or insufficient inclusion of patients. The Forensic Network complete an annual Forensic Census and it was determined that the definition of forensic employed for this census would be utilised for the purpose of the review (a full breakdown of the definition can be found in Appendix one). The definition outlines that all patients currently accessing medium or high secure care will be included in the census. At low secure, any patient currently being treated and detained under a criminal section of mental health legislation will be included. This encompasses patients on; Assessment Orders, Treatment Orders, Compulsion Orders, Interim-Compulsion Orders, Restriction Orders, Hospital Directions, Transferred Prisoners, and Temporary Hospital Orders. Patients should also be included if in this episode of care, they have been directly transferred from high or medium secure services, are detained under compulsory treatment orders and were previously subject to criminal section under the mental health legislation, or are on suspension of detention.

The group were aware that this definition does not necessarily include all patients deemed by services as 'forensic' and that there are also a significant proportion of patients with complex needs who may benefit from care and treatment in secure settings but do not have forensic backgrounds. The review group focused only on forensic services, as this wider group of challenging behavioural patients is out with the remit of this review. In addition, there is also a small group of patients within Intensive Psychiatric Care Units (IPCUs) who meet the forensic definition but are not routinely reported in the annual forensic census. A recent Quality Improvement Scotland (now Healthcare Improvement Scotland) report (2010) found this to be approximately 10% of IPCU patients (one in ten patients). The IPCU census does not specify for this 10% how many patients were female, but the report advised that women constitute approximately a quarter of all annual admissions to IPCUs (24% of the overall census return). From this, it can be estimated as five female patients in IPCUs who may require specialist forensic management, however not all people detained under the criminal provisions of the Mental Health Act would need to be managed by specialist forensic mental health services and these women many be appropriately placed in IPCUs. The report from HIS concluded that the mixing of patients requiring forensic provision and patients requiring IPCU provision was unsatisfactory, except in urgent acute circumstances and then should only be for a short period of time (Scottish Executive Health Department, 2006).

1.4 Review Methodology
The Review Group was established comprising representatives from female secure services and partner agencies. The group were then responsible for guiding the review, appraising relevant information documents, scoring the options appraisal, and contributing to the review recommendations.

The group's final report will be submitted to the NHS Board Chief Executives Group on 13th March 2019. A draft of this report was shared with local stakeholders prior to presentation at

the Chief Executives Group. It will be submitted to the Forensic Network Advisory Board and Inter-Regional Group for endorsement and consultation where appropriate.

1.5 Membership

Representation to the group was requested from:

- Scottish Government – Principal Medical Officer
- Mental Welfare Commission – Nursing Officer and Social Work Officer
- Chief Executive of The State Hospitals Board for Scotland (sponsoring CE)
- Director of Regional Services, NHS GG&C
- Forensic Network Chair
- Forensic Network Clinical Lead for Women
- Forensic Network Manager
- Forensic Network Administrator
- Forensic Mental Health Services (clinical and managerial leads from all three regions, plus representation from female low secure units, community and intellectual disability services):
    - High – Medical Director and Chief Executive
    - Medium – Consultant Forensic Psychiatrist and Clinical Nurse Manager, NHS Lothian; Consultant Forensic Psychiatrist and Regional Manager, NHS Tayside (also cover low secure services); Clinical Director Forensic Services, General Manager and Service Manager, NHS GG&C (also cover low secure and community services in NHS GG&C).
    - Low & Community – Consultant Forensic Psychiatrist and Senior Charge Nurse, NHS Forth Valley; Forensic Services Manager, NHS Lanarkshire (also covers community services)
    - Community – as above
    - Intellectual Disability – Southeast Scotland Learning Disability Managed Care Network Clinical Lead (Consultant Psychiatrist)
- National Planner – Planning Manager Regional Services, NHS GG&C
- Scottish Prison Service – Health Strategy and Suicide Prevention Manager
- National Services Division – Senior Programme Manager
- Advocacy – Lead Forensic Advocate, Circles
- Social Work – Representation from Forensic Network Social Work Subgroup
- Psychology – Representation from Scottish Clinical Forensic Psychology Group
- IPCU Representative – Consultant Psychiatrist, NHS Highland

1.6 Meeting dates

During the review the group met six times:

- *23rd May 2018:* The group discussed the Terms of Reference and agreed the scope of the review. A presentation of the needs of female forensic patients was delivered and members discussed the current service provisions across the estate.

- *25th July 2018:* The review group discussed the evidence from the information pack and the figures provided from the annual census detailing estate numbers. The group

discussed the generated list of service options with a view to short listing and considered relevant benefit criteria.

- *01st August 2018:* The review group reviewed the evidence to date, agreed the criteria to score against and completed the benefits matrix to determine appropriate weightings. Options were shortlisted for high security.

- *05th September 2018:* Current high secure pathways to Rampton Hospital were discussed and options for medium and low security were shortlisted. The High secure options were agreed and scored.

- *10th October 2018:* Medium and Low secure options were agreed and scored. The results of the high secure options appraisal were discussed.

- *13th November 2018:* The results from medium and low secure options appraisal were presented and the overall treatment pathway of highest scored options was discussed.

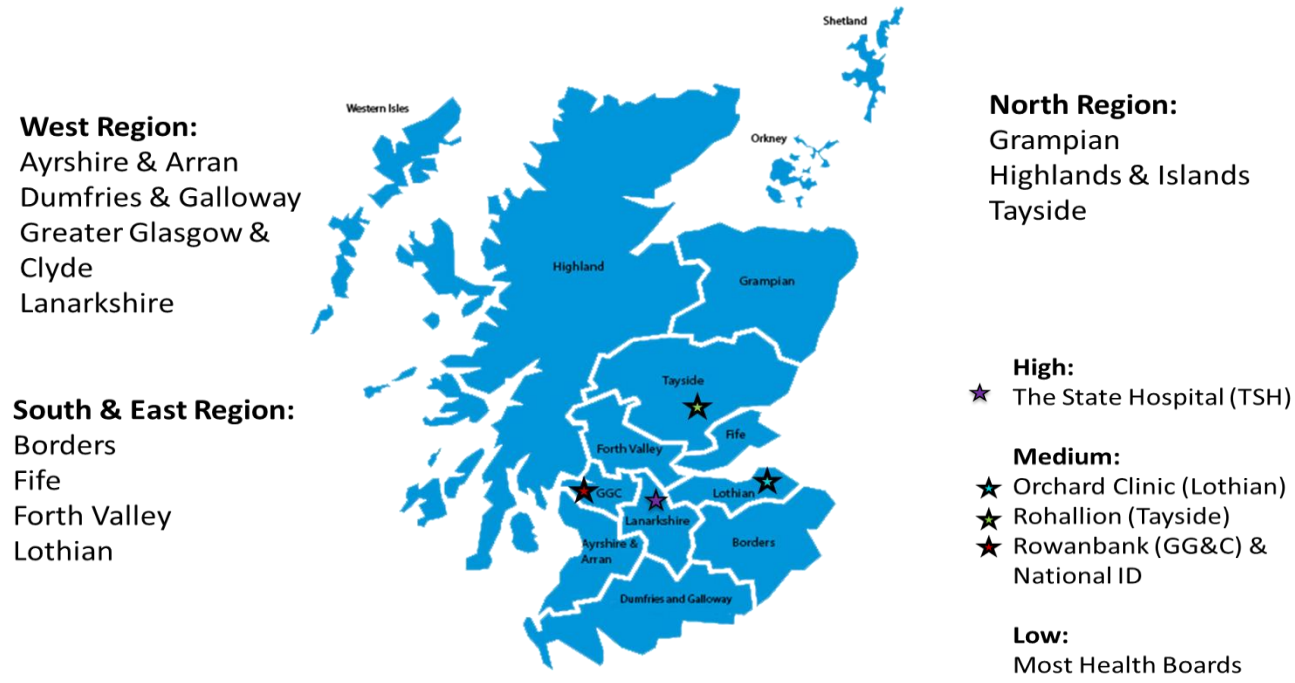
2. CURRENT SERVICES OVERVIEW

2.1 Scottish Forensic Estate Configuration

The forensic estate in Scotland is made up of three levels of secure inpatient services; high, medium and low. The differences between these levels of secure services are in physical and procedural security, and the criteria for each level of security is set out in the matrix of security (Forensic Mental Health Service Managed Care Network, 2004a).

There are approximately 520 forensic inpatient beds in Scotland. The numbers vary in the annual census year on year because some low secure units have a joint forensic and rehabilitation function, or take both forensic and general adult patients, resulting in beds being used flexibly. There is one national high secure facility (The State Hospital) that does not currently admit female patients and three regional medium secure units, of which two admit female patients. Figure 1 below provides an overview of the forensic estate, outlining the high and medium secure services, as well as the regional structure on which the Forensic Network is established.

Figure 1: Overview of Forensic Estate



The total number of patients reported in the Forensic Network annual census since it began in 2013 are provided in table 1, with an indication of the split of patients across the three security levels. Table 2 provides an overview of the numbers of high and medium secure bed numbers across the estate and the split of beds by services and regions. There are no female high secure beds in Scotland at present. Female beds currently make up approximately 11% of the forensic medium secure mental illness estate and half of the forensic medium secure intellectual disability estate.

The provision of low secure services across Scotland varies considerably, in areas where there are sparse forensic mental health service provisions, there can be blurred functions of wards and services, with patients being cared for in mixed population wards and services (Intensive Psychiatric Care Units (IPCU), Assessment and Treatment units, addiction or rehabilitation settings). These mixed purpose services are particularly prominent at low secure settings. A report by HIS (2010) focusing specifically on IPCUs and addressing their mixed function, reported that IPCUs often serve a dual function as both a low secure forensic unit and as an extension of general adult psychiatric services. The report identified that this dual function of IPCUs occurred for a number of reasons, including lack of inpatient forensic provision locally, or uncertainty regarding the level of risk that might be considered sufficiently significant for a person to be accepted into specialist forensic services. The number of patients identified in the HIS (2010) report as being placed in IPCU but having forensic needs was approximately 1 in 10 (19 patients in total) and although the gender split of these 19 patients was not provided, the report advised that approximately a quarter of patient's admitted to IPCUs annually are female. From this, it may be estimated that 5 female patients placed in IPCUs may require forensic care input. However, it should also be noted that not all people detained under the criminal provisions of the Mental Health Act would need to be managed by specialist forensic mental health services. In this way, placement in an IPCU may be considered appropriate.

In addition to mixed purpose wards, many female forensic patients are also cared for in mixed gender accommodation, where ensuring the safety, privacy and dignity of women can be challenging due to the much higher proportions of male patients. Difficulties that can be faced around patient vulnerabilities in mixed sex wards require extensive consideration, as do challenges around isolation of low numbers of female patients if male surge demand significantly suppresses female placements. For some vulnerable female patients this type of mixed accommodation is unsuitable.

The use of IPCU as low secure and the use of mixed wards, both in terms of gender and patient population (forensic or rehabilitation), causes complications when trying to determine the exact size of the forensic estate. This is particularly pertinent at low security. The number of beds being used for forensic patients and the gender split of beds in services can be frequently adapted to suit clinical need and respond to base rate fluctuations. It was estimated in 2017 that there were approximately 295 mental illness (MI) beds being accessed by forensic patients across low secure settings (low secure, low secure independent, low rehab, open rehab and Intensive Psychiatric Care Units (IPCU) or locked wards) and approximately 64 forensic intellectual disability (ID) beds (low secure and locked wards). These figures are outlined in table 3. Around 20% of these beds are accessible to female patients, though many of the wards are mixed gender rather than specifically designated for female forensic patients and with higher proportions of male patients accessing these services, it is unlikely that in practice this proportion of beds are available to female patients.

Table 1: Forensic Network Annual Census Data – Overall Estate Size, split by Security Level and Patient Type

	2013	2014	2015	2016	2017
Total Estate Size:	522	502	526	502	519

Approx. breakdown* by Patient Type & Security Level	Mental Illness					Intellectual Disabilities				
	2013	2014	2015	2016**	2017***	2013	2014	2015	2016**	2017
High Secure	120	111	108	100	100	12	11	12	11	11
Medium Secure	113	116	125	120	118	10	10	10	8	7
Low Secure (+ rehab/locked)	202	184	199	194	224	65	70	72	69	59****
TOTALS:	**435**	**411**	**432**	**414**	**442**	**87**	**91**	**94**	**88**	**77**

* These are approximated figures based on the services identification as either MH or ID site, rather than based on the primary diagnosis of the patient
**4 sites had missing data for this year – data from the previous year have been added to provide rough extrapolation
***data from 1 site is missing – data from the previous year has been added to provide rough extrapolation
***Closures of beds/services since last census account for lower figures

Table 2: Overview of High and Medium Secure Estate – Number of Beds by Unit and Estate

No. Beds by Unit	TSH	Orchard Clinic (South East)	Rohallion (North)	Rowanbank (West)	National ID
Male Mental Illness	108	33*	30	56	0
Female Mental Illness		7*		6	
Male ID	12				8
Female ID					4
TOTALS:	**120 (140)**	**40 (50)**	**30 (32)**	**62 (68)**	**12**

* These beds are flexible in terms of gender so split can be altered depending on estate need
() Full complement but do not operate at these numbers for reasons of clinical safety or current operational requirements

Total Beds for Estate	Male MI (Female)	Male ID (Female)
High	108	12
Medium	119 (13)	8 (4)

Table 3: Overview of Low Secure Estate

Low (approx. bed No.)	Mental Illness	Intellectual Disabilities
Low Secure (Independent beds)	198	51
Low Rehab	41	
Open Rehab	18	
IPCU/locked unit	38	13
TOTALS:	**295**	**64**

2.1.1 Appeals against Excessive Security

Under the 2003 Mental Health Act, there are processes for individuals detained in high and medium security hospitals to appeal against detention in conditions of excessive security. Appeals are made to the Tribunal which may rule that the patient is being detained in conditions of excessive security and require the NHS Board responsible to identify a hospital suitable lower security hospital for the patient (Scottish Government, 2015; Mental Welfare Commission, 2013).

At present, excessive security appeals have not been extended to the low secure estate, however if in the future this were to happen this could have a significant impact on the shape and size of the estate, particularly as there are patients in low secure settings across the estate awaiting community placements.

2.2 Scottish Female Forensic Bed Configuration

As described in section 2.1, many wards across the forensic estate are mixed sex and mixed population (IPCU, forensic or rehabilitation) and service structure can be frequently adapted to suit clinical need, it is therefore difficult to determine exactly how many forensic female beds there are across the estate.

To provide an estimated figure for services with mixed sex beds which are used flexibly and mixed purpose beds (rehabilitation & forensic), the total number of beds in each service have been halved to indicate estimated numbers for female forensic specific beds in each area. This estimation has been determined based on annual Forensic Network census results which provide a basis for determining the numbers of beds being utilised by forensic patients in mixed population wards, and by female patients in mixed sex wards, though this is very variable. This estimation of halving the number of available beds in a ward is likely to inflate the actual number of beds available, as mixed sex services will have larger numbers of male patients than female patients, and mixed population wards will have higher ratios of other patient populations to forensic patients. Therefore, these numbers are to be understood as a rough estimation and not precise figures.

Table 4: Estimated NHS Female Forensic Beds across the Estate

	Mental Illness (Estimated)	Intellectual Disability (Estimated)	TOTAL
Low Secure	16	3	19
Low Rehab	15	4	19
IPCU/Locked	20		20
Medium	13	4	17
TOTAL:	64	11	75

Table 5: Breakdown of Female Forensic Beds across independent care providers

Service	Type of Ward	No. Beds
Surehaven	Female Low Secure	6
Priory Ayr Clinic	Female Low Secure	12
	Mixed Low Secure	6*
	Female Rehab (Step Down - Locked)	8
	Mixed Rehab (Step Down - Locked)	5*
TOTAL:		37 (13 – Rehab)

* mixed sex

None of the independent beds are specified as being for Intellectual Disability (ID) patients, however some patients accessing these services at present do have a diagnosis of ID. The independent sector has helped to identify and fill service gaps and have been flexible with bed provision, more readily available to configure to service requirements than NHS services. Such provisions have provided a highly useful and accessible resource for NHS services.

Table 6 demonstrates that over half of the forensic female beds are located in the West region. In addition, independent secure care facilities (37 beds), which make up over a third of the 101 mental illness beds potentially available, are also located in the West, resulting in over 70% of female forensic estate provisions sitting in the West region. There are only two NHS female low secure facilities across the estate, one in Greater Glasgow & Clyde (West) and a recently opened unit in Forth Valley (South East).

It should again be highlighted that there will be an overestimation of NHS female secure beds as the number of beds for mixed population wards (either gender or diagnosis) has been halved, however the majority of mixed accommodation wards will be filled with predominantly male patients and there is likely to be more general adult than forensic patients accessing services. These figures should therefore only be used as a guideline.

Table 6: Breakdown of NHS Female Forensic Beds across Regions and Security

NORTH	Mental Illness	Intellectual Disability
Low Secure	5**	
Low Rehab	4**	
IPCU/Locked Unit	2	
Medium		
TOTAL:	**11**	
SOUTH EAST		
Low Secure	6	
Low Rehab		
IPCU/Locked Unit	4**	4*
Medium	7**	
TOTAL:	**17**	**4**
WEST		
Low Secure	5	3*
Low Rehab	11**	
IPCU/Locked Unit	14**	***
Medium	6	4
TOTAL:	**36**	**7**
GRAND TOTAL:	**Approx. 64**	**Approx. 11**

* mixed sex
** mixed sex & variable population mix
*** ward included in Mental Illness (MI) figures that is mixed sex and mixed population, so could also be used for Forensic Intellectual Disability patients

2.2.1 Female Mental Illness Medium Secure Bed Numbers

The Forensic Network collate weekly bed numbers for medium and high secure facilities in Scotland. Weekly bed numbers at medium secure can help to determine if beds are configured in the most effective way for services and outline any trends in fluctuating demand.

