



2807713458

ROYAL FREE THESES 1997

**A study of the  
community reprovision programmes  
of the  
psychiatric institutions  
in  
England 1993 - 1995**

by

**Colin John Rickard**

**M.A. F.R.I.C.S.**

**Thesis submitted to the Faculty of Medicine of the University of London  
for the degree of Doctor of Philosophy**

**Royal Free Hospital School of Medicine  
Department of Primary Care and Population Sciences**

**MEDICAL LIBRARY  
ROYAL FREE HOSPITAL  
HAMPSTEAD**

ProQuest Number: 10105753

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10105753

Published by ProQuest LLC(2016). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code.  
Microform Edition © ProQuest LLC.

ProQuest LLC  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106-1346

b 23351

09781 .

## **PREFACE**

The investigations which form the basis of this thesis were undertaken by the author between November 1992 and December 1995. Analysis of the results was undertaken as the work progressed and completed between January 1996 and March 1997.

Professor Shah Ebrahim acted as supervisor for this study.

The subject of the thesis was decided upon by the author who organised the running of the study. The author assisted the hospital managers at each of the three case studies in setting up a standard project management database to monitor key events, timetable and costs in their reprovion programme. All data was collected by the author with the exception of the majority of the patient interviews which were undertaken by a qualified psychiatric nurse acting as a research assistant. Both the researcher and the author were instructed in the use of the instruments for patient interviews by a consultant psycho-geriatrician. Approval for the studies was obtained from the Medical Ethics Committees and the Occupational Health Departments of the case study hospitals, general medical practitioners were contacted and informed of the nature of the intended research in the case of those patients remaining under their care. Analysis of data was performed by the author with advice from a statistician. The thesis presented here is entirely the work of the author.

**MEDICAL LIBRARY  
ROYAL FREE HOSPITAL  
HAMPSTEAD**



## **ABSTRACT**

The reprovizion of services in the community previously provided by psychiatric hospitals in the UK has taken from less than five to more than ten years to achieve for each hospital so far closed. Many psychiatric hospitals remain at least partially open. Protracted closures incur substantial double running costs to maintain both community and hospital reprovizion. Purchasers should bring all possible pressure on providers to reduce the duration of closure programmes in an effort to reduce these costs to a minimum. There is concern that rapid implementation of closure plans will result in the use of expedient, and possibly, sub-standard facilities, too little time to explain plans to all interested parties (patients, families, staff, local communities), and thus rapid closure plans may be seen as low quality.

The research tested the hypothesis: - "Planned short closure programmes can be achieved without detriment to the quality of reprovizion".

A database of all the English psychiatric hospitals, identifying those reprovizioning services in the community with a view to closure, was set up to map their progress over three years. Key steps associated with successful programmes from a macro-level, planning perspective were identified. Three psychiatric hospitals' reprovizion programmes were monitored in detail to provide a micro-level study of the quality of reprovizion from patient, family and staff perspectives.

The National study found that 24 (41%) of psychiatric institutions open in 1995 had no agreed plans for reprovizion in the community and at least 25 would still be open after the year 2000. Major capital schemes were a major determinant of programme length and only 40% of programmes completed on time. All hospitals studied were acquiring more complex case mixes and higher staff patient ratios whether they were closing or not. There were wide variations in both the level of reprovizion and the rate of closure of psychiatric institutions between the English health regions.

The case studies of closures shorter than the national average programme length, found no harm caused to patients, acceptable physical reprovizion standards and that patients, staff and relatives found the outcome satisfactory.

The conclusions reached were that short closure programmes can be satisfactorily implemented, inadequate management control and uncertainty of funding were major contributors to delays in implementation.

## **ACKNOWLEDGMENTS**

The author gratefully acknowledges the assistance of the following people:

Professor Shah Ebrahim for encouragement, inspired thoughts and supervision.

Pat McIntyre, an incredibly easy to work with and effective field research assistant.

Professor Barry Gurland and Dr. John Toner of the Centre for Geriatrics and Gerontology Columbia University, New York for their help and inspiration especially with Quality of Life issues and piloting of the questionnaires.

Wendy McLoughlin, who, as a Columbia University Masters student, investigated Common Mental Health Policy issues between the US and UK and assisted with the research.

The members of the Royal Free Hospital Projects Directorate for their help and forbearance whilst this work was researched.

Dr David St. George and Dr John Clark for their invaluable advice on the statistical analyses and structure of the thesis.

Dr Martin Blanchard for training on the instruments used for patient interviews.

Dr Noam Trieman for imparting a little of his specialist knowledge and expertise in this field.

The staff, patients and their relatives of the Case Study Sites for their co-operation and assistance.

Deborah Sinclair-Day for her help with Estates issues and assembling the final draft (again).

The Department of Health and the Mental Health Task Force for funding the research project.

Christina Emmett for her interest and support as research assistant for this study.

Mary, Victoria and James Rickard for their tolerance and understanding of the need to complete this thesis.

I have been grateful for the opportunity to present parts of this research as a speaker at the following conferences: -

New York Office of Mental Health Annual Conferences, Albany, New York, USA. 1993 & 1994

Columbia University, New York, Statewide Psychiatric Fellowship Programme, New York, USA: -

- Binghampton, 1994

- Poughkeepsie, 1995

The International Institute on Ageing, United Nations, Malta: - Study Course, 1996

Team for the Assessment of Psychiatric Services (TAPS) Conference, London, England, 1996

I am grateful to Columbia University, New York, Center for Geriatrics and Gerontology in the Faculty of Medicine for granting me the title of Stroud Scholar in the William W Stroud III program for collaborating in their study of "International comparisons of hospital closures on the quality of life in psychiatric patients".

# Table of Contents

<b>Preface</b>	<b>2</b>
<b>Abstract</b>	<b>3</b>
<b>Acknowledgments</b>	<b>4</b>
<b>Chapter 1      Mental Illness and Community Care</b>	<b>11</b>
1.0    Introduction	12
1.1    The Burden of Mental Illness	12
1.2    The History of Social and Health Care of the Mentally Ill	15
1.2.1.    Changes in the Law and Social Attitudes to the Mentally Ill	16
1.3    UK Government Policy - Care in the Community	17
1.4    Definition of Community Care for the Mentally Ill	18
1.5    Financing the "Care in the Community" Policy	20
1.6    The International Context	21
1.7    The Impact of Closure Programmes	22
1.7.1    Financial	22
1.7.2    Mental Health Services	22
1.8    Problems with Putting Community Care Policy into Practice	23
1.8.1    Finance Difficulties	23
1.8.2    Public Perception of Community Care	24
1.8.3    The Discharge of "Dangerously Ill" Patients	24
1.8.4    Costs of Long Term Care	25
1.8.5    Location of Community Care Facilities	26
1.9    Management of Capital and Major Change in the NHS	27
1.10   The Research Issues	34
<b>Chapter 2      Literature Review</b>	<b>36</b>
2.0    Introduction	37
2.1    Availability of Data	37
2.2.   Literature Review	38
2.2.1    British Studies	39
2.2.2    American Studies	40
2.2.3    Comparability of US and UK data	42
2.2.4    National Macro Studies	43

2.2.4.1	Studies of Deinstitutionalisation in Mental Health Reprovision	43
2.2.4.2	Learning Disabilities Reprovision - Possible Parallels	64
<b>Chapter 3</b>	<b>Study Design and Methods</b>	<b>76</b>
3.0	Hypothesis	77
3.1	Overall Study Design	77
3.2	Selection of the Research Methods	78
3.3	The National (England) Survey Design	81
3.3.1	Content of Questionnaires	81
3.3.2	Defining the Sample	82
3.3.3	Identifying the Appropriate Respondent	83
3.3.4	Pilot Study	83
3.3.5	Verification and Management of the Data in the National Study	84
3.3.6	Baseline and Annual Follow-up Surveys	85
3.3.7	Project Management Techniques in the Analysis of Programmes	86
3.4	In-depth Case Studies of Three Reprovision Programmes	88
3.4.1	Objectives	88
3.4.4.1	Case - Study Design	88
3.4.2	Content of Questionnaires	89
3.4.3	Patients' Perception Survey	90
3.5	Patient Assessment	92
3.5.1	The Brief Assessment Schedule	92
3.5.2	Dependency Measures for Patients Exhibiting Severe Dementia	93
3.5.3	Patients' Quality of Life Questionnaire	95
3.6	Staff and Carers' Surveys	97
3.6.1	Staff Perceptions Questionnaire	98
3.6.2	The General Health Questionnaire	99
3.7	Friends' and Relatives' Perceptions	99
3.8	Physical Survey of Facilities	101
3.9	Verification of Data in the In-depth Case Studies	102
3.10	Data Management	102
3.11	Sample Size Estimates	102

<b>Chapter 4</b>	<b>Results - The National (England) Study</b>	<b>104</b>
4.0	Introduction	105
4.1	Description of Population	105
4.1.1	Response Rate	105
4.2	Who completed the Questionnaire?	105
4.3	Hospital Reprovision Programmes	106
4.4	Geographical Variations in Progress	109
4.5	Purchaser/Provider Arrangements	112
4.6	Management Structures and Progress	112
4.7	Hospital Populations and Bedspaces in Use	114
4.8	Case Mixes of Hospital Populations	115
4.9	Associated Hospitals	120
4.10	Duration of Reprovision Programmes	121
4.11	Problems with Reprovision	124
4.12	Non-exchequer Funding	126
4.13	Estates Data	128
4.14	Retrenchment Efficiency	129
4.15	Quality of Institutional Facilities	130
4.16	Changes in the Scale of Reprovision Programmes	130
4.17	Numerical Differences in Reprovided Services	132
4.18	Staff Transferring to Community-based Facilities	132
4.19	Projected Completion of the Community Mental Health Reprovision Programmes in England	134
<b>Chapter 5</b>	<b>Results - Case Studies</b>	<b>136</b>
5.1	Introduction	137
5.2	Questionnaires and Methodologies	137
5.3	<b>CASE 1</b>	137
5.3.1	Brief History	137
5.3.2	The Closure Plan	137
5.3.3	Built Environment - Physical Surveys	137
5.3.4	Effects on Patients	140
5.3.4.1	Changes in Patients' Cognitive Impairment and Depression Levels	141
5.3.4.2	Quality of Life - The Patient's Perspective of Reprovision	143
5.3.5	Relatives' and Friends' Views	145

5.3.6	Staff Views	145
5.4	<b>CASE 2</b>	149
5.4.1	Brief History	149
5.4.2	The Closure Plan	150
5.4.3	Built Environment - Physical Surveys	150
5.4.4	Effects on patients	152
5.4.4.1	Changes in Patients' Dependency Level	153
5.4.4.2	Quality of Life - The Patient's Perspective of Reprovision	155
5.4.5	Relatives' and Friends' Views	156
5.4.6	Staff Views	156
5.4.7	General Health Questionnaire	159
5.5	<b>CASE 3</b>	160
5.5.1	Brief History	160
5.5.2	Closure Plan	160
5.5.3	Built Environment	160
5.5.4	Patient Data	161
5.6	Quality Control - Formal Audit of Fieldwork	161
<b>Chapter 6 Discussion - The National (England) Study</b>		163
6.0	Introduction	164
6.1	Limitations of the study	164
6.2	Strengths	164
6.3	Weaknesses in Study Design	165
6.4	Alternative Research Approaches	165
6.5	The Principal Findings	165
6.5.1	Success of Community Care Policy	165
6.5.2	Determinants of Progress	166
6.5.3	Problems of failure to close	167
6.5.4	Reductions in Provision	168
6.5.5	Inequalities	169
6.5.6	Funding	169
6.6	Summary	170

<b>Chapter 7</b>	<b>Discussion - The In-depth Case Studies</b>	<b>172</b>
7.0	Introduction - The Case Studies	173
7.1	Limitations of the Case Studies	173
7.2	Strengths of the Study	174
7.3	Alternative Approaches	174
7.4	The Principal Findings	175
7.5	Case 3 - What went wrong?	179
7.6	Case 3 - Could they have succeeded?	180
7.7	Summary - The Case Studies	181
<b>Chapter 8</b>	<b>Conclusion</b>	<b>183</b>
8.0	Introduction	184
8.1	Conclusions	184
8.2	Has the Hypothesis been supported?	193
8.3	Changes in Policy during the Study	193
8.3.1	Political Policy	193
8.3.2	Financial Policy	194
8.3.2.1	Cost Pressures Developing in the System	195
8.4	A Methodology for Analysing Reprovision Programmes	196
8.4.1	Analysis of Programmes	196
8.4.2	Project Management - Analysis Methodology	196
8.4.3	A National Standardised Reporting System for Hospital Closures	198
8.5	Further Research	204
<b>Appendices</b>		<b>204</b>
<b>Bibliography</b>		<b>296</b>
<b>Lists of Tables, Figures and Appendices</b>		<b>313</b>
<b>List of Abbreviations</b>		<b>318</b>



## **CHAPTER 1**

### **MENTAL ILLNESS AND COMMUNITY CARE**

<b>1.0</b>	<b>Introduction</b>	<b>12</b>
<b>1.1</b>	<b>The Burden of Mental Illness</b>	<b>12</b>
<b>1.2</b>	<b>The History of Social and Health Care of the Mentally Ill</b>	<b>15</b>
<b>1.2.1.</b>	<b>Changes in the Law and Social Attitudes to the Mentally Ill</b>	<b>16</b>
<b>1.3</b>	<b>UK Government Policy - Care in the Community</b>	<b>17</b>
<b>1.4</b>	<b>Definition of Community Care for the Mentally Ill</b>	<b>18</b>
<b>1.5</b>	<b>Financing the "Care in the Community" Policy</b>	<b>20</b>
<b>1.6</b>	<b>The International Context</b>	<b>21</b>
<b>1.7</b>	<b>The Impact of Closure Programmes</b>	<b>22</b>
<b>1.7.1</b>	<b>Financial</b>	<b>22</b>
<b>1.7.2</b>	<b>Mental Health Services</b>	<b>22</b>
<b>1.8</b>	<b>Problems with Putting Community Care Policy into Practice</b>	<b>23</b>
<b>1.8.1</b>	<b>Finance Difficulties</b>	<b>23</b>
<b>1.8.2</b>	<b>Public Perception of Community Care</b>	<b>24</b>
<b>1.8.3</b>	<b>The Discharge of "Dangerously Ill" Patients</b>	<b>24</b>
<b>1.8.4</b>	<b>Costs of Long Term Care</b>	<b>25</b>
<b>1.8.5</b>	<b>Location of Community Care Facilities</b>	<b>26</b>
<b>1.9</b>	<b>Management of Capital and Major Change in the NHS</b>	<b>27</b>
<b>1.10</b>	<b>The Research Issues</b>	<b>34</b>

## **1.0 INTRODUCTION**

In 1993 there appeared to be little understanding of the processes being adopted by psychiatric hospitals to implement community care and even less understanding of the progress they were making.

An article in the British Medical Journal in 1993 stated:

*" With so many problems impinging on the plans to close Britain's mental hospitals and, whether justified or not, a public perception that closures cause tragic failures of care, it seems extraordinary that the Department of Health cannot say how many mental hospitals are due to close. Such ignorance hardly inspires confidence. Nor is it in keeping with the call in the Health of the Nation (DoH, 1992) for better information and understanding about the burden of mental illness". (Groves, 1993)*

This study attempts to follow the successes and failures of the 82 psychiatric institutions that were open in 1993 in their plans to introduce community-based services for their patients over the three years to the end of 1995.

Three hospitals were also studied in depth seeking the views of both staff, relatives and patients. The patient group selected for these micro studies were the elderly mentally ill.

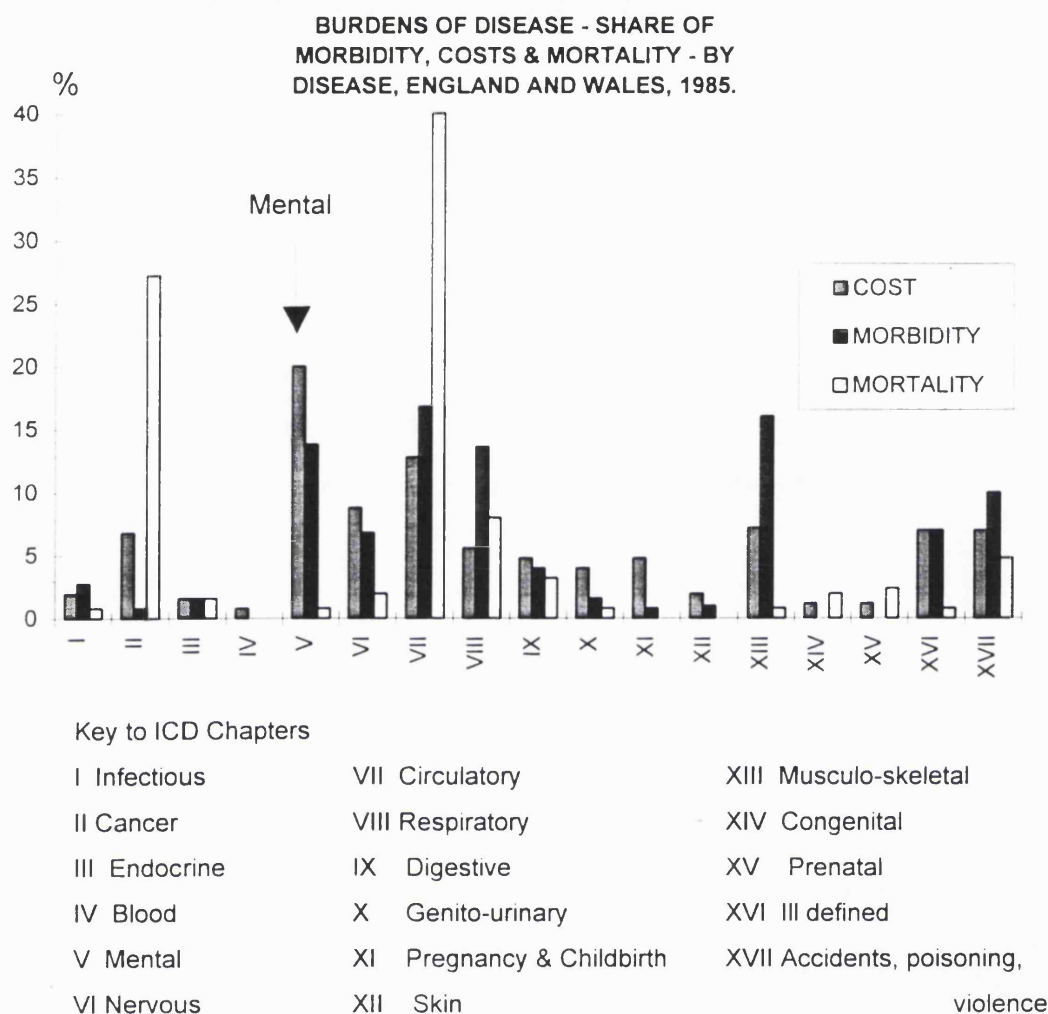
This chapter examines the changes in Mental Health Law and Government policy leading to the current environment in which the introduction of community care is being managed and examines some of the problems emerging.

### **1.1. THE BURDEN OF MENTAL ILLNESS**

The burden of mental illness can be presented as:

1. Prevalence of mental illness (morbidity);
2. Proportion of the Health Care Budget (costs);
3. Associated death rate (mortality).

FIGURE 1.1



Source: Department of Health, 1988

### Morbidity

Mental illness, ICD Chapter V (WHO, 1978) comprised 15% of the total morbidity as was measured by those in work who reported sickness days due to a mental illness. The mentally ill are less likely than average to be employed and would, if employed, seek to avoid the stigma caused by mental illness being stated as the reason for their absence and such a measurement will substantially understate the morbidity of mental illness.

## Costs of Mental Illness

Long term inpatient care, the majority of which transferred to Local Authority Social Services' budgets under Care in the Community plans (DoH, 1990), high usage of services such as outpatients, General Practitioner consultations and especially drugs by the mentally ill, all contribute to making mental illness the largest, at one fifth of the total costs, of the 17 ICD Chapters (see Figure 1.1).

Table 1.1 indicates that the burden of mortality and National Health Service (NHS) costs are spread fairly evenly between the four headings of Organic Psychoses, Other Psychoses, Neuroses etc., and Mental Retardation. Neuroses etc. however, accounted for relatively more morbidity days than any of the other categories. (Raftery 1993)

<b>Table 1.1 Burdens of Disease by Sub-Heading within Mental Illness 1985 data, England</b>				
	<b>% Deaths</b>	<b>% Life Years</b>	<b>% Morbidity</b>	<b>% NHS Costs</b>
Organic Psychoses	0.5	0.2	0.1	3.2
Other Psychoses	0.1	0.1	2.8	5
Neuroses etc.	0.1	0.2	11.9	5.8
Mental Retardation	0	0	0.5	6
TOTAL	0.7	0.5	15.2	20
Source: Department of Health, unpublished (Totals do not add due to rounding).				

Inpatient costs and GP prescription costs (23% of each of total inpatient and of prescribing costs) dominated NHS mental health costs with relatively low shares of other services devoted to mental health (3% of total outpatient and 8% of total GP consultation costs, DoH unpublished).

In the United States costs of mental illness, including those costs due to health service use and to private costs imposed by time-off work indicates that US spends roughly the same amount as the UK on mental health services, as measured by the proportion of Gross Domestic Product (GDP) accounted for by total (public plus private) spending (Raftery, 1993).

## Mortality and Mental Illness

Detailed analyses for England and Wales (DoH, 1988) for 1985 by each of the 17 Chapter headings of the International Classification of Disease (WHO, 1978) are shown in Figure 1.1. Mental Illness, which is included under ICD Chapter V, has a low burden in terms of mortality and (to a lesser extent) morbidity, but imposes the highest burden of any disease on health service costs. Mental illness hardly featured as a mortality burden accounting for less than 1% of all deaths.

A different picture emerges when considering the implications of relocating elderly mentally ill patients from the institution into the community. The effects of relocation have been extensively studied, however there has been little consensus amongst researchers. Cranz (1980) in a US based study of an entire geriatric hospital transferring to a new building reported a high mortality rate in organically brain damaged elderly patients. Marlowe (1974) in a similar relocation reported an increase in mortality. Borup (1983) reviewed 32 such studies and found that whilst five supported an increase in mortality, 23 did not.

## **1.2 THE HISTORY OF SOCIAL AND HEALTH CARE OF THE MENTALLY ILL**

Early legislation concerning the insane was primarily drawn up to protect the populace. A full table of Mental Health Legislation is shown at Appendix 1.1 and the legal process for the admission of patients at Appendix 1.2. The Vagrancy Act of 1744 required each parish to look after its own poor and the "furiously and dangerously mad" who were to be "locked up in a secure place as long as the madness shall contrive".

Public awareness of abuse and mistreatment of patients caused Parliament to set up a committee which produced The Asylum Act of 1808. The Act empowered every county, at its discretion, to provide an asylum. The Asylum Act of 1845 made the provision of such hospitals mandatory.

As the 19th century progressed, the County Mental Hospitals became increasingly overcrowded. The hospitals' inability to provide curative treatment, and an expanding population with a greater life expectancy, made the rising numbers inevitable. The mentally ill in addition to their psychiatric condition, suffered the same poor quality of health as the rest of the population.

Funding and clear identification of responsibilities for the care of the mentally ill was assisted by The Metropolitan Poor Act 1867, and its amendment in 1868, which obliged local authorities, (not elected at that time) to provide institutional care for the insane. Interestingly, the 1857 Lunacy Act in Scotland permitted voluntary admission, a possibility that was not formally copied until 1930 in England and Wales when the Mental Treatment Act was introduced.

The Workhouses catered for those excluded from the hospitals and in 1861 a total of some 50,000 persons were under the care of Workhouse Medical Officers. The aged and sick were supported in their homes under provisions in The Outdoor Relief Regulation Order of 1852. The elderly who could not manage at home were to be accommodated in separate buildings away from the punitive workhouse *"so that the old might enjoy their indulgences"*. (Fellows, 1834).

A national census of paupers in 1896 revealed that between 1861 and 1891 there was a rapid expansion of hospital facilities. Both hospitals and beds provided by charitable institutions more than doubled and accommodation for the sick provided by public authorities increased by over 50 per cent. The ability to better categorise and treat general illness as opposed to psychiatric illness brought about a greater contrast between those for whom hospital provided care and treatment and those to whom it was a place of detention and isolation.

Mental health inpatient provision in England and Wales grew steadily from the beginning of the 19th century and peaked at 151,000 patients in 1954. During that period, and until comparatively recently, over 95% of hospital care was in large, often isolated mental hospitals which were mainly built between 1811 and 1903.

Services for people with mental health problems in England began to change in the 1950s from a pattern which was almost totally dependent on large, isolated mental illness hospitals to one which offered a range of services in each local community. The reduction in patient numbers that began in 1954 is attributed to changes in treatment methods (especially the introduction of new drugs), changes in legal definition and classification of mental illness (e.g. 1959 Mental Health Act) and changes in public attitude to mental illness.

It was in 1961 that Enoch Powell, as Minister of Health, first announced the closure of mental illness hospitals and their replacement by alternative provision coining the expression "*water tower hospitals*". He eloquently described these hospitals as "*... isolated, majestic, imperious, brooded over by the giant water tower and chimney combined, rising unmistakable and daunting out of the countryside*". (Powell, 1961).

In 1991 the number of patients in NHS psychiatric hospitals in England had dropped sharply and stood at 47,000 but a year later had reduced to 40,000. By this time only just over 50% of these patients were accommodated in large ("water tower" type) mental illness hospitals.

### **1.2.1 Changes In The Law And Social Attitudes To The Mentally Ill**

The Royal Commission of 1909 was appointed to investigate the working of the Poor Laws. The matter turned on who in the population could and who could not afford the costs of health care, a debate that continues even more vociferously today. Evidence given conceded that it was now impossible to discriminate clearly between the destitute and the non-destitute sick. The Government of the day, faced with pressure from the vested interests in the system, was given the excuse to do very little and any radical reform of the Poor Laws was delayed a further twenty years.

In 1930 The Mental Treatment Act was introduced. The Act, for the first time, created a category of voluntary patient. Outpatient clinics for the mentally ill were at this time also given official sanction and local authorities were given powers for after care.

The 1959 Act derived directly from the findings of a Royal Commission, the Percy Commission, on the Law Relating to Mental Illness and Mental Deficiency 1957, whose aim was to review all prior legislation and effectively to make access to treatment and care a matter for professional (primarily medical) discretion. The Report was part of a social revolution; for the first time since 1774 there were to be no judicial controls prior to compulsory admission. This Commission defined governing principles that would ensure mentally disordered and physically ill patients would be treated in the same way. The clear trend of The Mental Health Act 1959 was towards informality and medical discretion, and away from judicially ordered civil commitment. Despite this Act however, the use of unlawful restraint and treatment without consent continued which led to the Mental Health (Amendment) Bill in 1982. This act was mainly concerned with the rights of the 10% of patients being compulsorily detained but also embodied further protection of the rights of voluntary patients.

The Mental Health Act 1983, currently in force, may be seen as a moderate swing back towards a more legal approach to mental health. Its three primary areas of change may be characterised as providing a right to services, setting limits on the exercise of compulsory powers and maintaining the civil and social status of patients.

### **1.3 UK GOVERNMENT POLICY - CARE IN THE COMMUNITY**

Current policy is set out in the National Health Service and Community Care Act (DoH, 1990). The Act enabled the formation of NHS Trust hospitals. It set up purchaser/provider arrangements through District Health Authorities (DHA) who would purchase services from Trust Hospitals for whom they no longer had direct management responsibility and permitted the formation of General Practitioner (GP) fundholder practices and enabled the further provision of accommodation and other welfare services by local authorities.

NHS Trust hospitals whilst not "Trusts" in law were given some independence. Property, subject to some restrictions, was theirs to acquire or dispose of, with the proceeds accruing to the Trust. Boards with Non-Executive part-time appointments from outside the NHS were set up to manage "Trusts".

The Family Health Services Authorities (FHSA) were formed from the Family Practitioner Committees (FPC) and were responsible for, amongst others, general medical practitioner services. The FHSAs subsequently merged with the District Health Authorities (DHAs) in April 1995 and GP (General Practitioner) Fundholding Practices were recognised. They were given funds taken from DHAs' budgets to enable them to purchase services directly from Trust Hospitals. In 1996 GP fundholding extended to some 50% of practices in England but was under-represented in urban areas. There are restrictions on the scope of services GPs can purchase.

The responsibility for the care of the mentally ill in the community with regard to their accommodation and all support other than health fell to local authority social services departments. They were responsible for assessing the needs of any person who might be in need of such services. They would then decide whether these needs call for the provision of any such services.

There is considerable local discretion left to local authorities as to the manner and form such an assessment might take. The Act does **not** include provision for appeal against failing to receive an assessment or an unreasonable delay in securing one. The services a mentally ill person might receive from a social services department could include home care services to provide relief for the carer in the home, day care centre placement for those with greater dependency and residential or nursing home care.

#### **1.4 DEFINITION OF COMMUNITY CARE FOR THE MENTALLY ILL**

'Community care' may be a current vogue but it is not a new idea. In 1857 the lunacy authorities in Scotland began community based care by funding the "boarding-out" of lunatics in residential accommodation. This practice was developed following a visit to Belgium by the Scottish Authorities. Lunatics in the village of Gheel had long been sent for domiciliary-type care provided by a religious order and Scotland followed this practice. Up to 1900 around 20% of all lunatics were boarded out.

The Wood Committee Report on Mental Deficiency (1929) appears to have first used the phrase "community care" and assumes a "model" of care encompassing care in and by the community. Community psychiatry however, as opposed to community care, involves psychiatric interventions such as diagnosis and treatment (both pharmacotherapy or psychotherapy) by psychiatrists or other psychiatric team members, in the home environment of the patient. It tends to involve both care and treatment primarily 'in' rather than by the community. This professional care is usually provided for those leaving long-stay hospitals. However, for new



referrals, more care may be provided by an individual's personal network if treated in the community rather than in the institution.

Public concerns about the introduction of community-based care for the mentally ill are nothing new. As far back as 1808 there was a Parliamentary Committee set up to investigate abuse and mistreatment of patients which resulted in the Asylum Act of 1808. Public concern continued which resulted in the Asylum Act of 1845 making the provision of properly run psychiatric hospitals mandatory and subject to review by a Board of Commissioners in Lunacy.

Yet again public concern was behind the 1930 Mental Treatment Act which allowed patients to request voluntarily treatment and also to be treated in the community at outpatient clinics. Public enquiries into the poor treatment of patients at St Augustine's, the use of unlawful restraint and treatment without consent resulted in the 1959 Act. Even today the Amendment Act of 1982 dealing with the rights of compulsorily detained patients is being reviewed.

Community care as a concept, allowing more patients to be treated at home or in their local communities safe from some of the abuses suffered by them in the institutions, unseen by the public, has many attractions. However, the scope for care being provided by members of the community also depends on many factors, including:

- the availability of carers (traditionally women not in paid employment),
- the provisions for income maintenance for both the cared and the carers, and
- the types of treatment favoured.

The inherent problems of translating the concept into a policy of "Community Care" capable of implementation which were identified by Bulmer (1987) remain largely true today. He defined four policy gaps in relation to community care in Britain:

- the lack of any consistent family policy,
- the failure to develop any policy to support women acting as informal carers,
- the failure to think through the implications for informal care of the de-institutionalisation of the mentally ill and mentally handicapped,
- the lack of serious attention to the interweaving of formal and informal care.

These omissions all apply to community-orientated psychiatry, the planning of which also involves assumptions about the nature of mental illness, its course and treatment, the proper scope for psychiatry, the efficacy of social work (Hawks, 1975), as well as the amount of services available.

Care provided by the community such as by family, friends, neighbours or voluntary organisations, imposes heavy burdens with such carers receiving little support, advice or information from official agencies (Fadden et al. 1987). A changing population and age structures will exacerbate this problem over time. The Organisation for Economic Co-operation and Development (OECD) has shown that the trends to smaller families, life-long involvement of women in the labour force and the consequently reduced scope for informal caring, all apply internationally (OECD,1986). Although the modern welfare state has evolved income-maintenance schemes which guarantee at least a minimum income to the sick, including the mentally ill, state support for carers remains limited.

## **1.5 FINANCING THE “CARE IN THE COMMUNITY” POLICY**

Unlike health services, social services care is not free at the point of use. Depending on income and assets, the user may have to make a contribution. In the Community Care Bill, the Secretary of State was given powers to make Mental Health Services Specific Grants (MHSSG), (Hogman, 1992), towards any “expenses” of local authorities in connection with their social services functions for persons suffering from mental illness. This Government funding assumes that local authorities recoup about 10% of the cost from user contribution (Labour Research, 1996).

### **The present costs of long-term care**

In 1996, The Department of Health, in giving evidence to the House of Commons Health Committee studying Long Term Care, estimated that publicly funded long-term costs in 1995/96 were as follows:-

- social services expenditure on long-term care - £6 billion after taking account of user charges;
- NHS expenditure on long-term care - £8 billion including all community health services for adults, as well as inpatient, out-patient and day care for adults in the geriatric, mental illness and learning disabilities specialties.

The Department of Health admitted it had extreme difficulty in making reliable long-term projections on costs and gave two forecasts, one optimistic and one pessimistic. Department of Health figures indicate a forecast for expenditure on long-term care in 2030 which, with the most optimistic assumptions for each variable, is £12.9 billion at 1995/96 prices (i.e. less than is spent now). Taking the most pessimistic forecasts for each variable, however, the forecast expenditure

in 2030 is over five times greater than now at £65.4 billion (4.8% of GDP). The Department of Health told the House of Commons Health Committee that these two outcomes are in practice the least likely and that, absolute demand for long-term care is likely to rise steadily. In its report, the Committee dismisses talk of a "demographic timebomb" waiting to explode over the next twenty to thirty years. It does, however, acknowledge possible significant increases in costs in the middle decades of the next century. (HMSO, 1996). These costs of long-term care and the exchequer or the individual, when they can afford it, takes the financial burden, are a matter of current debate and are further discussed in Chapter 8.

## 1.6 THE INTERNATIONAL CONTEXT

It has been estimated by the World Health Organisation (Cohen, 1988) that the total number of psychiatrically ill worldwide is no less than 250 million (around 4% of the global population) with a prevalence of schizophrenia, as suggested by psychiatric epidemiologists, at 1% of the population i.e. 60 million schizophrenics worldwide.

However, much higher figures are estimated by population-based studies. In such a study Robins & Regier (1991) reported that 2% of the population required psychiatric help annually whilst UK studies (Goldberg 1991), suggest 25% - 30% of the population experience psychological distress each year.

In the UK specialised psychiatric health services attend to around 580,000 persons annually mainly as outpatients (Rafferty 1991). Between 4% to 5% of the UK population is being treated for mental illness at any time based on estimates that one third of all psychiatric illness is dealt with by General Practitioners in primary care. Such estimates are paralleled by US figures (Regier, 1978, quoted in Mollica & Astrachan, 1991) whereby 3% of the population in 1975 was identified as receiving specialised psychiatric services each year.

Table 1.2 Direction of Change in Industrialised Countries	
UK	beds down by two thirds since 1955
Ireland	beds falling since 1955
US	beds down sharply since 1960
Germany	beds down since 1970s
Belgium	beds down since 1974
France	hospital expenditure falling
Finland	Inpatient rates down since 1974
Sweden	beds down from 1970
Italy	beds rose to 1963, decline since
Japan	1984 peak in beds
Source : Bennett (1991), Mangen (1987)	

Table 1.2. summarises some international trends. Levels of inpatient services in most industrial countries e.g. US, some EC members have been reducing (Mangen, 1987; Bennett, 1991)

although Japan is an exception. However, the supply of inpatient beds is increasing in some third world countries e.g. India, Pakistan but from low levels (United Nations, 1995).

## **1.7 THE IMPACT OF CLOSURE PROGRAMMES**

### **1.7.1 Financial**

As hospitals close the patterns of financing become complex, from a simple system where the hospital received funds to provide care for a large population usually on a single site to one where patients are transferred to a mixed economy service with funding coming from many sources. The funding is, in the case of health, in theory, free at the point of service use and for the Local Authority restricted to what is in their budget. The private and charitable sectors also provide services. For hospitals in closure, due to their high fixed infrastructure costs, their unit price per patient increases. The "reprovided services" have "upfront" revenue costs to carry out recruitment, training and commissioning of services before patients are moved. All of these cause high peaks of costs which, from anecdotal evidence, can double the costs of mental health services for a year or two whilst the final transition to closure takes place. High quality management combined with relatively sophisticated financial systems, both of which are in short supply in the NHS, are necessary to minimise these effects.

### **1.7.2. Mental Health Services**

There is no such thing as a typical mental health service. All services vary (Sainsbury, 1996) and depend on historical and local factors. This itself is confusing to the user; not only do services vary but the rate of implementation of community care varies widely between health regions in the UK. Some of the NHS Trusts' "brand names" (e.g. "Premier Trust") are not recognisable as mental health services. It is quite possible for a user to be faced with either old style services (i.e. all in the institution) or an entirely community-based service. In practice however, the user has been and will be in many parts of the country provided with a service that is partly in the institution and partly in the community and is constantly changing across an invisible boundary "seamless service" which throws up new bureaucracies for him to cope with. The Audit Commission in its report of 1996, "Balancing the Care Equation" confirmed this point, "... families were baffled by a "maze" of differing criteria for community care services and by inequalities between local authority areas". (HMSO, 1996).

## **1.8 PROBLEMS WITH PUTTING COMMUNITY CARE INTO PRACTICE**

### **1.8.1 Finance Difficulties**

Government traditionally splits finance into capital (the cost of building and equipment) and revenue (annual running costs in the NHS, principally staff costs). During the period of this study up to 1995, capital in the NHS was available through Regional Health Authorities (RHAs) with a defined and understood bid process for its acquisition. However, there were problems in the system. During this study Regional Offices replaced RHAs and lost their sources and ability to grant capital funding, temporarily recovered it (see Case 3 micro study) and then lost it again. Towards the end of the programme, the Private Finance Initiative (PFI), so far a monumental failure for the NHS, (Brown, 1995) replaced conventional capital funding. Other private sector funding for smaller schemes where funded by housing associations, e.g. hostels, was reduced due to government budget cuts. The charitable sector lost income in a depressed economy. Neither the private nor charitable sectors have been large players in NHS community reprovider. (See Chapter 4).

Revenue has been affected by both its dispersal and restricted availability. Purchaser/provider arrangements and the need to meet annual government efficiency cuts and targets, cause mental health services to struggle for funding against other emotive health issues such as poor A & E services, waiting list initiatives and the vast Information Technology programme in the NHS to administer purchaser/provider arrangements.

In addition, funds are being switched from the NHS into Local Authority Social Services. The Union funded Labour Research Department (1996) reported that two-thirds of local authorities have a minimum charge for home help services, but there are wide variations from £1 a week in Northern England to £320 a week in the South. Nine out of ten users of these services were elderly. The National Health Service is "the home of last resort" for those with nowhere else to turn and where community services are weak or too expensive. Even hospitals without closure problems seem to acquire more complex and costly case-mixes, as those nearing closure also do, but they have the further burden of high infrastructure costs combined with high, minimum staff costs. Protracted hospital closures, whether the fault of the NHS, third party providers or Social Services causes these costs to fall heavily on the NHS. Social Services and third parties do not have to bear these costs and no penalty befalls them.

### 1.8.2 Public Perception of Community Care

Community Care has acquired an unfortunate reputation. Mr Dorrell, Secretary of State for Health, as late as July 1996, in a speech discussing a proposed Charter which would set out what a mentally ill patient would be entitled to expect under the existing rules, said:

*"People often say that Care in the Community means this Government is not interested in hospital care, which isn't true". (Hawkes, 1996).*

Marjorie Wallace, of the Mental Health Charity, SANE, said in response ...

*"... the Government is still closing down psychiatric hospitals without replacing them and so no new patient can be admitted without discharging somebody equally ill."*

Kate Harrison, as reported in the same article, of the Mental Health Charity MIND, said:

*"The truth is that there is a dearth of services for the mentally ill, plus a lack of social support. The Government should provide more for community care and set national minimum standards".*

These statements worried the Government sufficiently that Gerard Malone, the health minister, told NHS Chairmen the next month to "improve care in the community standards". (Hawkes, 1996). He, however, did not make further funds available.

There are three public debates about community care which run contemporaneously:

- (i) The discharge of "dangerously ill" patients into the community;
- (ii) The burden of long term care falling to the individual and not as previously borne by the state;
- (iii) The location of care facilities for the mentally ill in the community.

### 1.8.3 The Discharge of "Dangerously Ill" Patients

The cases of Ben Silcock, a patient who had requested but had not received care, whose case came to the public's attention after he was mauled when he climbed into the lion's den in London Zoo, and Christopher Clunis, who fatally attacked someone unknown to him without provocation, caused the government to issue a ten-point plan to improve the supervision, control and care of severely mentally ill patients being discharged into the community. When John Bowlis, the Junior Health Minister, announced the plan in August 1994 (Brindle, 1994) to include supervision

registers, Labour Health spokesman, David Blunkett, MP, accused him of “breathtaking complacency”. He said:

*“We were promised legislation to introduce a new system of keyworkers, it didn’t come last year and we don’t know whether it will be introduced next year”.*

All this leaves the public concerned and forces the Government to make promises such as Stephen Dorrell in February, 1996, insisting that:

*“... nothing (the institutions) would close unless the proper facilities were up and running in the community”.* (Evening Standard, 1996)

These words echo those of Virginia Bottomley, the Secretary of State for Health at the time of the tragic Ben Silcock event, when she ordered a review of mental health law, to include possibly an element of compulsion into Community Care and also used the incident to review the issue of mental hospital closures. ( Groves,1993).

#### **1.8.4 Costs of long term care**

The NHS Community Care Act, 1990, set the framework of means testing of community care. This Act, although passed in 1990, was not implemented until 1993. According to the Institute of Health Service Management, in a meeting with the Assistant Director of Social Services, at the end of 1992, this was mainly due to the real organisational and financial issues not being addressed by Social Services.

The public is beginning to experience the effects of means testing by Local Authority Social Services Departments. Presently, if anyone seeks community care and they hold assets in excess of £8,000, they are not eligible for state help. In 1995, over 40,000 privately owned homes had been sold to finance their occupier’s need for long-term care. There has been a vigorous search for a remedy to this vote-losing issue where the thrifty are penalised and there is a direct threat to “wealth cascading down the generations”. (Eaglesham, 1997). The Government has investigated the subsidy of private insurance premiums which would permit the seeker of care to retain his assets on a pound per pound basis, working with the pensions industry to investigate earlier access to benefits. The pensions industry is rightly suspicious, after all it has been competing with the state for the younger generations’ investments for years. Why should it bail the Government out?

In October 1995, there was a dramatic clash between President Clinton and Congress when the Republican-dominated House of Representatives sought to make large reductions in the Medicare (The Health Insurance Programme for Elderly Americans), budget, (Fletcher, 1995). The American President was confident enough in the strength of the elderly vote to vigorously oppose such a move. The UK Government, also perhaps worried about voter reaction, continues to dither over the issue.

In September 1996, Mr Dorrell, the Secretary of State for Health, stated that the Government was deferring consideration of how the costs of long-term care might be met as an issue requiring more detailed consideration that could not be fitted in before the next election. (Murphy, 1996). However, this position did not remain sustainable and just before confirming the date of the election the government announced plans for a private insurance-based system to be paid for by the individual which would allow a higher level of personal assets to be retained after receiving state help for the costs of long-term care. (Eaglesham, 1997).

#### **1.8.5 Location of community care facilities**

Not surprisingly, after reading in the newspapers about unfortunate incidents involving discharged patients and a popularly perceived view that community care is in chaos, people discovering their local NHS Trust Hospital plans to place a community care facility for former psychiatric patients in a location near them respond negatively.

Whether or not the provider of community services for the mentally ill chooses voluntarily to consult with the potential neighbours on these sites, they cannot avoid the requirement to obtain change of use/town planning consent (Town and Country Planning Act, 1990). local authorities are required to follow a formal process of public consultation under Town Planning Law. Any attempt to take minor schemes through planning officers delegated powers falls foul of the "bad neighbour"<sup>1</sup> rules that require public consultation, an unfortunate stigma these schemes acquire even before consultation.

local authorities' views and possible support for these schemes vary widely, (see Chapters 4 and 5). Sometimes much time is spent in town planning appeals and litigation against a background of vociferous protests through the local press against these developments, "not in my back yard", (NIMBY's), but elsewhere the scheme would be acceptable. The government tried to help and so introduced an amendment to the Town and Country Planning Act, 1990

---

<sup>1</sup> Although many community schemes are of small size and could be dealt with by planning officers directly under delegated powers for small schemes, Community Mental Health schemes are classed as contentious and bad neighbours and therefore are exposed to the full public consultation process.



permitting small (< 5 persons) group homes for those persons who were former residents of psychiatric institutions to be classed as "family homes" thereby allowing these houses to be occupied without the need to acquire town planning consent.

Two problems arose. Firstly the number of residents had to include care staff, so for practical purposes the number was uneconomically small (although those involved in relocating patients with learning disabilities who require special needs housing have used this arrangement extensively and successfully). Secondly, there has been extensive litigation entered into by local residents to challenge planning applications made under this arrangement and some have met with success. (*C & G Homes Ltd vs Secretary of State for Health*, 1994). Local people still have rights under common law to challenge these schemes where there are restrictions (restrictive covenants on the use of the property) usually made on the first sale of the property when new, but binding in law on successor owners.

### **1.9 Management of Capital and Major Change in the NHS**

Assuming data on the progress of plans for the reprovion of mental health services could be collected to formulate a national study, how might the data be analysed? In the private sector Project Management techniques are well established and widely adopted for the management of capital and major change programmes.

*"Project Management can be defined as the provision of a management control system in which all participants can effectively perform and so ensure that the project is completed within the project constraints of time, cost, quality and function"*. (ECH Report, 1990).

Problems in the management of the NHS's capital programme , projected at £2.2 billion in 1992, (Social Services Statistics 1993) have resulted in several detailed reviews of process.

Capricode (HMSO 1978), (in use between 1978 and 1993), set out principles designed to improve both accountability and the management of capital schemes. In particular it introduced both the principle of project management and provided a clear set of definitions to specify the major stages of a capital project's development. Essential to the management of the process it stated what level of information in terms of scheme content, detail of development, cost and time-tabling data was necessary to define each of these stages.

Whilst Capricode provided the framework for project management it was not until 1985 that, with the issue of Health Circular 85 (26), (DoH, 1995), a Project Manager was required to be the named individual responsible for the overall management of a scheme. Health Circular 85(26)

was issued following a highly critical report by the Working Group on Capital Expenditure Contracts, H.M Treasury, 1986 on cost and time overruns on government contracts. The National Audit Office Report on the Hospital building programme issued in 1989 identified little progress, although at least it noted that project management had become a “buzz” word even if it were not taking place.

In 1990 the Department of Health commissioned E.C. Harris, (ECH), Project Management Consultants who produced “Report on Project Management in the NHS in England”. Their brief was to establish to what extent the recommendations of Central Government (mentioned above) for the improvement of management of capital projects (particularly the appointment of project managers) in the public sector had been adopted in the NHS.

The report had disappointing findings. Project managers were being appointed by the NHS, however only in few instances did they have the skills to undertake the task, their access to computer software packages essential to monitoring progress was minimal and they were generally of junior rank, lacked authority and were unsupported. NHS Finance departments however, no doubt alarmed by criticisms of overspending, had appointed more senior finance officers (but less qualified in project management), to “manage” the capital programme making the project manager’s role more difficult. The report recommended that project managers be given more support and training, a career structure and more direct financial control of their projects.

Three years later in 1993, Nigel Parry Associates were commissioned by the Department of Health and produced their report “Implementation of Health Care Building Projects”. The report identified that project managers in the NHS had *“neither a full understanding of their role nor the staff resources and needed more support and training”*, it also noted that the guidance in Capricode HMSO 1978, was now out of date, did not give project managers sufficient authority and needed urgent revision.

In 1993, the Department of Health issued the Capital Investment Manual [CIM], (HMSO, 1993), on which it had been working for several years which addressed many of the procedural problems obstructing the project management role. Unfortunately its issue coincided with the government “flag ship” policy of the Private Finance Initiative ([PFI] DoH, 1993, Executive Letter, 93(03)) which required all NHS procurements over £1m in value to be “tested” in the private sector as to the project’s possibility of being funded through PFI. Under PFI, other than specifying its basic requirements, the NHS was required to step back from management of capital schemes which were now to be controlled by contractual penalty and left to the private sector partner to deliver.

The working party that produced the important supporting documentation to the CIM appeared not to have noticed the change in policy and in 1995 issued the "Agreement for the appointment of project managers for the commissioning of construction projects in the NHS", (DOH 1995). This 60 page document sets out in precise detail the role of project managers, their powers and responsibilities and most particularly the minimum data bases they will acquire and maintain to manage projects.

At the time of writing the PFI programme in the NHS has been stopped, (Pike A & Timmins, The Financial Times, July 17th, 1997), with only a small number of schemes (14) progressing. All other PFI schemes have been stood down pending a review. It may be hoped the NHS will be permitted to project manage capital projects again; although one of the reasons for PFI's introduction was the government's hope of better cost control in capital projects. The failure of the PFI to generate new capital from the private sector means that the issue of better cost control in the NHS cannot be addressed.

### **Project Management Techniques**

*"In business enterprise forethought is necessary before useful decisions on and consequent action can be taken. The basis of short effective action is long term planning - without planning a course of action becomes a succession of random changes without direction". (Brecht, 1975).*

The theory of Project Management is formally based on operational research techniques which have been tested retrospectively on schemes where the outcome was known.

Activities within programmes are identified where they can be closely and specifically defined permitting accurate comparisons to be made between programmes for similar activities. The time required to complete specific activities, their costs and the relative criticality of the completion of these tasks to each other are recorded.

This knowledge is then applied to projects in progress with a view to predicting future outcomes in time to permit intervention where unacceptable divergence from the agreed programme is anticipated. Industries where these techniques are widely applied (e.g. oil, production engineering and construction) maintain standard data bases of time and cost for ranges and chronologies of activities which are of great assistance to project managers in formulating predictions.

It was only recently, in 1994, that the NHS noted the need to formally record scheme data retrospectively in the Capital Investment Manual, a section on "post project evaluation"

{{HSG(94)31}, HMSO, 1994), in order that such a database could be formulated. Consequently project management in the NHS lacks the basic tools to carry out acceptable work.

### **Project Management Tools**

A brief description of the scientific tools of the project manager is useful in understanding the NHS's obvious problem with its introduction.

The project manager is required to manage two variables, cost and time, and in this process maintain both quality and function. The latter two are controlled by a specification of quality requirements and an approved design solution both of which are agreed with the client and both of which must fit within the specified budget and time envelopes for the project. There are detailed techniques for ensuring that these envelopes do not become compromised which are based on disaggregated cost and time budgets. These increase in sophistication (and certainty) as the project is defined and are finalised at the end of the planning phase. Whilst it would have been desirable in any consideration of project management in the NHS to investigate the efficacy of the application of these techniques, it would itself have comprised a major study.

### **Managing Time**

NHS major projects are complex, multi-functional and multi-professional involving the co-ordination of many different activities. H.L. Gantt developed the simplest form of scheme analysis in the form of a bar chart described in detail by Moskowitz, (1979). Gantt charts have the great advantage of being readily understood, however, their inability to display multi sequence activities in other than an extremely cumbersome way limits their applications.

The first true Project Management tool with the ability to perform Critical Path Analysis (CPA) on networked data came into use in the mid 1960s. The formulation of a critical path enables a number of time and resource requirements taking place either sequentially or contemporaneously in a common time interval to be examined to determine which is critical to the maintenance of the programme. All the critical activities for a given set of circumstances are plotted for the activities of a project. The simplicity of presentation of the Critical Path usually outweighs its lack of sophistication in some applications.

Computers have made CPA a flexible and useful day to day management tool. There is substantial literature on CPA and Ackoff (1968) contextualised its application in Operational Research Techniques. In essence, CPA brings together large volumes of complex data to explain, on a time elapsed basis, the critical path of activities in sequence in a graphical form.

CPA itself has wide applications and more specialised industry specific versions have been developed. PERT, the Project Evaluation and Review Technique, developed by the US Military and explained by Phillips (1981), is applicable to combined capital and major change projects and is used, largely unchanged, in the UK as in the Prince system (described in Chapter 8, as a simple system the NHS could adopt).

CPA is useful to the Project Manager (PM) but difficult to understand without some training. Attempts have been made to produce the data displayed in a more simple format in the form of Precedence Diagrams, (in essence a histogram style of presentation which is restricted to displaying the critical path without extraneous information) but complex CPA data are still required by the PM.

A wide range of other techniques are available to tease out specific problems. Two useful examples are firstly, line of balance techniques using the same network data as CPA but allowing the detail of repetitive functions to be analysed in more detail and secondly, linear programming which is a useful resort for the PM who is working with scarce resources and where some details of planning will not be determined in time before decisions must be made to regain a late programme.

However, using these techniques will never be the complete answer to setting up the optimum starting plan.

*"It must be appreciated that in practical problems the use of mathematical decision making techniques does not give complete solutions and often only part of the overall problem which can be formulated in mathematical terms can be solved. Frequently a combined mathematical and intuitive approach will be required". (Cormican, 1985).*

## **Managing Cost**

Notwithstanding the lack of a standardised approach in the NHS for activities in its programmes (e.g. Business planning, Regional approval, Project team deliberations etc.), the formal design, construction and equipping phases can be calculated from commercially available data which is well founded. The DoH publishes cost data in the form of Departmental Cost Allowance Guides (DCAGs) - the current set being "Healthcare Capital Investment", Supplement to Quarterly Briefing, Vol 7, No.1, 1997/1998, NHS Estates, which give the cost of new hospitals disaggregated into functional components (e.g. wards, operating theatres). They also publish index based updates to take into account inflation and regional differences in construction costs. Due to the very limited hospital building programme, estimates are presently based on a small

sample causing instability in the data. Present attempts to smooth the data by introducing costs from the equally small public sector building programme, Median Index of Public Sector, (MIPS), issued by the Department of the Environment, do not appear to increase reliability.

Notwithstanding this current, hopefully short-term problem, it is possible to monitor both cost and time in the construction phase through well tried techniques. Some 20 years ago a formula was developed within the health service for predicting cash flow on construction projects. Over the years this DHSS expenditure forecasting method became something of a UK industry standard even though it was based entirely on health service data.

The formula was:  $V = S [x + Cx^2 - Cx - (6x^3 - 9x^2 + 3x) / K]$ , where V = cumulative value of work executed, S = contract sum, x = proportion of contract period elapsed, c & k "factors". The purpose of the this formula was to define a time and cost envelope within which progress would be considered satisfactory. In recent years, however, there has been some criticism of the method and so a study was commissioned to verify the validity of the system in the construction industry (DoH, 1994/5).

The original formula relied on a series of C and K factors, which varied depending on the contract value, giving a family of S-curves. The basis of the S-curve was that construction projects tended to have slow start-up and end phases with consistently faster development in between. Having studied recent development on almost 400 completed projects, it was concluded that there was a quite apparent S-shape definition but no significant improvement in the quality of prediction was to be gained by varying the C and K factors. It should be emphasised that the S-curve is an average estimation of expenditure, and specific projects will differ to a greater or lesser degree from this standard curve.

The results of this recent research recommend C and K factors of 0 and 4 respectively for all contract values. The values of C and K have deliberately been rounded to prevent spurious accuracy. No significant improvement was achieved by varying the C and K factors for different contract values. The zero value for C implies symmetry in the S-curve with, on average, half the expenditure achieved at the mid-point of the contract period. The value of K reflects the gentle curvature of the S-shape.

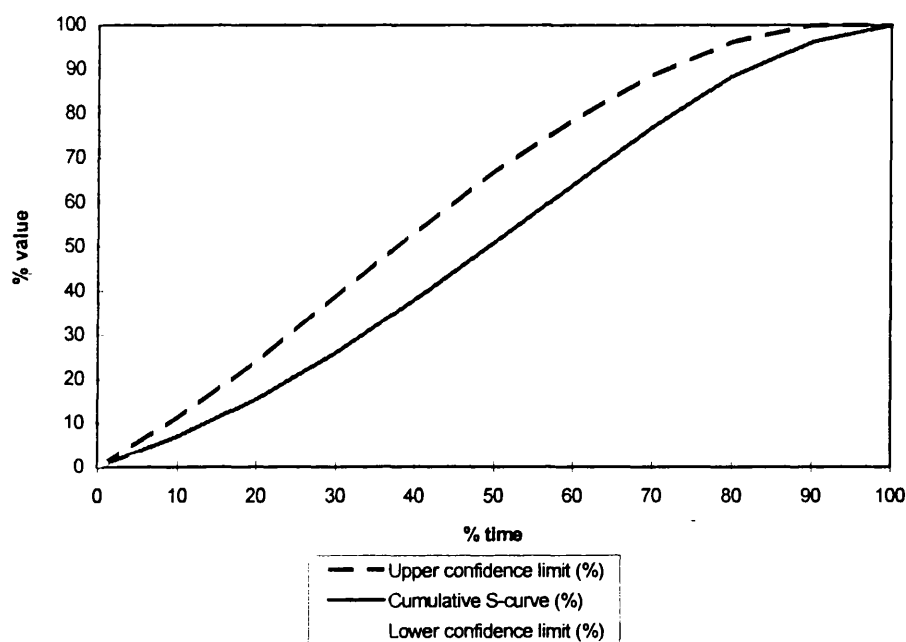
Where actual expenditure on the schemes studied deviated from the standard S-curve there was strong evidence of an attempt to regain the average expenditure profile, though this was not achieved in all cases. By using C = 0.5, K = 9 and C = -0.6, K = 5, upper and lower confidence limits can be established to help evaluate ongoing progress. Expenditure within this envelope

would normally indicate satisfactory progress, whilst expenditure outside these suggested limits could give cause for concern.

The following graph gives a representation of the standard S-curve together with the confidence limits expressed in terms of percentages rather than actual values.

**Figure - 1.2**

**Example of a standard time and expenditure S curve for new capital construction**



The ability to both forecast and track expenditure is extremely valuable to a project manager providing a relatively simple methodology for measuring progress and noting divergences. The methodology can also be applied to a delayed project to recalculate a new time and expenditure envelope. However, some caution must be used when applying the technique if the delay is not general in its nature.

### **Problems of Project Management in the NHS**

So, if the science of Project Management is available, what are the problems of introducing project management in the NHS?

1. Project Managers are insufficiently trained and supported and are junior officers with no career structure. (ECH & Nigel Parry Reports 1990 and 1993.)

2. Duties of Project Managers and the data sources they will use were not published until 1992.
3. A critical path is pointless if the initial time periods for activities are not based on a reliable data base. The NHS only thought its establishment necessary in 1994, as presented as requirements for those completing capital developments to undertake a Post Project Evaluation, [HSG(94(31)] , as published in the Capital Investment Manual. (DoH, 1994).
4. The attempt to introduce Project Management has been diluted by the introduction of PFI and the NHS being given a "hands off" approach to project delivery.

*"All this puts something of a burden on the project manager who supplies the "intuition", (Cormican, 1985)*

#### **1.10 THE RESEARCH ISSUES**

Since its formation in 1948, the NHS has been evolving to cope with new therapies and technological change. Most of these changes have been gradual and whether they immediately succeeded or even failed did not prejudice the service as a whole.

The National Health Service and Community Care Act left no part of the Health service untouched. The purchasing of services and the inherent culture of competition was beyond anything thought of in 1948. Against that background managing the closure of the psychiatric institutions and their reprovision with mental health services based in the community poses a challenge to patients, management, clinicians and carers alike. As discussed earlier, protracted reprovision programmes devour resources. The cost of keeping institutions partly open, and partly providing community care is not only uneconomic, it provides a poor service for the user, many of whom depend almost entirely for their continuing well being on the efficiency of these services.

This study attempts to examine and identify the criteria for success and the causes of failure of these programmes. It is important that speed and economy are not taken as the only measure of success. Quality is important; not only as laid down in health service standards, but also in the eyes of the patient, the relatives, staff and carers. Attempts have been made to secure these views in this study.



The study also examines the administrative mechanisms necessary to manage the process of closure and reprovision that allow rapid and economic implementation and the management of resource within allocations. Decision processes that involve a client whether patient, staff or carer, morale issues and training of staff are investigated. Systems that create plans in a multi-disciplinary environment involving third parties which attempt to predict outcomes, permit intervention and adaptation for unforeseen events and the required changes necessary are also investigated.

Sources of funding and methods of securing them are examined and the availability of NHS resources in land and buildings that could contribute to reprovision are considered. It should not be forgotten that these attempts to bring about change within the mental health services of the NHS are against a background where the whole of the NHS is changing radically.

## **CHAPTER 2**

### **LITERATURE REVIEW**

<b>2.0</b>	<b>Introduction</b>	<b>37</b>
<b>2.1</b>	<b>Availability of Data</b>	<b>37</b>
<b>2.2.</b>	<b>Literature Review</b>	<b>38</b>
<b>2.2.1</b>	British Studies	39
<b>2.2.2</b>	American Studies	40
<b>2.2.3</b>	Comparability of US and UK data	42
<b>2.2.4</b>	National Macro Studies	43
<b>2.2.4.1</b>	Studies of Deinstitutionalisation in Mental Health Reprovision	43
<b>2.2.4.2</b>	Learning Disabilities Reprovision - Possible Parallels	64

## 2.0 INTRODUCTION

This chapter examines available national studies' data on community reprovision programmes.

### 2.1 AVAILABILITY OF DATA

Comprehensive information on the mental health services is not readily available and this was made clear by the inability of the then Secretary for Health, Tim Yeo, in 1993 to respond to a written parliamentary question on how many mental illness hospitals were to close in England by 1997, (Groves, 1993). This was also confirmed by the responses of Dr. J. Yates in evidence to the Health Committee of the House of Commons in relation to their first report "Better off in the Community" Yates, J (1993). <sup>2</sup>

*"We no longer have data about individual sites...collected in Britain today...in that sense we are unable to monitor by gathering (existing) data...that avenue is closed to it (Department of Health) without special data collection".*

*"Assuming the problem of collecting data from individual sites could be overcome, it would be necessary to identify the proposed services for those suffering from mental illness. To do this it is necessary to accurately number and categorise those illnesses in the population to be served".*

The Mental Health Foundation also stated, (Lady Runciman 1994).

*"One of the greatest difficulties facing organisations concerned with mental health is the absence of reliable statistical data on the range of disorders commonly subsumed under the heading of mental illness. In addition, it is often difficult to reconcile the different taxonomies used by mental health professionals to classify disorders."*

Considering that the concept of community care and the attendant closure of the institutions had its roots in the 1950s, the above statements are surprising. Countries such as the UK and the USA have experienced considerable change in services and have been significant contributors to an extensive world-wide literature.

---

<sup>2</sup> Dr John Yates is the senior researcher in Inter Comparisons and Consultancy, a component of Birmingham University specialising in the interpretation and comparison of Health Service data.

## 2.2. LITERATURE REVIEW

A review was therefore undertaken to discover if other research data and methodologies existed which were not discovered by Yates, or the Department of Health. The focus of this review was studies which collected data directly relating to the closure of large mental institutions, their reprovion and their scope.

The dramatic decline in the number of inpatients which occurred after the mid 1950s, is generally seen as marking a major change in the history of psychiatric services with the subsequent run-down of the number of residents in mental hospitals and the associated turn to community-orientated policies whereby the mentally ill are maintained outside the hospital. Against the dramatic background of service changes the number of psychiatric inpatients in England and Wales declined from around 150,000 in 1955 to under 60,000 in 1986.

The ability of patients to be discharged from hospital is primarily linked to the "pharmacological revolution". This was built around chlorpromazine (largactil) and its derivatives to which Jones (1972) attributed a strong role:

*".. by 1955 they were being widely prescribed. Within the hospitals, they created a totally different atmosphere...facilitating the concurrent open-door policy and the movement to bring psychiatric nurses into closer contact with general nursing. It meant some patients could go home sooner, there might be no need for further hospitalisation, some patients did not have to come into hospital at all, their symptoms could be controlled and the illness treated at home. Imperceptibly, the emphasis began to shift from talk of 'after-care' to talk of 'alternative care'".*

The literature review considers work published after 1955 which may be the most important turning point in the recent history of care in the community.

Despite such a dramatic change in policy, there has been very little policy evaluation. O'Driscoll (1993) carried out a very comprehensive literature review on the feasibility of actually closing mental hospitals, covering several hundred papers. She shortlisted those considered to be of an acceptable scientific standard and to be representative of similar work. She agreed with Braun et al (1981), who undertook a similar literature review, that *"the failure to evaluate adequately the effect of discharging hundreds of thousands of chronically ill patients from large public mental hospitals has been a major failure in the conduct of public policy"*. O'Driscoll, (1993)

Leff J, (1993), confirms this gap in research, pointing to the fact that there had been few attempts to evaluate the policy, and none had been comprehensive. In that sense the Team for

the Assessment of Psychiatric Services' (TAPS) research project, which evaluated the reprovion programme for two psychiatric hospitals in north London, is unique in its scope.

Raftery (1993), who undertook a literature search as a basis for a national study, states that the subject has had limited research, and in particular the elderly mentally ill have received much less attention in the literature.

