

Initial Agreement

National Secure Adolescent Inpatient Service



Project ID	Initial Agreement
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1.0 Executive Summary

There is currently no secure adolescent inpatient service for young people in Scotland. National Services Division (NSD), an operating division of the Procurement, Commissioning and Facilities SBU (PCF), within NHS National Services Scotland (NSS), was asked by NSSC / SGHSC to identify an NHS Board to provide a new nationally designated service.

The main purpose of this Initial agreement (IA) is to confirm the need for investment in the proposal for the National Secure Adolescent Inpatient Service (NSAIS) to meet the requirements of the Mental Health Strategy 2017-2027 and provide at a high level the initial cost of the unit in the terms of capital and revenue.

The NSAIS would admit adolescents who meet the criteria for assessment or treatment of mental disorder under relevant sections of Mental Health (Care & Treatment) (Scotland) Act 2003 and whose risk of harming others is beyond that which can be provided by other mental health services.

NSAIS will provide for a population of young people whose complexity of presentation and severity of risk is currently not met within NHS Scotland. The challenges and complexities of working with these young people will require a dedicated and appropriately skilled multidisciplinary healthcare team to deliver the level of care that these young people deserve.

The ultimate aim is to return these young people to community services following therapeutic intervention that by definition, their current risk of harm renders them out with the scope of community services, at the time of need to admission to NSAIS.

Key roles for the national inpatient service are:

- Assessments of suitability for admission to adolescent secure hospital care;
- Provide consistent and equitable access for young people from or currently living in Scotland;
- Establish and maintain links with key stakeholder organisations and referrers to ensure a robust referral pathway and provide admission within specified timeframes;
- Coordination of a national referral system;
- Specialist secure inpatient assessments of young people referred from other specialist mental health services;

- Provision of a wide range of clinical interventions, to address young people's mental health needs within a secure hospital environment;
- Actively engage young people's local health care, education services and partner agencies in planning and delivering assessment and treatment as appropriate. In particular, locality 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 coordinated through the use of Care Programme Approach (CPA) framework; which will ensure that young people with severe and enduring mental illness, who also have complex health and social care needs, receive continuing care and appropriate supervision. This will incorporate the delivery of appropriate packages of care, services and accommodation which are fully co-ordinated by the agencies involved;
- Promote service user engagement and involvement to enhance service delivery and development;
- Promote best practice in the field of Adolescent Secure 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.

This Initial Agreement will outline the model of care for the proposed National Secure Adolescent Inpatient Service. Included within the outline of the model of care will be a pathway that details referral to discharge and beyond for any young person involved with the service.

2.0 Strategic Case

2.1 Service Details

2.1.1 Existing Service/Activity Provision

There is currently no secure adolescent inpatient service for young people in Scotland who require such a service. Currently this patient group is managed via the Scottish National Services Division (NSD) contract. NSD manage a risk share scheme on behalf of the NHS Board Chief Executives, which covers out of NHS Scotland referrals for specialist services.

The current commissioned specialist service is provided by NHS England's National Secure Forensic Mental Health for Young People. This clinical network consists of seven forensic adolescent units spread across England, which provide medium secure inpatient services for young people aged between 13 to 18yrs (and in some cases up to 19yrs depending on clinical and/or educational needs).

Changes in the central commissioning strategy, has led to young people from Scotland being dispersed across England rather than the previously preferred provider being located in Newcastle Upon Tyne (originally named Roycroft, now Alnwood Clinic). The other services are located in Manchester, Birmingham, Northampton, Southampton, Middlesex and Kent.

Clinicians from NHS England National Secure Forensic Mental Health for Young People service also provide assessments and consultation on complex cases not requiring admission. Part of the service that is provided by the clinician is an out-reach model which includes recommendations on clinical placement. This can lead to a further delay to admission if for example if there is need for a further assessment by a different service. The current service model has an average three year spend of £2.2million (based on years 2014-2016).

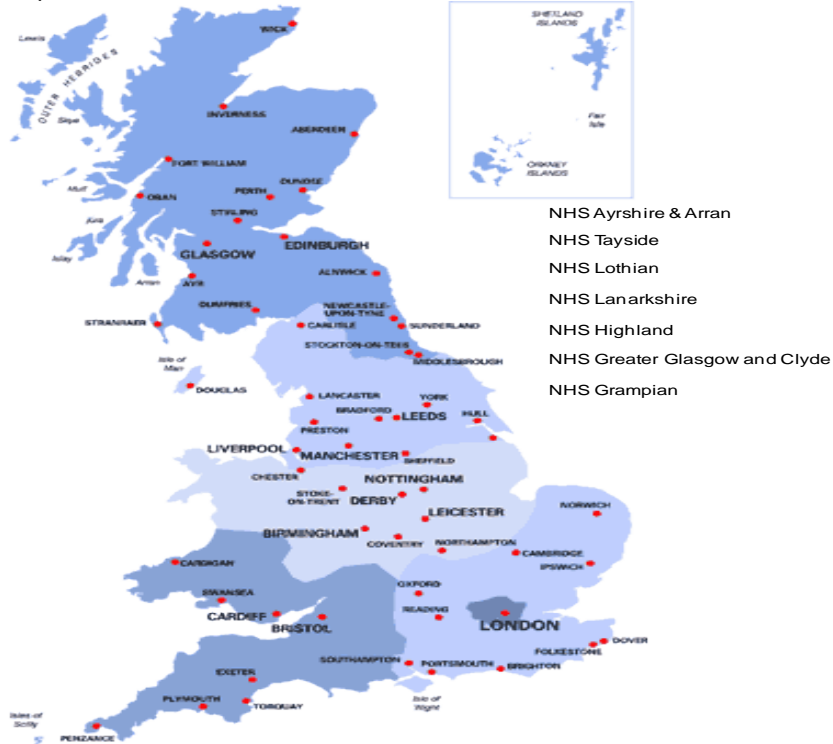
If a young person is unable to access the commissioned medium secure units in England then individual arrangements can be made via unplanned activity and expenditure requests (UNPACS) for admission to NHS low secure in England or independent providers in Scotland and England. At times, treatment is provided via this unplanned route or young people remain in Scotland within inappropriate care provision.

The following map illustrates the Cross Border Referrals for Low and Medium Secure CAMHS Inpatient Services over a three year period (2013-2016) from NHS Scotland Boards who were able to provide this information (not all boards provided data so the information is therefore incomplete but is helpful to show the geographical dispersal of Scottish patients). The majority of young people are resident within St Andrew's Hospital a non-NHS charitable provider which is part of the medium secure network for young people and has more beds than the others.

The services detailed in the map are the following facilities:

- St Andrew's Northampton (100 beds for young people)
- The Westwood Centre, Middlesbrough (10 beds for young people)
- Alnwood Clinic Northumberland Tyne & Wear (25 beds for young people)
- Huntercombe Stafford PICU
- Huntercombe Maidenhead PICU

Cross Border Referrals for Low and Medium Secure CAMHS Inpatient Services



The following table shows the NHS Board expenditure for UNPACS admissions to low and medium secure inpatient services in the United Kingdom:

Cross Border Referrals for Low and Medium Secure CAMHS Inpatient Services				
NHS Board Expenditure				
	2013/14	2014/15	2015/16	3 year average
Provider	£ ' 000	£ ' 000	£ ' 000	£ ' 000
NHS Ayrshire & Arran	285	213	0	166
NHS Grampian	975	339	301	538
NHS Greater Glasgow & Clyde	170	123	381	225
NHS Highland	0	97	0	32
NHS Lanarkshire	339	422	60	274
NHS Lothian	379	149	83	204
NHS Tayside	158	231	495	295
	2,306	1,575	1,320	1,734

2.1.2 NHS England Governance Network

When young people from Scotland are being referred to the medium secure services in England there is a referral process, an agreed admission criteria and peer review process that prioritises admissions. Consideration in the placement of young people is their risk and vulnerability. National referral meetings for entry into English services take place weekly.

2.1.3 Experience

The process for transfer is often lengthy and can leave the young person, family/carers and the multi-agency team around the young person in a state of limbo feeling anxious and uncertain of their destination.

2.1.4 Disadvantages of current provision

Barriers to access

NHS England has a policy of prioritising admission of English patients to their facilities, which will inevitably disadvantage young people from Scotland.

Delays

Due to geographical distance and clinical time commitments, English services typically take around a month from date of referral to a decision being made about suitability for admission to a service in England. Then a lengthy legal process begins.

Legal processes

Scotland and England have separate judicial arrangements with different mental health legislation; special regulations must be followed before any young person is moved across the border in either direction. Application must be made to the Scottish Ministers for a transfer warrant, with fixed time frames and a built-in appeal process. Due to the particular vulnerabilities of young people, clear processes must be followed before a warrant is granted; including gaining informed consent of the young person. In addition, remand prisoners cannot be moved across the border until their case is concluded which can result in prolonged delays in them receiving the appropriate assessment and treatment.

NHS England has a policy of prioritising admission of English patients to their facilities, which will inevitably disadvantage young people from Scotland.

2.1.5 Existing services or activities affected by this proposal

The proposed service will reduce the number of young people who require this level of care who were previously be held in adult care settings such as IPCU and adult mental health wards or secure accommodation and young offender's institutions.

2.1.6 Existing location of these services/activities

As previously stated there is no secure inpatient service for young people within Scotland. The only inpatient provision is general tier 4 facilities none of which fulfil a secure function.

The tier 4 facilities listed below will be part of a cohesive pathway and will, where appropriate provide step down care that is less restrictive. It should be noted that these facilities provide specialist care for young people with a range of severe mental health problems, but are not secure (for example, generally unlocked except under special circumstances). NHS Scotland provides and commissions the following services for under 18's:

- Three regional general adolescent inpatient services in Dundee, Edinburgh and Glasgow are for young people aged between 12-18 years.
- National Child Unit, Glasgow (referrals for young people aged 12 years).
- Other nationally or UNPACS commissioned services across the United Kingdom will be accessed in exceptional circumstances.

NHS Scotland:

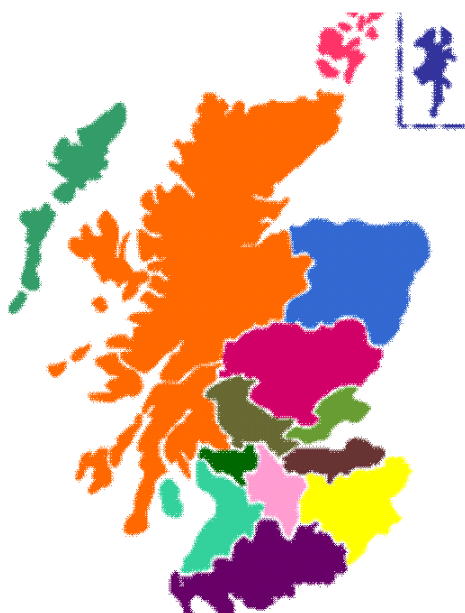
- National Child Unit (Glasgow)
- Regional adolescent inpatients units (Glasgow, Edinburgh Dundee)

UK Specialist Services:

- NHS England (medium secure)

Non-commissioned services:

- Independent adult – Scotland
- NHS low secure / IPCU / Independent adolescent units in England



2.1.7 Location of service users associated catchment areas

The location and catchment area of the service users is national and will affect all Health Boards across NHS Scotland.

2.1.8 Current functional size of service or activity

The spreadsheet below shows the NSS spend and expenditure against Cross Border Referrals.

NSS Expenditure

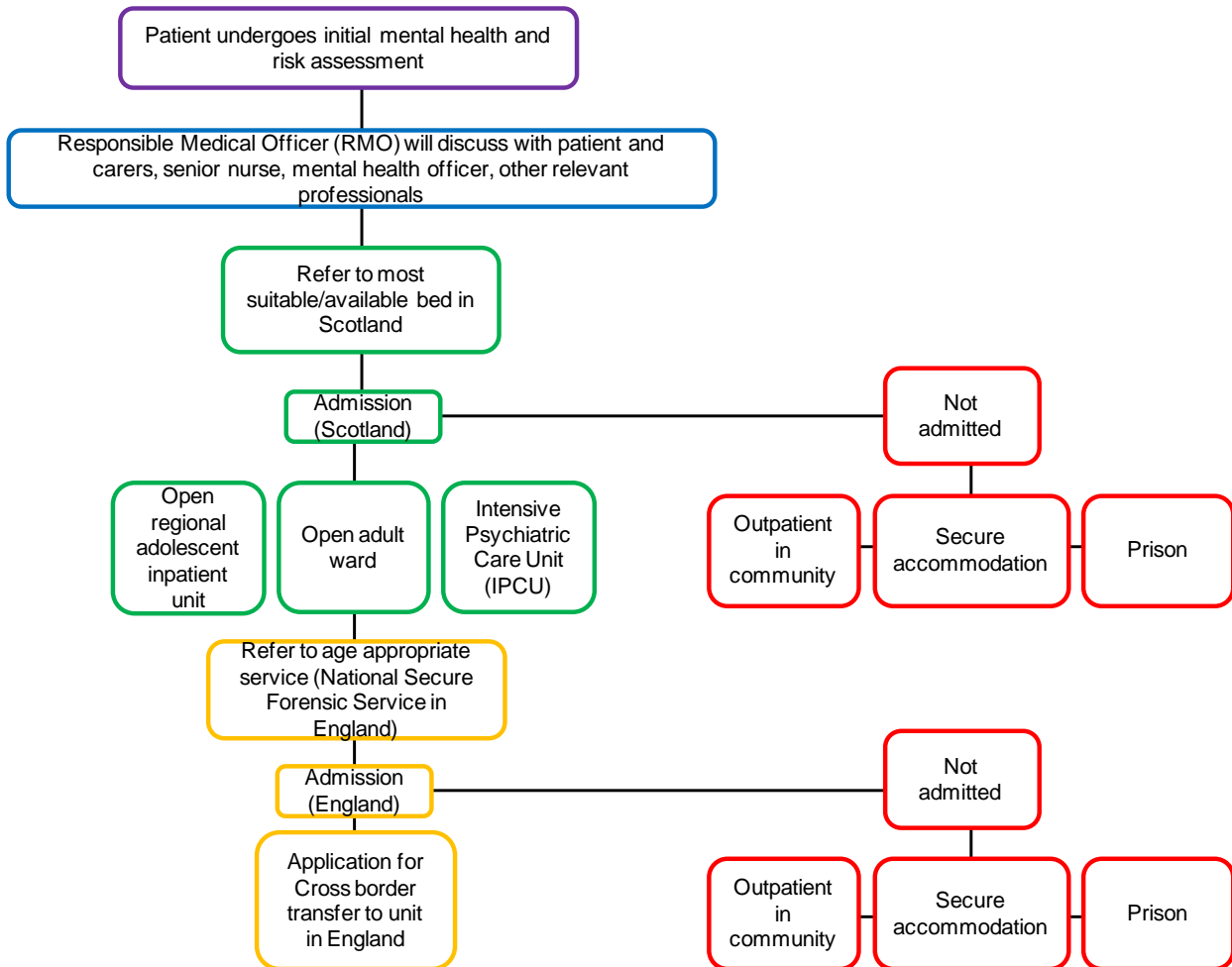
	2013/14	2014/15	2015/16	3 year average
<u>Provider</u>	£ ' 000	£ ' 000	£ ' 000	£ ' 000
NHS Ayrshire & Arran	0	0	91	30
NHS Fife	0	742	269	337
NHS Forth Valley	512	513	4	343
NHS Grampian	81	449	491	340
NHS Greater Glasgow & Clyde	602	774	490	622
NHS Lanarkshire	157	479	91	242
NHS Lothian	406	378	0	261
NHS Tayside	0	0	81	27
NHS Highland	0	0	0	0
	1,758	3,335	1,517	2,202

2.2 Service arrangements

2.2.1 Current Care Pathways

The following pathway describes the current process.

