SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	C11/S/c
Service	Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

This service specification covers the provision of Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)

1.2 Description

1.2.1 This service specification describes a Tier 4 community-based forensic Child and Adolescent Mental Health Service model that will be delivered within a clearly defined geographical area at Regional and sub-regional level.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

1.3.1 NHS England commissions Tier 4 Child and Adolescent Mental Health (CAMHS) services provided by Specialist Child and Adolescent Mental Health Centres. The range of Tier 4 services commissioned by NHS England includes inpatient care and associated non-admitted care including forensic outreach when delivered as part of a provider network.

1.3.2 CCGs commission CAMHS for children requiring care in Tier 1, Tier 2 or Tier 3 services.

2 Care Pathway and Clinical Dependencies

2.1 Care Pathway

2.1.1 Future in Mind (2015) emphasised the need for 'improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible'. This includes 'implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.

2.1.2 This service specification will focus on the functions required of a specialist mental health service to mediate transitions into and out of secure in-patient care. It is recognised that such a function requires a broad remit comprising full understanding of all forms of formal and less formal secure care in which young people from a given geographical catchment may be located. Such a service should support the prevention of admission to all secure settings when a meaningful alternative is feasible.

2.1.3 Secure mental health in-patient provision forms only a part of a range of formal secure settings for young people in England; the majority of young people in secure environments are detained either on remand or following sentence in secure youth justice settings (Young Offender Institutions, Secure Training Centres or Secure Children's Homes) or alternatively under the Children Act (1989 and 2004) on welfare grounds. 'Less formal' secure care refers to a range of other settings which are not classified as 'secure' but which may support high risk and complex young people by the provision of high levels of continual staff supervision.

2.1.4 There are currently two broadly distinguishable clinical groups of young people in secure mental in-patient provision ('forensic' and 'complex non-forensic'); such clinical groups are not necessarily mutually exclusive and there frequently is considerable overlap between them. There are three distinct forms of secure in-patient provision for young people

- **Medium secure** settings accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others (i.e. 'forensic' concerns) including those who have committed grave crimes. In such settings there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium secure settings frequently have longer durations of stay than young people in other inpatient settings.
- **Low secure** settings accommodate young people with mental and neurodevelopmental disorders (in particular learning disability and autism) at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-

forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low secure settings (as is the case for those admitted to medium secure settings) frequently have longer durations of stay than young people in other inpatient settings.

- **Psychiatric intensive care units (PICUs)** for young people allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit or where such behavioural disturbance is associated with mental health concerns in other non-mental health settings. Young people in such settings may belong to the 'forensic' or 'complex non-forensic' groups. Levels of physical, relational and procedural security in PICUs is similar to those in low security but there would be fewer facilities (e.g. educational and recreational settings) to support a young person over a sustained period of time than is the case within medium and low secure units

2.1.5 A secure outreach service needs to be familiar with the needs and differing care-pathways which exist for young people with 'forensic' and 'complex non-forensic' presentations. It is anticipated that such a service would have direct clinical involvement with the 'forensic' group who currently present particular challenges to generic local CAMHS and other services. Whilst such a service would necessarily need to understand the needs of the 'non-forensic' population and provide advice and consultation where necessary, it is envisaged that direct clinical involvement may not be required routinely as such presentations at entry into, or discharge, from secure care are more likely to fall into the day-to-day remit of existing non-secure ('Tier 4') in-patient units or community CAMHS provision. A secure outreach service needs to be flexible in its approach as many presentations do not divide neatly into 'forensic' and 'non-forensic' groups.

2.2 Service Requirements and Functions

2.2.1 The service is a tertiary referral service for CAMHS teams, CAMHS/Youth Offending Team (YOT) link workers and neurodisability services for young people and other agencies. The team will be accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education, health commissioners etc.) that may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. For this reason, initial contacts about possible referrals will be welcomed from all agencies and responses to initial contact from referrer will be made within 5 working days of receipt

The catchment for each service should be 'regional' in the sense that it covers a population and/or geographical area for a total population of about 2.5 million. It is likely that the catchments of some services working either in densely or sparsely populated areas or in areas with particularly high levels of deprivation will need to be organised accordingly.

2.2.2 Service functions include

- facilitation of smooth transitions for young people between services and agencies working with young people and between children's and adult services
- coordination of, and liaison with, mental health services across community and secure settings, and ensuring that care is provided in line with the welfare principles of the Children Act (1989 and 2004) and Code of Practice 2015 to the Mental Health Act (as amended 2007)
- specialist support for local services to enhance delivery of responsive child-centred care in high risk cases through multiagency care-planning and promotion of user engagement in care and wider service provision
- reduction and management of the potential risks posed by the young person to others and self through individualised treatment plans and clinical risk assessment and management processes; this will frequently be achieved in collaboration with other agencies
- specialist mental health assessment (including forensic assessment where appropriate, and access to timely assessment where undiagnosed learning disability or autism is suspected), Case-formulation and intervention in high risk cases where there is a need for specialist opinion to ensure that young people presenting high risk of harm to others or self are managed in the most appropriate way
- in collaboration with other agencies, where appropriate, provision of evidence-based treatment for complex high risk cases, through a wide range of interventions to address individual's mental health, welfare and educational needs
- development of joint working arrangements with CAMHS and other children's services (including community learning disability and autism services) to support the management of high risk and complex cases
- informing and developing strategic links between local provision and regional and national specialist services
- Facilitation of transition into, and out of, secure settings for young people, providing support, advice and practical input as required, follow-up of cases where young people move out of area, facilitating, where appropriate, return from secure custodial, welfare or mental health placements; the service will take a proactive role around the 'forensic' group of young people; adopting a facilitative role with less direct involvement for the 'complex challenging behaviour' group who are likely to be better known to and followed up by Tier 4 and CAMHS outreach teams
- Community intervention to prevent admission to in-patient settings where appropriate alternatives exist or where in-patient admission is unlikely to prove successful. This should include close adherence to the 'Transforming Care' agenda and engagement with the CETR process in cases of learning disability, autism or both.
- Strong emphasis on liaison with all agencies to promote working arrangements and facilitate access to mental health assessment and intervention
- Liaison and advice to youth offending teams; courts and the legal system as a resource for general advice, liaison, formal consultation and, on occasions, specialist assessment and management advice to

courts and the youth justice process (e.g.: potential for diversion, fitness to appear/plead; risk assessment in cases with clear mental health/neurodisability neurodevelopmental components, recommendations for appropriate disposal and follow-up)

- Formation of strong links with services providing mental health in-reach into youth justice or welfare secure settings within catchment and with agencies such as children's social care and education who may be placing young people with complex needs in highly supervised other settings
- Develop effective strategic partnerships, particularly with children's social care, education and the youth justice system, that successfully influence appropriate multi-agency developments to cater for other needs of complex, high risk young people (e.g. services for young people with sexually harmful behaviours, mental health in-reach to local secure welfare or custodial settings and involvement in criminal justice liaison and diversion teams).
- Identification of existing gaps in local and regional service provision and leadership in identifying remedial action.
- Provision of training to practitioners from all agencies in relation to areas within the service's specialist remit (e.g. principles of working with high risk and complexity, risk assessment and management, understanding the interface between different legislative frameworks in particular The Mental Health Act, The Mental Capacity Act, The Children Act, Education Act and SEND Reforms, and Youth Justice.)

2.3 Referrals

2.3.1 The team will seek to make itself accessible to any professional who wishes to make initial contact or enquiries regarding a young person giving cause for concern and about whom there are questions regarding his/her mental health ('the referrer').This will reduce risk of referrals not being made, delays in identification of need and potential disengagement by young people from services. The service must be sufficiently accessible at point of referral so that all cases requiring specialist input are identified. Discussion and formal consultation with referrers should be undertaken by experienced members of the team and not delegated elsewhere. There should be very clear expectation of meaningful engagement and joint working with the specialist outreach team from a child's local CAMHS team for any child referred by agencies other than CAMHS.

2.3.2 The service will have broad and inclusive criteria for initial contact with the team; flexibility should apply in some cases to age of young person depending on need and appropriateness of ongoing input beyond their eighteenth birthday. The team does not necessarily expect that a young person at referral will have a previously diagnosed mental health difficulty.

2.3.3 The referral process has been put in place to ensure

- specialist assessments and interventions are only undertaken when

absolutely necessary

- local services are supported to continue their work with identified young people and are encouraged to do this in situations where they might not have felt able to do so
- young people receive input at a level commensurate with their needs and with their potential for risk of harm to others or themselves

2.3.4 Referral Criteria are deliberately broad covering all young under 18 about whom there are questions regarding mental health or neurodevelopmental difficulties including learning disability and autism who:

- present high risk of harm towards others and about whom there is major family or professional concern
- and/or are in contact with the youth justice system
- OR about whom advice about the suitability of an appropriate secure setting is being sought because of complexity of presentation and severe, recurrent self-harm and or challenging behaviour which cannot be managed elsewhere; in such cases, where non-secure in-patient services or locality CAMHS teams are usually extensively involved, the input from the secure outreach service is likely to be advisory or consultative rather than requiring direct clinical involvement

2.3.5 Referral Process

- The referrer will undertake an initial short verbal discussion (either face to face or by phone) with a designated member of the service. The outcome of this initial discussion will result in feedback to the referrer and agreement about further action: a) no further input required (not within referral remit) or mediation of referral to more appropriate service b) referral accepted for further, more detailed formal consultation.
- If the referrer is not from a local CAMHS team and the referral is accepted for further input after an initial discussion, the secure outreach team will usually always discuss the referral with the young person's local CAMHS team. This will facilitate a clear joint approach to the referral from relevant mental health providers and, wherever possible, joint assessment and working can be undertaken.

2.3.6 Possible Referral Outcomes

Once contact has been made with the service there are a number of possible outcomes. These are as follows:

- Referral not accepted
- Referral accepted for either brief advice (including signposting/facilitation of access to more appropriate services) or more detailed formal consultation with referrer/local network regarding young person's presentation
- Formal consultation requires pre-arranged in-depth case discussion and should include prior provision of background documentary information

by the referrer. There is initial agreement that such discussion takes place on the basis that the outreach service has not had direct clinical input with the young person in question and that advice/recommendations are provided in line with general management principles.

- At the end of the formal consultation a course of action will be agreed between referrer and community forensic CAMHS secure outreach clinician. This may result in
    a. no further current input required
    b. referrer and outreach service clinician agree initial formulation and local plan of action and that direct input not immediately required; secure outreach team to keep case open and seek progress update before closing or becoming directly involved
    c. Outreach team agree to become directly clinically involved usually in conjunction with referrer.
- The forensic CAMHS outreach team will always summarise formal consultation and its agreed outcome in writing to the referrer.
- Following formal consultation referral accepted for specialist assessment and clinical input as required. This outcome requires the home team and network to remain involved with the case (e.g. by providing a care/case coordinator) and usually to participate in ongoing risk-management in conjunction with the outreach team. Following the assessment, the secure outreach team will remain involved, as appropriate, to support the local network to manage the case and to provide specific intervention. This will include in some cases facilitation of admission for secure in-patient care with relevant providers (with which the secure outreach service will be well-acquainted) and support for the referrer and local services within the formal NHS England referral process. Written feedback to referrer outlining details of assessment and recommendations will be provided to referrer and relevant others including family/carers and/or those with parental responsibility.

2.3.7 Contact with the case will not automatically end if the young person in question moves out of catchment into specialist residential, custodial, educational or secure mental health in-patient provision. Indeed, the secure outreach team may be the CAMHS team best placed to follow the young person through any out of county placement and ensure that the young person's needs continue to be met and that transition back to the home area can be facilitated.

2.4 Discharge and Care-Planning

2.4.1 Referrers will retain overall clinical responsibility for young people they refer and assume a case coordination role irrespective of level of outreach team involvement. In this way the service local to the child remains linked with the child's progress and can ensure local case management. Referring services must identify a case coordinator who will remain in contact with the case throughout the period of involvement from the specialist secure outreach team.

2.4.2 Any discharge from the service, irrespective of level of input required (whether short or longer term, consultative or involving direct clinical assessment and intervention), should be undertaken in consultation with the referrer and the child/young person and/or their parent/carer or person with parental responsibility, as appropriate.