### **2.2.1 British Studies**

Studies undertaken between 1961 and 1970, have a common theme of optimism and they anticipate that the trend of significant reductions in bed numbers experienced through the 1950s will continue. Tooth and Brooke (1961) produced a paper which was very influential at the time, and predicted that the long stay population at 1954 would run down at a rate that would eliminate it by 1975. Advocates of community care often chose to ignore warnings of the inevitable emergence of a new long stay population, believing that active care in the community would ameliorate such a trend. However, the emergence of a new long-stay population was confirmed by two national surveys; the classic study by Mann & Cree in 1976, and the recent survey by Lelliott et al (1994). The special needs of those often "hard to serve" patients are now receiving growing recognition.

Norton (1961), in a long term survey of a London mental hospital, concluded that "if changes in mental health policy are effective, mental hospitals may be reduced to one quarter of their present size". Cross & Yates (1961), in a larger study of four Birmingham hospitals, concluded that over the next ten years a significant reduction to 100 beds per 1000 would be possible, with half those beds being given over to psychogeriatric use. However, Gore & Jones (1961), in a contemporaneous study in Leeds, came to the conclusion that in their hospitals, the Ministry of Health targets for reductions were unlikely to be met. Hassal et al (1965), in a study of Powick Hospital followed the pattern of Norton's work and concluded that patterns for their hospital approximated to the national average. However, the danger was identified of applying a single national standard without introducing regional variations.

By 1976, the Tooth-Brooke prediction in 1961 that the need for long stay beds would be eliminated by 1975 were demonstrably unproven. Easton & Grimes (1976) modified their projections to demonstrate a continuing need for long stay beds, at least until the end of the century.

All these studies dealt with single or small groups of hospitals. They were often a local response to testing the predictions of Tooth and Brooke then in use by the Ministry of Health for predicting

service need. None of them gives a national picture, but they did challenge the prediction of Tooth and Brooke sufficiently to render their findings unsafe.

A national survey using data from each hospital collected over time would produce a more reliable picture, even allowing for the inherent problems of large scale data collection. In the USA attempts were made to gather national information.

### **2.2.2 American Studies**

As in the UK, no comprehensive review of psychiatric hospital closures and their reprovision programmes appears to have been undertaken. Several papers were published in the US which attempted a national review, albeit restricted in scope. It is also interesting to note that whilst the UK in the 1950s was recording a significant reduction in the inpatient population of psychiatric institutions, this was not the case in the USA. Perhaps this is also a reason why US studies do not reflect the UK optimism until the seventies. Kiesler (1987) reports that:

*"despite widespread use of chlorpromazines in 1954-55, episodes in state mental hospitals did not begin to decrease until 1965".*

He qualifies this with the remark:

*"the meaning of episodes is complex...i.e. more but shorter episodes being a probable but unproved answer to the statistical anomaly.*

Whilst not offering a detailed review by hospital, Bassuk & Gerson (1978) commented on 20 years of de-institutionalisation. They established that between 1955 and 1980 the population of state and county public mental hospitals had fallen from 559,000 to 138,000. Goldman et al. (1981) attempted to define the current prevalence of the chronically mentally ill in the USA and arrived at a national estimate of 2.05 million, of whom 900,000 were variously institutionalised. A further study by Goldman et al (1983), using information from the Division of Biometry and Epidemiology of the National Institute for Mental Health (NIMH), tested the conclusion of their 1981 paper, and showed that in the "myth of de-institutionalisation" inpatient care had not been replaced by outpatient care and state psychiatric hospitals had not been replaced by community care.

Many more restricted studies were undertaken. Craig (1981) identified a statistically significant correlation between the death rate of inpatients and the decline in patient numbers. Over a seven year period the inpatient numbers in the hospital under study reduced by 70% and the

death rate declined consistently throughout the period. In a further study Craig and Laska (1983), compared inpatient populations in a state mental hospital in 1972 and 1980. They discovered a 50% reduction in long stay patients coupled to a 27% reduction in admissions and identified a new long stay population. Taking this, together with a further study comparing new and old long stay patients Craig et al (1984), came to the conclusion that there would be a net increase in long stay patients. However, in surveys of the Maryland public health system, Platman et al (1983) concluded (as with the earlier British studies of the 70s), that there was no concern that a new population would accumulate.

Kiesler (1987) quotes himself as testifying before a US Senate appropriations committee in 1984 of the need to:

*"Develop a better national data base...to better understand the effect of different systems of service delivery ...provide co-operation between public and private sectors".*

These comments closely parallel those of Dr. John Yates (1993) quoted earlier, (giving evidence to the House of Commons Health Committee in 1993) concerning the lack of data in the UK system applicable to closure programmes.

Indeed a further parallel US/UK problem exists in that data collection requirements have changed over time and are incapable of absolute comparison. In his 1987 book, Kiesler is obliged to rely on 1977 figures "for which more data exists than other years." This is similar to Yates, who, in his evidence to the House of Commons in 1993, stated he could only report on 1991 data, being the last year in which comprehensive data had been collected.

The Task Panel on the Nature and Scope of the Problem of the President's Commission on Mental Health, (Mechanic, 1978) commented on the difficulty of deriving national figures from the variable and incomparable methodologies adopted for data collection. This again very closely mirrors the UK position, as stated by Lady Runciman in evidence to the House of Commons Health Committee in 1994.

*"It is difficult to reconcile the different taxonomies used by mental health professionals".*

The link between epidemiology, (another possible source of data) and service planning has also been poor. Klerman (1987), in one of the rare attempts to link the two, suggested four sub-populations of potential interest to service planners:

- an inner core group who are chronically mentally ill, amounting to around 1% of the population (all figures refer to the US),
- an outer core group with diagnosable mental disorders, amounting to perhaps 15% of the population,
- A large fringe group who are each year exposed to the risk factors of stress and distress associated with life events and social adversity, amounting to perhaps 25% of the population, and
- a new group using mental health facilities in the hope of realising their personal potential, estimated at 6%-10% of the population.

Although traditionally service providers have concentrated their efforts on the inner core group Klerman argued for greater understanding of the factors which lead members of these other groups into contact with mental health services.

Planning is made difficult by competition from the outer fringe and new groups for which data is limited as the proportion of services provided for the inner core continues to increase. This situation is mirrored in the UK where resource management in psychiatry, still at a very early stage of development, "*focuses on classifying the functional inputs of psychiatric services rather than the diagnoses of patients*". (Clifford, 1990).

### **2.2.3 Comparability of US and UK data**

A comparison between the US and UK is valid in studying Mental Health Services. Both operate a free market economy subject to world economic pressures, both have directly funded public Mental Health Services, and they are following largely parallel government policies. (O'Driscoll, 1993).

A recent analysis by Raftery (1992) provides a detailed comparison between the UK and US. While inpatient places have been drastically reduced in both countries, surprisingly few hospitals have closed in the US. Neither country has reduced direct expenditure on mental health services, which remains inpatient-orientated.

The number of residents in all types of mental hospitals per 1,000 population peaked in both the UK and US at around four places per 1,000 persons in the mid-1950s. In the UK the number of inpatients reached maxima before each of the major wars and again in 1955, while in the US, inpatient residents peaked in 1946 and again in 1955, although there was a time lag in the US. The pace of both expansion and contraction was more rapid in the US than in the UK, so that by 1986 the US had just under one inpatient per 1,000 persons compared to around 1.5 in the UK.



These declines in inpatient places have been accompanied by major expansions in the numbers of outpatient episodes, and by a more rapid turnover of patients who are admitted. Although the data are collected on different criteria in the US and the UK (care episodes in the US; attendances in the UK), it is clear that outpatient activity comprises the bulk of service contacts in each country. General hospitals have become the setting for the bulk of psychiatric admissions in the US, with relatively shorter lengths of stay offsetting these hospitals' small share of total beds.

Spending however, remains focused on the mainly inpatient-orientated mental hospitals. Inpatients accounted for some 70% of total mental health spending in the US (Kiesler & Sibulkin, 1987; Redick et al. 1987; Mollica & Astrachan, 1991) and the UK equivalent has been put at around 80% (House of Commons, 1989).

#### **2.2.4 National Macro Surveys**

No authoritative and comprehensive survey of the closure programmes of psychiatric hospitals, and their reprovion seems to have been undertaken in the UK or the US. O'Driscoll (1993), in her review of the literature on community, mental health reprovion in the US and UK, states that she was unable to identify any comprehensive national survey.

##### **2.2.4.1 Studies of Deinstitutionalisation in Mental Health Reprovion**

In his literature review of studies of deinstitutionalisation, Raftery (1993) came to the conclusion that the main studies of alternatives to long-term hospitalisation, (summarised in Table 2.1) covered relatively few patients, compared with the numbers of patients who have actually been "de-institutionalised".

Table 2.1 Summary of Studies of Deinstitutionalisation							
	Country	Number of patients	Follow up	Study type	Exclusions	Outcomes Exp. or Control Favoured?	Costs: Exp. or Control Favoured?
Brown (1966)	UK	339	5 years	Other	Homicidal/ Suicidal	No Diff	No Diff
Wing (1960)	UK	30	1 year	RCT	Severely Disturbed	No Diff	Not included
Marx (1973)	US	61	5 months	RCT	Chronic	Exp	Exp. - less service use
Linn (1977)	US	625	24 months	RCT	Sev. Disabled	No Diff	unclear
Weinman (1978)	US	516	4 months	RCT	?	Exp. perhaps	Exp. fewer readmissions
Knapp et al. (1989/90)	UK	136	9 months	Control	None	Exp.	* Exp. cost less
Sources: Braun 1981, Knapp 1990, 1991 Notes: Hom/Suic. = Homicidal/Suicidal, Sev. Dist. = Too Severely Disturbed to include, Chronic = Too Chronic to include, Sev. Disabled = Too Severely Disabled to include. Exp. = Experimental Group * Subsequent studies by the Team for the Assessment of Psychiatric Services (TAPS) show these costs to be more							

### Critical Review of UK and US studies of deinstitutionalisation

This section comprises a review of the seven studies in Table 2.1. Each study is presented in short form identifying the salient features together with a summary.

**Title:** - Brown GW, Bone M, Dalison, B. Schizophrenia and Social Care: A Comparative Follow-up of 339 Schizophrenic Patients, 1966.

Introduction: - The population of mental hospitals had been falling since 1954 and of the patients first admitted in 1954 or 1955, only 12-13% had remained in hospital for as long as two years. The drop in bed-occupancy began in 1955 at about the time when chlorpromazine was introduced and when the idea of the "therapeutic community" was beginning to take an extensive hold on psychiatric thought.

The first aim of this study therefore was to describe the clinical and social outcome over a period of five years, in order to throw light on this current controversy and secondly, the more tentative aim, was to make suggestions about the social factors which seem to influence the social and clinical course.

The authors also stated that:

*"At the present primitive stage in the development of operational research into the psychiatric services we do not think that it would be justifiable to attempt more".*

Design: - The basic design of the study was to obtain information about the morbidity, during the five-year period, of cohorts of schizophrenic patients admitted to hospitals in 1956. Information was obtained from records of many different kinds and from an interview with the patient and/or another informant at the end of the follow-up period. These data could therefore be divided into relatively "hard" (hospital admissions and discharges, out-patient and day centre attendances, social worker visits, weeks for which Ministry of Pensions and National Insurance stamps were credited, employment exchange data) and relatively "soft" (details of employment history from patient or family, reasons for admission to hospital, behaviour disorder at home, problems and attitudes of patient and relatives, competence of housewives who had been patients, effects on children of having a patient at home).

Sample: - 339 schizophrenic patients, aged 15 - 59, during the five years after they were admitted to three mental hospitals in 1956.

Methods: - Patients for the series were selected in the following manner: -

- a) The General Register Office admission cards for all patients admitted in 1956 were examined in order to find the case-records of patients who had been given diagnoses which included the words "Schizophrenia", "Schizo-affective", "Paranoid", "Paraphrenia", "Schizoid", "Stupor", "Confusional".-
- b) On the basis of information in the records, the following cases were rejected: -
  - Aged under 15, 60 and over
  - Ascertained as mentally subnormal
  - Concomitant organic condition
  - Concomitant alcoholism or epilepsy
  - Unable to speak English
- c) The remaining case-notes were read by two psychiatrists who independently categorised the diagnoses as follows: -
  - (+) Very probably schizophrenia
  - (?) Possibly schizophrenia
  - (0) Probably not schizophrenia

## Information collected during the Follow-up Period

There were four main stages in data collection:

- Information about symptoms,
- The out-patient notes of patients who attended clinics
- The records of various Mental Health Departments
- An interview was then arranged with someone living with the patient or, for inpatients, with an appropriate informant in the community.

The study was concerned with the performance of the patient in the community and those who were in hospital for the whole five years were not further followed-up.

Variables: - Most of the patients spent only a short time in hospital. Length of stay for first admitted patients tended to be even shorter than that for the previously admitted. For most patients, of course, discharge was not the end of the matter. The majority returned to hospital at least once. 27% of first admissions were re-admitted twice or more during the follow-up period, 21% once, and 51% not at all.

Results: - Patients who spent time in hospital during the fourth or fifth year of the follow-up period (28% of first admissions and 53% of previous admissions) were mainly those who had multiple short admissions throughout the five years or those who had inpatient admissions for two years or more.

The most striking finding was that at the end of the five years 55% of the men were out of work. Two-thirds of the first admissions and a fifth of the previous admissions had a job which was held open for them during the key admission. Just over two-thirds of the first admitted and half of the previously admitted women were employed or performing their domestic duties competently.

Information was collected about the patients' behaviour during the six months before the follow-up interview, and also during the week before the interview. 31% and 49% respectively showed delusions and hallucinations. 28% and 45% respectively showed other symptoms characteristic of schizophrenia (marked social withdrawal or slowness, posturing, odd behaviour etc.).

The proportions showing these kinds of symptoms during the week before the interview were roughly the same as during the six-month period.

### **Summary: Brown et al, 1966**

The purpose of this pioneering study was, as stated in its introduction, "to describe systematically and in fair detail, the behaviour, social circumstances and contacts with psychiatric services of 339 schizophrenic patients during the five years after they were admitted to three mental hospitals in 1956".

The authors, who could be regarded as pioneers in research within the field of social psychiatry, were acutely aware of the methodological limitations of their task, in aiming to identify interrelations between social factors and the social and clinical course of the illness, in times which they themselves regarded as: "the primitive stage in the development of operational research into psychiatric services".

The design of the study is basically retrospective, including three cohorts of patients admitted to three psychiatric hospitals in 1956, while the "follow-up" assessment was conducted during 1960. In this sense, the study is a reconstruction of the past course of illness, patterns of service use etc. for each of the subjects selected according to location, diagnosis and key admission (in 1956). This approach is widely regarded as inferior to prospective studies in which cohorts of patients are assessed at baseline and have then been followed up systematically at certain time intervals by using standard measurements.

The methodological faults of the study which from a current perspective were, at the time the study was conducted, quite normative. The following are some examples of research techniques which would not be acceptable by current standards: - the diagnosis of schizophrenia was crudely and subjectively defined by research psychiatrists based on patients' case notes descriptions, and with no standard criteria to rely upon (such as the International Classification of Disease[ICD]). Information was obtained from multiple and differing sources which inevitably, and significantly, affected its reliability. The follow-up interviews which were non-structured and did not use formal schedules, produced data which was not standardised (as would be expected by today's standards). Moreover, any comparison of a patient's current state with their previous state was as performed not possible since no comparable baseline variables had in fact been established.

The authors, being aware of problems regarding the validity of their data, made a distinction between soft data (history and attitude obtained from patients and relatives) and hard data (hospital admissions and discharge, use of outpatients services etc.) Indeed, the most robust conclusions of the study were derived from the "hard data", however the conclusions derived from information which was non validated and could not be considered reliable having been obtained from various informants (records, patients, relatives, carers) and must be treated with

some scepticism. In this respect, it should be appreciated that the researchers made systematic efforts to establish accurate and hard facts about the sample members, such as demographic details, pathways, use of community services and major events such as death, readmission to hospital, and employment over the course of five years.

This information enabled the researchers to draw some useful conclusions about the characteristics of service users, the course of their illness and the emerging patterns of service use in the early 60s.

The study, by its aim and design, was not meant to address issues regarding the long stay hospital populations (which were very large at that time) and, instead, targeted patients who were short term hospital users. This, in fact, reflected the newly emerging policy of discharging patients into the community as early as possible, a practice which was made possible by the growing use of antipsychotic drugs. The study tried to explore how and to what extent social factors and the availability of services did exert influence on the patients' outcomes. By selecting the sample from the three mental hospitals in catchment areas with different patterns of services, it was hoped to correlate differences in the outcomes of the three hospital cohorts with any distinctive social and service-related factors. This in practice proved to be impossible, due to many confounding and some unknown variables and the basic problem of comparability of the three cohorts. In this respect, only a limited insight is given by this study, certainly not in terms of 'cause and effect', which are as difficult to establish today as they were in the 60s. Another reservation, discussed by the researchers themselves, is the limited generalisability of their findings to other districts in the UK, particularly since the sweeping changes in the patterns of service delivery in the early 60s were uneven across the country.

In conclusion, this substantial and pioneering study in the field of social psychiatry allowed a better understanding of changes which occurred at the time, but it seems to be of little relevance to practices and policies in the current mental health system.

**Title: - Wing JK. A Pilot experiment in the rehabilitation of long stay hospitalised male schizophrenic patients. 1960.**

**Introduction: -** This small pilot experiment was designed to evaluate the effect of a course of rehabilitation at an Industrial Rehabilitation Unit on long-hospitalised male schizophrenics, compared with an equivalent period of time spent in hospital.

**Design: -** Utilised one experimental and one design group after assessment (see below); patients were randomly assigned to one of the two groups.

Sample: - A group of twenty male schizophrenics, aged 24-45, who had been in hospital over 2 years, attended routine courses at a Ministry of Labour Industrial Rehabilitation Unit. Ten equivalent patients who remained in hospital acted as controls. The two groups were not significantly dissimilar in respect of age (means 34.2 and 37.1, range 25-44 and 27-44 years), length of stay in hospital (means 4.8 and 5.4, range 2-20 and 2-11 years).

Methods: - No specification was made as to mental state and there was a wide range of severity of illness. A psychiatrist unconnected with the project was asked to see all the patients and to assess the mental state of each one in the following way. Four categories of symptoms were distinguished - flatness or incongruity of affect; speech disorder; delusions; and hallucinations - each of which could be rated on a 5-point scale according to its prominence during the interview. On the basis of these ratings the patients were divided into one group of fifteen patients with severe symptoms (a rating of 4 or 5) in one or more categories, and a second group rating 1 to 3. From these two groups patients were allocated at random to an experimental group of twenty patients or to a control group of ten patients.

Each patient was then rated by the investigator on his attitude towards leaving hospital and his plans for the future. No patient said he wished to stay in hospital, presumably because of the conditions of selection.

Finally ratings were made of the social behaviour shown by the patients on the wards. The charge nurses were asked to observe the patients' behaviour during the course of a week and then to complete a schedule of fourteen items, each of which could be rated as present in marked degree (+2), present in moderate degree (+1) or absent (0). Six items (social withdrawal, lack of conversation, lack of interest or curiosity, slovenliness of dress, slowness of movement, underactivity) were related together and formed a subscale of "Social Withdrawal". The other eight items (suspicion, excessive self-assertion, overactivity, irritability, hostility, gesticulations, talking to self, laughing to self) were related together, and formed a subscale of "Socially Embarrassing Behaviour".

Results: - It was shown that the two subscores were not significantly related together ( $r = +0.19$  and  $-0.08$  in two samples), and that after four independent sets of ratings, the mean  $r$  for "Social Withdrawal" was  $+0.85$ , and for "Socially Embarrassing Behaviour"  $+0.72$ ). It is considered that the two subscores measure different aspects of behaviour and that each is reproducible. There were no significant initial differences between the experimental and control groups for either score.

**Summary: Wing, 1960.**

This was a small scale random control trial (RCT) designated to examine the effectiveness of an industrial rehabilitation course on a group of young long-stay patients. Although the paper was written nearly forty years ago, the subject is still relevant in the context of community care and the current insufficiency of vocational facilities and schemes for the mentally ill.

The main methodological problem stems from the small sample (N=20). Moreover the division of the experimental group into two subgroups: moderately ill (N=10) and severely ill (N=10) has made the analysis even more problematic. As a consequence at least some of the results should be regarded as anecdotal rather than statistically sound.

In the context of deinstitutionalisation the study comes to a conclusion that: "the practical results of offering courses of industrial rehabilitation to moderately ill chronic schizophrenic patients who initially wish to leave hospital seem fairly good".

Whilst the potential short term benefit of such a course might be agreed with, the survival of patients in the community depends to a large extent on the availability and accessibility of suitable residential and vocational facilities, and the provision of a reliable support system.

**Title: - Marx AJ, Test MA and Stein LI. Extra-hospital management of severe mental illness: feasibility and effects of social functioning. 1973.**

Introduction: -The effectiveness of a new model, "total in-community treatment" was evaluated on a group of patients considered still in need of hospital care.

Design : - Utilised one experimental and two control groups. All patients were assigned randomly to one of the three treatment groups. During a very brief base line period (eight days maximum) on the research ward, patients in the Community Treatment Group (CTG) had their medications evaluated, base line measurements administered, and had plans made for the onset of their community living. These patients were then moved automatically into the community.

The patients in the Research Unit Control (RUC) and Other Unit Control (OCU) received an equal amount of staff time and attention as those in the CTG. These patients participated in an in-hospital treatment programme focused on "preparation" for community living. Patients in both the CTG and RUC received their respective therapy programmes for a five month period. The project ran over a one-year period, and new subjects were admitted into the sample (and randomly placed in one of the three treatment groups).



Sample: - 61 patients aged between 20 and 45 years, current inpatients at Mendota State Hospital, any diagnostic category, excluding organicity, mental retardation, severe physical disability or a primary diagnosis of alcoholism.

Methods: - The following measures were administered to the patients in the CTG and RUC at times specified below:

- (1) the Short Clinical Rating Form - administered by "blind" independent raters at the beginning and end of the five-month treatment phase;
- (2) the Lorr Inpatient Multidimensional Psychiatric Scale, administered by "blind" independent raters at the beginning and end of the five-month treatment phase;
- (3) the MACC II Behavioural Adjustment Scale, administered by research unit staff every four weeks during the five-month treatment phase;
- (4) the Adjective Check List (self report by patient) completed at the end of the five-month treatment phase;
- (5) parts of the KATZ Adjustment Scale (self report by patient) completed at the end of the five-month treatment phase;
- (6) the Rosenberg Self-Esteem Inventory (self report), completed at the end of the five-month treatment phase.

Additionally, at the end of the five months, measures of the autonomy and quality of the living and employment situations of patients in all three groups were taken.

Intervention: - Experimental or Community Treatment Group (CTG) received immediate and total treatment in the community. The control groups meanwhile, received in-hospital treatment, designed to prepare patients for future community living. One control group, designated Other Unit Controls (OUC), remained on the inpatient wards from which they were referred and were treated by staff of those wards. The second control group, designated the Research Unit Controls (RUC), was housed on the research unit and was treated by the identical staff that was working with the experimental group.

Variables: - The RUC group may have been confounded by a greater staff enthusiasm for the experimental approach, its inclusion was necessary to control for staff to patient ratio and staff personality variables.

Major dependent variables in the study were outcome measures of the duration and quality of community adjustment after discharge. Toward this end, all patients were followed for two years after the five-month treatment phase, with the following measures taken every four months by the follow-up worker.

- (1) Amount of time spent out of the hospital during the follow-up period.
- (2) The autonomy and quality of patients' community adjustment in the areas of living situation, economic situation, employment, self-maintenance activities, use of leisure time, and social relationships, as measured by the Community Adjustment Form (CAF).

Results: - The major findings of the study were as follows: -

- It was feasible to carry out a programme treating quite symptomatic patients in the community. It was possible to do so without alienating individuals and agencies in the community.
- At the end of the five-month treatment programme, CTG patients were living and working in more autonomous situations than control patients.
- The respective treatment approaches had no differential effects on symptomatology and self-esteem of patients in the CTG and control groups. The treatment programme had little effect on these variables at all.

Comment: - The fact that the respective treatment approaches had no differential effects on symptomatology is perhaps not surprising in view of previous studies of treating patients in the community vs. hospital. Specifically, neither Fairweather et al (1969) , Passamanick et al (1967) nor Rittenhouse (1970) found these differential effects although most found a differential influence of treatments on role functioning and hospital readmission variables. In part this can be accounted for by recognising that reduction in psychotic symptomatology may be largely contingent on phenothiazine treatment and in the study patients had begun pharmacotherapy well before their entrance into the research programme and were maintained on appropriate drug regimes

### **Summary - Marx, 1973**

This is a randomised control study, examining the effectiveness of "assertive" outreach community treatment. In 1973 this was a pioneering experiment which was later expanded and reported in a classic paper by Stein & Test (1980). Other influential studies of this alternative approach to inpatient care were conducted in Canada by Fenton et al (1979), Hoult et al, (1983) in Australia and more recently the Daily Living Programme (DLP) in England carried out by Marks et al, (1988).

The strength of this early study is:

1. The randomized allocation of patients into three groups (experimental and 2 controls), and
2. 'Blind' assessment by independent rater.

The weaknesses are:

1. A relatively small sample which reduces to some extent the statistical significance of the outcomes;
2. A short lived intervention (5 months). This is a period which is probably too short to implement a rehabilitation course and to detect its effectiveness (see later studies).

Although it is stated that the therapeutic input was comparable between the experimental and control groups, it is possible that the input and enthusiasm invested in the experimental group exceeded the other groups.

The researchers state their aim to achieve "a virtual abstention from rehospitalising any patients". While the readmission rate is a key outcome variable, it appears that assigning the same staff to both the experimental and the control group may have introduced a bias to the results (the researchers were aware of this limitation).

As with larger, more comprehensive studies which were to follow, the concept of assertive outreach treatment is effective as long as it is sustained. Often, as soon as the experiment reaches its end, the initial benefits tend to disappear in the longer term (Marx et al, 1996). In planning outreach services, it is necessary to ensure that the mechanism and the resources are available to maintain the continuity of such a service.

Finally two remarks on the general application of the findings: -

1. Similar to the demographic profile of the study group, young people in the early stage of their illness are the natural target population for such treatment. This approach is less applicable to the elderly long-stay populations who are usually incapable of living independently and benefit from stable residential care.
2. The results which show that the input and locum of care have no significant effect on the clinical symptomatology is consistent with other studies, notably the TAPS study (Leff et al, 1996).

**Title: - Linn MW, Caffey EMJ and Klett CJ. Hospital vs community (foster) care for psychiatric patients. 1977.**

Introduction: - The aim of this study was to determine the effectiveness of foster care preparation and placement.

Design: - Five Veterans Administration (VA) hospitals in the USA were selected on the basis of geographic distribution and the fact that they had very active foster care programmes. The hospitals were all large, predominantly psychiatric facilities. The study utilised one experimental and one control group.

Subjects referred for foster care entered the study if they were male, had a psychiatric diagnosis, had no previous foster care experience, and were cleared by social work staff as suitable candidates. Whenever two subjects were identified as eligible for the study, they received their base line ratings and were randomly assigned to preparation for foster care (experimental group), or to continued hospitalisation (control group).

Patient pairs were rated before random assignment, when the experimental subject was placed into foster care, and four months from the date of foster home placement. Control subjects remained in the hospital and were not approached about foster care until their participation in the study ended.

Sample: - 572 male patients over 20 years of age from five hospitals.

Methods: - Repeated measures were made with four instruments. A 21-item social dysfunction rating scale was scored by the project social worker using a semistructured interview guide. Items were rated on six-point scales, with a higher score indicating more dysfunction. Items measured the person's ability to cope with intrapersonal, interpersonal, and geographic environments. They draw heavily on the patient's assessment of life satisfactions. Activity was measured by 22 items selected from the Katz adjustment rating scale which recorded participation over the past week in activities such as hobbies, shopping, visiting friends, or writing letters. Items were selected on the basis of being applicable in both hospital and community, and to male patients.

Follow-up ratings - mood was assessed by the Clyde Mood Scale, a self-report card-sort technique that yields six mood factors; friendly, aggressive, clear thinking, sleepy, unhappy, and dizzy. Schizophrenic subjects were treated separately from non-schizophrenics in the analyses.

**Results:** - The 209 schizophrenic patients differed significantly from the 77 non-schizophrenics on all but one variable, income. The main effect of placement showed that three variables were statistically significant at the .05 level. Patients with more hospitalisations, alcoholism, and chronic brain syndrome were less likely to be placed in foster care. Hospitals also varied in the kinds of preparation for foster care. Most patients received individual casework or a combination of casework and group therapy.

The major findings were that patients showed little or no change in social functioning, mood, activity, and adjustment as the result of hospital preparation for foster care. However, within four months after being placed in foster care, experimental subjects showed significant improvements over controls, particularly related to functioning and overall adjustment. Although a longer follow-up period might be desirable, it can also be argued that four months was long enough to demonstrate effectiveness of foster care.

**Summary: - Linn, 1977**

This was a randomised control study which aimed to determine the effectiveness of foster care versus ordinary hospital care. A large sample was selected from five hospitals and patients were randomly assigned to preparation to foster care and continued hospitalisation (as control). Assessments were conducted at baseline (in hospital) and four months after patients moved to foster homes. It should be noted that a selection was done during the preparation period and patients who moved to foster homes were more socially functional than the controls. This might have introduced a bias to the results.

The multi-variate analysis of variance showed a small but significant reduction of social dysfunction in the experimental group and improved adjustment (as estimated by nurses). Mood factors had little changed over time. Perhaps more significant is the fact that foster homes managed to contain most of the patients (three quarters of the original referrals) after four months follow-up. If similar results could be demonstrated on subsequent one and two years follow-ups, this could be regarded as a very good outcome. Indeed, the researchers stated their intention to conduct longer-term follow-up.

Another useful conclusion which emerged from the analysis suggests that long preparation in hospital for this type of care is not justified.

Being among the few studies which specifically evaluated this form of community care, and considering the overall well designed methodology, this study provides quite convincing

evidence of the effectiveness of foster care placement. In view of the relatively limited use of this form of care in the UK, it might be a good idea to review its feasibility, effectiveness and cost effectiveness.

Title: Weinman B. The Impact of Community Living and Community Member Intervention on the Adjustment of the Chronic Psychotic Patient. 1978.

Introduction: - This study is an evaluation of a community treatment programme. "to enable chronic patients, heretofore considered to have poor potential for release, to gain direct and sustained experience in the community so as to enhance their level of adjustment and reduce their recidivism".

Design: - The programme focused on functional psychotic male and female patients, with more than one year's accumulated hospitalisation and who could not be placed with relatives. Most showed symptoms of chronic psychoses, many suffered from delusions and hallucinations. However, all were considered to show sufficient control to respond appropriately during the screening interview and to have the potential for developing the social and coping skills necessary for a least a minimal community adjustment.

The evaluation of the project included: -

- 1) assessing the effects of the community treatment on the patients' release rate, re-admission rate, and level of post-treatment community adjustment;
- 2) determining whether community members as "enablers" can serve in a major therapeutic capacity in influencing the behaviour of patients
- 3) delineating the type of living setting in which the community member as can generate the most successful treatment outcome, and
- 4) identifying the characteristics of community member-patient interaction which relate to successful treatment outcome.

The Effectiveness of Community Treatment Programme: - was to be determined by comparing the patient outcome measures in this programme with that of the two control programmes - socio-environmental therapy and traditional ward treatment.

Sample: - 263 patients participated of which 90% had been diagnosed as schizophrenic. The average age was 48.9 years, and average duration of accumulated hospitalisation was 13.2 years.

Method: - The patients were transferred to a special unit where they received a twelve week orientation for life in the community and were assigned to a counsellor, usually a psychologist or social worker, working in group and individual sessions, who arranged the financial support and placed the patient in the community with an appropriate community member, or enabler.

The enablers shared common socio-economic backgrounds with the patients, communicating with them in a down-to-earth manner, spending long periods of time assisting them with their daily life activities. Typically the enablers were women with time on their hands, a desire to be useful, with a high school education or less, with no particular training or experience with dealing with mental patients. Some had been nurses aides, a few had experience of mental illness in their own families.

The training of enablers was an experimental variable, although they were involved in several orientation sessions before working with patients.

The community treatment programme was subdivided into *patient-centred* and *enabler-centred conditions* - to determine the more effective use of professional intervention and viability of enabler services.

Each patient was assigned randomly to either live-in or visiting enabler condition and to either patient or enabler centred condition = 4 community treatment conditions established

- 1= patient-centred with live-in enabler
- 2 = patient-centred with visiting enabler
- 3 = enabler-centred within live-in enabler setting
- 4 = enabler-centred within visiting enabler setting

The following measures were taken at the end of the eight month study period for each of the four groups: -

Self esteem Scale, (Parker and Kleiner, 1966), where the mean discrepancy scores between descriptions of actual and ideal behaviour in seven different types of interpersonal situations constitute the measure of self-esteem.

Psychiatric Status Scale - five behavioural descriptions of symptomatology from essentially normal behaviour to behaviour which makes it inappropriate to live outside the hospital (Sanders, Smith and Weinman, 1967).

Social Performance Questionnaire - of five items covering patients' social contact with neighbours, relatives and friends.

Other measures were: -

Enabler Cohesion and Conflict - setting was the conjoint patient-enabler group therapy meetings, led by a counsellor, whilst another counsellor observed the group through a one way mirror.

Readmission rates were completed after a 24 month post-treatment period. Also patients in the various community treatment conditions were compared on their readmission rates.

Results: The following results were reported.

Patients:-

- i). A significantly greater number of patients in community treatment than in socio-environmental therapy successfully completed their treatment programme.
- ii). Community treatment generates somewhat fewer readmissions over a 24 month post-treatment period than socio-environmental treatment.
- iii). Patients released from traditional wards incur by far the highest return rate.
- iv). Community treatment patients show significantly greater improvement in self-esteem during treatment than socio-environmental patients.
- v). The community and traditional ward programmes surpass the socio-environmental treatment groups in social performance.

Patient Results Summary -

Community programme vs socio-environmental therapy

- superior in generating a higher separation rate from hospital
- improving self esteem
- producing superior levels of instrumental and social performance

Community programme vs traditional ward treatment

- much lower recidivism



The difference in return rates made comparison between the residual community samples of the two programmes tenuous.

#### Staff/Enablers Results Summary -

The results of the \*patient-centred and \*\* enabler-centred<sup>3</sup> programmes were:

- i). No difference in admission rates.
- ii). No difference In self-esteem.
- iii). Significant difference in less psychiatric disability in the enabler-centred programme.
- iv). Comparable and somewhat more favourable impact of enablers over professional staff on treatment outcome.
- v). The recidivism rate was significantly greater for visiting enabler condition than live-in enabler condition.
- vi). Enabler conflict does mediate patient outcome in the overall community treatment programme and in each of the experimental conditions.

#### **Summary: Weinman et al, 1978.**

This American study describes an innovative approach (at the time) to community care provision, in which ordinary, non-professional members of the community provide individual support to patients either in their house (live in) or on a visiting capacity. These so called "enablers" are in the focus of the study. Alongside a lengthy description of the project scheme, the researchers provide a quantitative evaluation of its effectiveness.

However, the study suffers from serious methodological problems, as it attempts to identify specific interactions between too many confounding factors. For example, there are four categories of community treatment conditions:

1. Patient-centred focus within a living-in enabler setting;
2. Patient-centred focus within a visiting enabler setting
3. Enabler-centred focus within a live-in enabler setting  
and
4. Enabler-centred focus within a visiting enabler setting.

In addition there are also three categories of care programmes, of which two are serving as controls.

---

<sup>3</sup> - \* patient-centred - professional staff acted as social change agents with patients,

\*\* enabler-centred - professional staff trained enablers as change agents

With such a variety of somewhat vaguely defined conditions it seems hardly possible to reach valid conclusions.

The research tools do not seem to be of established quality and their psychometric properties are obscure. The sample groups in terms of numbers and selection criteria are also not clearly defined in the text, and as matter of fact, are confusing. Although it is stated that randomised selection was employed, it is not clear how exactly this was achieved and whether the procedure of matching subjects to "enablers" was blind. Perhaps some of these issues were merely observed in the text. However, conclusions such as: "the enabler-centred condition generated a higher level of psychiatric status than the patient-centred condition" are, to say the least, problematic considering that the baseline scores for subjects in the two groups were not given in the paper. It could be assumed that differences in scores over time rather than the scores at follow-up should be referred to but this is unclear. In addition, four months follow-up is generally considered insufficient for detecting sustained changes.

In conclusion, the main contribution of the study is in describing a model of employing non professional people as care providers. Recently there were some reports from the US of employing consumers as carers (Cutler, 1996). This is, however, a contentious subject. Although substantial numbers of people suffering from chronic severe mental illness are cared for by relatives, or living in ordinary residential arrangements, most of the severely disabled people need continuous professional support.

**Titles:**

Knapp M and Beecham J. The cost effectiveness of community care for former long stay psychiatric hospital patients. 1989.

Knapp M, Beecham J, Anderson J, Dayson D, Leff J, Margolius O, O'Driscoll C and Wills W. Predicting the community costs of closing psychiatric hospitals: 1990.

The two papers quoted in Knapp/TAPS, in Table 2.1 are a preliminary tentative and a subsequent final version of the same research. The first paper is discussed here and a comparison of both is made in the summary.

Introduction: - in this paper the costs of community reprovion for the first 136 people to leave Claybury and Friern Hospitals are examined. The first cohorts of leavers are not, however, typical of the hospital populations, in particular, they exhibit fewer behavioural problems and other symptoms of mental illness. The prediction equation for the leavers is used to extrapolate community costs for those hospital residents yet to leave by a formulae based adjustment.

Design: -Baseline information for all such patients resident in both hospitals was collected, ranging over a number of clinical dimensions, including mental health status, using the Present State Examination (PSE) and the Social Behaviour Schedule (SBS); the Physical Health Index (PHI), patient personal and historical data; patient attitudes; information on patients' social networks; using the Social Network Schedule (SNS); and an assessment of living environments. (The study however, whilst controlled was not an RCT).

Sample - 136 patients reassessed after 9 months who had been in continuous residence for at least a year, and who, if over 65 years old, had a current diagnosis of dementia.

Methods - Comprehensive costings were sought across all relevant service components of a "package of care". Costing methodology employed in the study is based on the Client Service Receipt Interview (CSRI) developed at the Public and Social Services Research Unit (PSSRU), University of Kent at Canterbury. The CSRI was completed one year after discharge from hospital. The costs of community care are based on retrospective accounts of service utilisation, accommodation descriptions and histories, staffing arrangements, and social security and other income receipts including the opportunity costs of capital. The costing reflects service utilisation and living arrangements in the twelfth month after leaving hospital. All patients moved to a "formal care" setting.

Results:- There were wide variations in cost. The baseline (hospital) characteristics of leavers was used to explain the observed variations in community costs. Males were more costly than females, on average a difference of some £20 per week. The care of older patients was less costly. It appears they can be accommodated in the community at less cost. The institutionalisation effects of prolonged inpatient residence as measured by the receipt of more costly reprovion packages, were noticeably greater. Patients with a larger number of named social contacts when assessed in hospital, that is with wider social networks, cost less in terms of reprovion than their more withdrawn peers, being more communicative they make fewer demands on care staff and support workers. In fact, this result was confined only to males.

The costs of community reprovion packages for the populations of Claybury and Friern once relocated were no larger and probably smaller than their present hospital residence costs. Costs examined in the study were describing the costs after only nine months.

**Summary: Knapp et al**

These two studies aimed to estimate the cost of alternative care for long-stay patients in the community. This is a crucial dimension in evaluating the reprovion of care services following the run down of psychiatric hospitals. The economic study, performed by Knapp and his group from the Public and Social Services Research Unit (PSSRU) in Kent was incorporated to the main Team for the Assessment of Psychiatric Services (TAPS) longitudinal study which assessed the clinical and social outcomes of patients discharged from two psychiatric hospitals in London. At the time these studies were published, only a small proportion of the hospitals' population, in total 136 patients, were discharged, being the early cohorts of an eight year reprovion programme.

The gross costing calculation was based on the aggregation of detailed individual care packages, in which detailed accounts of service utilisation, accommodation, staffing arrangements and income receipts were all costed. The tool designed and applied by the research team, Client Service Receipt Interview (CSRI), has since proved to be an effective tool, and is currently used widely in the UK and with some modifications also abroad.

The study aimed to examine to what extent the baseline characteristics of hospital leavers can explain their cost of care in the community, which evidently varies a great deal. The regression equations were able to explain more than a third of the observed cost variation, which is a significant finding.

However, the more substantial proportion of the variance was determined by other factors which appear to be unrelated to the basic characteristics/needs of the users, and were probably determined by local circumstances, providing sectors etc. This notion is clearly acknowledged by the researchers.

The interesting, yet problematic aspect of the study, was the method of employing estimated cost equations for the early cohort of leavers to those patients yet to leave hospital, and thus to predict the cost of community care provision for the whole hospital population. An attempt was then made to predict what the cost of community care would be in comparison with hospital care.

There are two main limitations for such a prediction:

1. Being less disabled than subjects in subsequent cohorts, the study sample could not be considered to be representative of the whole hospital population. Thus, cost extrapolations applied to the total population cannot properly be made.

2. Changes in mental health care policies both locally and nationally introduce many factors which are independent of the individual needs for care, and as also implied in the study, account for much of the variance in costs. Such factors which represent modes of care provision are less predictable.

In retrospect, it is now known from the results of later studies by Knapp et al. that in contrast to the early prediction that community costs would be lower than hospital costs, in actual fact community costs are somewhat higher. This was mainly attributed to the cost burden of providing specialised services for the residual and most difficult patients (Trieman & Leff, 1996). It may be concluded that cost predictions based on baseline characteristics of hospital populations should take into account the special needs of the "difficult to place" patients, many of whom accumulated over the years and were not represented at the baseline assessment. The generalisability of this or any other method of cost prediction has yet to be tested in other reprovision programmes.

### **Summary of Critiques**

The studies for which these critiques have been given were undertaken over a thirty year period between 1960 and 1991. Some authors have explained the shortcomings of their methodologies with commendable candour as in Brown, 1966. Weinman 1978 produces a complex explanation of methodology which appears to be an attempt to dilute the issue of obvious confounding factors. Apart from Weinman a gradual increase in scientific rigour can be seen as the papers become more current. There is a common methodological problem which arises in these studies of community-based services for the mentally ill, in the potential for bias and the problem of small sample sizes.

Bias can be introduced in the selection of subjects as well as in the assessment of outcomes. Observational studies have the greatest potential for selection bias and differences in outcome between groups may be due to intrinsic group differences, rather than differences in service provision. Those studies which were based on observational designs are therefore limited by this weakness. RCTs can help minimise selection bias, but it is extremely difficult conducting trials in this area, i.e. when hospitals are being closed and services are being provided according to national and local policy and planning decisions. However, even when RCTs are attempted, the detailed selection process can still introduce the potential for bias (see the comments about Linn, (1977) above).

In terms of outcome assessment bias, all before-after and controlled studies, (even RCTs), can introduce bias if the assessors are not blinded to the "before/after" state of the patients, or to

their membership of the experimental or control group. Some of the studies do not appear to have carried out blind assessments, and at least part of the differences between assessments may be attributed to assessment bias.

The sample sizes of the studies ranged from 30 to 625 patients. The total available beds in hospitals and in community care settings for the mentally ill during the period of this survey was much larger. In the UK these ranged from 85,000 in 1992 to 89,000 in 1994. Accepting the principle of applying the findings of small local studies to attempt to predict a national picture in Mental Illness Services has in practice proved to be unsafe. Attempts to make these predictions in the 60s and 70s by Tooth and Brooke (1961), Norton (1961), Cross and Yates (1961), Hassal et al (1965) all based on small sample sizes were accepted as correct at the time and Mental Health Policy based on their predictions was implemented. By the 1970s all their predictions were patently proved wrong by actual events.

#### **2.2.4.2 Learning Disabilities Reprovision - possible parallels**

Researchers in the UK have examined US and UK papers and have highlighted the lack of national studies, O'Driscoll (1993), Leff J (1993) of the TAPS team and Raftery (1993) of the London School of Economics.

These researchers did not however search for national studies of community reprovision programmes being undertaken for the Learning Disabilities group in institutional care and whilst they are a different client group, an examination of the literature was made to see if useful parallels might be discovered.

#### **Separation of services from Mental Health for those with learning disabilities**

To define parallels in common health policies, financial and management regimes and reprovision problems, a brief examination of the division of mental health and learning disabilities services, formerly a single "service" and its separate development, is necessary.

The separation of care and physical accommodation for those patients with mental deficiency commenced with the Metropolitan Poor Act of 1867, under which the Metropolitan Asylum Board was established, to facilitate the transfer of imbeciles and chronic insane from the London workhouses (Hogkinson, 1966 )

The Metropolitan Asylum Board's purpose was to administer relief to the capital's non-able-bodied paupers with the aim of freeing the workhouses to service the "less eligible" able-bodied

(Powell, 1930). Its formal remit in lunacy administration, which was limited to chronic cases, led it to build several large institutions for "idiots and imbeciles" as well as for those with infectious diseases and harmless lunatics at Leavesden and Caterham, later adding Darenth Park Training Colony in Kent, Belmont in Sutton and a further large asylum for senile dementia cases in Tooting Bec in south London. All these asylums were legally designated as workhouses, and appeared as such in the statistics produced by the Lunacy Commissioners.

The Idiots Act of 1886 recognised idiots as a different group and initiated the movement to separate provision for them. From 1870, the Metropolitan Asylum Board had been providing such separate accommodation for this group in the London area. The 1886 Act achieved little, according to Jones, (1972) and clearly failed to affect the 1890 Lunacy Act, which did not recognise idiots as a separate group. The eugenics movement, however, in the period 1886 to 1904 led to greater segregation of idiots and imbeciles through special schools, and to the later development of colonies for the "feeble-minded" (Jones, 1972).

The Royal Commission on the Care of the Feeble Minded (HMSO, 1908) came down in favour of the argument that heredity played a large part in mental deficiency and advocated guardianship and, as required, permanent segregation.

The Mental Deficiency Act 1913, which resulted from the Royal Commission, was introduced after long delays and was met with accusations of being Anti-Christian in Parliament. It led to four classes of mentally deficient being identified: idiots, imbeciles, feeble minded persons and moral defectives. Only those "to be dealt with" (i.e. those who attracted the attention of the authorities) came under the Act. According to Jones (1972), the 1913 Act made possible the rapid growth of institutions caring for mental defectives.

The separate provision that had to be made for this group led to new institutions being established from 1917. While the old Metropolitan Asylum Board's hospitals for the mentally deficient had initially provided many of the places, further 'colonies' for the mentally handicapped were also developed (Jones, 1972).

Woods (1983) noted that following the National Health Service Act of 1947 a possible backward step was taken when all of these colonies for the mentally handicapped were designated hospitals and came under the overall supervision of the Regional Health Authorities. These "new" hospitals tended to be the poor relations of more prestigious hospitals and were starved of money. However, it was reported to Woods by staff who remembered those days that, under the then new system the hospital had received more money than it had done previously from the local authorities.

A Royal Commission, followed by the Mental Health Act of 1959 (for England and Wales only), recommended that the vast majority of mentally handicapped people need no longer be detained under a legal procedure and it also recommended that the local social services department should make themselves responsible for the care of the less severely handicapped.

Woods also comments that: -

*"The social services departments have dragged their feet about the second major recommendation. Partial implementation of the 1959 Act had meant a running down of the large hospitals for the subnormal, with a marked reduction in the number of resident children and a less dramatic reduction in the number of adults".*

Another change came in 1971 when the education authorities took over the responsibility for education of the educationally severely mentally subnormal, (ESN(S)), and no child in the United Kingdom is deemed "ineducable". This has been a major factor reducing the number of children for whom parents had requested residential care. Other milestones in the care of all handicapped children were the Sheldon Report (1967) and the Court Report (1976). These reports led to a marked increase in centres for the comprehensive assessment of handicapped children and of the problems involved for the families.

The White Paper, "Better Services for the Mentally Handicapped", published in June, 1971, laid down the principles underlying the necessary improvements in the provision of services to this group of patients. The Development Team for the Mentally Handicapped was established in 1976 to "strengthen the drive" towards implementing the broad pattern of proposals suggested in the White Paper. In its first report, covering the period June 1976 - December 1977, the Team introduced the twin concepts of the Community Mental Handicap Team and the Community Mental Handicap Unit, as the essential elements in the establishment of a localised service for the mentally handicapped. This was further developed in their second report covering the period January 1978 - June 1979. The key message was that mentally handicapped people have a right to enjoy normal patterns of life within the community as far as that is conceivably possible.

In 1980 when the King's Fund first published an "An Ordinary Life" there was much scepticism about its proposal that people with severe learning difficulties could be accommodated in ordinary houses in the community. The experience of the Wells Road Service in South Bristol, the NIMROD Service in South Glamorgan, and houses in Winchester however, gave the lie to those who airily dismissed the "Ordinary Life" movement as "pie in the sky". Positive gains for residents were seen, (Felce et al., 1986; Ward, 1990). Measured against the yardstick of the "five accomplishments" - choice, competence, respect, community presence and participation (O'Brien, 1987) - "...residents in small homes in the community were seen to be almost always



*better off in every respect” and “these ideas ten years before would have been considered on the radical fringe”.*

From 1993, local authorities were to have the responsibility for co-ordinating community care provision for people with learning disabilities (NHS & Community Care Act, 1990). The Audit Committee Report in 1990 of 50 Local Authority Community Care Services saw the forthcoming problems as: -

- Local authority services for people with learning difficulties were already under pressure because of the closure of mental handicap hospitals, changing ideas and expectations about the kind of community services that should be on offer, and an ageing population.
- There were significant resource problems: nearly 60 per cent of the combined local and health authority budget was still locked up in hospital provision and could only be released as and when residents were settled in the community.
- There had been slow progress on resettlement programmes: 60 per cent of local authorities had yet to reach agreement with local health authorities on financial and practical arrangements for resettlement. (Even where joint strategies had been agreed, half had not yet succeeded in co-operatively resettling **any** residents into the community).
- Existing support for people with learning difficulties and their families already living in the community was inadequate. Also, it was often inappropriate. There had been rapid, unplanned growth in private and voluntary residential homes - encouraged by the “perverse incentives” of the social security system - at the expense of other kinds of community provision which might be more appropriate and less costly. Meanwhile, most local authority provision remained institution-based - relying on traditional hostels and adult training centres, for example, at the expense of smaller, more flexible alternatives.
- There had been little progress on key aspects of government policy. The Audit Commission (1990) found that only 15 per cent of local authorities had an action plan to achieve their strategy and only 3 per cent had decentralised management and budgetary control. Only one in three authorities were developing individual programmes for service users, which should be the cornerstone of the community care of the future.
- Local authorities were, moreover, confronting competing pressures. Changes in community care were just one of the issues they were having to address. Although the Audit Commission did not comment on this, it is important to remember that local

authorities were simultaneously grappling with a variety of other changes within the social services departments and beyond - in education (local management of schools), in housing and in finance (the community charge).

In 1993, Professor J Mansell reported in "Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: "Report of a Project Group", (HMSO, 1993):-

*" There are two implications of our work to which we would particularly like to draw your attention. The first is that the key to the development of better services is management commitment. We are confident that there is now sufficient knowledge and practical experience to substantially improve services, given the kind of sustained commitment from policy-makers and managers that the services we studied had enjoyed.*

*Second, the proper role and characteristics of specialist services can only be achieved by attending to the competence of "mainstream learning disability services". The priority is to improve the capability of mainstream services to prevent problems arising in the first place, to manage them when they occur and to implement relatively sophisticated long-term arrangements for management, treatment and care. In so far as this can be achieved, specialist services will be able to concentrate on people with the most complex and difficult needs. At the moment, even moderate levels of challenging behaviour are not being appropriately managed in mainstream learning disability services and specialist services (including some of dubious quality) face apparently unlimited demand".*

However, Professor Mansell could report that: - *"the relatively small size of the client group and the enormous progress already made make this (the reprovision of LD services) easier to contemplate".*

It is almost certain that there will be a need for hospital care, not only for those in need of special treatment when mental handicap is compounded with psychiatric illness, but also, at least in the medium term, for those who are defined as "hard to place". Admissions to hospitals for people with a mental handicap for all age groups except those over 65 years, have risen, both as a proportion of their population and in absolute numbers over the past few years. All admissions were 39,110 in 1989-90; and 53,850 in 1994-95 (HPSS: 1996). These data include short term and respite admissions but it is evident that hospitals remain important providers of care.

However, available beds in NHS facilities have dropped from 30,000 in 1989 to 12,680 in 1995, the majority of these (10,500) being allocated to long-stay patients. The total number of places

in LA private and voluntary sectors principally funded by Local Authorities (excluding NHS beds) has remained virtually constant, i.e. 60,000 in 1989 to 61,630 in 1995.

The position in bed numbers for the mentally ill in NHS facilities is broadly mirrored, 63,000 in 1989 to 39,500 in 1995, however the NHS provided over 43% of all mental illness beds in 1995, the comparable figure for Learning Disabilities was 20%. The admission rates to NHS hospital per 1000 population (all ages) in 1995 for Mental Illness and Learning Disabilities was 4.4. and 1.1. respectively.

### **Summary - Services for those with learning disabilities**

The general message of Professor Mansell's Report was that the task of reprovizion was understood, the management had the skills and were competent and that the relatively small size of the client group and the substantial progress made to date made "the task easier to contemplate". These views seem optimistic against the disorder discovered in the Audit Committee Report of some three years earlier and no doubt many difficult problems will need to be overcome before reprovizion for the Learning Disabilities Group is completed, however the programme does at least continue.

Against this must be compared the chaos in the reprovizion of services for the mentally ill which caused the incoming government to halt the programme and place it under review. The Times' medical correspondent, Ian Murray, reported in September, 1997, (The Times, 13.9.97) that the plans to close the 35 remaining long-stay psychiatric hospitals had been frozen while a new vetting system was put in place to ensure that adequate alternative care in the community would be available. Announcing the freeze, Paul Boateng, the Health Minister, said that Care in the Community had lost its credibility. *"It is perceived as having failed to deliver both in terms of patients and in terms of the wider community"*. He also added that there would be no extra money for community care.

Advice on the level of care in each area was to be given to the Government by a 26-member independent group, including Marjorie Wallace, Chief Executive of the mental health charity, SANE, Matt Muijen, director of the Sainsbury Centre for Mental Health, and Michael Howlett from Zito Trust.

Ms Wallace, recently elected an honorary fellow of the Royal College of Psychiatrists, said she would feed in information received from the thousand people a week who called SANE's helpline.

In conclusion, the NHS has much further to go in reproviding services for the mentally ill in the community than with the programme for Learning Disabilities. The Learning Disabilities remaining with the NHS are predominantly static long-stay populations (82% of the provision is for long-stay as opposed to mental illness [excluding elderly] where only 29% is long-stay. The 71% short-stay mental illness population move in, out and between NHS facilities using a range of services and comprise a more complex reprovision problem.

### **Studies of Deinstitutionalisation in reprovision for those with Learning Disabilities**

Booth et al (1989) noted that those with Learning Disabilities are the least articulate group and the "pro-institutional" lobby has consistently fought a determined action to slow the pace of change in community developments, despite the number of places in (non-NHS) residential homes increasing from 14,300 in 1978 to 48,950 in 1996 (HPSS, 1997).

Raftery, 1992, stated that few studies have ever focused on the mentally handicapped despite the fact that they were included under the heading of lunatics, cared for under the same law and sometimes in the same institutions.

It is not encouraging to find, in examining "local" as opposed to national studies, that in their review of user studies of people with mental handicap, Simons, Booth and Booth (1989) did not find any random controlled trials (RCTs) or even quasi-experimental designs. Most studies were descriptive. In 1984, Richards could only identify five British studies involving opinions expressed by people with a mental handicap. These projects included the closure of Darenth Park Hospital (Wing, 1981). The evaluations of "Care in the Community" at the Personal Social Services Research Unit (Renshaw et al, 1988), the Nimrod project in South Glamorgan (Lowe et al, 1986), and the Kirklees Relocation Project (Simons, Booth and Booth, 1989) alluded to, but did not deal with management problems

Korman & Glennerster's evaluation (1990) of the closure of Darenth Park Hospital in Kent gives an insight into the complexity of the business. The authors confess they privately doubted the goal would be achieved. That it was, they attribute more to "*a series of accidents, policy lurches and ad hoc developments than any rationally worked out blueprint*" (Hatchett, 1990). Their painstaking study lays bare the web of issues and factors implicated in the near chaos (as they saw it) of the administrative processes involved, and gives some anecdotal pointers for those engaged in similar ventures elsewhere. In their findings about finance they found that significant costs were involved in both maintaining and running down a hospital, in addition to the higher costs of good quality community services as they are developed (subsequently supported by Knapp, 1990). New district health services were found to be heavily dependent on residents'

social security benefits. *"Changes to the social security system"*, Korman and Glennerster (1990) comment, *"can effectively jeopardise plans for community care"*. However, whilst they report "accidents", "policy lurches", "ad hoc developments", they failed to see that this is the process that must be effectively managed and can be with project management techniques. They also failed, although assembling a useful database, to make meaningful recommendations for improvement in management and communication.

Knapp's detailed study (1989) of 28 projects mentioned earlier, (included 11 projects which examined learning disabilities reprovion programmes) only addressed the management issues in passing and did not evaluate the process. Simons et al, (1990) examined the experiences of people resettling in the community and whilst not an examination of the management process, demonstrated a clear understanding of the problems of working in and managing a changing environment and the study could easily have been usefully further developed to expose management problems.

Bridge (1997) in her PhD, *"Parents as care managers: the experiences of those caring for young children with learning disabilities"*, examined implementation issues affecting the care provided to children with Learning Disabilities and in her literature review sought national (UK) studies without success. Like the author, she also sought research addressing how or whether policy for those with learning disabilities was being implemented nationally. She reported, after examining an abundance of literature, that *"... as to how and whether, it was inconclusive"*.

As with the mental health literature review there were however a number of studies from the USA, where there was a longer history of assessing the views of people with a mental handicap (e.g. Scheerenberger and Felsenthal, 1977, Gollay et al, 1978; Conroy and Bradley, 1985). However, again these were all local rather than national studies.

As with mental illness studies, as is attempted in this study, there appears to be no national study of reprovion of services for the Learning Disability group. As mentioned in the literature review on the reports of services for the mentally ill, in the 60's and 70's there were several well regarded local studies predicting Mental Health needs which were applied nationally (Tooth & Booth, 1961, Norton 1961, Cross & Yates 1961, Hassal et al 1965). These predictions were that effective community care would all but obviate the long stay population and that this population would disappear. All these predictions were demonstrably unproven by a study (Mann & Cree, 1976) confirming the emergence of a new long stay population.

## **Common Policies in Learning Disabilities and Mental Health Programmes**

1. Although the Learning Disabilities Institutions were built somewhat later than those for mental health (i.e. after 1913) they were equally in need of replacement and for many provided an inappropriate model. (Woods, 1983).
2. Community-based care, ("models which were social, family and education-based models rather than health-based"), were seen as more appropriate for most patients with learning disabilities. (Mental Health Act, 1959).

## **Differences in Provision**

1. The majority of the Learning Disability group have physical disabilities requiring support for day to day living for their lifetime (HSG(92)42).
2. Local Authority funded and managed continuing care services are the principal source of provision for the Learning Disability group other than those with chronic health needs or the dual diagnosis of a severe psychiatric condition. In June 1991, Stephen Dorell in his Mencap speech, (Evening Standard, 1991) described the future role of NHS-based learning disability services: -

*" There has been much concern that, with local authority social services departments becoming the main statutory agency for providing services for people with learning disabilities, the NHS would have no role... There may, however, be a small number of people with severe or profound learning disabilities, and physical, sensory or psychiatric conditions who need long-term residential care, where a multi-professional assessment and consultation with parents or carers leads to the conclusion that the services they need can only be effectively provided by the NHS... "*

3. Following diagnosis and assessment, the support needs requirements of Learning Disability patients remain relatively static in comparison with that of Psychiatric patients who move between services as their needs change (HPSS, 1995).
4. Funding for Learning Disabilities Capital developments is mainly through either Local Authority obtaining Supplementary Credit Approval from the Treasury (permission to borrow) to build or predominantly from placing contracts for care in the private or charitable sectors who provide their own premises (HPSS 1995).

5. Many Learning Disability patients were directly cared for by Local Authorities before the plans were introduced for the NHS Mental Illness institutions to be reprovided in the community (Mental Health Act 1959) and the programme is more advanced than for that in Mental Illness, (12,680 LD NHS beds compared with 40,000 NHS MI beds in 1995). (HPSS, 1996).
6. The Learning Disability patient population is a far smaller user of NHS services than the Mentally Ill population - admission rates of 1.1. and 4.4. per 1,000 population respectively.

### **Learning Disabilities Capital programmes compared with the NHS reprovision for Mental Health in these studies**

1. Learning Disability provision is principally in small domestic scale units (DoH, 1990). "The best model of residential care is the ordinary supported housing model" and "commissioners should purchase residential care in small community-based staffed houses rather than in large residential homes". (HMSO, 1992). This is not to say that the design of these specialist small units does not have its own problems, they do however not have the problems of scale. Psychiatric provision invariably requires large purpose built hospital style units to house acute and assessment facilities as part of a community reprovision programme and Korman and Glennester (1990) stated that "*acquiring houses in the community (for LD patients) is the easy part*" (although the author suspects they did not have personal experience of just how difficult this can be).
2. Large NHS units are, as a matter of policy, usually integrated with hospital developments to ensure appropriate supporting facilities. (HBN37: HMSO, 1973).
3. The large NHS units are more complex buildings with residence/accommodation (the principal function of Local Authority Learning Disability buildings) being only part of the provision.
4. The problem of meaningful daytime activities presents in both services. In the Learning Disability Service there is a clear lead in an Education-based approach (Sutcliffe, 1990).
5. Funding for NHS buildings through the Private Finance Initiative route has proved difficult for the NHS. Local Authority routes through Exchequer loans or contracts with the private sector have not changed and are well understood.

6. Complex Town Planning Applications for the larger NHS facilities are unavoidable due to their size. These applications are in themselves complex and if opposed or refused require an expensive and time consuming appeal to the Department of the Environment and even smaller community units have been successfully opposed (e.g. C & G Homes Ltd. vs Secretary of State for Health, 1994).

Many Learning Disability facilities are small and residential in nature and may be able to avoid the need for town planning applications. (Town and County Planning Act 1990). Where a planning consent is required, Local Authorities have the ability to grant themselves "deemed consent" i.e. the LA Town Planning Department can grant the Local Authority Social Services Department a Town Planning consent for its Learning Disability developments thereby largely avoiding the problems caused by public consultation. (Town and Country Planning Act 1990 "deemed consent").

7. The national problem (compared with mental illness reprovion) is of much smaller scale and the programme well advanced. In 1992 at the beginning of this study, Professor Mansell (HMSO, 1993) could report that: - *"the relatively small size of the client group and the enormous progress already made make this (the reprovion of LD services) easier to contemplate"*

**Table 2.2**

**Principal NHS problems encountered in community reprovion programmes compared with Local Authority position**

Problem	NHS Mental Health	L.A. Learning Disabilities
Town Planning	Protracted application process sometimes opposed.	L.A. can avoid altogether granting itself a planning consent.
Capital Funding	PFI route has not produced funds for larger schemes which are beyond NHS ability to fund locally.	Funding route for LAs is clear even if protracted and competitive
Capital Solutions	Larger schemes are complex multi - functional buildings on hospital sites.	Schemes are largely small with a principally residential function.
Management Structure	NHS has been subject to management change, purchaser/provider, formation of Trusts and the creation of radically different management structures.	L.A. has been subject to both budget pressures and changes in legislation but have the choice of the management structure it adopts to such local circumstances.
Sites	NHS only has sites for health use.	L.A. owns a wide range of properties especially in Public Housing programmes which can be adapted to L.D. use.



It would appear that many of those matters which are appearing in the national and case studies as barriers to implementing the NHS programmes for Mental Health reprovion, ownership of sites, Town Planning, Capital funding, all against the background of a major Management reorganisation, have not posed similar problems to L.A. provided reprovion.

There is of course the issue of scale and programme in that the Learning Disability programme is considerably smaller than the Mental Health programme in numbers of places to be reprovion. The Learning Disability programme of reprovion has been effected over a longer time span consequently being more manageable organisationally and poses less of a burden on total financial and management resources.

It would appear then as with Mental Illness that in the field of Learning Disabilities, numerous detailed local studies have been undertaken but none with a national or regional study size that could establish the national picture as is attempted in this research.

Undoubtedly, if a national study of the progress in the NHS of reprovion services for those with Learning Disabilities in the community were carried out, many complex management issues would be identified. Some could be drawn on to make comparisons with mental health reprovion however there are fundamental differences which would limit the scope of such an exercise.