The current pathway is led by the local specialist multi-disciplinary mental health services in full discussion with the patient, family and partner agencies.



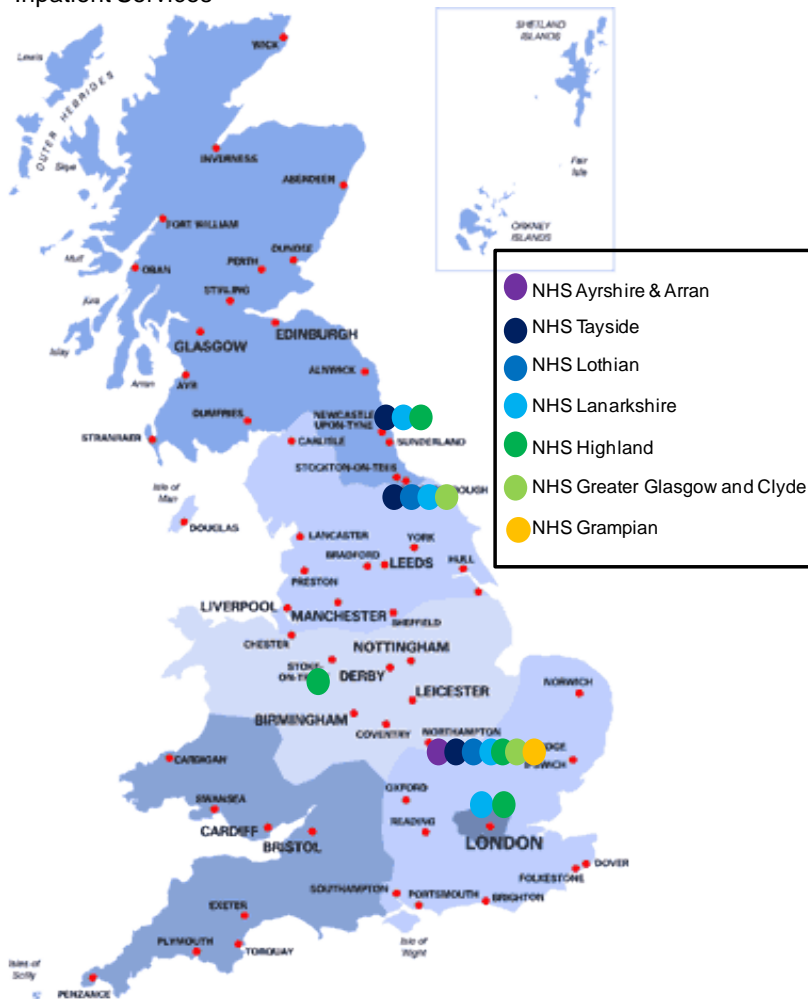
2.2.2 Existing service capacity and current utilisation

As previously stated (para 2.1.1) National Services Division (NSD) currently commissions a CAMHS secure service on behalf of the NHS Board Chief Executives, which covers out of NHS Scotland referrals.

The commissioned service for CAMHS patients in Scotland is the NHS England National Secure Forensic Mental Health for Young People. This clinical network consists of seven forensic adolescent units spread across England, which provide medium secure inpatient services for young people aged between 13 to 18yrs (and in some cases up to 19yrs depending on clinical and/or educational needs).

The map below, previously shown, illustrates the Cross Border Referrals.

Cross Border Referrals for Low and Medium Secure CAMHS
Inpatient Services



Currently, young people with a major mental health disorder and secure needs do not have access to treatment in a specialist NHS Scotland health setting, which is designed to meet the needs of the young person, for some or all of the period of their illness.

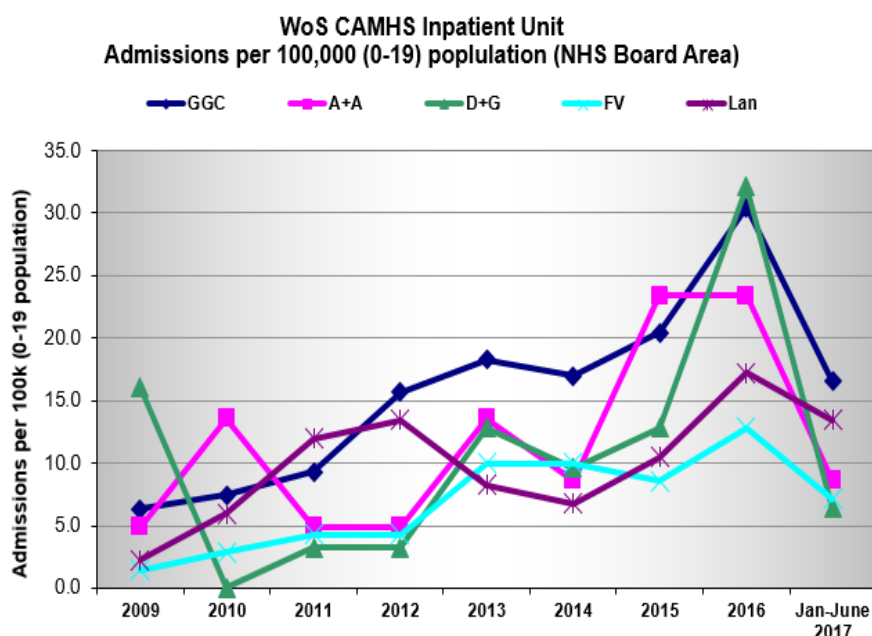
Typically, a young person has to wait several months until they are admitted to a suitable inpatient unit in NHS England, if they are able to access one at all.

It should be emphasised, that “time to treatment” is a strong predictor of outcome in mental illness. Delay to treatment predicts slower and less complete recovery. Conversely, with timely effective early intervention, young people with mental illness can recover and achieve. Early intervention also predicts good outcomes for youth offending.

A key commitment in the Mental Health Strategy for Scotland 2017 – 2027, is improved access to Child and Adolescent Mental Health Service (CAMHS). Whilst there has been success in improving access to community services, it has been difficult for CAMHS to meet the needs of high risk young people with secure needs.

In NHS Scotland, young people under the age of 18 years requiring urgent psychiatric admission may be admitted into an adult inpatient setting until a suitable age appropriate bed can be obtained (Mental Welfare Commission statistical monitoring Young Person Monitoring Report 2015/16).

National and regional commitment to the MH strategy has seen significant investment in community based CAMHS across Scotland. CAMHS across the country invested in intensive community services to increase access to adolescent inpatient units and reduce admissions to adult wards. Using the most populous region as an example, the graph below demonstrates progress made by West of Scotland:



On occasion the challenging presentation of the young person can be such that they are deemed inappropriate for the current NHS Scotland CAMHS inpatient settings and require to remain within an adult inpatient setting, subject to enhanced observations or, in extreme circumstances, a placement within an Intensive Psychiatric Care Unit (IPCU).

The following information is an extract from the West of Scotland (WoS) Development Group, Tier 4 CAMHS Network – Inpatient Data Report - 2009 – June 2017

The table below shows Intensive Psychiatric Care Unit (IPCU) admissions per 100,000 (0-19 years) population for the 5 West of Scotland Boards. Most Boards have shown varying rates of admission per population across the five years with an increasing trend towards 2013. This trend took a dip in 2014 but continues to increase in 2015 for all areas except Forth Valley.

Admissions per 100k (0-19)	2009	2010	2011	2012	2013	2014	2015	2016	Jan-June 2017
GGC	6.3	7.5	9.3	15.7	18.3	17.0	20.4	30.4	16.5
A+A	4.9	13.6	4.9	4.9	13.6	8.6	23.4	23.4	8.6
D+G	16.1	0.0	3.2	3.2	12.9	9.6	12.9	32.1	6.4
FV	1.4	2.9	4.3	4.3	10.0	10.0	8.6	12.8	7.1
Lan	2.2	6.0	12.0	13.5	8.2	6.7	10.5	17.2	13.5

Source: Business Objects & mid-2012 Population Estimates Scotland (31 May 2012, General Register Office for Scotland)

2.2.3 Service performance data

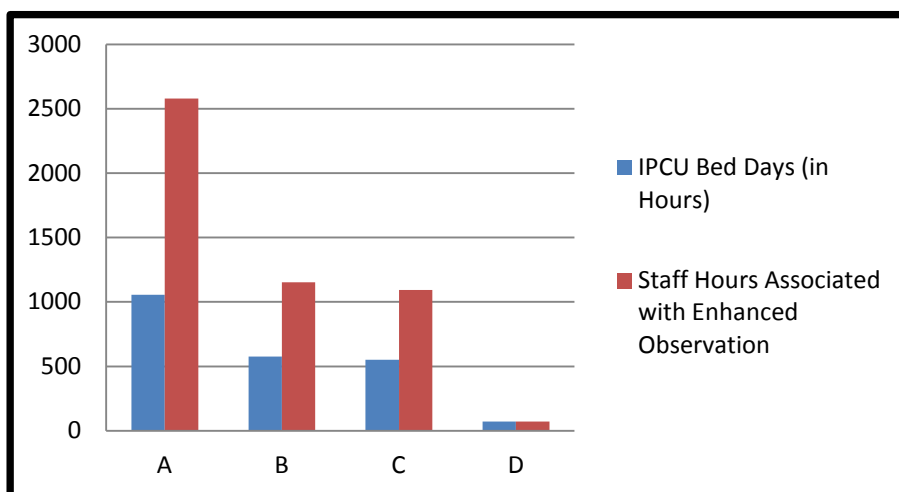
When a young person presents with risks which cannot be managed within an open regional adolescent unit, the only alternative is transfer to an adult Intensive Psychiatric Care Unit. The experience of the clinicians within NHS Ayrshire and Arran is that the young person remains within this setting for prolonged periods of time whilst they await transfer to a more suitable setting.

Admissions of young people to an inappropriate setting, places immense stress on the young person and their families. These admissions are also problematic for other patients and services. Young people in adult wards need to be kept safe. To ensure the young person's safety enhanced levels of nursing observation is required (see graph on next page). In addition young people are usually unable to access the age appropriate treatments that they require.

The need for in-reach from community CAMHS consultants and other staff can place additional pressures on teams which are not resourced for inpatient work with younger vulnerable patients.

The graph below illustrates the amount of resource expended on four young people (A,B,C,D) that were monitored and observed in a care setting that was not age appropriate. As an illustration this shows that a young person has spent approximately 90 bed days in an inappropriate care setting. In conjunction with the bed days the staff resource required to monitor and observe these young people was over 4000 staff hours.

IPCU bed days and Staff hours associated with enhanced observation



2.2.4 Existing Service Demand

Responses to requests for information from other NHS Scotland boards have been sporadic. Using NHS Ayrshire & Arran as an example, in recent times there has been a downward trend in bed days used within adult inpatient settings for young people. However the complexity of those requiring admission has increased with these young people frequently requiring enhanced nursing support and management within the adult IPCU setting.

2.3 Service Providers/Organisation Affected

With no current NHS Scotland secure adolescent inpatient provision all NHS Boards that require to access this service will commission services in NHS England through the current commissioned service managed by NSD.

2.3.1 Existing workforce arrangements

NHS Scotland Community CAMHS currently has no inpatient secure workforce. Under the current arrangements, support for young people within secure services in England is provided by NHS Scotland community CAMHS in conjunction with a multiagency team, ensuring continuity of care for young people admitted to commissioned services. This includes regular visits to the patient, attendance at inpatient reviews and managing rehabilitation to Scotland. There is currently no data on actual resources used in this pathway.

2.3.2 Conclusion

One of the key factors in the successful treatment of young people with major mental disorders is the time from referral to treatment. With no secure inpatient service in Scotland this is a significant impediment to the treatment of young people and with NHS England prioritising “English beds for English patients”, increasingly this will lead to more young people being held in inappropriate care settings, which are unable to meet the needs of the young person.

The proposed care pathway and model of care will address the issue of continuity in the young person's care and the data that surrounds resources used.

2.4 Care Pathway, Referral & Discharge¹

2.4.1 Overarching principles:

For patients, families and staff who use and work in the service, the secure adolescent inpatient unit will deliver:

- Safe, effective, person-centred care;
- Recovery-focussed practice ;
- Minimally restrictive rights-based care;
- Care which reduces health inequalities;
- Right help at the right time from the right people in the right place – as close as possible to patient's community of origin.

In keeping with:

- Policy and frameworks for planning and delivering integrated services for child patients in Scotland;
- Principles of children's and mental health legislation in Scotland;
- Relevant Good Practice Guidance and current best available evidence base.

2.4.2 Aim of service

The national adolescent medium secure service will provide care and treatment within a highly prescribed set of physical, relational and procedural security measures. The predominant need for care and treatment will be related to the young person's assessed risk of harm to others in the context of their mental disorder.

2.4.3 Care Pathway

Since 2005, there has been significant investment in specialist Child & Adolescent Mental Services (CAMHS) across Scotland. NHS Scotland provides a network of community multidisciplinary CAMHS across the 14 Health Boards.