2.4.3 The service will ensure rigorous care planning from the point of referral to discharge and ensure that meeting of need and risk management is clearly prioritised. This should take into consideration the needs and wishes of child, young person and family, and the involvement of other professionals. A copy of the discharge planning information will be given to referrers, families/carers or those with parental responsibility, general practitioners and, with the permission of the family, to any other involved professionals.

2.4.4 Children and young people may move to other services and other geographical locations. Such transitions will be planned and monitored as appropriate. This may require liaison and ongoing support for the young person from the service.

2.5 Interventions

2.5.1 Treatment of mental health and neurodevelopmental needs in high risk young people and young offenders is the same as that clearly evidenced for other young people with mental health difficulties.

2.5.2 The team is required to be competent in ensuring that such treatments are delivered when required in a wide variety of different settings and that professionals in such settings are adequately supported to do this.

2.5.3 In addition, it is necessary for the team to have wide experience of interventions or support packages which may be specifically of value in young people with offending or challenging behaviours. Whilst the team may not itself deliver such interventions, it will frequently be asked to provide clear opinion with regard to the best course of action in individual cases. Specialist knowledge of different types of residential and educational settings or the applicability of different therapeutic interventions (such as Multi-Systemic Therapy, Dialectical Behaviour Therapy, Treatment Foster Care or treatment of sexually harmful behaviours) in such situations is necessary.

2.5.4 In all situations, reasonable adjustments should be made for children and young people with learning disability, autism or both and adapted treatment programmes should be available.

2.6 Staffing

2.6.1 The secure outreach team will be multidisciplinary and will have specialist mental health and forensic experience in the assessment and treatment

needs of complex high-risk young people. In particular, the service will have specialist understanding of statutory mental health, welfare, youth justice and educational processes and understanding of the interfaces between them. It must be familiar with the needs of young people with neurodevelopmental disorders, including learning disability and autism. The emphasis should be on a small, highly experienced and active team whose members are equipped to provide authoritative specialist support to local generic networks.

2.6.2 Secure outreach Community FCAMHS team members should include combination of some of the following:

- Consultant psychiatrist (s) (wherever possible dual trained Forensic and CAMHs; otherwise clearly demonstrating the required clinical competencies formalised with a dual training)
- Senior grade clinical psychologist(s) with appropriate forensic experience
- Clinical nurse specialist/senior mental health practitioner(s) (at least Band 7)
- Other relevant specialist professionals (e.g. forensic psychologist, social worker) with appropriate experience in this area
- Dedicated team administration

2.6.3 The function of the specialist team combines support for generic child and adolescent services and specialist clinical assessment, formulation and intervention skills. The role of the consultant psychiatrist is essential given the specialist knowledge of the Mental Health Act required in this work. Psychology support is also crucial given the frequent need for structured psychometric cognitive and other psychological assessments as well as consideration of appropriate interventions. The administrator's role is central and requires a wide-range of skills and coordination of a peripatetic team.

2.6.4 Staffing levels per catchment will be determined in line with the team's core functions, catchment population and geographical size and levels of deprivation.

2.7 Co-located Services

2.7.1 Geographical colocation within existing CAMHS provision is highly advisable. This reinforces the fact that such services constitute a part of CAMHS provision and that their primary concern is to be part of an overall care pathway for children and young people with mental health or learning difficulties. Such an arrangement also facilitates access and allows meaningful feedback whilst preventing isolation of a specialist service. Premises should be available to the team to undertake clinical assessments as they are available within other CAMH services. However, it is likely that the team will need to exercise considerable flexibility to ensure that the best assessment outcome is achieved for the child and his/her family; clearly this will involve proximity to residential provision but

will require attention to the need for privacy and confidentiality and putting the young person at ease.

2.7.2 As a result, the team is likely to be peripatetic but should retain a clearly defined team base. It must provide outreach across each region/sub region and ensure that there is appropriate coverage to meet the population needs according to population density, geographical distribution and levels of deprivation. The services are to be:

- Located within providers with existing broad-based CAMHS provision
- Regionally located and provided on a network model to ensure there is consistent and equitable nationwide coverage.

2.8 Interdependence with other Services

2.8.1 Community Forensic CAMHS Secure outreach teams necessarily must be expert in liaising and establishing good working relationships with a wide variety of agencies and institutions. This is essential if they are to ensure the best outcomes for the young people with whom they have contact. The teams must be capable of advising, supporting and challenging such agencies and institutions as appropriate. At times their role in high risk cases will involve the containment of anxiety whilst at others it will involve the injection of concern where risks were hitherto poorly recognised and addressed.

2.8.2 Community FCAMHS Secure outreach teams will also provide education within the NHS and beyond to raise and maintain awareness of the needs of young people with high risk and complex presentations and needs.

2.8.3 All community FCAMHS teams secure outreach services should be adept at working across agencies and institutions operating not only locally but also at regional and national levels

2.8.4 It is expected that all community FCAMHS teams secure outreach services will actively contribute to a national clinical network (yet to be developed) which will ensure parity of provision and determination of uniform clinical standards and monitoring/evaluation. This network should also ensure continuity of provision for young people if they move between placements in different regions although it would be expected that the child's home-based service would maintain contact with the child and his/her family.

2.9 Interdependent Services

2.9.1 At National Level:

- Nationally recognised providers of specialist secure adolescent medium and low secure in-patient care for young people with mental or neurodevelopmental disorders, including learning disability or autism

- Youth justice custodial settings (Young Offender Institutions (YOIs), Secure Training Centres (STCs) or secure children's homes)
- Secure welfare settings
- Other community FCAMHS providers
- Other providers of highly specialist residential or educational care for young people

2.9.2 At Regional and Local Levels:

- Local establishments providing secure mental health or neurodisability or other inpatient care for young people or those providing other secure care on youth justice or welfare grounds
- Commissioners of CAMHS (including Learning Disability and neurodevelopmental) services
- Public health
- Senior managers in children's social care in different local authorities
- Youth justice (YOT) services and youth and crown courts
- NHS and independent providers of non-secure in-patient care
- Providers of residential care
- Providers of special education
- Police, in particular senior officers responsible for youth justice, but also teams particularly involved with young people (e.g. child abuse investigation units)
- 3rd sector organisations working with young people, particularly those who are hard to engage
- Crown Prosecution Service, in particular decision-makers in relation to youth crime
- Safeguarding leads in all organisations (e.g. named and designated professionals, local authority and education safeguarding leads)
- All services working with children and young people (e.g. CAMHS, social care, education, substance misuse, youth justice)
- Adult mental health and forensic mental health services (including those for people with neurodevelopmental difficulties, including learning disability and autism

3 Population Covered and Population Needs

3.1 Population Covered By This Specification

3.1.1 The service outlined in this specification is for young people ordinarily resident in England.

3.1.2 Specifically, the secure outreach service is commissioned to provide and deliver high quality mental health liaison, assessment and intervention for high risk young people with complex needs living within catchment (or belonging to that catchment but placed elsewhere) who meet the following criteria:

- under 18 years old at the time of referral (no lower age threshold for

access to the service although most referrals will be for 10 to 18 year olds)

- presenting with severe disorders of conduct and emotion, neuropsychological deficits, or serious mental health problems and/or neurodevelopmental disorders (including learning disability or autism) with/without learning difficulties or where there are legitimate concerns about the existence of such disorders
- usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.
- in exceptional cases, are not high risk (not primarily dangerous to others) but have highly complex needs (including legal complexities) and are causing major concern across agencies

3.2 Population Needs

3.2.1 In England in 2015 there were over 1450 young people in secure settings at any one time. Over 300 of these were in secure mental health settings; the remaining 1100 were in either welfare secure (approximately 100) or youth justice custodial settings (approximately 1000). Young people in all types of secure setting have clearly established significant mental health needs.

3.3 Expected Significant Future Demographic Changes

3.3.1 It is not known what the specific future demographic changes will be however there are significantly larger numbers of high risk young people with complex needs subject to high levels of supervision in a range of residential and special educational settings as well as in everyday community settings where needs and risk may be difficult to manage and therefore not be adequately addressed. ‘Transforming Care’ proposals sets out a requirement for dynamic registers and better understanding of local populations of children with learning disability, autism or both; such developments should feed into future developments in relation to high risk young people

3.4 Evidence Base

3.4.1 The evidence base is derived from an independent evaluation of the regional community FCAMHS service in the Thames Valley (Public Health Resource Unit, 2006) and subsequent re-evaluation of a second service replicating the service model across Hampshire and the Isle of Wight (Solutions in Public health, 2011). Both evaluations were supported by the Department of Health. A further national mapping exercise (Dent, Peto, Griffin and Hindley, 2013) identified significant disparity in provision (with many areas not having access to specialist FCAMHS) and heterogeneity of commissioning arrangements.

4 Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

4.1.1 The expected outcomes of the service support the national ambition to reduce numbers of inpatient admissions and lengths of stay; reduce variations in service availability and access and improve the experience of patients, families and carers using mental health services.

4.1.2 The expected outcome for this service include

- the provision for a specific geographical catchment of clinical consultation and specialist assessment, case formulation and interventions for young people with very complex needs across a variety of secure, custodial, residential and community settings.
- Flexibility in approach ensuring that all appropriately identified young people from the catchment receive the same quality of input and follow-up irrespective of their geographical location or the nature of their current placement
- The provision of a range of strategic, service development and training functions the maintenance of strong links with and between all agencies and services locally including children's social care, youth justice, education and third sector providers secure or specialist residential settings;
- Assessments delivered in the child's local area/current residential placement or in a setting appropriate to the child and family's needs
- Effective formulation of the needs of high risk young people with decisions on placement based on individual need rather than systemic constraints
- Appropriate access and transition to, and discharge from all forms of secure services for young people with highly complex needs.
- Admission to secure inpatient settings only undertaken when clearly indicated.
- Provision of safe, timely and effective (evidence based / best practice) assessment and intervention across the different stages of the care pathway.
- Admission of children and young people with learning disability and/or autism will be in line with 'Transforming Care' policy and 'Community Care, Education and Treatment Reviews' (CETRs) prior to any admission are actively supported
- Improved mental health and well-being by identifying and addressing the mental health needs of high risk young people in a range of secure, residential and community settings
- Minimisation of risk of harm to self and others
- An individualised, developmentally-appropriate framework of care that includes the young person and family/carers in decision making and provides for their needs.
- Principles of safe guarding children are embedded within the everyday practice of the service.
- Supplementation of local provision across agencies with specific specialist

input and case-formulation relating to the understanding and management of high risk cases
- Service accessible to all young people from an identified geographical catchment regardless of disability, sex, race, gender or current geographical location Promotion and support of young people's development
- Promotion of attachment, achievement of developmental potential, healthy family functioning and continuity of care wherever possible
- Inclusion of young people with neurodevelopmental disorders particularly learning disability and autism.