## **CHAPTER 3**

### **STUDY DESIGN AND METHODS**

<b>3.0</b>	<b>Hypothesis</b>	<b>77</b>
<b>3.1</b>	<b>Overall Study Design</b>	<b>77</b>
<b>3.2</b>	<b>Selection of the Research Methods</b>	<b>78</b>
<b>3.3</b>	<b>The National (England) Survey Design</b>	<b>81</b>
<b>3.3.1</b>	<b>Content of Questionnaires</b>	<b>81</b>
<b>3.3.2</b>	<b>Defining the Sample</b>	<b>82</b>
<b>3.3.3</b>	<b>Identifying the Appropriate Respondent</b>	<b>83</b>
<b>3.3.4</b>	<b>Pilot Study</b>	<b>83</b>
<b>3.3.5</b>	<b>Verification and Management of the Data in the National Study</b>	<b>84</b>
<b>3.3.6</b>	<b>Baseline and Annual Follow-up Surveys</b>	<b>85</b>
<b>3.3.7</b>	<b>Project Management Techniques in the Analysis of Programmes</b>	<b>86</b>
<b>3.4</b>	<b>In-depth Case Studies of Three Reprovision Programmes</b>	<b>88</b>
<b>3.4.1</b>	<b>Objectives</b>	<b>88</b>
<b>3.4.4.1</b>	<b>Case-Study Design</b>	<b>88</b>
<b>3.4.2</b>	<b>Content of Questionnaires</b>	<b>89</b>
<b>3.4.3</b>	<b>Patients' Perception Survey</b>	<b>90</b>
<b>3.5</b>	<b>Patient Assessment</b>	<b>92</b>
<b>3.5.1</b>	<b>The Brief Assessment Schedule</b>	<b>92</b>
<b>3.5.2</b>	<b>Dependency Measures for Patients Exhibiting Severe Dementia</b>	<b>93</b>
<b>3.5.3</b>	<b>Patients' Quality of Life Questionnaire</b>	<b>95</b>
<b>3.6</b>	<b>Staff and Carers' Surveys</b>	<b>97</b>
<b>3.6.1</b>	<b>Staff Perceptions Questionnaire</b>	<b>98</b>
<b>3.6.2</b>	<b>The General Health Questionnaire</b>	<b>99</b>
<b>3.7</b>	<b>Friends' and Relatives' Perceptions</b>	<b>99</b>
<b>3.8</b>	<b>Physical Survey of Facilities</b>	<b>101</b>
<b>3.9</b>	<b>Verification of Data in the In-depth Case Studies</b>	<b>102</b>
<b>3.1</b>	<b>Data Management</b>	<b>102</b>
<b>3.11</b>	<b>Sample Size Estimates</b>	<b>102</b>

### 3.0. HYPOTHESIS

This chapter sets out the study designs and the instruments used to collect data.

The hypothesis to be tested was:

*“Planned short closure programmes can be achieved without detriment to the quality of reprovion”.*

### 3.1 OVERALL STUDY DESIGN

Two distinct designs were used: a national prospective survey of all psychiatric institutions' closure plans and in-depth case studies of a small number of individual institutions.

#### **The National (England) Survey**

The objectives of the national survey were to :

- i. identify all psychiatric hospitals in England, their facilities, service provision, staff and bed numbers;
- ii. describe the closure programmes of hospital institutions;
- iii. monitor progress of closure programmes over a three year period (1993 -95).

A National Survey of community reprovion programmes was undertaken to examine the variation in approaches to closure programmes. This survey aimed to examine numbers of patients, facilities to be provided and any special local management problems. Other factors such as interrupted funding, changing policies, failure to commit resources and inability to order and prioritise the implementation process were also identified.

The outcomes of interest were measures of efficiency in securing funding, implementing closure programmes, and relocating staff and patients. However such outcomes do not measure quality of care other than in planning terms. It was essential to consider the views of both service providers and users in evaluating the effects of rapid closure programmes. Previous studies (see Chapter 2) indicated that data required to measure the quality of the facilities and the views of the users and providers would be of necessity quite detailed and impractical to collect at national level.

## Case Studies

In-depth case studies of three programmes were undertaken. The objectives of the case studies were to determine the quality of services and facilities achieved in "short" three to four year reprovision programmes from patient, staff and relative/carer perspectives.

"Micro level" observational studies were therefore undertaken of specific facilities in three reprovision programmes where the intention was to conduct a short programme. To obtain a balanced view of quality from all the users of the new facilities, views were sought from patients, staff, friends and relatives, using questionnaires based on similar user orientated surveys. Whilst all other measures of quality may be satisfactory, there are concerns in these reprovision programmes that the health of the patients (Schulz 1977, Antony 1987) and staff, (Cole 1994, Reda 1995, Wills 1996) is placed at risk, and therefore measures were sought of both patient and staff health.

The specific information was collected on:

- i) Patients' perception of the quality of their facilities **before** and **after** the move;
- ii) Patients' mood status **before** and **after** the move;
- iii) Staff/Carers perception of the reprovision process, the quality of facilities, and mood status **after** the move only;
- iv) Relatives perception of the patient and their view of the quality of the new facilities **after** the move;
- iv) Quality of facilities as compared with NHS standards, applied to **initial** and **reprovided** facilities.

### 3.2. SELECTION OF THE RESEARCH METHODS

Alternative study designs were considered as a means of tackling the research question posed. Since little control could be exerted over the process of closure programmes, any attempt at randomised allocation of patients to rapid or protracted closure programmes was impossible.

Observational methods were the only feasible approach and a prospective cohort of hospitals in varying steps of closure appeared to be the best means of examining the general question of the managerial efficiency of rapid versus slower programmes. However, since closure programmes are extremely complex, it was felt necessary to explore this using micro level case studies. Consideration was given as to whether the research should be conducted using quantitative or qualitative methods.

Qualitative and quantitative research are, it is suggested (Blinkhorn et al, 1989), each appropriate to answering differing research questions. This implies that the research inquiry determines which method is employed (Bryman, 1988). It is proposed "that certain questions cannot be answered by quantitative methods while others cannot be answered by qualitative ones" (Walker, 1985). This view implies that the decision over whether to use qualitative or quantitative methods is determined by two major factors, the questions to be answered and the situational constraints (Tones et al., 1990).

Quantitative research is associated with a range of study designs: cross sectional surveys, case control designs, cohort or prospective studies and controlled trials. Quantitative research aims to obtain information from a sample of the relevant population which is representative of the population as a whole. Such designs are often used to test a theory or hypothesis. Quantitative research tries to provide answers to "what", "where", "when" and "how" but may also be "fact finding" or exploratory. (Bell, 1987).

Qualitative research has characteristics which differentiate it from quantitative research. Its most fundamental characteristic is that it emphasises the importance of people's perspectives, perceptions and actions, and the meanings attributed to them (Nettleton, 1986). This type of approach often involves the researcher empathising with those being studied, and also requires a capacity to penetrate the frames of meaning in which respondents operate (Bryman, 1988). This results in data which is textual rather than numerical in character and based in the language and on the experiences of the respondent. Qualitative research aims to achieve this by means of deliberate interaction between researcher and those being studied (Walker, 1985). One of the main purposes of qualitative research is to describe a detailed social setting of those being investigated which should be consistent with the perspectives of the individual in that social setting. According to this view human behaviour is not to be understood in causal terms based on laws governed by external forces but through the revelation of meanings that people attribute to their own lives and actions. The underlying logic is inductive and, from a detailed understanding of specific situations, the suggestion of a more generalised explanation, i.e. a hypothesis or theory, may be arrived at. The emphasis therefore of qualitative research is a need to interpret events and experiences in terms of an understanding of the meaning they have for the respondents (Bryman, 1988). An unstructured and open research method is favoured by qualitative researchers rather than an approach which has decided in advance what is to be investigated and exactly how it should be done. In this method the researcher explores the many facets of the respondent's concerns, treating subjects as they arise and pursuing relevant leads. It is thought that this open approach increases the likelihood of uncovering entirely unexpected, relevant material which may be of interest to the researcher. Thus a qualitative

approach might seem the most obvious means of examining the quality of reprovision of particular programmes in the case studies.

Several factors make this approach inadvisable

- i) qualitative data collected can be difficult to compare both between sites in this study and with other published work;
- ii) qualitative research requires more lengthy contact with the respondent to understand the respondent's action and reasoning. The patients involved in psychiatric closure problems would not be easy to interview in-depth, which would require specific skills and would be time consuming.
- iii) Closure programmes tend to be emotive - for staff, patients and relatives - and cause concern to local communities. The perceived subjectivity of qualitative methods might be a relative disadvantage in providing evidence for or against a hypothesis that has a strong political content.

Quantitative methods therefore form the basis of all the questionnaires in this study. In making this choice it is accepted that some of the questions asked of the patients would benefit from an in-depth unstructured interview approach and this might have produced helpful results and might form the basis for further work on this topic.

### **Following government policy**

Over the period of the study attempts have been made to follow changes in government policy. Many of the issues studied here are the subject of policy reviews and intense public interest. The official source of government proposals for changes prior to legislation is through the Green Paper Consultative Process and where these have been available they have been incorporated in the research. A Green Paper represents the Government's formal position on a particular subject prior to parliamentary debate. However, pre-dating the publication of a Green Paper there is much informal consultation with specialist organisations usually to establish their degree of support or tolerance. Little of these debates are publicly available. When negotiations breakdown or demands become too extravagant however, both the Government and interested parties resort to the press to air their differences or strengthen their position as they see it by moving it into the public arena.

To gather this data a system was set up where the quality newspapers were monitored over three years through their health or science correspondents' articles to track and monitor the debate. In the text, where current policy issues are being discussed, references will be found from these correspondents. In using this information it is accepted that these reports are far

from unbiased, they are occasionally eccentric and wherever possible the counter argument, when published has also been examined to temper the views expressed. Wherever possible only attributable comments have been quoted.

### 3.3 THE NATIONAL (ENGLAND) SURVEY DESIGN

The National Survey was conceived as a baseline survey of the current position (i.e. 1993) followed by prospective follow up for two years to monitor progress in implementing closure programmes, inception of new closure programmes and failure to start closure programmes.

#### 3.3.1 Content of Questionnaires

The principal objectives of the questionnaires are set out in Table 3.1 and the final version questionnaire is shown at Appendix 3.1.

The answer to issues that would cause variations in programme duration or complexity were sought. These issues included the numbers of purchasers with whom hospitals were dealing, sizes, and variations in hospital population, sources of funding, and anticipated programme duration. The management structures of the hospitals together with the conditions of the premises, intended community reprovision levels and the staff transferring to them, were also investigated.

Table 3.1 National Survey-Content of Questionnaire			
	Question	Purpose of Measure	Comment
1.	N° of Purchasers	To assess management complexity	reorganisation changed numbers during survey
2.	Hospital Population	To measure changes in composition of patient population	definitions of population composition vary
3/4	Closure programme and funding	To establish if programme approved or funded	often several programmes
5.	Programme dates	To categorise hospitals into programmes	-
6/7	Trust Wave	To establish type of management structure	-
8-11	Age/design/occupancy	Age/utilisation level, site closure efficiency	-
12-14	Community programme	Content of programme	complex 1 page question
15/16	Staff employed and transferring	Staff employed over years and in community	Answer to latter question often not known

### **3.3.2 Defining the sample**

The first problem that became apparent in commencing the work is that no defined list of psychiatric hospitals whether in closure or not, was available. Neither the Regional Health Authorities nor the Department of Health collected such information.

In answer to a Parliamentary Question (PQ) "Can the Secretary of State for Health advise the House of those psychiatric institutions to be closed by the year 2000?", the then Secretary for Health, Tim Yeo, responded in January 1993 that there were 29 such closures proposed. The National Schizophrenia Fellowship carried out a survey through its members, identifying some 45 hospitals that proposed to close by the year 2000, which was published in the British Medical Journal (Groves 1993). This then achieved a more public exposure by being reported at length in the Guardian on February 24th, 1993.

As a result of this embarrassing disclosure, Birmingham University, through Dr John Yates of the Inter Authority Comparisons and Consultancy (IACC) was charged with assembling a list as rapidly as possible for the Mental Health Task Force, on behalf of the Department of Health, in order that a response be formulated in answer to the Parliamentary Question. Their subsequent "Water Tower Report" (Davidge, 1993) was used in this research as the first step in assembling a comprehensive database.

A second list was made from psychiatric hospitals shown in the Institute of Health Services Management (IHSM) Year Book for 1992. This list also had deficiencies. The IHSM rely on questionnaires completed by their members and when there is no response, the previous year's data is used. Their definitions of Community and Institutional Psychiatric services were unclear to those completing the form, and there was no quality control mechanism in the editing of the list.

Changes in names of hospitals, with many hospitals adopting non-geographical non-functional Trust names (e.g. "Premier Health") and with this process being spread over five waves of Trusts, caused additional difficulties in correctly identifying psychiatric hospitals. Furthermore, actual mergers or negotiations between Trusts about mergers complicated the picture. In addition consolidated Learning Difficulties and Psychiatric Services provided on one site were sometimes found to contain services for elderly mentally ill people.



### **3.3.3 Identifying The Appropriate Respondent**

A named respondent was identified by telephone to whom the reasons behind the questionnaire were explained following which they then agreed to provide the data. Whenever possible senior administrators, nurse managers and planners were asked to act as respondents. In all cases, the prime concern was to ensure that the individual identified was in a position to provide the information required.

The respondent in agreeing to complete the questionnaire, also agreed, subject to them still being in post, to complete years two and three questionnaires to ensure a consistency of response.

### **3.3.4 Pilot Study**

A draft questionnaire was designed covering the areas described in Table 3.1. Efforts were made to allow respondents to explain and amplify their answers. Where feasible, definitions of terms used were given. The initial version of the questionnaire was piloted with a sample of ten hospitals drawn from the Institute of Health Service Management Hospitals Year Book, using the following criteria:

- (i) Confirmed Psychiatric Service;
- (ii) A reprovision plan was either positively contemplated or in progress;
- (iii) The hospitals accommodated at least 150 patients at the time of receiving the questionnaire;
- (iv) A person of reasonable knowledge and seniority had agreed to complete the questionnaire.

No special coaching of recipients was undertaken. A telephone helpline was offered if any difficulties were experienced in completing the questionnaire.

As a result of the pilot study, minor changes were made in the layout of the questionnaire in the interest of clarity and further questions were added. An "other" category was included in ward design, and the cost of the total capital reprovision was requested. The pilot study questionnaire was followed up by telephone. Most respondents welcomed the research and felt positive about it. Some respondents were concerned about the purpose of the research and felt that the work might be used managerially "against them."

In the interests of obtaining complete responses, some questions were reformatted to allow for these concerns. Sellitz (1966) deals with this problem by converting "explicit" questions that might be discouraging into "inferred" questions, in which the desired information is obtained indirectly. Whenever possible "explicit" questions were asked, especially where they were not dissimilar from "standard issue" health service questions on bed states and hospital populations. Questions designed to answer potentially contentious issues, e.g., whether a hospital in poor condition was liable to close later than one in good condition, were asked indirectly.

### **Categorisation of hospital plans**

Over the period of the survey, hospitals were placed in categories A, B, C, or D (see below), depending on their progress with closure. The category placement was arrived at by comparing the declared date for closure of the hospital against the outstanding schemes necessary to complete the community reprovion programme. Where the hospitals' closure data was realistic against the programme, it was categorised as given. Where the programme, on examination, seemed to be exceeded by more than one year, the hospital was re-categorised..

The pilot study identified data that would enable hospitals to be categorised into stages of closure programme implementation. Hospitals could be placed into one of four categories: -

- Category A: those which had declared no closure programme and had no formalised and funded plan to allow them to alter significantly their pattern of service,
- Category B: those which had a funded plan for their principal schemes and were in the very early stages of implementation.
- Category C: those which had a funded reprovion plan in implementation and which had reduced their patient numbers by at least half from those at the commencement of the current plan.
- Category D: those hospitals which had an implementation plan that projected closure in less than a year.

### **3.3.5 Verification And Management Of The Data In The National Study**

- a) In verifying the accuracy of survey data, follow up allowed the opportunity for cross-checking data. Internal cross-checks of variables were undertaken.

- b) telephone checking for strange values:- Any dramatic or unlikely change between years was queried and a follow up telephone inquiry to the respondent was made.
- c) telephone help line:- A telephone helpline number was given to respondents to assist in the completion and interpretation of the questionnaires. This was used on 44 occasions over the three years of the study.
- d) 10% duplicate assessment exercise:- A random 10% of each year's responses was reassessed for categories A-D by an independent, and blinded, experienced capital planner with direct knowledge of psychiatric hospital closure and reprovision programmes.

### **3.3.6 Baseline And Annual Follow-Up Surveys**

Baseline survey (1993) questionnaires were sent to -

- a) All hospitals in the Institute of Health Service Management Year Book listed as psychiatric institutions;
- b) All hospitals listed in the IACC Water Tower report;
- c) All Learning Difficulties services where there was the possibility that a combined service existed and subsequent telephone inquiry revealed this to be so;
- d) All Directly Managed Units (Non Trusts) of Community Health Services with administrative headquarters not based at a Psychiatric Hospital site;
- e) All Community Trusts listed in the Department of Health Circulars formed in the 1,2 and 3 waves where their service could not be identified from lists a) - d) above.

An analysis was undertaken of the first year questionnaire to establish to which stage each hospital had progressed in its closure programme, categorising hospitals into groups A-D.

#### **The Annual follow up surveys 1994/1995**

A modified follow-up questionnaire was used seeking more detailed information on intended community reprovision. Notwithstanding the successful pilot questionnaire exercise the responses to these questions were often only partly completed. The principal changes from the baseline survey were:-

- Further detail on bed spaces in use was sought, and an explanatory note was attached to the questionnaire to explain categories of community reprovision (see Appendix 3.1).
- Further detail was sought on day patients and staff numbers transferring, to be given as Whole Time Equivalent (WTE) and head counts to avoid ambiguity.

Category D hospitals were all contacted by phone to check that closure had taken place. This work was undertaken between November 1994 and May 1995.

Hospitals were then recategorised in the light of annual follow up data to note their progress or otherwise as appropriate, and data supplied checked for inconsistencies against year 1 and 2 data. This work was undertaken between October 1995 and December 1995.

### **3.3.7 Project Management techniques used in the analysis of programmes**

The NHS has failed to compile a standard database to measure the progress of its capital schemes for project management purposes and is only just beginning to do so (Capital Investment Manual, HMSO, 1994). NHS scheme-specific data which would have permitted comparisons and could have been particularly useful for estimating pre-construction planning periods, were not available. As there is no standard database it follows that reprovision programmes could not be described by their managers in a common format permitting accurate comparisons between hospitals.

Without such a format available, analysis was restricted to that which could be reliably found in the reported data.

Analysis of programmes was undertaken for:-

1. Progress with reprovision category A, B, C and D (see 3.3.4) and those closed over the three years of the study.
2. At which of the 4 stages delays occurred in the programme once planning had commenced.
3. Hospitals planned closure dates against those achieved.
4. Geographical progress by NHS Region by hospital category.

5. Problems which could potentially affect progress with closure i.e. hospital population and case mixes. Beds in use and available, management arrangement.

Some semi-formal project management analysis was undertaken albeit with only limited applications being possible: -

- a) An analysis of schemes still to be provided in the last year of programmes and those causing actual delay was undertaken.

The NHS publish Departmental Cost Allowance Guides (DCAGs) "cost limits" which are available for the larger capital schemes (see Chapter 1, 1.9 Managing Costs). The DCAGs are calculated from the costs of NHS schemes in each category of functional content and are updated to reflect market changes in cost and technical content. From DCAGs it is possible to establish a notional capital cost from which a construction period could be extrapolated. This could then be compared with the stated programme period and enabled the conclusion to be reached that major capital schemes gave the greatest problem in estimating programme lengths and were the principal causes of delay.

- b) Overall programme lengths were also examined and a crude data base created with assumptions as set out at Appendix 4.2 from which could be calculated the possible closure dates of the institution yet to close based on present performance.
- c) Where costs were given for individual schemes these were on a broad basis checked against DGAGs for exceptional costs and this then gave them some indication as to appropriateness of the timescales stated for implementation.
- d) All programmes that showed lack of progress without an attendant end date revision were reviewed on a simple expenditure against time basis and revised to meet a more realistic end date. This methodology was used to adjust the A - D Categories, (see Table 4.4).
- e) One of the project manager's skills should be the concept of "completeness", (Brech, 1975) and in NHS schemes this is particularly relevant. The concept addresses the fact that no matter how skilled the multi-professional user briefing group, there will be gaps in knowledge at their boundaries or a risk of overlapping and duplication of requirements due to differing professional taxonomies (particularly in Mental Health). In the case studies detailed questioning was possible to explore these issues. In the

national study, whilst some phone call checks were made, the resource requirements would have been excessive had the questionnaire been incomplete and not provided a full description of the range of mental health components possible in the programme. Considerable efforts were therefore made to obtain complete data on programmes and the questionnaire (see Appendix 3.1) was specifically designed to permit checking in and between years for completeness. (See Tables 4.17 , 4.18 and 4.24).

### **3.4 IN-DEPTH CASE STUDIES OF THREE REPROVISION PROGRAMMES**

#### **3.4.1 Objectives**

With only limited resources it was not possible to study all closure programmes in depth. It was decided to focus on two programmes that were likely to achieve closure within three/four years (i.e. category A sites). A " before and after" study design was used with **changes** in patients' health status and quality of life outcomes being studied. In practice, owing to the differences in timing of programmes and the inability to control events, other outcomes were measured only **after** reprovision had taken place. In addition, it was decided to examine similar outcomes in a category C site where implementation had stalled.

An attempt was made to obtain a contemporary "control" group of patients who were not re-located but remained in institutional care. Assessments of these patients were made on two occasions, three months apart. This was done to examine the possibility that the process of assessment itself might result in changes in mood and other ratings.

#### **Selecting the Sites**

Sites were selected on the basis of accessibility, willingness to participate in an in-depth enquiry, and the availability of a suitable patient group for study. All three hospitals had developed detailed closure plans that appeared capable of implementation in three or four years.

##### **3.4.4.1 Case-study design**

#### **Selection**

It was not possible to select sites for study randomly from the national survey. It was necessary to study hospitals where there was agreement to the study, and which fitted the author's time schedule, and were reasonably accessible from London. While it is accepted this produces

limitations, it was felt that it was more important to include some assessment of the impacts on patients, relatives and staff than to ignore these aspects entirely.

### **Non-randomized design**

In common with many areas in health care, a randomized controlled trial was not a feasible design and a before-and-after comparison has been made in each of the case-studies. Where possible comparison groups were studied who were not re-located which strengthens the inferences that can be made from the case-studies.

### **Sample sizes**

Formal sample size estimates were not made as the purpose of the case-studies was to illustrate the changes that occurred in the complete sample of patients studied. This limited the patients available and no extra resources were available to increase the sample size by including more hospitals.

#### **3.4.2. Content of Questionnaires**

The questionnaires used in the in-depth studies are shown in Table 3.2 and their explanation is set out below.

Table 3.2 Questionnaires used in Case Studies								
	TIMING		Collection Method	RESPONDENT	CASE STUDY SITES			
	Before	After			1	2	3	C
PATIENTS								
BRIEF ASSESSMENT SCHEDULE and Quality of Life Questionnaire	✓	✓	Structured personal interview	Patients	✓			✓
CAPE B.R.S.	✓	✓	Structured personal interview	Staff for patients		✓		✓
Patients' Quality of Life	✓	✓	Patients supplemented by staff as appropriate	Patients supplemented by staff as appropriate	✓	✓		
STAFF & CARERS								
General views	✓	✓	Structured personal interview	Staff	✓	✓		-
General Health Questionnaire		✓	Completed by staff after interview	Staff	✓	✓		-
Verification of General Health Questionnaire		✓	Discussion with Occupational Health Dept.	Occupational Health Dept.	✓	✓		-
FRIENDS & RELATIVES		✓	Structured personal interview	Friend / Relative	✓	✓		-
PHYSICAL SURVEY OF FACILITIES	✓		Site Visit	Surveyor's inspection			✓	
'C' is the site for the control group study								

### 3.4.3. Patients' Perceptions Survey

Psychiatric institutions provide care for the full spectrum of mental illnesses ranging from relatively short periods of schizophrenia to those with chronic long term unremitting states. For the purposes of this research, it was necessary to identify a group of patients who would be provided with "Care in the Community" through the provision of purpose-built or adapted accommodation by the NHS.

### Objectives

- (i) To determine what the effects were on patients of relocation in an "accelerated" programme.
- (ii) To seek patients' views as to whether the move to new accommodation had increased or decreased their "quality of life".



## **Control Group**

A group of patients matched, as far as the sample would permit, by age, sex and broad diagnosis, were also administered the Brief Assessment Schedule (BAS) and the life events test or Clifton Assessment Procedures for the Elderly (CAPE), as appropriate, twice with a three month interval. The site chosen was in similarly poor facilities as the Case studies prior to their move. Reprovision had been discussed at the control sites but no move was planned.

## **Selecting the group to be interviewed**

A comparison was made between accommodation provided "in the institution" and that in the reprovision programme, and patients' reactions to this change. All patients in institutional care were considered as potential target respondents.

Criteria used to select patient groups for inclusion were: -

- (i) a substantial proportion of the patient group to be sufficiently free of cognitive impairment, to permit self-reports of quality of life.
- (ii) Groups that would, subject to their physical and mental state, be readily available for interview both before and after reprovision;
- (iii) Groups to whom the NHS staff caring for them could be readily identified.

The patient group best meeting these criteria was the Elderly Mentally ill (EMI). Elderly people in long term care were generally too cognitively impaired to actively participate in an interview and a proxy, in the form of their carers or relatives, would be necessary. To ensure that at least some views were obtained without the proxy filtering or biasing their response, a patient group in one case study was taken from an EMI day hospital allowing the patients to be interviewed directly. Furthermore, EMI patients' are probably most vulnerable to effects of reprovision and potentially might be expected to receive a "worse deal" than younger patients. The other large populations of psychiatric hospitals in the adult groups were also considered. The wider variation in the mental states of these groups would have made the comparisons difficult. Furthermore, these groups use a range of facilities other than the psychiatric institution and could be difficult to trace and contact and were therefore considered inappropriate for this study.

### **3.5 PATIENT ASSESSMENT**

The assessment process had three objectives:

- (i) to assess the presence of severe dementia, and in these patients to assess apathy, communication difficulties, disability and social disturbance before and after the move;
- (ii) to measure the presence of depression before and after the move;
- (iii) to obtain the patients' (or where appropriate their carers') views of their quality of life in regard to their accommodation initially within the institution and subsequently in the reprovided facility.

A standardised interview of mental state, the Brief Assessment Schedule, (McDonald, 1985) was used (see Appendix 3.2). The Clifton Assessment Procedure for the Elderly (see Appendix 3.3.) measuring apathy, communication difficulties, physical disability and social disturbance was used with demented patients, (Pattie & Gilliard, 1978). A "quality of life and accommodation" questionnaire was used specifically to examine issues of personal space, privacy, dignity, use of shared facilities, leisure and personal freedom. This questionnaire, (see Appendix 3.4), was derived from a section of the Team for the Assessment of Psychiatric Services (TAPS) project, (Thornicroft, 1993, Netten, 1989) and from the Multi-phasic Environmental Assessment Procedure Manual (Moos et al, 1984).

#### **Timing of Assessments**

The assessments were intended to be undertaken not more than three months before moving to the new facility, and then followed up not more than three months after the move.

##### **3.5.1 The Brief Assessment Schedule**

The schedule comprises eight items that assess the presence of dementia. A maximum score of eight indicates severe dementia, at which point the interview was discontinued. Those patients scoring less than eight were asked to complete the full interview to assess the presence of depression. Patients were asked to complete the assessment both before and after the move.

#### **Reliability of the Brief Assessment Schedule**

The Brief Assessment Schedule (BAS) is the accepted instrument for the rapid assessment of dementia and depression among the elderly in all forms of residential care (Macdonald et al.,

1982) in the UK and elsewhere. (Spagnoli et al., 1986; Weverer et al., 1988). This schedule contains two scales - the Organic Brain Syndrome and the Depression Scale from the Comprehensive Assessment and Referral Evaluation Schedule (CARE; Gurland et al.1983) together with some essential demographic information. The scales (See Table 3.3.) were validated against psychiatric judgement initially as part of the CARE, and again in subsequent use of the BAS.

<b>Table 3.3 Brief Assessment Schedule Scoring and Scales</b>	
<b>Items of the Organic Brain Syndrome Scale (Score out of 8)</b>	
1	Does not know age (1)
2	Does not know the year of birth (1)
3	Gives incorrect mailing address of the institution (1)
4	Does not recall the name of the interviewer (1)
5	Does not recall the name of the previous and current Prime Minister (1)
6	Does not know the month (1)
7	Does not know the year (1)
8	Hand-ear test (1)
Range: 0 = no cognitive impairment 8 = severe cognitive impairment	
<b>Items of the Depression Scale (Score out of 24)</b>	
1	Admits to worrying (1)
2	Worries about almost everything (1)
3	Sad or depressed mood during the past month (1)
4	Depression lasts longer than a few hours (1)
5	Depression worst in morning (1)
6	Felt life wasn't worth living (1)
7	Has cried or felt like crying (1)
8	Pessimistic or bleak future (2)
9	Suicidal thoughts or attempts (3)
10	Wasn't happy in past month (1)
11	Bothered and depressed by current loneliness (1)
12	Almost nothing enjoyed (1)
13	Less enjoyment in activities than previously (1)
14	Loss of interest / enjoyment because of depression / nervousness (1)
15	Regrets about life or self-blame (1)
16	Episodes of depression lasting over a week prior to past year (1)
17	Reports headaches (1)
18	Poor appetite in the absence of obvious medical cause (1) }
19	Has become slowed down in movements (1)
20	Sleep disorders due to moods (1)
21	Not very happy at all (1)
Range: 0 = no depression 24 = severe depression	

### 3.5.2 Dependency Measures For Patients Exhibiting Severe Dementia.

Patients exhibiting severe dementia would be incapable of meaningfully completing the health perception/depression section of the BAS. A range of dependency measures which could be applied by observation assisted by the patients' carers was considered. Table 3.4 shows the principal UK instruments available.

**Table 3.4 Dependency Measures in Elderly people**

INSTRUMENT	USES					ADMINISTRATION		
	Assessment of Individuals	POPULATION PROFILES			Longitudinal / Change	Informant (e.g. staff, relative)		Elderly Person
		Community	Residential Homes	Hospital	Studies	Postal / Self Completion	Interviewer Administrated	Interviewer Administrated
Crichton Royal Behavioural Rating Scale			*	*	*	*	*	
Clifton Assessment Procedures for the Elderly (CAPE)	*	*	*	*	*	*	*	
Sheffield JUSSR Assessment Schedule			*			*		
Leeds Scale		*						*
Glasgow Scale		*						*
York Guttman Scale		*				*	*	*
Hereford Guttman Scale		*				*		
Townsend Index of Incapacity		*	*				*	*
Clackmann Model of Dependency		*	*				*	*

Source: Wilkins, D. 1989. Users Guide to Dependency Measures in Elderly People. University of Sheffield.

The Clifton Assessment Procedure for the Elderly (CAPE) was chosen from the Dependency Measures listed as best meeting the needs of this research as :-

- (i) it discriminates well between varying levels of dependency but may be less useful in looking at more independent populations;
- (ii) the content of the schedule is clearly orientated towards the sorts of problems characteristic of elderly people suffering from mental illness or infirmity;
- (iii) it is most useful in psychiatric hospital settings and also in social service settings e.g. residential homes;
- (iv) it has been recommended for individual therapeutic assessment as well as for surveys of dependency;
- (v) it has been used as a monitoring instrument to evaluate the effects of therapeutic interventions;

- (vi) it has been recommended for use in screening populations as a means of selection and placement of individuals in appropriate accommodation;
- (vii) it can be used as a survey measure to describe and compare the characteristics of different populations;
- (viii) it has been extensively tested for reliability and validity.

### **Validity and Reliability**

The authors of the CAPE have made more efforts to establish validity and reliability than any of the other measures considered for use. They provide evidence demonstrating that it is capable of discriminating between groups of elderly people receiving different levels of care and support (Pattie and Gilleard, 1979). A number of studies show that the schedule scores discriminate between groups of elderly people with different outcomes. (Pattie and Gilleard, 1978a); between newly admitted residents in homes for the elderly in terms of their level of social adjustment twelve months after admission (Pattie and Gilleard, 1978b); and, together with age, between death and survival amongst groups of elderly mentally infirm people (Gilleard and Pattie, 1979).

### **Scoring and Scaling**

The first schedule for assessing cognitive impairment in CAPE was not used in this survey, its function being replaced by the first schedule of the BAS. All patients interviewed using CAPE had high scores on the BAS cognitive impairment scale.

CAPE comprises 18 items relating to dependency. Two further items covering "eyesight" and "hearing" appear on the form but do not contribute to the scale scores. Mobility, continence and activities of daily living are dealt with in the first four items. The remaining 14 deal with aspects of behaviour of particular relevance to people who are confused. The 18 items are grouped to form four sub-scales, termed "physical disability" (items 1-6), "apathy" (items 7-11), "communication difficulties" (items 12 and 13) and "social disturbance" (items 14-18). Each item has three response categories, coded 0, 1, 2. 0 indicates an absence or low level of problems, 2 indicates frequent or constant problems and 1 accounts for everything between the two extremes.

#### **3.5.3 Patients' Quality Of Life Questionnaire**

The survey of patients' quality of life issues in their accommodation was achieved by an interview of patients following satisfactory completion of the BAS. They were asked about their

personal space, preservation of dignity, shared facilities, opportunities for leisure and personal freedom, see Table 3.5.

This part of the assessment was designed not to tax the patient overly. Eight questions were asked before and ten after the move. Where the patient was incapable of completing the BAS by reason of cognitive impairment, both the CAPE and the Quality of Life Questionnaires were completed by observation and with the assistance of staff.

The interview instrument and a full explanation of the questionnaire is shown at Appendix 3.4

Table 3.5 Summary of Contents of Patient Quality of Life (Supplementary) Questionnaire		
Question	Purpose of Measure	Problems
1	Identifies patient, sites, time in care	N/A
2,3	Environment, personal possessions	Some questions difficult for some patients
4,5,6,7	Day activities, use of facilities	Varies with mobility
8,9	Familiarity and satisfaction	Acts as moderator
10	Is new facility better than old	Some patients preferred familiarity, did not get lost

### Reliability of Patient's Quality of Life Questionnaire

Patient surveys of this type have been used extensively for establishing patient attitudes. The Hospital/Hostel Practices Profile originally used by Wing and Brown (1970), which has been extensively modified over the years, asks many similar questions. These type of questionnaires have also been successfully used on a before and after basis, as in this survey. (Hansson et al., 1985). The Team for the Assessment of Psychiatric Services' (TAPS) study of 1989 (Thorncroft et al, 1990) stated in a survey of results that *"long term psychiatric patients are able to give clear and consistent views about their living arrangements - views that should be sought and respected."*

This "quality of life survey" derives directly from the Patient Attitude Questionnaire (PAQ) used by the TAPS project 9. The TAPS version of the patient quality of life survey has been tested for test-retest reliability and for inter-rater reliability and it appears to perform very well. (Thorncroft, 1993)

### Significant Life Events

Before the post-move interview, the interviewer, using a short check-list (see Table 3.6) ascertained whether or not there had been any occurrences in the patient's life since the first interview, which in themselves might change the person's mental state or general outlook on life, e.g. winning several million pounds on the national lottery might well alter the patient's outlook, as would the death of a partner or close friend in the opposite way).



<b>Table 3.6 Significant Life Events</b>	
1.	Serious health problem, (e.g. surgical operation) of self, close relative, or friend
2.	Serious accident involving as above
3.	Separation or divorce
4.	Bereavement or other loss of relative or close friend (e.g. moving away)
5.	Housing / accommodation problem
6.	Financial change / gain or loss
7.	Crisis e.g. crime or assault on person

The effect of a life event which could influence the patient between the administration of interviews was discussed by Murphy (1980) in her important paper "Social Origins of Depression in Old Age".

### **3.6 STAFF AND CARERS SURVEYS**

The engagement of care staff in the process of structuring a reprovided community service, and in the operational policies and the design of physical reprovion, is important if ownership of, and confidence in, the new service is to be achieved. Closure and reprovion programmes directly threaten staff whose future career development and job security are affected. Their good morale is an essential element in a successful reprovion programme.

#### **Objectives**

The carer/staff interview had the following objectives: -

To establish the extent to which staff were

- 1) aware of the reprovion planning process, and their involvement in the process.
- 2) able to influence outcome, and their views on the new facilities and the operational policies associated with them.
- 3) satisfied and had sufficient morale to cope with the changes.

#### **Selection Criteria**

Staff and carers were defined as those from the NHS, private and voluntary agencies who were responsible for the provision of "hands on" care to patients.

Several problems arose in the selection of individuals for interview. For staff, the period from when it is known that the institution may close, to the knowledge of the plan for reprovion, is often protracted, and staff opposed to change may leave, thus being unavailable for study. Purchaser pressures on revenue costs and uncertainty about the availability of capital for reprovion invariably cause initial plans to change, which may be a further cause of dissatisfaction. Nursing staff and managers in the psychiatric service are able to retire after 20

years service or at 55 years of age with pension. (Health Services Superannuation Branch, 1990). Effectively, many still young but longer serving staff can elect to retire, notwithstanding any plan the management might have devised for their re-employment, nor can they be bound to a decision to stay even if they have accepted retraining in a position in the new structure.

These factors make opinions given by staff before relocation potentially unsafe. Staff interviewed would still be considering their options and may not choose to join the new service, even if a job was offered.

For these reasons, it was decided that the only reliable procedure was to interview staff previously employed at the institution only after they had transferred to the new service. This decision obviously resulted in losses of the views of potentially important staff who decided that their (or their patients) lives would not be enhanced by sharing in the reprovion programme.

### 3.6.1 Staff Perceptions Questionnaire

The questionnaire was designed to follow the chronology of the process of reprovion from first advice to the final operation of the facility.

The questions related to planning follows the user involvement defined by CAPRICODE (DoH, 1978) the Department of Health planning procedure document for Health Service Buildings in force at the time these schemes were planned.

The questions related to building suitability were deliberately simple and did not require specialist technical knowledge, and were designed to identify whether involvement in planning teams gave more ownership of the eventual solution.

<b>Table 3.7 Summary Description of Staff Questionnaire</b>		
<b>Question</b>	<b>Purpose of Measure</b>	<b>Problem</b>
1,2,3	Identifies staff and grade, length of service	N/A
4,5,6,7,8 9,10	Advice to staff of proposed closure (morale)	Did not correlate to GHQ questions as expected.
11,12, 13,14, 15, 16, 17	Staff involvement with planning of new facilities (ownership)	Some staff involved moved elsewhere
18,19,20,21	Approval of solution by staff (user involvement)	---
22,23,24,25,26	Training requirements (unmet needs)	Not possible to cross-check with senior staff
27,28,29	Commissioning (efficiency of implementation)	Few staff directly involved
30,31,32,33,34	Environment (acceptability of solution)	---

The questionnaire and a full explanation of the questions is given at Appendix 3.5.



### 3.6.2 The General Health Questionnaire

The second objective to establish levels of general satisfaction and morale amongst staff was undertaken by completion of the General Health Questionnaire (GHQ, see Appendix 3.6, Goldberg 1972). The GHQ is a widely used questionnaire that aims to measure mood, and consequently may have some value in determining morale. It uses a four point Lickert scale for each of the items. Staff/carers were administered the GHQ by the interviewer.

#### Reliability of the General Health Questionnaire

The GHQ is available in several forms, 60, 30, 28 and 12 items. The short form of 30 items was chosen as it performs as well as the larger form, but appeared to have better internal consistency than the 12 item version.

<b>Table 3.8 Reliability of the GHQ</b>			
GHQ	Test Retest		Split half
	Patients	Doctors	
60 ITEMS	0.76	0.51	0.95
30 ITEMS	0.77	0.53	0.92
12 ITEMS	0.73	0.52	0.83
Goldberg 1972 Detection of Psychiatric illnesses by Questionnaire			

The questions in the GHQ deal with the individuals' perception of their mental state e.g. concentration, sleep, contribution, stress, confidence, depression, motivation: satisfaction, mobility, apathy, coping, communication and optimism.

Further information was sought from Occupational Health Records in each of the Case studies (which was only available in general terms and subject to data protection regulations) to determine whether sickness absence was a problem. The opinion of the District Psychologist / Occupational Health Department on the GHQ data gathered (in anonymous form) was also sought.

### 3.7 FRIENDS' AND RELATIVES' PERCEPTIONS

Friends' and relatives' views of whether the community reprovision of services was a success are important. In assessing the quality of life for the patient, anxieties transmitted to the patient by those nearest to them, directly affect their day to day living. Laming, (1993) in "Residential Care of the Elderly Mentally Ill", stresses the importance of involving relatives and friends including involving them in changes in policy and procedure. The friends' and relatives' concerns about relocation may be mixed with feelings of conscience that, despite many years of

providing care themselves, they eventually surrendered their loved ones to long term institutional care.

### Selection Criteria

The principal criterion was that there was evidence that the friend or relative had visited the patient within the last six months of their stay in the institution on more than two occasions, and had also visited in the new facility. The advice of the nurse managers for the facility was sought as to the frequency of visiting and the suitability for questioning of the visitor.

Obtaining reliable and useful information from friends and relatives is difficult.

Kellaher, L (1993) sets out the problem where views of residents, staff and relatives were taken into a review of residential homes. The difficulty of reconciling idiosyncratic individual views and preferences with the collective view were exposed. The system adopted was to permit the nurse/managers to "filter" relatives' views by first "educating" them through quality groups.

Since such an approach is of questionable validity, and was beyond the resources of this study, the questionnaire, see Table 3.9, was kept both short and simple and, as far as possible, non-emotive.

Table 3.9 Summary Description of Friend and Relative Questionnaire		
Question	Questionnaire	Problems
Pre	Identifies relationship to patient	
1 - 4	Compares quality of new facilities with old	
5 - 7	How friends and relatives were consulted on the move	Limited by friends and relatives understanding
8 - 10	Ease of visiting	"Conscience" factor may be involved
11 - 13	Friends and relatives' opinions of patient's feelings about the move	Difficult for friends and relatives of demented patients
14	Friends and relatives' comments	

No attempt was made to ask about frequency of visiting as this might be seen as a personal test, it might cause a crisis of conscience, and it would probably overstate the true level of visiting.

Consideration was given to making enquiries both before and after the move. The anxieties in friends and relatives caused by a pre-move questionnaire were seen as both potentially unreasonable in personal terms and not liable to yield objective responses. These views were only sought after the move.

A copy of the Friend and Relatives questionnaire is shown at Appendix 3.7.

### 3.8 PHYSICAL SURVEY OF FACILITIES

An assessment of the physical facilities was considered to be an essential component of testing the hypothesis of the quality of rapid reprovion programmes. A comparison was made between physical facilities in the old and new environments using NHS Health Building Notes (Health Building Note 35: Accommodation for People with Acute Mental Illness and Health Building Note 37: Hospital Accommodation for Elderly People) and environmental standards (see Table 3.10).

The data used to measure standards in each facility were collected through four questionnaires, each specific to the facility type.

Table 3.10 Summary Description of Physical Survey Questionnaires				
EMI		Adult Acute		Data sought
Inpatient	Day Hospital	Inpatient	Day Hospital	HBN Questions
√	√	√	√	Sanitary facilities - ratio to patients, location and size
√	√		√	Sitting / Dining / Therapy / Consulting Nº. adjacency
√		√		Bedrooms - size / occupancy / separation
√	√	√	√	Day facilities - size, quiet areas
		√		Secure areas - safety features
√	√		√	External areas access and use
Quality of the Environment				
√	√	√	√	Lighting, views, furnishings, decor, colours, heating levels

The survey questionnaires are shown in Appendices 3.8. a.b.c.d.

A decision therefore was made to examine **all** the facilities in reprovion programmes to determine the overall quality of the physical environments. A further issue was the use of "interim solutions" (see below) which were also included in the survey.

#### Built Environment

In each of the case studies data was collected on the built environment of other schemes in the same reprovion programme. This was undertaken to establish a measure of the overall programme quality. This process was necessary to ascertain whether the EMI scheme associated with the patients/staff/relative survey was either of an excessively good or excessively bad standard against those standards achieved in the overall programme.

#### Interim Solutions

At the early planning stages the length of a closure programme is often dictated by the time required to acquire or construct the largest of the capital replacement schemes. Later in the programme schemes may run into town planning or funding difficulties not foreseen. The role of

charitable bodies, local authorities and housing associations has increased. These "third parties" bring a range of new opportunities into the management of closure programmes. They do not however become responsible for the heavy costs of delay that the NHS must bear in the reprovision programmes if their third party schemes become delayed. A prudently planned programme may include interim schemes to deal with daily problems and permit closure to be brought forward.

### **3.9 VERIFICATION OF DATA IN THE IN-DEPTH CASE STUDIES**

Only limited verification checks could be made of the data collected in the case studies. Internal cross checks were made and any extreme or unlikely values were reviewed. Staff GHQ responses were reviewed by the local occupational health service, to determine whether any staff with high levels of distress had sought help.

### **3.10 DATA MANAGEMENT**

The macro and micro survey questionnaires were developed using a specialised questionnaire design and data management software set.

The computer software package used for the data and information processing of the questionnaires was Snap Professional™ for Windows™. This was one of the first practical applications of this software in Windows™ in the UK, and the suppliers gave considerable assistance to the installation and the software training and entry of the first year questionnaire. This package also provided the means of analysis for the data collected. The "SNAP" allows all results to be expressed in a range of formats and can provide simple descriptive statistics. The package is able to produce high quality printed reports in the form of tables and charts, which were then imported into the word-processing package for speed and accuracy.

"SNAP" also allows a verification by the user re-entering data. The system automatically notifies the user of any differences and data can be amended as appropriate. The level of data verification is optional i.e. 10%, 100% or selected cases only as desired. For these studies all complex data was checked.

### **3.11 SAMPLE SIZE ESTIMATES**

Sample size requirements for estimating the precision of rates or proportions (e.g. percent of hospitals closed quickly), and for comparisons between different hospitals assume that a sample can be selected from an infinitely large population. In practice this is often not the case, and in

the National Survey, **all** hospitals were included in the sample. Formal sample size estimation was not applied as it would have had little value. The appropriate statistical test has been applied to determine whether observed differences were likely to be due to the play of chance.

Previous experience using non-participant observation, satisfaction and quality of life scales making comparisons both before and after re-settlement have indicated that as few as 50 patients are sufficient to provide statistically acceptable sample sizes (Harwood, 1992). In practice these numbers were difficult to achieve in a single service. However all available patients, relatives and staff were included in the surveys.

## **CHAPTER 4**

### **RESULTS - THE NATIONAL (ENGLAND) STUDY**

<b>4.0</b>	<b>Introduction</b>	<b>105</b>
<b>4.1</b>	<b>Description of Population</b>	<b>105</b>
<b>4.1.1</b>	<b>Response Rate</b>	<b>105</b>
<b>4.2</b>	<b>Who completed the Questionnaire?</b>	<b>105</b>
<b>4.3</b>	<b>Hospital Reprovision Programmes</b>	<b>106</b>
<b>4.4</b>	<b>Geographical Variations in Progress</b>	<b>109</b>
<b>4.5</b>	<b>Purchaser/Provider Arrangements</b>	<b>112</b>
<b>4.6</b>	<b>Management Structures and Progress</b>	<b>112</b>
<b>4.7</b>	<b>Hospital Populations and Bedspaces in Use</b>	<b>114</b>
<b>4.8</b>	<b>Case Mixes of Hospital Populations</b>	<b>115</b>
<b>4.9</b>	<b>Associated Hospitals</b>	<b>120</b>
<b>4.10</b>	<b>Duration of Reprovision Programmes</b>	<b>121</b>
<b>4.11</b>	<b>Problems with Reprovision</b>	<b>124</b>
<b>4.12</b>	<b>Non-exchequer Funding</b>	<b>126</b>
<b>4.13</b>	<b>Estates Data</b>	<b>128</b>
<b>4.14</b>	<b>Retrenchment Efficiency</b>	<b>129</b>
<b>4.15</b>	<b>Quality of Institutional Facilities</b>	<b>130</b>
<b>4.16</b>	<b>Changes in the Scale of Reprovision Programmes</b>	<b>130</b>
<b>4.17</b>	<b>Numerical Differences in Reprovided Services</b>	<b>132</b>
<b>4.18</b>	<b>Staff Transferring to Community-based Facilities</b>	<b>132</b>
<b>4.19</b>	<b>Projected Completion of the Community Mental Health Reprovision Programmes in England</b>	<b>134</b>

## 4.0 INTRODUCTION

Information presented in this chapter was collected using the questionnaires described in Chapter 3. The 1994 questionnaire was modified to collect more data about community reprovion programmes. The 1995 survey utilised a redated 1994 questionnaire which was issued to the responding hospitals together with their 1994 data. It provided space for the 1995 data to be entered alongside the 1994 data, with instruction to amend as necessary.

## 4.1 DESCRIPTION OF POPULATION

At the commencement of the survey in 1993 there were 82 psychiatric institutions in the UK whose intention was to remain open for at least a year. Most of the hospitals had been built between 1811 and 1914 as a result of the County Asylums Act and other legislation (see Appendix 4.1, for a list of hospitals in this survey). They either were not intending to formulate plans for closure, were intending to close but had not yet formulated plans, or were in the process of reprovioning their services in the community. Hospitals that had already completed this evolution and remained open as part of a community-based service are not included in this survey.

### 4.1.1 Response Rate

The response rate to the questionnaires sent to all "open" hospitals was 71% in 1993, 63% in 1994 and 61% in 1995. (See Table 4.1.). Over the three year period of the survey 12 hospitals did not respond to any questionnaire, 20 responded in only one year (of which ten were in their final year before closure), 19 responded for two years, and 24 responded to all three questionnaires. In practice it was possible to get information on the closure status of all 82 hospitals identified by telephone contact.

Table 4.1. Summary of questionnaire returns over 3 years of study			
	1993	1994	1995
No of Responses	58	45	36
Total No Open	82	72	59
% Response	71	63	61

## 4.2 WHO COMPLETED THE QUESTIONNAIRE ?

To ensure the best possible quality of response throughout the survey it was sought to have the questionnaire completed by staff who were both senior and informed about the reprovion process for their hospital. If respondents were still in post they were targeted as the best informant for following years. Table 4.2. shows that this objective was largely met.

<b>Table 4.2 Respondents completing the questionnaire</b>			
<b>Professions of those completing questionnaire</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>
Associate/General Manager	9	9	10
Administration Manager	7	5	1
Director of Clinical Services	2	2	2
Business Development Manager	10	8	4
Chief / Deputy Chief Executive	5	2	1
Director of Mental Health Services	8	3	0
Operations Director	4	2	1
Director of Nursing Services	1	4	2
Senior Nurse Manager	3	3	2
Other	9	7	11
Total hospitals	58	45	36

Other professionals who completed the questionnaires included a project manager, an information officer, a contracts manager, project managers (mental health), performance management officers (mental health), project support managers and patient services managers.

### 4.3 HOSPITAL REPROVISION PROGRAMMES

<b>Table 4.3 Progress with reprovion by category</b>			
<b>Hospital Category</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>
<b>A - No plans</b>	31	25	24
<b>B - Plan commenced</b>	20	15	6
<b>C - Advanced plan</b>	21	19	19
<b>D - Closure within 1 year</b>	10	13	10
<b>Closed</b>	0	10	23
<b>Total</b>	82	82	82

As described in Chapter 3 hospitals were categorised into four groups A, B, C and D dependent upon their progress with reprovion and reduction of their patient population. As further years' data were received the categories were then reviewed to take account of delayed or accelerated programmes. (See Table 4.3). The categories were:-

Category A - No plan to close

Category B - A funded plan but not yet implemented

Category C - A funded plan and its population reduced to 50% of its Category A position

Category D - Plan largely implemented anticipating closure in the next year

The hospital categories are described in more detail in Chapter 3.

The total number of hospitals open in 1993 at the beginning of the research, was 82. At the end of 1994 there had been ten closures giving a total of 72 hospitals still open at the beginning of 1995. There were a further 13 closures by the end of 1995, leaving 59 hospitals open at the beginning of 1996.



It should be noted that in addition to the hospitals remaining open in their original institutional configuration, there were also others still open. However, these were for residual use of the institutional site in new or refurbished schemes, which functioned as part of a community-based service. The principal functions retained on former institution sites were acute units and secure units. (Sainsbury, 1996).

Table 4.4 shows the distribution of the 82 hospitals by category in 1993, as compared to the distribution in 1995.

<b>Table 4.4 Changes in category from 1993 - 1995</b>						
<b>1993 CATEGORIES</b>	<b>1995 CATEGORIES</b>					<b>TOTAL 1993</b>
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>CLOSED</b>	
<b>A</b>	23	3	5	-	-	<b>31</b>
<b>B</b>	1	3	11	4	1	<b>20</b>
<b>C</b>	-	-	3	6	12	<b>21</b>
<b>D</b>	-	-	-	-	10	<b>10</b>
<b>TOTAL 1995</b>	<b>24</b>	<b>6</b>	<b>19</b>	<b>10</b>	<b>23</b>	<b>82</b>

### **Category A Hospitals**

Category A hospitals (those without agreed closure programmes) moved from 31 in 1993 to 25 in 1994 and 24 in 1995. (On review in subsequent years some hospitals' projections had not been achieved, and they had to be recategorised). Progress was made by eight hospitals and in 1995 three had progressed to Category B and five to Category C.

### **Category B Hospitals**

These showed the greatest change over the survey. (A category B hospital is one which, within the year of the survey, had agreed a funded closure programme with the Regional Office and had moved into the implementation stage). In practice, the key schemes are agreed, being those where significant capital funding is required but those schemes which involve charitable or other sources of funding appear not to be so clearly defined. In the first year of implementation, after funding is made available, hospitals that are progressing their plans, resettle significant numbers of patients. There were 20 category B hospitals in 1993, reducing to 15 in 1994 and six in 1995. In 1994 ten of the 20 Category B hospitals progressed to Category C which required them to bring about a substantial reduction (50%) in their hospital population.

Notwithstanding the rapid move of many of the hospitals through the B category, there was a group of nine B hospitals in 1994 and four B hospitals in 1995 which had remained in that category for two years. Three B hospitals of the original 1993 group, (see Table 4.4) remained in that category for all three years of the survey indicating that the certainty of funding is not necessarily the principal problem in these programmes' failure to get underway. Eleven

hospitals when given funding made no movement in two years, and three had no change in population for three years. Undoubtedly some of these hospitals could not be assisted by local authorities or charities and had particular difficulties in implementation issues. However, this is unlikely to have been the case in all of them, and perhaps indicates a lack of ability to master the planning process on the part of some hospitals.

Five of the six hospitals which had moved from A to B in 1994 moved on to Category C in 1995 (i.e. a reduction inpatient population of 50+ %, but not yet closed) whilst the one other hospital remained in Category B in 1995. One hospital which had been Category B in 1993 and 1994 regressed to Category A in 1995. One category B hospital in 1993, as a result of an accelerated programme, moved to D in 1994 and closed in 1995.

### **Category C Hospitals**

Category C hospitals are those that had reduced their populations by 50% from when they were an A category, but were not yet in the last year of closure (i.e. in Category D). The number of category C hospitals in the years of the survey remained largely unchanged throughout i.e. 21 in 1993, 19 in 1994 and 19 in 1995. In 1994 there were ten Category C hospitals which had been Category B in 1993 but only four of them moved on to become Category D in 1995. The six hospitals whose closure programmes did not move on in 1995 all remained in Category C.

There were nine hospitals which had remained in Category C for two years in the 1994 survey, and nine which had remained in this category for two years in the 1995 survey. There were a further three hospitals which remained in Category C for all three years.

After securing funding to move from Category A to B, the C Category part of the programme is often outside the control of the hospital and it represents the highest risks both in financial and programme management terms. Whilst it is within the experience and the capability of Mental Health Trusts to implement the smaller community schemes, the larger schemes pose real problems and, as is shown later, they are often the cause for delay. Another cause for delay is where several Trusts have to interact in a capital scheme. This particularly relates to secure units which may serve an area larger than that of a single Trust's population. Secure units pose particular town planning problems and are not a welcome neighbour. In many instances they have been rebuilt on the original institution site. (Sainsbury 1996).

## Category D hospitals

These, by definition, are hospitals in their last year of closure. As shown later, their remaining populations are determined by, and relate directly to, specific outstanding capital schemes. The survey started with 82 hospitals open in an institutional configuration. Ten of these were Category D, i.e. they predicted closure in 1994 and all succeeded. In 1994, a further 15 predicted closure, but only 13 succeeded. 12 Category C hospitals in 1993 had moved to Category D in 1994 and they all closed in 1995. By the end of the survey in December 1995, a total of 23 had closed.

## Future Closure Plans

Future closure plans for the remaining open hospitals as given in 1995 are shown in Table 4.5. These are the dates given by the hospitals as their intended dates of closure. This is unlikely to be the actual pattern of closure (see Table 4.28).

Table 4.5 Hospitals' planned closure dates @ 1995							
Year	1995	1996	1997	1998	1999	2000	No plans to close
N° of Hospitals	13	10	13	7	4	1	24

## 4.4 GEOGRAPHICAL VARIATIONS IN PROGRESS

Tables 4.6a - d set out the progress of reprovision programmes by National Health Service Management Executive (NHSME) region. As an inter-regional comparator, the average regional population per remaining hospital was calculated and compared with the national average. As might be expected with a reduction in the number of hospitals through closure, the national average population per remaining institution rose from 592,000 in 1993 to 676,000 in 1994 and then to 829,000 in 1995. It was then projected to 1,040,000 in 1996.

Regions doing well with their closure programmes would therefore have a high population per remaining institution index and they would be **above** the national average.

Table 4.6.a 1993 - Hospital Categories by Region									
NHSME Region	Hospital categories				TOTAL Hospitals Open	Population x 1000	Population x 1000 per Remaining Institutions	+/- National Average = 592	
	A	B	C	D					%
Anglia & Oxford	6	0	2	0	8	5228	654	62	10.4
North Thames	5	3	3	0	11	6793	618	26	4.5
North West	2	3	1	0	6	6617	1103	511	86.3
North & Yorks	4	7	2	0	13	6638	511	-81	(13.7)
South Thames	7	3	3	5	18	6716	373	-219	(34.0)
South & West	4	1	3	1	9	6487	721	129	21.8
Trent	1	2	3	1	7	4766	681	89	15.0
West Midlands	2	1	4	3	10	5290	529	-63	(10.5)
Total	31	20	21	10	82	48535			

Table 4.6b 1994 - Hospital Categories by Region										
NHSME Region	Hospital categories					TOTAL Hospitals Open	Population x 1000	Population x 1000 per Remaining Institutions	+/- National Average = 676	
	A	B	C	D	Closed					%
Anglia & Oxford	6	0	1	1	0	8	5262	658	-18	(2.7)
North Thames	3	3	4	1	0	11	6814	619	-57	(8.4)
North West	1	2	3	0	0	6	6616	1103	427	(63.2)
North & Yorks	3	4	3	3	0	13	6647	511	-165	(24.4)
South Thames	5	4	2	2	5	13	6746	519	-157	(23.2)
South & West	4	0	3	1	1	8	6529	816	140	(20.7)
Trent	1	2	2	1	1	6	4781	797	121	17.9
West Midlands	2	0	1	4	3	7	5295	756	80	11.8
Total	25	15	19	13	10	72	48690			

Table 4.6c 1995 - Hospital Categories by Region											
NHSME Region	Hospital categories						TOTAL Hospitals Open	Population x 1000	000s Population per Remaining Institutions	+/- National Average = 829	
	A	B	C	D	Closed						%
					1994	1995					
Anglia & Oxford	5	1	1	0	0	1	7	5315	759	-70	(8.4)
North Thames	3	0	5	2	0	1	10	6872	687	-142	(17.1)
North West	0	1	4	1	0	0	6	6614	1102	273	32.9
North & Yorks	4	2	2	2	0	3	10	6649	665	-164	(19.8)
South Thames	5	2	2	2	5	2	11	6781	616	-213	(25.7)
South & West	4	0	2	1	1	1	7	6569	938	109	13.1
Trent	1	0	2	2	1	1	5	4796	959	130	16.9
West Midlands	2	0	1	0	3	4	3	5306	1769	940	113.4
Total	24	6	19	10	10	13	59	48902			

These figures look at those hospitals remaining open in each year and do not take into account previous closure programmes. South Thames, for example, had already closed several institutions, but it remained well below the national average.

Policies have varied between RHAs, producing different consequences. North Thames for example, specifically targeted resources at a limited number of hospitals, with more limited

consequences. In 1993, it was 5% above the national average, but by 1995 it was 17% below. West Midlands, on the other hand, adopted a broad front approach which has produced one of the most advanced reprovision programmes and the greatest change over the period. It moved from 10.5% below the national average in 1993 to 113% above in 1995, well ahead of the other regions.

The North West region, with only six hospitals in 1993 (the lowest of all regions), was a clear leader in that year but it moved into second place in 1995. Only one of its six hospitals progressed to Category D by 1996. Third place in 1995 went to Trent, which closed two hospitals and ended up at 17% above the national average.

Of the Regions with the most institutions open in 1993 (South Thames 18, North & Yorks 13, North Thames 11), South Thames made the most progress by closing seven during the period. North & Yorks closed three whilst North Thames only succeeded in closing one.

<b>Table 4.6d 1996 Projected Hospital Closures by Region</b>						
<b>NHSME Region</b>	<b>Predicted Closed</b>	<b>Open</b>	<b>Population x 1000</b>	<b>Population x 1000 per Remaining Institutions</b>	<b>+/- National Average = 1040</b>	
						<b>%</b>
Anglia & Oxford	0	7	5315	759	-281	(27.0)
North Thames	2	8	6872	859	-181	(17.4)
North West	1	5	6614	1323	283	27.2
North & Yorks	2	8	6649	831	-209	(20.1)
South Thames	2	9	6781	753	-287	(27.6)
South & West	1	6	6569	1095	55	5.3
Trent	2	3	4796	1599	559	53.8
West Midlands	0	3	5306	1769	729	70.1
<b>Total</b>	<b>10</b>	<b>47</b>	<b>48902</b>			
* Assumes no change in population 1995 / 1996				Ref: OPCS. 1995		

Table 4.6d. shows those closures predicted for 1996. West Midlands remained the lead region, although it predicted no closures in year. Trent predicted closing two hospitals which would move it to second place and North West predicted closing one hospital which would move it to third place. East Anglia and Oxford predicted no closures but South Thames notwithstanding the closure of two hospitals, would remain at the bottom of the league with nine hospitals still open (against a national average of just under six).

It might be thought that community-based mental health care is being introduced at an equal rate throughout England. However, there are wide variations across regions, both in the number of hospitals remaining open and in the number of those with no agreed plans to close.

## 4.5 PURCHASER / PROVIDER ARRANGEMENTS

The institutions traditionally served populations over large geographical areas, whose needs are now managed by a number of District Health Authority (DHA) purchasers. The numbers of purchasers against those hospitals categorised into A, B, C and D are shown in Table 4.7.

<b>Table 4.7 Number of Hospital Purchasers per Hospital Category per Year of Study</b>												
N° of Purchasers	Hospital Categories											
	A			B			C			D		
	1993	1994	1995	1993	1994	1995	1993	1994	1995	1993	1994	1995
1	7	5	5	1	3	1	3	4	4	2	3	1
2	7	4	3	4	1		2	1	1	2	3	
3	4	4	2	5	1	2	4	5	1	1		3
4+	2		5	5	1		4	3	4	2		1

The maximum number of purchasers was eight in one instance, and the minimum of a single purchaser was found in 13 instances.

DHA purchasers often have varying approaches to the patterns of reprovision they require. As an extreme example, this can vary from a requirement for traditional acute inpatient hospital facilities to the same service being provided in the patient's home. Where the hospital has multiple purchaser arrangements, the formulation of a closure programme and its implementation could therefore be seen to be more complex, with plans taking longer to formulate. Hospitals were required to include purchasers' intentions in their plans and obtain agreement annually from purchasers as they implement those plans.

Purchaser organisations were themselves engaged in merger discussions, both with other purchasers and with FHSAs, over the period of the survey. The implementation date for effecting such mergers was not until April 1996, although shadow management structures were in place before that time.

Larger numbers of purchasers undoubtedly increase the number of individual reprovision programme plans to be agreed by provider hospitals, and this might be thought to be delaying the planning and implementation process. However, there was no evidence to support this and even the hospital coping with eight purchasers had advanced programmes.

## 4.6 MANAGEMENT STRUCTURES AND PROGRESS

Part of the NHS reforms in the National Health Service and Community Care Act (HMSO, 1990) 1990, included the introduction of "Trust Hospitals" permitting local management structures to be developed and more direct management of budgets and less central control. In theory there should be a correlation between the advancement of the closure programme and the

achievement of Trust status. Trust status was granted to hospitals in waves. The 1st wave had been operating for over 4 years at the end of this study and the 4th wave were operationally independent from April 1994. It might reasonably be expected that earlier Trusts would be more advanced in their closure programmes than later Trusts. The annual business planning regime imposed on Trusts itself is a rigorous planning discipline which might be expected to lead to better planning of closure programmes.

In the first and second wave Trust applications, approval was only given to hospitals with firm future plans incorporated in a "strategic direction" (a three year plan) to be agreed with both purchasers and Regional Office. In the third and fourth wave standards reduced and Trust status was often granted without an agreed closure programme being in place. There are, of course, many other factors which affect the stage an institution might be in implementing its closure, not least the past Regional Health Authority targeting and financial policies.