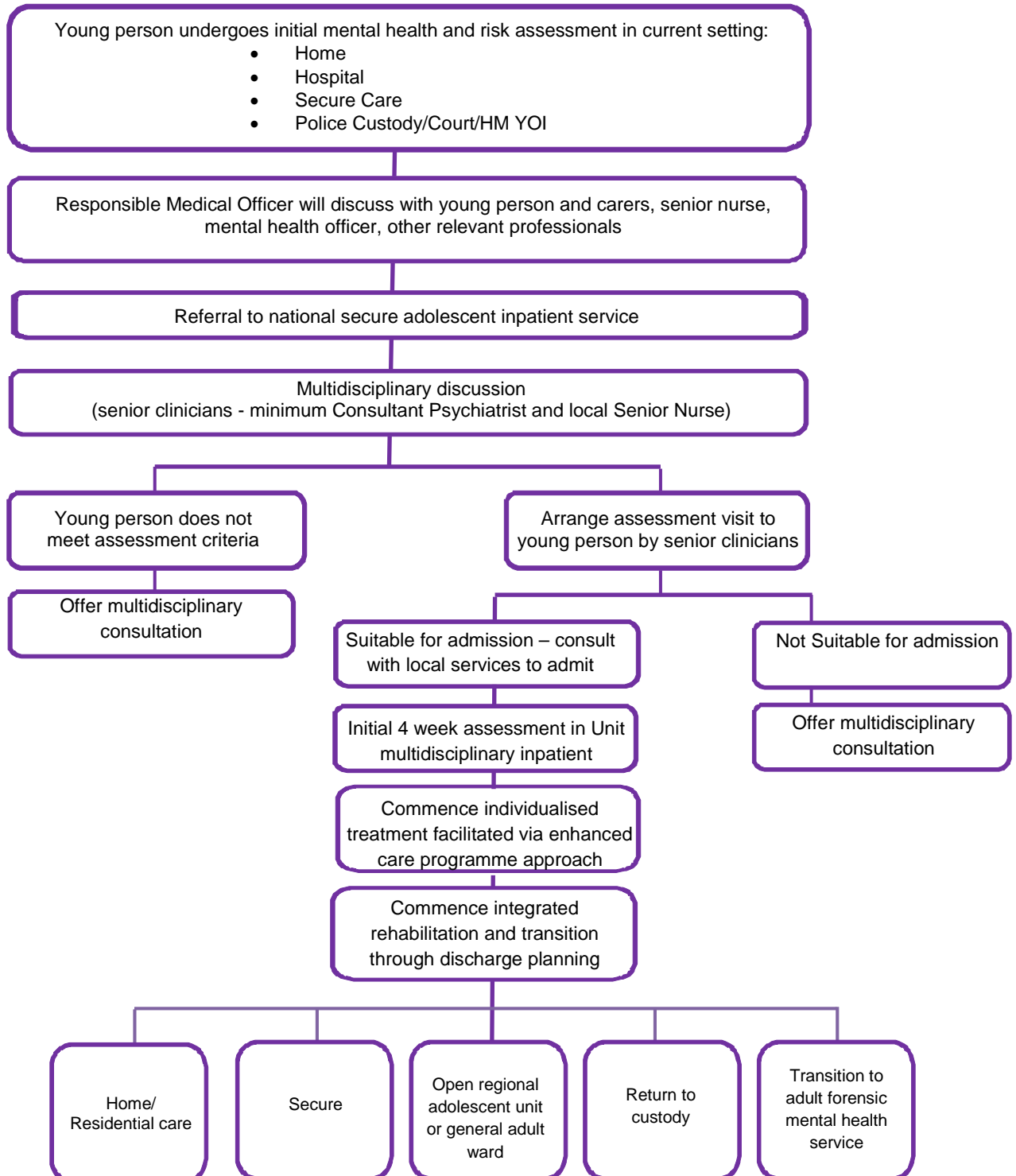
There are three regionally commissioned adolescent inpatient services in Dundee, Edinburgh and Glasgow, providing 48 beds for adolescents until their 18th birthday. The nationally commissioned child inpatient service in Glasgow provides 6 beds for under 12's.

Existing adolescent and child mental health inpatient services in Scotland provide care for young people who do not need enhanced physical or procedural security measures.

¹ Model of Care and Care Pathways based on consultation with key stakeholders and with reference to policy and practice in NHS Scotland policy at time of revision of Initial Agreement (April 2018).

National Services Scotland also commission highly specialist inpatient mental health care for young people under the age of 18 years who cannot be managed in any of the NHS child or adolescent services in Scotland. Currently services for young people under the age of 18, who have learning disability, forensic risk, or other complex needs, are commissioned from NHS England. This includes under 18's that require mental health care under conditions of medium security.

Young people who, due to high risk or legal barriers, cannot access developmentally appropriate specialist inpatient services in Scotland or England, are typically managed in adult wards.



2.4.4 Alternatives to secure hospital care

Recent policy for the care, treatment and education of children in Scotland, emphasises the need for provision in the right place, at the right time and as close to home as possible. In relation to mental health care, there has been emphasis on clear evidence-based pathways for community-based care to avoid unnecessary admissions to inpatient care. To varying extent across CAMHS in Scotland, there has been development of intensive treatment teams, which have resulted in reduced lengths of stay, and hence improved access to, the three regional adolescent inpatient services.

Intensive mental health treatment can be provided for high risk youth wherever they live: in their family home, residential home, school, secure accommodation or custody. Descriptions are available of good practice for mental health provision in secure accommodation and community settings.

However, it is recognised that there will always be some children and young people who require a period of more intensive and specialised inpatient care.

2.4.5 Whole system approach

In order to achieve continuity of care across community and hospital settings, a “whole system approach” is required. For decades, children’s services in Scotland have tried to ensure a multiagency, child-centred approach to assessing and meeting needs of the most vulnerable young people in our society. The proposed national secure adolescent inpatient service will be hosted by NHS Ayrshire & Arran and North Ayrshire Health and Social Care Partnership, which has experience of whole system working across several services, including mental health for high risk youth. Through development of this proposal, the Project Team have engaged with a range of stakeholders to ensure the national unit will be embedded within a network of Scottish services.

The national secure adolescent inpatient service will be part of a continuum of NHS Scotland care, involving other inpatient provision and intensive community services.

2.4.6 Pathway governance

The secure inpatient service will provide a single national coordinated referral and admission pathway. Processes will be clear, transparent and consistent.

Equity of access across Scotland will be monitored closely by the service provider and commissioner. The service will link to a referrer network who may be invited to mediate in disputes around access and / or provide independent review of individual cases.

2.4.7 Pathways into and out of secure service

Typically, patient will enter the adolescent secure service from:

- Criminal court or custody;
- Hospital: child, adolescent or adult inpatient service;

- Secure accommodation or other specialist residential care;
- Home.

Patients might be discharged to any of the above settings, depending on their circumstances and needs.

2.4.8 Statutory framework

All patients admitted to the secure adolescent inpatient service will be detained under relevant sections of the Mental Health (Care and Treatment) (Scotland) Act 2003.

All patients will have their care and risk management plans facilitated via the Care Programming Approach.

Given the vulnerability and complex needs of young people detained in a secure setting, consideration should be given to other multiagency frameworks.

Looked After Child reviews may be needed where a young person is subject to compulsory supervision and/or accommodated. Specialist education reviews may be required to meet a young person's additional support needs.

To minimise frequency of meetings and facilitate consistent decision-making, arrangements may be made for relevant authorities to co-chair multiagency reviews (such as hold "joint" LAAC and CPA Reviews).

2.4.9 Referral sources

Referrals would be accepted from a consultant psychiatrist with direct responsibility for the care of the young person. This would typically be a specialist in child & adolescent psychiatry from an outpatient or other inpatient CAMHS team. Alternatively, the referrer may be a consultant in general or forensic psychiatry, if the young person is in an adult ward or custodial setting.

In order to ensure specialist multidisciplinary input and continuity of care for all young people, the locality CAMHS team from the young person's community of origin must be involved prior to, and throughout, their admission. (For example, a 16 year old remanded from Kilmarnock into a young offender's institution in a different health board area, may be initially referred by the prison forensic psychiatrist but would need timely input from NHS Ayrshire & Arran community CAMHS).

Given the implications of assessment for a secure inpatient service, it would be expected that the referring consultant would consult widely with the family and relevant professionals. As the referred young person would need to be detained under civil or criminal mental health legislation, views of any Named Person and the designated Mental Health Officer must be sought.

Responsibility for the care of the young person remains with the referring mental health service until the point of admission to the secure inpatient unit.

2.4.10 Acceptance Criteria

The young person is under 18 at the point of referral
and
liable to be detained under relevant civil or criminal sections of the Mental Health (Care and Treatment) (Scotland) Act 2003
and
presents significant risk to others
and/or
is an untried or sentenced prisoner
and
there is clear evidence prior to referral that serious consideration of less secure provision has been made and/or tested and discounted as the young person's needs/risk exceed the threshold for and the ability of those services to manage.

2.4.11 Risks around acceptance criteria

As for all specialist mental health services, certain young people will clearly meet the described acceptance criteria: (for example, a 16 year old in custody and suffering from paranoid schizophrenia involving hallucinations which direct him not to accept food or medicines from prison staff). Such young people would be prioritised for admission to the secure inpatient service.

Other young people will less clearly meet the threshold for admission, but still present significant clinical and risk management challenges for the referring clinicians.

We might anticipate issues around any of the acceptance criteria, for example:

- Young person approaching their 18th birthday;
- High risk young person who has a mental disorder for which inpatient treatment is unlikely to be effective or even unhelpful (such as primary emerging antisocial personality disorder);
- Where there is limited evidence of offending risk (such as unsubstantiated accounts of sexual aggression);
- Limited local access to intensive community alternatives (such as in a remote community or a local authority which does not "place" young people in secure accommodation).

The latter issues in particular presents risk of variation in referral patterns across Scotland.

2.4.12 Mitigation

From the outset, the Project Team have engaged with potential referrers and wider networks across Scotland, to achieve agreement around acceptance criteria and other aspects of the Model of Care, as outlined in this Initial Agreement.

The Project Team will continue to work with existing regional and national networks to ensure risks are fully discussed and potential solutions considered.

In particular, these include:

- the three regional CAMHS networks which have well developed oversight of “Tier 4” intensive community CAMHS and the three existing adolescent mental health inpatient units;
- Scottish Practice Exchange for Children, hosted by the national child mental health inpatient service;
- Scottish Government CAMHS Lead Clinicians Group, which has oversight of CAMHS services from all Health Boards areas;
- Forensic Network, which has oversight of the secure hospital estate and related forensic community services across Scotland.

By the time the secure service becomes operational, it will be embedded in a well-functioning network of referring and associated services. As a whole, this wider network will continue to develop a Model of Care for assessing and treating mental disorder in high risk young people in all settings across Scotland. Ideally, the capacity of the network to effectively manage high risk young people out with the national secure inpatient service will also be enhanced.

2.4.13 Referral Process

The first point of contact for a referral to the National Secure Adolescent Inpatient Service (NSAIS) will be either a consultant psychiatrist, senior charge nurse or service manager from NSAIS. At least one will be available Monday to Friday 9am-5pm to discuss referrals.

During this process all essential information about the young person and their current situation will be discussed including a description of their current mental state and their perceived risks of harm to self and others. A standard referral form will be developed to ensure consistency and that sufficient information is available to the service in order to consider each referral. Due to the highly specialist nature of the service, and need for careful planning of admissions, it will not be appropriate to admit any young person as an emergency “out of hours” admission.

On receipt of the referral the senior NSAIS clinician will triage the case according to urgency. The majority of the cases will be taken to the regular referral meeting staffed by senior representatives from the multi-disciplinary team but urgent cases will be discussed as a matter of priority with as many senior clinicians as is practicable. At the referral meeting, if the young person meets the referral criteria an assessment team will be formed and plans made to initiate the next stage. For those that do not meet the criteria the referrer will be informed within 24 hours, with an offer of further consultation with the NSAIS. Cases will be prioritised according to level of risk and need.

2.4.14 Initial Assessment

In the first instance senior decision makers from NSAIS (as a minimum a psychiatrist and nurse) will undertake an assessment visit to the young person in their current setting and will share information about the available treatment and facilities with the young person, family/carers around the time of that visit.

The assessing team will discuss the outcome of the visit with other senior clinicians from the national secure service at its regular referral meeting. If the decision of the service is that the young person is suitable for admission a plan would be initiated to liaise with all parties concerned to make timely arrangements to do so.

If the young person does not meet the criteria for admission to the secure service, the assessing team will feedback to the referrer verbally within 24 hours of the referral meeting and provide a written assessment report as soon as possible for the referrer. The assessing team will provide advice on management or risk including alternative options for meeting the needs of the young person.

2.4.15 Pre-admission

Efforts will be made to admit the young person as soon as possible after it is agreed that they may benefit from the national secure service.

The secure service will liaise with the referring team to:

- ensure that they receive all relevant documents and information about the patient;
- remain up to date about the patient's condition, treatment and risks;
- obtain feedback about the young person's legal status and circumstances;
- provide guidance where appropriate on treatment and risk management whilst awaiting admission;
- plan safe transfer of young person to secure service, including legal status, escort, vehicles and risk management;
- agree a clear discharge plan.

2.4.16 Admission

On admission, the secure service will take over responsibility for the young person's medical care, whilst liaising with the referring service as appropriate.

On the day of admission meeting the young person's initial needs and risks are assessed to ensure the young person is being managed in the most appropriate, least restrictive manner.

This will be monitored daily by the care team with the first formal review by the full multidisciplinary team typically occurring within their week of stay.

A further care-planning meeting will be scheduled, involving family/carers, the responsible locality CAMHS team and other relevant agencies. Thereafter, the patient's progress will be reviewed via the Care Programming Approach and other relevant statutory procedures.

2.4.17 Assessment & Treatment

Once the young person is admitted to NSAIS, they will be provided with a range of specialist, multidisciplinary mental health interventions including:

- assessment and monitoring of mental and physical health;
- assessment and formulation of risks and needs;
- mental health treatments as indicated and in accordance with best available evidence;
- proactive management of aggression and self harm;
- psychological and social interventions to reduce risk of future offending;
- substance misuse work and other treatments as indicated;
- interventions to support the young person in achieving developmentally appropriate independence;
- family / carer therapy;
- consultation with agencies involved with the young person's care and risk management;
- structured activity programme including physical exercise;
- other recreational opportunities.

Where necessary, referrals will be made to other disciplines and specialist services to ensure safe, effective management of presenting needs and risks.

2.4.18 Physical healthcare

The service will promote positive health and wellbeing. It will ensure that young people have access to regular physical health needs assessment and treatments for emerging and ongoing physical health issues in a timely and effective manner. Active health promotion will be incorporated into the service. Routine physical healthcare will be provided by "on site" medical staff with access when necessary to paediatric and more specialist medical provision as required.

2.4.19 Rehabilitation

The model for rehabilitation for young people requiring more intensive support will be significantly improved within the new facility. Patients will be supported in an environment which enables a graduated recovery, building on their strengths in managing their activities of daily living. Easy access to the activity areas and safe external grounds will promote quicker recovery and improved opportunities to engage with the community. As an outcome patient length of stay in rehabilitation will reduce and this will further impact on the improved wellbeing of patients.

2.4.20 Discharge Planning

Discharge planning will start at admission and be supported by a network of community based services; ensuring young people are able to take advantage of a range of services to meet their individual needs. Accessing social, leisure and employment opportunities will be a distinct part of every discharge plan. Before admission, consideration will be given to likely timing and pathway for discharge. The secure service will work with the responsible locality CAMHS team around achieving an optimum outcome, including rehabilitation. This will incorporate managing the patient's care during suspensions of detention whilst preparing for discharge.