4.2 NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

4.3 Outcome indicators

The service will be subject to a formal independent evaluation after 12 months to be commissioned by NHS England; this will inform the on-going development of formal outcome measures. outcome and activity measures are subject to further development

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
101	Number of referrals received by the team.	Provider	1, 2, 3, 4, 5	safe, effective, caring, responsive
102	% of referrals	Provider	1, 2, 3, 5	safe,

		leading to indirect case involvement only.			effective, caring, responsive
	103	% of referrals that lead to direct clinical involvement	Provider	1, 2, 3, 5	safe, effective, caring, responsive
	104	% of cases with ongoing mental health involvement as part of an integrated care plan	Provider	2, 3, 4, 5	safe, effective, caring
	105	% of cases with formal indirect contact accessing feedback from referrer or other professional.	Provider	2, 3, 4	safe, effective, caring
	106	% of cases where reduced length of stay has resulted from active involvement in and facilitation of discharge from inpatient care	Provider	2,3,4,5	safe, effective, caring, responsive
	Patient Outcomes				
	201	% of cases with direct clinical contact receiving feedback	Provider	2, 3, 4	safe, effective, caring
	202	Provision of service-related information for young people and families/carers and professionals.	Provider	2, 3, 4	safe, effective, caring
	Structure & Process				
	301	Forensic MDT membership	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
	302	Service infrastructure	Self-declaration	1, 2, 3, 5	safe, effective

				responsive caring
303	Provision of cross agency training	Self-declaration	2, 3, 4, 5	Safe, effective, caring
304	There are agreed patient pathways as per the service specification.	Self-declaration	1, 3, 5	Safe, effective, caring
305	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring
306	Data collection	Self-declaration	2, 3	Safe, effective, caring

4.3.1 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.3.2 Applicable CQUIN goals are set out in Schedule 4D

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

5.1.1 The service must deliver services, comply to and work within the requirements of

- Mental Health Act 1983, as amended 2007
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 1998
- Criminal Justice Act 2003
- DoH Offender Mental Health Pathway 2005
- Mental Capacity Act 2005
- The Autism Act 2009
- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent legislation

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 The service is required to comply with the following national standards, guidance, frameworks and legislation as listed below:

- NICE guidelines for a range of disorders occurring in children and adolescents (e.g. psychosis and conduct disorder)
- National Service Framework for Children, Young People and Maternity Services (2004)
- Code of Practice: See Think Act (Department of Health 2010).
- Every Child Matters in the Health Service (DoH, 2006)
- New Horizons for Mental Health (DoH, 2009)
- DoH/YJB Information Sharing Guidance
- Future in Mind (DoH and DfE, 2014)
- Supporting people with a Learning Disability and/or Autism who Display Behaviour that Challenges, including those with a Mental Health Condition: Service Model for Commissioners of Health and Social Care Services ('Transforming Care')
- The Evidence Base to Guide Development of Tier 4 CAMHS (Department of Health; Kurtz, Z April 2009)
- Promoting mental health for children held in secure settings: a framework for commissioning services. London: DH, 2007
- Procedure for the Transfer from Custody of Children and Young People to and from Hospital under the Mental Health Act 1983 in England (DoH, June 2011)
- Information Sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, March 2015)
- UN Convention on the Rights of Persons with Disabilities
- Healthcare standards for children and young people in secure settings (2013) Intercollegiate Document (Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners, Royal College of Nursing; Royal College of Psychiatrists, Royal College of Forensic and Legal Medicine and Faculty of Public Health)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE March 2015)
- Healthy Children Safer Communities (DoH, 2009)

5.3 Other Applicable Local Standards

Not applicable

6 Designated Providers (if applicable)

Not applicable

7 Abbreviation and Acronyms Explained

7.1 The following abbreviations and acronyms have been used in this

document:

- **CAMHS** Child and Adolescent Mental Health Services
- **CCG** Clinical Commissioning Group
- **CETR** Care education and Treatment Review
- **FCAMHS** Forensic Child and Adolescent Mental Health Services
- **PICU** Psychiatric Intensive Care Unit
- **SCT** Secure Training Centre
- **SEND** Special Educational Needs and Disability
- **YOI** Young Offenders Institute
- **YOT** Youth Offending Team

Date published:

NORTH AYRSHIRE
Health and Social Care Partnership

NHS
Ayrshire & Arran

National Forensic Adolescent Service for Scotland

Benefit and Risk Workshop One

Benefits Scorecard v 1 (12 September 2017)

N°	Benefit Title	Measure
1	Having the right environment, in the right place, at the right time	• Measure reduction in time from assessment/agreement to receiving secure inpatient placement or admission to age appropriate care setting. • 85-90% reduction in the amount of cross border referrals
2	Increased contact between patients and their support system, including parents, carers and clinical teams	• Measure attendance of family and professionals at care programme approach (CPA) • Measure attendance of referring clinical team • Measure communication increase, if appropriate, with parents and carers • Increased frequency of meetings with parents and carers
3	Improved patient and family satisfaction facilitated by an improved commissioning model	• Patient and parents family structured interviews (description of family experience) • Patient Satisfaction Survey
4	Continuity of educational provision	• Qualifications attained • Wider Achievements recognised
5	Reduction in numbers of under 18 year olds being transferred cross border (English hospitals)	• 50% reduction in number of cross border transfer warrants in year one (incremental reduction year on year)

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6	Reduction in under 18 year olds in locked adult wards in Scotland	• XX% reduction of bed days in inappropriate accommodation (incremental reduction year on year) • XX% reduction in MWC ADM2 and ADM3 for young person detention, Benefit 2, reduction in inappropriate admissions • notifications to Mental Welfare Commission of admission of young person to locked adult setting • XX% reduction in the number of admissions in locked adult wards in Scotland
7	Suitability trained and skilled multidisciplinary team within a single service to efficiently and effectively meet complex needs and risks presented by this patient group	• XX% reduction of length of stay • Improved clinical outcomes
8	Ability to accurately capture/ measure clinical outcomes	• Established systems for data collection and analysis (local and national) • XX% reduction of length of stay
9	Increased ability to rehabilitate to identified placement as part of transitioning processes at discharge	• XX% reduced length of stay • Increased visits to placement to support rehabilitation • Use of suspension of detention prior to discharge (SUS)
10	Reduced number of bed days according to clinical need for patients already in secure hospitals in England	• XX% reduction in length of stay for under 18 year olds in English secure hospitals
11	Robust clinical governance framework	• Commission pathway and governance frameworks are developed
12	Clearly defined pathways for admission assessment and	• Defined pathway in keeping with ICP principals • Inclusion criteria measurement

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	through care	
13	Care delivery and restriction levels are in keeping with MILAN and GIRFEC principals and outcomes	• Measure against SHANARRI (safe, healthy, active, nurtured, achieving, respected, responsible and included) outcome (SRI 3) • Using outcomes framework to measure young persons care and restrictions within the SHANARRI indicators.
14	Improved person centredness care	• Increased choice of location of treatment • Increased continuity of culture • Improved proximity to community or origin

National Forensic Adolescent Service for Scotland
Benefit and Risk Workshop One

Risk Register v 2 as at 12 September 2017

NHS Ref N°	Risk Category	Risk Title	Risk Description (there is a risk that)	Impact Description (which if it occurs will)
1	Business Case	Failure to meet business case programme	the present target date for Initial Agreement through to Full Business Case is March 2019, this may be delayed.	delay the programme overall with consequential financial and reputational impact to the Board. There would also be a delay to commissioning the service.
2	Business Case	Addition of Learning Disabilities unit being integrated into current brief	A Learning Disabilities unit is added to the current brief, after approval of business case	Would result in the overall project having to re-submit business case, which would impact on programme, cost and design.
3	Change management	impact of organisational change nationally	as a consequence of organisational change, national stakeholders may have differing aspirations with regards to current project objectives, brief and deliverables	require increased communication with key stakeholders and may have an impact on cost and programme.
4	Change management	impact of organisational change locally	as a consequence of organisational change, local stakeholders may have differing aspirations with regards to current project objectives, brief, and deliverables	require increased communication with key local stakeholders and may have an impact on cost and programme.
5	Change management	Implementation of the Worforce Plan	the implementation of the Workforce Plan does not synchronise with the project timelines and that delivery of the Plan and any investment in staff is delayed	Appointments may not be made in time to realise the benefits of the service delivery plan and improved models of care
6	Clinical	Changes in medical technology/pharmacologal	unexpected changes in medical technology/pharmacologal could lead to change in workforce/patient services demand	require development and change in model of care and clinical workforce as appropriate
7	Clinical	Unable to agree treatment	Disagreement amongst clinicians	May lead to delays in treatment plan/ decisions and lack of clarity in care pathway
8	Clinical	Gender mix	Gender mix of patients	Females in secure setting require additional staffing requirement as a result of being more unwell and higher expressed emotions.
9	Clinical	Needs led placement	Patients unable to mix	result in challenge and restrictions for care pathway if referral opposite sex sexual offence.
10	Clinical	Seclusion	seclusion model needs further discussion	may require review of Schedule of Accommodation to include de-escalation rooms
11	Clinical	Size of facility	The size of the facility will not meet the demand.	Facility will not be able to treat the demand of young people requiring the facility in Scotland.
12	Clinical	Qualified teaching staff	unable to recruit a team of appropriately qualified teaching staff who can offer a curriculum which has both breadth and depth.	Facility would be unable to provide the teaching opportunities aspired to. Staff would need to have a unique set of skills, resilience etc to work in such an environment.
13	Communications	Clinical engagement during design and briefing phase	National stakeholder engagement during design stage does not fully embed current clinical and design functionality	Facility is designed that will not meet the needs of the service users.
14	Communications	Stakeholder involvement and enagement	The various stakeholders involved in the project do not effectively engage and interact with one another during business case and design	create disharmony and have the potential to delay reaching agreement on key issues, which may impact on the programme, cost and design. Benefits realisation may be impacted.
15	Communications	Effective Communication Plan	there is a lack of effective communication with stakeholders including the public	alienate stakeholders and create lack of ownership of the project.
16	Communications	Lack of engagement with supporting stakeholders e.g. Infection Control, H&S etc.	good practices with regards to infection control, H&S, etc. are not incorporated in the design and specs	Proper standards are not established with possible cost implications to subsequently rectify.
17	Communications	Contradictory aspirations of stakeholders	stakeholders may have contradictory aspirations with regards to project objectives and deliverables	challenge the premise on which the clinical and contract requirements have been prepared.
18	Construction	Continuity of existing services	existing services and utilities are disrupted during construction work	impact on Ayrshire Central site clinical and support service provision
19	Construction	Healthcare Associated Infection (HAI SCRIBE)	Control of Healthcare Acquired Infection during build	Impact on vulnerable patients and consequences of operational shutdowns.
20	Construction	Force Majeure	a Force majeure may occur outwith the control of NHS A&A	jeopardise the project and/or cause significant cost and service delivery implications

National Forensic Adolescent Service for Scotland
Benefit and Risk Workshop One

Risk Register v 2 as at 12 September 2017

NHS Ref N°	Risk Category	Risk Title	Risk Description (there is a risk that)	Impact Description (which if it occurs will)
21	Construction	Impact of Site Masterplanning exercise	The main project programme/works is disrupted by interdependent projects taking place on site. E.g. Land disposal programme	have the potential to impact on the project on site with possible cost implications
22	Construction	Limited capacity of utilities services for new facility	the capacity of utility services, gas, electric, drainage, adjacent to the hospital site could be insufficient to take the required capacity of the new facility	require the utilities companies to increase their capacity, which could impose cost and time implications on the project
23	Construction	Failure to comply with NHS Standards (HTM, BN etc)	the project may fail to comply with changes to NHS Standards	possibly require alterations to be made to the building to achieve compliance
24	Construction	Latent defects	the new build could suffer Latent defects	result in considerable disruption to clinical services while the latent defect is rectified
25	Construction	Legal rights of third parties on/or adjacent to site	existing legal rights of third parties on or adjacent to the site may require resolution.	result in agreement being required to the legal title with possible delays as a consequence
26	Construction	Early completion	the contractor offers an earlier completion date to the current programme	require the clinical team to review workforce plans.
27	Construction	Surplus land usage	potential sites for new development may be reallocated in the Boards overall land disposal/usage strategy	will result in the development not being able to be located in the preferred area
28	Construction	Enabling works including any potential demolitions do not take place	if enabling works and demolition do not take place this may result in the development being relocated or delayed	Result in the development being relocated to another location on the site. Worst case scenario would be relocation to another site outwith Ayrshire Central Hospital land
29	Construction	Unforeseen or unidentified services	unforeseen or unidentified services are discovered on site when construction work starts	require the services to be identified and diverted as necessary leading to a delay to the works programme
30	Construction	Authorities Construction Requirements (ACR's) are not robust	the ACR's may not effectively describe the requirements of the Authority	construction partner may provide a design/facility that does not meet the clinical functionality.
31	Construction	Red Burn Culvert, planning condition	This Planning Condition although removed from previous project may remain an obligation on NHS A&A.	Have potential patient safety risk issues and be a potential burden on the land marked for disposal.
32	Construction	Failure to comply with Statutory Legislations and Standards	the design of the project may fail to comply with changes to Legislation/Standards - DDA/Equality Act 2010.	be a Board risk up to FBC at which time the risk will transfer to te Contractor. This risk also relates to a change in building Legislation/standards (Part 6)
33	Construction	Protected species found on potential building site	protected species could be discovered in building site	has the potential to delay the works with subsequent cost and programme implications
34	Construction	Construction site inadequately secured.	The construction site is accessible to patients and local residents.	allow access to heavy construction machinery and equipment which could cause harm or damage.
35	Construction	Discovery of Asbestos	Asbestos is discovered in the construction site	have the potential to delay the works
36	Construction	Unstable ground conditions	ground conditions on site are unstable	possibly require robust foundations to be designed (ie use of piled solution). This may result in cost higher implications.
37	Construction	Changes to Legislation/Standards	changes to construction Legislation or building standards may impact on the project	require an assessment of impact at the point the change comes into effect.
38	Construction	Delay in achieving Statutory Approvals	Planning approval may be delayed	result in a delay in Statutory Approvals for the programme and may impact on the programme milestones
39	Design	Specific Clinical Requirements do not reflect current clinical need	The clinical specification - Specific Clinical Requirements - do not properly describe current clinical model of care	provide a facility that does not meet the operational needs of the service in the short and longer term or the flexibility that the service requires.
40	Design	Change in project scope after FBC	there is a change in the Authorities requirements in the project after FBC and therefore not allowed for in the final cost assessment.	carry financial and possible programme delays.
41	Design	Failure to consider an Art Strategy	an Arts Strategy is not considered during the business case process.	result in lack of a coherent Arts Strategy and late introduction of arts into the project.
42	Design	Patient arrival and discharge points	Patient arrival and discharge routes are not well designed to separate traffic flows leading to unsafe movement of patients and interface with staff/patients/public.	result in a lack of dignity and incur a risk of injury to staff/patients/public
43	Design	Introduction of Derogations	derogations to the Authorities requirements are introduced during tender and construction phase	introduce components or specifications that may not be fit for purpose and are contrary to the stated requirements