Across 2018, the figures from the weekly bed report demonstrate that the Orchard Clinic (South East) ran with an average of 4.7 female patients across the year and Rowanbank Clinic (West) with an average 5.7 female patients. The figures for Rowanbank Clinic remain fairly stable at six patients (service capacity) across the year, while female patient numbers at the Orchard Clinic fluctuated between three and six. Table 7 outlines figures for 2016, 2017 and 2018.

Table 7: Medium Secure Female Mental Illness Bed Use

Service (Bed Provision)	Year on Year Averages (Range) Median=		
	2016 (from March 16)	2017	2018
Orchard Clinic (7*)	6.6 (6-9)	5.7 (3-8) M=7	4.7 (3-6) M=5
Rowanbank (6)	5 (3-6)	4.9 (4-6) M=5	5.7 (5-6) M=6

* Bed configuration is mixed sex and number of beds provisioned can fluctuate

During 2018, female medium secure services did not usually operate with a waiting list, with figures evidencing a waiting list of one patient for five weeks across the year (four weeks at Rowanbank Clinic and one week at the Orchard Clinic). However, during 2017 services operated with a waiting list for 34 weeks of the year. The highest number of patients on the waiting list at any point was two and the waiting list was only for access to the Rowanbank Clinic service.

2.2.2 Female Intellectual Disability Medium Secure Bed Numbers

The weekly bed numbers for female patients at the national intellectual disability service in the West evidence an average of 2.07 patients during 2018. There were no weeks when the service operated with a waiting list in 2018.

Table 8: Medium Secure Female Intellectual Disability Bed Use

Service (Bed Provision)	Year on Year Averages (Range) Median=		
	2016	2017	2018
National ID Service (4)	2.2 (1-3)	1.5 (1-2) M=2	2.07 (2-3) M=2

2.2.3 Summary

Throughout 2018, the female mental illness service at Rowanbank Clinic has predominantly operated at capacity, though there have been no reported difficulties with access to beds or waiting lists. The capacity at the Orchard Clinic will have likely helped to support this. In 2017, there were a large number of weeks (34), in which Rowanbank Clinic operated a waiting list and bed capacity at the Orchard Clinic was increased to eight for a small number of weeks (2). This demonstrates that there is limited flexibility in the estate to respond to surge fluctuations, however the current bed numbers have been manageable to date. Mixed sex accommodation at the Orchard Clinic has supported the estate to respond flexibly in periods of increased demand, by increasing the number of beds that can be accessed by female patients.

At the National Intellectual Disability Service, there have been no reported periods of a waiting lists for female bed since 2016. On average in 2018, the unit operated at approximately 50% capacity and there is flexibility in the bed configuration to respond to urgent admissions.

2.3 Analysis of Female Patients across the Scottish Forensic Estate

To provide an overview of the current size of the female forensic estate, a breakdown of the female patients reported in the 2017 Scottish Forensic Network Annual Census has been included in the report for illustrative purposes. The annual census includes all forensic patients accessing inpatient services in Scotland and provides an overview of the female patients currently across the forensic estate. Patients with forensic needs being managed in general adult beds or IPCUs may not be captured in the annual census breakdown. It is thought from HIS's report of IPCUs (2010) that around 10% of patients in IPCU have forensic needs. The IPCU census does not specify the number of female patients in this 10%, but the report advised that women constitute approximately a quarter of all annual admissions to IPCUs (24% of the overall census return were female, 27 out of 112 returns). On this basis, it is estimated that there may be 5 patients placed in IPCUs that may require forensic care input. However, not all people detained under the criminal provisions of the Mental Health Act would need to be managed by specialist forensic mental health services. In this way, placement in an IPCU may be considered appropriate for these patients.

2.3.1 Overview of Scottish Forensic Female Patients

The annual census identified 60 female patients across the forensic estate, however on further exploration it was determined that only 33 of these patients met the forensic definition of 'mentally disordered offenders' employed by the census team to determine if a patient is 'forensic' in nature (definition included in appendix 1). For this reason, the tables below are split by the patients met the definition and those included in the annual census who did not.

Table 9 provides an overview of the female patients reported in the census, their primary diagnosis and whether or not the met the definition of forensic. The table outlines that although 60 female patients were reported in the forensic census, only 33 of these (55%) met the definition of forensic. 85% of the patients had a primary diagnosis of mental illness and one patient was reported as having a primary diagnosis of both mental illness and intellectual disability.

Table 10 provides a breakdown of patients across the three levels of security and evidences that approximately 65% of the patients reported in the census are accessing low secure care, however less than half of these patients meet the definition of forensic (35%).

Table 9: Breakdown of female patients by Diagnosis and Forensic Definition

	Forensic	Not Forensic	**TOTAL:**
Mental Illness	26	25	**51**
Intellectual Disability	7	1	**8**
Both		1	**1**
TOTAL:	**33**	**27**	**60**

Table 10: Breakdown by type of ward and Forensic Definition

	Forensic	Not Forensic	TOTAL:
Bespoke Ward	1		**1**
Open Rehab	2		**2**
IPCU	3	2	**5**
Locked Learning Disability ward	2		**2**
Low Secure	14	25	**39**
Medium Secure	11		**11**
TOTAL:	**33**	**27**	**60**

2.3.2 Overview of Forensic Female Patients by Region of current Placement

Estate numbers by region and NHS Board are provided in tables 11 and 12. These figures outline the regions in which patients are currently accessing care and demonstrate that just under half (43%) of the patients in the census are accessing care from independent healthcare providers. The majority of these patients accessing independent care do not meet the definition of forensic utilised by the census (73%).

Table 11: Breakdown by Region and Forensic Definition

	Forensic			Not Forensic				GRAND TOTAL:
	MI	ID	Total:	MI	ID	Both	Total:	
North	1		**1**	2		1	**3**	**4**
South East	5	5	**10**	5			**5**	**15**
West	13	2	**15**					**15**
Independent	7		**7**	18	1		**19**	**26**
TOTAL:	26	7	**33**	25	1	1	**27**	**60**

Table 12: Breakdown of services and NHS Boards patients are accessing

		Forensic	Not Forensic	TOTAL:
North	NHS Grampian	1	1	**2**
	NHS Highland		1	**1**
	NHS Tayside		1	**1**
	TOTAL	**1**	**3**	**4**
South East	NHS Fife	2		**2**
	NHS Forth Valley	1	5	**6**
	NHS Lothian	7		**7**
	TOTAL	**10**	**5**	**15**
West	NHS Ayrshire & Arran	2		**2**
	NHS GG&C	13		**13**
	TOTAL	**15**		**15**
Independent	Ayr Clinic	6	19	**25**
	Surehaven	1		**1**
	TOTAL	**7**	**19**	**26**
TOTAL:		**33**	**27**	**60**

2.3.3 Overview of patients placed Out Of Area (OOA)

There are 30 patients accessing Out Of Area (OOA) care (50%). Tables 13 shows which services OOA patients are accessing. Table 14 outlines the home NHS Boards and regions for these OOA patients. Only one OOA patient is accessing care in their home region, this is a medium secure patient accessing care in NHS Greater Glasgow & Clyde, coming from a home NHS Board of Ayrshire & Arran.

Table 13: Breakdown of Services OOA patients are accessing

		Forensic	Not Forensic	TOTAL:
Independent Low Secure	Ayr Clinic	6	19	**25**
	Surehaven	1		**1**
West - Medium Secure	NHS GG&C	4		**4**
TOTAL:		**11**	**19**	**30**

Table 14: OOA patients' home NHS Board and regions

		Forensic	Not Forensic	TOTAL:
North	Grampian		2	**2**
	Highland	2	1	**3**
	Tayside	2	2	**4**
	Orkney	1	2	**3**
	TOTAL:	**5**	**7**	**12**
South East	Borders		1	**1**
	Fife		2	**2**
	Lothian	2	3	**5**
	TOTAL:	**2**	**6**	**8**
West	Ayrshire & Arran	1	1	**2**
	Dumfries & Galloway	1		**1**
	Lanarkshire	1	4	**5**
	Western Isles	1	1	**2**
	TOTAL:	**4**	**6**	**10**
TOTAL:		**11**	**19**	**30**

2.3.4 Regional Needs based on Patient Numbers

If the home NHS Boards of all patients (including those currently placed out of area) are considered, then the regional requirement for services would be 14 mental illness beds in the North (2 at medium security and 12 at low security), 18 beds in the South East (4 at medium secure and 14 at low secure), and 15 in the West (4 at medium secure, 13 at low secure and 2 open rehab). For intellectual disability beds; for the North this would be 2 (1 medium and 1 low), for the South East this would be 5 (4 low and 1 bespoke) and for the West this would be 2 (both at low secure).

Tables 15 and 16 outline the home NHS Boards for all female patients in the estate and the security level requirements for those patients. It should however be noted that this includes patients in the census that are not designated as forensic in background and the requirements if just the forensic patients were accounted for would be much lower.

Table 15: Home NHS Boards and Regions of all Patients across the Estate

		Forensic	Not Forensic	Total
North	Grampian	1	3	**4**
	Highland	2	2	**4**
	Orkney	1	2	**3**
	Tayside	2	3	**5**
	TOTAL	**6**	**10**	**16**
South East	Borders		1	**1**
	Fife	2	2	**4**
	Forth Valley	1	5	**6**
	Lothian	9	3	**12**
	TOTAL	**12**	**11**	**23**
West	Ayrshire & Arran	3	1	**4**
	Dumfries & Galloway	1		**1**
	Greater Glasgow & Clyde	9		**9**
	Lanarkshire	1	4	**5**
	Western Isles	1	1	**2**
	TOTAL	**15**	**6**	**21**
Total		**33**	**27**	**60**

Table 16: Regional Bed Needs across Security Levels and Primary Diagnosis

		Forensic			Not Forensic				TOTAL
		MI	ID	TOTAL	MI	ID	Both	TOTAL	
North	IPCU	1		1	2			2	3
	Low	2		2	7		1	8	10
	MEDIUM	2	1	3					3
	TOTAL	**5**	**1**	**6**	**9**		**1**	**10**	**16**
South East	BESPOKE WARD		1	1					1
	IPCU		2	2					2
	Locked LD wards		2	2					2
	Low	3		3	11			11	14
	MEDIUM	4		4					4
	TOTAL	**7**	**5**	**12**	**11**			**11**	**23**
West	Low	8	1	9	5	1		6	15
	MEDIUM	4		4					4
	Open Rehab	2		2					2
	TOTAL	**14**	**1**	**15**	**5**	**1**		**6**	**21**
TOTAL		**26**	**7**	**33**	**25**	**1**	**1**	**27**	**60**

Table 17 provides an overview of current regional bed requirements against the current bed configuration outlined in section 2.2. As stated in earlier sections, the bed configuration over estimates the number of beds at each level of security due to the use if mixed units in many NHS Boards, which have mixed gender and mixed population provisions. For these services, the number of beds in the unit have been halved, however this likely overestimates potential bed provision, as it is unlikely that half of the beds will be used for forensic female patients considering the greater demand from male patients and general adult patients. The comparison is intended for general information purposes only.

Table 17: Regional Bed Needs and Current Bed Provision (includes both forensic and none forensic patients identified in the 2017 census)

		Regional Bed Needs				Current Bed Configuration			Surplus/Minus
		MI	ID	Both	TOTAL	MI	ID	TOTAL	Total +/-
North	IPCU	3			3	2		2	-1
	Low/ Low Rehab	9		1	10	9		9	-1
	MEDIUM	2	1		3				-3
	TOTAL	**14**	**1**	**1**	**16**	**11**		**11**	**-5**
South East	BESPOKE WARD		1		1		1		
	IPCU		2		2	4	4	8	+6
	Locked LD wards		2		2				-2
	Low	14			14	6		6	-8
	MEDIUM	4			4	7		7	+3
	TOTAL	**18**	**5**		**23**	**17**	**5**	**21**	**-1**
West	IPCU					7*	7*	14	+14
	Low/ Low Rehab	13	2		15	16	3	19	+4
	MEDIUM	4			4	6	4	10	+6
	Open Rehab	2			2				-2
	TOTAL	**19**	**2**		**21**	**29**	**14**	**43**	**+22**
TOTAL		**51**	**8**	**1**	**60**	**57**	**19**	**76**	**+16**

* These beds can be either MI or ID and have therefore been split between the two categories for the purpose of this illustration

2.3.5 Summary

The results of the 2017 census evidence that there were 60 female patients accessing care across the Scottish forensic mental health estate, however only just over half of these were found to meet the definition of forensic employed by the census team (55%). Of the 60 patients, 85% had a primary diagnosis of mental illness, 43% were accessing independent care, and around 65% of all patients were accessing low secure care. Of the patients accessing low secure care (39), less than half met the definition of 'forensic' used by the census (36%) and more than half (26) were accessing care in independent healthcare settings (66%). This evidences a dearth of NHS low secure female provision across the forensic estate.

Of the 60 patients identified in the census, 50% were found to be accessing Out of Area (OOA) care and the majority of these (97%) were not accessing care in their home regions. Table 15 (above) outlines the current requirements regionally if all patients identified in the 2017 census were accessing care in their home regions and compares this to the current bed configuration across the estate for illustrative purposes.

2.4 Scottish Female Forensic Patients accessing Care outside of Scotland

The breakdown from the 2017 Forensic Network Census does not include Scottish patients who are not currently accessing care in inpatient units in Scotland. There were an additional three female forensic patients identified by National Services Division (NSD) as currently accessing care south of the border, with one further patients receiving care within the inpatient specialist care adult autism unit; this patient was transferred from low secure unit. Two of these patients are accessing high secure care, however one of these has been identified as being ready for transfer to lower levels of security. Table 18 outlines these four patients, their diagnosis, and their admission status.

Two of the patients identified in this process are accessing specialist Personality Disorder (PD) services in England, as these services do not exist in Scotland. At present, forensic mental health services do not admit patients with a primary diagnosis of PD. If it was hoped that all female patients would be repatriated to Scotland this would require the development of specialist PD pathways in Scotland to support these patients, however this would be disparate to men's services and may result in a requirement to develop equitable men's PD pathways. It may therefore be acknowledged that even if there was a Scottish solution for high secure female care, there would likely still be a requirement to access some English specialist services (such as Autism and PD).

Table 18: Scottish Female Forensic Patients accessing care in England through National risk share scheme

Site	Unit/Ward	Diagnosis	Status
Northgate Hospital, Morpeth	Adult Autism Inpatient	ID, Psychosis PD & autism	Inpatient
Rampton Hospital	Forensic High Secure	PD	Fit for step down
Rampton Hospital	Forensic High Secure	ID	Inpatient
Roseberry Park, Middlesbrough	Female Medium Secure	PD	Fit for step down

In addition to those funded central through NSD, there are a small number of female patients funded by territorial Boards directly who are accessing care in England. Each NHS Board was contacted independently for this information. From the information received back from NHS Boards there was one ID patient (NHS Highland) who has no criminal charges but is being managed through secure services in England (previously funded through low secure national risk scheme) and is thought will require secure care in the future. NHS Grampian identified a

further three patients, two accessing care in St Andrews Northampton (one medium and one low) and one accessing care in the low secure independent sector in England (PIC). This makes a total of 4 further patients (3 low, one medium). Table 19 summarises all cross border female patients who may require secure care in Scottish inpatient settings, based on the information received back from NHS Boards (Replies were received from 8 NHS Boards in total; Ayrshire & Arran, Borders, Dumfries & Galloway, Highland, Lanarkshire, Lothian, Grampian, and Greater Glasgow & Clyde).

Table 19: Total Number of Scottish Female Patients accessing care south of the border

Security Level	Primary Diagnosis			TOTAL
	Mental Illness	Intellectual Disability	PD	
High		1	1	**2**
Medium	1		1	**2**
Low	2	2		**4**
TOTAL:	**3**	**3**	**2**	**8**

2.5 High Secure Services

2.5.1 Current Service and Pathways

At present, there are no high secure female beds in Scotland for either mental illness or intellectual disabilities. Scottish women requiring high secure care are transferred south of the border to Rampton Hospital, the only UK female high secure facility.

The position of high secure female patients in Scotland changed in 2008, following several reviews and assessments of the clinical needs of female patients who had been accessing high secure care in The State Hospital (TSH; Forensic Mental Health Services Managed Care Network, 2004(b); Thomson, 2008; Thomson, Bogue, Humphries & Johnstone, 2001). It was determined at this time that the female patients who had been accessing high secure care could have their needs more adequately met in lower levels of security, in line with principles of least restriction. The review of patient needs found that there were no female patients at the time that required high secure care. To provide a service for very low numbers, and at times no, female patients, was considered not viable in terms of resource and maintenance of staff expertise. It was also thought to be potentially detrimental to the low number of female patients who could become isolated in an all-male environment.

In order to provide for the very small numbers of female patients who might require access to high secure care in the future, a pathway was established with Rampton Hospital, a high secure female hospital in Nottingham, England. This involved the development of a transfer and admission protocol for Scottish patients (Rampton Hospital & Forensic Network, 2014; Rampton, 2014). Since the establishment of this pathway, there have consistently been low numbers of Scottish female patients requiring transfer to high secure care, normally between zero and two at any one time. It has been argued that there may be underrepresentation with this figure, as some patients who may be considered to require high secure care are not referred through the pathway due to the timescales for transfer, which are considered problematic for clinical reasons, or due to the patient's conviction status of being on remand.