**Figure 4.1.**

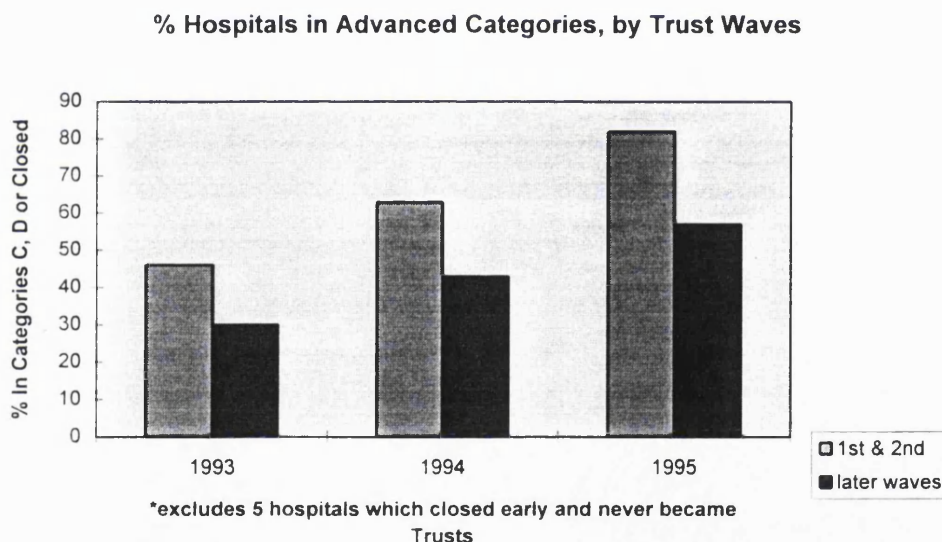


Figure 4.1. shows that in 1993 45% of the first and second wave Trusts had advanced programmes or had closed, compared with 30% of the later waves. Both groups of hospitals increased their proportion of advanced programmes over time, and the gradient was slightly greater for first and second wave Trusts. By 1995, the respective figures were 80% for first and second wave Trusts, and 54% for later waves, and this difference was statistically significant ( $X^2 = 4.08$ ,  $df=1$ ,  $p=0.043$ ).

This data indicates that the performance of those hospitals with earlier Trust Wave status (1st & 2nd) was better than those in later waves or without Trust status (3rd, 4th & 5th).

#### 4.7 HOSPITAL POPULATION AND BED SPACES IN USE

<b>Table 4.8. Beds in Use, Occupancy &amp; Vacancy Levels</b>		
	<b>1994</b>	<b>1995</b>
<b>Available</b>	8439	7148
<b>Occupied</b>	7668	6468
<b>Vacancies</b>	771	680
<b>% occupied</b>	91	90
<b>% vacant</b>	9	10
<b>% response</b>	50	53

As shown in Table 4.8, a comparison of beds occupied and available was made based on a 50% sample response in 1994, and in 1995. The percentage occupancy was 90% in 1994 and in 1995. This correlates closely with the findings in the Sainsbury study (Sainsbury, 1996) which gave a mean of 93%.

The above findings conflict with the reported pressure being placed on beds for the mentally ill. In part this has been attributed to reduced bed numbers and inappropriate placements caused by fragmented introduction of services. However the above figures suggest that higher levels of occupancy could be achieved. Whether the reported bed vacancy of around 10% is useable, however, depends on whether the patients requiring hospital care can be appropriately accommodated in those vacant beds.

<b>Table 4.9. Size of hospitals still in use by year</b>						
<b>N° of beds</b>	<b>1993</b>		<b>1994</b>		<b>1995</b>	
	<b>Hospitals</b>	<b>%</b>	<b>Hospitals</b>	<b>%</b>	<b>Hospitals</b>	<b>%</b>
<b>&lt;200</b>	18	32	14	39	13	42
<b>200 - 399</b>	28	50	17	47	15	48
<b>400+ -</b>	10	18	5	14	3	10
<b>No. reporting</b>	56	68	36	50	31	53
<b>Total still open</b>	82		72		59	

Table 4.9 identifies all hospitals open by the total number of beds in use. It indicates that 42% had less than 200 beds in 1995, at which point hospitals would be occupied to 25%, or in some cases considerably less, than their design size of about 800-1000 beds. This is an uneconomic configuration and gives rise to an increasing cost pressure on hospital budgets and reduces funds available for community care. The trend from 1993 to 1995 shows that closure programmes caused the proportion of hospitals with smaller populations to increase thereby exacerbating the problems.



<b>Table 4.10. Category of Closure Programme by hospital size in 1995</b>					
	<b>&lt;200</b>	<b>200 - 399</b>	<b>400+</b>	<b>Not reported</b>	<b>Total</b>
<b>A</b>	5	8	1	10	24
<b>B</b>	0	2	0	4	6
<b>C</b>	4	4	1	10	19
<b>D</b>	3	1	1	5	10
<b>Closed</b>	-	-	-		23
<b>23* - not reported as they had closed</b>					

An analysis of the hospitals bed size by closure category is shown at Table 4.10.

Hospitals with less than 200 beds in categories B and C would be indicative of those with a substantial proportion of their capital programmes still to implement. They would, notwithstanding the lack of reprovision, discharge patients (as widely surmised in the press) or would operate restrictive admission criteria. Such hospitals operating in areas where social services were slow to assess patients for placement might find that the only way to avoid the problem was not to admit some patients to start with.

Category B and C hospitals still have some years before closure and those that remained in those categories with small bed numbers (i.e. under 200) would absorb disproportionately high costs. Fortunately, no hospitals remained in Category B with fewer than 200 available beds. However, in 1995, there were four Category C hospitals with less than 200 beds. These hospitals would have to spend at least two years with less than 200 available beds.

The Category A hospitals' average population remained largely constant, approximately 200 patients, over three years although there were changes in their case mix as shown later. This indicates some patients were resettled and replaced with patients with more complex diagnoses.

In 1995, five of the 24 hospitals in Category A had populations of less than 200. These hospitals were apparently in a backwater. On examination, all of these hospitals had principally elderly populations, in three cases exclusively elderly populations. Three were also in comparatively isolated locations. One was a large and infamous institution which had failed to make any progress over several years and was in the process of being transferred into the management of another group of hospitals.

#### **4.8 CASE MIXES OF HOSPITAL POPULATIONS**

Reporting hospitals were asked to describe their patient populations in terms of case-mix: acute mentally ill (acute MI), elderly mentally ill (EMI), and long stay excluding the elderly mentally ill (LS, NON EMI). Table 4.11. shows the distribution of patients reported by year of survey.

<b>Table 4.11. Case mixes of the patient population of hospitals 1993, 1994, 1995</b>									
	<b>1993 Number</b>	<b>Average Population per open hospital</b>	<b>%</b>	<b>1994 Number</b>	<b>Average Population per open hospital</b>	<b>%</b>	<b>1995 Number</b>	<b>Average Population per open hospital</b>	<b>%</b>
<b>Acute MI</b>	3474	64	28	2254	56	28	1608	49	25
<b>All EMI</b>	5942	110	47	4355	109	54	3571	108	56
<b>LS NON EMI</b>	3119	58	25	1452	36	18	1211	37	19
<b>TOTALS</b>	12535	232	100	8061	202	100	6390	194	100

The acute mentally ill population showed a minimal change as a proportion of the total population. Between 1993 and 1995 the EMI category increased from 47% to 56% of the total population and the long-stay non EMI fell from 25% of the population in 1993 to 19% in 1995. These changes are statistically highly significant. ( $\chi^2 = 219.4$ ,  $p < 0.00001$ ); standard normal deviate for difference in EMI = 13.8,  $p < 0.0001$ .

<b>Table 4.12. Case mixes of the patient population of hospitals 1994 &amp; 1995</b>				
	<b>1994</b>		<b>1995</b>	
	<b>Total Population</b>	<b>%</b>	<b>Total Population</b>	<b>%</b>
<b>Acute MI</b>	2254	28	1608	25
<b>EMI Assessment</b>	1049	13	966	15
<b>EMI Cont. Care</b>	2110	26	1756	28
<b>LTEMI Rehab/Assess</b>	1196	15	849	13
<b>LTMI non EMI</b>	1452	18	1211	19
<b>TOTALS</b>	8061	100	6390	100

A more detailed examination of types of patients using hospitals was available in the 1994 and 1995 surveys and is shown in Table 4.12. The proportion of the various categories of elderly mentally ill patients did not show any major changes between 1994 and 1995. However, acutely mentally ill patients did fall slightly, from 28% to 25%. This difference was statistically significant (standard normal deviate,  $z = 3.75$ ,  $p < 0.00022$ ).

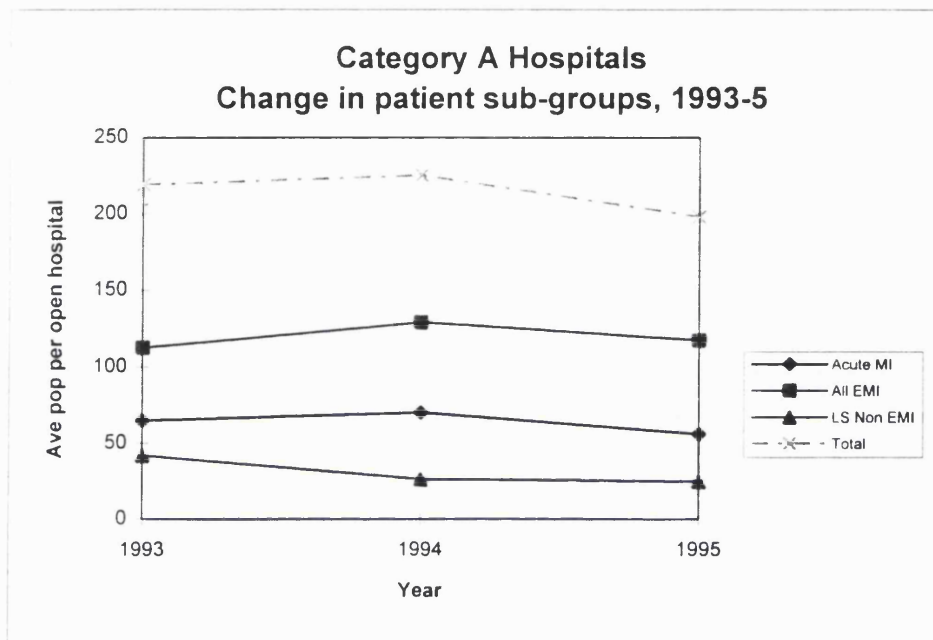
Tables 4.11. shows that, between 1993 and 1995, against a background of a declining population of mentally ill being treated in institutions, the largest relative change was in the Long Stay non-EMI which reduced in proportion by 6%. The proportion of Acute MI fell slightly (3%) and Elderly Mentally Ill increased (9%), but with no change in the proportions of EMI sub-categories.

These trends could be explained in that those first to move into the community are the "easy to place" whose requirements are for small or relatively simple reprovion. (e.g. group homes) possibly provided by non-NHS agencies, charities and housing associations. The patient group suitable for these would be the Long Stay non-EMI and a few of the Acute MI.

The increase in the EMI as a proportion of patients in a declining population indicates that services for EMI rehabilitation and assessment remain a core NHS function which cannot be

replicated in the community. The EMI continuing care patients remain with the NHS as they are either highly dependent or medically fragile.

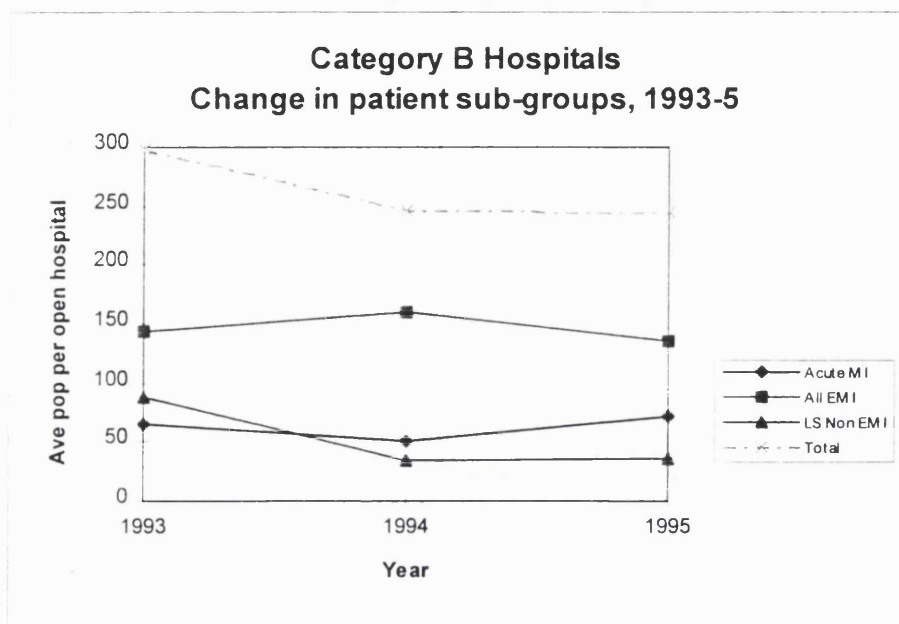
**Figure 4.2.**



For hospitals without closure programmes (Category A, see Figure 4.2.) there was a change in hospital populations closely following the national pattern for all hospital categories (see Table 4.11). This indicates that even hospitals which were not closing were acquiring more complex case mixes within their populations and were therefore more expensive to run.

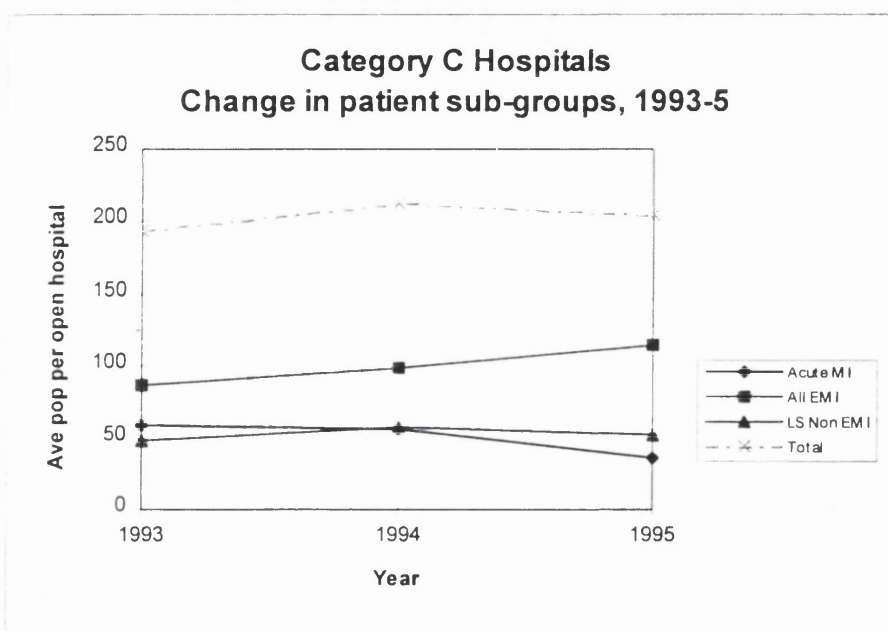
A group of five hospitals with no plans to close had predominantly elderly populations. Where no private sector competition exists (perhaps due to geographical isolation or limited catchment area), these hospitals could have a viable future, particularly if they gain support from GP fundholders or they contract with an acute hospital to take their "bed blocking" elderly. There were 24 Category A hospitals still open in 1995 and, subject to the configuration of their sites, this could be their future role.

Figure 4.3.



In hospitals with funding allocated and commencing the implementation of their plans, (Category B - see Figure 4.3.), a change in pattern emerged in their new populations even though they had only the time to make modest reductions. The long term non-EMI population reduced quickly as the Category B hospitals were now funded and could purchase group homes and small schemes suitable for this patient group. The proportion of the population who were EMI increased, probably as an increasingly fragile group. The Acutely Mentally Ill (Acute MI) group starting as a much smaller proportion of the population at 22%, increased to Category A levels at 30%, indicating either failed discharges or the cyclical nature of the illnesses of the acutely mentally ill patients requiring periodic readmission.

**Figure 4.4.**

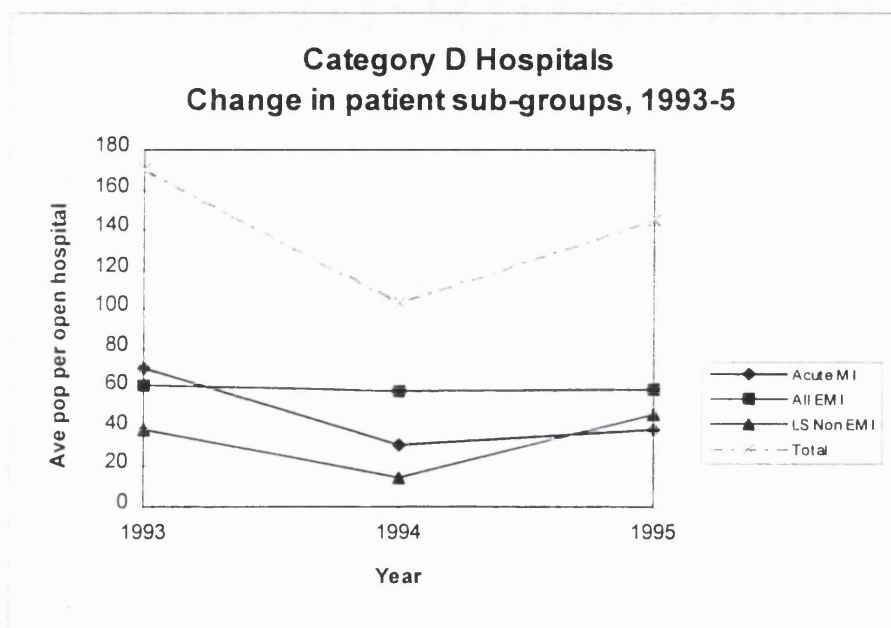


Those hospitals which have reduced their populations by 50% (Category C, see Figure 4.4.) also show a different case mix. The long term non-EMI population was unchanged and remained at about a quarter of the residual population probably comprising those more dependent patients who require specialised facilities to be completed before they can move. The EMI population as a proportion shows a similar trend to the Category B hospitals modestly increasing but within a considerably smaller total population.

The Acute MI population however shows a considerable reduction to only 18% of the total populations. There could be several reasons for this:

- i) that community support services, crisis intervention, diversion and day centres have developed sufficiently to encourage previously delayed discharges for want of these services;
- ii) that local authority Social Services are increasing their rate of assessment of this group and facilitating community placements;
- iii) that the schemes to house these patients have proved more complex or controversial to implement than those for long stay or elderly patients and are only coming on stream at the end of the programme;
- iv) that stringent admission criteria are being implemented by hospitals nearing closure to exclude this group and they are only admitted in extremis.

Figure 4.5.



The hospitals in their final year (Category D - see figure 4.5), have population variations which are difficult to explain. Later in this chapter schemes to be completed in the last year of programmes (Table 4.17) and schemes delaying programmes (Table 4.18) are examined. These indicate that Acute MI and EMI Assessment Units are often both the last to be built and the most likely to be delayed which may explain the variations.

#### 4.9 ASSOCIATED HOSPITALS

In the 1993 survey, it became apparent that, contrary to popular belief, the majority of the "water tower" hospitals did not operate in isolation. Prior to any attempt at community care in the current programme, they had other small sites providing mental health services within their management.

Table 4.13. Satellite Sites & Hospital Category 1994		
Hospital Category	No of Hospitals	No of Satellites
A	1	1
	1	2
	3	3
	1	4
B	1	1
	4	2
C	1	1
	1	2
	3	3
	3	4
	2	5
D	4	1

Many of the problems associated with the implementation of community mental health programmes relate to obtaining planning consents and procuring buildings suitable for community mental health use. It might be thought that owning several small satellite facilities with existing health use could facilitate such a programme. These satellites are not new schemes but part of the original institution's organisation.

Table 4.13. shows 25 hospitals of the 42 hospitals which answered this question in 1994 having 55 satellites by category for Categories A, B, C and D. Hospitals with only one satellite which would not be of significant assistance to a reprovision programme were compared with those having several sites. No evidence could be found of a correlation between multiple site ownership and category of implementation. However, in the case studies it will be seen that prior ownership of the large site(s) required for the development of the major scheme(s) in the reprovision is a success criterion.

#### 4.10 DURATION OF REPROVISION PROGRAMMES

The only declared two year programme in fact turned out to be a three-year programme, (see Table 4.14). Only two of six declared three-year programmes succeeded. Two of three four-year programmes succeeded. Three of eight five-year programmes succeeded. Two intended three-year and two intended five-year programmes collapsed and were regraded to Category A, with no programme.

<b>Table 4.14. Actual Duration of Closure Programmes compared with intended duration</b>									
<b>Closure programme planned - YEARS</b>	<b>Programme Achieved in Years</b>								
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>Failed</b>	<b>TOTAL</b>
<b>1</b>									<b>0</b>
<b>2</b>			<b>1</b>						<b>1</b>
<b>3</b>			<b>2</b>	<b>2</b>				<b>2</b>	<b>6</b>
<b>4</b>				<b>2</b>	<b>1</b>				<b>3</b>
<b>5</b>					<b>3</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>8</b>

No examination was made of programmes over five years in length as these rely heavily on projected data. As can be seen from the foregoing, this can be quite suspect. However, seven hospitals predicted six-year programmes, three seven-year programmes, two eight-year programmes, five nine-year programmes and there were two ten-year programmes, one eleven-year and one thirteen-year programme. Clearly many programmes of very long duration are still being planned.

As can be seen from Table 4.15. showing the original start and the actual or 1995 projected finish, the lengths of programme actually being achieved are in most instances longer than the original estimate.

Most programmes ran late, only about 40% finished on time . It might be thought that longer programmes where more time was allowed could be more robust. In fact this was not so. The effects of delays are manifold. Old facilities must remain open often in uneconomic configuration timetables. The recruitment and training of community based staff are dislocated and patients are denied the use of new facilities. Where budgets are stretched other agencies defer recruiting staff until the facilities are completed and further delay the transfer of patients.

It is not surprising that in the planning and implementation of community based Mental Health Care where co-ordinated inter agency working is required, the uncertainty of when NHS facilities will be available is quite often quoted as a problem by social services and other agencies.

<b>Table 4.15. Hospital closure plans reporting delay between 1993 &amp; 1995 by Category</b>						
<b>Category 1993</b>	<b>1 year</b>	<b>2 years</b>	<b>3 + years</b>	<b>No Delay</b>	<b>Total</b>	<b>% Delayed</b>
<b>B</b>	1	2	-	16	20	15
<b>C</b>	13	2	1	8	21	76
<b>D</b>	1	-	-	9	10	10

19 of the 61 hospitals with plans in 1993 (21 had no plans to close) had reported delays over the period of the survey as shown in Table 4.15. There were 11 programmes reporting delay in 1994 and eight in 1995.

Delays occur at all stages of the programme, with the least chance of delay occurring in the final part of the programme. The highest incidence of delay is in getting into or out of Category C. Over 76% of the Category C programmes ran into difficulties and sought further extensions to their programme. This is the "high risk" stage of the process. In the D category, as to be expected, the programme being fairly certain by this stage, only 10% required any extension.

To move from B to C, a 50% reduction in population over the hospital's Category A state, is required. This would require in addition to third party provision (e.g. Housing Association), some NHS schemes to have been completed, but not the completion of the major schemes. Much of the problem lies with hospital management's inability to estimate implementation periods accurately. The majority are underestimating the time required. In addition, at this stage, the real problems begin to show :- agreeing costs in detail with purchasers (see Case Study 3 where this collapsed the programme), obtaining sites and town planning, and implementing capital programmes.

Where delay occurs in moving from a C to D, as in 30% of the Category C delays, problems arise in extended double running costs for the hospital in under utilised configuration, in the frustration for staff whose personal plans are disrupted and third party agencies who are waiting for the NHS. Given the significance of these problems, it seems surprising that no model



programmes or specific project planning advice have been issued centrally. A standardised approach would have many benefits to management even if only as a checklist.

<b>Table 4.16. Projected dates of Category A hospitals (those with no closure plans) in 1993 to formulate a community reprovion plan and outcome in 1995</b>			
	<b>1993</b>	<b>1994</b>	<b>1995</b>
No agreed closure programme	31	25	24
Had a date by which a community reprovion plan was to be formulated	4 x 1994 1 x 1995	4 x 1995 2 x 1996	3 x 1996 1 x 1997
Had an intention to formulate a plan but no date	3	-	-
Had a community programme but no date by which a formal closure programme was to be formulated	10	2	4
No plan and no date for a plan	13	17	16

Table 4.16. shows the category A hospitals' projected dates for the formulation of plans for approval.

In attempting to project the completion date for the Completion of the Community reprovion programme (see later Table 4.28.), an understanding of Category A hospitals' intentions is required. They continued to have problems formulating plans. Of all the hospitals open the proportion of Category A hospitals was almost constant over the survey period, 38% in 1993, and 40% in 1995.

The number of hospitals without funded programmes had reduced from 31 to 24 by 1995 but the rate of decline slowed over the three years of the study and the number of hospitals with no plan and no date to formulate a plan had increased each year since 1993. As a consequence the proportion that had no plan and no date to formulate a plan increased from 42% in 1993 to 67% in 1995. It might be thought that the introduction of Community Care for the mentally ill has been seen as a priority for the NHS and that most hospitals should have agreed plans but this is not the case.

A significant impediment in obtaining funding arose for the hospitals who, in 1995, had yet to finalise their plans. During 1994 the Capital Investment Manual (CIM), (HMSO, 1990) required that Outline Business Case / Full Business Case processes came into effect. The CIM required firstly, detailed plans to be agreed with purchasers and secondly, private sector funding to be sought under the Private Finance Initiative (PFI).

The data shows that in 1993 five hospitals extended their estimates of when approval would be given to their plans by, in four cases, one year, and in one case two years. The two year case subsequently extended its view that a further year would be required in 1994 and another of the

1993 cases originally requesting one year, later requested a further three years to obtain approval.

Four of the hospitals reporting in 1994 asked for an additional year and two more for a further two years. In 1995, all confidence seemed to have disappeared and only some of the original 1993 Category As still unapproved in 1995 were giving projected dates when they thought approval might be given, two of 1997 and one of 1999.

Of the nine other hospitals who were in Category A none was willing to give a date when requested in 1995 as to when they thought their plans might be approved which seems to indicate that confidence in the system seems to have collapsed.

#### 4.11 PROBLEMS WITH REPROVISION

Problems with reprovision were examined in those hospitals nearing closure (Category D) as these schemes were sufficiently advanced for a clear picture to emerge of where the potential barriers to complete closure lay.

To examine reprovision schemes remaining to be completed in the last year of the programme an analysis was made of five category D hospitals (a sample of 50% of those reporting sufficient detail in 1995 of their schemes outstanding).

<b>Table 4.17. Schemes still to be provided in the last year in the plans of five Category "D" hospitals in 1995</b>					
	<b>Hospital 1</b>	<b>Hospital 2</b>	<b>Hospital 3</b>	<b>Hospital 4</b>	<b>Hospital 5</b>
Acute - General Psychiatry	109	60	88	40	25
Intensive Care	24		4	4	24
EMI Assessment	50		16		28
Long Term Difficult to Manage / Psychiatric	84		12	45	
Respite	6		9	3	8
Community-based L.T./ Rehabilitation	44	10	59	5	71
EMI Continuing Care	95		12		28
N.B. All numbers shown above are beds/places					

Acute MI, Intensive Care and EMI Assessment are usually housed in "hospital" style accommodation. The provision of secure services are similarly provided and are usually a multi-district service. The balance of services is usually planned to be provided as discrete services in the community, and any delay in reprovision should be more easily overcome by the provision of an interim scheme than those in major schemes. Unless there is a **planned** interim scheme almost any service with significant delay in community reprovision can cause the institution to remain open.

As shown in Table 4.17, and as might be expected, in all hospitals the major services were still to be completed in the final year. The Acute MI beds in all five hospitals, intensive care beds in four and EMI assessment beds in three hospitals were still outstanding.

<b>Table 4.18 Schemes delaying programmes where hospitals reported slippage</b>						
	<b>Original Programmes</b>	<b>3 to 4 years</b>	<b>3 to 4 years</b>	<b>3 to 4 years</b>	<b>5 to 7 years</b>	<b>5 to 7 years</b>
	<b>Delays</b>	<b>1 year</b>	<b>1 year</b>	<b>1 year</b>	<b>2 years</b>	<b>2 years</b>
<b>Beds provided</b>						
<b>Core NHS Provision</b>	<b>Acute</b>	76	88 (possible 2 year delay to 1997)	acute unit already built	85	35
	<b>Intensive Care</b>	3	4			
	<b>EMI Assess</b>	45	38		60 (1 year)	20 (1 year)
<b>Community Provision</b>	<b>Respite</b>		9			2 (1 year)
	<b>Continuing Care</b>		108		75 (1 year)	16 (1 year)
	<b>Community-based LT/Rehab</b>			5	75	27 (1 year)
	<b>Gen. Psychiatry Long Term DTM/ Psychiatric</b>			30 (+15 private)	10 (1 year)	12 (1 year)

It might be thought that those hospitals which are able to demonstrate clearly the schemes to be completed in the last year, would instate early management intervention to avoid delays in the delivery of those schemes.

Table 4.18. demonstrates that this is not always the case and shows the schemes which were delaying programmes. In four of five programmes, major NHS capital schemes were the cause of delay and in only one instance was the cause the late arrival of some community schemes, including some privately provided beds which indicates the major capital scheme is the determinant of progress and has the major capital risk. The other effects the data show, in the two year delay programmes, is that the balance of the programmes had been allowed to drift. If this were planned it could be seen as an attempt to maintain the institutional population and control the economic costs of rundown. However this seems unlikely. The lesson to be learnt from this data is that any delay in the major capital scheme will cause the institution to remain open. The potential benefits sought by any delays in planning (i.e. revisions to layouts or attempts to reduce capital costs) must be carefully weighed against the costs of the hospital's closure being delayed. In the instances of Hospitals 1 and 2 above with small populations averaging 140 the costs of keeping the hospital open for a further year must have been inordinately expensive.

### **Collapsed programmes**

Four hospitals' programmes, where they returned data indicating they were entering into the implementation stage (Category B), subsequently collapsed. These were all programmes that were proceeding in the belief that they had Regional Office approval under the former capital

allocation process. However, they failed to secure outline business case approval and therefore reverted to category A. Two hospitals failed to obtain purchaser's approval to their plans, one had to re-submit an outline business case and one hospital's "reward" for failing to proceed was to have its Trust status removed and to be merged with another Trust.

These hospitals appear to have fallen between stools. It is possible that they may have received approval under the CAPRICODE Approval in Principle (AIPs) System (HMSO, 1978) in which they queued in priority for Regional Capital Funding. This funding route ceased to apply after 1993 with the introduction of the Capital Investment Manual (HMSO 1993) when AIPs were replaced by Outline Business Cases (OBCs), but most importantly purchaser agreement to the Provider Trusts plans was required. Those who ignored this criterion and failed to accept the new culture were rewarded with an immediate block on funding (see Case Study 3).

The precise reasons for these failures are difficult to determine as senior staff associated with such planning problems find their careers rapidly change to less demanding roles, as in Case studies 1, 2 and 3.

#### 4.12 NON-EXCHEQUER FUNDING

Health service guidance on "Unconventional Finance" issued in 1989 (DoH,EL(89)MB142) specifically identified Housing Associations as acceptable partners and the Private Finance Initiative (DoH, EL(93)03) required all plans for capital development to be submitted throughout the NHSME office for evaluation for their ability to be "privately financed". Only after this scrutiny would consideration be given to exchequer funding, and it would be expected that a significant number of reprovion programmes would use non-exchequer funding.

All hospitals' core functions of Acute MI and EMI Assessment are invariably NHS funded and many specialist services (e.g. Alcohol Abuse, Mother and Baby) are usually NHS funded.

Hospitals were asked whether they had received non-NHS funding, the results of which are shown in Table 4.19.

<b>Table 4.19. Source of funding of programme</b>			
	<b>1993</b>	<b>1994</b>	<b>1995</b>
<b>Response % of total possible</b>	90%	85%	100%
<b>NHS funded only</b>	69%	69%	80%
<b>NHS &amp; other funding</b>	31%	31%	20%
<b>Source non-NHS funds</b>			
<b>Housing Association</b>	26%	33%	45%
<b>Private Sector</b>	26%	33%	36%
<b>Charities and other non profit</b>	52%	33%	19%

The schemes demonstrated here are either funded by housing associations, the private sector or the charitable sector. The schemes that they funded were relatively small capital value facilities and comprised group homes/hostels, elderly continuing care or sheltered accommodation. There was a single private sector provision of acute psychiatric services.

Over the three years the total percentage of non-NHS funded schemes by number (not value) fell from 31% to 20%, Housing Associations became the largest funders of these schemes with 45% of schemes and charitable funded schemes fell from 52% to 19% of total schemes.

The Housing Association proportion of schemes funded in the NHS has remained stable over the period. The private sector has declined significantly and charities even further. In 1993 charities represented 16% of all non-NHS funded reprovision and in 1995 this reduced to 4%. Possible explanations are that the charitable sector in times of recession receives a much reduced income and that existing charitably funded facilities are being required to deal with more complex and therefore expensive patients (a similar phenomena to that experienced by the institutions) reducing funding for new projects. The Mental Health charities have to compete with other more emotive charities and all charities complain about the effects of the National Lottery.

The limited number of schemes that have been revealed by this survey is surprising. It had been hoped that housing associations would be a significant provider in this field but they also have had problems in securing exchequer funding and are subject to the vagaries of a funding system that leaves many months between an application and a known outcome. However the virtual loss of the charitable sector will make future reprovision programmes more difficult not just for the loss of funding, but for their specialist expertise and innovation in the field of Community Care gained well before the current NHS programmes.

The question asked was whether any part of the NHS programme was non-exchequer funded i.e. a composite part of the service planned to operate in conjunction with NHS services. Large numbers of privately funded nursing homes (Laing and Buisson Report, 1996) separately managed from the NHS have opened and take patients formerly from the institutions.

The survey was completed before the effect of the Private Finance Initiative (PFI) could be seen in these programmes although the nine category A hospitals were reporting problems having their business cases agreed through the PFI process. It would not appear that the PFI will speed the process of planned closures.

#### 4.13 ESTATES DATA

<b>Table 4.20 Age of Institution (Number of asylums built under legislation)</b>	
<b>Mental Health Acts</b>	<b>No of Hospitals - built since each Act</b>
Hospitals built prior to the 1808 Asylum Act	3
1808 The Asylum Act - County discretionary powers to provide an asylum.	10
1845 Lunatics Act - Mandatory requirement	20
The Metropolitan Poor Act 1867 (amended 1868)	49
<b>TOTAL</b>	<b>82</b>

Table 4.20. shows that the hospitals in this survey are very old, functionally specific buildings that are difficult to adapt for other purposes. For many the only course is demolition and sale of the site. In many instances however planning permission is complex and time consuming to obtain particularly if best value is to be achieved.

<b>Table 4.21. Land use classification of institution sites</b>				
<b>Green Belt</b>	<b>Green &amp; Conservation</b>	<b>Metropolitan Open</b>	<b>Metropolitan Open &amp; Conservation</b>	<b>Conservation</b>
31	4	10	1	6
<b>Institutions classed as Listed Buildings</b>				
<b>Grade</b>	<b>Listed</b>	<b>Part Listed</b>	<b>Not Listed</b>	
I	0	0	-	
II	5	13	-	
II*	8	1	-	
<b>Not given</b>	1	3	-	
<b>Total N° of Hospitals Reporting</b>	<b>14</b>	<b>17</b>	<b>32</b>	

Table 4.21. shows that many of the buildings are listed, in a conservation area, in green belt or in metropolitan open land, this often proves contentious if demolition of the building or alternative uses of the land are sought.

If a large Victorian psychiatric hospital is "listed" by the Department of the Environment (DoE) it may not be demolished or significantly altered without extensive consultation. Of the 82 hospitals open in 1993, 63 replied to the question of listing and of those, 50% were listed. The original building fabric of such buildings must be maintained in good order for all time. Failure to maintain the building to the local planning authorities' required standards permits them to enter the buildings, execute repairs and charge the costs to the owner (DoE, 1990)

The prompt disposal of redundant sites following the closure of the institution was attempted by Regional Health Authorities. Many Regions' plans identified funding from the disposal programme as a major component in funding community based mental health care. In simple terms this was a reasonable assumption. Many of the sites were surrounded by valuable urban land where towns had expanded to encompass the formerly isolated institution. Their disposal

has however been neither prompt nor simple (Davidge, 1994). The buildings are all very old and difficult (but not impossible) to convert for commercially valuable uses.

Unfortunately whilst the town has expanded to meet the hospital and the surrounding land is valuable; the hospital site is now in an urban environment and often the only large open site left. Local planning authorities have moved to place development restrictions on these sites. Of the 65 hospitals responding, 52 (80%) had restrictions on the future use of the site which would affect both value and the timely disposal of the site.

Negotiating away all or part of a listing is a time consuming process and enhancing the land use classification of a site against the wishes of a Local Planning Authority can take several years in consultation with interested parties. If there is opposition the subsequent appeal to the Secretary of State for the Environment to remove the listing is both time-consuming and expensive.

#### 4.14 RETRENCHMENT EFFICIENCY

<b>Table 4.22. Retrenchment Efficiency</b>				
	<b>1993</b>	<b>%</b>	<b>1995</b>	<b>%</b>
<b>Wards Open</b>	420	44	313	44
<b>Wards Closed</b>	531	56	399	56
<b>Wards Total</b>	951	100	712	100
<b>Gross hospital population in sample</b>	11047		6722	
<b>Average population per open ward</b>	26.3		21.47	
<b>Reporting hospitals</b>	45/82	55	33/59	56

Management of the site in closure to match facilities in use as far as is possible to the reducing hospital population is an important exercise which becomes more difficult as the population diminishes. Eventually the support service costs (e.g. kitchens, heating systems) are incapable of further reduction due to minimum practicable operating levels. Failure to reduce site usage will however, escalate unit costs requiring additional funding.

Wards open versus closed was taken as a measure of the efficiency of use of the site at the beginning of the study. As Table 4.22. shows there was considerable consistency in the percentage of wards kept in operation which was 44% in 1993 and also 44% in 1995.

What was changing however was the number of patients per ward which would appear to be a result of shrinking populations and the necessary segregation of sexes and certain types of patient and the occupants per ward dropped from 26.3 persons per ward in 1993 to 21.47 in 1995, again giving a further problem in the economy of operating the institution. Although income would drop by 25% due to patient resettlement, the practical opportunities for reducing nursing staff would produce a considerably lesser saving. (See Table 4.26).

The data indicate that ward numbers cannot be reduced in line with hospital populations due to factors such as inappropriate case mixes and the need to provide single sex wards, requiring more wards to be kept open than the hospital population would at first suggest.

#### 4.15 QUALITY OF INSTITUTIONAL FACILITIES

Hospital inpatient accommodation was grouped into four categories:

- a) Unimproved Nightingale open wards;
- b) Improved Nightingale with sub-division into single rooms or bays (with part height partition);
- c) Single rooms (with full height partitions to the ceiling);
- d) Other (double occupancy rooms, 4-6 bedded bays or small wards maximum eight persons).

<b>Table 4.23 Quality of Institutional Accommodation</b>								
<b>CATEGORY</b>	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>1993 %</b>	<b>1995 %</b>	<b>1993 %</b>	<b>1995 %</b>	<b>1993 %</b>	<b>1995 %</b>	<b>1993 %</b>	<b>1995 %</b>
<b>Nightingale</b>	20	34	11	5	46	20	24	74
<b>Improved</b>	34	31	40	28	28	32	38	16
<b>Single Rooms</b>	16	10	18	16	9	22	10	10
<b>Other</b>	30	25	31	51	17	26	28	0
<b>Total</b>	100	100	100	100	100	100	100	100

The percentage of unimproved nightingale wards as a total of all accommodation was higher in those hospitals due to close first (Category D) and increased in 1995 (see Table 4.23). Those hospitals that will remain open the longest (Category A and Category B) had a higher proportion of improved and single rooms. The high proportion of unimproved Nightingale wards in Category D hospitals was probably due to the planned closure of sub-standard wards that would remain closed.

The results were very encouraging in the sample inspected. Substantial numbers of unimproved wards were closing in the advanced hospital programmes and those in earlier stages of reprovision had a larger proportion of improved accommodation.

#### 4.16 CHANGES IN SCALE OF REPROVISION PROGRAMMES

It is of interest to examine how the detail of reprovision programmes changed. The initial intentions of hospitals when agreeing plans are subject to both refinement and practical pressures such as the eventual level of funding, availability of services, changes in purchasers' plans and indeed those of other providers. It is also possible that plans are revised as the



institutional environment changes to a community environment and more experience is gained by the provider hospital.

Taking the midpoint of the survey at 1994 an examination was made of the data provided by the category B hospitals, those who had just agreed their plans for reprovision and received funding.

In 1994 there were 15 such category B hospitals of whom six provided comprehensive and comparable responses in 1995.

<b>Table 4.24 Changes in reprovision bed numbers for 6 Category B hospitals 1994 - 1995</b>				
	<b>1994 Beds Mean</b>	<b>1995 Beds Mean</b>	<b>Beds % change</b>	<b>N°s. of Hospitals providing 1994</b>
<b>Acute General Psychiatry</b>	51.8	52.7	+1.6	6
<b>NHS intensive Therapy</b>	11.3	8.8	-22.2	4
<b>DTM L Term</b>	24.0	21.8	-9.2	3
<b>NHS General Psychiatry - L Term</b>	35.0	31.7	-9.5	4
<b>NHS EMI Assessment</b>	37.0	38.0	+2.7	6
<b>NHS EMI Continuing Care</b>	94.0	92.5	-1.6	5
<b>NHS Other beds</b>	26.3	26.3	n/c	6
n/c = no change				

The only planned reprovision common to all six Category B hospitals was Acute Adult Mentally Ill and Elderly Mentally Ill Assessment. Service reprovision plans varied widely for given populations.

Table 4.24. shows that acute Adult MI and EMI Assessment numbers remained largely stable. All other services decreased over the original intended reprovision level. However, the only service that fell by more than 10% was intensive therapy (22%), a relatively small service. Of more significance was NHS long term rehabilitation which reduced by 25%. These falls reflect what happens to theoretical plans when they are implemented in the real world.

These are all core NHS functions which are being reduced and only certain (expensive) sub-categories can be provided by third parties. Such reductions do not lie easily with the government's statements concerning reprovision. Quite possibly some of these core services are replaced at lower dependency levels by community care. However the reduction found here is from those levels and type of service in the hospital's agreed reprovision plan on which it formally undertook its closure to public consultation and would have demonstrated the community reprovision. These changes in NHS services would seem to be undertaken covertly. The reduction appears to be across most services and as these occurred only one year after consultation the validity of the public consultation process must be in some doubt.

#### **4.17 NUMERICAL DIFFERENCES IN REPROVIDED SERVICES**

For all hospitals with reprovision plans an attempt was made to ascertain the overall difference in places provided in the institutions at the commencement of the programme and those to be provided in the community.

Hospitals were asked in 1993 what existing provision was in beds for all categories and what was the intended reprovision in the community. In 1994 and 1995 this was further subdivided into day places. This question was answered comprehensively by only a few hospitals. Notwithstanding they could describe their existing population and the principal components of their intended plans, total reprovision numbers were, it would appear, not known to them. In 1993 only 21 hospitals answered, in 1994 18 answered and in 1995, nine hospitals responded. This poor response rate over time may be due to the recognition of the political sensitivity of information on falls in planned reprovision. It is likely that those who did respond represented the "best case".

The responses available indicated that the overall NHS service planned in 1994 would shrink by 17½ % in bed numbers from those provided in the institution to those in the community. The number of day places however, would increase by 39%. In 1995 plans for a further reduction of 15% were noted in the inpatient beds planned in 1994 but the proportion of day places remained constant.

From this data it would appear that NHS Mental Health bedded provision in institutions is reprovided in community based care at a reduced level, however, other new services for both higher and lower dependency patients may in part replace them.

#### **4.18 STAFF TRANSFERRING TO COMMUNITY BASED SERVICES**

This question examined the numbers of staff of all disciplines at present on the site, and the proportion who were planned to transfer to community based facilities.

As can be seen in Table 4.25. over 50% of hospitals responding over the three years did not know how many staff would transfer to the community service.

<b>Table 4.25 Staff Transferring to Community-based services</b>						
	<b>1993</b>		<b>1994</b>		<b>1995</b>	
	<b>All hospitals</b>	<b>C and D hospitals</b>	<b>All hospitals</b>	<b>C and D hospitals</b>	<b>All hospitals</b>	<b>C and D hospitals</b>
<b>Respondents</b>	56	16	37	19	31	15
<b>N's not known</b>	30	9	22	9	18	8
<b>% not known</b>	54	56	59	47	58	53
<b>% of staff to transfer to reprovided facilities</b>						
<b>% staff</b>	<b>1993</b>		<b>1994</b>		<b>1995</b>	
<b>Range</b>	<b>C</b>	<b>D</b>	<b>C</b>	<b>D</b>	<b>C</b>	<b>D</b>
<b>90-100</b>	60	60	44	66	20	50
<b>75-90</b>	-	-	14	-	-	-
<b>50-75</b>	-	20	28	-	40	-
<b>25-50</b>	40	-	14	33	20	-
<b>0-25</b>	-	20	-	-	20	50

Increased certainty of closure dates in the later stages of the plans (Category C & D hospitals) did not apparently assist hospitals in determining the fate of their staff. As set out in Chapter 3, this is a problem for those planning these services and is partly due to the status of staff who can take redundancy or early retirement, even after retraining, and often do not exercise these options until a choice is forced upon them. For staff, uncertainty of their future is a significant contributor to the problems of morale. After, in most cases, a century in "steady state", an institution undertaking the community reprovision of its services, needs the full support and confidence of all its staff.

Over half of the Category C and D hospitals intended to transfer between 90-100% of staff into the community services. However, by 1995 there was a trend towards plans to transfer fewer staff.

Whilst on first inspection the figures for Category C and D hospitals are encouraging, hospitals in these categories will have in all probability already made significant staff reductions. Table 4.26. shows that as hospitals of all categories progressed through their reprovision programmes, the patient to total staff ratio steadily increased from 1:1.8 in 1993 to 1:2.0 in 1995 which supports the earlier finding that all hospitals are acquiring more complex case mixes (and therefore require more staff).

The increase by hospital category is from an average of 1:1.7 in category A to 1:2.3 in category D. The increase is comparatively gentle between A (1:1.7) and C (1:1.9), and most pronounced in the final year, category D hospitals (1:2.3) which may also reflect retrenchment inefficiency associated with high fixed double running costs.

<b>Table 4.26. Patient Staff Ratio per year by hospital category</b>				
	<b>1993</b>	<b>1994</b>	<b>1995</b>	<b>Average</b>
<b>A</b>	1:1.6	1:1.9	1:1.7	1:1.7
<b>B</b>	1:1.6	1:1.8	1:1.8	1:1.8
<b>C</b>	1:1.7	1:2.0	1:2.0	1:1.9
<b>D</b>	1:2.3	1:2.1	1:2.6	1:2.3
<b>Average</b>	1:1.8	1:2.0	1:2.0	

The effect was also demonstrated in the Sainsbury report (1996) where numbers of nursing staff were compared against hospital population. The hospitals in that study, equivalent to those in the category C to D range in this study, also showed higher ratios. The data supports the conclusion that a significant factor in the double running costs of hospitals near to closure is the high number of staff required to cope with partly filled wards and services dispersed over large sites.

#### **4.19. PROJECTED COMPLETION OF THE COMMUNITY MENTAL HEALTH REPROVISION PROGRAMMES IN ENGLAND**

One of the purposes of planning and management is to predict future patterns of reprovizion. To do this it is necessary to make assumptions which are detailed in Appendix 4.2.

<b>Table 4.27. Predicted closure programme for English Psychiatric hospitals by category in 1996 adjusted to reflect delays experienced in previous closure programmes.</b>												
<b>Category in 1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>TOTAL in 1995</b>
<b>A</b>							2	1	17		4	<b>24</b>
<b>B</b>				4	1	1						<b>6</b>
<b>C</b>		9	7	3								<b>19</b>
<b>D</b>	10											<b>10</b>
<b>Total</b>	<b>10</b>	<b>9</b>	<b>7</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>17</b>	<b>0</b>	<b>4</b>	<b>59</b>

The predicted pattern of closure dates is shown at Table 4.27. and the comparison with planned dates from each of the hospitals is shown in Table 4.28.

<b>Table 4.28. Predicted closure programme for English Psychiatric hospitals open in 1996 compared with given dates</b>												
<b>Hospitals Open in 1995 = 59</b>	<b>No closure plans</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
<b>Given date</b>	<b>24</b>	<b>10</b>	<b>13</b>	<b>8</b>	<b>4</b>							
<b>Predicted date</b>	<b>-</b>	<b>10</b>	<b>9</b>	<b>7</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>17</b>	<b>0</b>	<b>4</b>

The projections assume that:-

- 1) The existing policy of replacing all the institutions with community care programmes for the mentally ill remains in force;

- 2) The Private Finance Initiative produces the necessary capital funding for these programmes;
- 3) The funding to local authority Social Services Departments is sufficient for them to house and care for discharged patients;
- 4) The reviews of inappropriately discharged patients do not cause selected institutions to remain open indefinitely (as in the USA);
- 5) The schemes provided by Housing Associations (HA) do not diminish and that schemes provided by the charitable and private sector make only compensatory changes.

There was a substantial number of hospitals (24 of the 59 still open in 1995), that did not have any plans formulated for closure and reprovion. Applying the success rates of those hospitals that have closed both to those still implementing closure and to those yet to do so, shows these programmes extending to the year 2006, with 25 hospitals still to close after the year 2000, some 40% of those open in 1995.

## **CHAPTER 5**

### **CASE STUDY RESULTS**

<b>5.1</b>	<b>Introduction</b>	<b>137</b>
<b>5.2</b>	<b>Questionnaires and Methodologies</b>	<b>137</b>
<b>5.3</b>	<b>CASE 1</b>	<b>137</b>
<b>5.3.1</b>	Brief History	137
<b>5.3.2</b>	The Closure Plan	137
<b>5.3.3</b>	Built Environment - Physical Surveys	137
<b>5.3.4</b>	Effects on Patients	140
<b>5.3.4.1</b>	Changes in Patients' Cognitive Impairment and Depression Levels	141
<b>5.3.4.2</b>	Quality of Life - The Patient's Perspective of Reprovision	143
<b>5.3.5</b>	Relatives' and Friends' Views	145
<b>5.3.6</b>	Staff Views	145
<b>5.4</b>	<b>CASE 2</b>	<b>149</b>
<b>5.4.1</b>	Brief History	149
<b>5.4.2</b>	The Closure Plan	150
<b>5.4.3</b>	Built Environment - Physical Surveys	150
<b>5.4.4</b>	Effects on patients	152
<b>5.4.4.1</b>	Changes in Patients' Dependency Level	153
<b>5.4.4.2</b>	Quality of Life - The Patient's Perspective of Reprovision	155
<b>5.4.5</b>	Relatives' and Friends' Views	156
<b>5.4.6</b>	Staff Views	156
<b>5.4.7</b>	General Health Questionnaire	159
<b>5.5</b>	<b>CASE 3</b>	<b>160</b>
<b>5.5.1</b>	Brief History	160
<b>5.5.2</b>	Closure Plan	160
<b>5.5.3</b>	Built Environment	160
<b>5.5.4</b>	Patient Data	161
<b>5.6</b>	<b>Quality Control - Formal Audit of Fieldwork</b>	<b>161</b>

## **5.1. INTRODUCTION**

This chapter sets out the results of the case studies of three hospitals which formed the "micro level" study of the accelerated programmes.

## **5.2 QUESTIONNAIRES AND METHODOLOGIES**

The questionnaires and methodologies used in this study to collect data on patients, staff, friends and relatives and the already built environment are set out in Table 3.2.3, in the Methodology section, Chapter 3.

## **5.3 CASE 1**

### **5.3.1 Brief History**

The Case 1 hospital, a county asylum, was built in 1907. The hospital was set in grounds of 300 acres of greenbelt land. It was originally built to accommodate 254 male and 316 female patients, with on site accommodation for 75 attendants. At its height it was home to 800 patients.

It originally served an area with a population of 300,000. By the early 1980s the principal user reprovided mental health facilities more locally and this reduced the patient population to 200. Between 1985 - 1990 the continuing care and rehabilitation of inpatients moved to staffed group houses and a 14 bed purpose built long stay facility. Inpatient continuing care for the elderly was dispersed into private nursing homes.

### **5.3.2 The Closure Plan**

By the early 1990s the only services remaining on the Case 1 site were 42 acute adult beds in two wards of 17 and 25 beds; 25 acute adult day places and 25 elderly mentally ill (EMI) day places which comprise the schemes considered in this study.

### **5.3.3 Built Environment - Physical Surveys**

#### **Case 1 Reprovision - Interim Solutions**

Several attempts had been made over the years to close the Case 1 hospital. At the time this survey work started (1992/3) the hospital was under severe criticism from both the RHA and its

Purchaser due to very high running costs and poor facilities. Patient services had reduced to two day hospitals and two adult acute wards. No attempt had been made to rationalise services on the site. The survey therefore covers the original dispersed facilities, interim facilities, the EMI day hospital (opened in February 1995) and 25 Acute inpatient beds (opened in October 1994). The refurbished interim facilities were in use between December 1992 and January 1995.

A feasibility study demonstrated, even though the new facilities would take less than three years to provide, that for both financial and operational reasons it would be appropriate to condense remaining services as an interim solution onto one corner of the site. A low cost refurbishment was carried out and the remaining services (listed above) retrenched in December 1992 on schedule and with minimal disruption.

The rest of the site was declared surplus, blocked off and secured. The responsibility for and associated costs of security and maintenance of surplus sites fell to the Regional Health Authority and this gave some relief to Case 1's budget.

### Physical Survey Results

Two sets of data were collected, one measuring facilities against standards set out in the Health Building Notes (HBN37 1973) for elderly day hospitals and inpatient facilities, (HBN35 1988, HBN38 1982) adult acute inpatient and day hospitals and the other concerning environmental standards.

Table 5.1 Case 1 - Original and Reprovided Buildings Compared				
			TYPE	LOCATION
CASE STUDY	EMI Day Hospital	{	Original	Institution
		{	Interim	Institution
		{	New purpose built	Stand alone on community hospital site
COMPARISON OF QUALITY	Adult Acute Inpatient	{	Original	Institution
		{	New purpose built (H)	Stand alone on DGH site
	Adult Acute Day Hospital	{	Original	Institution
		{	New purpose built (B)	Stand alone on community hospital site
All schemes provided 25 beds / places				
EMI day hospital facilities old, interim and new compared				

A comparison was made of standards in the Health Building Note and that achieved in the reprovision. Specifically sizes, numbers and critical distances of WCs and bathrooms were examined, access arrangements, size and number of activity and single use rooms e.g. patients' utility room and a check made that all rooms required to meet the HBN had been provided to an adequate standard.



Table 5.2 shows the detailed survey data and scores of the facilities against the Health Building Note Standard. The detailed environmental data is shown at Appendix 5.1.

<b>Table 5.2. Case 1 EMI Day Hospital Health Building Note Standards</b>			
	<b>Original (vacant)</b>	<b>Interim</b>	<b>New</b>
<b>N° of places</b>	<b>25</b>	<b>25</b>	<b>25</b>
dist to w.c if > 12m	14.5m	20m	14.5m
w.c immediately inside entrance	no	yes	no
w.c. 4.5m2	4.5m2	3.5m2	2.2m2
w.c. - minimum n° = 8	4	4	4
assisted bathroom	yes	yes	yes
quiet room	yes	yes	yes
dining 2.5 m2 p/p	yes	no	yes
enable 1 sitting	yes	yes	yes
group therapy for 10/12	yes	yes	yes
kitchen facilities	no	yes	yes
quiet activity area	yes	yes	yes
clean activity area	yes	yes	yes
patients' utility room	no	no	yes
consulting/interview room	yes	yes	yes
beauty/hairdressing	no	yes	no
wheelchair access	yes	yes	yes
secure garden	yes	yes	no
ward/day integration	no	n/a	yes
handrails	yes	no	yes
ground floor location	yes	yes	yes
lift	n/a	n/a	n/a

The interim facility was planned at very short notice on a small budget within the Trust's block capital allocation (an annual capital grant to be spent at the Trust's discretion) and involved the conversion of a redundant ward which managed to correct some of the deficiencies of the old original day hospital. An ADL kitchen was provided and beauty/hairdressing facilities were made available. It was fortuitous that the design of the ward in the original hospital converted for the interim scheme had low enough windows for a seated patient to look out which is unusual. It is not surprising that the ward furnishings were good and of an acceptable standard as they had been newly purchased and were to transfer to the new day hospital. The decor was also considered "good" and pleasant as the ward had been only recently decorated as the interim scheme.

The creation of this better quality interim environment was undertaken for a low cost, adding strength to the argument that in hospitals in closure modest continuing investment on decorations and furnishings can do a lot to maintain standards even in very old buildings.

Two separate therapy offices were provided in both interim and new schemes as required by the HBN. Only the new facility had a patients utility room which would have been principally used by patients as a personal laundry. The secure garden was originally lost as an amenity in the new provision. However, the deficiency was made good several months after commissioning. The

new scheme carried forward many of the improvements in the interim scheme into the newly built day hospital including the Activities Daily Living (ADL) kitchen

The ward used for the original day hospital was vacant at the time the survey was undertaken. Furnishings and furniture had been removed and it was considered that it would be most difficult to make an assessment of the quality of the environment and therefore no data was recorded.

In all respects however both the interim and new schemes scored equally well on environmental standards, therefore the environmental improvement, (see Appendix 5.1.), can also be said to have been maintained.

### **Quality of other facilities in the programme compared**

As a quality comparison, surveys were made of the Adult Acute Day Hospital and Psychiatric Inpatient ward and Day Hospital (Appendix 5.2.). Both these new capital schemes were contemporaneously planned and constructed with the new EMI Day Hospital. Both new comparison schemes were of a similar standard indicating that the high standard of the EMI Day Hospital was not achieved at the price of reduced standards in the balance of the programme. The capital programme, including three major schemes required to reprovide the hospital, was completed within the originally projected programme of three years.

#### **5.3.4 Effects On Patients**

##### **Age and sex of patients**

The sample comprised 28 women and five men. The average age of the female patients was 74.6 years, range 20, maximum 85 years and minimum 65 years while the median was 74 years. The average age of the male patients was 76.8 years, the range 13, maximum 85 years and minimum 72 years while the median was 73 years. Further details are shown in Appendix 5.3.

##### **Duration in hospital**

75% of the 33 patients in the sample were long term attendees at the day hospital in the institution who had transferred to the new day hospital. The longest attendee was case 16 whose first contact with psychiatric services was in 1954. 25% of the sample had been in contact under 1 year. The mean length of contact with psychiatric services was 8.7 years, range 0.25 - 40 years.

Of the 33 patients interviewed three were discharged between the pre-interview and post interview dates, (one for major surgery, one discharged home and the third discharged as a result of an improvement in mental state). The average length of time elapsing between pre and post interviews was 102 days (range 74 - 126 days).

During the period of the survey, no deaths were recorded for Case 1 patients attending the day hospital, however one patient in the day patient control group died between interviews.

#### **5.3.4.1 Changes in Patients' Cognitive Impairment and Depression Levels**

Baseline and follow up (i.e. after the move) interviews were completed for a group of 30 patients. Each individual was assessed for cognitive and depression levels using the Brief Assessment Schedule (BAS). Appendix 5.4. shows the pre and post-move scores and magnitude of change for each patient.

##### **Cognitive Impairment**

18 out of the 30 patients showed no cognitive impairment on the pre-move interview (BAS score = 0), and the highest score obtained (the most severe cognitive impairment) was 5. The mean score was 0.7, (a median of 1.0). After the move, 11 out of 30 patients scored zero, the mean score was 0.93, (median was 1.0). A Wilcoxon matched-pairs signed ranks test was carried out showing that the difference between the pre and post-scores was not statistically significant (two-tailed  $p = 0.3088$ ). Overall, there were only minimal changes in the cognitive impairment scores of the patients between their move from the old to the new day hospital, and these changes were not statistically significant.

##### **Depression**

Before the move, the mean depression score was 9.1, (SD = 6.1, median = 8.0). After the move, the mean depression score had dropped to 7.8, (SD = 5.5, median = 6.0). A Wilcoxon matched-pairs signed ranks test was carried out showing that the difference was statistically significant (two-tailed  $p = 0.0156$ ). The overall level of depression was significantly reduced after the patients moved to the new day hospital.

## **Comparisons with a control group**

The day hospital group of EMI patients shared the following demographic and circumstantial characteristics with the Control Group. They were of similar age, sex and diagnosis and had spent a similar time in care, were all housed in old, institutional accommodation. Plans had been formulated for their move to other accommodation (which were known to both staff and patients).

It should be noted that whilst the physical accommodation was poor, the standard of care observed during the survey was equal to that of other hospitals in the survey.

The control group patients characteristics are shown at Appendix 5.5.

## **Changes in cognitive and depression levels in the control group**

Appendix 5.6 shows the BAS results for the control group and Table 5.3 provides a summary of these results. These patients did not move. Two interviews were obtained on 10 patients at similar intervals to the Case 1 group.

### **Cognitive Impairment**

Four out of ten patients (40%) had no cognitive impairment at baseline. The mean score was 1.2, (median = 1.0). On the second interview, the mean was 1.1, (median = 1.5). There was no difference between the two interviews (two-tailed  $p = 0.6547$ ).

### **Depression**

On the first interview, the mean depression score was 8.1, (median = 7.5) On the second interview, the mean depression score was 8.3, (median = 7.0). There was no difference between the two interview scores (two-tailed  $p = 0.9442$ ).

### **Life events and their influence on change**

The occurrence of recent life events which could influence change within the follow-up period was recorded for both the study group and the control group.

Patient No. 8, showed a ten point improvement. A contributing life event might have been that this patient had recently moved to a new house. Patient No. 30, whose spouse had been

involved in a road traffic accident, might have reacted by showing an increased level of depression.

### Case study and control group compared

As shown in Table 5.3, the control group showed no significant change in cognitive impairment between the two interviews, which is comparable with the Case 1 group. However, contrary to the experience of the Case 1 patients, the control group showed no significant change in depression scores. This suggests that the improvement in depression levels amongst the Case 1 patients could be attributed to relocation. However a comparison of Case 2 patient differences with the control group differences was not statistically significant ( $p=0.49$ ). It is accepted that a larger sample would be required to determine a more reliable statistical difference between the two groups.

<b>Table 5.3 BAS Scores - Case 1 and Control Group Compared</b>							
	<b>EMI Day Hospital Patients</b>			<b>EMI Control Group</b>			
	<b>Pre-move</b>	<b>Post-move</b>	<b>Diff (p)*</b>	<b>1st Ass</b>	<b>2nd Ass</b>	<b>Diff (p)</b>	<b>Patient diff vs Control diff (p)**</b>
<b>BAS Scale</b>	n = 30	n = 30		n = 10	n = 10		
	[mean(SD)]	[mean(SD)]		[mean(SD)]	[mean(SD)]		
<b>Cognitive Impairment</b>	0.7(1.1)	0.9(1.0)	0.31	1.2(1.3)	1.1(1.0)	0.65	0.38
<b>Depression</b>	9.1(6.0)	7.8(5.5)	0.02	8.1(6.0)	8.3(6.0)	0.94	0.49
* p for pre vs post differences based on Wilcoxon Matched-Pairs Signed-Ranks Test							
** p for patient differences vs control differences based on Mann-Whitney U Test							

#### 5.3.4.2 Quality Of Life - The Patient's Perspective of Reprovision

Patients were also asked to respond to a questionnaire on quality of life issues, selected results are shown at Appendix 5.7.

The distance to toilet/bathroom facilities had increased from an average of 13 metres in the old facility to 20 metres in the new one. However, when asked, patients found them as easily accessible. All patients obtained meals in the dining room. In both facilities the same number used the sitting room. There was a significant reduction in the use of the outside garden, eight patients had used it in the institution but only three used it in the new location. Although neither facility was secure, the outside garden in the new facility was both limited in size and near to busy roads. Larger numbers of patients went off site from the new facility, 15 as opposed to 12. The new facility was half a mile from the nearest shops whereas the old site was three miles.

In the new facility two patients used the kitchen or therapy room while none had made use of them at the old facility. The same number used to read in both facilities, 5% less went for walks

in the new facilities. TV had a limited attraction in both locations with only two watching it pre-move and four post move. Socialising and hobbies were engaged in at equal levels (29 out of 30 at both locations). Ten patients reported that they slept in the old facility during the day, while 14 slept in the new location.

The main difference was that 21 patients engaged in "other activities", which were not recorded in the old institution. Notably, a relaxation class had not previously been available. The availability of telephones was the same between the facilities. Overall, the new facility was seen to be better than the old by 77% of the patients. Better quality toilets scored high among the improvements as did the better environment (70% of the patients). Surprisingly only 13% of patients in the new facility recognised the improvement of being nearer to public facilities.

<b>Table 5.4 Case 1 Patients views on new facilities</b>			
<b>Reasons for contentment Base = 30</b>		<b>Reasons for discontentment Base = 30</b>	
Better environment	22	More Noisy	1
Better w.c.	21	Poorer dining facilities	1
Better Dining	14	Poorer environment	1
Nearer Public facilities	4	Other*	
Staff Access	3	*Not as cosy	2
More Privacy	2	*Less Homely	1
Other*		*Sharing Facilities	1
* Warmer / fewer draughts	1	*Worse furniture	1
		* More spread out	1

23% of patients found some fault with the new facility; five patients found it not as cosy or homely (which is an interesting perception as the facility for the old day hospital was an open ward with only modest conversion); one patient thought the new facility more noisy, another did not like the dining room, another the furniture.