National Forensic Adolescent Service for Scotland
Benefit and Risk Workshop One

Risk Register v 2 as at 12 September 2017

NHS Ref N°	Risk Category	Risk Title	Risk Description (there is a risk that)	Impact Description (which if it occurs will)
44	Design	Change in project scope - enforced design changes	external influences specific to NHS e.g. National Services Scotland or Architecture and Design Scotland may require changes to the design assumptions	impact on the programme with consequential cost implications
45	Design	Increase in referral rates	there is an increase in referral rates	require the facilities to be flexible to accommodate change to scope.
46	Design	Accuracy of Schedule of accommodation is insufficient or excessive	the Schedule of Accommodation has areas that prove to be excessive or insufficient	result in a change of scope with increased costs and delays. Result in increased capital and revenue costs and capital charges.
47	Funding	Scottish Government fail to fund the project	the project does not go ahead.	impact service users would continue to be treated outwith Scotland.
48	Funding	Clinical Support Services staff revenue assumptions are incorrect	the staffing figures in the business case may not be sufficient to carry out services to a proper standard	provide an inadequate service with risk of infection and/or increased costs to maintain standards.
49	Funding	Funding of enabling and demolition works	the there is no funding available for enabling works.	require the Board to commit funding for enabling works prior to full project approval.
50	Funding	Provision of an adequate contingency allowance during construction	the Board may fail to include adequate contingencies to cover eventualities e.g. Enabling works, changes to specs, failure to meet key dates/approvals etc.)	generate unexpected and unforeseen costs
51	Funding	Equipment budget is inadequate	The capital allowance made for equipment may be inadequate	Require additional funding. Robust equipment plan to be developed.
52	Funding	Financial impact of Planning conditions	The Planning Conditions may place obligations on the Authority and Contractor that were not originally envisaged.	Place cost pressures on the project and could risk dispute with Authority or North Ayrshire Council (NAC).
53	Funding	Increased revenue to regional boards to provide clinical services	The revenue cost of providing clinical services may be greater than expected for regional boards.	will require extensive stakeholder engagement to make sure that regional boards fully understand the revenue implications of the service provided.
54	Funding	Increased costs - capital or revenue	financial parameters as determined in the business case approval (Capital, Revenue, WLC), are exceeded	result in increased revenue and capital costs to all regional boards through NRAC contributions (National Resource Allocation Committee) and reputational damage.
55	Funding	Reduction in revenue funding for workforce	revenue funding is reduced	result in reduced workforce and will require replanning of staff complement.
56	Funding	Further VAT rate increase	there is an increase in VAT rate beyond 20% .	increase the project costs
57	Political	Political agenda/commitment may change	a change in political policies, e.g. A move away from a national service and provision on a regional/local basis will result in abortive time and costs	require a re-assessment of the options available, affordability etc. leading at the very least to a project delay and additional cost.
58	Political	Political influences affect project	The project may be impacted upon due to political elections e.g. A purdah period is introduced	Have the potential to delay the project with possible cost consequences, impacting on business case approval.
59	Political	National support for the service diminishes	National support for the service diminishes	jeopardise the basis of the project leading to uncertainty and delay with cost implications
60	Resources	Project Team Resources - loss of key individuals	key personnel may leave, and jeopardise the process of project delivery	create risk to the project in terms of knowledge transfer, possible delay, and consequential cost impact

Forensic Adolescent Mental Health Service (CAMHS)

Service Specification

1. Introduction

National Services Division (NSD), an operating division of the Procurement, Commissioning and Facilities SBU (PCF), within NHS National Services Scotland (NSS), has been asked by NSSC / SGHSC to identify an NHS Board to provide a new nationally designated service.

The Scottish Secure Forensic Mental Health service for young people (SSFMHSYP) would admit adolescents who are liable for detention for assessment or treatment of mental disorder under relevant sections of Mental Health (Care & Treatment) (Scotland) Act 2003, or Criminal Procedure (Scotland) Act 1995 and whose risk of harming others is beyond that which can be provided by other mental health services.

SSFMHSYP will provide for a population of young people whose complexity of presentation and severity of risk is set within a context of challenging legislative frameworks and systems. The challenges and complexities of working with these young people require a level of expertise that is, unfortunately, not widely available in the UK.

The aim is to return these young people to community services following therapeutic intervention but by definition, the risk of harm renders these young people outwith the scope of community services, at the time of need to admit.

Key roles for the national inpatient service are:

- Assessments of suitability for admission to adolescent medium secure care;
- Establish and maintain links with key stakeholder organisations and referrers to ensure a robust referral pathway and provide admission within specified timeframes
- Specialist forensic inpatient assessments of young people referred from other specialist mental health services
- Coordination of a national referral system

- Provision of a wide range of clinical and forensic interventions, to address young people's mental health and criminogenic needs within medium security;

- Actively engage young people's local health, care and education services and agencies in planning and delivering assessment and treatment as appropriate. In particular, local services would be supported to provide family work and other therapies best delivered in the community of origin

- Work with young people's local services and agencies to identify the most appropriate discharge pathway and support a smooth transition into the community or other inpatient service ;

- Delivery of responsive individualised care through the use of Care Programme Approach (CPA) framework

- Promote user engagement and family involvement in their care:

- Promote service user engagement and involvement to enhance service delivery and development;

- Promote best practice in the field of Adolescent Forensic Mental Health through teaching, research and service development;

- Delivery of high quality care and treatment within the appropriate legislative framework and a robust governance framework

- Ensure that, in all its functions, as the unit relates to its own patients, and other children, that special care is taken of the welfare of under 18's - in accordance with the United Nations Rights of the Child, as enshrined in the principles of the Mental Health (Care and Treatment)(Scotland) Act 2003 and Children and Young People (Scotland) Act 2014

- Provide a safe, secure, therapeutic environment which is the least restrictive necessary to ensure the welfare of patients, staff and visitors.

2. Context

There is currently no Secure Forensic Adolescent Inpatient service for young people in Scotland. Where adolescents require access to such an inpatient service the current requirement is to access services based in England via the Scottish National Services Division contract for access to these services within English based units.

However reliance on access to English services can be problematic:

- There are often significant delays whilst awaiting transfer to a unit outwith Scotland due to legal processes and constraints on national bed availability

- In cases where the Scottish legislative framework does not permit a patient to leave Scotland – for example, if they are awaiting criminal trial or have successfully appealed transfer across the Border

- Issues of distance, and differing educational syllabus can fragment care and education and mitigate continuity of family and carer connections

Two Scottish Government reports (2009 & 2014) have previously proposed the development of a Scottish Inpatient Service of between 8-12 beds.

The assessed need is for an 8-12 bed Inpatient service which responds to the needs of 3 main care groups:

- Mental health
- Learning disabilities
- Autistic Spectrum Disorder

Delivery of a service to each of the above care groups requires a staff group with competencies to respond to the needs of each of the care groups, and provision of distinct & discrete areas within the layout of the building to provide treatment. Additionally this layout enables a degree of flexibility to facilitate separation of individuals who present risk for others with particular vulnerabilities.

This service specification requires a flexible design layout within an overall 12 bedded unit: potentially 3 pods of 4 single rooms. The internal design of the unit would need to factor in flexibility in the deployment of beds and day areas within each of the pods to maximise flexibility in responding to fluctuating demand, gender and care group needs, & risk and vulnerability mix.

In broad terms staffing levels for a unit of 3 pods will not be significantly different whether the unit is operating at 6 beds or 12 beds as minimum levels of staff for 24/7 cover are unlikely to vary significantly within the range of 6-12 beds.

In order to ensure wider staffing support and back up (particularly nursing) in the event of emergency situations within the unit, the unit would need to be located on a Mental Health inpatient campus. In terms of the competencies of the wider staffing group on a hospital site the working group saw these coming from adult forensic services in the first instance, and CAMHS Adolescent inpatient services in the second instance.

3. Aims and objectives of service

Aims:

- To maximise the adolescent development, mental health, well being and social inclusion of patients with severe mental disorder through optimal clinical management and support;

- To gain an understanding of risk and its management to allow an appropriate and safe care pathway following discharge.

Objectives:

- To provide an exemplary and comprehensive service for all eligible referred young people with severe mental disorder who present a significant risk to others
- Provide specialist multidisciplinary assessment, diagnosis, management and treatment of severe mental disorder;
- To provide specialist multi-professional assessments on the link between mental disorder and offending in young people;
- To operate within a robust clinical governance framework;
- To provide an individualised, developmentally appropriate framework of care that provides for the needs of the young person and their families;
- To be seen as national leaders in the provision of adolescent secure forensic mental health services;
- To provide high quality information for patients, families and carers in appropriate and accessible formats and mediums.

4. Service description/care pathway

4.1 Treatments

The national service will work with community agencies to provide evidence-based treatment for young people throughout their inpatient stay and ensures that there is an effective, safe, and timely discharge to local services as appropriate. The service will provide the following:

- Person centred individualised evidence based treatment packages, based upon assessment of need and risk;
- Physical and mental health care that meets the needs of young people;
- Admission under relevant provisions of the Mental Health (Care and Treatment)
- (Scotland) Act 2003 or Criminal Procedure (Scotland) Act 1995
- Utilisation of the Care Programme Approach involving patient, referrers, family, carers and other relevant stakeholders;
- Comprehensive risk assessment and management;
- An extensive range of therapeutic, educational, occupational and recreational opportunities ;
- A secure environment where patients can address their problems in safety and with dignity;
- On-going assessment, which meets the needs of patients through their transition to discharge;
- A multidisciplinary approach to the provision of patient care;
- Provision of care in line with welfare principles from the Children (Scotland) Act
- 1995, the Mental Health (Care and Treatment) Scotland Act 2003, and other
- Relevant policy and legislation
- Effective, safe, and timely discharge;
- Specialist professional advice to referrers and other agencies;
- The provision of appropriate educational services
- The provision of an activities programme during periods where education is not provided (minimum of 25 hours of meaningful activities per week).

The competencies that are particularly needed to meet the needs of young people with a behavioural disorder are:

- A comprehensive Multi-Disciplinary Team (MDT) with a basic staffing of suitably trained and qualified psychiatry, psychology, social work and nursing (stable and experienced with an ability to sustain management of security and therapy delivery). Staff will be trained in developmentally appropriate approaches to the management of aggression in the unit.

This MDT will deliver:

- A robust process of assessment and risk management using theory and practice informed by best available evidence
- A therapeutic regime that places primary importance to behavioural and social learning approaches.
- The therapeutic milieu should have a capacity to effectively deliver interventions for protracted periods of time and should show a level of resilience capable of dealing with chronic challenging young people with past significant adversity. It should also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients;
- The interventions require robust evaluation and should evidence its outcomes in behavioural, emotional and cognitive terms.
- an environment which meets best practice for safety, welfare and security and adherence to adolescent medium secure care standards with respect to relational, procedural and physical security.

4.2 Governance

The service will be required to complete regular annual audits demonstrating the degree to which security within the unit is maintained and reviewed. The service will provide regular reports to NHS Scotland.

Equally, the service is expected to review all serious incidents (SI) and report to NHS Scotland and the Mental Welfare Commission within 24 hours of the SI.