Correspondence with Rampton (3rd July 2018) did not identify difficulties in maintaining the current high secure pathway for Scottish patients and highlighted that there has not been a referral from Scotland for high secure care for an extended period. Rampton advised that a new outreach service was being established to provide additional support to lower levels of security in managing challenging behaviours and that investment had been made in Skype to support patients maintaining contact with family and friends.

2.5.2 Challenges to Current Pathway

2.5.2.1 Access to Rampton

Clinicians report significant challenges with access to beds through the high secure pathway to Rampton Hospital. One of the main challenges surrounds timeframes for transfers between Scottish Secure Services and the English High Secure Service. Assessment processes for access to any service can cause delays, but in addition to the assessment period, this pathway requires the arrangement and agreement of cross border transfers between areas with different legislation and procedures, which can create further delays. It was advised by Scottish medium secure services that a transfer between medium and high secure that has few complications could easily take up to four months. This period can be dramatically extended if additional challenges to transfer are encountered, or if there is a lack of bed availability at Rampton Hospital.

Further delays to transfer times for challenges with access can be experienced due to the differences in clinical practice between Scotland and England. The threshold for high secure admittance may be considered significantly higher in England than the criteria utilised in Scotland. In addition, the assessment period for access to Rampton is considerably longer than the standard assessment period for access to TSH, with it taking approximately six weeks for assessment (in Scotland assessments to high secure are often completed within a week of referral). While awaiting transfer to high secure female patients are often being cared for in medium secure facilities that arguably do not adequately meet the patients' needs and put medium secure services under considerable strain, which can impact negatively on other patients in the services.

Due to the legislative differences between Scotland and England, patients on remand cannot be transferred across the border even if they require high secure care. At present, a transfer of a patient from a Scottish prison to an English hospital, must be done via an English prison or a Scottish Hospital. The latter would provide grounds for appeal against transfer. The last patient requiring transfer from a Scottish prison to Rampton was required to be transferred from Cornton Vale to Low Newton prison in England prior to being transferred to Rampton, a process that incurred unacceptable delay.

2.5.2.2 Repatriation to Scotland

Current discharge processes can be difficult to implement cross border. The current process requires a period of 'testing out' at medium security and familiarisation visits, where if a problem arises the patients can be easily transferred back to the sending services. However, ease of transferring a patient back to the sending service cross border may be may be considered impractical. There may then be reluctance to repatriate patients back to Scottish

medium secure facilities and it may be considered that Scottish patients accessing high secure care in England would be better provided for by transfer to a medium secure service in England, as if the patient deteriorates it will be easier to facilitate transfer back to Rampton. It was queried whether work could be carried out in conjunction with Scottish Government to resolve some of the experienced cross border transfer issues, as many of the difficulties result from legislation.

2.5.2.3 Lack of Capacity

In addition to these practical concerns around the pathway, logistical concerns were also raised around bed capacity at Rampton Hospital. Following correspondence with the Clinical Director at Rampton Hospital (3rd July 2018) it was determined that there are currently no empty beds in the service, but there are patients moving to lower levels of security in the coming months, so failure to access beds based on capacity was not considered an immediate problem by Rampton. In the preceding 6-12 months, the maximum waiting list at Rampton had been four months and at the time of correspondence there was a waiting list of 1 (with admittance expected in July 2018). It was advised that the longest wait for a bed had been 6 months, however this was not routine and timeframes had been expedited for urgent referrals.

2.5.3 Summary

There are currently no female high secure beds in Scotland and there are reported challenges to accessing beds through the current pathway to Rampton Hospital, which is the only female high secure facility in the UK. Differences in practice and processes between Scotland and England can result in lengthy wait times for patients requiring transfer to high secure care. There can also be significant challenges repatriating these patients back to Scotland, with concerns over the ability to test patients out safely in medium secure settings. This may result in lengthy periods of time for patients who need to access both high and medium secure care south of the border, away from their home areas and family or friends.

The access to services for female patients requiring high secure care is significantly different to that of their male counterparts, who can access care in Scotland, with more efficient and timely access to admission and rehabilitation opportunities in their home regions or NHS Boards. This is inequitable and may result in female patients being managed in highly restrictive manners in medium secure settings and spending long periods of enhanced observations within the confines of the ward. Female patients accessing this high secure pathway also do not have access to excessive security appeals, which is also at disparity with their male counterparts. However, there are also concerns that placing small numbers of female patients (between 0-2 at any one time, based on recent figures of Scottish patients accessing high secure care at Rampton) in an all-male environment may be considered isolating and may result in female patients not having access to all the facilities and services that would be available in a larger service like Rampton. Furthermore, maintaining staff skills and resourcing a high secure service for a low base numbers of patients may be challenging and may not be the best use of resources.

2.6 Medium Secure Services

2.6.1 Current Services and Pathways

Currently there are two medium secure services that take female forensic patients in Scotland. One of these is located in the South East, The Orchard Clinic in NHS Lothian, and the other is located in the West, Rowanbank Clinic in NHS Greater Glasgow and Clyde. There are currently no medium secure female beds in the North. At present, the beds provided in the West and South East are not regional provisions but NHS Board specific and patients from other health boards are considered as out of area placements. This may be an area for further consideration by NHS Boards, in terms of developing regional agreement for access.

2.6.1.1 'Enhanced' Medium Security

In England and Wales, there are services providing 'enhanced' medium secure care that help to bridge the gap between high and medium secure care. 'Enhanced' security provision refers to enhanced resources that are used to create a focused therapeutic environment and increased capacity for 1:1 time with patients and tailored psychological therapies. In general 'enhanced' services offer higher ratios of staff to patients, with higher staff training and clinical expertise for managing self-harm and challenging behaviour (training in trauma and self-injury, boundary training, physical health care to help manage self injury in house, additional support from management of violence and aggression departments e.g. RAID training, Positive Behavioural Support etc.) Enhanced secure provisioned services are likely to have access to seclusion and restraint processes above traditional medium secure operations and increased resource for staff training. The definition of 'enhanced' if adopted by Scotland does not need to reflect the definition taken by England and an alternative term could be adopted, such as 'heightened'. Enhanced security does not represent a different security level (high, medium, low) in its own right, and is delivered in the same physical building as medium secure (i.e. same physical security), but reflects increased relational secure methods and an extension of resource and capacity.

In England and Wales, these services are described as Women Enhanced Medium Secure Services (WEMSS) and it has been reported that they have provided additional support for transitioning complex patients between high and medium secure settings. A full evaluation of WEMSS services was completed in 2010-2011 (Edge, Walker & Meacock et al., 2017) soon after services opened (in 2007), which is thought may not have allowed for all the benefits of the services to be captured, a further evaluation is currently underway.

Although these 'enhanced' medium secure services have not been used to replace high secure care, they have supported a reduction in high secure female bed capacity in England and Wales. The provision of an 'enhanced' medium secure pathway may be beneficial to consider when developing a Scottish female services pathway, though all medium secure services will be aspiring to a WEMSS delivery of care and treatment model.

2.6.2 Challenges

2.6.2.1 Mixed Sex Services

The female beds provided by the Orchard Clinic in the South East are mixed sex, contrary to Scottish Government and Department of Health guidance (Scottish Executive, 2000; Department of Health, 2007). This allows for the configuration of beds to alter depending on demand, as beds can accommodate either male or female patients. Although this beneficially allows for flexibility in responding to clinical demand surge, which can be more common when there is low base rate fluctuation. It can also create challenges for placing vulnerable female patients who may require single sex accommodation. Reviews have suggested that approximately half of the female forensic population has a history of childhood sexual abuse and single sex accommodation is generally now viewed as being an essential requirement (Culshaw, 2010). Furthermore, ensuring the safety, privacy and dignity of women is challenging in an environment that has a much higher proportion of male patients. Difficulties that can be faced around patient vulnerabilities require extensive consideration, as do challenges around isolation of low numbers of female patients if male surge demand significantly suppresses female placements.

In cases where single sex accommodation is required, patients must be referred to Rowanbank Clinic in the West. These limitations on placements can result in delays for some patients who need to wait for a bed becoming available in the West and this can also limit access to family and friends depending on the patients home NHS Board.

2.6.2.2 North of Scotland Provision

At present, there is no medium secure service for females in the North of Scotland. North of Scotland patients access care in either of the other two services in the central belt, however this is inequitable to male North of Scotland patients who can access regional secure care in Tayside, which is often closer to their home NHS Board area. The North region of Scotland is expansive, for some patients travel to the central belt will not be much greater than travel to Tayside. At present, the beds provided in the West and South East are not regional provisions but NHS Board specific and patients from other health boards are considered as out of area placements. This may be an area for further consideration by NHS Boards, in terms of developing regional agreement for access.

2.6.2.3 Exceptional Circumstances Clause

There is currently an exceptional circumstances clause (The State Hospitals Board for Scotland, 2011) operated at TSH for male patients requiring access to a medium secure bed, that states that if a bed is required at medium security but there are none available, the patient can be accommodated for a limited period in TSH until one becomes available. This clause ensures that no vulnerable patients await care outside of a hospital setting in a potentially unsuitable environment, such as custody. At present, there is no obvious solution when there are no beds available at medium security for female patients. As outlined in section 2.2.1 this has not caused difficulties in recent years, partially due to the flexibility of mixed sex accommodation at the Orchard Clinic. However, the process is currently inequitable with male provisions and could create future challenges.

2.6.3 Summary

At present, there are no medium secure female beds in the North of Scotland and the only service able to accommodate female patients in single sex accommodation is in the West. This can create delays in access to beds for some patients and create challenges in sourcing suitable placements. Furthermore, there are no contingencies for when there are no available female medium secure beds.

In England and Wales an 'enhanced' medium secure service exists that supports transitions of complex patients between high and medium secure care. No comparable service currently exists in Scotland and the development of any service would need to be equitable for male patients.

2.7 Low Secure

2.7.1 Current Services and Pathways

The provision of low secure services across Scotland varies considerably, as does the role and responsibilities of IPCUs in the provision of inpatient care for individuals considered to fall within the remit of specialist forensic mental health services. Low secure forensic care has three essential functions; as a stepdown for conditional discharge; for those presenting chronic challenging behaviour but whom are not deemed to require medium secure care; and as an assessment of function. All of these functions require a different approach and can be difficult to manage in a single unit.

At present in Scotland, there are only two low secure units designated specifically for women; Leverndale Hospital, NHS Greater Glasgow & Clyde (West), and Hope House, NHS Forth Valley (South East). There are more bespoke arrangements in other NHS Boards, predominately with the use of IPCU (such as in NHS Highland or NHS Grampian) or the independent sector. Independent low secure care is highly used, with approximately 43% of the forensic female estate being placed there at the last census date in 2017 (for a full breakdown of female placements please see section 2.3).

At the time of the 2010 report by HIS on IPCU use it was found that approximately 1 in 10 people admitted to IPCUs were detained under the provisions of criminal law (19 patients overall). This gives some sense of the number of patients who may be better served within specialist forensic mental health services, however not all people detained under criminal provision of the Mental Health Act would be managed in forensic mental health services and some patients detained under civil provision may require management under forensic mental health services. It is unclear from the report how many of these 19 patients are female, though the report advised that approximately a quarter of all admissions to IPCU's annually are female patients, which estimates 5 possible female forensic patients. The report also highlighted that at the time of writing, there was no IPCU provision specifically for women in Scotland, with the exception of the IPCU at the Carseview Centre, Dundee (North), all of the IPCUs accommodated a mixed gender client group if required.

2.7.2 Challenges

2.7.2.1 Mixed Sex and Mixed Population Services

There was general recognition in the HIS (2010) report that the mixing of patients requiring forensic provision and patients requiring IPCU provision was unsatisfactory, except in urgent acute circumstances and then should only be for a short period of time (Scottish Executive Health Department, 2006). Clinical teams managing mixed ward environments are frequently stretched to balance what are often competing demands of meeting the needs of all individuals in the service, and this can compromise the care and treatment of each of these groups of individuals, challenge services and raise concerns for patients, their families and carers (HIS, 2010).

The review group discussed the possibility of offering forensic sessions into IPCU services to support female patients accessing these services, however this would require similar sessions to be offered to males in these services and does not resolve issues around the environment or procedural security that may not be suitable for the patient's needs.

Similar concerns to those raised above in section 2.6.2.1 exist for mixed sex accommodation at low secure.

2.7.2.2 Rehabilitation Pathways

There is a need for equity in any service propositions; male patients requiring low secure care will usually be transferred to local NHS provisions, however female patients are often cared for in mixed wards, or independent services, which may be at greater distance from their home areas, family and friends. It was reported that patients accessing independent care may frequently be rehabilitated to the local community of the independent service rather than their home NHS Board due to the length of time patients spend in these services and communities, as well as the challenges with providing long distance rehabilitative support.

Patients can spend long periods of time accessing low secure services and it is essential low secure services have an identified rehabilitation pathway for supporting patients back in to the community. Similarly, it is important that rehabilitation services have an identified low secure pathway for escalating patients when required.

2.7.2.3 Excessive Security Appeals

There may be future challenges for low secure services if excessive security appeals are introduced at this level of security. The introduction of excessive security appeals may reduce numbers of patients in low secure services.

2.7.3 Summary

The provision of low secure services across Scotland varies considerably and there are very few female only low secure services. The mixing of patients requiring specialist forensic mental health services and patients requiring IPCU services and rehabilitation happens to varying degrees across the estate, and many wards are mixed sex. Ensuring the safety, privacy and

dignity of women can be challenging in an environment that has a much higher proportion of male patients.

High proportions of female patients requiring low secure care access this in the independent sector and are often placed out with home regions, with limited access to rehabilitation pathways in their home communities. This creates issues of inequity with male pathways for care and treatment.

2.8 Forensic Intellectual Disability (ID) Services

2.8.1 High Secure Service and Pathways

There are no high secure female beds in Scotland. Similar to high secure mental illness (see section 2.5), this creates challenges with referring patients cross-border. At present, one of the Scottish female patients accessing high secure care in Rampton has a primary diagnosis of intellectual disability. Considering the low number of Scottish female patients requiring high secure care, it is imperative that any solutions reached by the review group can accommodate both intellectual disability and mental illness patients.

2.8.2 Medium Secure Services and Pathways

There is a national medium secure intellectual disability service located in the West of Scotland, NHS Greater Glasgow & Clyde, which provides four female beds. Section 2.2.2 outlines use of these beds across 2016-2018.

2.8.3 Low Secure Services and Pathways

Similar to low secure services in general (see section 2.7) provisions for low secure ID patients vary across the estate. There is also variety in terms of services being managed under forensic directorates or within intellectual disability directorates, with services often separate to mental illness forensic low secure services, due to the challenges in patient mix and management. Services taking female intellectual disability patients are often mixed sex provisions, the challenges of which are similar to those discussed in sections 2.6.2.1 and 2.7.2.1 above.

A primary challenge in this area is that although a forensic definition has been utilised in terms of the census, a lot of the challenging behaviour in ID services may not be from patients who meet the definition of 'forensic' but rather are on civil orders. These patients may not be accounted for in the 2017 annual census numbers reported in section 2.3.

2.8.4 Summary

One of the major challenges in forensic ID services is the mixed management between forensic and intellectual disability services, with varied structures across Scotland. This makes determining the numbers of forensic ID patients difficult and can lead to an underrepresentation of patients requiring care in secure forensic ID settings. It is vital that considering the low number of Scottish female patients requiring high secure care, any solutions reached by the review group can accommodate both intellectual disability and mental illness patients.

2.9 Prison Service

2.9.1 Challenges with Current Pathways

In February 2018, at the request of Scottish Government, the Forensic Network put in place a system for monitoring transfer times between prison and forensic mental health services. To date there have been three female transfers recorded and none of these transfers suffered delays. The longest transfer time was 11 working days and the shortest 5 working days.

The current high secure pathway presents challenges for prison transfers, as patients cannot be transferred to Rampton pre-trial or on remand.

2.10 Summary

In summary, there are significant challenges across all security levels in the forensic estate. One major challenge is that the number of Scottish women accessing, or requiring, care in a secure setting can fluctuate significantly. From the 2017 Forensic Network annual census, it appears that 60 women were accessing care in forensic mental health services and of these 33 (55%) met the definition of 'forensic' employed by the census. The census does not take into account patients in general adult mental health or IPCU settings who may also require specialist forensic mental health services and therefore this overall number may be slightly depressed.

Women accessing forensic mental health services often have highly complex needs, with chronic psychiatric and social histories. While forensic female inpatients often have fewer criminal convictions than their male counterparts do, female patients are frequently among the more difficult patients to manage in services, because their behaviour can be chaotic and challenging, often including self-harm or problematic anger and aggression towards fellow patients and staff (Forensic Network, 2004b). The compounding trauma of many patients who are estranged from children and the impact, including at times for staff, of patients who have committed offences against their children can also create significant service challenges. It has been stated that female forensic patients less frequently require the restrictions of physical security that their male counterparts require, with the most important aspect of security being relational. In this way, the focus of security is often required to be on relational and internal security, rather than external perimeters and geographical isolation. Increased relational and procedural security may take the form of specific therapeutic intervention and high levels of nursing support and supervision (Forensic Network, 2004b). The experience and expertise of the workforce are therefore crucial to safely managing complex and vulnerable female patients.