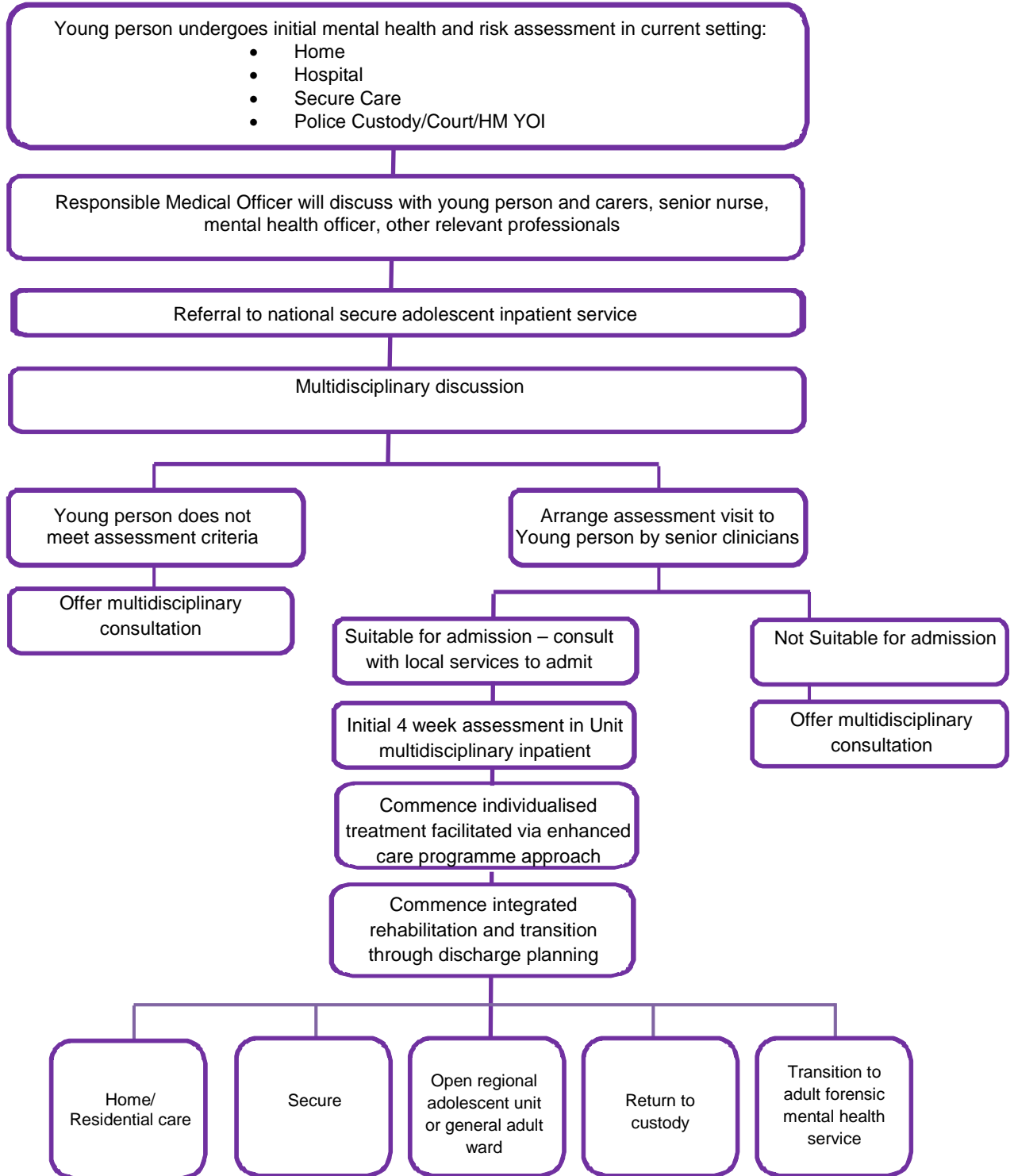
2.4.21 Transition to adult services

Young people, who are in the secure service within 6 months of their 18th birthday, will be referred to the most suitable adult mental health service. The secure service will liaise closely with adult community or inpatient services to ensure the most appropriate transition. This may require assessment of the patient by the accepting team – especially if transfer to another secure inpatient service is considered.

It is recognised that transition to adult services is a big step for vulnerable young people; NSAIS will ensure that the young person is given the appropriate support.

2.4.22 Delayed discharge

If discharge from the service is delayed for non-clinical reasons (such as lack of suitable accommodation), the commissioner will be informed and delayed discharge procedures followed.



2.5 Model of Care

2.5.1 Education

All young people admitted to the service will be encouraged to become successful learners, confident individuals, responsible citizens and effective contributors. This will be achieved through the programme of therapeutic and recreational activities, as well as formal education.

The aim of the education department will be to develop an imaginative flexible learning environment that offers young people access to the full curriculum and a range of wider achievement opportunities. The education offered will include opportunities to take part in focused recreational activities supported by a range of therapeutic interventions. The provision will be delivered by a Core Team of experienced and highly trained teachers and education support staff who will be supplemented, as required, by subject specialists drawn from across the local education authority.

Personal Education Plans will be prepared for every young person which will complement their care and treatment plans. These will be constructed by the care staff team with support from an Educational Psychologist and agreed with the Units Leadership Team. Young People's educational progress will be regularly monitored with reports being provided for planned care/ treatment reviews. Regular progress meetings will be held with parents/ carers.

Transition Planning will be a core part of the provision of education to ensure that, where appropriate, progression can be made through the curriculum, to College, Higher Education, employment or training. Key links with local and national partners will be essential for effective transition planning.

2.5.2 Evidence based care

The care provided by a large multi disciplinary team will be evidence based taking into account each person's individual needs. To support this, an Integrated Care Pathway which is neither condition nor setting specific, will be developed to provide a single coordinated pathway from referral to admission and will support discharge to less restrictive pathways as quickly as possible. The ICP will feed into and inform the national governance arrangements and assurances which are central to the service.

The model of care will be considered in light of available research evidence and examples of good practice in other adolescent secure inpatient services across the UK and the proposed model of care will be tested against standards set by the Royal College of Psychiatrists Quality Network for Inpatient CAMHS and the UK medium secure adolescent clinical network with reference to NICE and SIGN guidelines. The model of care will also take into account relevant legislation and policies and evidenced best practice for young people across health, social care and education.

However, the limits of available evidence for this complex patient group must be recognised.

This includes “off licence” prescribing of medicines and psychological therapies requiring modification to meet young people’s communication or other developmental needs.

When working outside the evidence base, innovative interventions will be theoretically sound and robustly evaluated. Young people and parents/carers will be provided with accessible information about recommended treatments and supported in making decisions about accepting therapies.

2.5.3 Therapeutic milieu

The national service will provide these interventions in a secure environment where young people can address their problems in safety and with dignity. All elements of the assessment and treatment programme will be young person centred and recovery-focussed.

The service will be resilient in the face of significant challenging behaviour and have a capacity to effectively deliver interventions for protracted periods of time. A robust safeguarding approach will balance therapy delivery and safety of young people, staff and visitors.

2.5.4 Secure environment & procedures

Young people admitted to this service will present a level of risk of harm to others which cannot be effectively managed in any other CAMHS hospital setting in Scotland. The unit must provide a robust level of security to ensure the safety of everyone being cared for, working in, and visiting the service.

Current services for adults in Scotland, and young people in England, differentiate between different levels of security. The physical, procedural and relational elements are specified for each level of security. This includes detail on the physical environment (such as perimeter, gate locks, fixtures), and procedures employed (personal searches, use of seclusion, policy of drugs and offences, response to alarms, etc) to minimise risk of absconding and personal injury.

Scottish secure inpatient services for adults are clearly specified and designated in a hierarchy of high, medium and low levels of security. In Scotland, applications can be made to the Mental Health Tribunal for Scotland for an order declaring that the patient is being detained in conditions of excessive security.

In order to meet known patient group need, the proposed NSAIS will be modelled primarily on a medium level of security. However, there will be flexibility built into the design to ensure that young people admitted to the service can be cared for at a level of security which meets their needs throughout their recovery. For example, as a young person progresses toward discharge, their ability to cope safely with a lower level of security may be “tested”, in particular with adaptations to aspects of procedural and relational security.

2.5.5 Seclusion

In order to appropriately manage the level of risk that a young person poses to others, NSAIS will have appropriate facilities for the management of young people who require periods of care in seclusion, or to be separated from the main patient group. Evidence from existing services in NHS England suggests that at least one seclusion facility is an essential element of the range of therapeutic options available to safely care for this very high risk patient group. Used appropriately, seclusion can be the least restrictive means of caring for vulnerable high risk young people.

2.5.6 Patient safety

Care in the national service will be underpinned by The United Nations Rights of the Child which discusses the young person's right to freedom and protection whilst balancing the fact that young people admitted to NSAIS will present significant risks of harm toward themselves and/or others. In order to care for them effectively, the unit will use periods of enhanced observations in line with good practice.

Use of physical restraint and "as required" medication will be used with caution and only when necessary, in keeping with good practice.

All physical seclusion facilities and patient management practices will comply with standards and requirements. Decisions and rationale will be clearly documented and reviewed regularly over the period it applies, to ensure minimal restriction to young people's freedom.

2.5.7 Family and carer involvement

- Children and young people will be supported in contact with their family/carers throughout their stay, by visits, phone calls and written communications, as appropriate;
- The service will liaise with social work services from patients' communities of origin to agree appropriate contact with parents, siblings and other relatives, and to support travel arrangements. During the design phase, family accommodation will be discussed and if possible factored into the design;
- Families and carers will be involved in all aspects of care-planning as appropriate.

2.5.8 Advocacy and independent legal advice

- All young people will be offered independent advocacy and legal advice throughout their period of care in the service;
- Young people and their families will be provided with accessible information about the nature and implications of their detention under mental health legislation and other aspects of their legal status.

2.5.9 Clinical standards

The secure adolescent inpatient mental health services will provide care and treatment balanced across the following three domains:

- developmentally appropriate care to facilitate adolescent emotional, cognitive, moral, educational and social development;
- a secure and safe environment that can effectively manage high-risk behaviours and high levels of vulnerability;
- a highly specialist multidisciplinary mental health service which provides comprehensive evidence-based treatments and evaluates their effectiveness.

Since treatment will be informed by best available evidence, the Model of Care will develop in accordance with Quality Improvement. The secure unit will therefore have sufficient flexibility in design to allow for adaptations as the Model evolves.

Adherence with these and other applicable standards will be assured by benchmarking with other related adolescent and/or secure inpatient services. Have we not already said this above.

As far as possible and where relevant, the Model of Care provided by the secure inpatient service will be consistent with that offered in existing Scottish regional adolescent services and comparable secure inpatient services in NHS England.

During the development of the NSAIS, a national referrer/stakeholder group will be established, and will evolve to provide a key function of ensuring equity of access for all young people in Scotland. A national practice exchange forum will also be established to support referrers in developing best practice in managing high risk youth with mental disorders.

2.5.10 Outcome monitoring

Clinical

The service will monitor clinical outcomes using a minimum dataset (as indicated in Royal College of Psychiatrists Quality Network for Inpatient CAMHS Routine Outcomes Measurement Service), and other measures relating to the care of children and treatment in conditions of security:

1. Clinical measures:

- SDQ (self-report, parent/carer and teacher);
- HoNOS-CA;
- HoNOS-Sec and CGAS.

These measures will be collected on admission, every six months and at discharge.

2. Physical health

The physical condition of young people will be monitored and information provided for the Forensic Network dataset.

3. Wellbeing indicators

The extent to which the service meets the welfare and safeguarding needs of each young people will be assessed using the 8 “SHANARRI” indicators of wellbeing, in accordance with GIRFEC principles.

4. Offending risk

Using best available tools, risks of physical/sexual violence and other harm to others will be assessed and monitored throughout each patient’s period of care in the service. These will primarily be structured professional judgement tools validated to be used with young people.

5. Parent / carer and young person feedback

Young people and carer’s experience of the service will be routinely sought during each episode of care and on discharge.

6. Indicators will be employed to monitor the extent to which the service implements recovery-oriented practices.

7. The unit school will monitor the following (in accordance with policy and guidance from education authorities):

- Attendance, Attainment and Leaver destinations;
- Literacy & numeracy;
- Achievement of Curriculum for Excellence Levels;
- School inclusion (Additional support needs) Literacy & numeracy;
- Best start: Physical education / Healthy living Literacy & numeracy.

8. Referrer feedback

Referrers will be invited to participate in surveys of their experience of using the service.

Performance

Access will be a key performance indicator:

1. Waiting times

Referred young people will be assessed, and where appropriate admitted; in a timely manner and in keeping with NHS Scotland standards (currently 90% of young people will start treatment within 18 weeks of referral).

2. Equity

Demographic indicators will be routinely collected to ensure that the service is equally accessed by young people from all communities in Scotland.

2.5.11 Interdependencies with other services and providers

The national secure inpatient service will be integrated into NHS Scotland care pathways involving:

- child and adolescent community mental health services;
- three regional adolescent inpatient units;
- national child inpatient unit;
- general adult community mental health service;
- general adult inpatient services;
- adult community forensic services;
- adult forensic inpatient units.

Due to its location within Woodland View Campus, a key interdependence will be with existing and future inpatient and community and support services based on that site.

The national secure adolescent unit will also form part of a spectrum of services which meet the needs of young people with high risk behaviours and/or who need care in secure environments:

- Whole System Approach /Criminal Justice services provided by local authority / third sector;
- Specialist residential care;
- Secure accommodation;
- Young Offenders Institutions.

The care pathway will support transitions into less restrictive environments as soon as possible, in keeping with current policy and best practice.

References for the model of care can be found in Appendix P.

2.6 Capacity Modelling

2.6.1 The Historical Perspective

As noted previously, two Scottish Government reports (2009 & 2014) have previously proposed the development of a Scottish adolescent medium secure inpatient service with between 8 and 12 beds. This proposed capacity is based on the needs of adolescents of all genders from the age of 12 up to their 18th birthday (and beyond in exceptional circumstances) with specific defined requirements. These are:

- Patients who are detained or liable to hospital detention under civil or criminal mental health legislation, where;

- Treatment in secure inpatient setting is necessary because the patient:
- Presents serious risk of harm to others; and/or
- Is in custody on remand/sentence.

The 2014 report, "Secure Inpatient Care for Young People" was presented to the National Planning Forum in February 2014. It was developed by a working group established as a result of an earlier NPF decision in December 2012 to undertake a review of access to secure care for young people in Scotland. This was in turn in response to previous work undertaken in 2009/10 in relation to secure inpatient services for young people in Scotland.

It identified:

- A small but prominent group of adolescents who suffer from severe and/or complex mental disorder and present serious risk of harm to others and require treatment in hospital;
- Secure inpatient care is an essential part of comprehensive Child and Adolescent Mental Health service provision;
- There are currently no secure inpatient beds for children in Scotland;
- Under current arrangements, adolescents subject to civil orders are transferred to Specialist units in England;
- Adolescents who are subject to criminal procedures cannot access age-appropriate inpatient care anywhere in the UK;
- Adolescents require to be admitted to inappropriate adult locked settings in Scotland whilst waiting transfer to England, or for the duration of their inpatient stay;
- There is a need for development of an 8-12 bedded secure inpatient unit for adolescents in Scotland.

It also considered:

- Historic and recent activity patterns;
- Current activity and spend;
- Unmet need;
- Projected capacity requirements of a Scottish Unit;
- Emerging Service pressures;
- Clinical views about the clinical viability of a Scottish Unit.

The 2014 report drew from all previous reports on the subject and made a number of relevant observations and recommendations including: "In principle that there is a case to develop a secure unit within Scotland for the patients described in this paper and a working group should be established to develop a detailed plan for implementation for approval by NPF".

It highlighted that projected activity levels "appear to be broadly in line with the 8-12 beds noted in the 2009/10 report" but also warned that "with such small numbers it is challenging to be completely certain of the long term annual trends. Ultimately the judgement to be considered is the risk of some surplus capacity, balanced against the quality of care issues associated with delayed access to placements and the risks of potentially less secure access to English placements subject to the course of the further evolution of the NHS England Specialist Commissioning arrangements".