In the old facility no patients used to get lost, however in the new facility four patients ( 5,6,10 and 18), regularly got lost and another four ( 4, 8, 16 and 20) sometimes got lost. It would seem that this disposition to be disoriented in the new facility could be attributed to the fact that the new facility comprised several contiguous rooms and the old day hospital was effectively a large ward.

Relationships with staff were predominately (87%) recorded as "same as before", with only 10% recording a "worse relationship" and 3% an "improved relationship".

## **Mental State Issues**

The interviewer was asked at the end of the interview whether he felt the patients comments were more reflectional of their mental state rather than a true opinion. One elderly man was said to be paranoid by nursing staff but this condition did not affect his answers. No other mental state issues were recorded that would cause the data to be qualified.

### **5.3.5 Relatives' and Friends' Views**

Six friends and relatives of patients attending the new day hospital were interviewed comprising two daughters, one husband , one son-in-law and two friends. With regard to the general question of an improved facility, 100% felt the living room decoration and furnishings were better than at the old facility, whilst 83% felt the overall general appearance and size was the same as before. 100% felt the new day hospital's dining room was better in all respects. All relatives advised they had been adequately informed about the new facility either by letter or by the patient. Five of the six relatives/friends had spoken to the nurse/carer about the new day hospital, four of whom had felt very much reassured after doing so, whilst one had felt a little reassured. The person who had not spoken to the nurse/carer had not wished to do so.

### **5.3.6 Staff Views**

A description of staff characteristics is shown at Appendix 5.8. 22 members of staff completed the questionnaire 11 of whom had worked on the Case 1 site prior to their transfer to the reprovided Adult Acute Day Hospital which was commissioned in October 1994, four months before the EMI day hospital. These staff were surveyed seven months after their move. The remaining staff were seven who transferred to the Adult Acute Inpatient unit and four who were relocated to the EMI Day Hospital. These staff members were surveyed three months after their move. The four staff members who transferred to the new EMI day hospital had worked in the day hospital within the institution. The average period of service was 13 years and therefore most staff had significant experience of "institutional hospital" work enabling them to make a comparison with the new facilities.

Staff who were willing to be interviewed were accepted from all grades and professions, the proviso being that they must have, in their professional duties, significant day to day contact with patients.

Amongst those completing the questionnaires was the consultant psychiatrist to the facility to whom the author is indebted for his help in undertaking this exercise. There had been some regradings generally to the benefit of staff.

All 22 staff reported that none of their conditions of service had changed as a result of the move. 10 staff had received increases in grade / status during the period of the move and 12 staff remained in the same grade. Staff were asked when and how they first became aware that the institution was due to close, and asked more specifically when they had found out that their ward/department was to transfer and how they were formally advised. Most staff were advised about closure more than three years before, mostly in staff meetings.

With regard to the hospital's service reprovision, of the 22 staff members responding, 15 were clear as to how that service reprovision was to be provided and seven were unclear. 21 of the 22 staff felt that it had been made clear where their part of the service would be relocated. Staff were also asked whether, if during the process of implementation, their understanding of the programme remained clear. Of the 22, 11 had remained clear and 11 had become less clear.

Staff were asked whether they had been advised in detail of the overall plan and its components together with its proposed timetable. 20 of the 22 staff felt that matters were fully explained to them whilst two did not. All staff members were also asked if changes in the plan as it was implemented were notified to them. Eight knew of changes, 12 were unaware of any and two did not know whether any changes had taken place. 20 staff responded that they had received regular updates, all through regular staff meetings. The two staff who said they had not were both enrolled nurses, grade D.

Questions were also asked to determine staff input to the planning process. It appeared that 11 of the 22 staff members had provided an input to the planning of services. Of those whose input had not been sought five replied that they felt it should have been and six that it had not been necessary. 19 staff members felt that their professional group had contributed to the planning process.

To the question whether they had known the professional representative/senior officer relevant to their work who was planning the service, 15 replied that they had and seven that they had not. Asked whether their "professional group" had contributed, 19 replied that they had, one thought they had not (nursing assistant) and two, that they did not know (nurses grade D). Staff were asked if the planning system had allowed them to make their views felt. 20 replied positively and two negatively.



Four staff members (consultant psychiatrist and 3 senior nurses) were members of the project team planning the service. Of the 18 who had not been members, three thought they should have been, (a deputy ward manager and a staff Nurse E). The four members of the project team were all involved in drafting operational policies and did this in multi-disciplinary groups with other care professionals. All felt they had been sufficiently involved in all aspects of the commissioning.

Of 20 staff members who had been shown the design of the facility, 19 had been able to comment as to whether it had met operational requirements. With regard to staff involvement in the choice of furniture and equipment, colour scheme and furnishings, ten staff members had been involved. Of the 12 who reported that they had not been involved, six thought they should have been.

### **Staff Training**

Staff were asked questions regarding training that would assist them with their work in the new facility - see Appendix 5.9. Of 22 staff, 11 staff members indicated that training had been offered to them and 11 that it had not. Of this latter group none thought that it should have been.

Of the 11 staff offered training, ten thought that it had been necessary. The staff member who did not avail him/herself of the offer was the physiotherapist as the training was facility related rather than clinical. Of the ten staff members who had received additional training, eight thought that the training had been good and two (staff nurse "D" and staff nurse "E") thought it adequate. Following the training process all staff were asked whether they now intended to seek any further training 19 thought no further training was necessary, but three would be seeking further training. Of the six that were not offered training only one had felt that further training was necessary to perform existing work and two wanted training for further career development.

### **Commissioning**

Four staff had been members of the commissioning team (consultant psychiatrist, nurse manager "G" and two ward managers "G"). Two (deputy ward managers "F") who had not been part of the commissioning team, thought that they should have been. The four members of the commissioning team advised they had had responsibility for all aspects of commissioning. With the exception of one staff member, all of the staff felt that the commissioning had gone well.

## Staff Views on the quality of the new facility

Overall 90% of staff views regarding the quality of the new facility were positive as to the adequacy of size, brightness, furnishings, decorations, durability and accessibility. Notably, proportions were somewhat lower for durability (86%) and size of rooms (77%). See Table 5.5.

<b>Table 5.5 Case 1 Staff Views on Quality of New Facilities</b>		
<b>Aspect of new facility</b>	<b>n = 22 max</b>	<b>(%) positive</b>
Adequate size	17	77
Bright / light	19	86
Furnishings	22	100
Decoration	22	100
Durability	19	86
Access	20	90
<b>WCs</b>		
Quantity	22	100
Proximity	22	100
Quality	22	100
<b>Bathing Facilities</b>		
Quantity	21	95
Proximity	21	95
Quality	19	86
<b>Support Facilities</b>		
Linen	22	100
Storage	21	95
Catering	20	90
Transport	19	86

In relation to the quality, quantity and convenient location of toileting facilities, an affirmative response was given by 100% of the staff. 92% of staff thought that bathing facilities were satisfactory across the range, but 13.5% thought that the bathing quality was not adequate.

All staff thought that facilities dedicated for their use were satisfactory.

Staff were asked whether support functions were satisfactory. Only in one facility was support services seen to be 100% satisfactory. In the other two, catering and storage attracted criticism, and transport in one facility was thought by 75% of staff to be unsatisfactory.

## Summary Staff Views

All 22 staff were asked, notwithstanding their degree of involvement, whether the final outcome "accepting that some physical and cost constraints will always apply" had been acceptable. All 22 staff replied that they thought it had been.

## General Health Questionnaire

The General Health Questionnaire was administered to 22 staff following their move to new facilities. This aimed to measure any impact the move might have had on the physical and mental health of staff members.

<b>Table 5.6 Case 1 - Summary of Staff Responses to General Health Questionnaire</b>											
	Score										
	0	1	2	3	4	5	6	7	8	9	10
Physical Health - Signs & Symptoms	20		1	1							
Tension / Stress	17	1	2			1	1				
Self Esteem / Job Satisfaction	17	5									
Depression	22	1						1			1
Total Score	16		1	2							

Only a few staff reported experiencing mood problems which is supported by correspondence from Chartered Clinical Psychologist 'J.S.' and Dr 'C.' Medical Officer, Occupational Health, responsible for staff - Appendix Letters 1 and 2.

It was anticipated that staff morale would be affected by the process of closure and subsequent redeployment to community facilities. GHQ scores indicate low anxiety and low depression levels in staff after the move. The occupational health department confirmed that mental health effects on staff as a consequence of the reprovision programme were indeed minimal.

## 5.4 CASE 2

### 5.4.1 Brief History

Case 2 was a county asylum and was opened in 1864. The hospital was set in 94 acres of land and had cost £6963 to purchase. The cost of construction at some £20,520 was a major issue as asylums were more expensive to build than workhouses. Charges of about ten shillings per head per week were being levied in an asylum whereas a pauper could be provided for, for as little as two shillings and six pence per week in a workhouse. Extensive grounds were a prerequisite, for like most other mental institutions of this era, the patients were encouraged to work for their keep in the many trades within the grounds, on a working farm or as a shoemaker etc.

Only the male wards were complete providing 240 beds when the hospital opened in 1864. The completion of the female wards added a further 530 beds.

### 5.4.2 The Closure Plan

Case 2, unlike Case 1, involved the complete reprovision in the community of a fully functioning Psychiatric Institution. Appendix 5.10 shows all the facilities to be reprovided in the programme and Table 5.7. shows those examined in this study.

Case 2 closure programme took place between early 1992 when the planning commenced and April 1995 when the hospital finally closed. Interim solutions were not necessary for inpatient reprovision but were required for Day Hospital services to achieve this closure programme.

### 5.4.3 Built Environment - Physical Surveys

The comparison of facilities is between the original institutional wards and day hospitals and the new or converted facilities in the community. The surveyed old ward (a 23 bedded EMI ward) had, in common with many other wards in these institutions, received some basic upgrading. The new facilities being compared are two 12 place EMI inpatient facilities which were former Local Authority Part III residential homes, managed by the Local Authority Social Services Department and partly funded by the NHS, a new purpose built building also providing 12 places for EMI inpatients as part of a larger new build psychiatric facility on a new community hospital site managed and funded by the NHS.

### Physical Survey Results

Two sets of data were collected; one measuring facilities against standards set out in the Health Building Notes (HBN 37, 1973) the other concerning environmental standards.

Table 5.7 Case 2 Original and Reprovided Facilities Compared			
CASE STUDY	EMI Inpatient (G)	TYPE	LOCATION
		Old (S)	Institution
		Refurbished / Conversion (G)	Stand alone in community
		Refurbished / Conversion (M)	Stand alone in community
		New Purpose Built (GB)	Stand alone on community hospital site
QUALITY COMPARISON	EMI - Day Hospital	Old (S/H)	Institution
		Interim (H)	Institution
		Refurbished / Conversion (W)	Stand alone in community
	Adult Acute Inpatient	Old (S/T)	Institution
		Purpose built (GB)	Stand alone on community hospital site

✓

Table 5.8 shows the detailed survey data and the scores of the facilities against the Health Building Note Standard. The detailed environmental data is shown at Appendix 5.11A

<b>Table 5.8 Case 2 EMI Inpatient Facilities Health Building Note</b>				
	<b>Old</b>	<b>New</b>	<b>New</b>	<b>New</b>
no. of places/beds	23	10	12	12
dist to wc >12m	14.5m	12m	11m2	11m2
w.c. 4.5m2	2.10m2	4.5m2	2.6m2	4.5m2
w.c. ratio 1:5	1 to 5	1 to 2.5	1 to 5	1 to 5
bathrm ratio 1:6	1 to 10	1 to 6	1 to 6	1 to 6
asst shower	yes	yes	yes	yes
asst bath	yes	no	yes	yes
single b/rms 11m2	12.18m2	9.25m2	yes	yes
multi-bed 8.5m2	n/a	n/a	n/a	n/a
curtained-off	n/a	n/a	n/a	n/a
single room whb	no	yes	yes	yes
quiet room	yes	yes	yes	yes
dining 2.5m2 p/p	yes	yes	yes	yes
enable 1 sitting	yes	yes	yes	yes
storage 0.2m2 p/p	yes	yes	yes	yes
consult/intervw rm	yes	yes	yes	yes
patient utility room	no	no	no	yes
wheelchair access	yes	yes	yes	yes
secure garden	no	yes	no	no
dorm/day identified	yes	yes	no	yes
ward/day integrate	no	n/a	no	no
handrails	no	yes	no	no
ground floor	no	yes	yes	yes
lift	yes	n/a	n/a	n/a

The distance to a wc improved in all the new facilities and met the required standards. Some compromises in the two converted schemes were necessary as they were refurbishments and extensions of existing buildings. The small wcs at 2.6m<sup>2</sup> in one conversion, where there was a highly dependent group of patients was some 1.9m<sup>2</sup> smaller than the required HBN standard

The size requirement for a single bedroom fell below the HBN standard in one of the new facilities.

The bathroom ratio in the old ward was only one to ten; on all new schemes the ratio of one to six was met. Both old and new schemes had assisted showers and assisted bathrooms to HBN standards and hand basins were not provided as in the old ward and were in all the new schemes.

All new schemes provided wheelchair access, dormitory and day space was clearly segregated. The integration of inpatient and day hospital facilities recommended in the HBN, however, could not be provided in the new facilities as they were all stand alone residential units.

The ground floor location which was not previously available at the old facilities, had a secure garden. Handrails throughout all the new buildings substantially increased the opportunities for those patients with limited mobility to use the facility more fully. All schemes were comparable on environmental standards and there was a marked improvement in all the new schemes in respect of their non-clinical appearance.

The number of places reduced from 23 in the old (S) provision to 10-12 places in the new facilities. However, there were now three inpatient facilities and thus a gain of 11 places had been effectively achieved.

Interestingly the decor within the new units only scored as "satisfactory", whereas the old facility was rated as "good". All the other standards were comparable.

Overall, this programme of accommodation for the elderly mentally ill represented a considerable improvement over previous facilities (albeit that the old facilities have been kept in very good condition). In terms of dignity and privacy the provision of single rooms, personal storage space and wash basin are significant "wins".

#### **Quality comparison of other facilities in the programme**

As a quality comparison surveys were made of old, interim and new EMI Day hospital facilities and Adult Acute Inpatient facilities old with new, see Appendix 5.11B. All these schemes were constructed in the same reprovision programme with the Elderly Inpatient facilities. All schemes both interim and new were significant improvements over the facilities they replaced and met all major requirements of the HBN and were equally well executed. The three EMI Inpatient schemes had not been developed at the price of reduced standards in other schemes.

#### **5.4.4 Effects On Patients**

##### **Age and Sex of patients**

The sample comprised 17 subjects, 11 women and six men. The mean age of the female patients was 77.8, (range was 25, maximum 91, minimum 66 while the median was 77 years). The mean age of the male patients was 71.7 years, (range 28, the maximum 84, minimum 56 whilst the median was 73.5 years. Further details are shown in Appendix 5.12

### **Duration in hospital**

Eight patients were selected from an assessment ward who had been in contact with this service for three months or less. Nine patients were long-term inpatients, with mean length of stay 10.6 years ranging between 37 maximum and 2 years minimum.

In Case 2 none of the patients interviewed died during the period of the study. In the control group, ( Case 'C'), four patients had died in the interval between first and second interviews.

### **Follow-up success**

The pre-move group comprised 17 patients. Eight of the patients interviewed were from (S), an assessment ward, and nine patients were from (F), a long term continuing care ward which was in good decorative order and was therefore chosen as the last to close.

A problem arose with the size of the patient sample. Originally a whole ward (22 patients) sample was to be available. The rapid reduction of the hospital population as the closure date approached was due to the activities of a very successful resettlement group. This group worked under the district psychologist as Director of Planning. This left only a small number of patients available. Appendix 5.13. demonstrates this effect and shows the discharge pattern which caused further problems as it was only possible to follow up those that went on to a case study site.

A Clifton Assessment Procedure for the Elderly (CAPE) interview was completed at baseline for 17 patients. The minimum time elapsing between pre and post-interviews was 69 days and the maximum time was 76 days. Of the 17 patients in the sample, four were discharged/transferred prior to the post-move interview and so were unavailable for post-move assessment. Two had been discharged to private nursing homes, one discharged home whilst the fourth had been transferred to the Adult Psychiatric Acute Unit at the local District General Hospital.

#### **5.4.4.1 Changes in Patients' Dependency Levels**

Baseline and follow up interviews (i.e. after the move) were completed for a group of 10 patients. They exhibited poor scores under physical disability, apathy and communication difficulties. There was however comparatively little social disturbance behaviour in this group.

Although there were differences in the pre and post-move scores, none of them reached statistical significance (using the Wilcoxon matched-pairs signed-ranks test). The total score



declined from a mean of 21.7 to 19.8, the apathy score declined from 8.3 to 7.7, communication difficulties declined from 2.5 to 2.2, physical difficulties from 8.8 to 8.2, and social disturbance from 2.2 to 1.8. (See Table 5.9 and Appendices 5.14. - 5.18).

Little change in the CAPE total scores was noted in this highly dependent group with only two patients out of thirteen showing any change. Although the mean total score improved (from 21.7 to 19.8) the difference was not statistically significant.

### Comparison with a control group

The EMI Inpatient control group of 14 (see Appendix 5.19) patients shared similar characteristics with the group from Case 2. They fell in similar age groups and had spent similar time in care; were in old and unsuitable accommodation of similar age; plans had been formulated for their move to other accommodation (which were known to both staff and patients).

### Changes over time

The control group scores showed little change between the first and second interviews. Total score changed from a mean of 20.1 to a mean of 21.3, the apathy score changed from 8.2 to 8.4, communication difficulties from 2.0 to 2.4, physical difficulties from 7.4 to 8.1 ( $p = 0.09$ ), and social disturbance from 2.5 to 2.4. None of the differences were statistically significant indicating that the level of dependency in the control group was stable. Further details are shown in Appendix 5.20 - 5.24.

### Case study and control group compared

<b>Table 5.9 CAPE Scores - Case 2 and Control Group Compared</b>							
	<b>EMI Day Hospital Patients</b>			<b>EMI Control Group</b>			
	<b>Pre-move</b>	<b>Post-move</b>	<b>Diff (p)*</b>	<b>1st Ass</b>	<b>2nd Ass</b>	<b>Diff (p)</b>	<b>Patient diff vs Control diff (p)**</b>
	<b>n = 13</b>	<b>n = 13</b>		<b>n = 10</b>	<b>n = 10</b>		
	<b>[mean(SD)]</b>	<b>[mean(SD)]</b>		<b>[mean(SD)]</b>	<b>[mean(SD)]</b>		
<b>Apathy</b>	8.3(1.0)	7.7(1.6)	0.23	8.2(2.7)	8.4(1.8)	0.75	0.46
<b>Communication Difficulties</b>	2.5(1.6)	2.2(1.4)	0.24	2.0(1.9)	2.4(1.8)	0.11	0.08
<b>Physical Difficulties</b>	8.8(2.1)	8.2(2.0)	0.28	7.4(2.3)	8.1(2.4)	0.09	0.05
<b>Social Disturbance</b>	2.1(2.2)	1.8(2.1)	0.29	2.5(2.4)	2.4(2.4)	0.87	0.35
<b>Total</b>	21.7(3.6)	19.8(3.8)	0.14	20.1(5.5)	21.3(4.4)	0.19	0.06
* p for pre vs post differences based on Wilcoxon Matched-Pairs Signed-Ranks Test							
** p for patient differences vs control differences based on Mann-Whitney U Test							

As shown in Table 5.9 the difference in physical difficulty scores between Case 2 patients and the control group reached statistical significance primarily because of a slight deterioration in the control group. The Case 2 group have shown a slight improvement, with the control group

remaining the same, or even deteriorating slightly. The overall difference almost revealed statistical significance and a larger sample would be required to determine whether these small changes were real or due to chance and whether indeed significant.

#### **5.4.4.2 Quality of Life - The Patient's Perspective of Reprovision**

Care staff in all three new facilities were asked to complete the Patient Questionnaire on Quality of Life on behalf of the patient immediately following the CAPE assessment and in the presence of the patient.

Patients / staff were asked if the bedroom was better than before and in all three new schemes the reply was positive, particularly since the previous accommodation had lacked privacy. In all three facilities the new accommodation had adequate heating levels, the room was of ample size, had adequate privacy and two cases had had a pleasant view which made it possible to see out of the windows from the bed whereas in the old facility it had not been possible to do so. In the new schemes telephones were available.

The old accommodation had been of the improved nightingale type, (an open ward with half height sub-divisions to create bays).

In the old facility the patients did not have personal belongings and in the new they were permitted furniture, pictures and ornaments. The new provision had been designed with en suite toilet facilities and it was easier to get the patient to the toilet than in the old accommodation. In two of the new schemes the patient could also get to the bathroom more easily.

In the old ward it was 20 metres to both the toilet and bathing facilities, and nearer in all the three cases in the new facility. The wc could not be locked by the patient in the old facilities and could be locked in all of the new schemes.

During the day in the old facilities the patients were taken to the dining room and sitting room, whilst in the new facility the patients were also taken to the outside garden. The patients' daily activities were limited due to their mental and physical condition and no organised activities were recorded.

With regard to how the new facility fared in comparison with the old facility, a 100% response agreed that the new facility was more private, quieter, had better dining and w.c. facilities. All three facilities were regarded as providing a better general environment and in two out of three cases they were nearer to public facilities.

The staff were asked on behalf of the patient whether or not the new facilities contributed to an improved relationship with the staff and in all cases this was recorded as same as before.

The three schemes had apparently all brought about significant improvements for this highly dependent group. The quality of the bedroom which is of prime importance had improved; heating levels were considered just right, (an important issue when the patient is incapable of controlling heating levels) and patients had acquired a view from windows not previously available. In addition, the new schemes allowed for a number of personal possessions to be kept in the patients' rooms. Toileting and bathing facilities, again of paramount importance to this group, had improved.

#### **5.4.5 Relatives' and Friends' Views**

Seven friends/relatives were interviewed comprising two sons, three daughters and two wives of the patients. Five of the patients had moved to (M) and two to (G). Both of these facilities were operated jointly by NHS and Social Services staff.

On the general question of improved facilities, all relatives agreed that they were better. The relatives felt that they had been informed adequately about the move mainly through the joint Local Authority Social Services/NHS Resettlement Group. Three relatives thought that the new site (M) was easier to visit being nearer, one reported an increased travel distance and one the same as before. All seven relatives spoke to a nurse/carers about the move. 85% had most of their questions answered with 60% feeling "very much reassured" and 40% a little reassured. Relatives, asked whether they thought that the patient liked the new facility, reported positively in four out of five cases.

Two of the relatives, related to patients going to (G), thought that the facilities were better in all respects with the exception of the size of the dining room and both felt that the patient liked the new facility in all respects.

#### **5.4.6 Staff Views**

Description of Staff characteristics is shown at Appendix 5.25. Ten staff completed the questionnaire. All had worked on the Case 2 site, all reported that none of their contract conditions of employment had changed as a result of the move. All staff had had significant experience of "institutional" hospitals. The average period of service was 13.7 years.

Staff, asked when they first became aware the institution was due to close, reported having been notified one to two years before closure mainly through staff meetings. Staff were asked whether they, on their first formal advice of the closure of their hospital and the reprovision of their facility, were clear or unclear as to how the service would then be provided. Nine of the ten staff felt that it had been clear where their part of the service would be relocated.

Staff were also asked whether if, during the process of implementation, their understanding of the programme remained clear. Of the ten, three remained clear and seven became less clear. Staff were asked whether they had been advised in detail of the overall plan and its components and its proposed timetable. Eight of the ten staff felt that matters had been fully explained to them. They were also asked if changes in the plan as it was implemented had occurred. Five knew of changes, four were unaware of any and one did not know whether changes had taken place. Nine staff members felt it had been made clear where their part of the service would be relocated, while one did not. Seven staff responded that they had received regular updates, mainly through staff meetings and three staff said they had not (staff nurse "D", staff nurse "E" and a health care assistant). Two of the ten staff members had provided an input to the planning of services.

Of those whose input had not been sought three said that they felt it should have been and five that it had not been necessary.

Staff were asked if they had known the representative/senior officer relevant to their work who was planning the service. Eight replied that they had. Asked whether their "professional group" had contributed seven replied that they had, two (staff nurses "E") thought they had not. To a question whether the planning system had allowed them to make their views felt six replied positively and four replied negatively.

Two staff had been members of a project team planning the service. Of the eight of the sample who were not members of a team, one (senior registered care worker) thought he/she should have been. Of the two members of the project team, only the senior charge nurse had been involved in drafting operational policies. The other senior sister "G" felt she should have been, however, both had been involved in multi-disciplinary groups with other care professionals. Staff were asked whether they had been shown the eventual design of the facility six replied they had, four (two staff nurses "D", one health care assistant and one senior registered care worker) had not and felt that they should have been. All four felt that they should have been shown the design. Five of the six staff members who had been shown the design reported that they had been given the chance to comment as to whether it met operational requirements. Four staff members had been involved in the choice of furniture and equipment, colour scheme and

furnishings. Four of the six replied that they had not and of those six that had not been four thought they should have been.

### Staff Training

Staff were asked questions regarding training that would assist them with their work in the new facility. Of ten staff, five indicated that it had been offered to them and five that it had not. Of those who had not been offered training, three (senior charge nurse, senior sister "G" and senior registered care worker) felt it should have been. (See Appendix 5.26). Of the five staff members who had been offered training, two (staff nurses, "D") felt it had not been satisfactory because it had been inappropriate/not targeted. One (staff nurse "E") thought that it had been good, whilst two (health care assistant, staff nurse "E") felt that it had been adequate.

### Commissioning

Two (staff nurse "E", senior sister "G") had been members of commissioning teams. They reported that their responsibility had been confined to the ward/department and not for all aspects of commissioning. With the exception of two staff members (staff nurse "E", senior registered care worker), the other eight staff felt that the commissioning had gone well.

### Staff views on the quality of new facilities

Staff were asked (specific questions principally relating to those facilities for patients) whether they thought the facilities were generally good or bad. 100% replied they thought the facilities were generally good.

<b>Table 5.10 Case 1 Staff Views on Quality of New Facilities</b>		
<b>Aspect of new facility</b>	<b>n = 10 max</b>	<b>(%) positive</b>
Adequate size	7	70
Bright / light	9	90
Furnishings	10	100
Decoration	10	100
Durability	10	100
Access	9	90
<b>Wcs</b>		
Quantity	8	80
Proximity	10	100
Quality	7	70
<b>Bathing Facilities</b>		
Quantity	10	100
Proximity	10	100
Quality	9	90
<b>Support Facilities</b>		
Linen	9	90
Storage	2	20
Catering	9	90
Transport	9	90

From Table 5.10 it can be seen that over 90% or more of respondents were positive as to the adequacy of , brightness, furnishings , decorations , durability and accessibility. A lower score of 70% was achieved to the question of "Are patient areas big enough?"

Further questions were asked on toileting facilities relating to their quality, quantity and convenient location. An average of 83% of staff thought that toileting facilities were of adequate quantity, proximity and quality. However two of the schemes were conversions of existing buildings requiring some compromises in standards. Staff were asked about the quality, quantity and convenient location of patient bathing facilities. 96% of staff replied that facilities were satisfactory across the range.

### Support Services

(M) & (G) scored high, with the exception of storage space which was considered by nearly all of the staff to be inadequate, a frequent complaint at almost every NHS facility.

### Summary of Staff Views

All ten staff members were asked notwithstanding their varying degrees of involvement, had the final outcome "accepting that some physical and cost constraints will always apply" been acceptable. Eight staff replied that they thought it had while two (staff nurse "E" and a senior sister "G") felt it had not.

In the development of these facilities attention was apparently paid to ensuring comprehensive consultation with staff during the planning process. The probable benefit of the consultation was that most of the staff as well as most of the patients and relatives found the solution acceptable.

#### 5.4.7 General Health Questionnaire

The General Health Questionnaire was administered to ten staff following their move to new facilities.

Table 5.11 Case 2 - Summary of Staff Responses to General Health Questionnaire											
	Score										
	0	1	2	3	4	5	6	7	8	9	10
Physical Health - Signs & Symptoms	10										
Tension / Stress	9		1								
Self Esteem / Job Satisfaction	10										
Depression	10										
Total Score	9		1								

Appendix Letter 3, correspondence to Chartered Clinical Psychologist 'R.H.', confirms that as the above result shows, with the exception of one staff member exhibiting mild symptoms of stress, no staff admitted to any mood problems. This indicates that mental health effects on staff due to the reprovision were minimal.

## **5.5 CASE 3**

### **5.5.1 Brief History**

Case 3, this hospital built in 1853, was set in 86 acres of land and purchased for £8000. The building contract was awarded in the sum of £57,920. The hospital was originally built to accommodate 300 patients but this was increased to 400 before the hospital opened. By the 1960s the hospital population exceeded 1,600 patients. At the time this research commenced, in 1993, it had the largest population of any UK psychiatric institution. The hospital was requested by its two purchasers to prepare a plan at the end of that year for reproviding its services in the community.

### **5.5.2 Closure Plan**

The Reprovision Plan, see Appendix 5.27, was formally placed before the Purchasers in mid 1993 and then similarly to the Provider Board. Discussions then took place with the NHSME as to the best process for submission as a case for funding.

### **5.5.3 Built Environment**

The pre-move survey of an EMI day hospital was made although there was no move to a new facility.

Generally the EMI day hospital was acceptable although no view was available from a sitting position which is a substantial criticism and, whilst the decor was satisfactory, the overall effect was still clinical and the heating was inadequate even on a warm June day. Patients would not therefore find this welcoming. They would be attending a converted ward in a large institution where it was not possible to see outside the windows, the building had a clinical feel and was cold in June and Case 3's hospital is, in any case, in a bleak and exposed position.

The ward was in an unfortunate location, inadequately lit and requiring artificial lighting all day. It was not the most uplifting environment for a group of patients who would spend much of their

day in the room. In other respects the ward was satisfactory. The ward and day hospital merit early replacement.

#### 5.5.4 Patient Data

No formal survey of patients could be undertaken as there was no move of patients into reprovided facilities. The Team for the Assessment of Psychiatric Services, (TAPS) however did undertake a survey which gives some indication of the population. This is of interest in support of the finding in the National Study that indicates an increasing complexity of case mix in hospitals with no closure programme.

The hospital population was surveyed by the Team for the Assessment of Psychiatric Services (TAPS) in November, 1995 to estimate levels of Difficult to Place (DTP) patients. The numbers of psychogeriatric patients designated as DTP are as follows:

Table 5.12 Case 3 - TAPS Difficult to Place ( DTP ) Study		
	DTP	LIKELY DTP
60-70 year olds: - mostly female, functionally ill, various behavioural problems	12	8
Over 70 year olds: - functionally ill problems: - incontinence, aggression	6	3
55-65 year olds:- Pre-senile dementia	17	-

In addition TAPS reported "*considerable numbers of elderly functional patients to have physical disabilities, incontinence and cognitive impairment not considered DTP which would be manageable in private nursing homes*". (Trieman, 1996).

TAPS considered that a notional three years before closure this population contained a relatively high proportion of DTP patients at a maximum of one third of the hospital long stay population.

#### 5.6 QUALITY CONTROL - FORMAL AUDIT OF FIELDWORK

##### I) BAS Scores

Five out of the 30 interviews in Case 1 and four out of the 10 interviews in the control group were conducted with a second "blind" marker present in the room. The measure of exact agreement between the two raters on the Organic Brain Syndrome Scale was 0.8, (Kappa = 0.44) and their measurement of agreement on the Depression Scale was 0.24 (Kappa = 0.27)

Five out of the nine patients were given the same dementia score by two raters, and the scores for the remaining four patients were all within one scale point of each other. However, only three



out of the nine patients were given the same depression score by the two raters. Four patients were given scores within one scale point, and two were rated two points apart.

**ii) CAPE Scores**

A 100% audit of the research assistant's work by the author was conducted by blind marked interviews for the CAPE control group patients. Of the total of 200 questions responded to by patient or staff, differences were recorded between blind marker and the research assistant for only four questions representing a 2% divergence.

Errors in marking were discussed with the researcher. With very few exceptions, the errors were on the part of the blind marker reflecting the greater experience of the research assistant who was a qualified psychiatric nurse and retired Director of Nursing.

<b>Chapter 6 Discussion - The National (England) Study</b>	<b>163</b>
<b>6.0</b> Introduction	<b>164</b>
<b>6.1</b> Limitations of the study	<b>164</b>
<b>6.2</b> Strengths	<b>164</b>
<b>6.3</b> Weaknesses	<b>165</b>
<b>6.4</b> Alternative Approaches	<b>165</b>
<b>6.5</b> The Principal Findings	<b>165</b>
<b>6.5.1</b> Success of Community Care Policy	<b>165</b>
<b>6.5.2</b> Determinants of Progress	<b>166</b>
<b>6.5.3</b> Problems of failure to close	<b>167</b>
<b>6.5.4</b> Reductions in Provision	<b>168</b>
<b>6.5.5</b> Inequalities	<b>169</b>
<b>6.5.6</b> Funding	<b>169</b>
<b>6.6</b> Summary	<b>170</b>

## **6.0 INTRODUCTION**

The study followed 82 hospitals through 1993-1995 and their attempts to formulate and implement reprovion programmes. The study examined the progress of each hospital, their management structures, funding sources, changes in their population, case mixes and staff numbers. Programmes and delays and the quality of remaining stock were examined.

### **6.1 LIMITATIONS OF THE STUDY**

The survey obtained its data through a postal questionnaire with telephone follow ups rather than direct face to face interviews. The questionnaires were not always fully completed and these were followed up. However, often the staff completing the questionnaires, for the most part senior (see Table 4.2.), did not know all of the answers.

Despite best efforts at consistency, questionnaires were completed at different times of the year. Terminology varied between hospitals and their interpretations varied despite an explanatory note which was issued for 1994/1995. Some "desirable" questions were omitted in order to keep the questionnaire of reasonable length. Furthermore, some sensitive questions simply could not be asked using this format. Finally, there were changes in respondents over the three years of the study and response rates fell in each successive survey.

### **6.2 STRENGTHS**

The literature review indicated that other than the IACC Water Tower Studies (Davidge, 1993 and 1994), which reported problems in obtaining data and some important gaps, there had been no attempt at a current national study. The lack of routine government data and the importance of being able to monitor the success (or otherwise) of Community Care policy means that this current study has a high profile.

The study design gave a complete and national picture. Some key data could be cross checked from secondary sources. e.g. Trust Status (DoH circular), hospital bed numbers (IHSM year book) Regional populations (DoH). Over a three years study, many of the discrepancies in data (e.g. unusual values) could be discussed with hospitals and rescheduled. The "delinquent" hospitals could be persuaded (some more easily than others) to give key data over the phone. Finally, there was a continuum of contact with the hospitals.

### **6.3 WEAKNESSES IN STUDY DESIGN**

In the final analysis, non-responders could not be persuaded to comply and further detail in responses could not be obtained. To ensure comparability of data between hospitals all data was quantitative (the case studies attempt to address some qualitative issues) in nature, and some of the sensitive issues might have been tackled better by in-depth interviewing.

The respondents, albeit senior and difficult to identify in the first place, had varying skills and degrees of knowledge and probably interpreted questions, at least to some degree, differently. Attempts to simplify questions made some responses difficult to interpret. Resources were limited and the need to embark on the next year's round of questionnaires overtook the ability to follow up observations on the previous years.

### **6.4 ALTERNATIVE RESEARCH APPROACHES**

The ideal, a randomised controlled trial would, considering the dynamics of the closure programme and the variables in the range of circumstances of each hospital, be impractical. The A group of hospitals being fairly static - "stable state", could comply. This group was however, the least able or willing to supply data and it is hard to imagine DoH funding a Region which allowed some category A hospitals to make no progress so that a scientifically respectable control group could be compared with a rapid planned closure group.

The response rate and quality of response might have been improved, if it had been possible to visit all of the 82 hospitals. Over three years this would have been beyond the resources of this study although some hospitals were visited in person.

A smaller sample could have been examined in more detail. This has been previously the normal practice for this type of study. The inherent strength of a national study was seen as a worthwhile goal despite the obvious drawbacks.

### **6.5 THE PRINCIPAL FINDINGS**

#### **6.5.1 Success of Community Care Policy**

- i) The introduction of Community Care for the mentally ill has been stated as a priority for the NHS and it would be thought that most hospitals should have agreed plans. In 1995 24 hospitals (41% of those remaining open) had no agreed programme and only four could advise that they were making any progress towards formulating one.

- ii) In a national reprovion programme it should be possible for hospitals with the worst accommodation to be targeted for early closure and the study showed that in many cases the worst hospitals i.e. those still with predominantly open plan "Nightingale" wards were closing first.
- iii) The psychiatric institution will be part of the NHS for many years to come. Projections based on the performance of those implementing programmes indicate that at least 25 institutions will still be open after the year 2000 assuming an immediate solution is found to the capital funding problem. This finding is supported by Davidge's report (1994) which predicted that 23 hospitals would be open after the year 2000. The years further data collection in this study is presumed to account for the difference.

### **6.5.2 Determinants of Progress**

- i) Both in the case studies and the national survey, the length of programme required for the largest capital scheme was shown to be the determinant of programme length after funding has been agreed. This is useful knowledge when examining progress with hospitals' closure programmes. Even though patient numbers may have reduced due to smaller schemes or alternative placements, the institution cannot close until its largest scheme is completed. If the large scheme has not yet started the hospital will take at least three years to close, as in Case Study 1.

The lesson to be learnt from this data is that programme lengths, once funding is in place, are often determined by the length of time the major capital scheme in the programme will take to be implemented and that management resources should be devoted to this part of the programme at the earliest possible date to avoid delay. As major capital schemes (usually at least the acute psychiatric units) determine programme lengths, if these schemes were pre-funded then programme lengths would be shortened.

Unfortunately purchasers are loath to approve discrete parts of community services without knowing the total picture and more particularly the total costs.

- ii) Those hospitals with Trust status performed better than those without. The reprovion programmes of those hospitals with earlier Trust wave status were more advanced than those with later Trust wave status and the earlier Trusts increased their proportion of the advanced programmes over time.

The national study showed that major capital schemes are the principal cause of delay in programmes after funding is agreed. Only 40% of programmes completed on time. Therefore, even when the major scheme is commenced the closure date is still not certain. This finding is supported by the comprehensive Kings Fund report (1997) commenting on the delays in introducing community services which identified that - *"There is a lack of management capacity and capability to manage change in a highly complex service" and that "only 9% of health service managers had a management qualification that would be recognised outside the NHS".*

The formulation of a closure programme and its implementation could be seen to be very complex. Plans might take longer to formulate where the hospital has multiple purchaser arrangements. No evidence was found to support this.

It might be thought that as many of the problems associated with the implementation of community mental health programmes are related to obtaining planning consents and procuring buildings suitable for community mental health use, owning a number of small satellite facilities with existing health use at the outset of the programme could facilitate implementation. No evidence was found to support this. (However in the Case studies the ownership of a large site permitting major capital development was seen to be influential on programme length).

### **6.5.3 Problems of failure to close**

- i) The percentage occupancy of available beds in institutions was 90% during the survey and ward numbers were not being reduced in line with hospital populations. This conflicts with the reported pressure on beds for the mentally ill. In Acute Psychiatric Units the mean occupancy rates can be as high as 114% to 122%. (Kings Fund, 1997). The 90% occupancy in institutions may be attributable to attempts to avoid inappropriate casemixes and single sex wards. The finding is supported by Knapp et al (1990) where he identifies the importance of "retrenchment" - relocation of patients within the hospital to maintain economic ward populations. He questions the desirability on clinical and social grounds which correlated with this study's finding that there are, notwithstanding national pressures for more beds, limits to the retrenchment process and that ward populations have decreased.
- ii) There is a change in case mix in hospital populations across all hospital categories (including those with no plans to close) which relates directly to the implementation of community mental health programmes by third parties not the NHS. This indicates the

placement of easy to settle patients first, acute, difficult to place and secure last and would support the case that small populations cost more. This is not only because of irreducible fixed costs but because the residual population comprises the more expensive patients. This finding is supported by Knapp et al (1990) in his paper predicting the community costs of closing hospitals where he states *"hospitals settle less dependent patients first, those remaining behind have increased dependency with a predictable impact on costs"*.

- iii) As hospitals advance their closure programmes through Categories A to D, they acquire more complex case mixes within their declining populations which increases their costs both to service these patients and reprovide for them. The finding is supported by Knapp et al 1990, who suggested that later cohorts with higher dependency require more expensive and specialised facilities for community placements.
- iv) It has been stated that a significant factor in the double running costs of hospitals near to closure is the higher number of staff required to cope with partly filled wards and services dispersed over large sites. This proved to be the case. The patient staff ratio increased significantly in the final year of closure (Category D), a steady state (Category A hospital), had typically a patient staff ratio of 1: 1.7 and a Category D in its last year of 1:2.3.
- v) The number of hospitals with small populations of less than 200 increased over the survey to 42% of all hospitals. This finding is supported by Davidge's data (1994) which showed the average population of institutions as 223 in 1993 and 206 in 1994 compared with this study's results of 232 in 1993 and 202 in 1994. The costs, therefore, of maintaining the institutionally-based patients increases with time due to substantially irreducible fixed costs being set against declining populations. This could be avoided if those managing the programmes maintained populations as high as possible until immediately before closure.

#### **6.5.4 Reductions in provision**

In the National survey responses indicated a 17% reduction in bedded provision. A survey of 6 hospitals' published detailed reprovision plans showed that NHS bed numbers were reduced in the subsequent year from the original (and presumably agreed through public consultation) planned numbers. The reduction ranged from 10% to 30%. This is supported by the findings of Lelliot et al (1993) and Lelliot and Wing, (1994) who stated that the massive bed closures have not generally resulted in equivalent investment in community facilities.

Community Health Councils have also noted these variations in plans. The chair of Barnet Community Health Council (CHC) announced that her CHC had voted unanimously to pursue legal action and would be seeking a judicial review against the decision of its local Health Authority's plans to begin the closure of services at a local hospital. The CHC's case is "the situation has changed ..... the plans are different from those consulted on and are therefore illegal". (N. Lambert, 1997).

If reductions of the services stated in published plans after consultation are found to be illegal many of the reprovision plans in this study could be open to legal challenge.

### **6.5.5 Inequalities**

- i) Community-based mental health care is not being introduced at an equal rate throughout England and there are also significant differences across the English health regions in the rate of closure of psychiatric institutions. The eight regions have broadly similar populations, however. At the end of 1995, South Thames, the worst performer, had eleven institutions still open and West Midlands, the best performer, only three.
- ii) It might be thought that for given populations similar services would be required. The study revealed that other than the core services of the acute adult inpatient, day hospital and elderly mentally ill assessment unit services appeared to be variable in their nature and some had apparently significant omissions. Sainsbury (1996) carried out a survey of 38 mental health services with similar findings and reported "scales and styles of Mental Health reprovision varied widely across the country". They also found no correlation between inpatient and day hospital places as in this study. Davidge (1994) also reported very wide variation levels of bed reprovision between localities, as found in this study.

### **6.5.6 Funding**

- i) The Government is currently promoting the Private Finance Initiative (PFI) and looks to the private sector to play an increasing role in the funding of NHS capital programmes. This study was carried out prior to the PFI. However, the Unconventional Finance (UF) procurement route was available and suitable for many of the smaller community schemes. The study showed that the private sector was showing a declining enthusiasm for these projects. This finding is supported by Appleby et al (1993) who found at the beginning of this study only limited use of private sector funding. It is therefore not surprising that present indications are the PFI which replaced UF and which is infinitely more complex is having less success.



- ii) The charitable sector's contribution to funding capital schemes for community mental health facilities fell from 16% of all non-NHS funded reprovion in 1993 to 4% in 1995. The reduction of activity by these specialist groups often with unique expertise in Community based services is most unfortunate and ways to encourage their return should be urgently investigated.
- iii) Regional Health Authorities formulated community reprovion programmes relying on the income from disposals of the former institutions' sites for a significant component of the funding of these programmes. These sites, due to the complexity of town planning, land use classes and the "listing" of the old institutions as buildings worthy of retention, have proved to take much longer to dispose of than anticipated and the NHS has had in the meantime to find funds from elsewhere to sustain the programme. Given time and the completion of the necessary complex negotiations, they are saleable and still remain an untapped source of funds.

## **6.6 SUMMARY**

- 1) The rate of reprovion of mental health services varies widely across England and the content of those services when provided, has few common elements.
- 2) Significant delays occurred in 60% of reprovion programmes and 41% of those hospitals open at the end of 1995, had no plans to close agreed.
- 3) The findings indicate that the cost of operating the institutions is rising whether they are closing or not due to increasingly complex case mixes, reducing populations, increasing staff patient ratios and the cost of providing services in old, large, dispersed and dilapidated buildings.
- 4) Funding pressures beset the system, the Private Finance Initiative, now the principal source of capital, has provided no significant funds to the NHS. Housing Associations have maintained their contribution. The charitable sector funded schemes in 1995 were less than a quarter of the level of preceding years.
- 5) The NHS management reforms, that set up Trust hospitals and introduced the purchaser and provider split, are not an impediment to the reprovion process. Trust hospitals had more advanced programmes than non-Trusts and continued to improve their position.

- 6) The mental health institutions will still be part of the NHS into the next century. Conservatively 25 hospitals will still be open even assuming capital funding solutions are immediately available. The reprovision of these facilities will be more costly than those for previous institutions as more specialised community facilities will be required for their more dependent populations.

## **CHAPTER 7**

### **DISCUSSION - THE IN-DEPTH CASE STUDIES**

<b>7.0</b>	<b>Introduction - The Case Studies</b>	<b>173</b>
<b>7.1</b>	<b>Limitations of the Case Studies</b>	<b>173</b>
<b>7.2</b>	<b>Strengths of the Study</b>	<b>174</b>
<b>7.3</b>	<b>Alternative Approaches</b>	<b>174</b>
<b>7.4</b>	<b>The Principal Findings</b>	<b>175</b>
<b>7.5</b>	<b>Case 3 - What went wrong?</b>	<b>179</b>
<b>7.6</b>	<b>Case 3 - Could they have succeeded?</b>	<b>180</b>
<b>7.7</b>	<b>Summary - The Case Studies</b>	<b>181</b>

## **7.0. THE CASE STUDIES - INTRODUCTION**

This chapter discusses and compares the findings set out in Chapter 5, the results of the micro studies. These three case studies demonstrate different patterns of closure planning.

Case 1, a Category C hospital when this survey commenced was largely closed having dispersed its "easy to place" patients. The closure programme had stalled due to inability to secure capital. The Regional Health Authority alarmed by the high unit costs of the hospital belatedly made capital available, the price of which was that the hospital was to close as quickly as possible. Case 1 closed in three years following this decision by the RHA.

Case 2, a Category A hospital when this survey commenced did not have an agreed and funded plan for reprovision nor had the RHA targeted it for closure. As part of its business plan applying for Trust status, it requested that funding. It achieved Trust status in the 2nd wave, one of very few community and mental health Trusts to do so and secured funding. Case 2 closed in just over four years from a "cold" start.

Case 3, a Category A hospital in a large community and a mental health Trust at the beginning of this survey has struggled and failed to achieve funding or agreement with its purchasers. It formulated its plans late, and now faces a more complex arrangement (PFI) to obtain capital.

### **7.1 LIMITATIONS OF THE CASE STUDIES**

The sample sizes of patients, staff and carers have been small. This was a necessary price for attempting to obtain the views of all users of a service, the staff, patients, relatives and friends. The interval pre and post-move had to be kept reasonably short to allow for the limited recall of patients and also to reduce the opportunities for patients to be transferred or die, and to avoid problems due to staff turnover. This created a relatively short "window of opportunity" preventing more extensive sampling. In addition, as the numbers of patients, staff and relatives were finite and relatively small, the usual statistical sample size estimates were not very helpful.

There were also problems in dealing with the issue of whether it was managerially prudent to interview staff before the move, as many of them would be undecided about their future and morale could be affected. Similarly, the possibility of affecting public relations was raised as an objection to interviewing relatives and friends before the move. In both cases a pre-move interview could have produced some interesting results to compare with the post-move interview. However, this was not possible but it might be expected that pre-move interviews would identify more dissatisfaction and anxiety associated with anticipation of the move.

## 7.2 STRENGTHS OF THE STUDY

The samples, whilst small, involved all users of a service and allowed the views of staff, patients relatives and friends to be compared. In total 76 patients, 32 staff and 13 relatives were interviewed. The buildings study allowed the old, interim and new facilities to be surveyed and compared. In the main they were in use allowing the involvement of staff and patients in those surveys and permitting the health building note standards to be compared with users' views. The survey of buildings also extended to other principal facilities in the reprovion programme allowing a check to be made of **overall** quality of reprovion to ensure that the case study building was not the only reprovion building of quality in the programme and that it had not been built to a standard that required the quality of other buildings in the programme to be reduced to stay in budget.

The case studies also provide an in-depth evaluation of how the closure plans studied nationally and reported in Chapter 6 were implemented. Of particular interest in any planning process is not just the achievement of a goal, in this case, closure of a hospital, but how the planning process affected people, the users and providers of the service.

## 7.3 ALTERNATIVE APPROACHES

The organisation of the case studies involved interviewing patients, staff and carers before (patients) and after moves. This was only possible with the extensive co-operation of users, particularly NHS staff. A longer time interval before post-move interviews could have been allowed probably with only minimal loss of quality of response, but with a considerably larger risk of loss of patients. Patients in such long stay institutions are particularly frail and deaths are common. The control group selection was a difficult process as it involved finding a comparable group of patients in equally poor pre-move accommodation and willing to be interviewed within the timescales of the study. Despite these difficulties the work was conducted with efficiency and without recourse to a large team of research assistants. Had extra resources been available, ideally a research assistant in each hospital would have been employed to carry out qualitative, in-depth interviews with services users, to quantify, using standardised tools, their quality of life pre and post-move, and conduct a long term follow up of users, once the post-move elation had died down.

#### 7.4. THE PRINCIPAL FINDINGS

1. *Cases 1 and 2 demonstrated that interim schemes to facilitate early closure if properly planned at the outset, can bring an improvement in quality over that in institutional facilities.*

The interim facilities in Case 1 and Case 2 were planned at very short notice on small budgets and comprised the conversion of a redundant ward which managed to correct many of the deficiencies of the old day hospital. The interim day hospital in Case 2 also managed to bring about an improvement, albeit less marked.

The creation of these better quality interim environments was undertaken for a low cost adding strength to the argument that for hospitals in closure, modest continuing investment on decorations and furnishings can do a lot to improve standards even in very old buildings.

2. *The case studies demonstrated that time constrained capital schemes in short programmes, including complete reprovisions (Case 2), can be completed to health building note standards.*

In Case 1 the new development, with only minor omissions, met all requirements resulting in a high standard EMI day hospital. The capital programme, including the three major schemes required to reprovide the hospital services, was completed in three years.

In Case 2, all three new schemes brought about improvements in accommodation standards as measured against the Health Building Note from those provided in the institution. Some compromises in the two refurbished schemes were necessary as they were conversions of existing buildings. In terms of dignity and privacy however, the provision of single rooms, personal storage space and possessions and wash basins are significant benefits.

These findings were supported by the views obtained from the patients. In Case 1, 77% of a group of largely physically active elderly mentally ill day patients, thought the new facilities were better. In Case 2, a group of largely bed-bound elderly mentally ill patients with severe physical and cognitive impairment, proxy respondents (their relatives) and staff, all thought the facilities better, and 85% of the relatives thought that the patient liked it in all or most respects. This is similar to the findings of Wills (1996) studying the views of family members on community placements of the elderly.

The majority of the staff were also of the opinion that the schemes were satisfactory. When asked if the final outcome "accepting that some physical and costing constraints will always apply" had been acceptable, in Case 1 100% and in Case 2, 80% of the staff felt that the outcome had been acceptable.

It is possible that their high levels of acceptance of the new schemes reflect "acquiescence" bias - the tendency for people to agree with authority. This is an unlikely explanation for the findings as the physical survey data also demonstrated tangible improvements in facilities, the objective mood ratings showed positive changes, and the interviews were not conducted by someone obviously associated with the closure programme.

3. *Cases 1 and 2 demonstrated that comprehensive consultation with staff in the briefing and design of capital schemes results in facilities that are more acceptable to them. This appears to be because even though there may be some shortcomings against "an ideal standard" due to financial or physical constraints the staff have been party to the options and the decisions, priorities and choices.*

The planning process for health services is complex, subject to setbacks, and changes in direction. It is difficult to choose the correct point in time to advise staff of progress as the explanation of current events can confuse rather than clarify the position. Judgement is required as it is likely that staff and patients in different positions will have different information needs.

Following a detailed initial explanation, in both Cases 1 and 2, 30% of the staff were uncertain of what the future plan meant to them. This rose to 50% during the implementation process. This, notwithstanding the fact that when asked whether the new service and its timetable were explained to them, over 90% responded that it had been. Staff were asked whether they had received regular updates on progress. In Case 1, 90% said they had, with over 90% in Case 2. Although there were very significant changes in the Case 1 plan, 64% of those responding claimed to be unaware that there had been any changes. It should be borne in mind telling people what is happening is no guarantee that they will either retain the knowledge or understand it. Also, it might be expected that as implementation of a plan occurred people would feel more anxiety and less certainty about its meaning for them.

Perhaps staff in clinical situations are more concerned with the detailed aspects of the moves and the personal implications than with the wider strategic aspects. Therefore, it is not until they have had operational experience in a new service that they can judge the acceptability of the outcome.

Staff were asked if either their representative or professional group had allowed them to make their views felt, 86% responded positively in Case 1 and only 60% in Case 2. This second case shows a much lower level of satisfaction with the planning process. This difference may in part be explained by the findings of Wills et al (1997) in his study where NHS staff were transferring to social services run buildings as in Case 2 (In Case 1 the transfer was solely to NHS building). NHS staff having to work in multi-disciplinary teams with non-medical personnel find it difficult to give up their professional identities.

In the commissioning of buildings it has to be accepted that some staff will change. In Case 2, only four of the staff interviewed had been involved in the choice of furniture and colour scheme. This is unfortunate; staff turnover itself conspires against involvement in the building design but furniture and equipment choices are made much later in the process, often not long before the building is to be commissioned and involvement in these choices assists in obtaining ownership of the scheme by the staff. Higher priority could have been given to this aspect of planning in both schemes.

4. *The study demonstrated that there is concern that elderly mentally ill patients are physically and mentally fragile and that moving them into new environments will bring about a deterioration in their health.*

Case 1 demonstrated a small improvement in the levels of depression in day hospital patients after the move in comparison with a control group who did not move. This suggests that the reduction in depression levels amongst the Case 1 patients could be attributed to relocation.

This finding is supported by Trieman et al (1995) who in a study of 130 functionally ill long stay patients compared outcomes of a group who had left the hospital with a similar group who remained there. The results indicated that the behaviour of patients settled in the community was stable and even improved slightly over time as opposed to those who remained in hospital and deteriorated.

In Case 2 the severely physically and cognitively impaired patients did not deteriorate and though none of the changes demonstrated statistical significance, they did suggest that the Case 2 group showed a trend of slight improvement compared with the control group which remained the same or deteriorated slightly.

It is to be expected that little improvement can be brought about for these patients as their condition is one of progressive degeneration. The findings are compatible with the observation made by Johnstone et al (1981) and Trieman et al (1996). "Community based patients showed



a more moderate decline in cognitive performance than their hospital counterparts" and the conclusion that "new forms of milieu which have proved more stimulating and interactive than hospitals seem to sustain a potential of slowing down the declining course of cognitive functioning".

Harwood (1992) in a much larger study of 101 patients relocating to new or refurbished accommodation and using CAPE to measure change discovered modest improvements after relocation. He also supports this finding.

There were no deaths recorded in Cases 1 and 2 over the follow up period. This finding is supported by Borup (1983) in his review of studies of relocation and mortality and by Harwood et al (1992). In the control groups who did not move there were five deaths.

It has been recommended, (Leff et al, 1995), that elderly patients with primary functional illness, should be transferred to community settings as soon as possible to prevent further deterioration of behavioural and cognitive functions. The patients in Case 3 did not move into the community and were not interviewed. They had, as shown in TAPS' difficult to place (DTP) study, a relatively high proportion of DTP at 33% of their long stay population (Trieman, 1996).

Delays in the reprovision programme may, for this group, accelerate their functional decline which in time will increase the numbers who become "difficult to place", increasing the cost and complexity of reprovision.

5. *There were concerns that staff morale would be adversely affected by the process of closure and redeployment to community-based facilities. In both Cases 1 and 2 the survey could not find any evidence to support this.*

In both Cases 1 & 2 General Health Questionnaire (GHQ) measures of staff recorded no case of depression. Stress, loss of self esteem and poor physical health were noted in both cases but at a very low level. The occupational health departments indicated that in their opinion, even these low levels were not attributable to the reprovision process. Both in Cases 1 and 2 no staff transferring had their conditions of service adversely changed which undoubtedly assisted stability.

Training in preparation for operating the new community services often under a different, uncertain and potentially worrying regime can do much to allay fears and increase staff confidence. In both Cases 1 and 2 additional training was offered to 50% of the staff. However,

up to a quarter of the staff to whom training had not been offered, thought that it should have been, which suggests that training should be offered to all staff.

Of those staff members offered training, 40% in Case 2 felt that it had not been satisfactory as opposed to 5% in Case 1. This might indicate that the training programme was not as comprehensive as in Case 1 or that the quality was lacking. Despite these perceived differences in satisfaction, similar proportions of staff (15% Case 1 and 20% Case 20) said they intended to seek further training to make good deficits.

## **7.5 CASE 3 - WHAT WENT WRONG?**

The study of Case 3 commenced in 1993. At that time they started to prepare a detailed strategy for the replacement of their 700 beds in a community based service. Consultation commenced immediately with their two purchasers and with social services.

By mid 1993, a workable costed and timetabled strategic plan for the replacement of services over five years had been completed which was agreed by the minor of their two purchasers. The major purchaser would not agree the plan on financial grounds. This purchaser expected every cost (both capital and revenue) to be precisely estimated over the five years for all the services and the 70+ capital schemes to replace the hospital. No flexibility or review was offered by the purchasers suggesting an intransigent stance. The major purchaser was also apparently unable or unwilling to issue a detailed brief for the services they required. Instead they returned the proposed implementation plans as "unsatisfactory submit again" without explanation. In 1995 the FHSA's and purchaser mergers started to take place and the planning process went into limbo as senior officers competed for their own jobs. A new Purchaser Chief Executive was then appointed, who reviewed the plans to date and progress made by the Purchaser's Directors.

The result of the review was that the Purchaser's Director of Finance and Director of Planning failed to secure their jobs and a further delay occurred whilst these positions were filled. In consultation with the new officers, a Purchaser Projects Director was deemed necessary and a further delay occurred.

In the meantime Case 3 hospital was having its problems. A ponderous and unwieldy project management structure had been established with no senior officer responsible for its leadership. Support staff seconded to the project were not always the best and the project's accountant after 18 months of getting the figures wrong was summarily fired for gross incompetence. Three years had now elapsed, not a patient had moved and the hospital had the largest population of

any open, namely 580 patients. TAPS carried out a survey which estimated that the hospital's population had a higher than average complex case mix (Trieman, 1996). The associated cost pressures resulted in the removal of some middle management, including the officers who had been working on the reprovion project.

At this stage the Regional Office who had been managing the disposal of the hospital's large and potentially valuable site announced that they had arranged with the Local Planning Authority that a nearby hospital site, would instead receive a beneficial consent permitting its valuable disposal at the price of Case 3 site being deferred for later consideration of town planning matters.

In April 1995 Regional Health Authorities (RHAs) were formally in dissolution to become Regional Offices (ROs) of the National Health Service Management Executive (NHSME). In their last year they were allowed to spend capital receipts from land sales in their region on local programmes and therefore made every effort to dispose of surplus land. Case 3 appeared to have escaped this rush but due to insufficient land sale realisations and RHA cash overspends the "local income retention initiative" was extended for a further year.

Regional financial deficits became a priority over local needs. The valuable town planning consent was changed to the nearby redundant hospital site and unfortunately sent the wrong messages to the Local Authority Social Services Department who had been told up to then that the NHS saw Case 3's closure as a priority.

The Regional Office (RO) was also not willing to make capital available to fund the closure until the Private Finance Initiative (PFI) process had been completed. The RO also decided it would be "simpler" if the whole of the programme of £40,000,000 comprising a diverse range of services in 70 locations was put out to PFI tender as a single entity. However they could not advise who could be approached to do this work and there was no example in the UK of anyone being willing to put in such a tender, let alone operate such a service.

In September 1995 Case 3 had not obtained any funds from the RO who published a consultation paper on how remaining RO funds might be distributed. Whilst this paper was being considered and until the end of this survey all funds were effectively frozen.

## **7.6 CASE 3 - COULD THEY HAVE SUCCEEDED?**

If the purchaser had been more organised, and the Regional policies on land sales and National policies on capital funding (PFI) been the same as for Case 1 and 2, could Case 3 have succeeded? The Case 1 hospital had, after all, prior to this survey, reduced its population

significantly without NHS funding by using charitable, housing association and local authority funding.

The project management structure in Case 3 was under resourced with only one full time post for a £40,000,000 equivalent capital spend programme of some 70 reprovion schemes. This officer reported through others to senior management level. Senior officers delegated most of their tasks on this project to junior officers. The junior and unqualified officers providing financial support produced poor to indifferent financial information. Guidance to the officers required to implement even the minor capital schemes attempted was scant and advice as to whether locally available capital was available for these schemes varied. No financial commitment was made even at local level.

Case 3 had several minor sites in its ownership suitable for small community developments (e.g. Mental Health Resource Centres, Drop-in Centres etc.), or for sale where funds realised could have been channeled into local schemes. There was an "on a plate" scheme of houses on the edge of Case 3's main site in their ownership which could have taken some community placements at modest cost. TAPS in their survey of four psychiatric hospitals scheduled to close (Trieman et al, 1997), recommended that such an interim scheme would be of significant benefit to patients, but at that time Case 3 could not agree internally on the advice given. After three years of effort only two "portacabin" based developments had been achieved.

The Private Finance Initiative was a problem in restricting access to funds. However the Trust's management structure was not suited to the management of change and locally available opportunities were not exploited.

The answer is that Case 3's failure was probably inevitable. They are not on their own. At the end of this survey there were 24 other Category A hospitals without reprovion programmes agreed.

## **7.7 SUMMARY - THE CASE STUDIES**

These studies have demonstrated extremes.

**Case 1** A stalled programme which, once motivated and funded, resolved its problems in three years, providing new facilities and closing the institution.

**Case 2** A newly formed Community Services Trust whose principal objective was closing its psychiatric institution and the introduction of community-based care for the mentally ill achieved its entire reprovision in four years.

The outcomes in both case studies were favourable and had the support of patients, and their friends and relatives. Staff morale was good and they approved of the new facilities. Above all no harm was done to patients by the move.

**Case 3** No move into the community took place over 3 years. No improvement was achieved for patients. In fact, the escalating costs of such a large institution being kept open resulted in staff cuts by the end of the survey.

## **CHAPTER 8**

### **CONCLUSION**

<b>8.0</b>	Introduction	184
<b>8.1</b>	Conclusions	184
<b>8.2</b>	Has the Hypothesis been supported?	193
<b>8.3</b>	Changes in Policy during the Study	193
<b>8.3.1</b>	Political Policy	193
<b>8.3.2</b>	Financial Policy	194
<b>8.3.2.1</b>	Cost Pressures Developing in the System	195
<b>8.4</b>	A Methodology for Analysing Reprovision Programmes	196
<b>8.4.1</b>	Analysis of Programmes	196
<b>8.4.2</b>	Project Management - Analysis Methodology	196
<b>8.4.3</b>	A National Standardised Reporting System for Hospital Closures	198
<b>8.5</b>	Further Research	204

## **8.0 INTRODUCTION**

This chapter brings together the discussion of the National study in Chapter 5 and that of the Case studies in Chapter 7. The principal findings from the National study are compared here with the findings in the successful reprovision programmes of the Case 1 and 2 studies and possible causes of failure of the Case 3 reprovision programme are discussed.

## **8.1 CONCLUSIONS**

### **Detailed Consideration of Limitations**

The limitations of the National Study are set out in Chapter 6, (see 6.1., 6.2., 6.3., 6.4). The general limitations of the case studies are set out in the Discussion chapter (7) of the case studies (see 7.1, 7.2, 7.3.). Alternative study designs are considered in Chapter 3, Section 3.2 "Selection of the Research Methods".

The detailed case studies were used primarily as a means of illustrating the possible effects of closure programmes on patients, families and staff. The extent to which generalised conclusions can be reached on these effects of closure programmes is very limited because of the design limitations of the case studies.

### **Selection of case-study hospitals**

It was not possible to take a random sample of hospitals in closure which would have been preferable as the effects of selecting those hospitals with which the author had access to would have been avoided. The hospitals selected were accessible and willing to cooperate with the study protocols and were selected on this basis. Any selection bias would tend to make it more likely that patients, relatives and staff would have better experiences of closure where management and clinical staff were willing to cooperate with the research. However, findings from the national survey suggest that management efficiency is of considerable importance in achieving hospital closure and the case study findings are probably a reasonable indication of what might be expected in hospitals with such management.

### **Non-random allocation of patients to closure**

A randomised controlled trial design is not feasible when studying the implementation of national policy and inevitably, when observational study designs are used, as in the case studies, the possibility of unrecognised confounding factors arises. In the comparisons that were made,

attempts were made to compare similar types of patients in different locations but it is possible that variation observed was due to the intrinsic differences between the groups compared.