3. PREDICTING FUTURE NEED AND CHALLENGES

3.1 Future Needs Assessment for High and Medium Secure Patients

The Forensic Network annually complete a needs assessment for all high and medium secure patients to determine the length of time clinicians expect them to remain in the level of security that they are currently accessing and also what future level of security or service the patient may require. It is generally accepted that clinicians have a tendency to be positive about the expected progress of their patients and at present the validity of estimations made in the needs assessment are untested. It is possible that the estimations over represent the number of patients potentially able to move to lower levels of security in the designated timeframe. Even without information on the processes validity, the needs assessment provides useful information around patient flow, expected length of stay and future service requirements.

The needs assessment from 2017 was conducted at the beginning of December 2017 and shows 12 female patients currently accessing medium secure care; four in the South East unit The Orchard Clinic, and eight in the West unit, Rowanbank Clinic (Table 20). Of the 12 patients identified in the needs assessment, two also had secondary diagnosis of personality disorder (PD).

Table 20: Female Patients Primary Diagnosis and Service in 2017 Needs Assessment

	Orchard Clinic	Rowanbank	Total
Intellectual Disability (ID)		2	**2**
Mental Illness (MI)	3	6	**9**
Blank (for Diagnosis)	1		**1**
Total	**4**	**8**	**12**

Table 21 outlines clinician's predictions about patient transfers and their expected length of stay in their current service. The needs assessment reported that of the 12 female patients; two were actively being considered for transfer (1 MI & 1 ID), eight were not being considered for transfer (7 MI & 1 ID), one mental illness patient was reported as unlikely to leave the current service in the foreseeable future, and one patient was currently accessing the service for assessment (primary diagnosis currently blank). The length of stay with the current service for the eight not currently being considered for transfer varied between 1 and 36 months.

In terms of predicted future services, clinicians predicted that patients would likely require rehabilitation through low secure services (6), community services (2), or through a non-forensic ward (2). Two of the future destinations for patients were left blank. Table 22 outlines these predicted future services with the anticipated length of stay for the patient at that future service. Of the 12 patients, it was estimated that 5 of the patients would be unable to return to their home NHS Board. For all 5 patients this was due to a lack of local services or beds that could accommodate their needs. All five of the patients were currently accessing Rowanbank Clinic and had home NHS Board areas of Ayrshire & Arran (2), Greater Glasgow & Clyde (2), and the Highlands (1).

Table 21: Transfer Status and Expected length of Stay in current Service

		Orchard Clinic	Rowanbank	Total
Intellectual Disability (ID)	actively being considered for transfer *(expected stay 6-12 months)*		1	**1**
	not currently being considered *(expected stay long term 24-36 months)*		1	**1**
	TOTAL		**2**	**2**
Mental Illness (MI)	actively being considered for transfer *(expected stay 1-6 months)*	1		**1**
	not currently being considered			
	Long term stay 24-36 months		1	**1**
	Medium stay 18-24 months	1	1	**2**
	Medium stay 6-12 months		2	**2**
	Short stay 1-6 months		2	**2**
	unlikely to leave in foreseeable future *(expected stay long term over 48 months)*	1		**1**
	TOTAL	**3**	**6**	**9**
Blank (for Diagnosis)	Currently under assessment (expected stay 1-6 months)	1		**1**
	TOTAL	**1**		**1**
GRAND TOTAL		**4**	**8**	**12**

Table 22: Expected Future Service Needs and anticipated Length of Stay

		Orchard Clinic	Rowanbank	Total
Community	Medium stay expected 18-24		1	**1**
	No length of stay identified	1		**1**
	TOTAL	**1**	**1**	**2**
Low	Long term stay over 48 months		3	**3**
	Long term stay 24-36 months	1		**1**
	Medium stay 12-18 months		2	**2**
	TOTAL	**1**	**5**	**6**
Non Forensic Ward	No length of stay identified		2	**2**
	TOTAL		**2**	**2**
No future service identified	No length of stay identified	2		**2**
	TOTAL	**2**		**2**
Grand Total		**4**	**8**	**12**

3.2 Future Service Needs and Challenges

3.2.1 Need for High Security

There are challenges predicting needs for high security demand based on the current needs assessment, which does not include Scottish females currently accessing high security in Rampton. Since the establishment of the pathway to Rampton Hospital, there have consistently been low numbers of Scottish female patients accessing high secure care, normally between zero and two at any one time. There may be underrepresentation with this figure, as some Scottish patients who may be considered to require high secure care are thought to not be referred through the pathway due to the predicted timescales for transfer, which are considered problematic for clinical reasons, or due to the patient's conviction status of being on remand. Due to the potential for underrepresentation, it is proposed that any future high secure development should be for a minimum of four beds to allow flexibility in the system.

3.2.2 Patients not meeting the definition of 'forensic'

The options appraisal focused on patients with forensic backgrounds (definition outlined in appendix 1); however, there may be additional groups that require care and treatment in specialist forensic mental health services. In particular, there are patients currently placed in IPCUs, patients with challenging behaviour, and patients accessing rehabilitation services who may benefit from care in forensic mental health settings. The options appraisal focused on the needs of patients who met the definition of 'forensic' employed by the Forensic Network annual census, though it is appreciated that this may be problematic as some of the patients who do not meet the forensic definition may be managed within the same pathway, or be co-

located in some NHS Boards. This is something that local NHS Boards and regional structures will need to consider and address within their area.

3.2.3 Personality Disorder Pathways

At present, forensic mental health services in Scotland do not admit patients with a primary diagnosis of personality disorder (PD). There are female patients accessing specialist care south of the border with this diagnosis. Therefore, even if high secure patients from Rampton hospital were repatriated there would be an ongoing requirement to access some specialist services in England. However, if it was deemed desirable to repatriate all patients, this would be an area that requires further consideration and development of both male and female pathways.

3.2.4 Different Diagnostic Groups

There may also be a future requirement to consider secure pathways for different diagnostic groups, including neurodevelopmental, perinatal mental health and foetal alcohol spectrum disorder. There is an ongoing need in services for secure services that care for the ageing population, such as secure nursing homes.

4. OPTIONS APPRAISAL

4.1 Option Appraisal Methodology

Option appraisal is a well-established form of multi-criteria analysis employed in the public sector to assess and evaluate a range of options for service configuration, analysing options relative benefits and non-financial costs. The results from this analysis are then used to aid decision-making. The options appraisal undertaken as part of this Review was carried out in line with recognised Government guidance on conducting appraisal and evaluation; the Green Book (HM Treasury, 2011). The options appraisal for this piece of work has been informed by a variety of options appraisal reports from different NHS Boards and National Services Division, with support from NHS Greater Glasgow & Clyde Regional Planning, to establish the most suitable process for this national working group. The option appraisal process comprises seven specific stages that define objectives, identify options and measure costs and benefits.

The steps below outline the process that was followed:

4.1.1 Stage 1 – Defining the Problem

The first stage of the process is to clearly outline the problem to be examined, as well as the specific objectives that need to be addressed. This was achieved primarily through the Terms of Reference for the review group which are outlined in the introduction to this report in section 1. These objectives were used to define the criteria upon which the assessment of alternative options were considered.

4.1.2 Stage 2 – Generating Options

The second stage involved the description and generation of potential options for each stage of secure care, which could deliver the agreed aims and objectives of the terms of reference (see section 1). It is a requirement to include a 'Status Quo' or 'do nothing' option in every options appraisal, in order to assess the potential costs and benefits of any change in care provision (as recommended in HM Treasury Guidance (2018).

4.1.3 Stage 3 – Shortlisting Options

This stage involved eliminating options in order to assess a manageable list of alternative solutions. Elimination can occur for a number of reasons, such as clearly excessive costs or option unfeasibility from the point of view of implementation. Options were eliminated only after full discussion and agreement within the group, to give shortlisted options for each level of security.

4.1.4 Stage 4 – Identifying, Measuring and Valuing Benefits

The next stage involved the identification of benefit criteria, these are measurable outcomes of the project which allow the level of compliance of each option to be determined and presented as a numerical score. Benefit criteria support the measurement of what extent each option meets the objectives specified at the outset of the working group. Once benefit criteria are defined, the criteria are weighted to reflect their relative importance to one another. After defining and weighting the benefit criteria, the group then reviewed evidence relating to the

criteria for each option. Individuals were asked to assess each option against each criterion and give a score. The score for each criterion is multiplied by the weight that criterion has attached to it. The conclusion of this stage is to provide a tabulation of the relative scores which identifies the relevant ranking for each option, by summing to provide a total weighted benefit score.

4.1.5 Stage 5 – Appraisal of Financial Benefits
This involved capturing the projected cost of the preferred options. Costs include both capital and revenue elements of necessary expenditure. As affordability is not considered as part of the benefits criteria, a cost benefit analysis will allow consideration of any waste in current services and disinvestment to follow, or efficiencies to be built into service pathways.

4.1.6 Stage 6 – Dealing with Risk and Uncertainty: Sensitivity Analysis
Any exercise of this nature requires that a number of assumptions are inherent in the analysis of the costs and benefits associated with each option. Key assumptions are varied to assess the degree of certainty surrounding the selection of a preferred option. Exploring the information in this way improves the robustness of any estimates presented and any subsequent decision analysis.

A sensitivity analysis has not been fully undertaken for this options appraisal as the group were not comparing fully worked up or costed options. At present there are no concrete proposals on which such an analysis would be based and this likely sits better at regional and local NHS Board level.

4.1.7 Stage 7 – Decision Analysis
Data on costs and benefits are then brought together and summarised using marginal analysis usually with respect to the Status Quo option.

In this case, as no risk or uncertainty analysis could be completed, the benefits and limitations of the highest ranked options are discussed in section 5. This section provides a comparison of the option of doing nothing against the review groups identified pathway.

4.2 Objective of the Options Appraisal
It was agreed that the objective of this options appraisal was *"to assess and identify the most efficient, effective, safe and sustainable model of service delivery for the female forensic population of Scotland.'*

4.3 Option Appraisal Process
The options appraisal was conducted based on the methodology in section 4.1, across a series of meetings. The first meeting agreed an initial list of options split by security level (high, medium and low), which were then circulated around all members of the working group between meetings to contribute any additional options. Once this initial option generation phase was completed, the options were collated and recirculated around working group members to allow for an initial consideration of the pros and cons for each option. Following

this, a final list of options and initial pros and cons was produced and brought to a second meeting of the working group. At this meeting, review group members short listed the options based on group discussion and consideration of the pros and cons. The working group also agreed the benefits criteria and weighting for the options appraisal. The third meeting then proceeded to scoring of the agreed shortlisted options against the weighted benefits criteria to provide a ranking of the available options.

4.3.1 Option Shortlisting

Option shortlisting was achieved through group discussion and a consideration of the pros and cons of each option. A full list of generated options can be found in Appendix 1. The agreed shortlisted options are outlined below for each level of secure care.

4.3.1.1 High Secure Shortlisted Options

Option	
Status quo	Maintenance of pathways to Rampton for High Secure Care
Development of High Secure Female Unit at The State Hospital	Development of a bespoke women's service within the current high secure male service at The State Hospital (TSH)
Development of a Co-located Women's Service offering Medium and High Secure Provision	Co-location of high and medium secure services
Development of an 'Enhanced' Medium Secure Service with maintenance of the Rampton High Secure Pathway	Development of an 'enhanced' environment (see section 2.6.1.1 for description) whilst maintaining a high secure pathway to Rampton. (NB. There was limited agreement on the term 'enhanced' which does not have to offer the same provision as WEMSS in England). This Rampton Pathway would also include the newly developed 'outreach' service to support medium secure services caring for patients with challenging and complex behaviours

4.3.1.2 Medium Secure Shortlisted Options

Option	
Status quo	Continued situation of two of the three medium secure services offering female beds. Only one of these services (Rowanbank Clinic, West) has single sex accommodation for females, which can be required depending on the patients history and previous experiences (e.g. sexual abuse)
Female beds at Rowanbank Clinic and Orchard Clinic with both providing single sex accommodation	Development of single sex accommodation at the Orchard Clinic, NHS Lothian, and maintenance of the current service provisions
Development of medium secure female unit at Rohallion Clinic	Creation of a regional ward for the North that would admit female medium secure patients, increasing the number of beds across the estate at medium security and providing care for North of Scotland patients closer to home

4.3.1.4 Low Secure Shortlisted Options

Option	
Status quo	Maintain the current estate configuration, with two purpose built female low secure services (NHS Greater Glasgow & Clyde and NHS Forth Valley) and other female patients being accommodated in mixed patient population and mixed sex wards (e.g. IPCU, Rehab) or independent care
Regional low secure services (2 or 3 - may vary dependent on local general adult rehab provisions)	Creation of three regional low secure services that work with local areas to develop robust community links
Local female low secure services	Development of female low secure beds/services in all local NHS Boards
Hybrid model of regional and local secure services across Scotland	This model suggests a hybrid of regional and local services that work together to maximise local bed capacity and rehabilitation pathways to support patients transferring to community services. The exact configuration of services and pathways would be determined in regional partnership

4.4 Criteria for Scoring the Options

The benefit criteria for scoring the short listed options were the same for all levels of security. Once the benefit criteria had been agreed, the group completed a benefits matrix to allocate each benefit criterion a weighting out of 100.

4.4.1 Benefit Criteria

No	Description	Definition
A.	Accessibility & Patient Journey	Any option should provide a safe service for all, patients, carers, visitors and staff. Any clinical risks associated with the option should be assessed, managed and minimised so that the provision of the service should do no harm and aim to avoid preventable adverse events. The option should facilitate provision of services as close as possible to where patients are in need. Consideration should be given to maintaining family contact and minimising the need for patient and carer travel. Convenience of accessibility by public transport and the local road network for patients and their families and/or carers, staff and by emergency transport should be considered.
B.	Positive Environment	Care should be provided in an environment that will maximise benefit to the individuals to aid their health and wellbeing. This includes the design and functionality of the building, along with a wider consideration of the location of the service and the environment in which it is located. Recognition should be given to the therapeutic benefit of outside recreational facilities, rehabilitation focus, patient mix and natural space.
C.	Staffing, Recruitment & Retention	The extent to which there can be adequate safe staffing and adequate staff training delivered. The option should facilitate both retention and recruitment of high calibre staff across all disciplines both now and in the future. This should consider rotas, training, and accreditation.
D.	Legislative & Policy Standards	The extent to which the option satisfies and complies with legal requirements and published standards (such as the Millan Principles, MEL 5(99), National Clinical Strategy, Realistic Medicine, Excessive Security Appeals, and the Matrix of Security) and the ability to manage the risk associated with not meeting any required standards, and any need for derogations.

No	Description	Definition
E.	Promotes Non-Discrimination & Equality	Any option should comply with the European Commission of Human Rights and the UN Convention on the Rights of Persons' with Disabilities. The level of care should ensure that patients are treated equally where they are in equal need, promoting equity not increasing inequity, including between service provisions available for different genders.
F.	Long-term Sustainability	The option should be able to accommodate changes in patterns of care and the changing needs of the population over the longer term. It should enable optimal and efficient deployment of all types of resources including staff, facilities and equipment to meet the expansion or contraction of services in the future (e.g. the possibility of multi-level facilities that can operate at different levels of security depending on need). The extent to which the facility improves the current and future capacity to deliver appropriate services to the population of Scotland, in line with ongoing planned expansion.
G.	Appropriate Strategic Fit	The provision of the option to support robust and efficient patient pathways across security levels and NHS Board boundaries should be considered. The option should identify an appropriate pathway of care throughout the secure pathway, developed through a multi-agency and multi-disciplinary approach, to provide care and treatment in the most appropriate setting wherever possible. There should be continuity of care and/or treatment, regardless of the position on the pathway of care, designed to match the needs of the patients and their carers. This should also consider access to physical health services for patients and support working relationships between staff groups. There should be established links to national, regional and local strategies for delivering services. The option should promote integration within Forensic Mental Health services and with other NHS services across the estate, and with partner agencies.
H.	Implementation & Delivery Timescales	The extent to which clinical services can be maintained during any required construction and/or implementation phase. The timescale for delivery for any option should also be considered, with recognition that resolution to challenges requires as swifter solution as possible.

4.4.2 Weighting of Benefit Criteria

Following identification of Benefit Criteria, the Benefits Matrix was completed, in which the individual criteria are compared against each other. Each group member completed a matrix and the scores were collated to provide the final results below.

		A	B	C	D	E	F	G	H
Accessibility & Patient Journey	A		A	A	A	E	A	A	A
Positive Environment	B			B	B	B	B	B	B
Staffing, Recruitment & Retention	C				D	E	C	C	C
Legislative & Policy Standards	D					E	D	D	D
Promotes Non-discrimination & Equality	E						E	E	E
Long-Term Sustainability	F							F	F
Appropriate Strategic Fit	G								G
Implementation & Delivery Timescales	H								
		Accessibility & Patient Journey	Positive Environment	Staffing, Recruitment & Retention	Legislative & Policy Standards	Promotes Non-discrimination & Equality	Long-Term Sustainability	Appropriate Strategic Fit	Implementation & Delivery Timescales

It was discussed that item H in the benefit criteria; implementation and delivery timescales, did not score in the benefits matrix and it was therefore suggested that this option be removed from the scoring process. This was agreed and the criterion will not influence the scoring or weightings for options; however, it was advised that members should still score this item in case it was useful for determining between options at a later date.