A literature review carried out for North Ayrshire Health & Social Care Partnership's Stage 3 proposal for the commissioning and designation of a "National Secure Adolescent In-patient Service for Scotland" confirmed what Hoare & Wilson (2010) had identified previously. Namely, that:

"Little hard evidence (exists) about the need for forensic services in terms of population, bed numbers, staffing requirements or outcomes...instead of looking at the outcomes of forensic mental health services, researchers have tended to direct their energies towards assessing the needs of those using existing forensic mental health services, predominantly those placed in secure residential settings."

The proposal identified this as a clear issue that must be taken into account when developing the future facility model and recognised that capacity planning was likely to require a scoping exercise to ascertain current and future need.

The primary objective of the capacity modelling element of the overall business case process therefore remains to test and challenge historical assumptions relating to required capacity and, if appropriate, to table proposed changes.

2.6.2 The Capacity Modelling Challenge

As noted elsewhere in the IA, there is currently no existing secure adolescent Inpatient service for young people in Scotland. This means that the young people who will in future be cared for within the new unit are currently being looked after in a wide range of different environments across a large geographical area. This makes baseline capacity modelling significantly more challenging as:

- there is no single established process for managing young people who in future will be cared for within the new unit;
- there is no single information repository that helps NHS A&A understand the specific care needs of this patient group that is complete and comparable;
- there is no single existing dataset relating to this patient group that would support a traditional capacity modelling methodology based on likely admission numbers over time and length of stay based on an alternative/enhanced model of care; there is no published data relating to young people who might benefit from the proposed unit in Scotland but who have not been referred to existing services because these are deemed unsuitable/inappropriate for whatever reason. (Unmet need)

The process being pursued to determine physical capacity requirements for the unit, is therefore:

- to collect and collate information from multiple referral sources in order to establish a historical baseline of referral numbers and patterns;

- to collect and collate information from multiple existing units/facilities in order to establish a historical baseline relating to specific interventions undertaken and length of stay completed using needs analysis questionnaire attached within appendix L;
- to review any historical “unmet need” and factor the impact of this along with any other current issues into an “amended baseline” that identifies the capacity we need now within the defined single unit based on current performance and metrics;
- to identify “what will change” through modelling the impact of a wide range of passive and active considerations such as demography, corporate performance and clinical performance, on capacity requirements within a new unit;
- to compile a range of alternative future capacity scenarios that present different assumptions/combinations of changes in a number of credible futures with potentially different capacity requirements;
- to identify/agree a preferred future scenario for capacity planning purposes that is best able to meet the challenges of these alternative futures.

Primary data collection methodologies in use currently include:

- Undertaking a retrospective study of historical capacity needs;
- Undertaking a prospective study of current capacity needs;
- Bench-marking against similar services across the UK.

2.6.3 Undertaking a retrospective study of historical capacity needs

This study, which is being overseen by the project’s co-clinical leads, has identified all of the actual and potential referrers into the proposed new service based on the referral criteria agreed. This includes every CAMHS consultant in Scotland along with a defined group of forensic psychiatrists who manage a small group of young people who may benefit from the new unit who are currently in either prison or an adult secure hospital.

These referrers will receive a retrospective study questionnaire that will be distributed via the CAMHS faculty of the Royal College of Psychiatrists (in the case of CAMHS consultants) or directly from the planning team (in the case of the forensic psychiatry group). This questionnaire is intended to understand the actual historical position over the last 5 years regarding adolescent patients in Scotland requiring medium secure provision who received this and/or who may have benefitted from it within the new unit as it is currently defined. It includes key information relating to numbers; dates; diagnosis/presentation; length of stay (if admitted); risk profile; specific care needs; and relevant discharge information.

In addition to the questionnaire, where indicated, responders (referrers) will be contacted directly to participate in telephone interviews/discussions intended to ensure the robustness and appropriateness of the information provided. All responses will be collated to give us an indication of activity over the last 5 years that will be collated and available to support detailed capacity modelling assumptions presented within the OBC as well as facility scheduling and detailed design.

Whilst the capture of information from the previous 5 years retrospectively appears challenging, it should be recognised that actual patient numbers are very low and spread over a large geographical area. The individuals involved are consequently highly likely to have been/remain very well known to the services involved.

This study, will to an extent build upon the “snapshot” study undertaken within the 2014 report, bringing it up to date but also reflecting the more detailed understanding developed in relation to the secure unit now being planned.

2.6.4 Undertaking a prospective study of current capacity needs

In order to test changing demands over time, both in terms of bed and service capacity required, a prospective study is also being undertaken. This is seeking a similar dataset to that identified by the retrospective study from the same identified referring services but will be repeated every 3 months from now in order to gather “real time” data.

Given the small numbers of patients involved, slow change to demand anticipated and high manual workload involved, no advantage is seen in increasing this frequency at this time, although this remains an option if required.

Where potential referrals are identified in the prospective study, follow up information will be gathered to allow us to see how they progress and whether any changes in need/numbers is occurring. This information will again be used to inform the overall capacity model and detailed facility design.

2.6.5 Bench-marking against similar services across England

As well as seeking new data on historical and current service need, a key means of determining/testing potential capacity for the proposed new service in Scotland is to benchmark against similar, established services across England before determining specific reasons to deviate from the baseline established.

2.6.6 Additional Challenges & Opportunities

The planning team are aware that the capacity planning process is further challenged by a range of issues that require on-going consideration throughout business case development. Whilst these can be seen as serious challenges to the process, some also present opportunities that it is important to explore further and capitalise on as appropriate. These include but are not limited to:

- Low patient/bed/activity numbers overall;
- The high variability of care needs (Bed vs staffing capacity requirements);
- Assumptions regarding future change and growth;
- Future flexibility;
- Surplus Capacity vs Quality of Care;
- Capital and revenue affordability;

2.6.7 Low patient/bed/activity numbers

Specialist low volume, high intensity units of this kind, face inevitable difficulties meeting wide fluctuations in demand. This can lead to impediment to access when demand vs capacity is high and sub-optimal utilisation when demand vs capacity is low. In the developing service model we plan to mitigate against these risks by:

- using the best data available to calculate bed and staffing capacity – including the collection of additional data when required, as noted previously;
- aiming for an optimum target facility occupancy of 85%;
- fully realising the benefits of delivering a co-ordinated national service, with better global intelligence that is consequently better able to manage the wider referral process/network to manage peaks and troughs in activity as far as possible;
- managing pre-admission processes and lengths of stay as far as possible by planning for defined intervention periods and ensuring that effective discharge planning in place before admission.

2.6.8 The high variability of care needs (Bed vs staffing capacity requirements)

Staff modelling activity has identified that the nurse:patient ratio within the unit is likely to vary hugely from patient to patient (range 1:1 to 5:1) which will present a very specific management challenge.

This variance will also affect the physical space required to support individual patients on a day-to-day basis and challenge the traditional measure of bedrooms as the primary measure of physical capacity.

e.g. Whilst one patient may require/be most appropriately managed in a domestic sense within a single bedroom, another may require additional space in the form of a dedicated day and/or “extra care area” to support their needs and those of the nursing team supporting them.

This challenge is exacerbated in this small size of the unit and means that the clinical output specification being developed will insist on a highly flexible design layout, able to respond to fluctuating demand within all, gender, care, risk and vulnerability groups within a defined physical area.

Staffing levels within the unit will also be flexible enough to meet the changing operational demands of the service – tailored to meet the final unit design - whether it is operating at full capacity or less.

Current modelling indicates that minimum levels of staff for 24/7 cover are unlikely to vary significantly regardless of occupancy/assessed clinical need but that upper staffing levels may vary significantly, with a consequential impact on the number of “beds” it is possible to staff. This is likely to mean occasional mismatches between staffed and physical capacity available that will need to be managed but also presents the opportunity to re-align bedroom spaces into day areas/extra care areas for patients with the greatest need if the unit design is sufficiently flexible to realise this. i.e. Support less patients, requiring more staff input in a smaller number of domestic spaces (bedrooms) but with a higher number of related rooms.

It is thus possible to conclude that “bed numbers” in the traditional sense is far less useful as a measure of required/available capacity than “staffed” and “physical capacity” as a percentage of current patient needs. For example the unit may have 3-4 young people within the rehabilitation/ discharge planning phase, who require support within the local area as well as their own community. The staff required facilitate to these visits would mean that the staffing level within the service should take these activities into account to provide the appropriate, safe and therapeutic environment, for those remaining in the secure setting and those being progressed to treatment in other settings.

2.6.9 Assumptions regarding future change and growth

A key element of the capacity planning process is to determine the capacity required now and in the future based on evidence-based assumptions relating to the impact of demography and planned changes in the way services are delivered. This requires a shared understanding of all of the things that will/may change (the planning team have termed ‘future impact factors’) and a sense of the likely impact they will have.

Based on the highly successful work previously undertaken in support of capacity modelling at Woodlands View, which accurately predicted radically different bed requirements from the historical proposition based on improved models of care, future impact factors have been identified within 4 categories:

- Demographic Change Elements;
- Corporate Performance Elements;
- Clinical Performance Elements;
- Financial Performance Elements and Targets.

Demographic elements include population and epidemiological factors that are wholly out with the influence of the NHS Board. They are considered within the model to reflect a shifting baseline over time that other changes/inputs will deviate from.

Corporate performance elements represent potential changes / improvements in patient management that could have an immediate and lasting effect on capacity requirements if implemented and managed appropriately. Although feasible and desirable, corporate performance elements may have a direct and/or indirect cost/impact to implement. Examples include the removal of delayed discharges; removal of out of area placements; service re-alignment; etc.

Clinical performance elements represent the potential impact of changes in clinical practice/re-design on future capacity requirements. E.g. Changes in the length of stay; altered staff models; higher levels of clinical intervention; etc.

Although out with the scope of this review, financial performance elements and targets reflect the frequent requirement to set specific targets that push services and practice beyond where clinical negotiation and modelling may indicate they could be. They also reflect the potential impact of improved “whole system” financial and service planning along with clarity around the requirement and options for resource transfer and service “buy in”.

In order to present a changing picture, impacts of these factors will be assessed at 5, 10 and 15 year intervals from the current baseline.

It is important to underline that no one knows what the future really holds and that as well as current projections proving to be wrong, new as yet unknown factors may appear that have a significant and un-assessed impact on future capacity requirements. These arguments are often used as an excuse for undertaking no real detailed future service modelling or as the reason why models have to be majorly re-worked at regular intervals. Such modelling is extremely important and valid however, so long as all assumptions and modelling data are based on the best evidence or assumptions available and clearly documented to allow scrutiny, challenge and future revision as appropriate. (Modification if/when new/better data becomes available)

2.6.10 Future Flexibility

In reflection of the wide range of risks regarding capacity modelling identified throughout all of the planning, modelling and early design work undertaken thus far, a key priority identified has always been the need for future flexibility – whether this is on a day to day basis or over a longer period of time.

Specifically, the project team acknowledge that, despite the detailed capacity and service modelling currently on-going, it is simply not possible to guarantee the capacity required at all times. Future facility flexibility is therefore seen as a key design challenge that will be emphasised in the clinical and technical briefs.

In addition, the developing clinical brief will include an expansion strategy that recognises operational, service-specific and building options for short-term (operational/service-related) to long-term (strategic/buildings related) development/growth in order to further mitigate this risk.

2.6.11 Surplus Capacity vs Quality of Care

The 2014 report identified that projected activity levels “appear to be broadly in line with the 8-12 beds noted in the 2009/10 report” but also warned that “with such small numbers it is challenging to be completely certain of the long term annual trends. It noted that:

“ultimately the judgement to be considered is the risk of some surplus capacity, balanced against the quality of care issues associated with delayed access to placements”.

In reflection of this consideration – which remains valid – the project team have/will continue to consider the consequences of delivering alternative capacity models based on the detailed planning now being undertaken. e.g. The current preferred physical model requires that bedrooms be provided in 3 x clusters, which is believed to be the optimal as it will allow for a notional Male cluster, a notional Female cluster and a notional "swing bed" cluster. (Single bedrooms are not seen as sufficient to provide the necessary segregation within this complex patient group).

This immediately makes an 8 bed option unfavourable from a design perspective – with a more likely bed range 9 or 12 beds in either 3 “clusters” of 3 or 3 “clusters” of 4. This is highlighted in the relationship diagram (below) which is taken from the developing Clinical Output Specification.

Further analysis, only now possible based on the developing COS and detailed Schedule of Accommodation that supports it, indicates that the area difference between a 9 and 12 bed unit is around 130m² or 7% of the gross area. It is thus possible to conclude that, due to the increasing diseconomies of scale associated with smaller units, a 12 bed facility is likely to be able to deliver 25% more physical capacity for only 7% more area/capital cost overall.

This presents a case for constructing additional space initially as a component of a wider future growth strategy but will continue to be further scrutinised and challenged as detailed service planning is progressed.

2.6.12 Capital and revenue affordability

The planning team are aware that capital and revenue funding for the project is finite and will only be made available based on agreed need. Given previous comments regarding the unique and complex relationship between staffing and physical capacity, they also recognise the need to ensure that differences are reconciled as far as possible and that any short-term mis-match between the two is managed effectively for the benefit of the overall service.

2.6.13 Summary

Whilst a significant amount of historical data has been gathered by the wider planning team to date that has led to a baseline assumption about the size of the proposed 12 bed unit, this is now being further tested and challenged to ensure that the accommodation provided and wider service model is able to cope with the differing demands likely to be placed upon it.

This includes collecting new data from the full range of referrers to a potential new facility that will be used to supplement previous modelling and, based on a series of alternative assumptions about how the future may change, help to inform the optimal size and configuration of the new facility.

This detailed activity – following on from similar successful work that supported radical re-design in support of the Woodland View development - is also now testing and challenging the simplistic historical number of “beds” as the only measure of physical capacity. This is in reflection of the complex clinical needs of a patient population who require considerably more than somewhere to sleep.

It will ultimately be fed into the developing business case process through the Clinical Output Specification; Technical Specification; Staffing Model; and Schedule of Accommodation.

2.7 Draft Schedule of Accommodation

The draft schedule of accommodation below has been developed using the guidance and Schedule of Accommodation detailed in HBN 03-02 Facilities for Child & Adolescent Mental Health Services (CAMHS) and complements the Model of Care described in section 2.4.

The SoA has evolved in conjunction with the Model of Care. The spreadsheet included at Appendix O details the progression. A brief overview of the tabs on the spreadsheet is:

CAMHS Schedule of Accommodation (SoA)

This tab is an un-modified version of the Schedule of Accommodation noted in HBN 03-02.

SoA 1

A modified version of the baseline guidance that reflects a developing model of care.

SoA 2

Further development based on the outcomes and discussions from the clinical workshops.

SoA 3

A further development of the previous versions that removes zero rated areas and realigns rooms so that they reflect the zones identified in the developing Model of Care/ Clinical Output Specification.

SoA 4

This is the preferred draft that reflects the current Model of Care.

SoA 4 (9 beds)

This version is used as a benchmark against the current version of the SoA.

What this SoA shows is that the space saving associated with 9 beds instead of the proposed 12 beds is not dramatic e.g. for a 25% reduction in beds it realises a 7% reduction in the overall SoA.

The last tab on the spreadsheet is a diagrammatic representation of the core areas/zones and how they relate to each other and also reflects the accommodation presented on the Schedule of Accommodation.