The provider will work with NHS Scotland to ensure that there are robust governance arrangements in place with regard to communication and information governance.

All communication should aim to allow the young person to access information about their care in a way that is meaningful for them and also to enable them to provide feedback about their care. Information should be given to the young person about the unit they are referred to prior to admission. All information and feedback from service users should contribute towards future service development.

The service is expected to ensure robust systems are in place to gather patient feedback to include information on:

- Social group in wards;
- Therapeutic intervention programmes;
- Discharge questionnaires;
- Patients self-report on care and treatment;
- Families' experience of their child's care

The above is not meant to be an exhaustive list of patient feedback but rather the minimum necessary.

Patient's access to independent advocacy services is to be ensured.

The delivery of services within SSFMHSYP includes child welfare, clinical, educational and vocational services. The provision of clinical services is made by a wide variety of professionals with background in specialist mental health services. Clinicians would develop their expertise within the SSFMHSYP which will therefore promote a thorough clinical governance agenda for training, research and supervision of all staff.

4.3 Care Pathway

The service will provide safe and effective clinical care across the different stages of the following care pathway:

1. Initial referral;
2. Initial assessment;
3. Pre-admission;
4. Admission;
5. Treatment programmes/CPA process;
6. Discharge;
7. Transition into appropriate aftercare.

It is very important that local service involvement is maintained throughout individual young person's admission and transfer. This will be maintained through effective communication and attendance at clinical reviews, including local health and social work professionals, especially the referring RMO, clinical case manager and Mental Health Officer

4.3.1 Referral Process

Young people are referred from other specialist mental health services following an initial assessment from that service.

If the young person is deemed to have met the criteria for assessment by the SSFMHSYP, an initial assessment will be carried out.

4.3.2 Initial Assessment

Ideally this should be a multidisciplinary team assessment with a minimum of a psychiatrist and nurse involved. Following the assessment, the Service will give an opinion as to whether the young person fulfils the criteria for admission to their Service. The initial assessment should be completed within 14 days of receiving the referral. If the young person does not meet the criteria for admission to the SSFMHSYP, a full assessment report will be provided and an alternative option be suggested where appropriate.

4.3.3 Pre-admission

The referrer will be informed whether or not the patient has been accepted for admission and, if the referral has been accepted, the arrangements for admission will be jointly agreed by the referring agency and the SSFMHSYP: This communication will be undertaken verbally initially and followed by a full written report:

- Non-urgent is defined as where healthcare professionals consider and agree that there is a stable risk of significant harm;
- Urgent is defined as where healthcare professionals consider and agree that there is a significant risk that an emergency may arise;
- Emergency is defined as where healthcare professionals consider and agree that there is an unmanageable risk of serious harm.

The SSFMHSYP will give information about their unit and services offered to the young person prior to admission.

4.3.4 Admission

Admission to the national service should take place within a reasonable time period following decision to admit:

- Transfer of patients or young offenders will be in accordance with relevant procedures.
- Emergency “out of hours” admissions will only take place when absolutely necessary
- All patients admitted should have a designated Health Board and Health & Social Care Partnership who will maintain responsibility for ongoing aftercare of the patient.

The referring RMO and community case manager will be updated on patient’s progress during the assessment period and are expected to remain involved with the young person’s care:

- Initial treatment plan needs to be agreed within first 7 days of admission and reviewed on a regular basis thereafter;
- Young people should have weekly multidisciplinary inpatient reviews and full CPA reviews at least six monthly

4.3.5 Treatment and CPA

The inpatient centre will operate 24 hours a day, 365 days per year and will provide care that meets the following standards in delivering the national service:

- All patient will have their own bedroom;
- Every patient will have a Responsible Medical Officer;
- The nursing model of care will be based on the 'primary nurse' model, where every patient will have a named nurse who will be responsible for their day to day nursing needs. The patient will also have an allocated care co-ordinator, who will co-ordinate the care for the individual within the CPA framework;
- The overall model of care will be through a MDT approach consisting of medical staff, nurses, psychologists, occupational therapists and social workers

Each patient will:

- Be reviewed by the MDT at least weekly;
- Have an up to date MDT care plan that has been consulted and communicated with the patient;
- Have a named psychologist who will undertake a risk and needs based assessment to identify the appropriate psychological treatment programme on either an individual or group basis;
- Have a named Occupational Therapist who will undertake a full Occupational Therapy assessment and will deliver an appropriate programme;
- Maintain links with their referring service who will provide ongoing care, family work and other interventions as appropriate within the community of origin have access to independent mental health advocacy and legal advice
- Receive three culturally and nutritionally appropriate meals per day.
- The cultural needs of patients will be catered for;
- Have their rights under the Mental Health (Care and Treatment) (Scotland) Act 2003 explained.

Interventions will be provided in structured days across three domains:

- **Leisure:** activities provided on and off the ward such as art, music, gym, sports and group games

- **Education**: All young people are encouraged to attend the unit school to improve their educational attainment.

- **Therapeutic interventions**:
  - Formal assessment and monitoring of mental state;
  - Assessment of clinical risks and development of management

plans;

- Management of physical health care;
- Prescribing and monitoring of drugs and their side effects in line with
- Relevant guidance;
- Range of psychological therapies (both group and individual)
- Specific offence reduction programmes if indicated
- Family therapy/work
- Occupational therapy;
- Health promotion (physical & mental health) and relapse prevention;
- Other therapeutic interventions that may include music therapy and art therapy.

Vocational work activities may also be appropriate. The Secure Forensic Inpatient Service for Young People will require educational input based in the unit using the wider day spaces within the unit. The statutory responsibility for education provision to the Unit lies with the relevant education authorities and there should be no funding implication to the NHS per se, albeit the detailed provision would need to be negotiated with Education Authorities. This issue has been raised with Scottish Government in the context that this would be a national service and should not rely on a series of individual patient interactions to achieve effective educational provision.

4.3.6 Discharge

Young people are to be supported to play an active part in their discharge planning and would normally be discharged into the following settings:

- Family home, open residential settings or secure care with input from community CAMHS or adult community mental health services;
- Open adolescent or adult inpatient services
- Adult low, medium or high secure services where appropriate.

Providers are required to actively involve the local and originating Local Authorities to enable them to honour their statutory responsibility in support all young people's discharge into appropriate accommodation.

5. Key Service Outcomes

Performance Indicators:

- % number of patients who have 25 hours of meaningful activities per month
- Number of consecutive days without reported incidences of aggression
- Proportion of shifts covered using bank or agency staff
- No of incidents of aggression/restraint involving 3 or more staff
- Number of incidents of attempted and actual absconding
- Number of incidents of self-harm requiring medical intervention
- Total incidents of aggression against objects (property damage above £100 etc.)

Outcomes Indicators:

- Improvement in global functioning – Health of the Nation Outcome Scales for Children and Adolescents (HoNOS-CA)
- Improvement in global functioning - Health of the Nation Outcome Scale for Users of Secure and Forensic Services (HoNOS-Secure)
- Improvement in function and development - Children's Global Assessment Scale (CGAS)
- Strength & Difficulties Questionnaire (SDQ)
- Educational attainment & attendance

6. Location

The national service comprises of one NHS provided designated centre providing medium secure adolescent inpatient services for a mixed gender population of young people that have medium secure needs for assessment and treatment of developmental mental disorder.

In order to ensure wider staffing support and back up (particularly nursing) in the event of emergency situations within the unit, the unit would need to be located on a Mental Health inpatient campus. In terms of the competencies of the wider staffing group on a hospital site the working group saw these coming from adult forensic services in the first instance, and CAMHS Adolescent inpatient services in the second instance.

These competency requirements would suggest a hierarchy of preferred collocation requirements as follows:

- Co-location on hospital site with both adult secure psychiatric service and CAMHS adolescent inpatient service
- Co-location on hospital site with adult Secure psychiatric service
- Co-location on a site with CAMHs adolescent service only
- Co-location on a site with adult psychiatric inpatient services

NSD
January 2016

Ryder

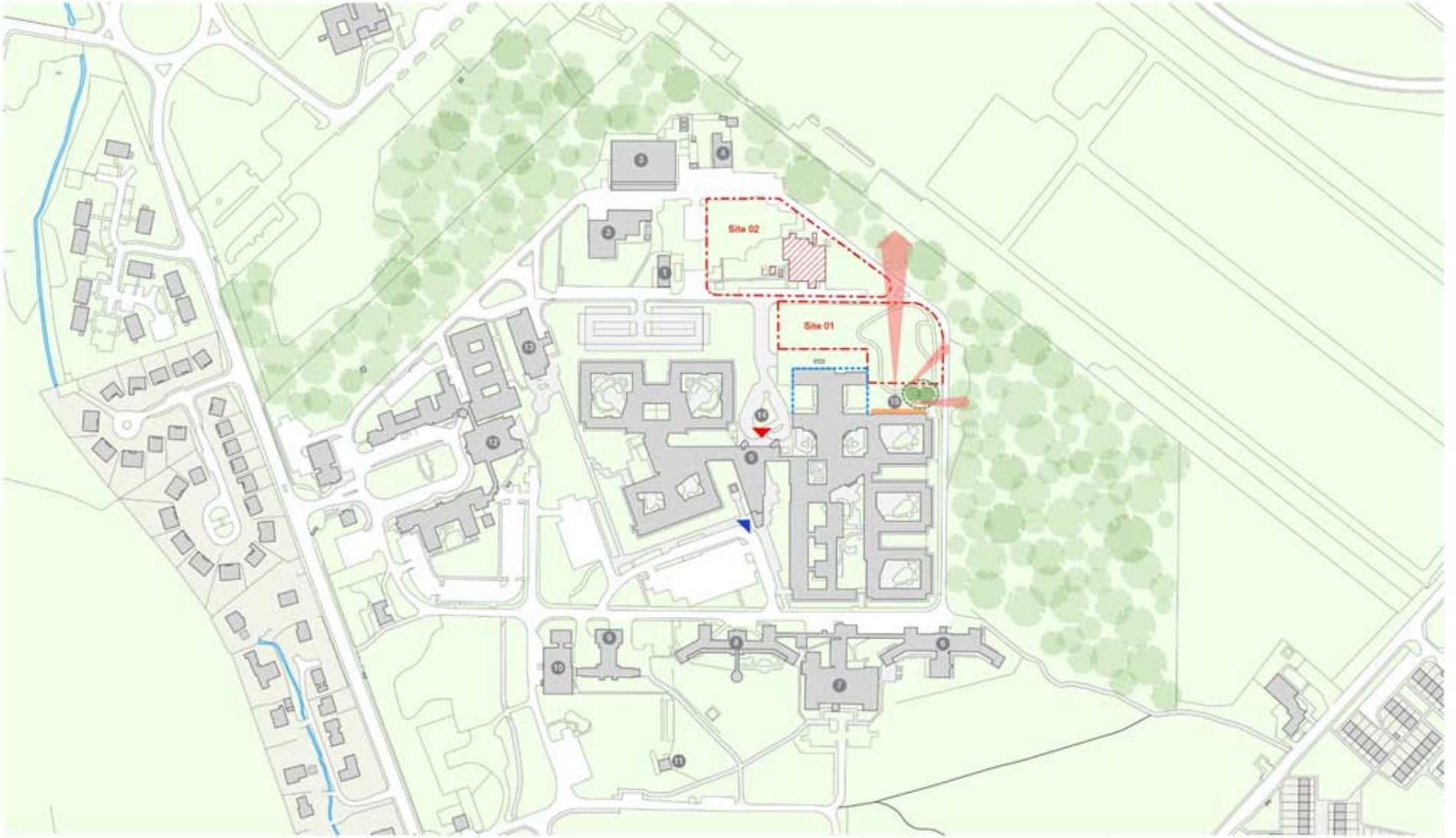
National Forensic Adolescent Service for Scotland (NFASS) Unit at Ayrshire Central Hospital
NHS Ayrshire and Arran