The identified benefit criteria were therefore ranked as follows:

	Criteria	Score	Rank	Weight
A	Accessibility & Patient Journey	**6**	**1**	**21.43**
B	Positive Environment	**6**	**1**	**21.43**
E	Promotes Non-discrimination & Equality	**6**	**1**	**21.43**
D	Legislative & Policy Standards	**4**	**4**	**14.29**
C	Staffing, Recruitment & Retention	**3**	**5**	**10.71**
F	Long-Term Sustainability	**2**	**6**	**7.14**
G	Appropriate Strategic Fit	**1**	**7**	**3.57**
H	Implementation & Delivery Timescales	0	8	0

4.5 Results of the Options Appraisal

The group then scored the short listed options against the benefit criteria. The scores were separated into three main groups for reporting purposes, Providers split by security level (high, medium, low), Professional group representatives, and Other partner agencies (including the Mental Welfare Commission, Scottish Government, National Services Division and Scottish Prison Service).

The scores for individuals in each of these groups were combined and averaged to provide a group score. The totals of these group scores were then combined and averaged to give an overall result, this allowed for an equal voice to be given to all stakeholders and avoided imbalance based on the number of people attending the review meetings from a particular group. To consider the robustness of scoring, several versions of the scoring were completed, such as removing extreme scorers and removing scores from people who had not attended any of the meetings. None of these variations affected the overall ranking of the options. A full breakdown of scoring for each of the options can be found in Appendix 3.

Based on this method, the group ranked the four options for high security as:-

OPTION	WEIGHTED SCORE	RANKING
Status Quo	318	4
Service at TSH	607	2
Co-location of high & MSU	621	1
Enhanced med & Rampton	521	3

The scores and the ranking of the three options for medium security were:-

OPTION	WEIGHTED SCORE	RANKING
Status Quo	536	3
Female beds at Rowanbank Clinic and Orchard Clinic	868	1
Development of MSU at Rohallion and option 2	714	2

The results for low secure followed the same procedure. The outcome of the results were:-

OPTION	WEIGHTED SCORE	RANKING
Status Quo	425	4
Regional low secure units	604	3
Local NHS Board services	746	2
Hybrid model of regional and local secure services	789	1

4.5.1 Overall Pathway:

The group considered the overall pathway being proposed from the highest scored options, as well as each secure level individually. With the small size of the estate as a whole and the requirement for efficient patient flow, the options need to work together to create robust treatment pathways that work for the estate. The overall pathway suggested from the highest scored options would be:-

LEVEL OF SECURITY	HIGHEST SCORED OPTIONS
High	Co-location high and medium
Medium	Development of single sex female beds at the Orchard Clinic
Low	Hybrid model of regional and local secure services.

The working group agreed that the proposed pathway has a range of potential benefits for services and estate function as a whole, however there are also challenges with any proposed changes to the current configuration. These are summarised for each level of security below.

4.5.1.1 Benefits and Challenges of Co-Located High and Medium Secure Unit

The development of a co-located high and medium secure unit would address the inequity in Scottish service provision between male and female services, whilst still allowing for the flexible use of resources as service demands fluctuate at high security. The option maximises the recovery potential for medium secure transfer and due to the co-located nature of the service would support clear pathways for transition, with a move within the same hospital being straightforward. In addition, staff working across both security levels could ease transitions for patients.

In comparison to the current pathway to Rampton, this option would allow easier access to high secure beds and would support patients' rights in Scotland to appeal against excessive security conditions. The proposition of a unit being developed out with The State Hospital

(TSH), also provides opportunities; the development of the service would likely be at one of the existing medium secure services (Edinburgh or Glasgow), meaning that there would be better transport links for Suspension of Detention opportunities and for supporting visiting to and of family and friends. There may also be additional recruitment benefits to these locations.

The main drawbacks of the option are the cost implications and the possible timescale for developing and delivering such a service. Timescales may be inflated by difficulties in securing planning permission or gaining the support of the local community for a high secure development. It is possible that the option would incur significantly higher running costs than the current pathway to Rampton, partially due to economies of scale. The running costs for a small service may be higher than Rampton, as this larger service can make efficiencies, splitting costs over a larger bed base.

There may also be additional operational challenges of co-location and it would be necessary to ensure that procedural and physical security at a combined unit were considered robust, to prevent any reputational risk to NHS Boards. The review group also considered that there may be challenges providing required social work input to a national co-located service, with some medium secure services already experiencing ongoing challenges with input.

It was notable that there was significant divergence in views regarding the optimal arrangement for female high secure provision and that this remains the case for some stakeholders even after the option appraisal process and the preferred outcome of co-location with a medium secure female forensic service.

4.5.1.2 Benefits and Challenges of developing single sex accommodation at the Orchard Clinic
Developing single sex accommodation at the Orchard Clinic without greatly altering bed configuration prevents the risk of over provision, which could come as a result of developing new units and creating excess capacity. The smallest ward size in the Orchard Clinic is 11 beds based on current configuration and routinely 7 beds are used for female patients in the service, though this can increase depending on need. Alteration to provide single sex accommodation to one of the Orchard Clinic's existing wards could increase the number of beds routinely available to female patients, even if some beds are lost in modifications. This would provide some capacity in the female medium secure estate to respond to demand fluctuation if required (section 2.2.1 outlines current bed use in the medium secure estate and demonstrates that services have ran at capacity in some areas over the past couple of years). Maintaining two units with sufficient patient numbers rather than dramatically increasing bed provisions with the development of a third unit, supports services to preserve and develop staff expertise.

The development of single sex accommodation at the Orchard Clinic would broaden the range of patients that could be electively admitted to the service and address the issue of a few mediums secure patients transferring to England for care in single sex services. Furthermore, it would bring medium secure forensic female provisions in to line with Scottish Government and Department of Health guidance (Scottish Executive, 2000; Department of Health, 2007).

Despite these benefits, the option would still provide no medium secure female provision north of the central belt, meaning that North of Scotland patients would be cared for further away from their home localities, families and friends. There would be a requirement to explore North of Scotland pathways to accessing these services to ensure that needs of these patients can be met timeously. Current service provision is funded by NHS Boards and is not part of a risk share, out of area patients are accepted based on capacity.

The options does not address operational differences and variation in patient experiences between medium secure services and there may be an additional requirement to address areas of operative variances to provide consistency in care and treatment provision.

4.5.1.3 Benefits and Challenges of a Hybrid Model of Regional and Local Services

At low secure, the preferred option was for a hybrid model of regional and local secure services across Scotland. This option offers the greatest amount of flexibility for NHS Boards and can accommodate the needs of smaller NHS Boards by supporting bespoke solutions between NHS Boards and regions. Regional units have previously been suggested in the Scottish Executive Health Directorate (2006) planning letter. From a patient and carer perspective, this option also supports the opportunity to be cared for closer to home. Supporting patients to be cared for in localities closer to their home NHS Boards would also allow for the development of efficient rehabilitation pathways, support community in reach working and enable smoother transitions to community placements.

This review focused on the configuration of inpatient service, but there would be a requirement with any low secure option for local NHS Boards and partner agencies to ensure effective community and rehabilitation pathways are developed from services. Services would need to work effectively and collaboratively regionally to ensure that there were not high amounts of service over-provision as a result of any new developments. The boundaries between complex pathways of regional, local, and community care, as well as the demarcation of roles between regional and local units would require careful consideration.

It would also be important for NHS Boards to work nationally with the Forensic Network to ensure consistency in approach and that the principles of least restriction were consistently met across the estate. Variations on practice and operational process were highlighted in the Mental Welfare Commission Themed Visit Report (2017), outlining the challenges operational differences can cause to patients.

4.6 Appraisal of Financial Benefits

As there are currently no concrete proposals for progressing the options and as any recommendations for the report initially sit with the NHS Chief Executives group, this section seeks only to provide indicative costs. The implementation of any option will be down to NHS Boards, with capital and staffing costs varying considerably between regions and levels of security. With this in mind, this section uses a generic standardised figure based on recent construction cost estimations and should not be used for anything more than comparative costs

between options. The specific costs of any development will greatly depend on the site, groundwork and existing facilities, which cannot be factored in to an analysis at this point.

In order to provide a standard financial measure for across the estate, this financial analysis is based on benchmarked information provided to Rowanbank Clinic, NHS Greater Glasgow & Clyde, by construction partners (Currie & Brown) for standard construction costs of similar units across the UK. This benchmarked information is based on costs for medium and low secure developments UK wide and has been used as the basis for providing general costings in this section.

Similarly, general and standardised costs for refurbishment have been used throughout the financial analysis based on information provided by NHS Greater Glasgow & Clyde Capital Finance Team. It has been determined that the cost of refurbishing a non-secure setting or general hospital building in to a secure facility, will likely incur similar costs to that of a new build, due to the required upgrades to the fabric of the building and surrounding land. The cost of refurbishing existing secure facilitates to meet current standards is likely to be significantly less. The standard costs utilised in the financial analysis can be seen in the table below.

Cost Type	Cost per square metre
New Build Construction Cost /m^2	**£3,080**
Refurbishment Cost General Hospital to Secure Facility /m^2	**£3,000**
Refurbishment Cost existing Secure Facility /m^2	**£1,500**

The size of the new Rowanbank Clinic extension for 18 medium secure beds is approximately 1500m^2 (square metres). Sizes of any proposed developments have been based on this approximation for determining figures.

In addition to construction or refurbishment costs, any development will incur staffing costs. A generic staffing cost has been utilised throughout to provide indicative figures for financial comparison. Staff profiles were considered for two medium security wards, one six-bed female mental illness and one four-bed female intellectual disability ward. Both wards had a similar staff profile and similar costs across a year, with staffing costing approximately £1m based on 1:1 nursing. It is likely that higher costs would be incurred for wards that had significant numbers of patients on 2:1 or 3:1 nursing ratios. There are likely to be a number of reasons why both wards, despite differences in size, had similar staffing costs; economies of scale with marginal additional costs for larger wards as spread over a larger bed base, and different patient populations with more intensive staffing required in intellectual disability settings. These figures will be used as the basis for indicative costs.

4.6.1 High Secure Financial Analysis

It has been determined based on the recent number of Scottish patients accessing care in Rampton Hospital, and considering the potential for underrepresentation in these figures, that proposals for high security should be based on a four-bed unit.

Option	Costs
Status quo	This would involve maintenance of costs to Rampton. Costs in 2016/17 and in 2017/18 the costs were £724k and £744k respectively. This equated to £367k per patient (on average) or £31k per patient per month.
Development of High Secure Female Unit at The State Hospital	This would likely incur structural changes to the design of The State Hospital (TSH), changes to staffing and changes to the daily structure as TSH currently accommodates an all-male population. *Capital Cost* Initial costs for a four bed unit (based on 334 m^2) have been estimated at £501k for conversion of existing accommodation, or £1.029m for a new build. *Staffing Cost* Staffing costs would be c.£1m for 1:1 nursing based on the proposed four bed unit, and higher ratios of 2:1 and 3:1 would need further modelling. Costs for male patients at TSH are in line with the current costs incurred at Rampton of over £300k per annum. A smaller all-female unit may incur a higher cost per patient if staff could not be redeployed during times of low activity.
Development of Co-located Women's Service offering Medium and High Secure Provision	This would likely incur structural changes to the design of medium secure unit to allow for a co-located annex that could make communal use of some existing ward amenities and facilities. There would be additionally incurred staffing costs and possibly a need to accommodate changes to daily routines, however the intention of co-location would be for female patients to combine with existing medium secure activities and facilities for female patients where possible. *Capital Cost* If co-location could be accommodated in existing ward structures, a four-bed unit within the Orchard Clinic, indicative costs would range from £501k for refurb of existing accommodation to £1.03m for a new build. *Staffing Cost* Staffing costs for 1:1 nursing would again be £1m and higher ratios of 2:1 and 3:1 would be between £1.5-£1.7m, not including any non-recurring costs of increased levels of observation, which may be incurred over the base staffing levels. Any final modelling should consider whether a single staff group could work across both high and medium secure female services to ensure best value and the ability to cope with fluctuations within patient numbers at each level of security.

Development of an 'Enhanced' Medium Secure Service with maintenance of the Rampton High Secure Pathway	The costs in relation to this option reflect the costs outlined in Status Quo (option 1) as well as increased staffing costs to allow for more therapeutic time to be spent with patients and support further training etc. for staff. *Capital Cost* No additional capital cost. *Staffing Cost* Recurring staff costs to step up to 2:1 and/or 3:1 staffing for a four-bedded unit would be £500k-£700k per annum. There would also be ongoing costs to Rampton Hospital.

4.6.2 Medium Secure Financial Analysis

Option	Costs
Status quo	This option incurs no capital costs and no additional revenue costs.
Female beds at Rowanbank Clinic and Orchard Clinic with both providing single sex accommodation	This would incur a capital cost at NHS Lothian for the development of single-sex accommodation. *Capital Cost* Refurb costs for 7 beds or 583m^2 (the number of female patients in the Orchard Clinic has not been above 6 in 2018) would be c.£875k. *Staffing Cost* The beds at Orchard Clinic are already staffed, but further work would be required to determine the marginal additional costs of developing single-sex services rather than the current mixed provision.
Development of medium secure female unit at Rohallion Clinic	*Capital Cost* This would likely involve capital costs of building a new ward, as it could not be accommodated in current provision. For the build of a 10 bed unit 833m^2 (according to 2017 census there are 11 North region patients in medium security in other areas, one of these patients is reported as ID) this would be approximately £2.6m. *Staffing Cost* Staffing costs would be approximately £2m per annum. Marginal nursing resource could be released from other centres if there were to be a reallocation of patients across Scotland, but some of the Rowanbank and Orchard staffing costs are fixed and would not be released by closing a small number of beds in each location.

4.6.3 Low Secure Financial Analysis

Option	Costs
Status quo	There are no clear ways to provide even indicative costs for low secure developments as many of these rely on regional and local NHS Board solutions, particularly in terms of bed numbers and size of services. From the 2017 census at low security there are regionally: Mental Illness – 6 South East, 5 West and 25 in independent Care (total: 36 Low MI estate) ID – 1 West, 1 Independent, 1 North (identified ad both MI & ID, included in ID) (total: 3 Low ID estate) Of the 26 patients across low secure state accessing independent care there are: 9 from the North, 8 from the West (plus 1 ID), and 8 from the South East. TOTAL regional figures: North – 9 MI & 1 ID West – 13 MI & 2 ID South East – 14 MI TOTAL ESTATE = 39 (36 MI & 3 ID) *Capital Cost* New build inpatient regional low secure services (not taking into account existing configuration or existing local NHS Board beds) would incur costs of: North: £2.6m West: £3.85m South East: £3.6m *Staffing Cost* Staffing could not be estimated. It should be noted that many forensic ID patients are not managed under forensic service structures and may require separate provisions. **Regional solutions should be discussed between local NHS Boards, considering local NHS Board provisions and requirements for effective and collaborative solutions**
Regional low secure services (2 or 3 - may vary dependent on local general adult rehab provisions)	
Local female low secure services	
Hybrid model of regional and local secure services across Scotland	

5. ISSUES TO CONSIDER AND SERVICE PRESSURES

Service pressures with any of the proposed options could be encountered due to the delay in time developing the delivery models. However, the current pathways of Rampton for high secure and independent provision for low secure care would provide some respite during development phases. There are other potential sensitivities at each of the security levels, for forensic intellectual disabilities, and based on the definition of 'forensic', that are explored below.

5.1 Sensitivity of High Secure Proposition

There are potential sensitivities of labelling any beds as high secure in a service outside of The State Hospital (TSH) due to public perception.

5.2 Sensitivity of Medium Secure Proposition

There are no foreseen sensitivities to developing single sex accommodation in the Orchard Clinic, South East Region. This development would support the service to broaden the range of patients that could be electively admitted to the service and present a solution to the need for patients to travel south of the border for single sex medium secure care.

The proposed option does not address the lack of medium secure female provision in the North, which would result in some continued inequity with male service provision. However, not adding additional beds in to the estate configuration would reduce the risk of overcapacity.

5.3 Sensitivity of Low Secure Proposition

At present female forensic patients are predominantly cared for in mixed sex accommodation, in mixed purpose environments (rehabilitation, IPCU, addiction, assessment and treatment units), or in independent care facilities out with their home localities. There are a large proportion of patients accessing low secure services who may not be considered 'forensic' in their background (see section 5.5) and services struggle to accommodate the needs of a broad patient population.

The proposed option for low secure care would address this by supporting regional solutions for forensic and non-forensic patients, with some local NHS Board provisions where larger numbers required this. Services would be encouraged to look at the regional requirements for low secure beds (see section 2.3, table 16) and work with other providers to develop regional and local service plans that meet clinical demand. Services would be required to define pathways for low secure provision, with clear rehabilitation and community pathways for supported step-down transitions.

Even with these developments, due to the low numbers of female forensic patients, it is likely that male patients will remain geographically closer to home localities than female patients will.

5.4 Forensic Intellectual Disability (ID) Patients

The review group recognised that because of the small numbers of patients concerned (8 identified in Forensic Network 2017 annual census, of which 7 were identified as forensic; see section 2.3), solutions for forensic intellectual disability patients have not been separated from forensic mental illness patients in this options appraisal. This is at odds with the male forensic intellectual disability population where services are traditionally separate; however, the current national female provision of medium secure care for intellectual disability (ID) and regional provisions for mental illness (MI) at Rowanbank Clinic, NHS Greater Glasgow & Clyde, appear to provide effective care in mixed ID and MI wards.