One strong point in the case study design is that the patients were assessed on two occasions and changes in ability and behaviour were examined. This enables patients to be compared with themselves and strengthens the interpretation made that no disadvantage resulted from closure programmes.

### **Confounding**

It is well recognised that any form of change in environment independent of the primary change studied may lead to improvements in outcomes - the Hawthorne effect. It is possible that the improvements observed in some measurements were not causally related to the re-location in better environments but was due to associated changes in operational policies. The case study designs are open to this form of confounding as one of the pre-requisites of the project planning process is the explicit definition of operational policies as an aid to defining the structural requirements of new buildings. In the hospitals studied, operational policies had been developed for some time prior to the implementation of the closure programme, which makes this less likely. However, it was not possible to control for confounding by staff who might have changed during the closure process, feel more secure or simply be better at doing their jobs in better surroundings. If these factors are responsible for improvements in patient outcomes, they may be considered as some of the non-structural benefits of closure programmes.

### **Variability in types of patients re-located**

It is quite possible that different types of patients may be more or less adversely affected by re-location. In particular, very frail demented patients might be considered to be more vulnerable to changes in environment. It was not possible given the small sample sizes studied to examine the effects on different types of patients and this remains a weakness of approach used. Successful re-location of frail patients probably relies as much on maintenance of the same staff as on the quality of the environment and it is beyond the scientific approach to control for staff willingness to re-locate with their patients.

### **Sample size**

The sample sizes for all the case studies were small which was a reflection of the sizes of patient groups relocated and also the resources available for the case studies. Only three case



studies were undertaken and with more resources it would have been valuable to examine the effects on patients, relatives and staff of all closure programmes.

The main problem of small studies is failure to discover differences when they are really there - a so-called Type II error. In these studies, the major hypothesis was of "no detriment" and consequently the sample sizes that would have been required to ensure that not even a small (eg. 5% reduction in activities of daily living) detriment had occurred would have been very large indeed and would have run into the hundreds.

In practice, the concern is that no major detriment occurred to the patients in the study groups. Case 1 showed no significant change in the BAS cognitive impairment score before and after the move, but a significant improvement in the depression score. For cognitive impairment, the mean before-after difference was 0.23 scale points, and the 95% confidence interval for this was -0.16 to +0.62. This means that despite the small sample size, we can be 95% sure that the true before-after difference is less than one scale point. In practice a change of more than two scale points is required to confirm a change between no dementia, mild dementia and severe dementia (Ames, 1988). For depression, there was a small but significant improvement: the mean before-after difference was -1.31, and the 95% confidence interval was -2.51 to -0.11. Case 2 showed no significant difference in the CAPE scores. The total score had a mean before-after difference of -1.85, with a confidence interval of -3.72 to +0.01.

### **Programme Length**

The "better" of the hospitals in the National study had proceeded promptly through the stages of planning and brought their schemes to fruition and closed their institutions. The mean elapsed time from start to completed reprovision was six and a half years. The "best" achieved closure was within three and four years, although these were only four in number.

Case 1 reprovision comprised two 25 bedded acute psychiatric units and an EMI day hospital which were required to be constructed from new, all of these were constructed on existing NHS sites but notwithstanding this programme took three years.

Case 2's reprovision comprised all services necessary to close the institution, (see Appendix 5.10), and took just over 4 years to complete. As found in the National study, the principal determinant of programme length once funded is the time taken to provide the major capital scheme.

## **Funding**

The National study demonstrated the importance of obtaining capital funding.

In the case studies both Case 1 and Case 2 were among the "better" hospitals. The funding for Case 2 was acquired in the euphoria of the early Trust waves when most new Trusts were allocated the capital they were requesting in their first year. Case 1 got its funding the hard way and was a hospital which we have now identified as the group of Bs and Cs who appear, after a good start, to make little progress with their programmes. In fact this would be a harsh judgement in as much as that even without specific regional funding it had made good progress with resettling many of its residents in the community and had been quite ingenious in this, setting up its own charity to secure funds that would not have been available to the NHS to permit this to happen. The problem this caused the hospital, which was quite wrongly seen as management failure, was that the group of patients for whom capital funding was essential for their move, remained in the institution. As seen in the National study the easy to settle patients had been placed first leaving the difficult to place patients in the institution.

Eventually, alarmed by rising unit costs, the RHA supported Case 1 reprovision and provided capital funding. The hospital, through this mechanism, successfully obtained Region's support. The capital cost in both case 1 and 2's short programmes were however, nearly equivalent to the Trusts' annual revenue turnover and in both cases the Trusts' financial systems collapsed under the pressure and both their financial directors were summarily dismissed.

## **Involvement of users**

In both cases 1 and 2, the quality of the facilities provided and the comments of the staff, friends and relatives gave good scores to both the management and quality of the process. Particularly the patients suffered no harm through this accelerated process and indeed bearing in mind the severity of the condition of the inpatients, some even showed a small improvement. In these studies the accelerated reprovision process caused no harm to patients. The National study indicated that both Case 1 and 2 were completed in 2 years less than the National average.

## **Project Management**

Cases 1 and 2 were, in nearly all respects, good programmes in both expediency and quality. The management process for the development and delivery of the schemes was a textbook project management exercise. Starting from the outset project management systems reported progress directly to the chief executive and the senior officers of the Trust therefore both had effective project management information allowing them the opportunity for early management intervention. The availability of finance, which is now causing so many programmes to slip, was whilst problematical in arriving at the precise funds to be allocated, obtained through a clearly defined system. The financial allocation system had its deficiencies but notwithstanding the vagaries of annual allocation systems and an unclear prioritisation in the choice of schemes to be funded was, despite these defects, understood. Both reprovion programmes were delivered with minimal delays and within the agreed costing and systems to monitor implementation were therefore successfully operated.

## **Planning Permissions and Sites**

Cases 1 and 2 had access to NHS owned sites capable of supporting major development with existing "health" town planning use. Therefore there was no delay in obtaining planning permission. These sites were transferred to the Trust to permit the building of the major capital schemes in the programme, the acute units, and the purchasers came on board very promptly. As shown in the National study existing ownership of small sites does not appear to shorten the reprovion programme however the availability of large sites does.

## **Local Authority Active Support**

Patients not moving to NHS facilities left the site on programme due to well co-ordinated and active joint Social Services/NHS resettlement teams. In Case 2 the local authority, largely due to the efforts of one officer in the Trust was turned from being cynical and unhelpful to giving an almost exemplary performance in providing residential properties and former Part III homes, all assisting the speedy delivery of the programme.

## **NHS Organisational Change**

Throughout the period of the study major organisational changes in the NHS have been implemented. The National study found early Trust status to be a significant factor towards successfully progressing reprovion. Both Case 1 and 2 were early Trusts.

Case 1 had a further organisational change problem. The Regional Office, whilst the accelerated programme it had requested was being implemented, nominated its purchaser to operate as one of six National pilot studies of total General Medical Practitioner (GP) fundholding projects. This effectively meant the scheme, in the midst of implementation, had to be discussed with the local GPs who were trying to start the debate from basics as to whether, for instance, they required a district general hospital at all. The GP fundholding project was not adequately co-ordinated with the closure project. Since the purchaser was a "capitation losing district" and having its budgets reduced, there is an argument that volunteering for a pilot project was not a good choice, and that existing implemented projects should have been left out of the GP fundholding project remit. The result for Case 1 was that a scheme about to start on site for one psychiatric unit had to be frozen for several months whilst the GPs considered the issue. In fact the GPs never did agree. The implication of the GPs delay for the Chief Executive was that the institution would have remained open for an undetermined period with a population of only 25 patients at a huge cost. He decided unilaterally to proceed with the plan. In this instance the GPs had the power but were not held responsible for the financial implications of these delays. The Chief Executive was subsequently dismissed.

The National study found that Trusts with large numbers of purchasers performed no differently to those with few. Despite Case 1 having a new additional purchaser, introduced at a late stage, in the form of the GP fundholding project, the schemes were completed and, as found in the National study, major NHS re-organisations adds to the management burden but do not prevent implementation.

### **The causes of failure**

Case 3 is a case of almost total failure to achieve anything. It had not shown the initiative of Case 1 in trying to move some patients. All staff and patients remained on the original institutional site for the three years of this survey whilst plans were debated. Other than some small schemes achieved with the hospital's own capital resources no development had taken place. This hospital at the beginning of the study had one of the largest populations in any institution, and at the end of the survey three years later had much the same size population. The hospital was a third wave trust and, as shown in the National survey, later wave trusts were less successful in achieving closure.

Lack of progress had not gone unnoticed by the Regional Office and in Case 3 it was the major purchaser organisation who could not be brought to agree the programmes proposed by the hospital. Early purchaser agreement was therefore not obtained. Many of their senior officers paid the price for that inaction failing to obtain posts on reorganisation of the purchaser/FHSA

functions. The other smaller purchaser had been prepared to agree to the same plan 24 months earlier. Two other problems faced this particular plan. Firstly, the introduction of the Capital Investment Manual (CIM) and the necessity to go through the PFI process. Access to conventional NHS capital was therefore not available. Secondly, the unfamiliarity of the approving officers at RO with the system caused delays whilst negotiations took place as to whether, against all commercial logic, the hospital's reprovion programme, estimated at a capital cost of £40,000,000, should be processed as an entire single private finance initiative.

The hospital had no large sites of its own and attempted to acquire sites from its local acute trusts who had plans themselves for the sites that they were not willing to change. Unlike Cases 1 & 2, major sites were not available.

Notwithstanding this problem Case 3 worked hard to access capital funding under the PFI process. After nearly three years advertising, interviewing, shortlisting, seeking more detailed proposals, final shortlisting and negotiations with three possible providers/developers, the PFI scheme stalled. Initially two of the contenders withdrew before the final competition leaving a single contender who then wished to re-negotiate the position. After much work and three years later no progress had been made. This was probably one of the more advanced schemes involved in using the PFI although, as can be seen from the category A hospital responses in the National study, very few hospitals were willing to hazard a date when they might obtain approval and be able to proceed with their reprovion programme.

The Local Authority Social Services department attended meetings and wanted to assist in the process. They had problems as internal policy required them to obtain full commercial value for any sites then contributed to community care and the hospital had no funds to purchase them. Local Authority Social Services' active support as given to Case 2 was not obtained.

The management style of Case 3 was fragmented. There was an acceptance of the theory of project management, but in fact this role never evolved beyond the first stage of developing plans and effective Project management could not be said to have been established. The Project teams reported to a Services Manager who was not a Board level appointment and the manager did not have total control of the process. The capital planning function and the source of providing costed estimates was divorced from the project management and was managed through a finance organisation who had no previous experience of undertaking these programmes. Its principal contribution was one of obfuscation and the failure to deliver a PFI project. External advice which could have been obtained as to the viability of the schemes in commercial terms was not sought.

Tables 8.1 and 8.2 set out the success criteria for the planning and implementation stages identified in the study.

<b>Table 8.1 Success Criteria the planning stages</b>			
	<b>Case</b>		
	<b>1</b>	<b>2</b>	<b>3</b>
Clear project management structure senior staff adequately resourced reporting to Chief Executive	✓	✓	x
Availability of major sites for principal capital schemes	✓	✓	x
Access to funding from NHS Capital for major schemes	✓	✓	x
Early Purchaser agreement to reprovion and attendant funds	✓	✓	x
Availability of suitable sites for community developments	x	x	✓
Local Authority Social Services active support	✓	✓	x
Supportive RHA (RO) with a clear priority given to mental Health reprovion	✓	✓	x
Early Trust Status	✓	✓	x

<b>Table 8.2 Success Criteria in the implementation stages</b>		
	<b>Case</b>	
	<b>1</b>	<b>2</b>
Clear project management structure	✓	✓
RO Funding once agreed remains available	✓	✓
No delay in obtaining Town planning	✓	✓
Early and continuing consultation with staff and users	✓	✓
Purchasers remains supportive	✓	✓
GP accept (eventually) previous decisions	✓	n/a
Active Local Authority / NHS resettlement teams	n/a	✓
Close working with social services	✓	✓
Joint schemes remain supported	✓	✓
Capital costs remain in budget during design and construction	✓	✓
Implementation programme monitoring system in place to predict delays and allows timely intervention	✓	✓
Resources devoted to getting major capital schemes funded at earliest stage	✓	✓

### Discounted Criteria

Some of the factors examined did not appear sufficiently critical to prevent programmes from being implemented although in some instances no doubt the absence of the problem would have facilitated the task.

### Major change in the NHS

During the period of this survey the changes have been legion: GP fundholders, Trust hospitals; re-organisation of RHAs' purchaser/provider arrangements. All these appear to have been taken in the NHS's stride. Large numbers of purchasers did not impede reprovion and Trust status assisted reprovion.

## **Private Sector funding**

This was only available for a very limited number of NHS schemes in this study. It does not seem to have been relied on and its relative absence has not hindered closures. The ownership of satellite sites with existing town planning health use for smaller schemes, neither helps nor hinders. It is access to the large sites that is a success criterion.

The concept that sites of the former institutions once redundant would be capable of early disposal has not proved to be the case and many remain unsold (Davidge 1993). The NHS has funded the capital element of mental health reprovion by taking funds from elsewhere (at least up to the end of 1995 and the introduction of PFI).

## **Project Management in the NHS**

This research shows nevertheless that although a range of Project Management techniques are available, e.g. Critical Path Analysis and Expenditure Forecasting, the majority of schemes had deferred completion dates. The Project Manager's first duty to create an agreed programme could therefore at least have some scientific basis included in its formulation. However the problem seems to rest with the project manager and not the data.

The management of the programme where intuition and experience count is more difficult given the position of the Project Manager and, in the NHS management hierarchy his voice may not even be heard. The micro level research bore this out and although obtaining finance was a critical factor, effective project management was also important.

In 1993 a dedicated Masters degree level course was established, devoted entirely to project management with entry requirements of an appropriate first degree and membership of one of the Chartered Construction or Engineering Disciplines; most NHS project managers do not have the entry qualifications. (Chapter 8 discusses a position the NHS could take which would improve the present position).

Had even the simple data suggested later at 8.4.2 been available to a common standard for each of the hospitals in the National Study, it would have been possible to carry out a useful and detailed analysis in this study which would have better informed the discussion on delays in the programme and enabled their specific identification. The NHS only saw the need for this common standard in 1994. Had the data been available, the Health Minister, at the time, Tim Yeo, would also have been able to answer the question put to him in as to how many psychiatric institutions were to close. (Groves 1993).

In the future it might be hoped that a full data set be created from which model programmes could be formulated with some examples of the more common variances from programme and their delay effect. This information would be invaluable to both the experienced and inexperienced project manager.

## **8.2 HAS THE HYPOTHESIS BEEN SUPPORTED?**

The hypothesis was *"Planned short closure programmes can be achieved without detriment to the quality of reprovision"*

Two of the case studies showed that it is possible to reprovide community care facilities for the mentally ill in programmes of a substantially shorter time than the national average with no detriment to the quality of reprovision from user perspectives. The National study had demonstrated that few programmes are progressed so expediently. Those hospitals with shorter programmes nationally had capital funding agreed for their reprovision at an early stage, avoided delays in implementation, worked successfully with other NHS and third party agencies to place their patients in the community and would be likely to have earlier Trust Status.

## **8.3 CHANGES IN POLICY DURING THE STUDY**

Since this study was completed there have been changes in the political and financial environments which change the context of some of the principal findings.

### **8.3.1 Political Policy**

The Government's commitment to close "many" of the psychiatric institutions through the introduction of community care by the year 2000 set out in the Green Paper for Health of the Nation (HMSO, 1991) disappeared in its White Paper in 1992 and is no longer mentioned as policy. The expression "Community Care" itself is now out of fashion being replaced with "Spectrum of Care" (Dorrell 7/96 interview with the Times) which he stated *"does not necessarily mean the closure of the institutions"* and *"I can't wave a wand and deal with all the inadequacies overnight"*. General Practitioners support for the provision of individual primary care for those in nursing homes is being challenged (BMA press release, October, 1996) as possibly no longer available in the future unless General Practitioners are additionally recompensated. They argue that the additional burdens of Primary Care, for which they have already received additional funding, have overloaded them.



The issue of who pays for the care of the elderly has been extensive and occupied many column inches of debate in National newspapers. The re-possession and sale of the homes of the elderly by local authorities to pay for their care amounts to 40,000 homes sold in 1995 to fund nursing home care, (Wood, 1996) and has highlighted this issue to the public.

The debate has included insurance paid care, dedicated funds derived from additional taxation (as adopted by the German Government), tax break incentives (US style) for savings to be devoted to care in old age. There was even a suggestion following a review ordered by the Prime Minister carried out by the Downing Street policy unit that the Government would pay for the nursing element but not the hotel cost of long term care (Times 19/9/95). The debate concluded in September 1996 when the Health Secretary, S. Dorrell, announced (29/9 DoH 1996 - press release) that this matter could not be settled within the remaining space of this Government as it was *"too complex ... requiring another phase of consultation"* and *"will be dealt with after the election in May 1997"*.

### **8.3.2 Financial Policy**

The financial environment changed significantly during the period of this study. The first set of problems emerge from the operation of the purchaser/provider arrangements (plans for Cases 1 & 2 were agreed before these took full effect). Purchasers faced with, as they see it, intractable cost pressures are very cautious and want very detailed information on the full final cost of contracts before they will proceed.

Purchasers therefore will regard it as out of the question to enter into any community based care contracts unless their liabilities are absolutely determined. This leads to the second set of problems.

Capital funding is, for practical purposes, not available within the NHS. The examination of options through the Private Finance Initiative (PFI) must be the first route to be followed by the NHS. The PFI requires the examination of whether the private sector could fund, design, build and operate (presently with the exception of direct clinical activities) NHS services. Both political parties agree (with some differences) this is the "new way". The PFI process has successfully funded roads, bridges, equipment purchases and prisons. At the date of writing it has been, other than for equipment, a complete failure in the NHS and so far has deferred significant capital expenditure in the NHS for over two years.

One of the significant differences between conventional and PFI procurement is in the virtual exclusion of the client/user from the detailed planning. The case studies showed that

comprehensive user involvement in design, results in more acceptable schemes and this seems to be a retrograde step. The PFI process requires a preferred bidder to be selected based on a design and price in which the client has only been permitted to give "outputs" (e.g. numbers of episodes, case mixes of patients). Once the price is fixed any change becomes difficult. The Audit Commission investigating the need to change completed PFI schemes (the new NHS HQ in Leeds is one example) because they do not meet the client needs, not surprisingly is raising questions.

Kenneth Clarke, Chancellor of the Exchequer in his budget speech of 26 November 1996 claimed an extra £7 billion of public investment was being provided by the PFI, (of which £900 million would be provided to the NHS over the next three years). The Independent newspaper reporting on the budget the following day quoted a recent International Monetary Fund study which had concluded that "the PFI was contributing no extra money but substituting for investment that would otherwise be funded by normal methods" (Walker 1996). Until PFI can be made to produce the capital funds the NHS needs or conventional Treasury finance is re-instated, it is difficult to see how the momentum of change can be maintained in re-providing services for the mentally ill in a community setting.

The capital budget of the NHS, already reduced by a third in two years, was reduced by a further 16% in the 1996 Budget (The Red Book HMSO London 1996). The NHS capital budget was projected to be £2.2 billion in 1992 (Social Services Stats 1993) and now must be little more than £1 billion which has to meet the costs of replacing equipment, introducing new technologies and maintaining existing infrastructure.

Many of the hospitals in this survey are enmeshed in the process of seeking capital and in the final year of the survey very few of the hospitals without agreed plans were willing to hazard a date when they would have funding and have a programme in place.

#### **8.3.2.1 Cost pressures developing in the system**

The research demonstrated that hospitals with and without re-provision programmes acquire more complex case mixes. Those with smaller populations have higher staff patient ratios and lower ward occupancy levels. All these factors mean that the remaining institutions become more costly to operate. General Practitioner fundholding decisions can reduce budgets available to purchasers to fund these costs and General Practitioner's are seeking to increase charges for their services to patients in the community.

In the meantime these old buildings provide poor accommodation which, in the absence of significant maintenance funds, will decline further in quality. PFI may be seen as the way forward by government but the delays it is causing make the cost of reprovion escalate both in revenue and capital terms.

## **8.4 A METHODOLOGY FOR ANALYSING REPROVISION PROGRAMMES**

### **8.4.1 Analysis of Programmes**

One of the difficulties encountered in carrying out this study was that there is little or no standard methodology available to hospitals to describe where they are in their closure and reprovion programmes. This may be due to the Department of Health deciding not to collect information on hospital closure programmes, (Groves 1993) but is nonetheless surprising. Most professions have standardised descriptions of each of the stages of the processes they undertake. These methodologies are adopted to allow others in the profession to understand rapidly and precisely to what stage the proceedings have evolved. The reprovion of mental health services has been an issue that the health service has been addressing since the 1960's, such a methodology would appear to be overdue.

### **8.4.2 Project Management - Analysis methodology**

The King's Fund Report on London's Mental Health Community Reprovion Programme is harsh in its judgement of Health Service Administrators and feels that many of the problems in introducing these services could have been better managed. Project Management now appears as a module in many first degree Management Courses and its principals are addressed in a few lessons and sometimes examined. This is plainly not enough to warrant a qualification in Project Management. The brevity of the courses necessarily causes them to concentrate on the "raison d'être" for Project Management. Most students having completed these courses can answer fundamental questions concerning what Project Management is and what are the benefits of instituting such processes. The "How" of Project Management seems to remain elusive.

The more informed will answer that the Prince <sup>™ 1</sup> computer software for the management of projects is a useful starting point, and in this they are correct. Simple software which can demonstrate Network Analysis and define critical paths, and above all be capable of easy and

---

<sup>1</sup> Prince <sup>™</sup> project management methodology was originally a government sponsored development, it was updated in 1996. It is relatively user friendly and whilst not a professional system has many useful applications.

frequent amendment if necessary are a very useful tool, but "How" is somewhat more complex than software. The reality is that the "How" of Project Management is a complex issue because the Project Manager has to have a good working understanding of the duties of the different professionals within the service, an understanding of the importance of information transfer between the professional groups at their interfaces, remedies to the defects within this information or its late arrival, and requires the resources to make up these deficits. Appendix 8.1 demonstrates a simplified organisation chart for the management of a mental health reprovion programme. A Project Manager also has to operate at a senior enough level to secure the direct attention of his Chief Executive and/or Board. Few professions study Project Management in depth and it is most developed in the Construction and Process Engineering Industries which have the advantage of having high standard refined reporting systems which enables maximum benefit of these techniques to be made. A standardised reporting system for projects could be introduced into the NHS, but considerable work and consultation would be required to achieve this.

#### ***What could be done?***

The Reprovision of Mental Health Services in the Community is complex and the project management process requires the oversight and management of a wide range of interests many of them competing or even directly conflicting.

Three principal groups interact in this process:-

- Service Manager
  - operating old and new services
  - retrenching site
  - resettling patients
  - retraining and allocating staff
  - control of revenue budgets
  
- Project Director
  - overall co-ordination and timetabling
  - financial control of capital
  - management of design team and procurement of new physical services
  - control of main project management group
  - reports to Chief Executive/Board on progress
  
- NHS Management Liaison and Support Groups
  - other providers
  - mental health/charities/3rd party providers

- mental health services users group
- liaison Region/ DoH
- public relations

It is not possible to change significant numbers of Health Service Administrators into Professional Project Managers. Indeed, the complexities of Community Mental Health Reprovision and Psychiatric Hospital closure pose a challenge to qualified and experienced Project Managers. The introduction of a standardised project progress reporting system would also pose considerable difficulties. However if the data required to be collected could be identified by an experienced Project Manager as that necessary to reliably inform Health Service managers, in lay terms, of progress being made, the effort could be worthwhile. Such a system, when constructed, would pose strains on Health Service staff in completing it to the required standard and essentially on time. However, Project Management Systems can be robust enough to use in the NHS and can take account of late responses and intermittent absences of data. The objective of such systems is to be able to predict adverse trends and divergences from the agreed programme and above all indicate the need for management intervention.

Early experience by one RHA with a standardised Project Management information system devised by the author proved sufficiently robust to be used for three years. It may be no coincidence that most of this region's psychiatric institutions are now closed.

A similar information gathering system was used by the hospital managements of the three case research study hospitals in this study. In each hospital the system was modified to reflect the hospital's particular information needs and take account of strengths and weaknesses in their management team.

#### **8.4.3 A National Standardised Reporting System for Hospital Closures**

To create a National Standardised Reporting System the current problem would be to identify key stages in the programmes of 60 Hospitals as at 1996, which are considering closure or actually implementing programmes. The A, B, C, D categories of closure programme which were used in this study have the advantage that from the available data, hospitals could be categorised with a reasonable degree of accuracy and also their movement between categories could be identified. However, such a division would be too unrefined and within each category further sub-categories require definition to create those which would have to be built into a standardised Project Management Information System.

The essence of these systems is that the data available to identify a key stage in the progression of a project are:-

- 1) Clearly identifiable;
- 2) Known with reasonable certainty close enough to the event in time;
- 3) Does not require particular specialist knowledge to identify (in the NHS context can be completed by NHS managers).

There are important key stages which cannot be so easily identified e.g. the precise position of negotiations with potential partners in a PFI process <sup>2</sup>, and notwithstanding the perceived value of such information, they should be omitted and only data which are certain should be included. The completion of data for Project Management Information Systems imposes a considerable and repetitive burden on those required to supply the information (every month to six weeks for NHS projects being a suitable interval) and it is important that uncertain data are not allowed to devalue the system.

The discussion that follows is principally concerned with identifying progress by recording the achievement of key stages. It should not be forgotten that this is only one component of concern to a project manager albeit the one that seems most problematical for the NHS (the study showed 40% of programmes suffering delay). The other components are the financial elements - budgets, the firming of costs from feasibility through to contracted sums to out-turn costs. The management of cash flows, accounting for inflation, operating a master budget and coping with the financial implications of late programme changes.

#### **Key stages of progress for Capital Schemes acquired through the Private Finance Initiative Process.**

1. The category A hospitals were those which were unable to identify that they had a funded closure programme. There is a sub-group of those hospitals who were attempting to form late programmes, a group with no programmes, and a sub-group with no intention to formulate plans. They fall therefore into the following sub-categories:-
  - a) No plan and no intention to carry out a plan;
  - b) A plan to be formulated by a given date;

---

<sup>2</sup> PFI is a considerably more complex procurement process than that of conventional procurement using DOH funds and key stages for conventional procurement would be considerably less than here described.

- c) No plan, but planning to merge with another Trust;
- d) Plan completed and with their purchaser for discussion;
- e) Plan completed - returned by purchaser for amendment

2. Category B hospitals were those who had passed through the above stages and secured funding for their programmes. However, the Capital Investment Manual/PFI Process prolongs these negotiations by a considerable amount, and indeed funding approval has not come for some considerable time, notwithstanding purchaser agreements. The process is now as follows:-

- f) Obtained outline business case approval;
- g) Commenced preparation of full business case;
- h) Place advertisements in European Journal under EC Procurement regulations to seek PFI partners;
- i) Shortlist responses;
- j) Interview not more than six partners;
- k) Issue output specification describing the service to be provided;
- l) Interview three partners more detailed submissions, which are based on an "invitation to negotiate" document and shortlist to two;
- m) Commence negotiations with two partners on more detailed specifications;
- n) Reduce negotiations to a single partner and negotiate further;
- o) Agreed type of premises/level of facilities management, services/length of contract, (now about 25 years), agree bank funding details, quality specification and annual lease cost of total service;
- p) Agree all this with purchaser as affordable as to revenue costs;

After this it is quite difficult to establish the next stage in practice as no PFI Contracts, even after three years, have been finally agreed and implemented. However, assuming they were, the next stage would be the construction of the facility required.

### **Construction Phase, Site Acquisition and Commissioning**

This broadly relates to Category 'C' in the national study. Monitoring the construction phase is a well understood process and a proforma at setting out key stages is shown at Table 8.3 which is in fact the model used for this component in the Friern Hospital Closure Programme. The document identifies site acquisition, obtaining planning consents, finalising a contract prior to progressing through the construction stages to commissioning.

Additional proformas would be included for the monitoring of other schemes being carried out in parallel (not under the PFI process) or by Charitable bodies, Social Services and Housing Associations, their commissioning of the buildings and process of monitoring sale of surplus sites.

The problems that occurred in the study placing hospitals would have been resolved had more information being available on those hospitals entering, remaining in and leaving Category C. The data collection required could largely be addressed by the system shown here for monitoring the progress of the planning and construction of Capital Schemes.

### **Other Project Management Responsibilities**

In the closure of institutions there are three other key processes. Firstly, progress being made with the training and reallocation or redundancy programmes for staff. This is both to monitor the run-down of staff in the institution as patients are relocated, to ensure that the optimal pattern is achieved, and to ensure that recruitment, training/re-training of staff provided a flow of new staff into community facilities. The type of detailed planning that is undertaken by personnel specialists lends itself easily to producing data suitable for a relatively simple Project Management system.

The second significant issue that must be monitored is the selection and evaluation of patients who are to move into the community to ensure that they are given sufficient rehabilitation to acquire any skills which will enable them to enhance their quality of life in any facility and to ensure that they are correctly placed. To begin this exercise provides, through the professionals



undertaking these assessments, a ready flow of information which is adaptable to Project Management Systems.

Indeed initial survey and categorisation of patients is the central component of the very earliest studies used in preparing outline business case studies to design the services that will best match the needs of the hospital's population. TAPS, in their paper (Trieman 1995), provided a means to assess the expensive "difficult to place patients" at a very early stage in the planning process. The principal objective of the management of this element is to ensure that a steady flow of patients move out of the institution, without the rehabilitation and assessment staff being duly overloaded by peaks of patients moving through.

The third exercise which requires monitoring is the progress in retrenching the site (i.e. progressively closing down the site) as far as possible, to match the reducing numbers of patients on site to the facilities open. In the early stage, substantial benefits can be reaped by closing wards, maintaining occupancy levels of those wards open at economic levels and closing down redundant parts of the site. In the later stages this becomes most difficult to do.

### **Presentation of Data**

Master programming data displays need not be complex. Whilst the detail of project management of multiple schemes is complex, methods of displaying delay or programme maintenance must be simple and readily understood. Many participants in the process will be essential in ensuring delivery of the programme but some will be complete novices in project management. Most project management software systems produce outputs at "expert" interpretation level completely baffling to the novice (and occasionally the expert). Appendix 8.2. shows how the progress of seven DHAs' reprovision programmes totaling 70 capital schemes costing £40 million, was monitored. In this display, beds (readily understood by all) as a proxy for schemes, is set against target dates. This chart is then repeated for each District's group of schemes and then individual schemes in more detailed stages.

Table 8.3 Standard proforma to monitor acquisition and construction phases

[illegible]

## **8.5 FURTHER RESEARCH**

- 1) The data collection for this study closed at the end of 1995 when the full implications of the Private Finance Initiative process were not known although initial indications from the Category A hospitals who had still to agree their plans was a lack of confidence in the system and refusal to give closure dates. The continuation of the National study for at least a further two years would give a clearer indication of how PFI was continuing to affect the community reprovizion programmes.
- 2) An investigation into the practicality of introducing a National Standardised Reporting System specifically orientated to measuring progress with the reprovizion of mental health services in the community. Experience thus far shows that there will never be adequate funding and data in this area is required to better target the resources that are available.
- 3) A longer term follow up of users (where possible) to study whether their views remain the same after time and compare those with the views of new users not previously in the institution.
- 4) Comparisons between patients, staff and relatives views of service facilities highlighting areas of similarity and difference, using qualitative and quantitative methods should be explored in an attempt to improve NHS building standards.
- 5) The precise level of reprovizion of services in the community remains elusive. Attempts to obtain these answers through postal questionnaires were only partly satisfactory. A survey including site visits and discussions with a range of managers in a hospital and the purchasers of services would be more likely to elicit a comprehensive answer.

## APPENDICES

<b>Appendix 1.1: Major Mental Health Legislation in England And Wales</b>	
<b>Year</b>	<b>Act</b>
1601	Poor Law Act
1714	Vagrancy Act
1774	Madhouse Act
1800	Committal of Dangerous Lunatics
1808	County Asylums Act
1828	Madhouses Act
1834	Poor Law Act
1838	Dangerous Lunatics Act
1845	Lunacy Acts / Asylum Act
1857	Lunacy Acts (1853)
1867	Dangerous Lunatics Act: Metropolitan Poor Act
1868	Pharmacy Act
1874	Grant-in-Aid
1888	Inebriates Act
1890	Lunacy Act
1913	Mental Deficiency Act
1929	Local Govt. Act
1930	Mental Treatment Act
1946	NHS Act
1959	Mental Health Act
1983	Mental Health Act

<b>Appendix 1.2: Legal Processes for admission of patients</b>	
<b>Year</b>	<b>Act</b>
1744	Paupers - 2 Justices of the Peace, a magisterial order
1774	Private - 1 Medical Certificate of Lunacy
1800	Dangerous - Justice of the Peace, a magisterial order or Clergy + Relieving Officer - to Gaol
1819	Pauper - 1 Medical Certificate of Lunacy + Justice of the Peace, a magisterial order Private - 2 Medical Certificates
1828	Pauper - 1 Medical Certificate of Lunacy + 2 Justices of the Peace, a magisterial order
1838	Dangerous - 1 Justice of the Peace or Clergy + Relieving Officer - to asylum
1890	Private - 2 Medical Certificates of Lunacy + 1 Justice of the Peace, a magisterial order Pauper - 1 Medical Certificate + 2 Justices of the Peace, a magisterial order
1930	Voluntary & Temporary admissions allowed
1948	End pauper/private distinction
1959	Informal admissions allowed
1983	Automatic reviews, tighter definitions, duration of sections reduced

**1995**

**QUESTIONNAIRE**

**ROYAL FREE HOSPITAL**

**SCHOOL OF MEDICINE**

**COMMUNITY REPROVISION**

**RESEARCH PROGRAMME**

**HOSPITAL NAME .....**

The Royal Free Hospital is undertaking a three-year study in England to monitor the progress of closure programmes for long-stay institutions.

#### Object of Research

There are estimated to be 84 major institutions which are in the process of implementing community-based programmes for the mentally ill. Only limited data is available nationally. This exercise is intended to produce a comprehensive database

You may recall that you received a similar questionnaire in 1994. We would be very grateful for your co-operation in completing this follow-up questionnaire which includes recent recommendations made by the Royal College of Psychiatrists for a comprehensive community service.

The information received from those hospitals who completed the 1994 questionnaire is shown herein.

Should any of this information be incorrect we would very much appreciate your amending it where necessary.

We would be pleased to make an abstract of the data collected available to you should you agree to assist us.

To ensure the most up to date information on your hospital is listed correctly please insert the following: -

Hospital Name

.....

Address

.....

.....

.....

RHA

.....

Bed spaces in use:-

- a) Available beds in main hospital at the moment
- b) Number occupied
- c) Vacancies

1994	1995
No.	No.
No.	No.
No.	No.

Associated MI / MH  
Hospitals

.....

.....

.....

.....

If you have any queries regarding this form / the attached questionnaire or would like to know more about this research, please telephone Ms Christina Emmett at the Royal Free Hospital on 071 830 2889.

# QUESTIONNAIRE

Page 1

1 What DHA (Purchasers) areas does the Hospital serve ?

(i)	
(ii)	
(iii)	
(iv)	

2 What was your hospital population\* on 30th September 1995?

\*Hospital population in this case refers to patients occupying accommodation which will be closed in the future following planned / anticipated relocation (including patients on leave).

- a. Acute mental illness
- b. Elderly mentally ill (assessment)
- c. Elderly mentally ill continuing care (including respite beds)
- d. Active rehab/assessment of long term mentally ill (usually under 65 years)
- e. Continuing care of long term mentally ill (non EMI)
- f. Mental handicap
- g. Others (please specify)

TOTAL

1994	1995
No. of Patients	No. of Patients

3a Is there an agreed closure relocation programme for your hospital?  
(defined as approved by RHA/Outpost for a funded programme)  
If "No" go to Question 6

Please tick

1994	1995
YES	YES
NO	NO

b Is any part of the programme funded from non NHS funds  
If YES - please indicate -

YES	YES
NO	NO

	1994		1995	
	TYPE OF ACCOMMODATION	No. of Places	TYPE OF ACCOMMODATION	No. of Places
Housing Association				
Private Sector (non-exchequer)				
Other- please specify				

4 When did the formal closure programme start?

1994	1995
19	19

5 When is it intended that closure will be completed?

1994	1995
19	19

- 6 Is your hospital part of a Trust?  
If so, which wave?

1994				1995			
YES		NO		YES		NO	
1st				5th			
2nd							
3rd							
4th							
5th							

- 7 What is the name of the Trust?

\_\_\_\_\_

- 8a How old is the present institution? (Date opened)

\_\_\_\_\_

- b i) Is the main building listed ?  
i) Is part of the main building listed ?

Please tick

YES		NO	
YES		NO	

If YES

Grade I	
Grade II*	
Grade II	

- 9 (i) How many wards are there in the hospital  
(ii) and how many are presently closed?

1994	1995
No.	No.
No.	No.

- 10 What is the design of the wards still in use?

No. of	Open Nightingale		"Improved" Nightingale		Single Rooms		Other	
	94	95	94	95	94	95	94	95
Wards								
Beds								

- 11a Are the buildings set in open grounds?

YES		NO	
-----	--	----	--

- b Approximately what size is the site?

No. of Acres:	
No of Hectares:	

- c Is the building set in:

Green Belt  
Metropolitan Open Land  
Conservation Area

YES	NO	Don't Know



12 Is there a Community reprovion programme? 1994 1995  
 YES ☐ NO ☐ YES ☐ NO ☐

If NO, when will a plan be formulated?

18

19

13 If YES, and a plan for future services is agreed, what does it include of the following: (A detailed explanation of the categories below is given in Appendix 1 attached)

	No. of Beds / Places in Operation now in the reprovion service				No. of Beds / Places to be provided				Date of Intended Reprovion	
	NHS		PRIVATE		NHS		PRIVATE		YEAR	
	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995
a) Acute Hospital beds - General psychiatry	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Intensive care beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Longer term staffed beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i) Difficult to manage	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) General psychiatry	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Secure hospital beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Crisis community beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) Respite community beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g) Rehabilitation community beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i) Quarter-way / rehabilitation beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) Half-way / rehabilitation beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii) Longer term community beds	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
h) E.M.I.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
a) Assessment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Continuing care (Nursing)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Continuing care (Residential)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i) Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- 14 Is there a numerical difference in places provided in the institution at the commencement of the plan and those to be provided "in the community" for:

- a) In patients  
b) Day patients

Places at commencement	Places in the community

- 15 Total Number of staff of all disciplines employed at present on hospital site:

	1994	1995
W.T.E		
Head count		

- 16 What proportion of staff is it proposed will transfer to Community Services?

	%
--	---

- 17 Completed by: NAME \_\_\_\_\_
- POSITION \_\_\_\_\_
- DEPARTMENT \_\_\_\_\_
- DATE \_\_\_\_\_
- Tel. contact No. \_\_\_\_\_

Please return this questionnaire to:

Mr Colin Rickard  
Director of Projects  
Royal Free Hampstead NHS Trust  
Pond Street  
LONDON NW3 2QG  
or fax to: 071 830 2897

## APPENDIX 1

### A Full Range of Hospital and Community Beds

The following range of residential provision must be readily available to every mental health service in order to accommodate people, appropriate to their needs, to provide safe care and to avoid inefficient and wasteful use of resources:

- a) **Acute hospital beds** for people who have relapsed and who cannot be safely treated out of hospital.
- b) **Intensive care hospital beds** for those whose behaviour, during acute relapse, is temporarily threatening, self-harming or overactive. Stays will be brief (usually days) before transfer to a lower staffed hospital bed.
- c) **Longer-term staffed beds** for those whose behaviour or poor living skills mean they need constant supervision with staff awake at night. These beds might be provided in continuing care or rehabilitation wards or in domestic-style hospital hostels.
- d) **Secure hospital beds** for those who pose a danger to others and require secure accommodation and intensive care for a longer period of time than would be appropriate for an intensive care bed. Easy and rapid access to a grade of facilities is required: low secure; medium secure (eg. Regional Secure Unit) and high secure (eg Special Hospital).
- e) **Crisis community beds** for those in the early stages of relapse for whom hospital admission might be avoided.
- f) **Respite community beds** to allow individuals or families a short (a few days) planned period away from a stressful situation that might precipitate a relapse.
- g) **Rehabilitation community beds:-**
  - a. Quarter-way community beds to accommodate those whose discharge from hospital is delayed because of difficulties in finding appropriate accommodation (up to 3 month stays).
  - b. Half-way/rehabilitation community beds for 6-8 month placements of those whose rehabilitation period would be more appropriately spent outside a hospital setting.
  - c. Longer-term community beds and places for those not capable of coping with full independence. The range of facilities would include: 24 hour staffed hostels; low-staffed hostels, with and without sleep-in staff; supported and unsupported domestic style accommodation; family placement schemes and supported flats.
- h) **Elderly Mentally Ill** - patients over 65 years of age.
- i) **Any category** for whom services are provided not described above.

# Appendix 3.2

## P.547 CROSS NATIONAL STUDY OF THE ELDERLY

### BRIEF ASSESSMENT INTERVIEW

ASSURANCE OF CONFIDENTIALITY. All information which would permit identification of the individual or individual facility will be held in strict confidence, will be used only by persons engaged in and for the purpose of the survey, and will not be disclosed or released to others for any purpose.

Study number  
Phase  
Card

CODE	COL.
82.	(1-2)
1	(3)
1	(4)

A

(i)

Respondent's name:

Last First MI

(5) (6-8)

0	0		
---	---	--	--

Sample issue number

(ii)

Institution: Name

Address:

(9-11)

0		
---	--	--

Institution number

(iii)

Instrument:

(12)

2
---

(iv)

Date of interview:

(13-14) (15-16) (17-18)

--	--	--

Day Month Year

Interviewer's name:

(19-22)

0	0	0	0
---	---	---	---

Auth. number

Rater's signature:

(23-24)

--	--

Rater code

B

(i)

Sex of respondent:

Male  
Female

(25)  
1  
2

(ii)

Date of birth:

(26-27) (28-29) (30-31)

--	--	--

Day Month Year

(iii)

Date of admission to institution:

(32-33) (34-35) (36-37)

--	--	--

Day Month Year

(iv)

Last known address:

B(v) RECORD HERE RESPONDENT'S YEAR OF BIRTH FROM B(ii)

(vi) RECORD HERE MOST ACCURATE ESTIMATE OF RESPONDENT'S AGE CALCULATED FROM YEAR OF BIRTH

Card 1

	ASSESSMENT	CODE	COL.
		(t) (f) (?) (r) (n)	
<p>Cla) Would you spell your last name for me? And your first name?</p> <p>_____</p> <p>_____</p> <p>CHECK WITH A(i) IF CANNOT SPELL BOTH NAMES CORRECTLY</p> <p>What is your last name? And your first name?</p> <p>_____</p> <p>_____</p> <p>CHECK WITH A(i)</p>	<p>Cannot spell both names correctly. ALLOW ONE MINOR SPELLING ERROR.</p>	<p>1 2 6 7 8</p>	(38)
	<p>Cannot state both names correctly. ALLOW ONE INTELLIGIBLE APPROXIMATION OF CORRECT NAME.</p>	<p>1 2 6 7 8</p>	(39)
<p>2. I'd like you to remember my name. My name is _____</p> <p>GIVE LAST NAME ONLY. REPEAT UP TO 3 TIMES IF NECESSARY.</p> <p>Can you repeat that please?</p> <p>_____</p>	<p>Cannot repeat even rough approximation of name after 3 repeats.</p>	<p>(t) (f) (?) (r) (n)</p> <p>1 2 6 7 8</p>	(40)
<p>3. How old are you?</p> <p>_____</p> <p>CHECK WITH B(vi)</p>	<p>States an age which is different from most accurate estimate.</p> <p>States does not know or gives incomplete reply.</p>	<p>(t) (f) (?) (r) (n)</p> <p>1 2 6 7 8</p> <p>1 2 6 7 8</p>	(41) (42)
<p>4. So in what year were you born?</p> <p>_____</p> <p>CHECK WITH B(v)</p>	<p>States a year of birth which is different from year given.</p> <p>States does not know or gives incomplete reply.</p>	<p>(t) (f) (?) (r) (n)</p> <p>1 2 6 7 8</p> <p>1 2 6 7 8</p>	(43) (44)

		ASSESSMENT	CODE					COL
			(t)	(f)	(?)	(r)	(n)	
5.	What is the name of this place/facility? _____ CHECK WITH A(11)	States a name which is incorrect. States does not know name or gives incomplete reply.	1	2	6	7	8	(45) (46)
6.	Where is it located? GENERAL AREA OF CITY (eg. BOROUGH). _____ CHECK WITH A(11) IF CORRECT AREA GIVEN AT Q.6. What is the postal/mailling address for this place? _____ CHECK WITH A(11)	States a general area which is incorrect. States does not know or gives incomplete reply. States postal address which is incorrect. States does not know or gives incomplete reply. RESPONSE SHOULD BE ACCURATE ENOUGH FOR A LETTER TO BE DELIVERED.	1	2	6	7	8	(47) (48) (49) (50)
7.	What is the correct postal/mailling address for your (last) home address? _____ CHECK WITH B(1V)	States postal address which is incorrect. States does not know or gives incomplete reply.	1	2	6	7	8	(51) (52)
INTERVIEWER CHECK								
TO BE COMPLETED FOR ALL RESPONDENTS.								
RING CODE X IF RESPONDENT DOES NOT KNOW								
AGE (CODE 1 AT Q.3) X								
YEAR OF BIRTH (CODE 1 AT Q.4) X								
NAME OF FACILITY (CODE 1 AT Q.5) X								
GENERAL LOCATION (CODE 1 AT Q.6) X								
IF ALL FOUR ITEMS CODED X, RING CODE _____ → 1 (54)								
AND END INTERVIEW.								
OTHERS RING CODE _____ → 2								
AND GO TO SECTION D, Q.8.								
Blank (55-80)								

08a) Now I'd like you to tell me how you have been over the past month.

b) Has there been anything troubling you over the past month?  
IF YES: What kind of problems have you been having?

c) Have you had any problems with your health?

d) Have you had any recent illnesses?

e) (When were you admitted to) When did you start coming to/living in this .....  
(NAME TYPE OF FACILITY)?

f) Why was that?  
IF NO REASON GIVEN PROBE: 'Why are you staying/coming here?'

Study number 82 (1-  
Phase 1 {3  
Card 2 {4  
Sample issue number (5-

		<u>ASSESSMENT</u>					<u>CODE</u>					<u>COL</u>
							(t)	(f)	(?)	(r)	(n)	
9.	Do you worry? What kinds of things do you worry about? In the past month?	Admits to worrying.					1	2	6	7	8	(9)
		Worries a lot about one or two things.					1	2	6	7	8	(10)
	<u>IF WORRIES</u> How much do you worry? Do you worry about almost everything? Can you stop yourself from worrying?	Worries about almost everything.					1	2	6	7	8	(11)
		Cannot stop worrying.					1	2	6	7	8	(12)
10.	Have you been sad or depressed during the past month?	Sad or depressed mood during past month.					1	2	6	7	8	(13)
	<u>IF SAD-OR DEPRESSED</u> How long does the depression last? Is it just for a few hours at a time or does it last longer than that? What time of day does your depression feel worst?	Depression lasts longer than just the occasional few hours.					1	2	6	7	8	(14)
		Depression worst at beginning of day.					1	2	6	7	8	(15)
11.	During the past month have you ever felt that life wasn't worth living?	Has felt that life was not worth living.					1	2	6	7	8	(16)
12.	Have you felt like crying in the past month?	Has felt like crying in past month.					1	2	6	7	8	(17)
	<u>IF FELT LIKE CRYING</u> Have you cried in the last month?	Has cried in past month.					1	2	6	7	8	(18)



		Card 2	
		CODE	COL.
13.	How do you feel about your future?		
	What are your hopes for the future?		
	Not pessimistic	0	
	Is pessimistic about the future or has empty expectations	1	
	Future bleak or unbearable	2	(19)
	Query	6	
	Refusal	7	
	Not applicable	8	
14.	In the past month have you at any time felt you would rather be dead?		
	<u>IF YES</u>		
	Did you think of doing anything about it yourself (anything to end it all)?		
	How often do you think about it?		
	What did you plan to do?		
	Did you actually try anything?		
	Not wished to be dead	0	
	Has wished to be dead but rejects suicide	1	
	Considered suicide but suicidal thoughts only	2	(20)
	Has seriously considered a method of suicide but not attempted it	3	
	Has attempted suicide	4	
	Query	6	
	Refusal	7	
	Not applicable	8	

		ASSESSMENT	CODE	COL.
			(t) (f) (?) (r) (n)	
15.	When did you last feel happy? And in the last month?	Does not mention feeling happy in the last month.	1 2 6 7 8	(21)
16.	Have you felt lonely in the past month?  <u>IF LONELY</u> How often have you felt lonely? Can you turn away from it (forget about it)? Does it bother you very much? Does it make you feel depressed?	Feels lonely.  Often feels lonely.  Feels lonely and cannot turn away from it.  Bothered and depressed by current loneliness.	1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8	(22) (23) (24) (25)
17.	What have you enjoyed doing in the last month?	Almost nothing enjoyed.	1 2 6 7 8	(26)
18.	Do you enjoy things as much as you used to - say like you did a year ago? What sorts of things did you use to enjoy?  <u>IF LESS ENJOYMENT</u> When did you notice this loss of enjoyment? Has it been in the last month? Did it (this loss of enjoyment) happen suddenly or come on slowly? Is it because you feel ill that this has happened? Is it because you're depressed or nervous?	Less enjoyment in activities than previously.  Loss of interest/enjoyment in past month.  Sudden loss of interest/enjoyment,  Loss of interest/enjoyment due to illness.  Loss of interest/enjoyment because of depression/nervousness.	1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8	(27) (28) (29) (30) (31)

		<u>ASSESSMENT</u>					<u>CODE</u>		<u>COL.</u>
		(t)	(f)	(?)	(r)	(n)			
19.	Do you feel happy about yourself as a person?	Does not feel happy about self.					1	2 6 7 8	(32)
	<u>IF NOT HAPPY ABOUT SELF</u>	Unrealistic self-depreciation.					1	2 6 7 8	(33)
	Can you tell me more about that?								
20.	Do you have regrets about your life?	Mentions regrets.					1	2 6 7 8	(34)
	<u>IF YES</u>	Mentions regret about past which may or may not be justifiable.					1	2 6 7 8	(35)
	Do you blame yourself for anything?	Obvious self blame over past or present minor misdeeds.					1	2 6 7 8	(36)
	What do you blame yourself for?	DO NOT INCLUDE JUSTIFIABLE OR MINOR SELF BLAME.							
	In the past month?	Keeps blaming self for harmful effect of his/her illness or behaviour on others (family, friends, etc.).					1	2 6 7 8	(37)
	Is that on your mind a lot?								
21.	How about before this past month have there been times when you felt sad or depressed?	Reports previous episode of sadness/depression.					1	2 6 7 8	(38)
	<u>IF YES</u>	Episodes of depression lasting over a week prior to past year.					1	2 6 7 8	(39)
	When was that?	Suicidal thoughts, however fleeting, during an episode.					1	2 6 7 8	(40)
	How long did it last?								
	Did you ever feel so bad at that time that you wanted to end your life?								

		ASSESSMENT	CODE	COL.
			(t) (f) (?) (r) (n)	
22.	Have you had any difficulty with your memory?	Claims difficulty with, or impaired, memory.	1 2 6 7 8	(41)
23.	I wonder if you remember my name? What is it?  <u>IF INCORRECT</u> Actually it is _____	Does not recall even gross approximation of interviewer's name.	1 2 6 7 8	(42)
24.	Do you remember the name of the Prime Minister.  <u>IF INCORRECT</u> Actually it is Mr/Mrs/ _____	Does not recall name of Prime Minister.	1 2 6 7 8	(43)
25.	Who was it before him/her? _____	Does not recall previous Prime Minister	1 2 6 7 8	(44)
26.	What is the date today? _____ What is the day of the week? _____ What month is it? _____ What year is it? _____	States a date of the month which is incorrect. States does not know or does not complete reply. States a day of the week which is incorrect. States does not know or does not complete reply. States a month which is incorrect. States does not know or does not complete reply. States a year which is incorrect. States does not know or does not complete reply.	1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8 1 2 6 7 8	(45) (46) (47) (48) (49) (50) (51) (52)

<u>ASSESSMENT</u>		<u>CODE</u>					<u>COL.</u>
		(t)	(f)	(?)	(r)	(n)	
27.	I'd like to ask some questions about your health now.  Do you have headaches?	Reports headaches. in last month					
		1	2	6	7	8	(53)
28.	Do you have backaches?	Reports backaches. in last month					
		(t)	(f)	(?)	(r)	(n)	
		1	2	6	7	8	(54)
29.	Have you been eating well in the last month? <u>IF NOT EATING WELL</u> Is that because you don't feel like eating or for some other reason?	Not eating well.  Has poor appetite in the absence of obvious medical cause.					
		(t)	(f)	(?)	(r)	(n)	
		1	2	6	7	8	(55)
		1	2	6	7	8	(56)
30.	Have you lost any weight during the past 3 months?  <u>IF LOST WEIGHT</u> About how much weight have you lost? PROBE WHETHER MORE OR LESS THAN 10 LBS.	Not lost any weight.  Lost some weight but not sure how much.  Lost less than 10 lbs during past 3 months.  Lost 10 lbs or more during past 3 months.  Query Refusal Not applicable					
						0	
						1	
						2	
						3	(57)
						6	
						7	
						8	
31.	Do you feel that you have become slowed down in your physical movement compared to a year ago?	Has become slowed down in movements.					
		(t)	(f)	(?)	(r)	(n)	
		1	2	6	7	8	(58)

ASSESSMENT

32a) Have you had any trouble sleeping over the past month - I mean regularly? What sort of trouble?

Trouble falling asleep or wakes early.

b) Have you been taking anything to help you sleep?  
IF YES: If you weren't taking this, would you have trouble sleeping?

Taking medication for sleep.

Dependent on medication for sleep.

IF a) OR b) ARE TRUE

Is your sleep interrupted during the night?

Do you wake very early in the morning?

IF YES: Is that normal for you? Can you get back to sleep?

Sleep interrupted during night.

Wakes about 2 hours or more before normal time of waking and cannot go back to sleep.

When you get up in the morning do you feel you have had enough sleep?

Wakes up feeling tired. Difficulty getting to sleep due to altered moods or thoughts, or tension.

What is it that prevents you from sleeping or wakes you up?

Is it because you feel tense or depressed? What goes through your mind while you are lying awake?

Lies awake with depressed or anxious thoughts.

<u>CODE</u>					<u>COL.</u>
(t)	(f)	(?)	(r)	(n)	
1	2	6	7	8	(59)
1	2	6	7	8	(60)
1	2	6	7	8	(61)
1	2	6	7	8	(62)
1	2	6	7	8	(63)
1	2	6	7	8	(64)
1	2	6	7	8	(65)
1	2	6	7	8	(66)

		ASSESSMENT	CODE					COL.
			(t)	(f)	(?)	(r)	(n)	
33.	Do you feel yourself trembling? <u>IF YES:</u> Has that happened in the past month?	Trembling or tremulous feelings in the past month.	1	2	6	7	8	(67)
34.	Do you get dizzy or weak? <u>IF YES:</u> Has that happened in the past month?	Dizziness or weakness in past month.	1	2	6	7	8	(68)
35.	Do you feel your heart pounding? <u>IF YES:</u> Has that happened in the past month?	Palpitations in past month	1	2	6	7	8	(69)
36.	Are your bowels regular? Do you have constipation? <u>IF YES:</u> In the past month?	Constipated in past month.	1	2	6	7	8	(70)
37.	Would you please help me with this test?  Please place your hands on your knees. Please touch your right ear with your right hand. Now your right ear with your left hand; now your left ear with your right hand.	Number of incorrectly performed manoeuvres. →  Though correct, all very hesitant, or correct only after several attempts.	<div> <div>(t) (f) (?) (r) (n)</div> <div> <div></div> <div>1 2 6 7 8</div> </div> </div>					(71)
			1	2	6	7	8	(72)

		<u>ASSESSMENT</u>					<u>CODE</u>					<u>COL</u>	
		(t)	(f)	(?)	(r)	(n)							
38.	Did you need to stay in bed in the past month?	Reports staying in bed					1	2	6	7	8	(73)	
	<u>IF YES:</u> What was wrong with you?												
	Did you see a doctor?	Reports seeing a doctor.					1	2	6	7	8	(74)	
	<u>IF YES:</u> What did he say was wrong with you?											(75-)	
												Blank (77-)	
												Study number (1-2)	
												Phase 1 (3)	
												Card 3 (4)	
												Sample issue number (5-8)	
39.	What about the last 6 months - Have you been ill or had an operation?	Reports illness or operation.					1	2	6	7	8	(9)	
	<u>IF YES:</u> Did you need to stay in bed?	Reports staying in bed.					1	2	6	7	8	(10)	
	Did you see a doctor?	Reports seeing doctor.					1	2	6	7	8	(11)	
	<u>IF YES:</u> What did he say was wrong with you?											(12-)	



		CODE	COL
40.	Now I would like to ask you a few general questions.  Are you single or married or are you widowed (divorced or separated)?	Single 1 Married 2 Widowed 3 Divorced 4 Separated 5	(
41a)	Did you work for most of your life before you reached retiring age?  <div style="text-align: right;">             Worked for most of life              Never worked/did not work for most of life           </div>	1 2	(
b)	What was the main job you did for most of your life? JOB TITLE:  NATURE OF ACTIVITY:		SKIP TO
	IF EVER MARRIED (CODES 2-5 AT Q.40) OTHERS SKIP TO Q.43		(16
42a)	What kind of work did your husband/wife do?  <div style="text-align: right;">             RECORD DETAILS OF MAIN OCCUPATION               Spouse never worked/did not work for most of life → X           </div>		SKIP TO Q
	JOB TITLE:  NATURE OF ACTIVITY:		
43.	Where were you living (staying) <u>just</u> before you came to stay here?  RECORD TYPE OF INSTITUTION/FACILITY IMMEDIATELY PRIOR TO ADMISSION.	Private residence 1 Other (SPECIFY) 2	(18)
44a(1).	When you were last at home, were you living alone or did you live with friends?  <div style="text-align: right;">             Lives/lived alone              Lives lived with relatives/friends              Other (SPECIFY)           </div>	1 2 3	(19) SKIP TO

Card 3

			CODE	COL
TO ALL				
45a)	What is your religion?	None/Agnostic/Atheist	1	(62)
		Anglican/Church of England/Episcopalian	2	
		Roman Catholic	3	
		Baptist/Methodist/Presbyterian	4	
		Greek/Russian Orthodox	5	
		Reform Jewish	6	
		Orthodox Jewish	7	
		Moslem	8	
		Other (SPECIFY) _____	9	
b)	Do you go to church fairly regularly now?	Yes	1	(63)
		No	2	
		Can't say	3	
46.	At what age did you finish your full time education? (i.e. school, college, university)	Up to 14	1	(64)
		15	2	
		16	3	
		17 - 19	4	
		20 - 21	5	
		22 or over	6	
		(Can't say)	7	
IF EVER MARRIED      OTHERS SKIP TO Q.48				
47.	And at what age did your husband/wife finish his/her full time education?	Up to 14	1	(65)
		15	2	
		16	3	
		17 - 19	4	
		20 - 21	5	
		22 or over	6	
		(Can't say)	7	
48a)	Taking everything into consideration, how would you describe your satisfaction with life in general at the present time. Would you say it was ..... READ OUT.	Good	1	(66)
		Fair	2	
		OR Poor	3	
b)	And in general how happy are you? Are you ..... READ OUT.	Very happy	1	(67)
		Fairly happy	2	
		Not very happy	3	
		OR Not happy at all	4	

TO BE COMPLETED BY INTERVIEWER.			CODE	COL
1) Ethnic group				
ASK RESPONDENT IF NOT APPARENT.				
	White		1	(68)
	Hispanic		2	
	Black		3	
	Brown		4	
	Other (SPECIFY) _____		5	
11) RECORD WHETHER DURING INTERVIEW RESPONDENT:	Did not laugh or smile at any time		1	(69)
	Cried at any time		2	
111) Length of Interview:	Less than 20 mins		1	(70)
	20 - 29 mins		2	
	30 - 39 mins		3	
	40 - 49 mins		4	
	50 - 59 mins		5	
	60 mins or longer		6	
Rate: Vision:	No impairment		0	(71)
	Impaired vision (can read or sew only with difficulty despite aids)		1	
	Totally blind		2	
Hearing:	Adequate communication		0	(72)
(rate state with hearing aid on)	Interviewer has to shout		1	
	Communication virtually impossible		2	
Mobility:	Patient appears mobile		0	(73)
	Patient walks with mechanical aide		1	
	Patient chairbound unless helped by staff		2	

## CLIFTON ASSESSMENT PROCEDURES FOR THE ELDERLY (CAPE)

## Behaviour Rating Scale

Name: ..... Date of birth: .....

Current address/placement: .....

.....

Please ring the appropriate number for each item

- |  |   |   |
|--|---|---|
| 1. When bathing or dressing, he/she requires:  | — no assistance   | 0 |
|  | — some assistance   | 1 |
|  | — maximum assistance  | 2 |
| 2. With regard to walking, he/she:   | — shows no signs of weakness  | 0 |
|  | — walks slowly without aid, or uses a stick   | 1 |
|  | — is unable to walk, or if able to walk, needs frame, crutches or someone by his/her side | 2 |
| 3. He/she is incontinent of urine and/or faeces (day or night):  | — never   | 0 |
|  | — sometimes (once or twice per week)  | 1 |
|  | — frequently (3 times per week or more)   | 2 |
| 4. He/she is in bed during the day (bed does not include couch, settee, etc):  | — never   | 0 |
|  | — sometimes   | 1 |
|  | — almost always   | 2 |
| 5. He/she is confused (unable to find way around, loses possessions, etc):   | — almost never confused   | 0 |
|  | — sometimes confused  | 1 |
|  | — almost always confused  | 2 |
| 6. When left to his/her own devices, his/her appearance (clothes and/or hair) is:  | — almost never disorderly   | 0 |
|  | — sometimes disorderly  | 1 |
|  | — almost always disorderly  | 2 |
| 7. If allowed outside, he/she would:   | — never need supervision  | 0 |
|  | — sometimes need supervision  | 1 |
|  | — always need supervision   | 2 |
| 8. He/she helps out in the home/ward:  | — often helps out   | 0 |
|  | — sometimes helps out   | 1 |
|  | — never helps out   | 2 |
| 9. He/she keeps him/herself occupied in a constructive or useful activity (works, reads, plays games, has hobbies, etc): | — almost always occupied  | 0 |
|  | — sometimes occupied  | 1 |
|  | — almost never occupied   | 2 |
| 10. He/she socialises with others:   | — does establish a good relationship with others  | 0 |
|  | — has some difficulty establishing good relationships                                     | 1 |
|  | — has a great deal of difficulty establishing good relationships                          | 2 |
| 11. He/she is willing to do things suggested or asked of him/her:  | — often goes along  | 0 |
|  | — sometimes goes along  | 1 |
|  | — almost never goes along   | 2 |

12. He/she understands what you communicate to him/her (you may use speaking, writing, or gesturing):
- understands almost everything you communicate 0
  - understands some of what you communicate 1
  - understands almost nothing of what you communicate 2
13. He/she communicates in any manner (by speaking, writing or gesturing):
- well enough to make him/herself easily understood at all times 0
  - can be understood sometimes or with some difficulty 1
  - can rarely or never be understood for whatever reason 2
14. He/she is objectionable to others during the day (loud or constant talking, pilfering, soiling furniture, interfering with affairs of others):
- rarely or never 0
  - sometimes 1
  - frequently 2
15. He/she is objectionable to others during the night (loud or constant talking, pilfering, soiling furniture, interfering in affairs of others, wandering about, etc.):
- rarely or never 0
  - sometimes 1
  - frequently 2
16. He/she accuses others of doing him/her bodily harm or stealing his/her personal possessions — if you are sure the accusations are true, rate zero, otherwise rate one or two:
- never 0
  - sometimes 1
  - frequently 2
17. He/she hoards apparently meaningless items (wads of paper, string, scraps of food, etc.):
- never 0
  - sometimes 1
  - frequently 2
18. His/her sleep pattern at night is:
- almost never awake 0
  - sometimes awake 1
  - often awake 2
- 
- Eyesight:  
(tick which applies)
- can see (or can see with glasses)
  - partially blind
  - totally blind
- Hearing:  
(tick which applies)
- no hearing difficulties, without hearing aid
  - no hearing difficulties, though requires hearing aid
  - has hearing difficulties which interfere with communication
  - is very deaf

Rated by: ..... Date: .....  
Staff/Relative

Copyright © 1979 A. H. Patie and C. J. Gilleard

Eleventh impression 1983

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, without permission in writing from the publisher.

This publication is excluded from the reprographic licensing scheme administered by the Copyright Licensing Agency Limited.