NSAMHIS DRAFT SCHEDULE OF ACCOMMODATION

Activity Space	HBN Reference	Unit area allowance m ²	Quantity	Total area m ²	Notes
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MAIN ENTRANCE HUB & ADMIN					
Draught Lobby	HBN 03-01	6	1	6	
Main entrance/reception	HBN 03-01 HBN 00-03	20	1	20	
Reception desk. (Size based on number of places.)	HBN 03-01 HBN 00-03	5.5	2	11	
Reception office. (Size based on number of places)	HBN 03-01 HBN 00-04	6	2	12	
Waiting area (5 places including wheelchair space). (Size based on number of places.)	HBN 03-01 HBN 00-03	1.8	6	10.8	
Interview room	HBN 03-01	12	1	12	
Office - 1 person with informal meeting space	HBN 00-03	12	3	36	SCN x1, visiting consultants x 2.
WC - semi-ambulant	HBN 00-02	2.5	1	2.5	
WC (independent wheelchair/semi-ambulant)	HBN 00-02	5.5	1	5.5	Visitor toilet. HBN notes: The accessible WC should be kept locked when located in the reception area, to be opened upon request.

STAFF AREA					
Staff rest room and mini-kitchen (size based on number of spaces)	HBN 03-01 HBN 00-03	1.8	15	27	Assumes max of 15 staff at any one time.
WC - ambulant	HBN 00-02	2	4	8	
WC (independent wheelchair/semi-ambulant)	HBN 00-02	5.5	1	5.5	
Staff WCs, changing rooms and showers (10 lockers)	HBN 00-02	6	4	24	Assumes 40 lockers required. HBN states: May include lockers and hanging space (see below).

VISITING AREA					
Visiting room	HBN 03-02	16	1	16	Accesses toilets in the entrance hub.

DAY, DINING & LOCAL ACTIVITY AREAS					
Ward entrance (Secure lobbies)	HBN 03-02	6	2	12	
Dining area (size based on number of places)	HBN 03-01	2	18	36	
Unit kitchen / ward kitchen	HBN 03-01 HBN 00-03	20	1	20	Increased to suit local catering provision. (HBN states: The catering solution and the size of the unit will determine the requirements for either a kitchen for the unit and / or ward kitchens)
Activities area	HBN 03-01	16	1	16	This area should include appropriate activities for the age group. This may include electronic games.
Games area / social room	HBN 03-01	24	1	24	Space should be considered carefully if a table tennis and / or pool table is required. Lockable storage may also be required for the tables and other equipment.
Patients' beverage area	HBN 03-01 HBN 00-03	6	1	6	
Patients' laundry	HBN 03-01	12	1	12	Inclusion of this room in the unit, can assist in developing life skills.
Staff communication base/ward base (size based on number of places)	HBN 03-01	5.5	2	11	
WC - semi-ambulant	HBN 00-02	2.5	2	5	

PATIENT: BEDROOM AREAS					
Sitting area/room (size based on number of places) (Located within bedroom "clusters").	HBN 03-01	3	12	36	Assumes small sitting areas provided with 3 x bedroom "clusters". Also doubles as "quiet room provision through the day?
Staff "touch-down" bases		2	3	6	As per HBN 00-02
Single bedroom (Accessible)	HBN 03-01	12.5	9	112.5	Personalisation of the room by the patient would be advantageous. The opportunity to display posters and photographs. Lighting which can reflect mood, colour changing, dimmable and controlled from within the room would be advantageous.
Single bedroom for extra care/seclusion	HBN 03-01	15	3	45	Final model to be determined. Current notional allowance is for 3 bedrooms (1 per "cluster") to be able to support seclusion/extra care needs.
Lobby to seclusion room	HBN 03-01	8	3	24	As above.
De-escalation area	HBN 03-01	12	3	36	As above.
En-suite	HBN 03-01	4.5	12	54	A lockback door gives the opportunity for the door to be locked in the open or closed position by staff.
Linen storage	HBN 03-01	5	3	15	This can be one linen store or could be small cupboard areas located in bedroom corridors. Increased to meet local needs - assumes 3 x "clusters"
Assisted bathroom	HBN 03-01	15	1	15	Consider provision of a 'domestic'-type bathroom, feels like being at home. Also consider DDA shower as young people often prefer showers to baths. (Reduced from 2)
Mobile hoist storage	HBN 03-01	2	1	2	Hoists may be stored within a dedicated lockable recess within the bathroom. If this is unavailable, the hoist should be stored in a locked store room within the area which may also contain weighing / sanitary chairs. (Reduced from 2 as above)

UNIT SUPPORT & STORAGE AREAS					
Patients' property store (Personal goods store)	HBN 03-01	12	1	12	HBN notes: The size of this room may be smaller than previously as single bedrooms with lockable storage allows more property to be kept in a secure manner. The lockable storage can be mixed and some can be controlled by staff only within the bedroom. Local model assumes 3 "clusters" of rooms and need for storage space for larger personal items within clusters. (Cases, boxes, etc)
Equipment store	HBN 03-01	12	1	12	Sockets may be required for equipment which requires charging.
Dirty utility	HBN 00-03	10	1	10	No requirement for bed pan processing.
Disposal hold	HBN 00-03	10	1	10	Increased to meet local needs.
Cleaners' rooms	HBN 00-03	10	2	20	Increased to meet local needs.

CLINICAL SUPPORT & CONSULTING AREAS WITH DISCRETE ENTRANCE					
Discrete entrance (Secure lobby)	HBN 03-02	6	1	6	Separate discrete side entrance for prisoners, etc.
Treatment room/clinic utility	HBN 00-03 HBN 03-01	16	1	16	
Clinical consulting room		13.5	3	40.5	Supporting a range of clinical consulting activity and patient searches for clients admitted via the discrete entrance, e.g. From custody..(Equivalent to "single-sided consulting room areas)
Meeting room / Staff handover / group therapy / activities (Duty room)	HBN 03-01	16	1	16	These rooms should be multi-functional and offer the opportunity for other activities to take place, when not in use for meetings. Ideally a bookable facility will offer more flexibility. Furnishings and storage for unused furniture should be considered carefully to allow for the room layout to be changed.
WC - ambulant	HBN 00-02	2	6	12	Notionally staff
MDT Room		20	1	20	Supporting daily MDT meetings

GROUP/ THERAPY AREA					
Group therapy rooms		20	3	60	Assumes all rooms are multi-functional! Size per room increased from 16m ² to support multi-functional element. Specific teaching rooms listed separately under education.
Group therapy room store		4	3	12	En-suite to group rooms for local eqpt storage to support multi-functionality.
Therapy kitchen		20	1	20	Assumes not required as patient pantry available for therapeutic activity.
Gym	HBN 03-01	30	1	30	
WC (independent wheelchair/semi-ambulant)	HBN 00-02	5.5	2	11	Shared with school area.
WC - ambulant	HBN 00-02	2	2	4	Notionally staff
Therapy office (size based on number of places)		6	2	12	

SCHOOL AREA					
Teaching room (minimum recommended space for any teaching room is 3 persons) (size based on number of spaces)	HBN 03-02	4	8	32	In smaller units this room could be shared to allow a number of staff members to teach different subjects.
ICT room (size based on number of computers required)	HBN 03-02	4	4	16	
Learning resource area	HBN 03-02	10	1	10	
Staff room/office space (size based on number of spaces)	HBN 03-02	6.6	2	13.2	

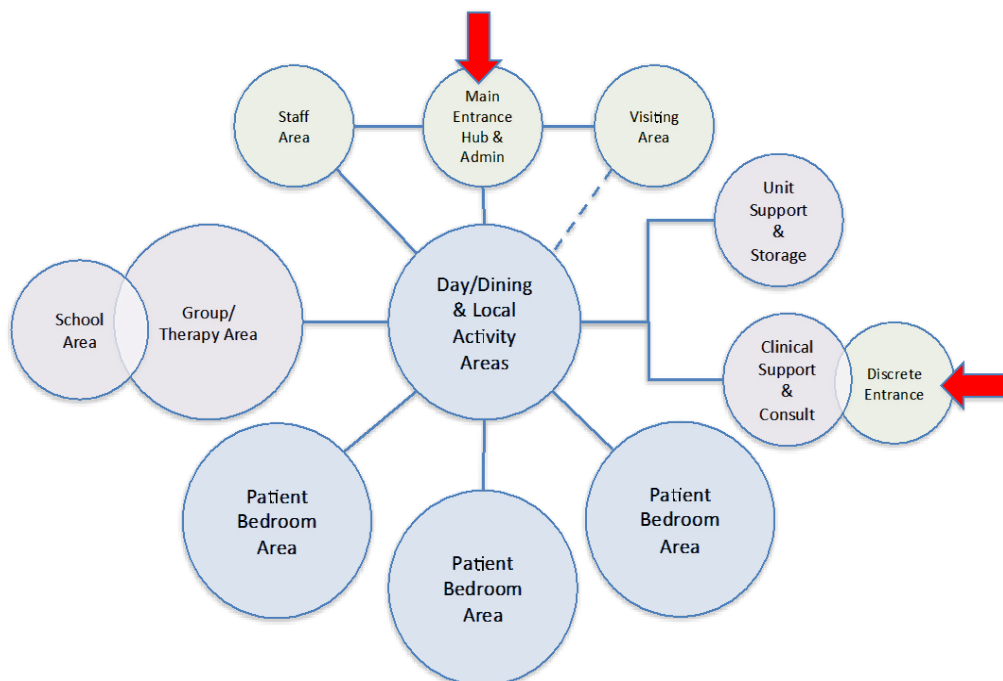
Sub-total		1079	
Plant	12%	129	HBN recommends 12% of NIA is allowed (depending on the size and nature of the building, and the location of the plant - rooftop plant, for instance, will require negligible m ²).
EDC/Switch Cupboard (x6 @2.5m²)		15	
Comms		14	Estimate based on historical projects
Net internal area (NIA) m²		1237	

Net internal area (NIA) m²		1237	
Circulation allowance	25%	309	HBN figure used.
Communication	0%	0	Not required in a single unit of this size.
Engineering	25%	309	HBN figure used.
Gross internal area (GIA) m²		1855	

Notes:

- Baseline guidance Sofa Based on HBN 03-02 (12 beds)
- Modified by N Sutherland (HGHP) to reflect local service planning & client comments (11/5/18)
- Does not include external areas (Outdoor storage, secure garden areas and secure vehicular/ambulance compound)
- Still being developed and modified as COS discussions are on-going.
- Comments removed from this version for inclusion in IA documentation.
- This version re-aligned to reflect notional zonal/area relationships and flow. (See relationship diagram)

NSAMHIS Core Areas & Relationships



2.8 Workforce Planning Strategy

NHS Ayrshire and Arran's workforce will be instrumental in the successful delivery of the NSAIS through making best use of the skills and capabilities of its staff. The workforce, in all professions and at all levels, will have a part to play and staff will be supported and developed to ensure they can fully engage and commit to the service delivery model. The future workforce will be based on teams of staff rather than individual practitioners to develop an effective multi-disciplinary teams working with the appropriate knowledge and skills. It will integrate more closely the work of mental health based specialties alongside community based teams, with a clear understanding and value of each other's roles and a culture which supports young people with mental health difficulties and offending behaviour.

2.9 Workforce Availability

2.9.1 Staffing

Currently, there are ongoing issues with availability of healthcare staff within Child and Adolescent Mental Health Services (CAMHS) across Scotland and this is even more pronounced within Forensic CAMHS. With an ageing workforce, the continuation of CAMHS delivery, based on the current workforce model with the same level of reliance on healthcare staff, is unsustainable. There requires to be a development of specialist roles from several professional backgrounds (nursing, allied health professionals, pharmacy and a combination of Forensic Consultant Psychiatrists and CAMHS Consultant Psychiatrists)all of whom will be trained to undertake highly skilled roles/tasks within NSAIS.

2.9.2 Service Delivery

To provide safe, effective and person-centred care, the workforce should match the workload demands in the care context, location and hours of service. Initial scoping has been undertaken to determine the resource. This has been conducted taking into account recommendations from the Safe Staffing initiative.

2.9.3 Recruitment & Retention

NHS Ayrshire and Arran recognises the importance of being an Employer of choice which can attract and retain high quality staff. To do this we are supported by excellent, recruitment, selection procedures, inductions, performance management, strong leadership and staff development processes.

To maximise workforce availability and reduce agency/locum spend, NHS Ayrshire and Arran will promote NSAIS as an attractive place to work and, where possible, review workforce strategies and policies to reflect and support staff.

2.10 Workforce Adaptability

2.10.1 Commissioning New Roles

NHS Ayrshire and Arran have commenced detailed multi-professional workload and workforce planning to support the development of NSAIS. Because of the unique nature of the proposed service NHS Ayrshire and Arran will consider use of existing resources by up-skilling. The identification of skills and competency gaps will be equally important in ensuring appropriate training and development is ongoing to ensure the workforce is appropriately prepared and supported for the future.

Again, the unique nature of the proposed service will require a period of familiarisation and training prior to the service being operational. At the moment it is anticipated that a significant portion of the work force will require to be in place for a minimum of 6 months before operation. This is based on the successful commissioning of the adult low secure service within Woodland View.

A similar approach will be required to define the nursing assistant role. It was not possible within the workforce group to determine the exact numbers required and so an initial estimate of need was agreed and will be developed further during the OBC. It is essential that professions are able to define their unique professional contribution and identify tasks which can be delegated and carried out effectively by nursing assistants, thus building safe and effective capacity.

2.10.2 Influencing Undergraduate Programmes

Ongoing work is required with Regulators, Scottish Government and Higher Educational Institutions (HEIs) to ensure that the development of undergraduate programmes is designed in line with the future healthcare need.

2.11 Associated Buildings & Assets

2.11.1 Condition and performance of existing assets (affected by this proposal)

NHS Scotland does not have a physical or built asset associated with the National Secure Adolescent Inpatient Service (NSAIS) .

The following ADET review used two buildings familiar to those using the commissioned service as a benchmark. The benchmark properties are described in more detail below.

2.11.2 AEDET Review

The first AEDET workshop was held on 13 December 2017 with the assistance of Susan Grant, Principal Architect for Health Facilities Scotland.

The first workshop captured the needs of the service, sets actions and notes before the design is developed. Relevant and important questions related to this project were weighted and benchmarked against a target score.

As there is no built asset relating to this service the group agreed to set the benchmark against two facilities used for, either treatment or holding patients awaiting transfer to an appropriate service for treatment.

The first property benchmarked was a commissioned service in NHS England. It is on an established site, in the suburb of major city, and is easily accessible. It is a converted old style asylum that has been developed for young people. A recent refurbishment programme has updated the interior to provide a “homely feel”. The clinic is classed as medium secure facility. The patients are encouraged to attend school and undertake other activities within the unit. The second property is an Intensive Psychiatric Care Unit (IPCU) set in the grounds of Ailsa Hospital. The unit is an old Victorian Asylum site. Patients and visitors are very fond of the site as it is set in a quiet green space with good transport links to the nearby town.

The IPCU is a large linear single storey building, with single bedrooms and ensuite off one long corridor. The communal space is at both extremities of the corridor. The unit has been adapted over the years and has lost a lot of its character. The functionality of the unit is poor, with poor sound attenuation and high reverberation rates.