5.4.1 High Secure ID

In terms of high security, there are currently two patients accessing high secure care, of which one has a primary diagnosis of intellectual disability. It is felt that due to such low base numbers any high secure solution should accommodate both primary diagnosis mental illness and intellectual disability patients. A diverse service of this type would need to be highly aware of patient mix and the vulnerability of this patient group.

5.4.2 Medium Secure ID

The proposed medium secure solution would not affect the provision at the National Intellectual Disability (ID) Service at Rowanbank Clinic, NHS Greater Glasgow & Clyde. Reports from the service show that the provision meets current needs (running at approximately 50% capacity during 2018, section 2.2.2). Discussions with clinicians from across the ID estate suggest some concern with high threshold admission criteria for the service. A recent ID pathways meeting for women (13th December 2018) suggests the completion of a scoping exercise to explore the number of referrals made and the grounds for rejection. Despite these challenges, there is no current evidence that the number of patients would be dramatically increased in the medium secure estate in the near future, meaning that the current configuration should be sufficient to meet demand.

5.4.3 Low Secure ID

Many forensic intellectual disability low secure services are managed out with forensic directorates and the number of patients requiring access are low (8 in the Forensic Network 2017 annual census, see section 2.3). There are also a proportion of intellectual disability patients managed on civil orders that would not meet the 'forensic' definition currently employed by the census (appendix 1) and there is acknowledgement that numbers captured in the annual census may under represent the numbers considered by ID clinicians to require forensic low secure care (see section 2.8). Despite these limitations, the review would propose that services consider how the needs of ID patients can be met in any regional or local low secure developments. At present, there are no clear figures provided for how many patients in forensic ID services not captured in the Forensic Network annual census, would require low secure care, though clinicians have discussed that numbers may be so low that a national service may best meet the clinical demand and support development and preservation of staff expertise. It may be that in some areas, bespoke solutions are required and that further work in this area is needed to identify and implement workable resolutions for ID patients, such as

Tayview in NHS Fife. Any solutions should strive to be close to patients home localities, single sex and provide specialist forensic input where required.

5.5 Definition of 'Forensic' Patients

The Forensic Network and the review group utilised a definition of 'forensic' from the annual census (outlined in Appendix 1). However, this definition does not apply to a number of patients who may have ended up in forensic service through other routes and require secure care, such as patients without a conviction who may have been unmanageable in the open estate. There are arguments that any patient requiring secure psychiatric services share certain characteristics (Kennedy, 2002) and that in this way divisions of 'forensic' patients from other secure care patients is not greatly beneficial. However, this is not the approach currently employed in Scotland. There may be benefits of scale to amalgamating the numbers of patients requiring secure care with forensic patients, however this would be highly complex and may arguably result in patients not being held in environments conducive with the principle of least restriction. This review specifically focused on pathways and services for forensic patients; however, it is acknowledged that the boundaries between services is hugely challenging and there are degrees of overlap.

6. CONCLUSIONS

The provisions for female forensic patients across the Scottish estate are varied, with some areas meeting need through mixed provisions (rehabilitation and IPCUs; HIS, 2010) and mixed sex accommodation, despite eradication of mixed sex accommodation in NHS Scotland being a target for Scottish Government since 2002 (Scottish Executive, 2000; Department of Health, 2007). The present pathway for high secure care to Rampton can create significant clinical and operational challenges, while at the other end of the spectrum low secure female provisions are sparse, with many vulnerable female patients often ending up in independent accommodation out with their home localities and away from family and friends.

The outcomes of the options appraisals for all levels of security seek to address these challenges, with:

- The development of a co-located high secure female service within medium security, seeking to provide equity of service with male patients and preventing the need for Scottish patients to travel South of the Border for care. The co-location with medium security allows for economies of scale and resource during periods of significant demand fluctuation.
- The development of single sex medium secure accommodation at the Orchard Clinic, NHS Lothian, which would support complex and vulnerable patients to access care in a suitable environment and reduce the number of patients having to access care South of the Border to obtain single sex medium secure care.
- The development of a hybrid model of regional and local secure services which would limit the amount of patients placed out of area in independent healthcare provisions away from their communities, families and friends. This would also provide equitable services to male patients.

The review group recommend that action is taken to address female provision at all levels of secure care. To do this effectively for this small, but complex population, will require joined up and coordinated regional approaches.

7. RECOMMENDATIONS

Recommendation 1:

National and Local Planning – NHS Boards that have medium secure female provision should explore possibility of co-located high secure. This should be done in conjunction with national planning and National Services Division

Recommendation 2:

Regional and Local Planning - NHS Lothian and the South East Region should progress single sex accommodation in the Orchard Clinic

Recommendation 3:

Regional and Local Planning – NHS Boards should work regionally to determine the best solution based on clinical need for female low secure provision. This will need to incorporate existing local NHS Board facilities and protect against risks of over-provision nationally. In some areas, solutions may be bespoke, particularly for small forensic intellectual disability populations. To meet these needs effectively, services should define clear pathways for low secure provision, with clear rehabilitation and community pathways to support patient flow and transitions to lower levels of security.

Recommendation 4:

Local Planning – Closer planning between intellectual disability and forensic directorates should be undertaken by NHS Boards to ensure local and regional solutions meet patients' needs.

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9. APPENDICES

Appendix One: Definition of Mentally Disordered Offenders for Forensic Network Annual Census

Definition of Mentally Disordered Offenders

The Forensic Network Inpatient census will include **all** patients from high and medium security establishments. For other establishments which employ lower levels of security provision, the following definition has been provided in order for clinicians to identify which of their patients are defined as mentally disordered offenders and will therefore be included in the census.

The Scottish Office policy on *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland* describes mentally disordered offenders as those who are:

"Considered to suffer from a mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003, whether or not they are, or may be, managed under its provisions and come to the attention of the criminal justice system or whose behaviour poses a risk of such contact" (Scottish Office, 1999 – with update for 2003 Act)

This includes **everyone** currently being treated and detained under a criminal section of mental health legislation, namely:

- Assessment Orders
- Treatment Orders
- Compulsion Orders
- Interim-Compulsion Orders
- Restriction Orders
- Hospital Directions
- Transferred Prisoners
- Temporary Hospital Orders

Patients should also be included if, in this episode of care, they:

a) have been directly transferred from high or medium security services,
b) are detained under compulsory treatment orders and were previously subject to criminal section under the mental health legislation
c) are on suspension of detention

Appendix Two: Complete Options List with Pros and Cons

	Short Listed Option		Highest Scored Option

Low Secure

OPTION	PROS	CONS
1. Status quo	• Most areas of Scotland do not have adequate provision, so the outliers are those with well-developed female low secure provision. Not a pro, but at least arguably makes it easier to defend not doing much in the short term. • Acute assessment can be undertaken in IPCU. • We have the staff and facilities in place. • Provides a low security provision (of sorts) for patients and independent provision for NHS Boards with no low secure provision. • Meets some needs. • Works reasonably well in most cases due to relatively small numbers. • Continuity of care by local team in some areas with easier discharge planning. • Multiagency working relationships already exist. • Provides care and treatment to patients near to their own homes or families.	• Longer term rehab should not be in an IPCU environment, but should be sufficiently close to patient's home to facilitate transition back to community living. • Reliance on the independent sector in geographical locations generally out with their NHS Board area and at a distance from follow-on care limiting the recovery potential of patients. • Independent sector units are currently focussed in the West. Little cover for North. • Boards are using IPCUs for assessment and longer-term care. This is a problem because they are all a mixed sex environment and there is not access to forensic rehabilitation interventions. • Requires a significant number of women to be transferred to out of area placements for long term care and treatment • Low numbers of beds and due to the limited number of beds there can be a significant delay in transfer from prison for some women. • Unclear pathways. • Access to locked rehabilitation wards not managed by forensic services are problematic – perception of risk and already dealing with significant level of need from GAP.
2. National long stay secure service for women	• Could be of benefit as part of a larger service with medium secure provision on site too – facilitating moves between tiers of security; providing a wider range of therapeutic and rehabilitative facilities on site; opportunities for building staff expertise;	• Will not be as close as reasonably possible to the patient's home area. As unlikely that there's sufficient demand to justify this option and development of local service provision in each territorial Board. Potential for gender discrimination i.e. male patients being offered services in

	potential benefits of assessment opportunities e.g. prison estate. • Maintain resources and expertise of staff • Good for meeting rehabilitation needs. Gives an opportunity to maximise rehabilitation potential provided there is the full range of pharmacological, psychological and AHP services. • May give some additional beds and would provide more viability of numbers. • Gives a single facility which would provide a consistency of experience of 'low security' (currently exists at Ayr Clinic). • Single sex ward would be available.	their home areas (or at least home regions) whilst some female patients potentially being distant from their home areas. Location likely to be in central belt therefore families and carers in NoS will have to travel significant distance. • Friends and relatives at a distance which limits family contact. • Recovery potential to move seamlessly to a less restrictive rehabilitation environment impeded and does not allow rehabilitation activities that can be continued into the community. • Likely to result in delays in patients progressing to home areas. Moving people at the end of their rehab to a different area can be destabilising. Need transitional planning and support for local teams when returning to local area. Discharge planning is more difficult at a distance. • Most slow stream women are held back by personality disorders and if you concentrate all the challenging presentations in one area then that is a difficult proposition for that unit. • Due to the likely need for assessment and consideration by a referrals panel prior to admission this option is unlikely to be responsive enough for acute admissions. • This option is anticipated to have a longer length of stay due to in built delays with all transitions between Boards. This give concern about flow through such a unit and it could effectively be shut to admissions for long periods. • MHO likely to be involved only at CPA and it will be difficult to get SW input for patients. • Staff are likely to already be in the system wherever the unit is developed but this may result in loss of experienced staff from other services. • Unless a unit has central funding it is unlikely to be seen as an attractive option for Boards. • No current demand in NoS

3. Regional low secure services (2 or 3 - may vary dependent on local general adult rehab provisions)	• Arguably, could present a good balance between resourcing and developing high quality services in each area of the country – where staff groups could be trained up well and patients would be within reasonable travel time and distance of their home areas. • There may be cost savings with economies of scale • An improvement on a national provision and would allow all Heath Boards to access low security beds. • Cost to Boards could be agreed by nationally agreed formulation. Governance strategies could be agreed and reported via regional governance groups. • This option gives an opportunity to maximise rehabilitation potential provided there is the full range of pharmacological, psychological and AHP services. • Single sex ward. • Pathways in and out of the unit will need to be defined but likely to be easier than national unit. • Potential for specialist skills/training/expertise to be developed which could improve recruitment and retention of staff. Staff training and supervision will support the staff and patient group and filtration to other partner Boards would be much easier to do.	• With Scotland's geography there may be wide variation between the regions regarding proximity to family friends and follow-on units. Geographical separation in a regional unit will be less than a national unit but still different from what is provided for men therefore could be seen as discriminatory. • Still not providing care in patient's locality and potential for variation in patient experience. • Likely to result in delays in patients progressing to home areas. • With current provision in some NHS Boards (e.g. newly opened local low secure units) it's difficult to see the advantage to those NHS Board's unless they expand and charge for a set number of beds to other NHS Board's in the region. This may not be appealing to some NHS Board's who only use female low secure sparingly. • Difficulty in testing out in the local community if expectation is to be discharged directly from hospital. • Challenges may arise over readmission/progression to General Adult services. • Problems already exist with not having in-house social work cover in NoS MSU. Local authorities will have difficulty providing input at a distance which impacts on safe discharge planning. • May require new build or development of existing estate within some regions (NoS).
4. Local female low secure services	• Consistent with service model for male patients. Would dovetail with governance and clinical strategy for male low secure/rehab provision. • Gender specific. • Care closest to the patient's home area, family and friends. • Proximity to the local rehabilitation open estate allowing for maximisation of recovery potential and ease of testing out in less restrictive care.	• Smaller NHS Boards couldn't justify developing such a service and would need to buy in services from a larger neigNHS Boardouring Board (but no different to how those Boards offer services to male forensic patients.) • May present issues give low numbers of women. Base rate fluctuations in a small population likely to result in units, particularly in smaller Boards, being under-occupied at times. The service would need to be flexible enough to

	• Individual can move through the system easily • The current level of demand on IPCU beds and OOA placements will be reduced.	care for females who require it but have continuity plans when there are no requirement for the beds • Some units would be small and probably would need to be planned to be part of a wider open rehabilitation facility – but that in turn could be an advantage. • Variation of patient experience. • Some Boards are already carrying vacancies in some professional groups and have problems recruiting. Developing a new service will require experienced and knowledgeable staff that may not already be in the system within each Board. • Some areas may find very difficult to set –up which will result in postcode lottery and continued use of OOA placements. •
5. Hybrid model of regional and local secure services across Scotland	• Flexible. Could accommodate smaller NHS Boards needs better. • This may be the solution for those areas with projected small numbers. Would allow large enough Boards to do this locally and allow for smaller Boards. Smaller NHS Boards can work together. The larger Boards might be able to justify their own unit. • From a patient and carer perspective there would be an opportunity to be cared for closer to home.	• Complex model with significant risks of service over-provision. Seems ambitious / overly extensive. • It may be difficult to ensure least restriction in a hybrid model. • Variation of patient experience. • It's not clear that it would offer much more than what some NHS Board's already have locally given the development of forensic rehab units in some NHS Board's. • For some areas numbers may still be too low to make it a viable option. • Demarcation of roles between regional and local units would need careful consideration. • Likely complexity around transitions and boundaries of care. Maintaining organisation of network maybe more complex.
6. Use of IPCUs for assessment and acute treatment of female offenders	• This is very close to the status quo option, albeit implying that longer term rehab female patients would access another service.	• IPCU staff less likely to have a good understanding of the expectations of restricted patient management. IPCU may have a lack of knowledge/ experience of forensics issues /risk issues/ legal paperwork etc.

	• IPCU staff well practised in managing acutely disturbed patients. Staff are already within the system. • Many likely to have relatively more modest offending histories and may therefore be closer to general adult patients than their male counterparts. Any support required for assessment regarding fitness to stand trial or criminal responsibility can be provided by local forensic service. Similarly advice and support in risk assessment and risk management plans can be provided locally. • IPCUs are currently used for minor offenders across Scotland. There is an advantage in ease of access as they are readily available in most areas. • Need to recognise that some remote areas will use IPCU for rehab. • This option anticipates a reduced length of stay with easier transfer to GAP services once any legal process is completed. • Due to the nature of these units there can be an impact on family involvement (visits). • Relatively straightforward and working relationships already exist. Needs local discussion and arrangement with GAP colleagues	• When does "assessment and acute treatment" end – and how readily can a bed be identified in another service if the patient requires continuing care and treatment – limited access to psychology & OT interventions. • This is the status quo. (Contrary to some speculation since 2010 remand patients at Orchard Clinic have most commonly been charged with the most serious of offences – most commonly homicide of their own child.) • IPCUs are invariably mixed sex. Male patients may be sexually disinhibited. Potential for retraumatisation for female patients with previous experiences of trauma. • There is often discontinuity of care with patients dispersed far from their home and issues of local ownership. Most patients in this population progress to GAP or rehabilitation – sometimes at a distance from the IPCU. • Not sure they will be able to deliver the care the patients need as they already have competing demands/ pressures. • Likely to clog up adult non-forensic system. The need to have women on an ICO for a prolonged period or a TTD serving a long sentence can lead to bed blocking with an impact on patient flow and increased use of OOA placement for other patients. • Inappropriate level of security if low is needed. If not then they already go to IPCU. Obtaining IPCU beds often requires diplomacy skills because of the pressures on beds. • There can be resistance to forensic patients because of a lack of experience with the population
7. Low secure units for rehabilitation alone	• Would link in logically with option (6) above and good to separate acute care from rehab. • As part of the rehabilitation estate can maximise recovery potential provided there is the full range of pharmacological, psychological and AHP services. • Allows for a more focused service and could promote links with community services.	• Numbers are small to begin with so may not be justifiable. Services may be better placed to assess, diagnose, rehabilitate. • By having no pre-discharge facility for those with low rehabilitation need but high risk management need they are likely to remain in medium security or be transferred to the independent sector. • May result in challenges for patients requiring assessment.

	• Low secure units are already primarily rehabilitation units where there is a focus on recovery. E.g. locally NHSL has a 'forensic' aligned rehab unit which has the flexibility to be an open unit but can also be secured if necessary. • Reduced demand for IPCU beds to a degree. • Discharge planning and testing out in the community easier. • Provides care and treatment near to their own homes or families • Relatively straightforward and working relationships already exist.	• This could mean development of either a different model of care or a capital programme which may not be financially viable. • Transfer of care to GAP and rehabilitation Services more difficult due to perception of risk. Still a requirement to use IPCU beds. • In current financial climate it may be difficult to justify if there is already a locked rehabilitation unit. • Other areas may have to develop a new unit or re purpose an existing ward. • If it is about low secure not taking acute cases and them going to medium then it just makes the medium bed situation worse, deskills low secure, puts people in an inappropriate unit that might be far from their home, and it may increase excessive security appeals
8. Provision for women with ID – separate from women with MI	• Specialist IDDS service provision= better practice, meets individuals needs • ID and MI needs can be different. The environment can be tailored to meet patient needs better. Historically it was believed ID women were subject to bullying and intimidation in mixed MI ID facilities • ID trained staff can be deployed to work specially in that environment. • Currently a model of care used in some NHS Board's- Learning Disability low secure unit. Small amount of beds, mixed sex environment • Care pathway from MSU and community can be coordinated. • Established working relationships already in place in some NHS Board's. • Provides care and treatment near to their own homes or families. • Improve multiagency working.	• Numbers very low. May be more logical to look at how existing IDDS female patients access services locally (less of a problem than for the mental illness population and more significantly intellectually impaired women fit well into mainstream IDDS services). • Expense and viability. Additional cost inherent in likely duplication of services. • Challenges of having a mixed low secure environment (no different to general admission) • May be difficult to achieve necessary skill mix of staff.