Site Feasibility Study

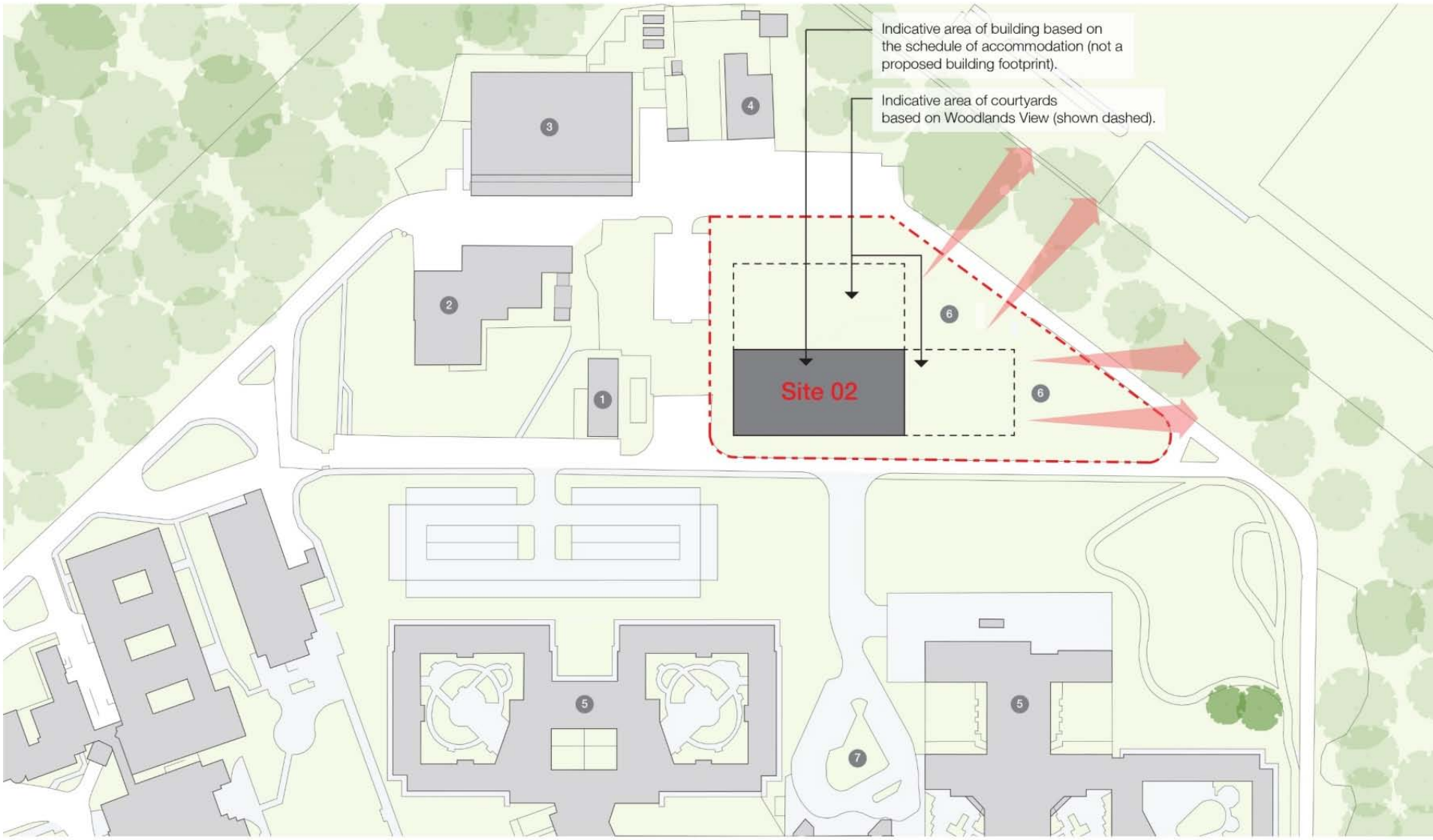
Draft Accommodation Schedule

Room Name	No of Rooms	Area (sqm)	Total (sqm)	Comments
Entrance Lobby	1	6.5	6.5	
Waiting Area	1	18	18	Increased from 9 - 18sqm
AWC	1	5.5	5.5	
Reception	1	12	12	
Air Lock	2	5	10	
Interview Room	1	12	12	Increased from 9 - 12sqm
Staff WC	2	2.5	5	Increased from 1 Staff WC to 2
Multi Disciplinary	1	20	20	
Dirty Utility	1	8	8	
Linen	1	4	4	
SCN Office	1	10.5	10.5	
Kitchen	1	20	20	
Pantry	1	15	15	Staff or patient?
Duty Room	1	10	10	
Staff Base	1	9	9	
Social / Activity / Dining	1	40	40	
Fitness Suite	1	24	24	
Personal Goods	1	8	8	
Special Care Area	1	8	8	
DB Cupboard	1	2	2	
Large Bedroom with En-suite	2	23	46	
Bedroom with En-suite	10	21	210	Increased by 1sqm to match bedroom sizes of Woodland View
Assisted Bathroom	1	16	16	Increased by 1sqm
Personal Laundry	1	11	11	
Sitting Area	1	12	12	
Lobby	1	3.7	3.7	
DSR	1	10	10	
Store	1	10	10	Distributed
Patient WC	1	2.5	2.5	
Clean Utility	1	13.5	13.5	
Touch Down Base	3	2	6	
Engineering (Service Zone)	7	2.5	17.5	Bedroom ensuite service access spaces
Courtyard	2	0	0	
Consulting Room	2	12	24	
Group Therapy Room	2	40	80	
Store	2	5	10	
Staff Base (for 6)	1	30	30	Reduced to 30sqm
AWC	1	5.5	5.5	
Staff Change and Rest	1	30	30	Staff numbers to be confirmed
DSR	1	10	10	
DB Cupboard	1	2	2	
Wait	2	9	18	
Staff WC	2	2.5	5	
Disposal / Hold	1	10	10	
Plant Room				Area to be confirmed - meantime included within engineering percentage
Total NET Area			**830.2**	
Circulation (35%)			290.57	
Engineering (10%)			83.02	
Partitions (5%)			41.51	
Total			**1245.3**	

Site Analysis



Site 02



N

0 5 10 20 50m

Note: This site has space for additional accommodation either built at the same time or as a later extension (all single storey).

Windowless/Hard Boundary
Feature Trees to be Maintained
Site Boundary
Mature Trees

1 Sub Station 1
2 Supplies
3 Central Decontamination Unit
4 Workshops
5 Woodland View
6 Views toward wooded area
7 Secure entrance to Woodland View

10.0
Precedents


Stratheden Hospital IPCU

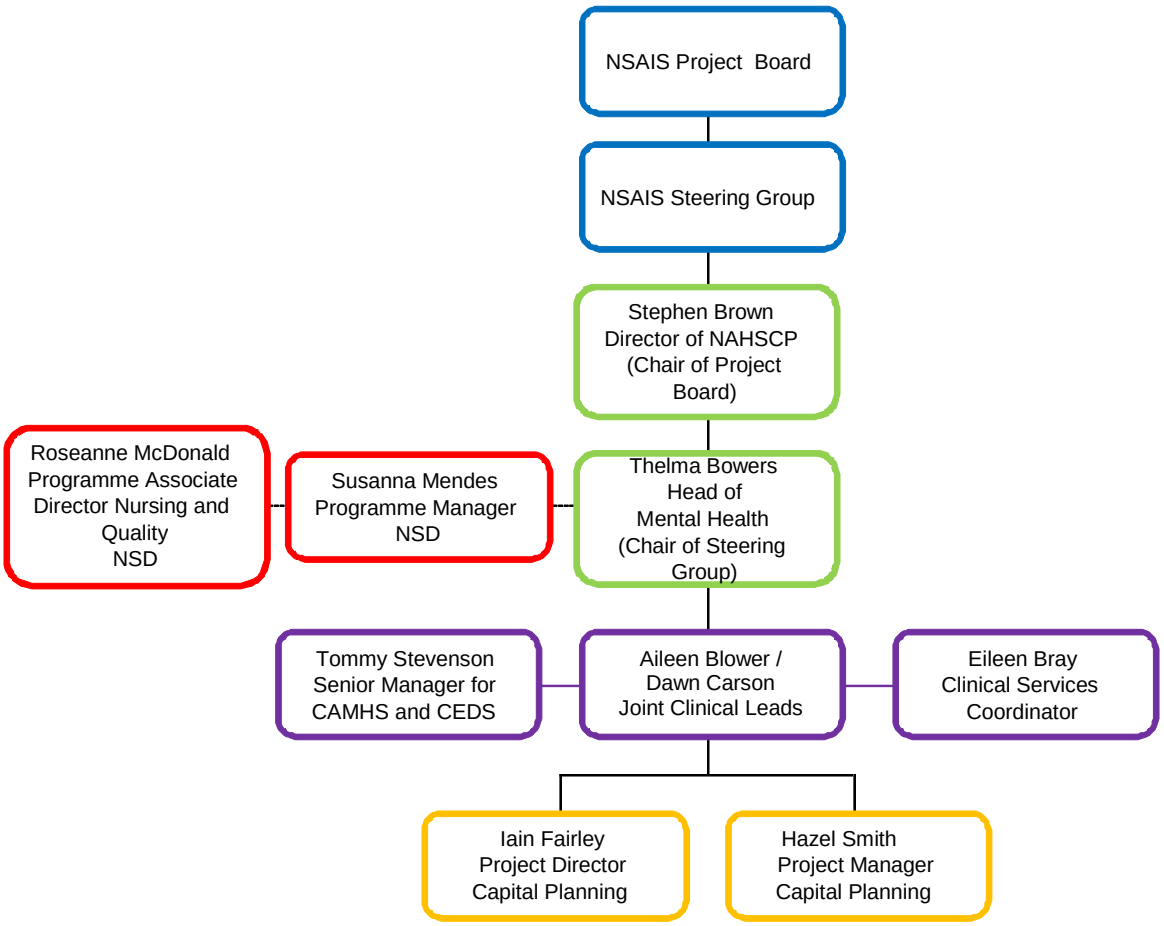

Stratheden Hospital IPCU


Child Care Facility


Rothschild Foundation


Woodland
View

The diagram below shows the project team responsible for the delivery of the National Secure Adolescent Inpatient service. The following pages capture their experience.



Stephen Brown

Job Title: Director of North Ayrshire Health and Social Care Partnership

Chair: Project Board – National Secure Adolescent Inpatient Service

Background: Stephen is a social worker who took up his first post in the City Centre Team in Glasgow at the age of 23. He has spent his entire career since then within the public sector.

He joined North Ayrshire Council as a Senior Social Worker in 1999 and has been a Local Manager, Reception Services Manager and Senior Manager within Children and Families Services throughout that time.

With the establishment of the North Ayrshire Health and Social Care Partnership in 2014, he was appointed Head of Service for Children, Families and Criminal Justice and also became Chief Social Work Officer to the Council.

In April of this year, he was appointed as Interim Director of the Health and Social Care Partnership and Chief Officer to the Integration Joint Board.

In his role as Lead Health Care Director / Senior Responsible Owner (SRO) he is the Chair for the National Secure Adolescent Inpatient Service Project Board. He primarily responsibility is for ensuring that the project delivers the specified clinical benefits, to the required quality, cost and time.

Roseanne McDonald

Job Title: **Programme Associate Director Nursing and Quality NSD**

Reports to: Project Board - National Secure Adolescent Inpatient Service
National Specialist Services Committee (NSSC)

Background: Roseanne is the Programme Associate, she is responsible for the effective commissioning of a range of national programmes including specialist paediatrics, solid organ transplantation, mental health and specialist adult cardiac.

As the NSD Senior Nurse, her remit is to oversee the quality framework within the NSD Commissioning framework, she has a keen interest in benchmarking and developing quality outcomes.

The development of new national services for designation is a key and challenging focus of her role. This involves engaging with a range of stakeholders to understand the population needs and evidence base for new clinical pathways.

Susannah Mendes

Job Title: **Programme Manager NSD**

Reports to: Steering Group - National Secure Adolescent Inpatient Service

Background: In her role as Programme Manager she is responsible for the commissioning arrangements, performance, and quality management of several specialist services across Scotland.

Her previous experience includes working in Mental Health Planning in NHSGG&C and involvement in Programme Managing Capital initiatives, taking them through the Scottish Capital Investment Group (SCIG) process.

Thelma Bowers

Job Title: **Head of Mental Health Service**
North Ayrshire Health & Social Care Partnership

Chair: Steering Group - National Secure Adolescent Inpatient Service

Reports to: Project Board - National Secure Adolescent Inpatient Service
Mental Health Change Programme Board
NAHSCP Change Steering Group

Thelma is a Learning disability nurse behaviour specialist by background and joined the NHS in England in 1989, working across mental health, Learning disability and children's services in Birmingham and the Black Country in strategic management and service development roles before moving to Scotland. Thelma was appointed to the lead Partnership role of Head of Mental Health on 1st April 2015.