The environmental conditions are poor with a single pipe heating system, with little or no control. The outside space is a small locked courtyard to the rear of the building that gets no natural light and is often cold and damp.

The outcome of the initial AEDET (refresh) workshop is attached at Appendix J.

2.12 Need for change

2.12.1 Opinion on existing arrangements

The current commissioned service (across England) and problems associated with this service are documented in the sections above. There are four key issues relating to the current service that can negatively impact on the outcome for the young person. These are:

1. Time from referral to treatment;
2. Equity of access to appropriate inpatient secure facilities;
3. Proximity to the young person’s support system, including family, friends and clinical support;
4. convoluted legal processes in terms of cross border transfers;
Key to the successful outcome for a young person is the time taken to from referral to treatment, the quicker the response the higher the success rate. Currently the commissioned service takes on average three months from referral to admission to the inpatient facility. Within those three months, the care setting for that young person maybe inappropriate, potentially leading to a less positive outcome.

Over the past twelve months cross border transfers have dropped significantly.

This appears to be due to a change in practice where regarding English services prioritising English young people. We can speculate that there are a number of reasons for this change, such as, political spotlight being placed on CAMHS in England and an increased need being identified within the young people of England.

It has been well documented that there is a benefit to the young person being as close to their support system as possible. The support system can include family, friends and a professional care team around the young person. By placing the young person in England; the physical distance can hamper or lengthen the time to a successful outcome. Education also plays a key part in recovery and development of the young person. Transferring to the English curriculum can add to the difficulties encountered by the young person at an already challenging time for them.

The legal complexity of cross border transfers and the time taken to complete this can create anxiety and uncertainty for the young person and their families whilst they are waiting for a decision. In addition the young person may be placed within an inappropriate care setting for a protracted period whilst awaiting the outcome.

In the opinion of the project team, the NSAIS will be of benefit to, and enhance the probability of a successful clinical outcome for the young people either awaiting or currently being referred to the commissioned service in England.

2.12.2 Enhanced quality of service or asset provision

The quality of service will be in alignment with the development of integrated services in Scotland.

Once the facility is designed and built, it will be the first secure inpatient service dedicated to the care of young people in Scotland. This new national service will have a clearly specified role within the range of specialist mental health services for young people across the country.

The model of care for the new facility will be part of clear care pathways for young people who present a combination of clinical need and risk of harm to others. These pathways will include all existing community and inpatient CAMHS services, in partnership with justice, social work and other children's services throughout Scotland.

NHS Ayrshire & Arran and the North Ayrshire Health and Social Care Partnership (NAHSCP) have established working links with other NHS Boards via regional and national forums. These include representation at the Scottish Government CAMHS Lead Clinicians Group, Children & Young People's Health Strategy Group and Secure Care Board. Much of the work undertaken in these groups is currently focussed on implementing the new Mental Health Strategy for Scotland, including mental health care for young offenders, pathways into secure care, transitions across mental health services and scoping the need for highly specialist inpatient care for young people with learning disability and/or offending risk.

We have worked closely with colleagues in the West of Scotland Clinical Reference Group to develop care pathways and treatment models for young people who require intensive community and/or inpatient care in open settings. This work is connected with similar developments across the North and South East of Scotland. We also have close links with colleagues from the National Child Inpatient Unit and the Forensic Network for Scotland - which will be essential in considering transitions, care pathways and developing model of care.

The governance framework directed by NSD will ensure equitable and appropriate access to the service. This will include a national clinical reference group which will have a role in reviewing referrals and admissions to the unit.

2.12.3 IT/ Technology

The new facility will be connected directly to the Ayrshire Central Hospital fibre ring to provide appropriate bandwidth to meet the requirements of staff, young people (where considered appropriate) and visitors.

The fibre will require to be terminated in a dedicated and secure communications room within the facility. The room must be capable of housing a full sized communications cabinet and be in an area accessible to eHealth staff and third party contractors.

The facility should be fully cabled with CAT 6 cabling run in trays with no cable ties. Wireless access will also be provided according to clinical requirements for electronic prescribing as an example.

If patient / public network access is required then this will attract an additional cost and should be confined to a separate network comprising both physical and wireless connections.

New devices will be required for clinical use, and type and number will be defined by clinicians.

Printing will be provided via central multi functional devices and again numbers will be dictated by clinical requirements.

Telephony, paging and radio provision will also be dependent on clinical requirements.

2.12.4 Problems with current arrangement

- Currently, English units prioritise local patients and may not always be able to admit young people from Scotland;
- Due to geographical distance, young people treated in English facilities cannot readily access their support system. This will include family, friends and clinical staff involved in their care;
- Scotland and England have separate jurisdictions and different mental health legislation;

- Special regulations must be followed before any young person is moved across the border or returned to their community;
- There is a lengthy judicial process to be followed before a young person can be transferred from, or returned, to their community;
- Due to the distance and time constraints, referring clinicians may find it difficult to maintain contact with their young person;
- Young people transferring across the border will need to adjust to an English education system, with different curriculum and examinations. Similar problems recur for them on their return to Scotland.

Currently, NHS Boards in Scotland have no cost certainty for the provision of secure services for young people transferring to a commissioned unit in England. The services for young people transferred to England are competitively commissioned, which may result in costs varying depending on the facility they are admitted to.

2.12.5 Other drivers for change

As described in 2.1.1 Existing service/activity provision, the following emphasise the drives for change.

Barriers to access

Due to commissioning arrangements, English units necessarily prioritise local patients and may not be able to admit young people from Scotland.

Delays

Due to geographical distance and time commitments, English services cannot readily arrange assessment visits to young people in Scotland. Typically, it would take around a month from date of referral to a decision about suitability for admission to a service in England. Then a lengthy legal process begins:

Legal processes

Since Scotland and England are separate jurisdictions with different mental health legislation, special regulations must be followed before any patient is moved across the border in either direction. Application must be made to the Scottish Ministers for a transfer warrant, with fixed time frames and appeal processes. Due to the particular vulnerabilities of children, clear processes must be followed before a warrant is granted, including gaining informed consent of the patient. In addition, remand prisoners cannot be moved across the border until their case is concluded.

Once a patient is admitted to an English hospital, they become subject to English mental health legislation. Similar processes must be followed before a detained patient can return to Scotland.

These necessary procedures and safeguards result in significant delays. Typically, several weeks or months pass between acceptance of a patient for admission and their actual transfer to an English hospital. Such delays mean that a child patient must wait in an inappropriate setting (adult ward, community, custody) without suitable treatment.

Separation from families

Efforts are made to ensure that young people transferred to English services are supported to receive visits from families and otherwise stay in touch with people who matter to them. However, such contact is inevitably limited by geographical distance, and restrictions of access to mobile phones, internet and contact with younger siblings in secure settings.

Disconnection from services

Referring clinicians are expected to maintain contact with patients and contribute to their care planning. In practice, this would involve attendance at 3/6 monthly reviews and mental health tribunals' and/or other statutory hearings. Social workers and other professionals achieve similar levels of contact. However, this involves time out of local services and difficulty maintaining therapeutic relationships.

Disruption to education

Young people requiring secure inpatient care typically have increased risk of disrupted education and learning difficulties. These can be exacerbated by the need to adjust to an English education system, with different curriculum and examinations. Similar problems arise on return to Scotland.

Challenges to rehabilitation

The goal of inpatient treatment is recovery and eventual return to their community of origin. Young people need considerable supervision to support their safe transition from secure to open settings. This is particularly challenging over long distances and different jurisdictions, (for example, a young person on leave from their English hospital is not "detained" when they visit Scotland). Such barriers either mean delayed discharge or challenging "testing out".

2.12.6 Summarising the Need for Change

As previously mentioned, the new Mental Health Strategy for Scotland 2017-27 includes several actions of relevance to mental health care for children and young people who display offending behaviour. In particular, Action 20: "scope the required level of highly specialist mental health inpatient services for young people, and act on its findings.

These collective actions will support progress in developing care pathways for patient who may be admitted to the proposed national secure service. When developing the clinical brief cognisance will have to be taken of the specialist nature of the service and workforce expertise.

The clinical workshop held in Stirling Court on 19 April 2018 determined a number of key principals that will be adopted and embedded within the Model of Care, these are:

- Clarity of referral criteria and pathway;
- Active planning for discharge;
- Outcomes and benchmarking;
- Maximising assessment prior to admission;
- Minimising length of stay;
- Reducing variation and promoting consistency;
- Capacity modelling.

The key principals noted above are imbedded with the IA and will continue to be developed though the business case process and into the operational phase of the project.

The table below summarises the need for change.

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
No provision in Scotland	Patients would be transferred to England for specialist provision, raising significant costs, disconnection for children and families and potentially compromised clinical outcome	Extensive stakeholder consultation has highlighted lack of provision and risk associated with this highly vulnerable population.
Dispersed service locations	Existing service arrangements effect service access and travel arrangements	Service access is currently inequitable for this in Scotland
High risk service arrangements	Inefficient service provision	Continuation of the existing service performance is unsustainable and we are unable to adequately meeting demand. There is a delay in young people getting the right service
Service arrangements not person centred	Service is not meeting current or future user requirements	A service that isn't meeting user requirements is unsustainable, even in the short term
Increased complexity with children and young people	Increased requirement to have highly specialist facilities.	Service provision is not currently available within Scotland.

2.12.7 What is the organisation looking to achieve?

The service will provide a recovery focused, person centred package of care and treatment to all young people admitted. This will be multidisciplinary and multiagency in nature with collaborative working being a key feature to ensure each young person is managed as safely and effectively as possible, to promote their independence and wellness, further rehabilitation and integration into their local community; and protection of the public through the provision of a secure inpatient facility.

The model of care will continue to be developed in collaboration with representatives of all key stakeholders, professionals, carers and service users; from across Scotland.

It is also recognised that the service would continue to evolve after it opens, as it builds confidence and learns through direct experience. Additionally, it is recognised that the needs of the young people/service users may well change following its inception and thus the service must always have the capacity to develop to meet these evolving needs.

2.13 Investment objectives

2.13.1 Identification of what has to be achieved to deliver change

The following table identifies the objectives for the new service to address the gaps in the current service.

Effect of the need for change on the organisation:	What has to be achieved to deliver the necessary change? (Investment Objectives)
Prevent cross border transfers.	Provide an Adolescent Inpatient Service in Scotland.
Avoid the costs associated with support and travel arrangements to England. Reinvest the costs above into the new service.	Improve service access by providing in Scotland.
Improve the time taken from referral to admission of a young person into an appropriate inpatient facility. Delays will be reduced due to the elimination of, legal/procedural constraints. This will reduce delays in to treatment. This is not currently measured, however more detail will be provided within the OBC.	Improve service delivery and performance by providing in Scotland.
90% of young offenders on remand who require inpatient care will in the future receive appropriate treatment within service standard timeframe.	Service arrangements in Scotland would meet user requirements for service
Provision of a Scottish inpatient facility will meet the treatment needs of 85-90% of the patients who fulfil its admission criteria.	Improve safety, risk and effectiveness by developing a specialist facility in Scotland.

2.14 Benefits Realisation Plan

2.14.1 Development of Benefit Criteria

A large stakeholder workshop took place on Tuesday 12 September 2017. Over 30 stakeholders took part in discussions and developing the benefits for the project. The main focus was commenting on the Benefits Scorecard. The Benefits Scorecard can be found in Appendix B.

Clinical staff representing a number of Boards north and south of the border included a range of national professional, operational, management and non-clinical support services were asked to consider the benefits scorecard. The result was over 12 high level benefits criteria were identified, which are listed below.

2.14.2 Benefits realised by New Models of Care

having the right environment in the right place, at the right time;

- increased contact between young people, patients and their support system, including parents, carers and clinical teams;
- improved patient and family satisfaction facilitated by an improved commissioning model;
- continuity of educational provision;
- reduction in numbers of young people under the age of 18 year being transferred cross border (English hospitals);
- reduction in young people under the age of 18 year in locked adult wards in Scotland;
- suitably trained and skilled multidisciplinary team within a single service to efficiently and effectively meet complex needs and risks presented by this patient group;
- ability to accurately capture/measure clinical outcomes;
- increased ability to rehabilitate to identified placement as part of transitioning processes at discharge;
- reduced number of bed days according to clinical need for young people already in secure hospitals in England;
- robust clinical governance framework;
- clearly defined pathways for admission assessment and through care;
- care delivery and restriction levels are in keeping with MILAN and GIRFEC principals and outcomes;
- improved person centeredness care;
- The identified benefits at this stage will help meet expectations for a Scottish service, will address the need for change and demonstrate the national importance of the proposal.

The new Mental Health Strategy for Scotland 2017-27 includes several actions of relevance to mental health care for children and young people who display offending behaviour.

In particular, Action 20: “scope the required level of highly specialist mental health inpatient services for young people, and act on its findings.

These collective benefits will support progress in developing care pathways for young people who may be admitted to the proposed national secure service.

2.14.3 Benefits Management

The benefits scorecard will be subject to ongoing review and refinement as the project progresses into a Benefits Realisation Plan that will monitor and manage the stated benefits for the project

2.15 Risk Management Strategy

Effective risk management will provide a safer environment and better care for young people and, will help the organisation to capitalise on opportunities and fulfil its corporate objectives in the short and longer term. There is a commitment to making risk management a core organisational process and to ensure that it is embedded in our business planning and that it becomes an integral part of our philosophy and practices and that responsibility for implementation is accepted at all levels of the organisation.

2.15.1 What is risk?

At its simplest, risk is the possibility of loss or harm and that this may arise from any given situation. In the context of this strategy, this encompasses the possibility of injury to an individual patient or member of staff or to any part of the built environment which impacts upon an organisations ability to fulfil its aims and objectives.

2.15.2 What is risk management?

Risk management is defined as a proactive approach to the:

- identification of risks;
- analysis and assessment of the likelihood and potential impact of risks;
- elimination of those risks that can be reasonably and practicably eliminated;
- control of those risks that cannot be eliminated by reducing their effects to an acceptable level.

Risk management is an integral part of an organisation’s Code of Corporate Governance. Corporate assurance is a process designed to provide evidence that an organisation is doing its “reasonable best” to meet objectives, protect patients, staff, the public and all stakeholders against risks of all kinds.

2.15.3 Why manage risk?

Risk and risk taking is inherent within an organisations planning and processes. For example: assessing levels of healthcare needs in the community, determining service priorities, managing a project, taking decisions about future strategies, or even deciding not to take any action at all.

There is a need, therefore, to adopt a systematic and consistent approach to risk management, which encompasses the organisations functions and activities.

2.15.4 Integration of risk management

Successful alignment of risk management and governance requires four key factors:

- 1) an organisational focus – where there is an identifiable source of risk management expertise within the organisation and senior managers come together on a regular basis to discuss risk management issues;
- 2) an organisational direction – where a clear direction and strategy is established for risk management, including articulating the organisation's risk appetite and giving a clear mandate for what constitutes effective risk management;
- 3) decision-making structures – where risk management is not a separate process, but a key consideration at all parts of the decision-making chain: being factored into strategic and operational planning; included as a common component in all project proposals and business cases; and,
- 4) capacity and capability – where the organisation's senior management invests time and resources to build momentum, capacity and capability, including: ensuring that there is a shared language of risk management; a common understanding of the principles; training and development to build expertise; and established tools and processes for risk management.