Printed in Great Britain for Hodder and Stoughton Educational, a division of Hodder and Stoughton Ltd., Mill Road, Dunton Green, Sevenoaks, Kent, by CW Print Group, Oakwood Hill Industrial Estate, Oakwood Hill, Loughton, Essex IG10 3TZ

**PATIENT  
QUALITY OF LIFE  
(Supplementary)  
QUESTIONNAIRE**

(Interview in conjunction with B.A.S.)  
(For use before and after the move to Community Facilities)

**ROYAL FREE HOSPITAL  
SCHOOL OF MEDICINE**

**COMMUNITY REPROVISION  
RESEARCH PROGRAMME**

**PATIENT'S NAME**

---

**NAME OF NEW FACILITY**

---

**NAME OF OLD FACILITY**

---

**DATE OF MOVE**

---

**INTERVIEW -  
BEFORE / AFTER MOVE (Delete)**

PATIENT'S NAME

\_\_\_\_\_

DATE OF INTERVIEW

\_\_\_\_\_

1 How long have you been here?

Years

\_\_\_\_\_

Months

\_\_\_\_\_

2a Do you like the bedroom you are in?

Yes

☐

No

☐

2b If no, for which of the following reasons:

Too hot

☐

Too cold

☐

Too small

☐

Too big

☐

Isolated

☐

Lacks privacy

☐

No View

☐

2c If yes, for which of the following reasons:

Heating levels just right

☐

Ample sized room

☐

Not isolated

☐

Adequate privacy

☐

Pleasant view

☐

2d Can you see out of the window?

Yes

☐

No

☐

A little

☐

2e Interviewer to note if patient can control heating levels

Yes

☐

No

☐

The interviewer ascertains from patient or staff, if the patient is not in own room at time, the type of accommodation:-

nightingale

☐

improved nightingale

☐

single

☐

double room

☐

4/5/6 bay

☐

Other - please specify below

☐

3a Do you have any personal things here?

Yes

☐

No

☐

3b If yes, which of the following do you have?

furniture

☐

pictures

☐

books

☐

ornaments

☐

others

☐

4a	Can you get to the toilet easily?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
4b	Can you get to the bathroom easily?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
<b>Interviewer to note</b>			
4c	Approx. distance in metres to toilet facilities	metres	_____
4d	Approx. distance in metres to bathing facilities	metres	_____
4e	Does patient require assistance?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
4f	Can w.c. be locked by patient?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
5	Where do you go in the day?	Dining Room	<input type="checkbox"/>
		Sitting Room	<input type="checkbox"/>
		Outside Garden	<input type="checkbox"/>
		Stay in Room	<input type="checkbox"/>
		Off site	<input type="checkbox"/>
6a	What do you do in the day?	Read	<input type="checkbox"/>
		Walk	<input type="checkbox"/>
		Watch T.V.	<input type="checkbox"/>
		Socialise	<input type="checkbox"/>
		Hobby	<input type="checkbox"/>
		Sleep	<input type="checkbox"/>
		Other - please specify below	<input type="checkbox"/>
_____			
6b	Interviewer to note if the patient is bedbound or immobile	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
7a	Is it easy for you to make a telephone call?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
<b>Interviewer to note</b>			
7b	Distance in metres to nearest phone/s	metres	_____
7c	Number of phones available	No. of phones	_____
7d	and/or telephone trolley with bedhead service	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
8	Do you get lost in the building?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		Sometimes	<input type="checkbox"/>
9a	Are you contented here apart from being away from home?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>



9b If yes

In all respects  
In most respects  
Only in some respects


**Question for the new facility only:**

10a Is this place better than

\_\_\_\_\_

(name of old one)

Yes  
No


10b If yes, for which of the following reasons: -

More privacy  
Quieter  
Better dining facilities  
Better w.c. facilities  
More visits from relatives  
Better general environment  
Nearer to public facilities  
Better access to staff


10c If no, for which of the following reasons: -

Lack of privacy  
More noisy  
Poorer dining facilities  
Poorer w.c. facilities  
Fewer visits from relatives  
Poorer general environment  
Further from public facilities  
Worse access to staff


11 Has the new facility contributed to an improved relationship with the staff?

Yes  
No  
Same as before


**Interviewer's comments:**

The interviewer is to state here if patient's comments are more reflectional of his/her mental state.


Interviewer thanks patient for taking part.

<p><b>STAFF</b></p> <p><b>QUESTIONNAIRE</b></p>
---

To be completed in conjunction with the General Health Questionnaire

**ROYAL FREE HOSPITAL  
SCHOOL OF MEDICINE**

**COMMUNITY REPROVISION  
RESEARCH PROGRAMME**

**STAFF NAME**

---

**NAME OF NEW FACILITY**

---

**NAME OF CLOSED / CLOSING INSTITUTION**

---

The Royal Free Hospital School of Medicine is undertaking a three year study to monitor the closure programmes of long stay institutions.

Over 90 major institutions are being monitored in this research.

Your former hospital \_\_\_\_\_ has been selected as one where more detailed views of those involved (affected) in the process are being sought.

The intention of this questionnaire is to ascertain the levels of staff involvement in the reprovion programme and whether they were advised in sufficient detail of the intended services and their contribution to the design and operation of the facilities provided.

Thank you for co-operating.

No individuals will be named in the published research and any information given will only be used in arriving at the total views of a staff group at a particular hospital.

DATE OF INTERVIEW \_\_\_\_\_

NAME \_\_\_\_\_

JOB TITLE \_\_\_\_\_

NAME OF NEW FACILITY \_\_\_\_\_

NAME OF CLOSED / CLOSING INSTITUTION \_\_\_\_\_

1a Is the Institution completely closed? Yes ☐  
No ☐

1b If yes, what was the date of closure? \_\_\_\_\_

1c If no, when is the anticipated date of closure? \_\_\_\_\_

2 What was the date of transfer of your ward/department \_\_\_\_\_

**Service**

3a When did you commence work at the old institution? Month   
Year 19

3b Length of service accrued at the old institution? Years  Months

4a In what capacity did you commence work at the old institution? \_\_\_\_\_

4b On transfer, in what capacity did you commence work at the new facility? \_\_\_\_\_

5 Has your contract / conditions of service changed as a result of the move? Yes ☐  
No ☐

**First advice**

6a When did you first find out the institution was due to close? more than 3 years before ☐  
3 years before ☐  
2 years before ☐  
1 year before ☐  
9 months before ☐  
6 months before ☐  
3 months before ☐

Less than  
3 months before ☐

6b How did you find out?

by letter ☐  
staff meeting ☐  
individually ☐  
colleague ☐  
press ☐  
other (please  
specify below) ☐

---

7a When did you find out your ward or  
department was to transfer?

more than 3 years  
before ☐  
3 years before ☐  
2 years before ☐  
1 year before ☐  
9 months before ☐  
6 months before ☐  
3 months before ☐  
Less than  
3 months before ☐

7b How did you find out your ward or department  
was to transfer?

by letter ☐  
staff meeting ☐  
individually ☐  
colleague ☐  
press ☐  
other (please  
specify below) ☐

8a How were you formally informed by management  
of the closure of the institution?

by letter ☐  
staff meeting ☐  
individually ☐  
other (please  
specify below) ☐

---

8b How were you formally informed by management  
of the closure of your ward/department.

by letter ☐  
staff meeting ☐  
individually ☐  
other (please  
specify below) ☐

---

9a How did you and the staff feel when management  
first advised you of the future plan?

unclear ☐  
clear ☐

- |     |   |                         |  |
|-----|---|-------------------------|--|
| 9b  | Did those feelings change during the implementation of the plan?                      | Yes<br>No               | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 10a | Was the new service and its timetable for implementation explained?                   | Yes<br>No<br>Don't know | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 10b | Was the plan significantly changed during its implementation?                         | Yes<br>No<br>Don't know | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 11  | Was it clear where your part of the service would be relocated following the closure? | Yes<br>No<br>Don't know | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

#### Updates

- |     |  |  |  |
|-----|--|--|--|
| 12a | Were regular updates on progress given to you? | Yes<br>No<br>Don't know  | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/>                             |
| 12b | If yes, how?                                   | by letter<br>staff meeting<br>individually<br>other (please specify below) | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

#### Planning

- |     |  |                         |  |
|-----|--|-------------------------|--|
| 13a | Was your input sought in the planning of services?   | Yes<br>No               | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 13b | If no, do you think it should have been?   | Yes<br>No               | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 14  | Did you know the representative / senior officer relevant to your work who was planning the service? | Yes<br>No               | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 15  | Did your professional group contribute?  | Yes<br>No<br>Don't know | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

16	Are you satisfied that the system allowed you to make your views felt?	Yes No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
17a	Were you a member of a project team for a specific service or facility?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
17b	If no, do you think you should have been?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
<b>If no, go to question 20a</b>			
18a	Were you involved in drafting operational policies?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
18b	If no, do you think you should have been?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
19a	Were you involved in multi-disciplinary work with other care professionals/planners?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
19b	If no, do you think you should have been?	Yes No	<input type="checkbox"/> <input type="checkbox"/>

### Approvals

20a	Were you shown the eventual design of the facility?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
21a	If no, Do you think you should have been?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
<b>Go to question 22</b>			
21b	If yes, Were you given the chance to comment on whether this adequately met the operational requirements?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
22	Accepting that some physical and cost restraints will always apply, do you think the final outcome was acceptable?	Yes No Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
23a	Did you get involved in the choice of furniture and equipment and the colour scheme and furnishings?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
23b	If no, do you think you should have been?	Yes No	<input type="checkbox"/> <input type="checkbox"/>

## Training

24a Was additional training offered to you to enhance your work in the new facility?

Yes  
No


24b If no  
Do you think it should have been?

Yes  
No


Go to question 25a

24c If yes  
Was this training necessary?

Yes  
No


24d Was this training

good  
adequate  
not satisfactory


24e If not satisfactory, why not?

inappropriate -  
not targeted  
too short  
badly taught  
other (please  
specify below)


25a Do you intend to seek training (further) as a result of your transfer?

Yes  
No  
Undecided


25b If yes, why?

Needed to perform  
existing work  
Career  
development  
Expanded role  
other (please  
specify below)


## Commissioning

26a Were you part of the commissioning team for the new facility?

Yes  
No


26b If no,  
Do you think you should have been?  
Go to question 27

Yes  
No


26c If yes,  
Was this general or confined to your

General

--



ward/department?	Own ward/dept	<input type="checkbox"/>
27 Do you think the commissioning generally went well ?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
<b>New Facilities</b>		
28 How do you feel about the new facility ? (more specific questions to follow)	Generally good Generally bad	<input type="checkbox"/> <input type="checkbox"/>
29 Are the patient areas		
big enough	Yes No	<input type="checkbox"/> <input type="checkbox"/>
bright enough	Yes No	<input type="checkbox"/> <input type="checkbox"/>
well furnished	Yes No	<input type="checkbox"/> <input type="checkbox"/>
well decorated	Yes No	<input type="checkbox"/> <input type="checkbox"/>
wearing well	Yes No	<input type="checkbox"/> <input type="checkbox"/>
easily accessible	Yes No	<input type="checkbox"/> <input type="checkbox"/>
30 Is there wheelchair access?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
31 Are patient toileting facilities		
of sufficient quantity	Yes No	<input type="checkbox"/> <input type="checkbox"/>
near enough to patient areas	Yes No	<input type="checkbox"/> <input type="checkbox"/>
of sufficient quality	Yes No	<input type="checkbox"/> <input type="checkbox"/>
32 Are patient bathing facilities		
of sufficient quantity	Yes No	<input type="checkbox"/> <input type="checkbox"/>
near enough to patient areas	Yes No	<input type="checkbox"/> <input type="checkbox"/>
of sufficient quality	Yes No	<input type="checkbox"/> <input type="checkbox"/>
33a Is there a staff amenity area?	Yes	<input type="checkbox"/>

33b If no,	No	<input type="checkbox"/>
Is this a serious disadvantage?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Go to question 34		

33c If yes,		
Is the staff amenity area		
big enough	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
bright enough	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
well furnished	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
well decorated	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
wearing well	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

34 Are support functions satisfactory?

linen supplies	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
storage	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
catering	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
transport	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

35 Is there anything you would like to suggest as to how the process might be improved?

---



---



---



---



---



---

Interviewer thanks staff member for interview and explains the General Health Questionnaire

# GENERAL HEALTH QUESTIONNAIRE

GHQ-28

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

## HAVE YOU RECENTLY:

A1 — been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 — been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 — been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 — felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 — been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 — been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 — been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1 — lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 — had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 — felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 — been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 — been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 — found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 — been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

PLEASE TURN OVER

# HAVE YOU RECENTLY

C1 - been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2 - been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 - felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4 - been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5 - felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 - felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7 - been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
D1 - been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2 - felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 - felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 - thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5 - found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 - found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 - found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has
A <input type="text"/>	B <input type="text"/>	C <input type="text"/>	D <input type="text"/>	TOTAL <input type="text"/>

Copyright © General Practice Research Unit 1978  
 Published by The NFER-Nelson Publishing Company Ltd.  
 Darnley House, 2 Oxford Road East, Windsor, SL4 1DF, Berks.  
 All rights reserved. Not to be reproduced in any form  
 or by any means without the written permission of the publisher.  
 First published 1978.  
 © General Practice Research Unit 1978.  
 ISBN 07005 0210 6  
 Printed in Great Britain.

Code 4073 02.4

**FRIEND / RELATIVE**

**QUESTIONNAIRE**

**ROYAL FREE HOSPITAL  
SCHOOL OF MEDICINE**

**COMMUNITY REPROVISION  
RESEARCH PROGRAMME**

**FRIEND'S / RELATIVE'S NAME** \_\_\_\_\_

**DATE OF INTERVIEW** \_\_\_\_\_

**NAME OF NEW FACILITY** \_\_\_\_\_

The Royal Free Hospital School of Medicine is undertaking a three year study to monitor the closure programmes of long stay institutions.

Your friend's/relative's previous hospital \_\_\_\_\_  
has been selected as one where more detailed views of those affected in the process are being sought.

The intention of this questionnaire is to ascertain levels of friend/relative satisfaction with the reprovision programme and whether you think it has been better for the user of the service.

No individuals will be named in the published research and any information given will only be used in arriving at the total views of a friend/relative group at a particular hospital.

Thank you for agreeing to take part in this research.

DATE OF INTERVIEW

\_\_\_\_\_

NAME of Friend or Relative

\_\_\_\_\_

RELATIONSHIP to Patient

Son/ Daughter  
Wife/Husband  
Friend  
Other (please  
specify below)


\_\_\_\_\_

Patient's Present Hospital / Home

\_\_\_\_\_

Patient's Former Hospital

\_\_\_\_\_

The following questions are part of a national survey to help NHS staff plan facilities for patients.

**New Facilities**

- 1 In general do you think the new facilities provided are

better than  
worse than  
the same as


those at the former hospital.

- 2 Specifically, the bedroom

generally is

better  
worse  
the same


decoration is

better  
worse  
the same


furnishings are

better  
worse  
the same


size is

better  
worse  
the same


- 3 The living/day rooms

generally are

better  
worse  
the same


decoration is

better  
worse  
the same


furnishings are

better  
worse  
the same


size is

better  
worse  
the same


4 The dining area

generally is

better  
worse  
the same


decoration is

better  
worse  
the same


furnishings are

better  
worse  
the same


size is

better  
worse  
the same


5 How were you told that your friend/relative was moving from the former hospital to the new facility?

by nurse / doctor  
by another professional  
by letter  
by friend / relative  
don't remember  
Other (please specify)


6 How long before the move were you told?

Over 6 months  
6 months  
5 months  
4 months




3 months  
2 months  
1 month  
Less than a month  
Don't remember


7a Did you speak to the nurse/carers about the move?

Yes  
No


If no, go to question 7d

7b If yes,  
How many of your questions could they answer?

all  
most  
few  
none


7c Did you feel reassured after asking  
your questions?

Very much  
A little  
Not at all


Go to question 8

7d Did you want to?

Yes  
No


#### VISITS

8a Is it easier to visit your friend/relative at the  
new facility than the former hospital?

Yes  
No  
Same as before


8b If yes,  
For which of the following reasons?

location of the site  
better public transport  
vehicle ownership


8c If no,  
For which of the following reasons?

location of the site  
worse public transport  
non-vehicle ownership


9 What was the approximate distance from your  
normal place of residence to the old facility?

miles .....

10 What is the approximate distance from your  
normal place of residence to the new facility?

miles .....

11 How was your friend/relative the patient told  
about the move?

by nurse/carers  
by letter  
by you


don't remember  
Other (please specify)


12 How did you friend/relative feel about the move?

very pleased  
pleased  
indifferent  
a little worried  
very worried


13 Does your friend/relative like it  
at the new facility?

In all respects  
In most respects  
Only in some respects  
Not at all


14 Do you have a suggestion, from the point of view as a friend or relative, that would

a) improve the planning of the accommodation within such new facilities?


b) improve the planning of the way in which such moves are made?


The interviewer thanks the friend/relative for completing this questionnaire.

## INPATIENT WARDS - ADULT ACUTE MENTALLY ILL

NAME OF HOSPITAL:

NO. OF BEDS:

STATUS:

DATE:

## SANITARY FACILITIES

1. Is there at least 1 w.c. to 5 patients?

Yes

No


If no, what is the ratio?

1:6

1:7

1:8

1:9

1:10


2. Is there at least 1 bath or shower to every 6 patients?

Yes

No


If no, what is the ratio?

1:7

1:8

1:9

1:10


3. Is there at least 1 assisted shower/wc/whb of 6.00 m<sup>2</sup> on ward?

Yes

No


If no, what is the actual size?

m<sup>2</sup>

5.5

5.0

4.5

4.0


4	Is there at least 1 assisted bath/wc/whb of 12.50m <sup>2</sup> on the ward?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		m <sup>2</sup>	
	If no, what is the actual size?	12.00	<input type="checkbox"/>
		11.50	<input type="checkbox"/>
		11.00	<input type="checkbox"/>
		10.50	<input type="checkbox"/>
		10.00	<input type="checkbox"/>
		9.50	<input type="checkbox"/>
		9.00	<input type="checkbox"/>
		8.50	<input type="checkbox"/>
		8.00	<input type="checkbox"/>

### Dormitory Facilities

5	Are the single bedrooms at least 11m <sup>2</sup> ?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		m <sup>2</sup>	
	If no, what is actual size	10.50	<input type="checkbox"/>
		10.00	<input type="checkbox"/>
		09.50	<input type="checkbox"/>
		09.00	<input type="checkbox"/>
		08.50	<input type="checkbox"/>
6	Are the multi-bedded areas (divan beds) a minimum of 8.5m <sup>2</sup> per occupant?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		m <sup>2</sup>	
	If no, what is the actual size?	8.00	<input type="checkbox"/>
		7.50	<input type="checkbox"/>
		7.00	<input type="checkbox"/>
		6.50	<input type="checkbox"/>
		6.00	<input type="checkbox"/>
		5.50	<input type="checkbox"/>
		5.00	<input type="checkbox"/>
7	Are individual bed spaces curtained?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
8a.	Is there one special bedroom for the temporary use of severely disturbed patients adjacent to the staffbase?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>

8b Which of the following does this special room have:

- |       |      |  |                          |
|-------|------|--|--------------------------|
|       | i)   | a robust door which can be opened only by the staff from the outside and which opens outwards  | <input type="checkbox"/> |
|       | ii)  | a vision panel of toughened glazing suitable for staff observation either in the door, or in a wall, which can be screened from the outside when privacy is required, and which gives as much all round vision of the room as possible | <input type="checkbox"/> |
|       | iii) | windows with safety glass and restricted opening   | <input type="checkbox"/> |
| flush | iv)  | three light fittings which should all be ceiling mounted, and unbreakable with   | <input type="checkbox"/> |
|       | a)   | the main light controlled by a switch outside the room;  | <input type="checkbox"/> |
|       | b)   | a separate night light to give a pool of light by the door with a switch outside the room;   | <input type="checkbox"/> |
|       | c)   | an overbed light. The local bed-head switch should be capable of being isolated by means of an over-ride switch mounted outside the room;  | <input type="checkbox"/> |
|       | v)   | heating which cannot be tampered with, controlled from the outside of the room;  | <input type="checkbox"/> |
|       | vi)  | sound containment to a reasonable level.   | <input type="checkbox"/> |

## DAY FACILITIES

9	Is there a quiet room separate from sitting/dining/therapy rooms?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
10	Is the ward self-contained (i.e. stand alone)?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
11a	Does the total area of dining room/sitting room space equate to at least 2.30m <sup>2</sup> per patient (excluding Quiet Room)?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
11b	If no, how much does it measure per patient?	m <sup>2</sup>	
	2.4		<input type="checkbox"/>
	2.3		<input type="checkbox"/>
	2.2		<input type="checkbox"/>
	2.1		<input type="checkbox"/>
	2.0		<input type="checkbox"/>
	1.9		<input type="checkbox"/>
	1.8		<input type="checkbox"/>
12	Is there a Consulting / Interview room within the ward area?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
13	Is there a dining/sitting/group therapy room to permit meals to be taken in a single sitting?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
14	Is there the availability in the day area of a patients utility room?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
15	Does the patients storage space for personal belongings measure a minimum of 0.2m <sup>2</sup> per patient?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
	If no, what is the actual size?	0.15	<input type="checkbox"/>
		0.10	<input type="checkbox"/>
16	Is there a clean utility / treatment room available in the ward area?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>

- |    |   |                  |  |
|----|---|------------------|--|
| 17 | Is there a "forum" (informal sitting) space contiguous with, but not part of the circulation route and adjacent to the staffbase as an informal meeting space for patients and staff? | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 18 | If located on a DGH site, is there a separate identifiable entrance to the Mental Health facilities?  | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

**General**

- |     |  |           |  |
|-----|--|-----------|--|
| 19  | Is there clear separation and identification of "dormitory" and "day" areas? | Yes<br>No | <input type="checkbox"/><br><input type="checkbox"/> |
| 20a | Is the ward located on the ground floor?                                     | Yes<br>No | <input type="checkbox"/><br><input type="checkbox"/> |
| 20b | If no, is there a lift?  | Yes<br>No | <input type="checkbox"/><br><input type="checkbox"/> |

**QUALITY OF ENVIRONMENT OR GENERAL SURROUNDINGS**

- |     |  |                  |  |
|-----|--|------------------|--|
| 21  | Is the sitting /dining area bright?                        | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 22a | Is it predominately lit from natural light?                | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 22b | If no, does the sitting/dining room have windows?          | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 23  | Are patients able to view external surroundings with ease? | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

24	Is the ward comfortably furnished?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
25a	Is the decor (curtains, carpets, general decorations) poor?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
25b	If no, is the decor satisfactory?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
25c	If no, is the decor good?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
26	Is the color scheme pleasing to the eye/pleasant?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
27	Does the setting of the ward appear to be clinical?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
28a	Is the sitting/dining room temperature too hot?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
28b	If, no is it too cold?	Yes No	<input type="checkbox"/> <input type="checkbox"/>

Interviewer:



**DAY HOSPITALS - ADULT ACUTE MENTALLY ILL****NAME OF HOSPITAL:****NO. OF BEDS:****STATUS:****DATE:****SANITARY FACILITIES**

1)a. Is there 1 w.c. for every 3 patients?

Yes

No

☐  
☐

1)b If no, what is the ratio?

1:4

1:5

1:6

1:7

other

☐  
☐  
☐  
☐  
☐

2. Are w.c. facilities immediately available inside the main entrance?

Yes

No

☐  
☐
3. Is each w.c. at least 4.5m<sup>2</sup> to permit staff to assist the patients?

Yes

No

☐  
☐
m<sup>2</sup>

If no, actual size

4.0

3.5

3.0

☐  
☐  
☐
**SITTING / DINING ROOMS**

5. Is there a quiet room separate from sitting/dining rooms?

Yes

No

☐  
☐

6. Does the total area of dining room/sitting/therapy room space equate to at least 2.25m<sup>2</sup> per patient (excluding Quiet Room)?
- Yes ☐
- No ☐

If no, how much does it measure per patient?

m<sup>2</sup>

2.4 ☐

2.3 ☐

2.2 ☐

2.1 ☐

2.0 ☐

1.9 ☐

1.8 ☐

- 7 Do the sitting/dining/therapy rooms permit meals to be taken in a single sitting?
- Yes ☐
- No ☐

### THERAPY AREAS

8. Is there an area available, either purposely provided or shared within the Day Hospital for group therapy for 10 - 12 people?
- Yes ☐
- No ☐
9. Does the unit have the activities of daily living kitchen?
- Yes ☐
- No ☐
- 10 Is the activity area quiet?
- Yes ☐
- No ☐
- N/A ☐
- 11 Is the activity area clean?
- Yes ☐
- No ☐
- 12a If the day hospital has 10-24 places, does it have a shared therapy office?
- Yes ☐
- No ☐
- N/A ☐
- 12b If the day hospital has 25 - 40 places does it have two separate therapy offices?
- Yes ☐
- No ☐
- N/A ☐

- |     |   |     |                          |
|-----|---|-----|--------------------------|
| 13. | Is there a patients utility room?   | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |
| 14. | Is there a consulting or interview room available?  | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |
| 15  | Is there a beauty / hairdressing space?   | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |
| 16  | Is there a forum (informal sitting) space contiguous with, but not part of the circulation route, adjacent to the staff office as an informal waiting space and an informal meeting space for patients and staff? | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |

#### EXTERNAL FACILITIES

- |     |  |     |                          |
|-----|--|-----|--------------------------|
| 17  | Is there a secure garden area?                               | Yes | <input type="checkbox"/> |
|     |  | No  | <input type="checkbox"/> |
|     |  | N/A | <input type="checkbox"/> |
| 18  | Is there integration of Ward and Day Hospital accommodation? | Yes | <input type="checkbox"/> |
|     |  | No  | <input type="checkbox"/> |
|     |  | N/A | <input type="checkbox"/> |
| 19a | Is the ward located on the ground floor?                     | Yes | <input type="checkbox"/> |
|     |  | No  | <input type="checkbox"/> |
| 19b | If no, is there a lift?                                      | Yes | <input type="checkbox"/> |
|     |  | No  | <input type="checkbox"/> |

#### QUALITY OF ENVIRONMENT OR GENERAL SURROUNDINGS

- |     |   |     |                          |
|-----|---|-----|--------------------------|
| 20  | Is the sitting /dining area bright?               | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |
| 21a | Is it predominately lit from natural light?       | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |
| 21b | If no, does the sitting/dining room have windows? | Yes | <input type="checkbox"/> |
|     |   | No  | <input type="checkbox"/> |

22	Are patients able to view external surroundings with ease?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
23	Is the ward comfortably furnished?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
24a	Is the decor (curtains, carpets, general decorations) poor?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
24b	If no, is the decor satisfactory?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
24c	If no, is the decor good?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
25	Is the color scheme pleasing to the eye/pleasant?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
26	Does the setting of the ward appear to be clinical?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
27a	Is the sitting/dining room temperature too hot?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
27b	If no, is it too cold?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Interviewer:

INPATIENT WARDS - ELDERLY MENTALLY ILL

NAME OF HOSPITAL:

NO. OF BEDS:

STATUS:

DATE:

SANITARY FACILITIES

1)a. Are the patients at any point in the ward more than 12 metres from a w.c.?

Yes ☐  
No ☐

1)b If yes, how far away?

metres  
12.5 ☐  
13 ☐  
13.5 ☐  
14 ☐  
14.5 ☐

2. Is each w.c. at least 4.5 m<sup>2</sup> in size?

Yes ☐  
No ☐

If no, actual size

m<sup>2</sup>  
3 ☐  
3.5 ☐  
4 ☐

3. Is there at least 1 w.c. to 5 patients?

Yes ☐  
No ☐

If no, what is the ratio?

1:6 ☐  
1:7 ☐  
1:8 ☐  
1:9 ☐  
1:10 ☐

4. Is there at least 1 bath or shower to every 6 patients?

Yes ☐  
No ☐

If no, what is the ratio?

1:7  
1:8  
1:9  
1:10


5a Is there at least 1 assisted shower/wc/whb of 6.00 m<sup>2</sup> on the ward?

Yes  
No


5b If no, what is the actual size?

m<sup>2</sup>  
5.5  
5.0  
4.5  
4.0


6a Is there at least 1 assisted bath/wc/whb of 12.50m<sup>2</sup> on the ward?

Yes  
No


6b If no, what is the actual size?

m<sup>2</sup>  
12.00  
11.50  
11.00  
10.50  
10.00  
9.50  
9.00  
8.50  
8.00


### Dormitory Facilities

7 Are the single bedrooms at least 11m<sup>2</sup>?

Yes  
No


7B If no, what is actual size

m<sup>2</sup>  
10.50  
10.00  
09.50  
09.00  
08.50


8	Are the multi-bedded areas a minimum of 8.5m <sup>2</sup> per occupant?	Yes No	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
---	---	-----------	---

If no, what is the actual size?	m <sup>2</sup>	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
---------------------------------	----------------	---

9	Are individual bed spaces curtained?	Yes No	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
---	--------------------------------------	-----------	---

10	Do the single bedrooms have a hand basin?	Yes No	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
----	---	-----------	---

#### DAY FACILITIES

11	Is there a quiet room separate from sitting/dining rooms?	Yes No	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
----	---	-----------	---

12	Does the total area of dining room/sitting room space equate to at least 2.50m <sup>2</sup> per patient (excluding Quiet Room)?	Yes No	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
----	---	-----------	---

If no, how much does it measure per patient	m <sup>2</sup>	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
---	----------------	---

13	Does the patients storage space for personal belongings measure a minimum of 0.2m <sup>2</sup> per patient?	Yes No N/A	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
----	---	------------------	---

If no, what is the actual size?	0.15 0.10	<div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>
---------------------------------	--------------	---

14	Is there a Consulting / Interview room within the ward day area?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
15	Is there a dining/sitting room to permit meals to be taken in a single sitting?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
16	Is there the availability in the day area of a patients utility room?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
17	Is there any wheelchair access from the building into external landscaped garden areas?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18	Is there a secure garden area?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>General</b>			
19	Is there clear separation and identification of "dormitory" and "day" areas?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
20	Is there integration of Ward and Day Hospital accommodation?	Yes No N/A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21	Are there handrails in the corridors?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
22a	Is the ward located on the ground floor?	Yes No	<input type="checkbox"/> <input type="checkbox"/>
22b	If no, is there a lift?	Yes No	<input type="checkbox"/> <input type="checkbox"/>



## QUALITY OF ENVIRONMENT OR GENERAL SURROUNDINGS

23	Is the sitting /dining area bright?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
24a	Is it predominately lit from natural light?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
24b	If no, does the sitting/dining room have windows?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
25	Are patients able to view external surroundings with ease?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
26	Is the ward comfortably furnished?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
27a	Is the decor (curtains, carpets, general decorations) poor?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
27b	If no, is the decor satisfactory?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
27c	If no, is the decor good?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
28	Is the color scheme pleasing to the eye/pleasant?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
29	Does the setting of the ward appear to be clinical?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>

30a Is the sitting/dining room temperature too hot?

Yes

No

N/A


30b If no, is it too cold?

Yes

No


Interviewer:

## DAY HOSPITALS - ELDERLY MENTALLY ILL

NAME OF HOSPITAL:

NO. OF BEDS:

STATUS:

DATE:

## SANITARY FACILITIES

1. Are the patients at any point in the ward more than 12 metres from a w.c.?
 

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
  
2. If yes, how far away?
 

metres	
12.5	<input type="checkbox"/>
13.0	<input type="checkbox"/>
13.5	<input type="checkbox"/>
14.0	<input type="checkbox"/>
14.5	<input type="checkbox"/>
  
3. Are w.c. facilities immediately available inside the main entrance?
 

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
  
4. Is each w.c. at least 4.5m<sup>2</sup> to permit staff to assist the patient?
 

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

m <sup>2</sup>	
4.0	<input type="checkbox"/>
3.5	<input type="checkbox"/>
3.0	<input type="checkbox"/>
  
5. Is there an assisted shower and / or bathroom facility?
 

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

## SITTING / DINING ROOMS

6. Is there a quiet room separate from sitting/dining rooms? Yes ☐  
No ☐

7. Does the total area of dining room/sitting room space equate to at least 2.50m<sup>2</sup> per patient (excluding Quiet Room)? Yes ☐  
No ☐

If no, how much does it measure per patient? m<sup>2</sup>  
2.4 ☐  
2.3 ☐  
2.2 ☐  
2.1 ☐  
2.0 ☐  
1.9 ☐  
1.8 ☐

8. Do the sitting/dining rooms permit meals to be taken in a single sitting? Yes ☐  
No ☐

## THERAPY AREAS

9. Is there an area available, either purposely provided or shared within the Day Hospital for group therapy for 10-12 people? Yes ☐  
No ☐

10. Does the unit have the activities of daily living kitchen? Yes ☐  
No ☐

11. Is the activity area quiet? Yes ☐  
No ☐  
N/A ☐

12. Is the activity area clean? Yes ☐  
No ☐

13a. If the day hospital has 24 places or less, does it have a shared therapy office? Yes ☐  
No ☐  
N/A ☐

- |     |   |                  |  |
|-----|---|------------------|--|
| 13b | If the day hospital has 25 - 40 places does it have two separate therapy offices? | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 14. | Is there a patients utility room?   | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 15. | Is there a consulting or interview room available?                                | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 16. | Is there a beauty / hairdressing space?   | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |

### EXTERNAL FACILITIES

- |     |   |                  |  |
|-----|---|------------------|--|
| 17a | Is there any wheelchair access from the building into external landscaped garden areas? | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 18  | Is there a secure garden area?  | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 19  | Is there integration of Ward and Day Hospital accommodation?                            | Yes<br>No<br>N/A | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |
| 20. | Are there handrails in the corridors?   | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 21a | Is the ward located on the ground floor?  | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |
| 21b | If no, is there a lift?   | Yes<br>No        | <input type="checkbox"/><br><input type="checkbox"/>                             |

### QUALITY OF ENVIRONMENT OR GENERAL SURROUNDINGS

- |    |                                     |           |  |
|----|-------------------------------------|-----------|--|
| 22 | Is the sitting /dining area bright? | Yes<br>No | <input type="checkbox"/><br><input type="checkbox"/> |
|----|-------------------------------------|-----------|--|

23a	Is it predominately lit from natural light?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
23b	If no, does the sitting/dining room have windows?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
24	Are patients able to view external surroundings with ease?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
25	Is the ward comfortably furnished?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
26a	Is the decor (curtains, carpets, general decorations) poor?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
26b	If no, is the decor satisfactory?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
26c	If no, is the decor good?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
27	Is the color scheme pleasing to the eye/pleasant?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
28	Does the setting of the ward appear to be clinical?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
29a	Is the sitting/dining room temperature too hot?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
29b	If no, is it too cold?	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>
		N/A	<input type="checkbox"/>

Interviewer:

Appendix 4.1. List of Water Tower Hospitals in the study	
Lancaster Moor	Bethlehem Royal
All Saints	Prestwich
Barnsley Hall	The Princess Royal
Barrow	Rauceby
Bexley	Roundway
Littlemore	The Royal London
Bootham	The Royal Shrewsbury
Brookwood	Runwell
Carlton Hayes	Scalebor
Central	Severalls
Cherry Knowle	Shenley
Claybury	Springfield
Clifton	St Andrew's
Coney Hill	St Augustine's
Countess of Chester	St Clement's
De La Pole	St Crispin's
Fair Mile	St Edward's
Fairfield	St Francis'
Fulbourn	St George's, Morpeth
Garlands	St George's, Staffs
Goodmayes	St James'
Graylingwell	St Lawrence's
Hellesdon	St Luke's
Hellingley	St Martin's
High Royds	St Mary's, Hereford
Highcroft	St Mary's, Morpeth
Hill End	St Matthew's
Hollymoor	St Nicholas'
Horton	Stanley Royd
Kingsway	Stone House
Knowle	Sundridge
Maidstone	Tone Vale
Mapperley	Tooting Bec
Maudsley	Towers
Middlewood	Warley
Napsbury	Warlingham
Netherne	Warneford
Old Manor	West Park
Parkside	Whittingham
ParkPrewitt	Winterton
Pastures	Winwick

## Appendix 4.2

### Projected Completion of the Community Mental Health Reprovision Programmes in England - Assumptions

In attempting to predict the final closure of the psychiatric institutions in England the following data was derived from the results. These assumptions take into account the delays experienced at various stages of closure between 1993 and 1995 of the hospitals studied.

- 1) 20 Hospitals with no plans to formulate a plan will do so by 1998 and will move to category B one year later.
- 2) 22% of category B hospitals will fail to proceed and be recategorised A delaying two years.
- 3) One third of all two year programmes fail / one third of programmes with three years to run will delay one year similarly two thirds of four year and one third of five year will delay one year.
- 4) Average full programmes calculated at six years actual elapsed allowing for delays.
- 5) Figures calculated to nearest hospital

Appendix 5.1 Case 1 Environmental Data			
	Original	Interim	New
sitting/dining area bright	n/s (not scored)	yes	yes
predom natural light	n/s	yes	yes
If No, windows?	n/s	n/a	n/a
external view - ease	n/s	yes	yes
comfort furnished ward	n/s	yes	yes
temperature: too hot	n/s	no	no
temperature: too cold	n/s	no	no
decor			
poor	n/s	no	no
satisfactory	n/s	no	no
good	n/s	yes	yes
colours pleasant	n/s	yes	yes
clinical appearance	n/s	no	no

Appendix 5.2 Case 1 HBN & Environmental Data			
Adult Acute Day Hospital		Inpatient Adult Acute	
n°. places	25	n°. of places	25
w.c ratio	1 to 4	w.c ratio 1:5	1 to 5
w.c main	no	bath ratio 1:6	1 to 6
w.c m2	yes	assisted shower	yes
quiet room	yes	single bedrooms 11m2	9.2m2
dining m2 pp	yes	multi-bed min 8.5m2	no
1 sitting	yes	curtained-off	n/a
group therapy 10-12	yes	special bed severe disturbed	yes
kitchen	yes	quiet room	yes
quiet activity	yes	is ward self contained?	yes
clean activity	yes	dining area 2.3m2 pp	yes
utility	yes	enable 1 sitting	yes
consult	yes	consult/interview room	yes
beauty	no	patient utility room	yes
informal	yes	treatment room	yes
secure garden	no	informal sitting room	yes
day/ward	yes	DGH location	n/a
ground	yes	dorm/day clear separation	yes
lift	n/a	ground floor location	no
		lift	yes
Quality of the Environment			
sitting/dining area bright	yes	sitting/dining area bright	yes
predom natural light?	yes	predom natural light?	yes
If No, windows?	n/a	If No, windows?	n/a
able to view external	yes	external view with ease	yes
comfort furnished ward	yes	comfortably furnished ward	yes
decor: poor	no	decor: poor	-
satisfactory	yes	satisfactory	-
good	no	good	yes
colours - pleasant	yes	colours pleasant	yes
clinical	no	clinical appearance	yes
too hot	no	temperature: too hot	no
too cold	no	too cold	no



Appendix 5.3 Case 1 Patient Characteristics							
Pat N°	Date of Birth	Age	Sex	First Contact with Services	Length of time in Care	Follow up period (Months)	N° of days per week attending
1	10.04.20	74	F	01.01.63	31	3.5	2
2	31.10.29	65	F	01.12.88	6	3	1
3	13.01.95	75	F	08.07.93	1	3	1
4	30.09.21	73	F	30.09.92	2	4	1
5	06.12.15	79	F	15.06.79	15	4	1
6	15.12.15	76	F	05.04.94	0.75	3	2
7	28.09.21	73	M	14.04.89	5	3.5	2
8	14.02.22	72	F	31.01.76	18	4	3
9	06.05.23	71	F	29.06.94	0.5	4	1
10	04.05.19	75	F	29.09.92	2	3	5
11	19.07.17	77	F	09.09.94	0.25	3	1
12	31.12.18	76	F	11.05.73	21	3	1
13	02.95.21	73	M	14.04.94	0.75	4	2
14	11.04.11	83	F	18.03.93	1	3	1
15	21.08.13	81	F	26.02.91	3	4	1
16	21.01.21	73	F	16.08.54	40	3	1
17	21.01.10	84	F	17.10.90	4	4	2
18	10.08.23	71	F	15.04.91	3	3	2
19	29.06.09	85	F	12.05.92	12	3.5	1
20	19.08.22	72	M	27.07.89	5	3	2
21	27.12.15	79	F	29.12.90	4	3	1
22	01.11.26	68	F	04.10.83	11	3	1
23	08.07.27	67	F	23.02.78	16	3	1
24	26.06.28	66	F	21.06.94	0.5	3	2
25	21.08.09	85	M	19.06.74	20	4	2
26	27.01.24	70	F	19.06.90	4	3	1
27	02.08.18	76	F	12.05.70	24	3	1
28	19.01.13	81	M	01.10.93	1	3	3
29	27.01.28	66	F	11.06.85	9	4	2
30	29.10.20	74	F	13.09.88	6	3.5	2
31	10.04.20	74	F	07.06.84	10	Discharged/ Transferred	1
32	31.10.29	71	F	03.11.93	1	"	2
33	03.02.19	84	F	09.01.86	8	"	2

**Appendix 5.4 Case 1 BAS Instrument - Cognitive and Depression Scores**

Pat. No.	BAS Cognitive impairment Scores Score out of 8				BAS Depression Level Scores Score out of 24			
	PRE		POST	CHANGE	PRE		POST	Change
1	0		1	+1	3		5	+2
2	0		0	N/C	19		19	n/c
3	1		1	N/C	2		2	n/c
4	1		0	-1	7		4	-3
5	1		1	N/C	2		2	n/c
6	1		3	+2	16		13	-3
7*	0		0	N/C	17		16	-1
8	1		0	-1	12		2	-10
9	0		1	+1	7		6	-1
10	0		0	N/C	16		16	n/c
11	1		1	N/C	9		6	-3
12	0		0	N/C	13		7	-6
13*	0		1	+1	11		8	-3
14	5		4	-1	4		6	+2
15	0		1	+1	3		3	n/c
16	0		0	N/C	8		9	+1
17	2		2	N/C	8		5	-3
18	1		1	N/C	24		24	n/c
19	0		1	+1	12		11	-1
20	0		0	N/C	5		5	n/c
21	2		0	-2	6		4	-2
22	0		1	+1	10		8	-2
23	2		1	-1	2		3	+1
24	0		0	N/C	1		9	+8
25*	0		1	+1	13		6	-7
26	0		1	+1	3		2	-1
27	3		1	-2	20		13	-7
28*	0		2	+2	7		7	n/c
29	0		3	+3	5		2	-3
30*	0		0	N/C	9		10	+1
31	0		discharged /transferred		9		discharged /transferred	
32	0		discharged /transferred		5		discharged /transferred	
33	1		discharged /transferred		16		discharged /transferred	

- = Improvement    + = decline    n/c = no change

Appendix 5.5 Control Group - BAS Patient Characteristics							
Pat N°.	DoB	Age	Sex	First Contact with Services	Length of time in Care (Years)	Follow-up period (Months)	N° of Visits
1	13.10.27	68	M	03.95	0.50	Transferred	n/a
2	22.08.20	75	F	03.94	1.50	Deceased	n/a
3	16.09.35	60	F	06.94	2.25	4	3
4	19.04.30	65	M	10.92	3.00	4	3
5	09.10.21	73	F	06.93	2.75	4	2
6	11.03.17	78	M	07.92	3.00	4	3
7	11.06.23	72	F	05.93	2.75	4	2
8	09.03.06	89	M	01.95	0.75	4	2
9	17.02.15	80	F	06.95	0.25	4	2
10	03.04.18	77	M	04.94	1.50	4	5
11	23.08.29	66	M	07.93	2.75	4	7*
12	18.09.15	80	M	06.95	0.25	4	2

Patient N° 1 not available for 2nd interview, admitted for inpatient care, therefore assume some deterioration. Patient N° 2 died in the interim period  
 \* Voluntary organisation staffs day hospital @ weekends

Appendix 5.6 Control Group BAS Changes in Cognitive and Depression Levels						
Pat. N°.	Depression Levels		Change	Cognitive Impairment		Change
	1st	2nd		1st	2nd	
1*	9	n/a *		1	n/a *	
2**	5	n/a **		2	n/a **	
3	2	2	n/c	0	0	n/c
4	18	20	+2	1	1	n/c
5	7	11	+4	0	0	n/c
6	11	7	-4	0	0	n/c
7	15	7	-8	0	0	n/c
8	1	10	+9	1	2	+1
9	8	15	+7	2	2	n/c
10	12	7	-5	2	2	n/c
11	0	0	n/c	2	2	n/c
12	7	4	-3	4	2	-2

\* Patient N° 1 not available for 2nd interview, admitted for inpatient care, therefore assume some deterioration.  
 \*\* Case 2 - died in the interim period

<b>Appendix 5.7 Case 1 Patients' Quality of Life (Patient Activities)</b>		
<b>Location</b>	<b>Pre-Move</b>	<b>Post Move</b>
<b>Base</b>	<b>33</b>	<b>30</b>
Dining Room	33 (100%)	30 (100%)
Sitting Room	18 (55%)	18 (60%)
Outside Garden	8 (25%)	3 * ( %)
Stay in Room	0 (0%)	0 (0%)
Off site	12 (36%)	15 (50%)
Other*	0 (0%)	2 (7%)
*Kitchen		1 (3%)
*Therapy Room		1 (3%)
<b>Activity</b>	<b>Pre-Move</b>	<b>Post Move</b>
Read	13 (39%)	11 (37%)
Walk	15 (46%)	12 (40%)
Watch T.V.	2 (6%)	4 (13%)
Socialise	31 (94%)	29 (97%)
Hobby	24 (73%)	21 (70%)
Sleep	11 (33%)	14 (47%)
Other *	1 (3%)	21 (70%)
*Relaxation Classes	1 (3%)	20 (67%)
Smoke (designated area)		1 ( 3%)
Dominoes		1 ( 3%)

<b>Appendix 5.8 Case 1 Staff - Description of Sample</b>		
<b>Job Title</b> (after move at the time of completing the staff questionnaire)	<b>Length of Service</b> (Years)	<b>Sex</b>
Physiotherapist I	11.5	F
Consultant Psychiatrist	9	M
OT Technical Instructor	8.5	F
Staff Nurse "D"	0.5	F
Enrolled Nurse "D"	20.5	F
Deputy Ward Manager "F"	14.5	M
Deputy Ward Manager	20.5	M
Staff Nurse "D"	5.5	F
Enrolled Nurse "D"	12	F
Deputy Ward Manager "F"	9.5	M
Nurse Manager "G"	29.5	M
Enrolled Nurse "D"	21	F
Staff Nurse "E"	16	F
Ward Manager "G"	21	F
Staff Nurse "D"	0.5	F
Nursing Assistant	1	F
Staff Nurse "E"	16.5	F
Deputy Sister "F"	14	F
Staff Nurse "D"	0.5	F
Staff Nurse "E"	11.5	F
Ward Manager "G"	22	F
Deputy Ward Manager "F"	16	M

<b>Appendix 5.9 Case 1 Staff Views on Training</b>			
<b>Staff</b>	<b>Training Offered</b>	<b>Valued</b>	<b>No Training but wanted</b>
<b>Nurses</b>	8	6	3
<b>Managers</b>	2	1	0
<b>Other</b>	1	1	0

# COMMUNITY HEALTHCARE

DEPARTMENT OF CLINICAL PSYCHOLOGY

Your Ref:

Our Ref: JVS/DJR

Date: 21.7.95

## Appendix Letter 1

### Case 1 Correspondence from Clinical Psychologist

Dear

Re: Staff Counselling Referrals

I can confirm that we have been operating a staff counselling service in the district since July 1990. This was set up specifically to be available to staff who might experience difficulties coping with change arising from the closure of Case 1 Hospital (see copy of staff counselling leaflet attached). However, this service has been extended to all staff working in the Trust experiencing work related difficulties.

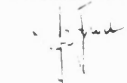
The service is a confidential counselling service open to all staff in the Trust. Staff can self refer without a G.P. referral and we offer a rapid access appointment, generally within about 2 working days following contact with the department. Staff are able to see any of the psychologists and preferably a psychologist with whom they would not necessarily have work contact.

I can confirm that the service has been used by a considerable number of staff over the 5 year period for work related difficulties, including staff from the Mental Health Service. However, as far as I am aware from the scant records that we do keep, we have not seen any staff where the main specific problem has been coping with Case 1 hospital closure and changes arising from that. Most problems which people have self referred have involved a mix of different reasons, most often where home or relationship difficulties are affecting general coping and work performance.

I hope this is the information you require.

With best wishes.

Yours sincerely



J. S. PhD  
Chartered Clinical Psychologist  
Head of Adult Clinical Psychology Service.



## Case 1 Correspondence from Medical Officer, Occupational Health

22nd July 1995.

Dear

Thank you for your letter.  
Please excuse this scrawl but am writing  
this at the airport before take off (6.30 am)  
as I realised last night that I hadn't  
sent it earlier.

I can redo this on return (7th August.)  
if this is unsatisfactory.

The Local Acute Trust provided an  
occupational health service to  
Staff from 1984 till 1994.

Although I was involved with many  
Staff who were stressed due to their  
work and other problems, I can  
confirm that they were not  
due to the closure of the hospital.

To me, the closure appeared to  
be well structured in that

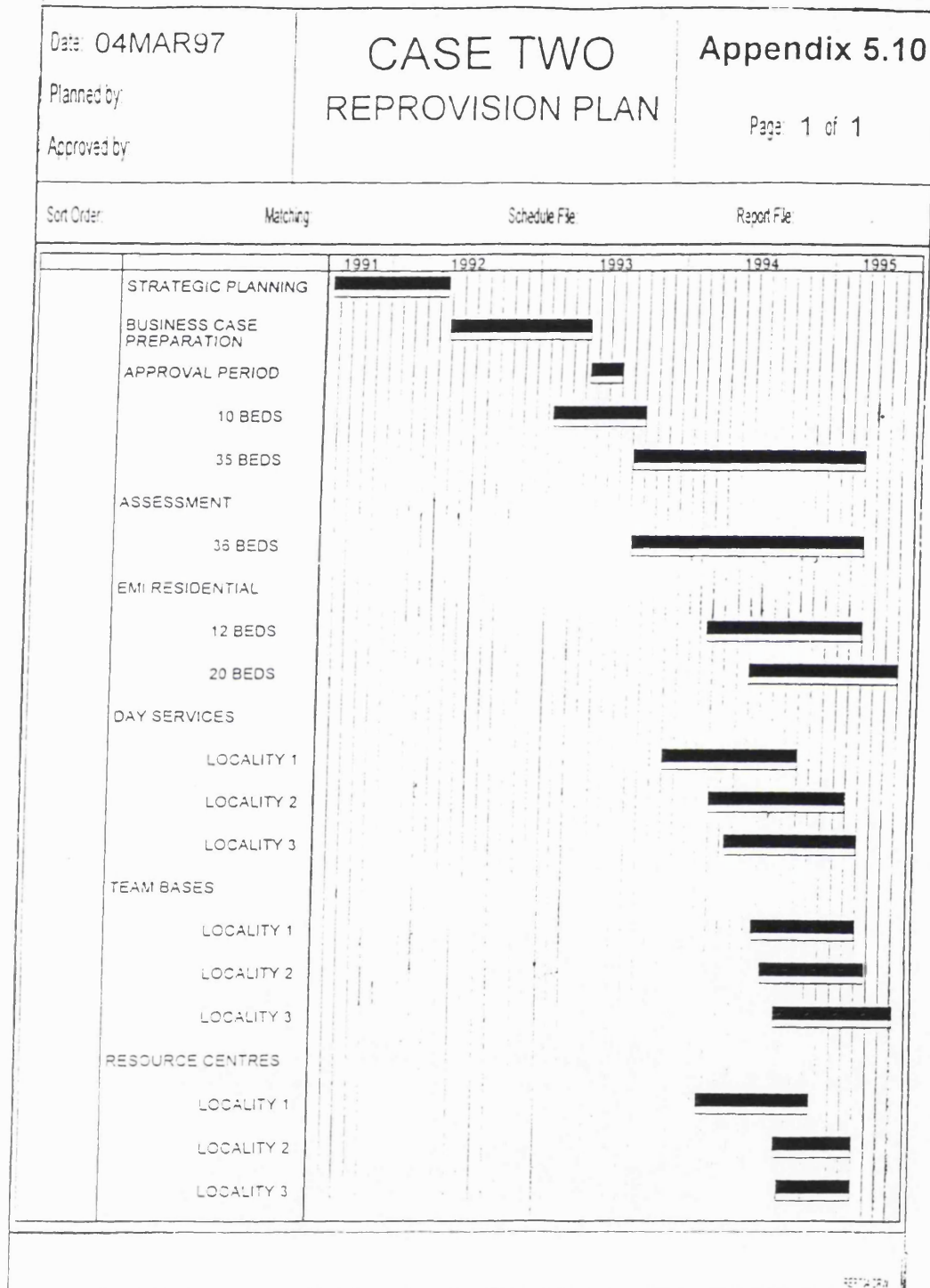
Staff knew what was happening.

I believe there was an organized  
staff support system through  
Psychology which had been  
set up to prepare for closure.

I apologize for the state of  
this letter but would be happy  
to retype one in 2 weeks

Yours sincerely





Appendix 5.11A Case 2 EMI Inpatient Facilities Environmental Data				
	Old	New	New	New
Sitting/Dining bright	yes	yes	yes	yes
predom naturally lit	yes	yes	yes	yes
if No. windows?	n/a	n/a	n/a	n/a
external view	yes	yes	yes	yes
comfort furnish ward	yes	yes	yes	yes
decor: poor	no	no	no	no
satisfactory	no	yes	yes	yes
good	yes	no	no	no
colours pleasant	yes	yes	yes	yes
clinical appearance	no	no	no	no
temperature: too hot	no	no	no	no
too cold	no	no	no	no

Appendix 5.11B Case 2 EMI Day Hospital & Adult Inpatient HBN & Environmental Data			
	Elderly Day Hospital	Adult Acute Inpatient	
n°. of places	15	no. of places	18
dist to w.c. if > 12m	14.5m	w.c ratio 1:5	1 to 5
immed. inside entrance	no	bath ratio 1:6	1 to 6
w.c. 4.5m2	4.5m2	asst shower	yes
assisted bathroom	yes	single bedrooms 11m2	11m2
quiet room	yes	multi-bed min 8.5m2	n/a
dining 2.5 m2 p/p	yes	curtained-off	n/a
enable 1 sitting	yes	special bed - severe disturbed	yes
group therapy for 10/12	yes	quiet room	yes
kitchen facilities	yes	is ward self contained?	no
quiet activity area	yes	dining area 2.3m2 pp	yes
clean activity area	yes	enable 1 sitting	yes
patients utility room	no	consult/interview room	yes
consult/interview room	yes	patient utility room	yes
beauty/hairdressing	yes	storage	yes
wheelchair access	n/a	treatment room	yes
secure garden	n/a	informal sitting room	yes
ward/day integration	no	DGH location	yes
handrails	yes	dorm/day clear separation	yes
ground floor location	yes	ground floor location	yes
lift	n/a	lift	n/a
Quality of the Environment			
sitting/dining area bright	yes	sitting/dining area bright	yes
predom natural light	yes	predom natural light?	yes
if No. windows	n/a	If No. windows?	n/a
external view with ease	yes	external view with ease	yes
comfort furnished ward	yes	comfortably furnished ward	yes
decor: poor	no	decor: poor	no
satisfactory	no	satisfactory	no
good	yes	good	yes
colours pleasant	yes	colours pleasant	yes
clinical appearance	no	clinical appearance	no
temperature: too hot	no	temperature: too hot	no
too cold	no	too cold	yes

<b>Appendix 5.12 Case 2 Patient Characteristics</b>						
<b>Pat. No.</b>	<b>DoB</b>	<b>Age</b>	<b>Sex</b>	<b>First Contact with Services</b>	<b>Length of time in Care (Years)</b>	<b>Follow-up period (months)</b>
1	29.11.29	66	F	*		3
2	06.05.24	71	F	*		3
3	29.09.26	69	M	*		3
4	17.11.14	81	F	*		3
5	09.05.18	77	F	02.03.90	5	3
6	08.07.17	78	M	11.12.86	9	3
7	10.10.10	85	F	19.08.58	37	3
8	28.10.30	65	M	02.08.90	5	3
9	28.10.17	78	M	14.05.93	2	3
10	21.05.19	76	F	11.02.89	6	3
11	20.02.13	82	F	08.03.87	8	3
12	20.06.11	84	M	19.10.88	7	4
13	07.08.04	91	F	28.09.79	16	4
14	20.07.21	74	F	*		Discharged/ Transferred
15	06.01.29	66	F	*		*
16	01.10.39	56	M	*		*
17	03.10.08	87	F	*		*
* Patients attending inpatient assessment ward						

<b>Table 5.13 Case 2 "F" WARD - Rundown of Patient Numbers on a 22 bed EMI inpatient ward</b>		
<b>Date</b>	<b>Activity</b>	<b>Occupied Beds</b>
1.10.93		22
Dec '93	9 Discharges to Social Services run residential accommodation	13
Jan '94	8 transfers in from other wards	21
	1 admission	22
	1 discharge home	21
	1 death	20
Feb '94	1 admission	21
	1 discharge to Private Nursing Home	20
	2 deaths	18
March '94	1 discharge to Private Nursing Home	17
	1 discharge home	16
April '94	1 death	15
June '94	1 admission	16
	1 discharge home	15
July '94	3 deaths	12
	1 admission	13
Aug '94	1 discharge home	12
	1 discharge to other NHS hospital	11
Sept '94	1 admission	12
	1 discharge home	11
	1 transfer in from other wards	12
Oct '94	1 transfer in from other wards	13
Nov '94	1 admission	14
	1 discharge home	13
	1 discharge to General Hospital	12
Dec '94	1 admission	13
	1 discharge home	12
	1 admission	13
	1 discharge to nursing home	12
	1 transfer to other ward	11
	1 discharge home	10
Jan 95	1 death	9
Admissions	a) retrenchment transfers	10
	b) general admissions	22
TOTAL		18
Discharges	a) To Social Services Residential Accommodation	9
	b) Home	8
	c) Private Nursing Home	3
	d) Other NHS Hospitals	2
	Transfer to:	
	Other ward	1
	Deaths	8
TOTAL		31

Appendix 5.14 Case 2 CAPE Total Scores					
	Pre		Post		Change
Pat. N°					
1	27	E	18	E	-
2	15	D	15	D	n/c
3 *	22	E	18	E	-
4	25	E	20	E	-
5	23	E	23	E	n/c
6 *	18	E	19	E	+
7	24	E	17	D	-
8 *	21	E	22	E	+
9 *	15	D	12	C	-
10	23	E	23	E	n/c
11	23	E	23	E	n/c
12 *	24	E	25	E	+
13	22	E	23	E	+
14	24	E	Discharged / Transferred		
15	11	C	Discharged / Transferred		
16 *	26	E	Discharged / Transferred		
17*	14	D	Discharged / Transferred		
* Male x 6 - = improvement + = decline n/c = no change					

Appendix 5.15 Case 2 CAPE Apathy Scores					
Pat. N°.	Pre-	Grade	Post-	Grade	Change
1	10	E	7	D	-
2	6	D	6	D	n/c
3 *	9	E	6	D	-
4	9	E	5	C	-
5	9	E	9	E	n/c
6 *	9	E	9	E	n/c
7	9	E	7	D	-
8 *	8	E	9	E	+
9 *	7	D	6	D	-
10	8	E	8	E	n/c
11	8	E	8	E	n/c
12 *	8	E	10	E	+
13	8	E	10	E	+
14	10	E	Discharged / Transferred		
15	6	D	Discharged / Transferred		
16 *	9	E	Discharged / Transferred		
17	7	D	Discharged / Transferred		
* = male      - = improvement      + = deterioration      n/c = no change					

Appendix 5.16 Case 2 CAPE Communication Difficulties Scores					
	Pre	Grade	Post	Grade	Change
Pat. N°					
1	2	E	2	E	n/c
2	0	A,B,C	1	D	+
3 *	1	D	1	D	n/c
4	4	E	2	E	-
5	4	E	4	E	n/c
6 *	1	D	2	E	+
7	2	E	0	A,B,C	-
8 *	3	E	3	E	n/c
9 *	0	A,B,C	0	A,B,C	n/c
10	4	E	4	E	n/c
11	4	E	4	E	n/c
12 *	3	E	2	E	-
13	4	E	3	E	-
14	3	E	Discharged / Transferred		
15	1	D	Discharged / Transferred		
16 *	2	E	Discharged / Transferred		
17	0	A,B,C	Discharged / Transferred		
* = male      - = improvement      + = deterioration      n/c = no change					

Appendix 5.17 Case 2 CAPE Physical Difficulties Scores					
Pat. N°	Pre	Grade	Post	Grade	Change
1	9	E	5	C	-
2	3	B	6	D	+
3 *	8	E	8	E	n/c
4	9	E	6	D	-
5	10	E	10	E	n/c
6 *	7	D	7	D	n/c
7	10	E	8	E	-
8 *	10	E	10	E	n/c
9 *	7	D	6	D	-
10	10	E	10	E	n/c
11	11	E	11	E	n/c
12 *	10	E	10	E	n/c
13	10	E	10	E	n/c
14	7	D	Discharged / Transferred		
15	4	C	Discharged / Transferred		
16 *	10	E	Discharged / Transferred		
17	7	D	Discharged / Transferred		
* = male      - = improvement      + = deterioration      n/c = no change					



Appendix 5.18 Case 2 CAPE Social Disturbance Scores					
Pat. N°	Pre-	Grade	Post-	Grade	Change
1	6	E	4	D	-
2	6	E	2	C	-
3 *	4	D	3	D	-
4	3	D	7	E	+
5	0	A	0	A	n/c
6 *	1	B	1	B	n/c
7	3	D	2	C	-
8 *	0	A	0	A	n/c
9 *	1	B	0	A	-
10	1	B	1	B	n/c
11	0	A	0	A	n/c
12 *	3	D	3	D	n/c
13	0	A	0	A	n/c
14	4	D	Discharged / Transferred		
15	0	A	Discharged / Transferred		
16 *	5	E	Discharged / Transferred		
17	0	A	Discharged / Transferred		
* = male      - = improvement      + = deterioration      n/c = no change					

Appendix 5.19 Control Group CAPE Patient Characteristics						
Pat. No.	DoB	Age	Sex	First Contact with Services	Length of time in Care (Years)	Follow-up period (months)
1	09.10.16	79	M	19.03.93	3	4
2	16.08.24	71	F	04.01.90	6	4
3	26.10.19	76	M	10.02.95	1	4
4	26.09.32	63	M	13.04.93	2.75	4
5	14.02.11	84	F	06.01.89	7	4
6	12.07.08	87	F	10.12.94	1	4
7	24.02.11	84	F	16.07.90	5.5	4
8	17.02.17	78	F	03.06.88	7.5	4
9	25.04.14	81	M	15.06.94	1.5	4
10	06.07.23	72	M	06.05.94	1.5	4
11	09.03.10	85	M	03.10.91	4	Deceased
12	14.09.21	74	F	15.03.93	2.75	Deceased
13	03.11.05	90	M	17.10.88	7	Deceased
14	10.11.08	87	F	07.02.90	5	Deceased

Appendix 5.20 Control Group CAPE Total Scores					
	1st	Grade	2nd	Grade	Change
Pat. N°.					
1	20	E	20	E	n/c
2	15	D	21	E	+
3	23	E	18	E	-
4	25	E	24	E	-
5	21	E	24	E	+
6	22	E	24	E	+
7	24	E	25	E	+
8	27	E	26	E	-
9	15	D	20	E	+
10	9	C	11	D	+
11	15	D	Deceased		
12	15	D	Deceased		
13	27	E	Deceased		
14	25	E	Deceased		
- = improvement + = decline n/c = no change					

Appendix 5.21 Control Group CAPE Apathy Scores					
Pat. N°.	1st	Grade	2nd	Grade	Change
1	9	E	6	D	-
2	5	C	8	E	+
3	10	E	8	E	-
4	10	E	10	E	n/c
5	10	E	10	E	n/c
6	10	E	9	E	-
7	10	E	10	E	n/c
8	10	E	10	E	n/c
9	4	C	8	E	+
10	4	C	5	C	+
11	7	D	Deceased		
12	4	C	Deceased		
13	10	E	Deceased		
14	10	E	Deceased		
- = improvement    + = decline    n/c = no change					



Appendix 5.22 Control Group CAPE Communication Difficulties Scores					
Pat. N°.	1st	Grade	2nd	Grade	Change
1	0	A,B,C	2	E	+
2	0	A,B,C	0	A,B,C	n/c
3	1	D	2	E	+
4	3	E	4	E	+
5	4	E	4	E	n/c
6	4	E	4	E	n/c
7	4	E	4	E	n/c
8	4	E	4	E	n/c
9	0	A,B,C	0	A,B,C	n/c
10	0	A,B,C	0	A,B,C	n/c
11	0	A,B,C	Deceased		
12	0	A,B,C	Deceased		
13	4	E	Deceased		
14	4	E	Deceased		
- = improvement + = decline n/c = no change					

Appendix 5.23 Control Group Physical Difficulties Scores					
Pat. N°.	1st	Grade	2nd	Grade	Change
1	7	D	6	D	-
2	7	D	9	E	+
3	7	D	6	D	-
4	9	E	9	E	n/c
5	7	D	9	E	+
6	8	E	10	E	+
7	10	E	11	E	+
8	11	E	11	E	n/c
9	4	C	5	C	+
10	4	C	5	C	+
11	8	E	Deceased		
12	5	C	Deceased		
13	11	E	Deceased		
14	11	E	Deceased		
- = improvement    + = decline    n/c = no change					

Appendix 5.24 Control Group CAPE Social Disturbance Scores					
	1st	Grade	2nd	Grade	Change
Pat. N°.					
1	4	D	6	E	+
2	3	D	4	D	+
3	5	E	2	C	-
4	3	D	1	B	-
5	0	A	1	B	+
6	0	A	1	B	+
7	0	A	0	A	n/c
8	2	C	1	C	-
9	7	E	7	E	n/c
10	1	B	1	B	n/c
11	0	A	Deceased		
12	6	E	Deceased		
13	2	C	Deceased		
14	0	A	Deceased		
- = improvement + = decline n/c = no change					

Appendix 5.25 Case 2 Staff Characteristics		
Job Title (after move at the time of completing the staff questionnaire)	Length of Service (Years)	Sex
Staff Nurse	12	M
Nursing Assistant	12½	F
Health Care Assistant	12½	F
Senior Staff Nurse "D"	7½	F
Staff Nurse "D"	10	M
Senior Charge Nurse	31½	M
Health Care Assistant	15½	F
Senior Sister "G"	17	F
Senior Staff Nurse	9½	F
Senior Regional Care Worker	8½	F

Appendix 5.26 Case 2 Staff Views on Training			
Staff	Training Offered	Valued	No Training but wanted
Nurses	4	3	3
Managers	-	-	-
Other	1	-	-

# HOSPITAL

HOSPITALS NHS TRUST

## Appendix Letter 3

Our Ref: MPS/PP

**Mrs R            H**  
**Director of Corporate Development**  
**Hospital**

23 January 1997

Dear

Please find enclosed appointments for the last 6 months of the financial years April 1993 - March 1994 and April 1994 - March 1995, when Case 2 Hospital closed.