In her role as Head of Mental Health Services, she is responsible for the strategic planning and delivery of strategic priorities for mental health services across Ayrshire and Arran. This includes improving services available to support mental health and well being, ensuring effective implementation of the Mental Health Strategy for Scotland, developing new services and re-designing existing services. An integral part of this is the development of Woodland View which will ensure the provision of modern, purpose built facilities to meet local needs with a focus on recovery focused interventions.

Thelma was a member of the Woodland View Programme Board and Workforce subgroup. She also chairs the North Ayrshire Health and Social Care Partnership (NAHSCP) Mental Health Change Programme Board and is a member of the NAHSCP Change Steering Group into which the progress and exceptions from the Woodland Programme Board were reported.

Aileen Blower

Job Title: **Clinical Director / Designated Clinical Lead for Project**

Reports to: Project Board - National Secure Adolescent Inpatient Service (NSAIS)
Steering Group – NSAIS
Scottish Government (SG) Mental Health & Protection of Rights Division (Action 20, Mental Health Strategy 17-27)
SG CAMHS Lead Clinicians Group
SG Secure Care Strategic Board
SG Children & Young People's Support Group
Speciality Advisor in Child Psychiatry to Chief Medical Officer for Scotland

Background: In her role as Clinical Director for CAMHS, Aileen Blower is responsible for ensuring quality of care delivered to patients who require specialist multidisciplinary mental health treatment. The proposed national service will share the same commitment to safety, effectiveness and person centred-ness.

In her previous post as Consultant with NHS GGC Forensic CAMHS, Aileen was co-located with Glasgow City Intensive Support Team and worked with youth justice services, secure accommodation, young offenders' institutions and secure schools. She provided evidence to courts, undertook supervised practice in forensic adult / learning disability psychiatry in different levels of security, and has an Honorary Consultant position at The State Hospital. Aileen has provided care for many adolescents treated in secure hospitals in England and Scotland. In her current clinical post in East Ayrshire CAMHS, she has opportunities to test whole system pathways for high risk youth. These will inform approaches to capacity-building across other localities and regions.

Aileen has joint responsibility for scoping the need for highly specialist inpatient mental health care in Scotland. She has established links with colleagues in the UK secure inpatient estate and Royal College of Psychiatrists for CPD, research and quality improvement. Current focus is on measuring meaningful clinical outcomes. These associations will help ensure that the proposed facility is equipped and positioned to equitably serve the needs of mentally disordered young offenders across Scotland.

Tommy Stevenson

Job Title:	**Senior Manager for Child and Adolescent Mental Health Services (CAMHS) and Community Eating Disorder Service (CEDS)**
Reports to:	Steering Group - National Secure Adolescent Inpatient Service
Background:	Tommy has been involved in specialist learning disability services for a period of 8 years as a Professional Nurse Advisor and then Senior Nurse in Learning Disability. Prior to this he was an Educational Project Manager for NHS Education Scotland and has also held roles as a Community Team Co-ordinator and Charge Nurse for Learning Disability.

Eileen Bray

Job Title: **Clinical Services Coordinator**
Service Manager for Child and Adolescent Mental Health Services

Reports to: Steering Group - National Secure Adolescent Inpatient Service

Background: As Service Manager for CAMHS, Eileen is responsible for managing the three locality CAMHS teams and the Intensive Support Team. Since qualifying Eileen has gained experience predominately within CAMHS both community and inpatients settings. Eileen is line managed by Tommy Stevenson Senior Manager CAMHS/CEDS.

As Clinical Services Coordinator, Eileen will be responsible for:-

- supporting the project management team throughout the life of the project
- Hosting stakeholder/public involvement events
- Contributing to public awareness and information sessions/briefings
- Liaising with partner agencies throughout the life of the project i.e. education, social work, police as well as public reference groups
- Coordinate the sharing of relevant information between project management and stakeholder group/members
- Contribute to decisions around the design of clinical areas, workforce requirements, patient and staff safety and risk management.

Iain Fairley

Job Title: **Project Director / Senior Project Manager**

Reports to:
Capital Programme Management Group
Project Board - National Secure Adolescent Inpatient Service
Steering Group - National Secure Adolescent Inpatient Service
Formula Allocation Management Group
Estates, Environment & Sustainability Group

Background:
Iain has 15 years experience working as a Project Manager & Senior Project Manager within the NHS successfully delivering numerous Capital Projects most recently the new £47m Woodland View development.

For the National Secure Adolescent Inpatient Service his role is as Project Director, Iain inputs to all the governance groups for the project. He provides the strategic direction, leadership and ensures that the business case reflects the views of all the stakeholders, including:-

- Ensuring realistic aspirations, budgets and timescales are set;
- Ensuring appropriate Professional Advisors are appointed that can demonstrate experience, understanding and the willingness to work in a collaborative environment;
- Establishing a Project organisation;
- Establishing a defined Brief to user's agreement;
- Establishing reporting procedures;
- Approving change and acting as arbitrator on disputes;
- Informing Investment Decision Maker of delay/cost increase;
- Ensuring adequate resources to deliver the Project are in place;
- Promoting the Project;
- Reporting to the Project Board;
- Leading the Project Team;
- Ensuring delivery of the Project in accordance with the Project programme; and
- Providing all decisions and directions on behalf of the Board.

His previous experience of Capital projects are as follows:-

Woodland View
This is a new build £47m Mental Health and Care of the Elderly facility that was procured through NPD. My role was Project Manager responsible for all technical aspects for the project including co ordination of Employers Requirements.

Backlog/Formula Allocation Projects
This is dealing with the Board's Formula projects. Cumulatively these projects have a worth of around 10m and have include the upgrade of the theatres at Ayr and Crosshouse, demolition of residency buildings at University Hospital Crosshouse, and water infrastructure projects.

Infrastructure Projects at Ayrshire Central Hospital
In preparation for Woodland View the Board undertook a number of infrastructure projects – these included a new treatment and admin facility for CAMHS and CLDT, new Physiotherapy accommodation, upgrading the Horseshoe building to include new, roof, windows and render. Together these projects had a capital value of circa £20M

Hazel Smith

Job Title: **Project Manager, Capital Planning**

Reports to: Steering Group - National Secure Adolescent Inpatient Service

Background: Hazel has over 10 years of Project Management experience within NHS Ayrshire & Arran. Hazel was responsible for Group 2 and Group 3 equipment for Building for Better Care.

Hazel will be responsible for providing the following:-

- Collation of the Initial Agreement;
- Liaise with colleagues and be responsible for the collation of the Outline Business Case;
- Participate in the development of the Design Brief;
- Develop the Full Business Case;
- Appoint external advisors as required;
- During construction, responsiblity for providing the monthly progress reports on Construction to the Project Director;
- Monitor and progress any change requests;
- Manage the capital and revenue budgets
- Act as liaison between the Board and Contractor;
- Ensuring aspirations, budgets and timescales are met;
- Managing Professional Advisors;
- Liaison between Capital Planning and Clinical colleagues ensuring the brief is met and promotes understanding of the more technical elements of the build;
- Ensuring delivery of the Project in accordance with the Project; and
- Informs all decisions and directions on behalf of the Board.

SRO	SRO/Project Director	Project Manager
Development Management	Experienced The Project Director was responsible for project management of major capital projects and has extensive experience in development management gained on a number of capital Projects, including £46m Acute Mental Health project. The Project Director has extensive experience in the preparation of initial agreement, outline and full business cases using previous iteration of SCIM. This is the first project to be delivered under new guidance. The Project Director has been a member of the Capital Planning Team for over 15 years and has delivered a number of Capital Projects ranging from resource centres to new hospital developments. The Project Director led in the development of a Project Brief for the new Acute Mental Health Hospital.	Experienced The Project Manager has direct experience in leading and participating in development management of major capital projects. Experience was gained by working with key stakeholders for a £46m Acute Mental Health project (Woodland View). The Project Manager has extensive experience in the preparation of initial agreement, outline and full business cases. The Project Manager has been a member of the Capital Planning Team for 5 years (14 years in healthcare) and has 10 years previous construction experience in the private sector. The Project Manager assisted in the development of a Project Brief for the new Acute Mental Health Hospital.
Governance	Expert The Project Director has chaired a number of Project Boards.	Previous involvement The Project Manager has supported the Project Director (Chair) of the Project Board in more than one project.

	The Project Director has gained approval for a number of capital projects through the Authorities overarching governing body (Capital Planning Management Group). The Project Director gained both Scottish Government and Authority approval for project budgets for a number of capital projects.	The Project Manager was responsible for creating papers and reports and disseminating and distributing to all project members for Woodland View. All Project Managers currently working in Capital Planning have led in the creation and management of risk registers. The Project Manager was responsible for the delivery of the OBC and FBC for Woodland View.
Commercial Acumen	Expert The Project Director has led commercial and business management on a traditional, design and build and NPD projects. The Project Director was responsible for the identifying and monitoring of project risk for Woodland View and the overarching backlog maintenance schemes for NHS A&A with a Capital value of £5m. The Project Director also led the risk management strategy for Brooksby Resource Centre which had a Capital value of £6m.	Expert The Project Manager has assisted in the commercial and business management on a traditional and NPD projects. The Project Manager assisted in identifying and monitoring project risk for Woodland View and the overarching backlog maintenance schemes for NHS A&A with a Capital value of £5m. The Project Manager also led the risk management strategy for the demolition of a number of buildings across NHS A&A, Capital value of £3m
Project Management	Experienced The Project Director has been part of the Capital Planning Team for 15 years and has led a number of projects using different techniques for programme and project	Expert The Project Manager has led a number of projects using different techniques for programme and project management. (eg. Microsoft Project. The Project Manager has extensive

	management. (eg. Microsoft Project and Primavera. The Project Director was responsible for the project execution plan for Woodland View, NHS A&A backlog, Ayrshire Central service continuity plan which was a phased approach to the preparation of the Ayrshire Central Hospital site for Woodland View and had a capital cost of c. £21m. The Project Director has successfully delivered between 8-10 capital projects, using traditional,NEC3 and Standard Form Contracts working with a number of design and project teams.	experience in providing costs for risks that have been identified for Capital Projects. This has been carried out using building indices and our extensive database of capital costs built and maintained over the three years. The Project Manager has extensive experience of critical path and root cause analysis. The Project Manager has been responsible for chairing project and cost control meetings and using appropriate governance to either amend or enhance project execution plans.
Stakeholder management	Experienced The Project Director has experience of managing the Stakeholder Management of Capital Projects within their remit for five years or more. Capital Projects were:- • Woodland View (£46m) • Backlog Maintenance (£5m) • Ayrshire Central Hospital service continuity (£21m) • Brooksby resource (£6m) All the above included multi-agency and service	Expert The Project Manager was responsible for the Stakeholder Management of the following projects:- • Review of Services (3 years project - most comprehensive consultation exercise led by NHS A&A) • Mind your health (3 years consultation exercise for Mental Health services NHS A&A) • Woodland View (£46m) The Project Manager developed a Stakeholder Management Plan and Communications Plan for the above projects.

	stakeholders. The Project Director has been involved in the creation of stakeholder management strategies for the projects listed above. The Project Director has experience of leading and implementing communication plans for the projects listed above.	
Procurement management	Previous involvement The Project Director was responsible for procuring main contractors and design teams, either through OJEU or Public Contract Scotland portal and has extensive experience in collating and evaluating tender documentation. The Project Director has published three OJEU notices including Woodland View, Procurement of Designer Framework for NHS A&A, Clerk of Works Framework.	Experienced The Project Manager has been responsible for the procurement and selection of a number of main contractors and design teams. The procurement routes have been Traditional, Frameworks 2 and NPD. The Project Manager was responsible for preparing the tender evaluation criteria, weight and scoring for Woodland View (NPD), Backlog maintenance (F2) and Demolition of buildings (Traditional). The Project Manager led the procurement process for the Advisors for Woodland View this involved the procurement of Technical, Legal and Financial Advisors through an open OJEU process. The Project Manager was extensively involved in the procurement of F2 PSCP and PSCs.
Contract management	Experienced The Project Director has had responsibility for managing and administering all of the Capital Projects listed	Experienced The Project Manager has had responsibility for managing and administering all of the Capital Projects listed previously.

	previously. The Project Director has experience in JCT, NEC and Standard Form contracts and has resolved a number of contractual issues in Capital Projects. The Project Director has had to resolve a number of issues relating to defect rectification. Most of the issues have had to do with flooring.	The Project Manager has experience in JCT, NEC and Standard Form contracts and has resolved a number of contractual issues in Capital Projects. The Project Manager has had to resolve a number of issues relating to defect rectification.