9. Provision for women with ID – combined with women with MI	• Easier to justify economic arguments i.e. numbers more likely to justify service provision. • Many of the issues patients need help with are similar between the IDDS population and the non-IDDS population i.e. trauma/complex PTSD, poor educational attainment/literacy, self-harm, personality disorder. • Promotes integration of ID patients and reduces stigma. • Avoids clinical conflict in such cases. • Risk of victimisation and increased vulnerability of some patients with IDDS. Could potentially be mitigated by separation of patient groups within a unit e.g. separate wards or separate "pods". • Cost lower than separate units.	• Historically it was believed ID women were subject to bullying and intimidation in mixed MI ID facilities. • MMI and ID patient needs are different. • Challenges of having a mixed low secure (no different to general admission) • Need to work with different models of care within the same ward. • Transitions of care from ID to forensic will need to be clear pathways. • May be difficult to achieve necessary skill mix of staff.
10. Mixed model of separate or combined (8 and 9) provision for women with ID	• More flexible. • Economies of scale making organisation and staffing easier. Only placing those together who have similar clinical needs reducing the risk of bullying. • Allows for local availability of services. • A mixed model would allow flexibility with better use of resources, would offer more person centred approach to patient care. Would support an increase in skill sets.	• May result in different service provision in different areas of the country - confusing. • A lot depends on a suitable patient mix and with low base rate fluctuation that cannot always be guaranteed. • MMI and ID patient needs are different. • Likely complexity around transitions and boundaries of care. Maintaining organisation of network maybe more complex.

MEDIUM SECURE

OPTION	PROS	CONS
1. Status quo	• Adequate number of beds already for women requiring medium secure care. • Mixed gender wards at Orchard Clinic allow flexibility in female bed numbers at periods of surge demands (which are more common when there is low base rate fluctuation). • Currently effective and efficient with 2 units.	• Mixed sex provision can be challenging and limits patients that can be taken by the service -particularly unsatisfactory on Redwood, but far from ideal in rehab wards too. Restrictions on vulnerable women admitted alongside men - some of whom for gender based violence. This results in special observations and restrictive care which is otherwise unnecessary. Mixed gender can increase the risk of sexual assault and inappropriate intimate relationships between patients. • Shared garden areas/courtyards in both medium secure units (though perhaps not a significant issue and arguably separating female from male patients entirely has disadvantages) • No medium secure female provision north of central belt. • Inadequate psychotherapeutic resources to admit women with complex personality difficulties. • As there is no alternative, medium secure can be occasional used as a remand high secure facility. Much more restrictive care given than would occur in high security with use of seclusion rooms to manage press intrusion and targeting. Major negative effect on the running of the unit generally with restrictions to general admissions and rehabilitation activities effecting a broad number of patients. Risk of staff stress very high and insufficient psychotherapeutic resources available to support staff. Inadequate physical environment to allow exercising fresh air etc. Major difficulties in terms of facilitating general hospital visits either for emergencies or for elective treatment. Special police planning required with increased risk of adverse incident.

		• Some NHS BOARD's do not have an SLA and are reliant on spot purchase when required. The success is reliant on the availability of beds. • There is concern that the threshold or admission to an MSU is higher than for men. The result is women receiving care and treatment in less suitable environments with poorer access to certain interventions. • This does not maximise the rehabilitation potential of individuals and may lead to longer lengths of stay in hospital • There is a significant difference in the daily bed cost between Orchard Clinic and Rowanbank Clinic. NoS Boards have been required to fund placements in MSU in England because of lack of single sex environment in the current configuration of female beds. • Finding a MSU bed in England is the responsibility of individual clinicians and therefore lacks coordinated/consistent approach.
2. Female beds at Rowanbank and Orchard Clinics with both providing single sex accommodation	• Number of beds is about right for demand, whilst maintaining two units with sufficient numbers to develop staff/team expertise. • This would broaden the range of patients that could be electively admitted to Orchard Clinic but would have to be complemented by enhancement in psychotherapeutic resources to adequately manage complex trauma. • Single sex accommodation is preferred option. Likely to beneficial to some female patients and provide a better balance particularly in assessment wards. Would address issue that has resulted in some patients being transferred to MSU in England. • Biggest catchment areas are from East and West. • This would be the preferred model. An SLA or nationally agreed model would be preferable.	• No medium secure female provision north of central belt. • Mixed gender wards at Orchard Clinic allow flexibility in female bed numbers at periods of surge demands (which are more common when there is low base rate fluctuation). • Difference in medium security across the estate e.g. OC has seclusion, whereas Rowanbank presently does not.

	• There would also be the opportunity to operationalize the same admission criteria.	
3. Development of medium secure female unit at Rohallion Clinic	• Equity of service provision for men and women. • Improved care pathways for patients from north region – downstream services maintain good links with Rohallion. Established pathways and processes (for male patients) can be adapted • Easier to manage transitions e.g. visits to home area services. • Patients would be closer to their family and friends and would be in greater proximity to follow on units. Easier for local support services • A new unit would be single sex accommodation and adequately resourced • Would increase female bed provision. • Some existing staff have specialist knowledge and experience but this can be developed • Takes pressure off low secure wards which currently manage limited MSU access by increasing staffing for one patient to the detriment of other patients' care and treatment. • Reduces OOA placements	• Difficulty with service location. Rohallion's spare capacity is disappearing in next few weeks as services in Tayside reconfigure. This may mean a build within the existing MSU perimeter, which has space, but costs are likely to be substantial because it is a PFI • If female beds are developed at Rohallion, there will be an impact upon female services at Rowanbank and Orchard (particularly Orchard, where female bed numbers can be low). It may create excess capacity in the estate • The numbers of women requiring service are likely to be low. • There is still considerable travel distance for patients/carers from Grampian and Highland • Large cost implications for low numbers • Problems already exist with not having in-house social work cover in NoS MSU. Options around this are currently being explored.
4. Development of enhanced medium secure provision (NB. This option is listed under high secure also)	• Some enhancement of medium secure facilities would be likely to assist medium security managing challenging patients e.g. seclusion, suites of rooms for more acutely disturbed patients – particularly limited/lacking at Rowanbank. • Proximity to medium secure follow-on. • Help keep women with higher care needs in Scotland. A bespoke plan for Scotland should be developed. • Most sensible option. • Female patients need procedural and relational security rather than major physical security – this is met by enhanced medium secure provision.	• Potential for confusion around terminology and meaning of the service. Could be seen to add an extra tier into secure levels possibly unnecessarily. Could cause confusion around excessive security appeals (this is not an enhanced physical security level, but an enhanced relational secure level so this is perhaps not an issue) • Depending on the development and service model adopted, it could be more restrictive than would occur compared to a bespoke high security environment, with use of a relatively small footprint for a possibly lengthy period of time. May result in inadequate physical environment to allow exercising fresh air etc. and access to a range of therapeutic activities safe and secure

	• Solves problem of sufficient numbers to make a unit viable. • Opportunity to develop knowledge and skills to benefit the most difficult to treat patients. • If one unit then funding will likely be central therefore may be attractive to Boards. • If within the same MSU then this should be straightforward.	environment which also afforded privacy from press intrusion. Could result in major difficulties in terms of facilitating general hospital visits either for emergencies or for elective treatment. Possibly special police planning required with increased risk of adverse incident. • Question if this would meet the High Security provision need. • A challenge could arise if there is one enhanced MSU in Scotland which may give rise to issues with regard to equity and ease of access • Staff are probably already in the system and any additional training can be developed. It is easier to recruit staff to work in Edinburgh or Glasgow • If each MSU is to develop an enhanced MSU provision and the additional staff cost have to come from within existing budgets this would lead to reduction in service for other patients. • May require similar service for men to create equity in system
5. Status quo – ID service for women provided on a national basis at Rowanbank Clinic	• Established service that appears to meet demand. The numbers of ID women requiring medium secure care would appear to justify a single unit. • Specialist ID service and sensible option, works reasonably well the majority of the time. • Provided in a national resource with the full range of pharmacological, psychological and AHP services. • The staff are already in the system.	• Difficulties with ease of transfer to local ID low secure estate. • As this is a national service patients could be a long way from their home area/ family. • Patient mix difficulties. • Due to increasing patient numbers there have been occasions where it has been difficult to access a bed, resulting in the patient requiring admission in England, nearest being Northgate in Morpeth.
6. Provision for women with ID – separate from women with MI within option 4 (NB. Option listed under high secure	• The numbers would make this necessary – whatever disadvantage of mixing would have to be managed. Solves problem of sufficient numbers to make a unit viable. • ID and MI needs are different. The environment can be tailored to meet patient needs better. Maximises	• There are low numbers which might make this unviable. Although numbers are increasing the numbers requiring medium secure remain low. • Potentially large cost implications • Unsure of location for service • May be difficult to achieve necessary skill mix of staff. Additional cost inherent in likely duplication of services.

also). Please note that ID beds for women at Rowanbank are located within the female MI wards	rehabilitation potential with a specialist service that is more likely to meet an individual's needs. • ID trained staff can be deployed to work specially in that environment. Would offer the opportunity for development of a more specialist ID service. • Would improve specialist provision and remove current difficulties relating to patient mix. • Sensible option and bespoke plan for Scotland • Female patients need procedural and relational security rather than major physical security – this is met by enhanced security. • Consideration could be given to one development with a few low secure beds as well as a number of medium secure beds which would offer consistency in staff with reasonable patient flow through levels of security.	

HIGH SECURE

OPTION	PROS	CONS
1. Status quo	• No additional cost pressures. • Protocols are in place. • English independent medium secure facilities can be used to allow High secure step down within the jurisdiction. • Efficient with one UK national high secure unit for women based in Rampton and meets current needs. • Provided in a national resource with the full range of pharmacological, psychological and AHP services. • The cost of the service, training and HR implications are held by Rampton, although Scottish patients paid by NSD on an individual basis.	• Limited availability of high secure female beds at National Women's Service at Rampton • No access for high secure remand. There have been considerable problems with Scottish patients at Rampton not having continued good links with their territorial Board in Scotland – barrier to rehabilitation • Cross border transfer processes cannot accommodate swift transfers across border. Plus challenges of transferring patients long distances to Nottinghamshire while potentially acutely unwell and behaviourally disturbed • Difficult for families, friends and carers • Lacks equity with provisions for male patients (legal challenges) • If NHS Boards do meet expectations (e.g. local consultant attending 6 monthly CPAs), this is a significant expense/resource requirement for local services • Divergent standards for medium and high secure care in Scotland vs England • Lack of familiarity of service configuration in Scotland for colleagues at Rampton • No care available for women requiring high secure care in the remand period and challenges for those coming from custody • Normal discharge arrangements with graduated transfer and trial transfer impossible cross border. No defined pathway back to Scotland for NoS patients and in the past some women have had to move to a MSU in England • Lack of access to high secure in desirable timeframe can result in patients being transferred to MSU where management can be challenging. The effect on the

		function of the MSU is significant with increased staff burnout and reduced service to other patients. • There is no right of appeal in England about detention in excessive security. • Local authorities will not allocate an MHO to a person detained in England and do not always proved social work input. • Members of staff who already have knowledge and experience of high secure female care are retiring or working elsewhere. This body of expertise is being lost.
2. Development of high secure unit for women at TSH	• Equity of service provision for men and women. • Possibly reduction of disadvantages faced by female patients currently requiring high secure care (e.g. family contact). • Modern, high quality physical environment with significant inpatient capacity spare/unused; potential, if trends continue in future, for a further ward to close thereby freeing up one hub entirely. • Efficiencies of scale e.g. security; sharing staffing and facilities such as estates. • Previous expertise in female high secure care so would not be difficult to re-establish this expertise. • There is the availability of a secure and independent campus with state of the art rehabilitation and occupational facilities within the secure perimeter allowing for safe and private recovery and the potential of longer stays if required. • Sophisticated contingency plans for safe management of medical emergencies and elective high secure outing for elective or compassionate visits. • The presence of high secure excessive security appeals reducing the risk of inappropriate lengthy stays. Anticipate shorter length of stay than current patients	• Possible stigma associated with admittance to TSH • Lack of numbers who truly require high security and too expensive. Would needed a clearly defined admission criteria. • Even if we assume that Rampton have declined some referrals from Scotland (because of different admission thresholds for high security in England) and we'd have occasional additional demand from remand patients, the numbers are likely to remain very low. This was the original argument for closing high secure services in Scotland. Could be mitigated in a variety of ways potentially e.g. linking to efforts to assist some of the very disabled challenging to manage prisoners in the female prison estate (possible legal challenges); offering beds to services south of the border. • Isolation of patients due to low numbers (no access to peer group), or targeted patients due to mixed sex environment. • Complexities of providing mixed sex provision - though this is mainly the case in non-secure care and several prisons. There would need to be a return of safe practices regarding shared space and recreational activities with male patients, this may cause challenges • There is a fear of recreating the type of female facility prior to 2006, which clearly had numerous

	• Would assist in access to high secure beds, particularly from the prison. • Existing referral pathways between less secure hospitals and prisons in Scotland. • This is still an issue for NoS patients but similar to the situation for men and therefore not discriminatory. • Established SW service at TSH which works well with local MHO and supports families.	inappropriately placed women trapped because of inadequate local resources. This population is now found in the low secure local/ independent rehabilitation estate. • Female patients need procedural and relational security rather than major physical security. • Staff use would be intermittent and maintenance of skills difficult. There would be an initial need to train staff
3. Development of high secure unit for women elsewhere in Scotland	• Bespoke service design – physical environment and staffing. • Addresses service gaps in Scotland. • Could potentially have a high + medium area – thereby allowing other aspects of service provision to be improved. • The disadvantage of transferring women to England would be avoided. • Provided in a national resource with the full range of pharmacological, psychological and AHP services. Funding will be central therefore may be attractive to Boards. • Existing referral pathways between less secure hospitals and prisons in Scotland. • Patients will have the right to appeal detention in conditions of excessive security. • Anticipates a reduced length of stay over current system. Easier access to high secure than current system. • Likely to be a relatively small unit and located in a major city with other secure services therefore better transport links than with TSH. • Staff are probably already in the system and it is easier to recruit staff to work in Edinburgh or Glasgow. • No stigma associated with current high secure services	• Large cost in an era of enormous cost pressures for the NHS. • Staffing – female services are challenging to work in and arguably better resourced on a site co-located with other services so that staff can be rotated in and out of female services as necessary. • It is challenging to recruit staff of most disciplines in mental health. Consider geography/likelihood of recruitment if considering this option. • Staff use would be intermittent and maintenance of skills difficulty. Recruitment of staff may result in loss of experienced staff from other services. • It would be highly problematic to provide a service when the demand will be variable. To operate it safely there would have to be uneconomic overstaffing. • Small numbers require this level of care. • Location unsure and also timescales for delivery of the service unclear. Potential local opposition from those living close to the new unit and media interest more difficult to control than at TSH. • Female patients need procedural and relational security rather than major physical security. • Would seem easier to simply open one of the existing closed wards in our current high secure unit rather than attempt to open a new one

		• Problems already exist with not having in-house social work cover in some MSU. Local authorities will have difficulty providing input at a distance.
4. Development of high secure at TSH with the possibility of TSH functioning as part of the UK high secure female estate	• The UK high secure female estate is under extreme pressure with waiting lists of 18 months for transfer. The State Hospital is already funded and has spare bed capacity. Empty facilities could be used and income generated securing expertise and staffing numbers • Would provide the numbers of women required to maintain a viable service and may bring in an income. • Would improve access to beds. • Provided in a national resource with the full range of pharmacological, psychological and AHP services. • Existing referral pathways between less secure hospitals and prisons in Scotland. Opportunity to develop formal links with secure units in North of England as part of developing care pathway. • Patients will have the right to appeal detention in conditions of excessive security, including English and N Irish patients. • Anticipate a reduced length of stay over current system. • Established SW service at TSH which works well with local MHO and supports families. • Knowledge and experience may already be in the system.	• This is still an issues for NoS patients but similar to the situation for men and therefore not discriminatory. • May not be realistic, given the divergence in organisation of the NHS in Scotland and England and also the legal impediments to cross border transfer. • Planning for a service to be developed that would care for patients from UK in Scotland replicates the problem of distance for the patients "imported" from elsewhere in the UK. That does not seem to be something we should be aiming to achieve. • The difficulties in cross border transfer would occur in reverse. • Excessive security appeals may mean English domiciled patients are obliged to continue their pathway of recovery in Scotland. • It may be unlikely that English Commissioners would see this is as viable or desirable
5. Development of enhanced medium secure provision (NB. Option listed under medium secure also)	• Enhanced medium security is not intended as an alternative to high security in England. Question whether it accommodate current women in Rampton. • Similar comments as per Option 4 in medium secure section above • Proximity to medium secure follow-on. • Most sensible option and a bespoke plan for Scotland	• Similar to comments as per option 4 medium secure. • Depending on the development and service model adopted, it could be more restrictive than would occur compared to a bespoke high security environment, with use of a relatively small footprint for a possibly lengthy period of time. May result in inadequate physical environment to allow exercising fresh air etc. and access to a range of therapeutic activities safe and secure