Apart from the obvious drop in numbers as 1995 approached, I don't see a significant change.

I hope this is of assistance to you.

Yours sincerely

Dr M P S.  
Senior Medical Officer  
**OCCUPATIONAL HEALTH DEPARTMENT**

enc

Date: 04MAR97

Planned by:

Approved by:

## CASE THREE REPROVISION PLAN

Appendix 5.27

Page: 1 of 1

Sort Order:

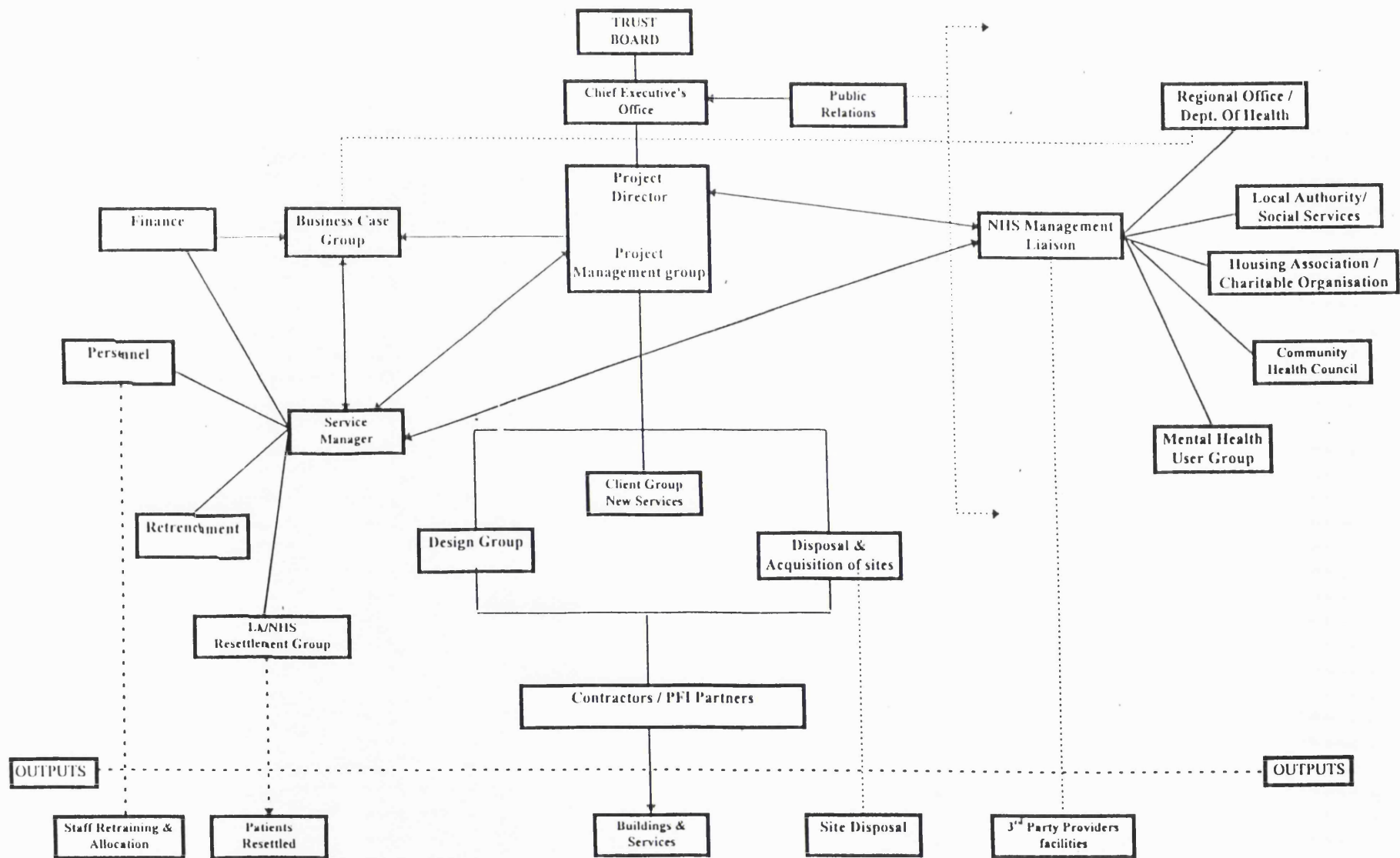
Matching:

Schedule File:

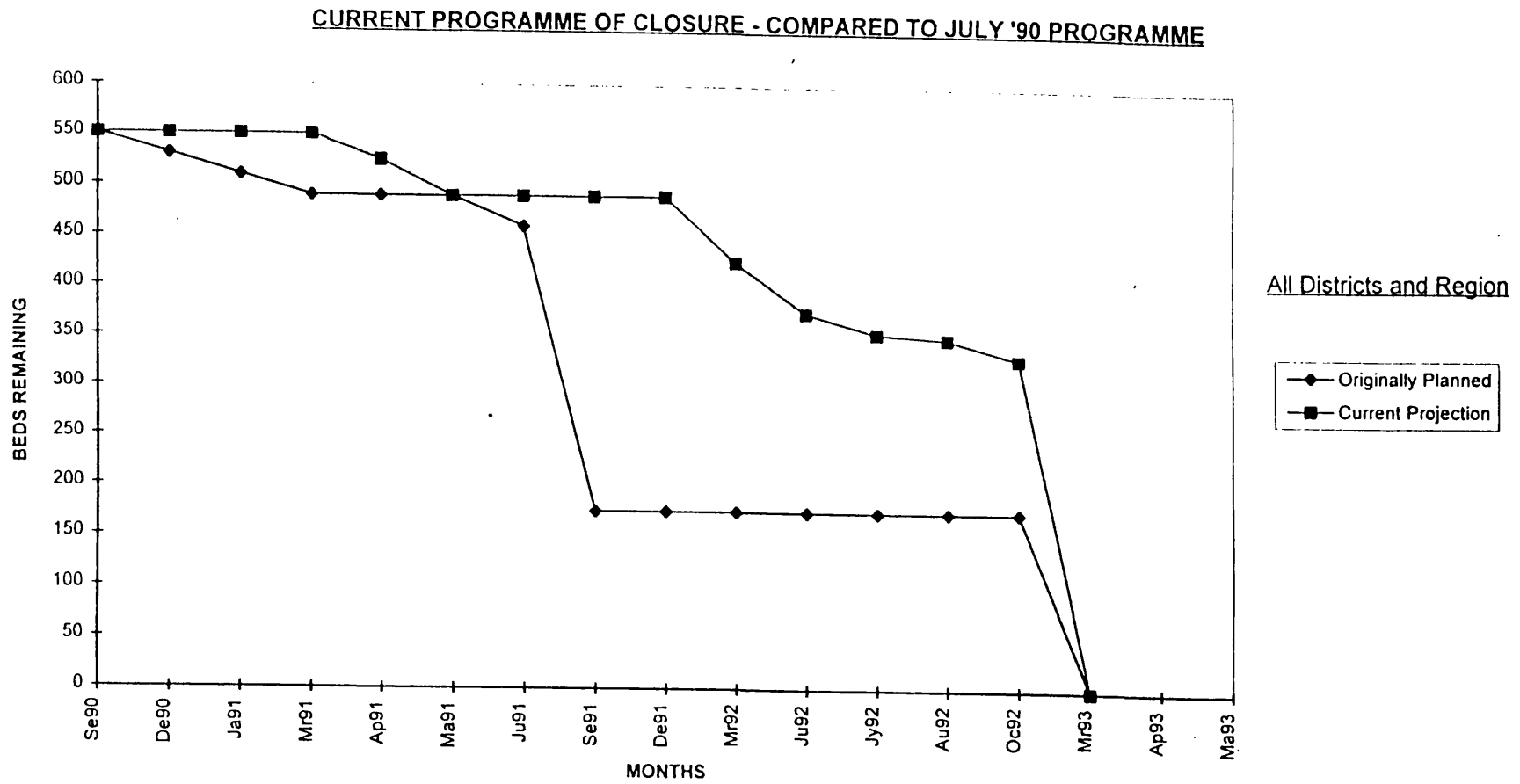
Report File:

	1993	1994	1995	1996	1997
STRATEGIC PLANNING					
BUSINESS CASE PREPARATION					
TEAM BASES (5 no )					
TEAM BASES (3no )					
DEMENTIA TEAM (1no )					
DEMENTIA TEAMS (7 no )					
ACUTE 47 BEDS					
ASSESSMENT 49 BEDS					
MOTHER AND BABY UNIT					
SECURE UNIT					
CRISIS SERVICE					
CRISIS LINE					
CHILD CARE FACILITIES					
ADVICE LINE					
SITTING SERVICE					
BEFRIEND, GOOD NEIGHBOUR SERVICE					
STAFF TRAINING PROCESS					
SUPPORTED LIVING					
Difficult to place 108 beds					
Mild dementia 31 beds					
Cont. care 151 beds					
Long stay 50 beds					
Pre-senile 16 beds					
Work based therapies (3no )					
COURT DIVERSION					
CHILD & FAMILY SERVICE					
ADOLESCENT DROP-IN CENTRE					
MENTAL HEALTH REGISTER					
RESPIRE CARE POLICY					
SUBSTANCE ABUSE SERVICE					

REF: 10/97



# Simple Presentation of progress being made with implementation



## BIBLIOGRAPHY

- Abel-Smith B. The Hospitals 1800 - 1948. Heinemann: London, 1964.
- Ackoff RL and Sasieni MW. Fundamentals of Operations Research, Wiley, New York. 1968
- Allon-Smith R. The evolving geography of the elderly in England and Wales. London: Heinemann, 1982.
- Ames, D. Depression in old People living in Residential Care. PhD Thesis. 1988.
- Anderton BH, Brion JP. Ultrastructural and biochemical basis of Alzheimer's disease. Reviews in Clinical Gerontology, 1991, **1**: 17-28.
- Anthony K, Proctor AW, Silverman AM, Murphy E. Mood and behaviour problems following the relocation of elderly patients with mental illness. Age & Ageing, 1987; **16**: 355 - 65.
- Appleby J, Smith P, Renade W, Little V, Robinson R. Competition and the NHS: monitoring the market in managing the market. I Tilley (ed.) London: Paul Chapman Publishing, 1993.
- Audit Commission. Balancing the Care Equation. London: HMSO, 1996.
- Audit Commission. Finding a Place. A review of mental health services for adults. London: HMSO, 1994.
- The Audit Committee Report. 1990.
- Audit Commission. Making a Reality of Community Care. London: HMSO, 1986.
- Avison W R, and Speechley K N. The Discharged Psychiatric Patient: A Review of the Social, Social-Psychological and Psychiatric Correlates of Outcome. American Journal of Psychiatry. 1: 1987.
- Baldwin B. Late life depression: undertreated? British Medical Journal, 1988; **296**: 519.
- Bartko JJ, Carpenter WT. On the methods and theory of reliability. Journal of Nervous Mental Disorders, 1976; **163**: 307 - 317.
- Bassuk E.L. & Gerson S. Deinstitutionalisation and mental health services. Scientific American, 1978; **238**: 46 - 53.
- Bell, J. Doing your research project. Milton Keynes Open University Press, 1987.
- Bennett D. The international perspective. In: Community psychiatry: the Principles, edited by Bennett D, Freeman H. London: Churchill Livingstone, 1991.
- Blessed G. Long stay beds for the elderly severely mentally ill: a discussion paper. Bulletin of the Royal College of Psychiatrists, 1988; **12**: 250 - 27.
- Blinkthorn AS, Leathar DS, Kay EJ. An assessment of the value of quantative and qualitative data collection. Community Dental Health. Macmillian, 1989.
- Bond S & Bond J. Outcomes of Care within a Multiple-case Study in the Evaluation of the Experimental National Health Service Nursing Home. Age & Ageing, 1990, **19**: 11-18.
- Booth T, Simons K, Booth W. Transition shock and the relocation of people from mental handicap hospitals and hostels. Social Policy and Administration, **23(3)** 211-228. 1989.

Booth T, Simons K, Booth W. Speaking out: user studies and people with learning difficulties, *Research, Policy and Planning*, 7,1, 9-17. 1989.

Booth T. Better Lives. Changing Services for People with Learning Difficulties. Social Services Monographs: Research in Practice. 1990.

Booth T, Simons K, Booth W. Outward Bound: Relocation and Community Care for People with Learning Difficulties. Buckingham: Open University Press. 1990.

Borup JH. Relocation mortality research: assessment, reply to the need to focus on the issues. *Gerontologist*, 1983; 23: 35-42.

Braun P, Kochansky G, Shapiro R et al.. Overview: deinstitutionalisation of psychiatric patients, a critical review of outcome studies. *American Journal of Psychiatry*, 1981; 138, 736 - 749.

Brech EFL. Construction Management in Principle and Practice. Longman, London. 1975

Bridge, C. "Parents as care managers: the experiences of those caring for young children with learning disabilities". PhD thesis, 1997.

Brindle D. More delays hit community care programme. *Guardian*. 10.08.94.

Brown GW, Bone M, Dalison, B. Schizophrenia and Social Care: A Comparative Follow-up of 339 Schizophrenic Patients. London: Oxford University Press, 1966.

Brown S. Who will pay for new hospitals? *Guardian*, 22.11.1995.

Bryman A. Quantity and Quality in Social Research. London: Unwin Hyman, 1988.

Bulman JS. A critical approach to the reading of Analytical Reports. *British Dental Journal*, 1988, 180 - 182.

Bulmer M. The Social Basis of Community Care, London: Allen and Unwin, 1987.

Burglass R. Maintaining the treatment of mentally ill people in the community. *Br Med J* 1993; 306: 159 - 160.

Butler T. Mental Health, Social Policy and the Law. London: Macmillan. 1985.

C & G Homes Ltd. vs Secretary for Health reported in Health Law Bulletin. 1995. N° 37, p3.  
Capital Investment Manual (CIM) 1993

Carey S. OPCS interviewing the elderly - problems encountered. Older people and community care. OPCS, London: 1993.

Census of Population, HMSO, various years

Charitable Organisation Society, 1884

Clifford P, Charman A, Webb Y et al. Planning for community care: long-stay populations of hospitals scheduled for rundown or closure. *Br J of Psychiatry* 1991; 158: 190 - 196.

Clifford P. The FACE project: a research and development programme in mental health resource management. London: Quality Development Unit, 1990.

Cohen D. Forgotten Millions. The Treatment of the Mentally Ill - a global perspective. London: Paladin, 1988.



Cohen J. A co-efficient of agreement for nominal scales. *Educational Psychological Measures*, 1960; **20**: 37 - 46.

Cole A. Investing in people. *Nursing Times*, 1994; 90(7)0: 26-30.

Community Care: Agenda for Action. A report to the Secretary of State for Social Services by Sir Roy Griffiths. London: HMSO, 1988.

Coni N. Lecture notes on Geriatrics. Oxford: Blackwell Publications, 1993.

Conroy J W and Bradley V J. The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. Philadelphia: Temple University development and Disability Centre. Boston: Human Services Research Institute. 1985

Cormican D. Construction management: planning and finance. Construction Press, London and New York. 1985

Court D. Fit for the Future. Report of the Committee on Child Health Services. London, HMSO. 1976.

Craig TJ & Lin SP. Death and de-institutionalisation. *Annual Journal of Psychiatry*, 1981; **138**: 224 - 227.

Craig TJ & Laska EM. De-institutionalisation and the survival of the state hospital. *Hospital and Community Psychiatry*, 1983; **34**: 616 - 622.

Craig TJ, Goodman AB, Siegal C et al. The dynamics of hospitalization in a defined population during deinstitutionalization. *American Journal of Psychiatry*, 1984; **34**: 616 - 622.

Cranz Z, Zweiey JP. Relative mortality of chronically ill geriatric patients with organic brain damage before and after relocation J. *Ari Geriatric Society*, 1980; **28**: 76-83.

Croft-Jeffreys C and Wilkinson G. Estimated costs of neurotic disorder in UK general practice. *Psychological Medicine* 1989; **19**: 549-558.

Cross KWJ & Yates J. Follow up study of admissions to mental hospitals. *Lancet* 1961; i: 989-991.

Cross P & Gurland BJ. The Epidemiology of Dementing Disorders. Office of Technology Assessment, Washington, 1986.

Cruze AM, Harwood HJ, Kristianen PL, Collins JJ and Jones D. Economic Costs to society of alcohol and drug abuse and mental illness - 1977, Triangle Research Park, NC: Triangle Research Institute, 1981.

Culyer A J and Jacobs D. The War and Public Expenditure on Mental Health Services in England and Wales - The Postponement Effect. *Social Science and Medicine* **6**: 35-56. 1972.

Curphey M. Health care of the elderly. *The Times*. 10.09.96.

Dalgleish M, Matthews R. Mental Health Buildings Evaluation Pamphlet 1. Residential Facilities for Mentally Handicapped Children DHSS Works Group. 1981.

Davidge M, Elias S, Jayes R, Wood K and Yates J. Survey of English Mental Illness Hospitals. Monitoring the Closure. Birmingham, Inter-Authority Comparisons & Consultancy. 1994.

Davidge M, Elias S, Jayes R, Wood K and Yates J. Survey of English Mental Illness Hospitals. Birmingham, Inter-Authority Comparisons & Consultancy. 1993.

Department of Health (DoH) White Paper. Better Services for the Mentally Handicapped. 1971

Department of Health and Social Security (DHSS) White Paper. Better services for the mentally ill. Cmnd. 6233, London: HMSO, 1975.

Department of Health. CAPRICODE - Capital Procurement of Health Health Buildings. London: HMSO, 1978.

Department of Health. Care in the Community: A consultative document on moving resources for care in England, London: HMSO, 1981.

Department of Health. 1985 HC(85)26, Health Services Management Operation of the Property and Works function. 1985

Department of Health and Social Security (DHSS). Government Response to the Second Report from the Social Services Committee 1984 - 1985 Session, London: HMSO (CMND9674), 1985.

Department of Health. HC(85)26 - Health Services Management Operation of the Property and Works function. 1985.

Department of Health. The Health of the Nation. A strategy for health in England. London: HMSO, 1992 (Cm 1986).

Department of Health. Executive Letter (89)MB142 Unconventional Finance. 1989.

Department of Health. Caring for People. Community care in the next decade and beyond. CM849. London: HMSO, 1990.

Department of Health. National Health Service and Community Care Act. London: HMSO, 1990

Department of Health (DoH) Community Care: Services for People with a Mental Handicap and People with a Mental Illness. London: HMSO (Cm1522), 1991.

Department of Health. Health and Personal Social Services Statistics for England. London: HMSO. 1991.

Department of Health Capital Investment Manual. London: HMSO, 1993.

Department of Health. Executive Letter (93)03 Private Finance Initiative. 1993.

Department of Health. Social Services Statistics, 1993

Department of Health. Nigel Parry Associates. Report on Implementation of Health Care Building Projects". 1993.

Department of Health. HSG(94)31}, London: HMSO. 1994.

Department of Health. Quarterly Briefing. Winter 1994/95.

Department of Health. Mental health in England. Prepared by Government Statistical Service. Statistics Division 2. Crown Copyright 1995.

Department of Health. The Spectrum of Care: Local Services for people with Mental Health Problems. Leeds: NHS Executive, 1996.

Department of Health. Health and Personal Social Services Statistics for England. London: HMSO. 1996.

Department of Health. The Health of the Nation. Mental Illness. Mental Health and older people. London: HMSO, 1996.

Department of Health. "Healthcare Capital Investment", Supplement to Quarterly Briefing, Vol 7, No.1, NHS Estates, 1997/1998.

Department of the Environment. Town and Country Planning Act. London: HMSO, 1990.

Dieck M. Politics for Elderly People in Germany in Contrasting European Policies for Older People. Avebury, Eastbourne. 1990.

Diggory P, Homer A, Liddle J. Medicine in the elderly. Postgraduate Medical Journal, 1991; **67**: 423-45.

Donaldson C, Bond J. Evaluation of Continuing Care for Elderly People. Vol 6. Views of relatives and volunteers. University of Newcastle on Tyne. Newcastle, 1989.

Eaglesham J. "New plan gets cool reception". Financial Times, 16.03.1997.

Easton RJ & Grimes JA. Inpatient care of the mentally ill: a statistical study of future provision. Health Trends, 1976, **8**: 13-18.

ECH Project Services Ltd. Report on Project Management in the National Health Service in England for the DoH. 1990.

Evening Standard. Dorrell S. setting out what a mentally ill patient would be entitled to expect under the existing rule (Mental Health Patients Charter) and quoting " people often say that care in the community means this government is not interested in hospital care, which isn't true" . 01.08.1993.

Evening Standard. Dorrell S. reported as saying: no institutions to close unless proper facilities were up and running in the community. 02.02.1996.

Evening Standard. Dorrell S. The future role of NHS-based learning disability services. 29.06.1991.

Fadden G, Bebbington P and Kuipers L. The burden of care: the impact of functional psychiatric illness on the patient's family. British Journal of Psychiatry 1987; **150**: 285-292.

Fairweather GW et al: Community Life for the Mentally Ill, Chicago, Aldine Publishing Co. 1969

Fein R. The Economics of Mental Illness, New York: Basic Books Incorporated, 1958.

Felce D. deKock, U and Repp A. An eco-behavioural analysis of small community-based houses and traditional large hospitals for severely and profoundly mentally handicapped adults. Applied Research in Mental Retardation. **7,4**, 393-408. 1986.

Fellows A. Report HM Commission for Inquiry into the Administration on Practical Order of the Poor Laws. London, 1834.

Fenton FR, Tessier L, Struvening EL, Smith FA and Benoit C. Home and hospital psychiatric treatment, London: Croom Helm, 1982.

Fitzpatrick RM, Scrambler G and Locker D. Sociology as applied to medicine. Bailliere Tindall, Eastbourne. 1986.

Fleiss J. Statistical Methods for Rates and Proportions. (Ch 13) New York: Wiley, 1981.

Fletcher J. Medicare cuts set to spark clash. Times. 17.10.1995.

Freeman HL, Fryers T, Henderson JH. Mental Health Services in Europe: 10 years on. World Health Organisation Regional Office for Europe, Copenhagen.

Gilleard CJ & Pattie AH. The effect of location on the elderly mentally infirm: relationship to mortality and behavioural deterioration. Age and ageing, 1978; 7: 1-6.

Goldberg D & Huxley P. Mental illness in the community: The Pathway to Psychiatric Care. London: Tavistock. 1980.

Goldberg D and Hiller V. A scaled version of the General Health Questionnaire. 1992, Psychol Med, 9: 139-145.

Goldberg D. Filters to care - a model. In: Indicators for mental health in the population. A series of two workshops organised by the Faculty of Public Health Medicine, the Royal College of Psychiatrists and Department of Health ED Jenkins R. Ed. Griffiths S. Department of Health. 1991.

Goldberg D. The detection of psychiatric illness by questionnaire. London Oxford University Press. (Maudsley Monograph 21). 1972.

Goldman HH, Adams NH & Taube CA. Deinstitutionalization: the data demythologized. Hospital and Community Psychiatry, 34: 129 - 134. 1983.

Goldman HH, Gattozzi AA, Taube CA. Defining and counting the chronically mentally ill. Hospital and Community Psychiatry, 1981; 32: 21-27.

Gollay E, Freedman R, Wyngaarden M and Kurtz N. Coming Back: The Community Experience of Deinstitutionalised Mentally Retarded People. Cambridge, Massachusetts, Abt Books, 1978.

Gore CP & Jones K. Survey of a long-stay mental hospital population. Lancet, 1961: ii: 544 - 546.

Gostin L. Mental Health Services, Shaw & Sons, London. 1986.

Groves T. Government Lacks Data on Mental Hospital Closures, Br Med J 1993; 306: 475 - 476.

Gurland BJ, Copeland J, Kuriansky J, Kelleher M, Sharpe L and Dean LL. The Mind and Mood of Ageing. Mental Health Problems of the Community Elderly in New York and London. The Haworth Press, New York. 1983.

Gurland BJ, Cross P, Defiguerido J, Shannon, M (US), Mann AH & Jenkins R, (UK), with Bennett R, Wilder D, Wright H, Killeffer R, Godlove C, Thompson P, Ross M & Deming WW. A cross-national comparison of the institutionalized elderly in the cities of New York and London. Preliminary Communication. Psychol. Med., 1979; 9: 781-788.

Gurland BJ, Kuriansky J, Sharpe L, Simon R, Stiller P, Birkett P, Bennett R, Copeland J, Cowan D, Dean LL, Denning WE, Holland C, Kelleher M, Shannon M and Wilder D. The Comprehensive Assessment and Referral Evaluation (CARE): Rationale, development and reliability. Int. J. Aging Hum. Devel. 1977; 8: 9 - 42.

Hafner H. Do we still need beds for psychiatric patients? *Acta Psychiatrica Scandinavica* 1987; **75**: 113-126.

Hansson Berglund M, Liljencrantz C et al. Patients' attitudes in short-term psychiatric care. *Acta Psychiatrica Scandinavica*, 1985, **72**: 193 - 201.

Hare E. Was insanity on the increase? *British Journal of Psychiatry* **142**: 439-455. 1983

Hare E. Epidemiological evidence for a viral factor in aetiology of the functional psychoses. In: *Research on the viral hypotheses of mental disorders*, edited by Moravcsik, P.V. Basel: Karger. 1983.

Harwood RH & Ebrahim S. Long Term institutionalised residents. Does the environment effect outcomes? *Journal of the Royal College of Physicians of London* 1992; **26**: 134-138.

Harwood RH & Ebrahim S. Is Relocation Harmful to Institutionalised Elderly People? *Age and Ageing* 1992; **21**: 61- 66.

Haslam MT, *Psychiatry - Made Simple*. Heinemann : Oxford 1990.

Hassall C, Spencer AM & Cross KW. Some changes in the composition of mental hospital population. *Br Journal of Psychiatry* 1965; **iii**: 420 - 428.

Hatchett, W. A cool satisfaction. *Community Care*, 15 March, 31. 1990

Hawkes N. Minister to issue pledge on the release of the mentally ill. *The Times*, 09.09.1996.

Hawkes D. Community care: an analysis of assumptions. *British Journal of Psychiatry* 1975; **127**: 276-285.

HBN 35: Accommodation for people with Acute Mental Illness. *Health Building Note 35*. London: HMSO, 1973.

HBN 37: Hospital accommodation for elderly people. *Health Building Note 37*. London: HMSO, 1973.

HBN 38: Accommodation for Adult Acute Day Patients. *Health Building Note 38*. London: HMSO, 1982.

HBN8: Rehabilitation - Accommodation for physiotherapy, occupational and speech therapy. HMSO, 1991

Health Care Evaluation Research Team. 2nd Annual Report of the Small Homes for severely and profoundly mentally handicapped adults. University of Southampton. August, 1984.

Health Circular (85) Health Service Management. Operation of the Property and Works Functions. July 1985.

Health Service Development: Care in the Community and Joint Finance. Circular HC(83) 6/LAC(8315), London: HMSO, 1983.

HMSO 1808 - Royal Commission on the Care of the Feeble Minded

Hodgkinson R. Provision for Pauper Lunatics, 1834-1871. *Medical History*: 138-154, 1966.

Hodgkinson R. The origins of the NHS: the medical services of the new poor law 1834-1871. London: Wellcome, 1967.

Hogman G. Window dressing: the care programme approach and the mental illness specific grant. April 1991 - April 1992. Kingston upon Thames: National Schizophrenia Fellowship, 1992.

Holland CA & Rabbitt P. The course and causes of cognitive change with advancing age. *Reviews in Clinical Gerontology*. 1991; **1**: 81-96.

Hoult J, Rosen A, Reynolds I. Community orientated treatment compared to psychiatric hospital orientated treatment. *Soc. Sci. Med.* 1984; **18**: 1005 -10.

House of Commons Committee third report, Vol. 1. Long Term Care future provision and funding. London: HMSO, 1996.

House of Commons Select Committees: On Criminal and Pauper Lunatics. London: HMSO. 1807.

House of Commons Social Services Committee. Community Care, with Special Reference to Adult Mentally Ill and Mentally Handicapped People, London: HMSO, 1989.

Healthcare Capital Investment. Supplement to Quarterly Briefing, Vol 7, No.1, 1997/1998, NHS Estates.

Illich I. Medical Nemesis: The Expropriation of Health. New York: Pantheon. Interstate Clearing House on Mental Health. 1976.

Johnstone E et al. Institutionalisation and the defects of schizophrenia. *British Journal of Psychiatry*, 1982; **139**: 195 - 203.

Johnstone EC, Owens DG, Gold A et al. Schizophrenic patients discharged from hospital - a follow-up study. *British Journal of Psychiatry*, 1984; **145**: 586 - 590.

Jones K. A history of the mental health services. London: RKP, 1972.

Jones K. After Hospital: A Study of Long-Term Psychiatric Patients in York. Department of Social Policy and Social Work, University of York. 1985.

Jones K. Lunacy Law on Conscience. London: RKP, 1959.

Jones K. Trends in the organisation of mental health services in Great Britain in the past 25 years. *International Journal Mental Health*, 1981; **16**: 94 - 107.

Kay DWK. The epidemiology of dementia: a review of recent work. *Reviews in Clinical Gerontology*, 1991; **1**: 55-66.

Kellaher L. Inside quality assurance. University of London, 1993.

Kellaher LA, Pearce SM & Wilcocks DM. Living in Homes: A Consumer View of Old People's Homes. Centre for Environment and Social Studies in Ageing. Polytechnic of North London & British Association of Service to the Elderly.

Kiesler C A and Sibulkin AE. Mental hospitalisation: myths and facts about a national crisis. *British Journal of Psychiatry*, 1994. 165: 170 - 178. Newbury Pk. California Sage, 1987.

King's Fund. London's Mental Health. London: King's Fund, 1997.

King's Fund. The need for asylum in society for the mentally ill or infirm: consensus statement from the third King's Fund Forum. London: King's Fund, 1987.

King's Fund Centre. *An Ordinary Life: Comprehensive Locally-Based Residential Services for Mentally Handicapped People*, London: King Edward's Hospital Fund.

Klerman GL. Psychiatric epidemiology and mental health policy. In: *Epidemiology and health policy*. edited by Levine, S. and Lilienfeld, A. London: Tavistock Publications, 1987.

Korman N & Glennerster H. *Hospital Closure: A Political and Economic Study*. Milton Keynes: Open University Press. 1990.

Knapp M and Beecham J. *The cost effectiveness of community care for former long stay psychiatric hospital patients*, Canterbury: PSSRU, University of Kent, 1989.

Knapp M, Beecham J and Allen C. *The Methodology of costing community and hospital services used by clients in the care in the community programme*, Canterbury: PSSRU, University of Kent, 1989.

Knapp M, Beecham J, Anderson J, Dayson D, Leff J, Margolius O, O'Driscoll C and Wills W. *Predicting the community costs of closing psychiatric hospitals: the TAPS project*. Canterbury: PSSRU, University of Kent, 1990.

Knapp M, Cambridge P, Thompson C. *Care in the community: Evaluating a Demonstration Programme*. Aldershot Gower, 1991.

Kuhn T. *The Structure of Scientific Revolutions*, Chicago: University of Chicago Press, 1970. Ed. 2nd.

Labour Research Department. *Report on Local Authority charges for Home Help*. London, 1996.

Lady Runciman. Quoted in *First Report Vol I House of Commons Health Committee*. London: HMSO, 1994.

Laing & Buisson Report. *Care of Elderly people market survey*. London: Laing & Buisson, 1996.

Laing W. *Laing's Guide to Private Healthcare*, London: Laing & Buisson, 1989.

Lambert N. Watchdog set to sue Health Secretary. *Edgware and Mill Hill Times*. 14.02.97.

Laming H. *Inspecting for quality. Residential Care of the elderly mentally ill*. HMSO: London, 1993.

Laming H. *Standards for the residential care of the elderly mentally ill*. HMSO, London. 1993.

Leff J, Knapp M, Carrier J, Trieman N. Beyond the asylum. Reprovision for psychiatric hospitals: recommendations from TAPS/PSSRU research findings. *The Health Service Journal*, 1995. **105**: 28-30.

Leff J. The TAPS Project: Evaluating Community Placement of Long-Stay Psychiatric Patients. *British Journal of Psychiatry*. 1993; **162** (suppl 19).

Leff J., Trieman N., Gooch C. TAPS Project 33: Prospective Follow-Up Study of Long-Stay Patients Discharged from Two Psychiatric Hospitals. *Am J Psychiatry*, 1996; **153**: 1318-1324.

Lelliot L, Audini B, Knapp M et al. The Mental Health residential care study: Classification of facilities and description of residents. *British Journal of Psychiatry*, 1996; **169**: 139 - 147.

Lelliott P, Audini B, Darroch B. Resolving London's bed crisis, there might be a way, is there the will? *Psychiatric Bulletin*. 1995; **19**: 273 - 275.

Lelliott P, Wing J and Clifford P. A national audit of new long-stay psychiatric patients. II: Impact on services. *British Journal of Psychiatry*. 1994; **165**: 170 - 178.

Lelliott, L. National Audit of new long-stay psychiatric patients II: Impact on services. *British Journal of Psychiatry*, 1994. **165**: 170 - 178.

Lindesay J, Briggs K, MacDonald A, Lawes M et al. The Domus philosophy: A comparative evaluation of a new approach to residential care for the demented elderly. *International Journal of Geriatric Psychiatry*. 1991; **6**: 727-734.

Linn MW, Caffey EMJ and Klett CJ. Hospital vs community (foster) care for psychiatric patients. *Archives of General Psychiatry*, 1977; **34**: 78 - 83.

Lowe K, de Pavia S and Humphreys S. Long-term Evaluation of Services for People with a Mental Handicap in Cardiff: Clients' Views. *Mental Handicap in Wales*. Applied Research Unit, St Davids Hospital Cardiff. 1986.

MacDonald AJD, Craig TKJ and Warner L. The development of a short observational method for the study of activity and contacts of old people in residential settings. *Psychol. Med.*, 1985; **15**: 167 - 172.

MacDonald AJD, Mann AH, Jenkins R, Richard L, Godlove C and Rodwell G. An attempt to determine the impact of four types of care upon the elderly in London by the study of matched groups. *Psychol. Med.* 1982; **12**, 193 - 200.

Mahendra B. *Prognosis in Dementia*. MTP Press, Lancaster. 1987.

Mangen SP. In: *Mental health care in the European Community*, edited by Mangen SP. London: Croom Helm, 1987.

Mann AH, Graham N and Ashby D. Psychiatric illness in residential homes for the elderly: A survey in one London borough. *Age & Aging*, 1984; **13**, 257 - 264.

Mann S & Cree W. New long-stay psychiatric patients: a national sample survey of fifteen mental hospitals in England and Wales, 1972/3. *Psychological Medicine*, 1976; **6**: 603 - 616.

Mansell J L. *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: Report of a Project Group*. HMSO, London. 1993.

Mansell J. *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: Report of a Project Group*. HMSO: London, 1993

Marlow RE. When they closed the doors at Modesto. Paper presented at the National Institute of Mental Health Conference on closure of state hospitals, Scottsdale, AZ. February 1974.

Marx AJ, Test MA and Stein LI. Extra-hospital management of severe mental illness: feasibility and effects of social functioning. *General Archives of Psychiatry* 1973; **19**: 505 - 511

Marks I, Connolly J & Muijen M. The Maudsley Daily Living Programme: A controlled Cost-Effectiveness Study of Community Based Versus Standard In-patient Care of Serious Mental Illness". *Bulletin of the Royal College of Psychiatrists* 12 (January): 22-23. 1988.

McDowell T & Newell C. *Measuring Health: A guide to rating scales and questionnaires*. New York: Oxford University Press 1987.



McGuire T. Measuring the economic costs of schizophrenia. *Schizophrenia Bulletin* 17, 1991; **3**: 375 - 388.

McIver S. Obtaining the views of users of mental health services. London: King's Fund Centre for Health Services Development. 1991.

Mechanic D. quoted in The Task Panel on the Nature and Scope of the Problem. The President's Commission on Mental Health. Washington 1978.

Mellet DJ. The Prerogative of Asyludom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth Century Britain. London and New York: Garland. 1982.

Mellet D J. Bureaucracy and mental illness: the Commissioners in Lunacy 1845 - 90. *Medical History* **25**:221-250, 1981

Mellet DJ. Bureaucracy and mental illness: the Commissioners in Lunacy 1845-90. *Medical History* **25**:221-250, 1981.

Mental Health Task Force, Grassroots, no. 26, 29th November, 1994.

Mollica RF and Astrachan BM. Equity, effectiveness and equality in mental health services. In: *Community Psychiatry, the principles*, edited by Freeman H and Bennett D. London: Churchill Livingstone, 1991.

Moos RH & Lemke S. Assessing the Physical & Architectural Features of Sheltered Care Settings. *Journal of Gerontology*. 1980; **35**(4): 571-83.

Moos RH and Lemke S. *Multiphasic Environmental Assessment Procedure Manual*. Palo Alto CA: Social Ecology Laboratory, Veterans Administration and Stanford University Medical Center. 1984.

Mosher L R. Why has research failed to be translated into practice? *New England Journal of Medicine* **309**: 1579-1580, 1983.

Moskowitz H and Wright G. *Operations Research Techniques for Management*, Prentice Hall, Englewood Cliffs, New Jersey. 1979.

Murray I. Mental hospital closures halted. *TheTimes*, 13.9.1997.

Murphy E, Social origins of depression in Old age. *B.J. Psychiatry*, 1982; **141**: 135-142.

Murphy E, Brown G. Life events, psychiatric disturbance and physical illness. *British Journal of Psychiatry*, 1980; **136**: 326-38.

Murphy E, Lindesay J, Dean R. *The DOMUS Project*. London Sainsbury Centre for Mental Health. 1994.

National Audit Office Report on Hospital Building in England. July 1989.

National Health Service and Community Care Act. London: HMSO, 1990.

National Institute for Mental Health Community Support Systems for Persons with Long Term Mental Illness: Questions and Answers, Maryland: NIMH Community Support Program. 1988.

Netten A. The effect of the design of residential homes on elderly residents. *International Journal of Psychiatry* 1989; **4**: 143-153.

Nettleton S. Understanding Dental Health Beliefs: An introduction to etiology. *British Dental Journal*, 1986; 145-147.

NHS Management Executive (1992) HSG(92)42 Health Services for people with learning disabilities (mental handicap).

Norton A. Mental Hospital ins and outs. *British Medical Journal*, 1961; I, 528 - 536.

O'Brien J. A guide to personal futures planning. In E T Bellamy and B Wilcox (eds), *A comprehensive Guide to the Activities Catalogue: An alternative Curriculum for Youth and Adults with Severe Disabilities*, Baltimore: P H Brookes. 1987

O'Brien JT & Levy R. Age associated memory impairment. *Br Med J*. 1992; **304**: 5-6.

O'Driscoll C. The TAPS project: 7. Mental hospital Closure: A literature review of outcome studies and evaluative techniques. In (ed.J.Leff) *Evaluating the transfer of care from psychiatric hospitals to district based services*. *British Journal of Psychiatry* 1993; **162** (suppl. 19): 7-17.

Office of Health Economics. *Mental Handicap: Partnership in the Community?* No. 83. July 1986.

Office of Population Censuses and Surveys Population Projections. Publications Unit. OPCS, 1990.

Office of Population Censuses and Surveys Population Projections. Publications Unit. OPCS, 1995.

Olson M. Assertive Community Treatment: An Evaluation of the Experimental Evidence. *Hospital and Community Psychiatry*, 1990; **41**: 634 - 641.

Organisation for Economic Co-operation and Development (OECD). *The integration of women into the economy*, Paris: OECD, 1986.

Pasamanick B, Scarpitti F, Dinitz S. *Schizophrenics in the Community: An Experimental Study in the Prevention of Hospitalisation*. New York, Appleton Century Crofts Inc. 1967.

Patmore C, Weaver T. *Community Mental Health Teams: Lessons for Planners and Managers. Good Practices in Mental Health*, London. 1991.

Pattie AH, Gilleard CJ. Admission and adjustment of residents in homes for the elderly. *Journal of Epidemiology and Community Health*, 1978b; **32**: 212-214.

Pattie AH, Gilleard CJ. *Manual of the Clifton Assessment Procedures for the Elderly, (CAPE)*. Sevenoaks: Hodder & Sloughton. 1979.

Pattie AH, Gilleard CJ. The two year predictive validity of the Clifton Stockton geriatric rating scale, *British Journal of Psychiatry*, 1978a; **133**: 457-460.

Phillips DT and Gracia-Diaz A. *Fundamentals of Network Analysis*, Prentice Hall, Englewood Cliffs, New Jersey. 1981.

Pike A & Timmins N. Private Finance Initiative. *Financial Times Survey*, 17.07.97.

Platman SR, Karahasan A & Booker TC. The new long-term patient in the public mental hospital. *American Journal of Psychiatry*, 1983; **140**: 606 - 608.

Powell A. *The Metropolitan Asylums Board and its work, 1867-1930*. London: The Board, 1930.

Powell The Rt Hon J Enoch. Official Opening of National Association for Mental Health Conference. In: Emerging Patterns for the Mental Health Services and the Public, Proceedings of a conference held at Church House, Westminster, London, NAMH. 9 - 10 March 1961.

Raftery J. Social policy and community psychiatry. In: Community Psychiatry, the principles, edited by Freeman H and Bennett D. London: Churchill Livingstone, 1991.

Raftery J. Mental Health Systems in Transitions: the U.S and U.K. British Journal of Psychiatry. 1992; **161**: 589-593.

Raftery J. The economics of psychiatric services in the UK and Ireland, 1845-1985. Submitted for the degree of Doctor of Philosophy (PhD) in the faculty of Economics, London School of Economics and Political Sciences, University of London. 1993.

Raggett T. Healthcare in the Developing World. Opportunities in emerging markets. A Financial Times Management Report, published and distributed by Financial Times Management Reports. 1995.

Raphael W. Just an Ordinary Patient: A preliminary survey of opinions on psychiatric units in general hospitals. London: King Edward's Hospital Fund for London, 1974.

Raphael W. Psychiatric Hospitals Viewed by their Patients. London: King Edward's Hospital Fund for London, 1972, 1977.

Reda S. Staff perceptions of their roles during the transition of psychiatric care into the community. Journal of Psychiatric and Mental Health Nursing, 1995; **1** (2): 13-22.

Redick RW, Witkin M and Attay J. Expenditure and sources of funds for mental health organisations Rockville, MD: NIMH, 1987.

Regier DA, Goldberg ID & Taube CA. The de facto US mental health services system: a public health perspective. Archives of General Psychiatry, 1978; **35**: -693.

Renshaw J, Hampson R, Thomason C, Darton R A, Judge K and Knapp M R J. Care in the Community: The First Steps, Aldershot: Gower. 1988.

Report by the Working Group and Capital Expenditure Contract, H.M. Treasury, 1986

Report by the Working Group on Capital Expenditure Contracts, H.M Treasury, 1986

Report of Joint Committee on Mental Deficiency (Wood Report), London: HMSO, 1929.

Report of the Royal Commission on the Care and Control of the Feeble Minded. London: HMSO, 1908.

Rice DP, Kelaman S and Miller LS. The economic costs of alcohol and drug abuse and mental illness: 1985, Rockville, MD: NIMH, 1990.

Richards, S. Community Care of the Mentally Handicapped: Consumer Perspectives. University of Birmingham. 1984.

Rittenhouse JD. Endurance of effect: Family unit treatment compared to identified patient treatment, in the Proceedings of the Annual Convention of American Psychological Association. Washington, D.C., American Psychological Association, 1970, vol 2, pp 535-536.

Robins LN, Regier DA (editors) Psychiatric Disorders in America. The Epidemiological Catchment area study. New York, Free Press 1991.

Root-Bernstein S R. *Discovering*. Cambridge, USA: Harvard University Press, 1989.  
Royal College of Psychiatrists. *The Provision of Mental Health Services in Britain: The Way Ahead*. Ed. by Wilkinson G & Freeman H, Gaskell. 1986.

Royal College of Physicians, *High quality long term care for the elderly*. Cradley Print, Warley. 1992.

Sainsbury Draft Report. *Acute Care Inpatient Study. Stage 1 - The National Survey of Acute Inpatient Services. A Draft Report to Participating Services*. The Sainsbury Centre for Mental Health, January 1996.

Schreenberger R and Felsenthal D *Community settings for mentally retarded persons: satisfactions and activities*. *Mental Retardation*, **15(4)**, 3-7. 1977,

Schultz R, Brenner G. *Relocation of the aged: a review and theoretical analysis*. *Journal of Gerontology*. 1977; **32**: 323 - 333.

Scull A T. *Museums of madness: lunacy in Britain, 1800-1860*. London: Penquin, 1979

Sellitz C. *Research methods in social relations*. Holt Reinhart & Winston, New York. 1966.

Sheldon W. *Government Standing Medical Advisory Committee: Child Welfare Centres, Report of the Subcommittee*. London, HMSO. 1967.

Simons K, Booth T and Booth W. *Speaking out: user studies and people with learning difficulties*. *Research, Policy and Planning* **7(1)**, 9-17. 1989.

Smith AHW. et al. *The reliability and validity of two assessment scales for the elderly mentally handicapped*. *British Journal of Psychiatry*, 1981; **138**: 15-16.

*Social Trends*. Government Statistical Services, HMSO, 1993 and 1994.

Spagnoli A, Foresti G, MacDonald A & Williams P. *Dementia and Depression in Italian geriatric institutions*. *International Journal of Geriatric Psychiatry*. 1986. **1**, 15 - 23.

Stein LI & Test MA. *An alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation*. *Archives of General Psychiatry*, 1990; **37**: 392 - 397.

Sutcliffe J. *Adults with learning difficulties: Education for choice and empowerment*. In: *Better Lives. Changing Services for people with learning difficulties*. Edited by Tim Booth. Social Services Monographs: Research in Practice. 1990.

Tantam D. *Alternatives to hospitalisation*. *British Journal of Psychiatry* 146: 1-4. 1985

Taylor D. *Mental health in the 1990s. From custody to care?* London Office of Health Economics. 1989

The 1890 Lunacy Act

The Builder Group. *Building "Procurement" Supplement*. November 1996.

*The Burden of Disease*. Economic Advisors Office, London, Department of Health, 1988.

The Children Act 1989

*The Hospitals and Health Services Year Books - 1992 - 1995*. London: Clowes, 1992 - 1995.

The Housing Act 1988

The Idiots Act 1886

The Mental Deficiency Act 1913

The Mental Health Act, 1959.

The Mental Health Act, 1983.

The Metropolitan Poor Law Act 1867

The National Audit Office Report on Hospital Building programme. 1989

The Wood Report. Report of Joint Committee on Mental Deficiency. London: HMSO, 1929

Thornicroft G & Bebbington P. Deinstitutionalisation - from hospital closure to service development. *British Journal of Psychiatry*, 1989; **155**, 739 - 753.

Thornicroft G, Cooch C, O'Driscoll C, Reda S. The TAPS Project. 9: The Reliability of the Patient Attitude Questionnaire. In (Ed. J Leff). *Evaluating community placement of long-stay psychiatric patients*. *British Journal of Psychiatry*. 1993, 162: Supplement 19: 25 - 29.

Thornicroft G, Gooch C, Dayson D. The TAPS Project: 17: Readmission to hospital for long-term psychiatric patients after discharge into the community. *Br Med J* 1992; **305**: 996-8.

Tomlinson D. *Utopia, Community Care and the Retreat from the Asylums*. Milton Keynes: Open University Press. 1991.

Tones K, Toiford S & Robinson Y. *Health Education, effectiveness & efficiency*. London: Chapman & Hall 1990.

Tooth GC & Brooke EM. Trends in the mental hospital population and their effect on future planning. *Lancet*; i: 710-713. 1961

Town and Country Planning Act. Department of the Environment. London: HMSO, 1990.

Trieman N, Hughes J, Leff J. The TAPS Project 42: the last to leave hospital: profile of residual long-stay populations and plans for their resettlement. *Acta Psychiatrica Scandinavica* 1997. (Submitted).

Trieman N, Leff J. The difficult to place patients in a psychiatric hospital closure programme. The TAPS Project: 24. 1996, *Psychological Medicine*, 26: 765 - 774.

Trieman N, Wills W, Leff J. Does reprovision benefit elderly long stay mental patients? *Schizophrenia research*. London, 1995.

Trieman N, Wills W, Leff J. The TAPS Project. 28: Does reprovision benefit psychogeriatric long-stay patients? 1996. *Schizophrenia Research*, **21**: 199-208.

\* Trieman N. The Difficult to place (DTP) patients at Warley Hospital - a preliminary (internal) report. 1996. Unpublished.

Trieman N. The Psychogeriatric Population: In Transition from hospital to community-based services. Chapter 7 in Leff J: *"Community Care. Illusion or Reality?"*. Sussex: Wiley, 1997.

UNEC for Europe Changing population and age structures: 1990 - 2015. UN, Geneva: 1992.  
United Nations. *Global Population Policy* 1993. Department for Economic and Social Policy Analysis. New York: 1995.

Unsworth C. The politics of mental health legislation. Oxford: Clarendon Press, 1987.

Walker D. Study by International Monetary Fund (IMF) contradicts Chancellor's Private Finance Initiative (PFI) claim. Independent. 27.11.96.

Walker R. Applied Qualitative Research. Aldershot, Gower 1-26, 1985.

Wang HS. Prognosis in Dementia. New York Raven Press, 1978.

Ward L. A Programme for Change: Current issues in services for people with learning difficulties. In: Better Lives. Changing Services for people with learning difficulties. Edited by Tim Booth. Social Services Monographs: Research in Practice. 1990.

Warnes A. The Demography of Ageing in the United Kingdom of Great Britain and Northern Ireland. International Institute on Aging (United Nations - Malta), 1993.

Waterhouse R. Bottomley seeks change in mental care. Independent on Sunday Feb 7:2.3. 1993.

Weinman B and Kleiner RJ. The impact of community living and community member intervention on the adjustment of the chronic psychotic patient. In: Alternatives to Mental Hospital Treatment, edited by Stein LI and Test MA New York: Plenum Press, 1978.

Weyerer S, Platz S, Eichorn S, Mann AH, Ames D and Graham N. Die Deutsche version des Brief Assessments Interviews (BAI): Ein Instrument zur Erfassung von Demenz und Depression. 1988; Zeits. Gerontopsychol. psychiat. 1988; 1 (2), 147 - 152.

Wilkin D & Thompson C. Users' Guide to Dependency Measures for Elderly People. Social Services Monographs: Research in Practice. University of Sheffield. Joint Unit for Social Services Research, 1989.

Wilkus D. Users Guide to Dependancy measured in Elderly people. University of Sheffield, 1989.

Wills W, Leff J. The TAPS Project. 30: Quality of life for elderly mentally-ill patients: a comparison of hospital and community settings. 1996. International Journal of Geriatric Psychiatry; 11: 953-963.

Wills W, Trieman N, Leff J. Evaluation of psychogeriatric physical facilities in London. Care practices, physical features and staff attitudes. (Unpublished) 1996.

Wills W, Trieman N, Leff J. The TAPS Project 40: Quality of care provisions for the elderly mentally ill: traditional vs alternative care. International Journal of Geriatric Psychiatry. 1997. Submitted.

Wing JK & Brown GW. Institutionalisation and Schizophrenia. London: Cambridge University Press. 1970.

Wing JK, Cooper JE, Sartorius N. The measurement and classification of psychiatric symptoms. London: Cambridge University Press, 1974.

Wing JK. Pilot experiment in the rehabilitation of long stay hospitalised male schizophrenic patients. British Journal of Preventative and Social Medicine, 14: 173 - 180. 1960.

Wing, L. Evaluation of New Services to be Provided for Residents of Darenth Park Hospital - First Annual Report. MRC Social Psychiatry Unit, Institute of Psychiatry. London. 1981

Wing L. Hospital Closures & Resettlement of Residents. Aldershot: Avebury, 1989.

Wood N. Dorrell S quoted as stating that the costs of long term care needed detailed consideration but not before the next election. Times, 03.01.1997.

Wood N. Plea for elderly adds to Budget pressure. Times 21.10.1996.

Woods GE. Care of the Mentally Handicapped. Past and Present. Wright PSG. 1983.

Working Group on Capital Expenditure Contracts - Original IBBS - Final Report. H M Treasury, 2nd May 1986. Reprinted 13th May 1986.

Working Party - Agreement for the appointment of project managers for commission for construction projects in the NHS. 1995.

World Health Organisation. Mental Disorders: Glossary and Guide to their classification in accordance with the Ninth Revision of the International Classification of Diseases (ICD) Geneva: WHO, 1978.

## **Lists of Tables, Figures and Appendices**

### **List of Tables**

#### **Chapter 1**

Table 1.1	Burdens of Disease by Sub-Heading within Mental Illness 1985 data, England	14
Table 1.2	Direction of Change in Industrialised Countries	21

#### **Chapter 2**

Table 2.1	Summary of Studies of Deinstitutionalisation	44
Table 2.2	Principal NHS Problems encountered by the NHS in Community Reprovision Programmes compared with Local Authority	74

#### **Chapter 3**

Table 3.1	National Survey - Content of Questionnaire	81
Table 3.2	Questionnaires used in Case Studies	90
Table 3.3	Brief Assessment Schedule Scoring and Scales	93
Table 3.4	Dependency Measures in Elderly People	94
Table 3.5	Summary of Contents of Patient Quality of Life (Supplementary) Questionnaire	96
Table 3.6	Significant Life Events	97
Table 3.7	Summary Description of Staff Questionnaire	98
Table 3.8	Reliability of the GHQ	99
Table 3.9	Summary Description of Friend and Relative Questionnaire	100
Table 3.10	Summary Description of Physical Survey Questionnaires	101

#### **Chapter 4**

Table 4.1	Summary of Questionnaire Returns over Three Years of the Study	105
Table 4.2	Respondents Completing the Questionnaire	106
Table 4.3	Progress with Reprovision by Category	106
Table 4.4	Changes in Category from 1993 to 1995	107
Table 4.5	Hospitals' Planned Closure Dates @ 1995	109
Table 4.6a	1993 Hospital Categories by Region	110
Table 4.6b	1994 Hospital Categories by Region	110
Table 4.6c	1995 Hospital Categories by Region	110
Table 4.6d	1996 Projected Hospital Closures by Region	111
Table 4.7	Number of Hospital Purchasers per Category per Year of the Study	112
Table 4.8	Beds in Use, Occupancy and Vacancy Levels	114
Table 4.9	Size of Hospitals Still in Use by Year	114



Table 4.10	Category of Closure Programme by Hospital Size in 1995	115
Table 4.11	Case Mixes of the Patient Population of Hospitals 1993, 1994 & 1995	116
Table 4.12	Case Mixes of the Patient Population of Hospitals 1994 & 1995	116
Table 4.13	Satellite Sites and Hospital Category - 1994	120
Table 4.14	Actual Duration of Closure Programmes Compared with Intended Duration	121
Table 4.15	Hospital Closure Plans Reporting Delay between 1993 & 1995 by Category	122
Table 4.16	Projected Dates of Category A Hospitals (those with no closure plans) in 1993 to Formulate a Community Reprovision Plan and Outcome in 1995	123
Table 4.17	Schemes still to be Provided in the Last Year in the Plans of 5 Category "D" Hospitals in 1995	124
Table 4.18	Schemes Delaying Programmes where Hospitals Reported Slippage	125
Table 4.19	Source of Funding of Programme	126
Table 4.20	Age of Institution (Number of Asylums built under Legislation)	128
Table 4.21	Land Use Classification of Institution Sites / Institutions Classed as Listed Buildings	128
Table 4.22	Retrenchment Efficiency	129
Table 4.23	Quality of Institutional Accommodation	130
Table 4.24	Changes in Reprovision Bed Numbers for 6 Category B Hospitals 1994 - 1995	131
Table 4.25	Staff Transferring to Community-based Services/% of Staff to Transfer to Reprovided Facilities	133
Table 4.26	Patient Staff Ratio per Year by Hospital Category	134
Table 4.27	Predicted Closure Programme for English Psychiatric Hospitals by Category in 1996 Adjusted to Reflect Delays Experienced in Previous Closure Programmes	134
Table 4.28	Predicted Closure Programme for English Psychiatric Hospitals open in 1996 Compared with Given Dates	134

## Chapter 5

Table 5.1	Case 1 - Original and Reprovided Buildings Compared	138
Table 5.2	Case 1 EMI Day Hospital Health Building Note Standards	139
Table 5.3	BAS Scores - Case 1 and Control Group Compared	143
Table 5.4	Case 1 - Patients Views on New Facilities	144
Table 5.5	Case 1 - Staff Views on Quality of New Facilities	148
Table 5.6	Case 1 - Summary of Staff Responses to General Health Questionnaire	149
Table 5.7	Case 2 Original and Reprovided Facilities Compared	150
Table 5.8	Case 2 EMI Inpatient Facilities Health Building Note	151
Table 5.9	CAPE Scores - Case 2 and Control Group Compared	154
Table 5.10	Case 1 - Staff Views on Quality of New Facilities	158

Table 5.11	Case 2 Summary of Staff Responses to General Health Questionnaire	159
Table 5.12	Case 3 - TAPS Difficult to Place (DTP) Study	161

## **Chapter 8**

Table 8.1	Success Criteria in the Planning Stages	191
Table 8.2	Success Criteria in the Implementation Stages	191
Table 8.3	Standard Proforma to Monitor Acquisition and Construction Phases	203

## **List of Figures**

### **Chapter 1**

Figure 1.1.	Burdens of Disease - Share of Morbidity, Costs & Mortality - by Disease, England & Wales, 1985	13
Figure 1.2	Example of a Standard time and expenditure 'S' curve for New Capital Construction	33

### **Chapter 4**

Figure 4.1	% Hospitals in Advanced Categories by Trust Waves	113
Figure 4.2	Category A Hospitals: Changes in Patient Sub-groups, 1993 - 1995	117
Figure 4.3	Category B Hospitals: Changes in Patient Sub-groups, 1993 - 1995	118
Figure 4.4	Category C Hospitals: Changes In Patient Sub-groups, 1993 - 1995	119
Figure 4.5	Category D Hospitals: Changes In Patient Sub-groups, 1993 - 1995	120

## **List of Appendices**

### **Chapter 1**

Appendix 1.1	Major Mental Health Legislation in England and Wales	205
Appendix 1.2	Legal Processes for Admission of Patients	205

### **Chapter 3**

Appendix 3.1	1995 National Study Questionnaire	206
Appendix 3.2	BAS - Brief Assessment Schedule	213
Appendix 3.3	CAPE - Behaviour Rating Scale	229
Appendix 3.4	Patient Quality of Life (Supplementary) Questionnaire	231
Appendix 3.5	Staff Questionnaire	235
Appendix 3.6	General Health Questionnaire (GHQ)	244
Appendix 3.7	Friend/Relative Questionnaire	246
Appendix 3.8A	Physical Survey - In-patient Adult HBN and Environmental Standards	252
Appendix 3.8B	Physical Survey - Day Hospitals Adult Acute Mentally Ill HBN and Environmental Standards	258
Appendix 3.8C	Physical Survey - Inpatient Elderly Mentally Ill HBN and Environmental Standards	262
Appendix 3.8D	Physical Survey - Day Hospitals Elderly Mentally Ill HBN and Environmental Standards	268

### **Chapter 4**

Appendix 4.1	List of Water Tower Hospitals in the Study	272
Appendix 4.2	Projected Completion of the Community Mental Health Reprovision Programmes in England - Assumptions	272

### **Chapter 5**

#### **Case 1**

Appendix 5.1	Case 1 EMI Day Hospital Environmental Data	273
Appendix 5.2	Case 1 Adult Acute Inpatient and Day Hospital HBN & Environmental Data	273
Appendix 5.3	Case 1 Patient Characteristics	274
Appendix 5.4	Case 1 BAS Results - Cognitive and Depression Scores	275
Appendix 5.5	Control Group BAS Patient Characteristics	276
Appendix 5.6	Control Group BAS - Changes in Cognitive and Depression Levels	276
Appendix 5.7	Case 1 Patients " Quality of Life (Patient Activities)	277

Appendix 5.8	Case 1 Staff Description of Sample	277
Appendix 5.9	Case 1 Staff Views on Training	278
Appendix Letter 1	Case 1 Correspondence from Clinical Psychologist	279
Appendix Letter 2	Case 1 Correspondence From Medical Officer Occupational Health	280
 <b>Case 2</b>		
Appendix 5.10	Case 2 Reprovision Plan	282
Appendix 5.11A	Case 2 EMI Inpatient Facilities Environmental Data	283
Appendix 5.11B	Case 2 EMI Day Hospital & Adult Inpatient HBN & Environmental Data	283
Appendix 5.12	Case 2 Patient Characteristics	284
Appendix 5.13	Case 2 "F" Ward Rundown of Patient Numbers on a 22 bed EMI Inpatient Ward	285
Appendix 5.14	Case 2 CAPE Total Scores	286
Appendix 5.15	Case 2 CAPE Apathy Scores	286
Appendix 5.16	Case 2 CAPE Communication Difficulties Scores	287
Appendix 5.17	Case 2 CAPE Physical Difficulties Scores	287
Appendix 5.18	Case 2 CAPE Social Disturbance Scores	288
Appendix 5.19	Control Group CAPE Patient Characteristics	288
Appendix 5.20	Control Group CAPE Total Scores	289
Appendix 5.21	Control Group CAPE Apathy Scores	289
Appendix 5.22	Control Group CAPE Communication Difficulties Scores	290
Appendix 5.23	Control Group CAPE Physical Difficulties Scores	290
Appendix 5.24	Control Group CAPE Social Disturbance Scores	291
Appendix 5.25	Case 2 Staff Characteristics	291
Appendix 5.26	Case 2 Staff Views on Training	291
Appendix Letter 3	Case 2 Correspondence to District Psychologist	292
Appendix 5.27	Case 3 Reprovision Plan	293
 <b>Chapter 8</b>		
Appendix 8.1	Typical Project Management Organisation for a Mental Health Reprovision Programme	294
Appendix 8.2	Simple Presentation of Progress being made with Implementation	295

## List of Abbreviations

ADL	Activities of Daily Living
AIP	Approval in Principle
BAS	Brief Assessment Schedule
BRS	Behavioural Rating Scale
CAPE	Clifton Assessment Procedures for the Elderly
CAPRICODE	NHS Capital Procurement Code
CIM	Capital Investment Manual
DGH	District General Hospital
DHA	District Health Authority
DoE	Department of the Environment
DoH	Department of Health
DTP	Difficult to Place
EMI	Elderly Mentally Ill
E(S)MI	Elderly (Severely) Mentally Ill
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee
GHQ	General Health Questionnaire
GDP	Gross Domestic Product
GP	General Practitioner
HA	Housing Association
HBN	Health (Service) Building Note
HMSO	Her Majesty's Stationery Office
IACC	Inter Authority Comparison Consulting (Birmingham University)
ICD	International Classification of Disease
IHSM	Institute of Health Service Management
IHSMYB	Institute of Health Service Management Year Book
LA	Local Authority
LPA	Local Planning Authority
LOS	Length of Stay
LS NON EMI	Long Stay Non-EMI
MH	Mental Health
MHSSG	Mental Health Services Specific Grant
MI	Mentally Ill
NAHAT	National Association of Health Authorities and Trusts
NHS	National Health Service
NHSME	National Health Service Management Executive
NIMBY	Not in my back yard
NIMH	National Institute for Mental Health
OBC	Outline Business Case
OECD	Organisation for Economic Co-operation and Development
OPCS	Office for Population Census and Survey
PAQ	Patient Attitude Questionnaire
PFI	Private Finance Initiative
PQ	Parliamentary Question
PPG	Planning Policy Guidelines
RHA	Regional Health Authority
RO(NHSME)	Regional Office (National Health Service Management Executive)
SNAP	Survey Analysis Package (Computer Software)
TAPS	Team for the Assessment of Psychiatric Services
TCP	Town and Country Planning
WHO	World Health Organisation

**MEDICAL LIBRARY**

**ROYAL FREE HOSPITAL**

**HAMPSTEAD**