National Adolescent Secure Mental Health Inpatient Service

Project Board

TERMS OF REFERENCE

1. Objectives

1.1 The objective of the Project Board is to provide leadership and make executive decisions for project and ensure that the project:

- Remains on programme;
- Receives status and current reported progress which will be reviewed against Project Plan;
- Key risks and issues are reviewed and resolved;
- Reviews and monitors project budget; and
- Review of benefits realisation plan.

2. Responsibilities

2.1 To take overall responsibility for the delivery of the project. Specifically, the Project Board will approve:-

- business case documents
- project plan and milestones
- communication and engagement plan
- Change Management Strategy
- Project budget
- Benefit Realisation Plan
- Risk Management Strategy

2.2 The Project Board will ensure that appropriate mechanisms are in place to receive feedback from the Steering Group and from stakeholders and provide assurance to Capital Planning Management Group (CPMG) and Joint Property Meeting within NAHSCP (North Ayrshire Health & Social Care Partnership) that appropriate arrangements have been made for the management of the project. National Services Scotland (NSS) will report to National Patient & Public Reference Group (NPPRG) every three months and National Specialised Services Committee (NSSC).

2.3 The Project Board will:

- Approve business case documents;
- significant variations to the Project Plan;
- Monitor and manage project progress;
- Provide visible leadership, direction and commitment to the project, promoting effective communication of the projects goals and progress;
- Own Risk Register and agree proposals and mitigation for risks;
- Ensure the project is properly resourced; and
- Ensure key stakeholder engagement is fully realised.

2.4 The Project Board will provide assurance to the Senior Responsible Owner (SRO) that decisions and deliverables at each phase of the project are fit for purpose and the intended benefits are realised. The SRO will update NSS, NHS Boards and the NAHSCP on progress of the project and provides assurance that governance arrangements are appropriate.

2.5 To ensure a balance participation with no single interest predominating.

2.6 Set agendas for each meeting and ensure agendas and supporting materials are delivered in advance of meetings.

2.7 Make the purpose of each meeting clear.

2.8 Project Board members have the following responsibilities:-

- Understand the goals, objectives and the desired outcomes of the project;
- Understand and represent the interests of project stakeholders;
- Take a genuine interest in the projects outcomes and overall success;
- Act on opportunities to communicate positively about the project;
- Check that the project is making sensible financial decisions – especially in procurement and responding to issues, risks and proposed project changes;
- Check the project is aligned with the National Strategy as well as policies and directions across Government as a whole;
- Actively participate in meetings, through attendance, discussion and review of minutes, papers and other Project Board documents; and
- Support open discussion and debate, and encourage fellow Project Board members to voice their insights.

3. Governance

3.1 The Project Board has overall responsibility for the approval of Business Cases.

3.2 The Project Board will receive regular reports on progress.

3.3 The Project Board will discuss and approve or escalate as required any financial or design change that is out with the agreed project parameters.

National Adolescent Secure Mental Health Inpatient Service

Project Board

TERMS OF REFERENCE

4. Responsibility of the Project Board Chair

The Project Board Chair will be the Director of NAHSCP. Stephen Brown holds this position. Should the NAHSCP Project Board Chair be unable to attend the meeting, NAHSCP will provide a deputy to serve as Chair.

4.1 The Chair will set the agenda for each meeting.

4.2 The Chair will approve the agenda and supporting materials and ensure they are delivered to members in advance of meetings.

4.3 The Chair will make the purpose of each meeting clear to members and will explain the agenda at the beginning of each meeting.

4.4 The Chair clarifies and summaries what is happening throughout each meeting.

4.5 The Chair will keep the meeting moving by putting time limits on each agenda item and keeping meetings to two hours or less.

4.6 The Chair will encourage broad participation from members and discussion.

4.7 The Chair will end each meeting with a summary of decisions and actions.

4.8 The Chair will follow up with consistently absent members to determine if they wish to continue membership.

4.9 The Chair will find replacements for members who discontinue participation.

National Adolescent Secure Mental Health Inpatient Service

Project Board

TERMS OF REFERENCE

5. General

5.1 Membership

The table below details the membership of the Project Board.

Name	Title	Organisation
Stephen Brown (Chair)	Director of North Ayrshire Health and Social Care Partnership	NAHSCP
Roseanne McDonald	NSS Lead	NSS
Thelma Bowers	Head of Mental Health Services	NAHSCP
Andy Brown	Interim Head of Capital Planning	NHS Ayrshire & Arran
Aileen Blower	Clinical Director CAMHS	NHS Ayrshire & Arran
To advise	Regional representative	
Iain McInally	Head of Estates	NHS Ayrshire & Arran
Sandy Agnew	Assistant Director of Clinical Support Services	NHS Ayrshire & Arran
Derek Lindsay	Director of Finance	NHS Ayrshire & Arran
Andy Grayer	Assistant Director, eHealth & Information Services	NHS Ayrshire & Arran
Hugh Currie	Assistant Director for Occupational Health, Safety and Risk Management	NHS Ayrshire & Arran
Dan Doherty	Assistant Director of Estates and Capital Planning	NHS Ayrshire & Arran
Stewart Donnelly	Employee Director	NHS Ayrshire & Arran
TBC	Public Representative	
NHS Board representative TBC		NHS Board
Scottish Government representation		
Alan Morrison	Health Finance and Infrastructure	Scottish Government Health and Social Care Directorates
In attendance		
Iain Fairley	Project Director	NHS Ayrshire & Arran
Eileen Bray	Clinical Services Co-ordinator	NAHSCP
Luan Johnston	Communications Officer	NHS Ayrshire & Arran
Hazel Smith	Project Manager, Capital Planning	NHS Ayrshire & Arran

5.2 Quorum and decision making

5.2.1 Quorum

A minimum number of five Project Board members are required for decision making purposes.

5.2.2 Decision making process

- Majority: a course of action requires support from more than 50% members who attend the meeting if there is a quorum; and
- Two thirds majority: a course of action requires support from two thirds of the members who attend the meeting if there is a quorum.

5.3 Frequency of meetings

5.3.1 The Project Board will meet either monthly or at key milestones which are set out in the Project Plan.

5.4 Agenda, minutes and decision papers

5.4.1 Papers will be sent to members 3-5 working days in advance of the meeting. The papers will include the following:-

- Agenda for upcoming meeting
- Minutes of previous meeting
- Progress Report for project
- Decision papers
- Any other documents/ information to be considered at the meeting.

5.5 Deputy/Representative

5.5.1 Members of the Project Board may send deputy's by exception only. Deputy's/Representatives would be expected to participate in discussions and decision making.

5.5.2 Project Board members will inform the Chair as soon as possible if they intend to send a deputy to a meeting, and no less than two business days before the scheduled meeting.

National Secure Adolescent Inpatient Service

Steering Group

TERMS OF REFERENCE

1. Objectives

1.1 The objective of the group is to provide a level of governance for the provision of the provision of the National Secure Adolescent Inpatient Service by way of a Steering Group, to ensure a representative approach is achieved.

2. Responsibilities

2.1 To advise on the revision of business case documents.

2.2 To represent stakeholder needs.

2.3 To advise on the impacts of design and technical matters.

2.4 To promote and advise on best practice for Child and Adolescent Mental Health Services.

2.5 To review and feedback on engagement progress.

2.6 To advise on any issues that may impact on the reputation or integrity of the National Service.

2.7 To ensure a balance participation with no single interest predominating.

2.8 Set agendas for each meeting and ensure agendas and supporting materials are delivered in advance of meetings.

2.9 Make the purpose of each meeting clear.

2.10 Steering Group members have the following responsibilities:-

- Understand the goals, objectives and the desired outcomes of the project;
- Understand and represent the interests of project stakeholders;
- Take a genuine interest in the projects outcomes and overall success;
- Act on opportunities to communicate positively about the project;
- Check that the project is making sensible financial decisions – especially in procurement and responding to issues, risks and proposed project changes;
- Ensure that all material risks and appropriate mitigation actions are recorded in the risk register;
- Escalate risks to the Programme Board as necessary;
- Check the project is aligned with the National Strategy as well as policies and directions across Government as a whole;
- Actively participate in meetings, through attendance, discussion and review of minutes, papers and other steering group documents; and
- Support open discussion and debate, and encourage fellow Steering Group members to voice their insights.

National Secure Adolescent Inpatient Service

Steering Group

TERMS OF REFERENCE

3. Governance

3.1 The Steering Group has overall responsibility for the technical and editorial content of the Business Cases. To this end, the Steering Group will seek contributions from stakeholders of the project through a process of engagement.

3.2 The Steering Group will report progress directly to the Programme Board.

3.3 The Steering Group will escalate any financial or design change that is out with the agreed project parameters.

4. Responsibility of the Steering Group Chair

The Steering Group Chair will be the Head of Mental Health Services. Thelma Bowers is the Head of Mental Health Services. Should the Chair be unable to attend the meeting, Iain Fairley, Programme Director will serve as Chair.

4.1 The Chair will set the agenda for each meeting.

4.2 The Chair will ensure that agenda and supporting materials are delivered to members in advance of meetings.

4.3 The Chair will make the purpose of each meeting clear to members and explains the agenda at the beginning of each meeting.

4.4 The Chair clarifies and summaries what is happening throughout each meeting.

4.5 The Chair will keep the meeting moving by putting time limits on each agenda item and keep meetings to two hours or less.

4.6 The Chair will encourage broad participation from members and discussion.

4.7 The Chair will end each meeting with a summary of decisions and actions.

4.8 The Chair will follow up with consistently absent members to determine if they wish to continue membership.

4.9 The Chair will find replacements for members who discontinue participation.

National Secure Adolescent Inpatient Service

Steering Group

TERMS OF REFERENCE

5. General

5.1 Membership

The table below details the membership of the Steering Group

Name	Title	Organisation
Thelma Bowers	Head of Mental Health Services	NAHSCP
Iain Fairley	Programme Director	NHS Ayrshire & Arran
Aileen Blower	Clinical Director CAMHS	NHS Ayrshire & Arran
Tommy Stevenson	Senior Manager for CAMHS and CEDS	NHS Ayrshire & Arran
Eileen Bray	Clinical Services Co-ordinator/ Service Manager for CAMHS	NHS Ayrshire & Arran
Susannah Mendes	Project Lead	NSS
TBC	Regional representative	TBC
Steven Lees	Estates Manager (North)	NHS Ayrshire & Arran
Audrey Fisher	Head of Clinical Support Services (North)	NHS Ayrshire & Arran
Ian Ferris	Capital Accounting	NHS Ayrshire & Arran
Derek Gemmell	eHealth	NHS Ayrshire & Arran
Luan Johnston	Communications Officer	NHS Ayrshire & Arran
Hugh Currie	Health and Safety	NHS Ayrshire & Arran
Hazel Smith	Project Manager, Capital Planning	NHS Ayrshire & Arran

5.2 Quorum and decision making

5.2.1 Quorum

A minimum number of five Steering Group members are required for decision making purposes.

5.2.2 Decision making process

- Majority: a course of action requires support from more than 50% members who attend the meeting if there is a quorum; and
- Two thirds majority: a course of action requires support from two thirds of the members who attend the meeting if there is a quorum.

5.3 Frequency of meetings

5.3.1 The Steering Group will meet either monthly or at key milestones which are set out in the Project Plan.

5.4 Agenda, minutes and decision papers

5.4.1 Papers will be sent to members 3-5 working days in advance of the meeting. The papers will include the following:-

- Agenda for upcoming meeting
- Minutes of previous meeting
- Progress Report for project
- Decision papers
- Any other documents/ information to be considered at the meeting.

5.5 Deputy/Representative

5.5.1 Members of the Steering Group can send a deputy to the meetings. Deputy's/Representatives would be expected to participate in discussions and decision making.

5.5.2 Steering Group members will inform the Chair as soon as possible if they intend to send a deputy to a meeting, and no less than two business days before the scheduled meeting.