	• Female patients need procedural and relational security rather than major physical security – this is met by enhanced security. • May solve problem of sufficient numbers to make a unit viable. • It may improve challenges faced by the lack of immediate access to high secure beds. • Might add to flexibility. • Location likely to have better transport links than with TSH (particularly if located at OC or Rowanbank). • Staff are probably already in the system and any additional training can be developed. It is easier to recruit staff to work in Edinburgh or Glasgow. • As with enhanced MSU it is anticipated that funding will be central therefore may be attractive to Boards.	environment which also afforded privacy from press intrusion. Could result in major difficulties in terms of facilitating general hospital visits either for emergencies or for elective treatment. Possibly special police planning required with increased risk of adverse incident. • Potential for confusion around terminology and meaning of the service. Could be seen to add an extra tier into secure levels possibly unnecessarily. Could cause confusion around excessive security appeals (this is not an enhanced physical security level, but an enhanced relational secure level so this is perhaps not an issue) • May require similar services for men to create equity in the system • Does not fulfil needs for high secure and may not always provide equivalent physical or procedural security to allow therapeutic work • There will still be a need for access to high secure care in England at times. • Needs a clinical team that wants to do this and is resourced to do this. • Not practical to modify existing medium secure units to the level of high security (this would not be required for WEMSS).
6. Development of national women's secure service offering flexible secure provision at TSH (medium and high)	• Addresses gap in service provision. • Numbers might better justify such a service development. This would allow for flexible use of resources which can be used most flexibly as demand fluctuates and maximises the recovery potential for medium secure transfer because of close proximity. • Patients requiring longer term care could potentially benefit from some of the wider opportunities on the high secure estate • Utilises existing provision – provides required high security beds and increase medium security beds for additional flexibility. A move between levels of	• More significant building works would be required at State Hospital. A medium secure service would surely require its own access road and entrance/egress. Costs of such a development could outweigh the advantage of recommissioning wards that are currently (and likely to remain) closed at the State Hospital. • Disruption to male patients within State Hospital whilst build project underway. • If medium and high secure female environments not adequately separated and defined, potential for legal challenges re excessive security.

	security but within the same hospital is straightforward. Staff working across both levels of security can make transition easier for patients. • Sufficient space at high secure estate for such a development and makes use of current empty facilities. Services likely to be in place that could be adapted relatively easily. • Maintenance of overall staff numbers and expertise reducing the risk of staff redundancy as the male patient population falls. • Provided in a national resource with the full range of pharmacological, psychological and AHP services. • Already nationally funded • Existing referral pathways between less secure hospitals and prisons in Scotland. • Patients will have the right to appeal detention in conditions of excessive security • Easier access to high secure than current system. • Established SW service at TSH which works well with local MHO and supports families • Knowledge and experience may already be in the system	• Stigma of State Hospital for a female patient admitted to medium security on the new service adjacent to State Hospital – would be seen by the lay person as "Carstairs". • The overall campus of High security would be reduced. • Remote location from family and friends. • There is already women's medium secure provision in other locations with advantage to patient care (such as non-rural location) • Patients would be potentially be further away from home. • This is still an issues for NoS patients but similar to the situation for men and therefore not discriminatory • Financial implication
7. Development of a co-located national women's secure service offering flexible secure provision elsewhere in Scotland (medium and high)	• Addresses service gap. • Co-location with medium security services has potential advantages – similar pros and cons to option 3 above. • This would allow for flexible use of resources which can be used most flexibly as demand fluctuates and maximises the recovery potential for medium secure transfer because of close proximity. • Provided in a national resource with the full range of pharmacological, psychological and AHP services • Existing referral pathways between less secure hospitals and prisons in Scotland. A move between	• There are large cost implications to this option. • Location unsure and also timescales for delivery of the service unclear. Potential local opposition from those living close to the new unit and media interest more difficult to control than at TSH. There may be difficulties in securing planning permission and the support of the local community. Development probably best on an existing mental health campus. • Overall staffing may continue to be low for what may be a combined medium and high secure population varying between 12 and 18 patients making a response to a surge demand or a number of challenging clinical scenarios at once problematic.

	levels of security but within the same hospital is straightforward. • Staff working across both levels of security can make transition easier for patients. • Patients will have the right to appeal detention in conditions of excessive security • Easier access to high secure than current system. • Likely to be a relatively small unit and located in a major city with other secure services therefore better transport links than with TSH. • Staff are probably already in the system and it is easier to recruit staff to work in Edinburgh or Glasgow. • Funding will be central therefore may be attractive to Boards. • No stigma associated with current high secure services	• Potential issues regarding challenges to excessive security. • Similar issues as option 1. • Problems already exist with not having in house social work cover in some MSU. Local authorities will have difficulty providing input at a distance. • Recruitment of staff may result in loss of experienced staff from other services. • Female patients need procedural and relational security rather than major physical security
8. Development of female high security (mental illness / ID), but may also be used for other cases requiring tailored approach e.g. transgender patients	• Provides required high security beds and increase flexibility. Provision of high security LD beds needs to be addressed in any new provision.	• Confusing service model may be a disadvantage. With too many variables – would become a catch all/mismatch of service. • A transgender woman is a women and must not be discriminated against. There may be concerns about the possible risks and vulnerabilities that could arise as a consequence of a trans person being admitted to a ward in accordance with their preferred gender but all services should develop processes to support transgender patients. • Decisions on level of security should be based on the assessment of risk of harm to others and not individual characteristics. • Insufficient numbers. • Female patients need procedural and relational security rather than major physical security. • High staff training needs. Staff use would be intermittent and maintenance of skills difficult.

9. Provision for women with ID – separate for women with MI within option 2 or 3	• Equity of service provision for men and women. • This may help in terms of bed numbers • More specialist provision. • Same as medium secure pros and cons • Maximises rehabilitation potential with a specialist service that is more likely to meet an individual's needs.	• Increased risk of bullying. • Difficulties with small numbers. • May be difficult to achieve necessary skill mix of staff. • Additional cost inherent in likely duplication of services
10. Provision for women with ID – combined with women with MI within option 2 or 3	• This may help in terms of bed numbers. • More realistic given low numbers. • Same as medium secure pros and cons • Promotes integration of ID patients and reduces stigma. • There is an overlap in presentations and avoids clinical conflict in such cases.	• Increased risk of bullying. • May be difficult to achieve necessary skill mix of staff.
11. Provision for women with ID – separate from women with MI within option 5 (NB. Option listed under medium secure also)	• This may help in terms of bed numbers. • More specialist provision. • Maximises rehabilitation potential with a specialist service that is more likely to meet an individual's needs.	• Very low numbers • Enhanced medium security is not an alternative to high security. • Increased risk of bullying. • May be difficult to achieve necessary skill mix of staff. • Additional cost inherent in likely duplication of services.
12. Provision for women with ID – combined with women with MI within option 5 (NB. Option listed under medium secure also)	• More realistic given low numbers. • Promotes integration of ID patients and reduces stigma. • There is an overlap in presentations and avoids clinical conflict in such cases.	• Enhanced medium security is not an alternative to high security. • Increased risk of bullying. • MMI and ID patient needs are different. • May be difficult to achieve necessary skill mix of staff.

Appendix Three: Full Scoring Outcomes

The scores were separated into three main groups for reporting purposes, care providers group broken down by security level (high, medium, low), professional group representatives, and other (including MWC, SG, NSD and SPS). The results for individuals in each of these groups scores were combined and averaged to provide a group score. Then the totals of these groups scores were combined and averaged to give an overall result, this allowed for an equal voice to be given to all stakeholders and avoided imbalance based on the number of people attending the working group from a particular group.

Scores in brackets throughout show the range of scores, or for the Providers group, the range of the averaged scores for individuals in the three security level groups.

High Secure

Option 1: Status quo

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	2 (1-3.5)	1	2
2	Positive Environment	4 (2-7)	6	5
3	Staffing, Recruitment & Retention	5 (3-8)	3	7
4	Legislative & Policy Standards	3 (1-6.5)	3	4
5	Promotes Non-discrimination & Equality	2 (1-4.5)	1	14
6	Long-Term Sustainability	4 (1-5.5)	2	2
7	Appropriate Strategic Fit	2 (1-4.5)	2	3
8	Implementation & Delivery Timescales	8 (4-10)	5	7
	TOTAL:	28 (16 – 44.5)	23 (19-29)	30 (23-39)

Option 2: Service at TSH

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	5 (2-9)	6	7
2	Positive Environment	5 (3-9)	9	6
3	Staffing, Recruitment & Retention	5 (2-9)	8	6
4	Legislative & Policy Standards	7 (5-9)	9	7
5	Promotes Non-discrimination & Equality	5 (2.5-9.5)	8	8
6	Long-Term Sustainability	4 (1-9)	7	6
7	Appropriate Strategic Fit	5 (2.5-9)	7	6
8	Implementation & Delivery Timescales	6 (4.5-9)	6	7
	TOTAL:	42 (25 – 73)	61 (49-72)	53 (30-68)

Option 3: Co-location of Medium & High

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	5 (3.5 - 6.5)	6	8
2	Positive Environment	5 (3.5–7.5)	7	8
3	Staffing, Recruitment & Retention	6 (4-8)	7	7
4	Legislative & Policy Standards	5 (3-8.5)	6	8
5	Promotes Non-discrimination & Equality	6 (4.5-9)	7	9
6	Long-Term Sustainability	5 (4-7)	7	8
7	Appropriate Strategic Fit	5 (4-8)	6	8
8	Implementation & Delivery Timescales	3 (2-4)	5	4
	TOTAL:	40 (31– 58.5)	53 (35-68)	60 (43-67)

Option 4: Enhanced medium Security and Pathway to Rampton

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	5 (2 - 7.5)	4	4
2	Positive Environment	7 (3–9.5)	6	6
3	Staffing, Recruitment & Retention	6 (2-9)	8	7
4	Legislative & Policy Standards	5 (2-9)	6	4
5	Promotes Non-discrimination & Equality	4.5 (1.5-7)	4	2
6	Long-Term Sustainability	4.5 (1-7.5)	5	4
7	Appropriate Strategic Fit	5 (2-7)	5	4
8	Implementation & Delivery Timescales	5 (4-7.5)	5	5
	TOTAL:	41.5 (16.5-64)	43 (33-53)	35.5 (22-55)

High Secure Overall Results

	Benefit Criteria	weight	Status Quo	Service at TSH	Co-location med & high	Enhanced Med & Rampton
1	Accessibility & Patient Journey	21	43	129	129	86
2	Positive Environment	21	107	129	129	150
3	Staffing, Recruitment & Retention	11	54	64	64	75
4	Legislative & Policy Standards	14	43	100	86	71
5	Promotes Non-discrimination & Equality	21	43	129	150	86
6	Long-Term Sustainability	7	21	36	43	36
7	Appropriate Strategic Fit	4	7	21	21	18
8	Implementation & Delivery Timescales	0	0	0	0	0
	TOTAL (out of possible 1000)	**100**	**318**	**607**	**621**	**521**

Medium Secure

Option 1: Status Quo

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	5.5 (3.6-7)	4	4.5
2	Positive Environment	5 (3.3-7)	4	5
3	Staffing, Recruitment & Retention	7 (6-8)	4	8
4	Legislative & Policy Standards	7 (7)	5	5
5	Promotes Non-discrimination & Equality	5 (3.6-6)	4	4
6	Long-Term Sustainability	5 (3.6-6)	4	4.5
7	Appropriate Strategic Fit	5.4 (5-6)	4	5
8	Implementation & Delivery Timescales	7 (6.6-8)	6	8.5
	TOTAL:	**45.6 (39.6–53)**	**35.75 (8 – 65)**	**44.85 (20-68)**

Option 2: Single sex female beds at Rowanbank and the Orchard Clinic

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	7 (5.3-8.5)	8.75	7.5
2	Positive Environment	8.6 (8.3-9.5)	8	9
3	Staffing, Recruitment & Retention	8 (7.6-8.5)	7.5	8
4	Legislative & Policy Standards	9 (8.6-9.5)	8.75	8.5
5	Promotes Non-discrimination & Equality	8 (7.6-9)	8.5	9
6	Long-Term Sustainability	8 (7.7-9.5)	9	8.5
7	Appropriate Strategic Fit	8.7 (8.3 – 9.5)	8.5	8
8	Implementation & Delivery Timescales	7 (6-8.5)	9	7.7
	TOTAL:	**63 (56.8–72.5)**	**68 (55 – 79)**	**66.7 (59-79)**

Option 3: Development of medium secure beds at Rohallion and option 2

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	6.8 (6–8.5)	7	8.5
2	Positive Environment	7 (6.4–8)	8	8
3	Staffing, Recruitment & Retention	5.7 (3.8-8)	5	6
4	Legislative & Policy Standards	7 (5.2-9.5)	8	7.5
5	Promotes Non-discrimination & Equality	7 (5.4-9)	6.7	8.7
6	Long-Term Sustainability	5 (3.2-7)	6.5	6.7
7	Appropriate Strategic Fit	6 (3.6-9)	6.5	7
8	Implementation & Delivery Timescales	3.8 (2.9-5.5)	4.5	6
	TOTAL:	**48 (32– 64.5)**	**52.5 (44–58)**	**59 (53-66)**

Medium Secure Overall Results

	Benefit Criteria	weight	Status Quo	Female beds at RB & OC	Develop MSU at Rohallion + option 2
1	Accessibility & Patient Journey	21	107	171	150
2	Positive Environment	21	107	193	171
3	Staffing, Recruitment & Retention	11	75	86	64
4	Legislative & Policy Standards	14	86	129	114
5	Promotes Non-discrimination & Equality	21	107	193	150
6	Long-Term Sustainability	7	36	64	43
7	Appropriate Strategic Fit	4	18	32	21
8	Implementation & Delivery Timescales	0	0	0	0
	TOTAL (out of possible 1000)	**100**	**536**	**868**	**714**

Low Secure

Option 1: Status Quo

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	3 (2.6-4)	2.5	5
2	Positive Environment	4 (4-5.2)	3.75	4.7
3	Staffing, Recruitment & Retention	5.6 (3.6-7)	3.5	6.7
4	Legislative & Policy Standards	5 (5-5.5)	4	5
5	Promotes Non-discrimination & Equality	4 (3.6-4.5)	1.75	4
6	Long-Term Sustainability	4.7 (6-7)	2	5
7	Appropriate Strategic Fit	3 (2.3-4)	2.75	4.8
8	Implementation & Delivery Timescales	8.5 (7-10)	4.75	7.7
	TOTAL:	**37.5 (31–45.5)**	**25 (8-35)**	**43.7 (30-55)**

Option 2: Regional Low Secure Services

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	5 (3-7)	6	5
2	Positive Environment	6 (4.3-7.5)	6	6.7
3	Staffing, Recruitment & Retention	6.5 (5-7.5)	8.5	6.8
4	Legislative & Policy Standards	6.7 (5.6-7.5)	6	6
5	Promotes Non-discrimination & Equality	6.5 (5.6-7)	4.5	6
6	Long-Term Sustainability	6 (4-8)	7	6
7	Appropriate Strategic Fit	6 (4.3–7)	6	5.8
8	Implementation & Delivery Timescales	6 (5.6-7)	6.7	5.8
	TOTAL:	**47.8 (37.6–58.5)**	**51.25 (45-62)**	**49 (30 – 68)**

Option 3: Local Services

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	8 (8)	7.5	8
2	Positive Environment	6 (5-7.4)	7.7	8
3	Staffing, Recruitment & Retention	5.6 (5-6.4)	6.7	7
4	Legislative & Policy Standards	7.5 (7-8)	8	7
5	Promotes Non-discrimination & Equality	7.4 (7-7.9)	8	8
6	Long-Term Sustainability	6 (6-7.3)	6.5	7
7	Appropriate Strategic Fit	7 (7-7.5)	6.7	7.7
8	Implementation & Delivery Timescales	6 (5.4-7)	5.5	7
	TOTAL:	**52 (50– 53.6)**	**57.25 (56-59)**	**60.85 (46-73)**

Option 4: Hybrid model of regional and local services

	Benefit Criteria	Providers (3 group average)	Professional Groups	Other
1	Accessibility & Patient Journey	7.8 (6.2-9.5)	8.7	8.6
2	Positive Environment	8 (6.8-9)	8.5	8
3	Staffing, Recruitment & Retention	6 (6-6.85)	7.7	7
4	Legislative & Policy Standards	8 (7.2-8.6)	8.7	8
5	Promotes Non-discrimination & Equality	7.6 (7.2-8)	8.5	8
6	Long-Term Sustainability	7.6 (6.7-8)	8.5	8
7	Appropriate Strategic Fit	7.9 (6.85-8.5)	8	8
8	Implementation & Delivery Timescales	5.8 (4.85-6.6)	6.5	6.8
	TOTAL:	**57.2 (46.3– 64)**	**65.5 (55-76)**	**63.7 (48-78)**

Low Secure Overall Results

	Benefit Criteria	weight	Status Quo	Regional Low Secure	Local NHS Board Services	Hybrid model of regional & local secure services
1	Accessibility & Patient Journey	21	86	107	171	171
2	Positive Environment	21	86	129	150	171
3	Staffing, Recruitment & Retention	11	54	75	64	75
4	Legislative & Policy Standards	14	71	100	114	114
5	Promotes Non-discrimination & Equality	21	86	129	171	171
6	Long-Term Sustainability	7	29	43	50	57
7	Appropriate Strategic Fit	4	14	21	25	29
8	Implementation & Delivery Timescales	0	0	0	0	0
	TOTAL (out of possible 1000)	**100**	**425**	**604**	**746**	**789**