Integrated risk management requires an ongoing assessment of potential risks and opportunities for an organisation at every level. The results should inform all organisational level risks, facilitate priority setting and improve decision making.

Clear responsibility and accountability needs to be in place otherwise risks may remain unidentified; causing loss or harm that could be controlled or avoided. The organisation's Risk Management Strategy defines individual and organisation arrangements at local, system wide and Board levels.

For the purposes of this project NHS Ayrshire & Arran's Board has overall responsibility for Risk Management and for ensuring that significant risks are identified and controlled. To facilitate this a workshop was held on 12 September 2017. This identified a number of clinical and built environment risks which are described below.

This text is derived from NHS Ayrshire & Arran's Risk Management Strategy and North Ayrshire Integrated Joint Board Risk Management Strategy.

2.15.5 Risks identified

Best practice for risk management for NHS Ayrshire & Arran has taken the approach that risks should be borne by the party best able to manage them effectively.

NHS Ayrshire & Arran's Risk Management Strategy identifies the following risk management objectives:

- develop a risk management framework, which provides assurances to the Board that strategic, operational and partnership risks are being managed effectively;
- maintain a cohesive approach to corporate governance and effectively manage all risk management activity;
- minimise the chance of adverse events, risks and complaints through effective risk identification, prioritisation, treatment and monitoring;
- ensure that risk management is an integral part of NHS Ayrshire & Arran's culture; and,
- ensure that NHS Ayrshire & Arran meets all its legal obligations and aspires to meet healthcare best practice where possible.

2.15.6 Identifying risk

To identify risks think through the things that could prevent or hinder your team from achieving its business objectives. There are three parts to a risk – an event that has a consequence that leads to an impact on our objectives. Typical risk phrasing could be:

loss of...
failure of.....
failure to...
lack of...
development of...

} *leads to resulting in.....*

2.15.7 Assessing Risk

Residual = the level of risk remaining after managing it through treatment and/or control measures.

To identify the Residual risk we simply identify the consequence score from the appropriate domain listed in table below after we have identified the control measure. We then multiple the consequence score by the likelihood of the event occurring. The likelihood score is taken from the matrix below.

Multiplying the consequence x likelihood then provides us with the Residual Risk. The Residual risk score helps to make decisions about the significance of risks to the NHS Ayrshire & Arran, and how they will be managed, the controls required and the treatment of the risk.

2.15.8 Severity consequence matrix

Description and definition of the CONSEQUENCE / IMPACT of the risk should it occur (these are a guide)

Consequence/Impact

“Domains”	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Objectives and projects	<ul style="list-style-type: none"> ▪ Barely noticeable reduction in scope / quality / schedule 	<ul style="list-style-type: none"> ▪ Minor reduction in scope / quality / schedule 	<ul style="list-style-type: none"> ▪ Reduction in scope or quality, project objectives or schedule. 	<ul style="list-style-type: none"> ▪ Significant reduction in ability to meet project objectives or schedule. 	<ul style="list-style-type: none"> ▪ Inability to meet project objectives, reputation of the organisation seriously damaged and failure to appropriately manage finances.
Injury (physical and psychological) to service users/staff.	<ul style="list-style-type: none"> ▪ Adverse event leading to minor injury not requiring first aid. 	<ul style="list-style-type: none"> ▪ Minor injury or illness, first-aid treatment needed. No staff absence required. 	<ul style="list-style-type: none"> ▪ Significant injury requiring medical treatment and/or counselling. 	<ul style="list-style-type: none"> ▪ Major injuries or long term incapacity / disability (loss of limb), requiring medical treatment and/or counselling. 	<ul style="list-style-type: none"> ▪ Incident leading to death or major permanent incapacity.

<p>Patient/Service User experience & outcome</p>	<ul style="list-style-type: none"> ▪ Reduced quality of service user experience / clinical outcome not directly related to delivery of clinical care. 	<ul style="list-style-type: none"> ▪ Unsatisfactory service user experience / clinical outcome directly related to care provision – readily resolvable 	<ul style="list-style-type: none"> ▪ Unsatisfactory service user experience / clinical outcome, short term effects – expect recovery < 1Wk 	<ul style="list-style-type: none"> ▪ Unsatisfactory service user experience / clinical outcome, long term effects - expect recovery > 1Wk 	<ul style="list-style-type: none"> ▪ Unsatisfactory service user experience / clinical outcome, continued ongoing long term effects.
<p>Complaints / claims</p>	<ul style="list-style-type: none"> ▪ Locally resolved complaint 	<ul style="list-style-type: none"> ▪ Justified complaint peripheral to clinical care 	<ul style="list-style-type: none"> ▪ Below excess claim. ▪ Justified complaint involving lack of appropriate care. 	<ul style="list-style-type: none"> ▪ Claim above excess level. ▪ Multiple justified complaints 	<ul style="list-style-type: none"> ▪ Multiple claims or single major claim.
<p>Staffing and competence</p>	<ul style="list-style-type: none"> ▪ Short term low staffing level (< 1 day), where there is no disruption to patient care. 	<ul style="list-style-type: none"> ▪ Ongoing low staffing level results in minor reduction in quality of service user care ▪ Minor error due to ineffective training / implementation of training. 	<ul style="list-style-type: none"> ▪ Late delivery of key objective / service due to lack of staff. ▪ Moderate error due to ineffective training / implementation of training. ▪ Ongoing problems with staffing levels 	<ul style="list-style-type: none"> ▪ Uncertain delivery of key objective / service due to lack of staff. ▪ Major error due to ineffective training / implementation of training. 	<ul style="list-style-type: none"> ▪ Non delivery of key objective / service due to lack of staff. ▪ Loss of key staff. ▪ Critical error due to insufficient training / implementation of training.

Service / business interruption	<ul style="list-style-type: none"> ▪ Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service 	<ul style="list-style-type: none"> ▪ Short term disruption to service with minor impact on service user care. 	<ul style="list-style-type: none"> ▪ Some disruption in service with unacceptable impact on service user care. ▪ Temporary loss of ability to provide service. 	<ul style="list-style-type: none"> ▪ Sustained loss of service which has serious impact on delivery of service user care resulting in major contingency plans being invoked. 	<ul style="list-style-type: none"> ▪ Permanent loss of core service or facility. ▪ Disruption to facility leading to significant “knock on” effect.
Financial	<ul style="list-style-type: none"> ▪ Negligible organisational financial loss (£ < 1k). 	<ul style="list-style-type: none"> ▪ Minor organisational financial loss (£, 1-10k). 	<ul style="list-style-type: none"> ▪ Significant organisational financial loss (£, 10-100k). 	<ul style="list-style-type: none"> ▪ Major organisational financial loss (£, 100k-1m). 	<ul style="list-style-type: none"> ▪ Severe organisational financial loss (£ > 1m).
Compliance	<ul style="list-style-type: none"> ▪ Small number of recommendations which focus on minor quality improvement issues. 	<ul style="list-style-type: none"> ▪ Minor recommendations made which can be addressed by low level of management action. 	<ul style="list-style-type: none"> ▪ Challenging recommendations but can be addressed with appropriate action plan. 	<ul style="list-style-type: none"> ▪ Enforcement Action. ▪ Low rating. ▪ Critical report. 	<ul style="list-style-type: none"> ▪ Prosecution. ▪ Zero Rating. ▪ Severely critical report.
Adverse publicity / reputation	<ul style="list-style-type: none"> ▪ No media coverage, little effect on staff morale. 	<ul style="list-style-type: none"> ▪ Local Media – short term. ▪ Minor effect on staff morale / public attitudes. 	<ul style="list-style-type: none"> ▪ Local Media – long term. ▪ Impact on staff morale and public perception of the organisation. 	<ul style="list-style-type: none"> ▪ National Media (< 3 days). ▪ Public confidence in the organisation undermined. ▪ Usage of services affected. 	<ul style="list-style-type: none"> ▪ National Media (> 3 days). ▪ MP / MSP Concern (Questions in Parliament).
Organisational / Personal Security, and Equipment	<ul style="list-style-type: none"> ▪ Damage, loss, theft (£ < 1k). 	<ul style="list-style-type: none"> ▪ Damage, loss, theft (£, 1-10k). 	<ul style="list-style-type: none"> ▪ Damage, loss, theft (£, 10-100k). 	<ul style="list-style-type: none"> ▪ Damage, loss, theft (£, 100k-1m). 	<ul style="list-style-type: none"> ▪ Damage, loss, theft (£ > 1m).

Likelihood

	1 Remote	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Probability	▪ Will only occur in exceptional circumstances.	▪ Unlikely to occur but definite potential exists.	▪ Reasonable chance of occurring – has happened before on occasions.	▪ Likely to occur – strong possibility.	▪ The event will occur in most circumstances.

Risk rating

LIKELIHOOD	SEVERITY				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Remote	1	2	3	4	5

How risks should be managed

Level of Risk	Risk	How the risk should be managed
VeryHigh (20-25)	Immediate Action Required Intolerable	Requires active management to manage down and maintain the exposure at an acceptable level. Escalate upwards. The activity or process should not be started or allowed to continue until the risk level has been reduced. While the control measures selected should be cost-effective, legally there is an absolute duty to reduce the risk. Review every 3 months.
High (10-16)	Immediate Action Required Unacceptable	Contingency plans may suffice together with early warning mechanisms to detect any deviation from the profile. Escalate upwards. If a new activity or process, it should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves an existing activity or process, the problem should normally be remedied within one to three months. Review every 6 months.

Level of Risk	Risk	How the risk should be managed
Moderate (4-9)	Action Required	Efforts should be made to reduce the risk, but the cost of reduction should be carefully measured and limited. Risk reduction measures should normally be implemented within three to six months. Re-assess frequently.
Low (1-3)	Acceptable	No further preventative action is necessary, but consideration should be given to more cost-effective solutions or improvements that impose no additional cost burden. Monitoring is required to ensure that the controls are maintained. Review periodically to ensure conditions have not changed.

The four T's

The level of the inherent risk will help determine the best treatment for a risk, whether strategic, partnership or operational. Once the type of risk has been determined, consideration must be given to the most appropriate to treat the risk, action plan will be require to be drawn up and implemented. The rating and prioritisation of the risk will determine the speed with which the risk action plan should be implemented and at which level of the organisation the risk needs to be reported. This is described in more detail below.

Tolerating	<p>The organisation may tolerate a risk where:</p> <ul style="list-style-type: none"> the risk is effectively mitigated by internal controls, even if it is a high risk; the risk cannot be mitigated cost effectively; the risk opens up greater benefits; <p>These risks must be monitored and contingency plans should be put in place in case the risks occur.</p>
Treating	<p>This is the most widely used approach. The purpose of treating a risk is to continue with the activity which gives rise to the risk, but to bring the risk to an acceptable level by taking action to control it in some way through either:</p> <ul style="list-style-type: none"> containment actions (these lessen the likelihood or consequences of a risk and are applied before the risk materialises); or contingency actions (these are put into action after the risk has happened, thus reducing the impact. These must be pre-planned)
Terminating	<p>Doing things differently and therefore removing the risk. This is particularly important in terms of project risk, but is often severely limited in terms of the strategic risks of an organisation.</p>
Transfer	<p>Transferring some aspects of the risk to a third party, e.g. via insurance, or by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks, or risks to assets. However it is a limited option.</p>

An early risk register is attached which identifies the risks, however a further workshop is being arranged to score and update this document which is attached within Appendix C.

The risk register is a live document and will be regularly reviewed by key stakeholders as well as at the Steering Group and Project Board. The key owners of risks will be the following:

- SRO (Senior Responsible Owner);
- Project Director;
- Project Manager;
- Finance;
- Clinical Managers;
- Support Services.

The risk register, which is appended to this document, identifies risk under the following headings:

- Business Case;
- Change Management;
- Clinical;
- Communications;
- Construction;
- Design;
- Funding;
- Political;
- Resources.

2.15.9 Reporting on risk

The Risk Register is a dynamic document that is reviewed and updated by the Project Team on a weekly basis. Any new risks are introduced through the Steering Group and ratified at the Project Board.

As detailed in 2.6 the following investment objectives have been identified. The table below summarises these and identifies the risk that might impact on their achievement.

Investment objectives	Risk identified that might impact on their achievement	Impact of risk
Provide service capacity in Scotland.	<p>Scottish Government fail to fund the project</p> <p>Failure to meet business case programme</p> <p>Political agenda/commitment may change</p> <p>Stakeholder involvement and engagement</p>	<p>Impact service users would continue to be treated out with Scotland.</p> <p>Delay the project overall with consequential financial and reputational impact to the Board.</p> <p>There would also be a delay to commissioning the service.</p> <p>Require a re-assessment of the options available, affordability etc. leading at the very least to a project delay and additional cost.</p> <p>Create disharmony and have the potential to delay reaching agreement on key issues, which may impact on the project, cost and design. Benefits realisation may be impacted.</p>
Improve service access by providing in Scotland.	<p>Size of facility</p> <p>Implementation of the Workforce Plan</p>	<p>Facility will not be able to treat the demand of young people requiring the facility in Scotland</p> <p>Appointments may not be made in time to realise the benefits of the service delivery plan and improved models of care</p>
Improve service performance and outcomes by providing the service in Scotland.	Service is not provided in Scotland (i.e. Status quo)	<p>Impact service users would continue to be treated out with Scotland.</p> <p>Delay from referral to treatment.</p> <p>Continued separation from families, clinical support and local support network.</p> <p>Continued prioritisation of English patients over Scottish patients.</p> <p>No opportunity to develop a sustainable clinical model for the patient.</p>
Service arrangements in Scotland would meet user requirements for service	Qualified teaching staff	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.
Improve safety, risk and effectiveness by developing a specialist facility in Scotland.	<p>Unable to agree treatment</p> <p>Clinical engagement during design and briefing phase</p>	<p>May lead to delays in treatment plan/ decisions and lack of clarity in care pathway</p> <p>Facility is designed that will not meet the needs of the service users.</p>

Investment objectives	Risk identified that might impact on their achievement	Impact of risk
	Accuracy of Schedule of accommodation is insufficient or excessive	Result in a change of scope with increased costs and delays and an increase in capital and revenue costs and capital charges.

2.15.10 Constraints or Dependencies

There are no land or adjacency constraints with this facility due to the nearby location of a specialist mental health facility, Woodland View which includes adult low secure provision. The latter is designed to a low secure specification and includes a specialist deployed workforce.

Dependency would be to develop a specialist workforce to be in place leading into the service launch.

3.0 Economic Case

This section of the IA outlines the options that were considered by National Specialist Services Committee (NSSC) It includes do nothing/minimum and Options 1 to 3.

- The content of this section includes:
- Description of process and decision making;
- Initial assessment of proposed solution;
- Service details of proposed option;
- Service arrangements of proposed option;
- Proposed functional size of the service;
- Proposed service demand and provision;
- Indicative costs;
- Stakeholders identified;
- Design quality objectives.

3.1 Description of process and decision making

The diagram below summarises the decision making process up to and including submission of the Strategic Assessment for the project on 26 January 2017.

In March 2016, the Scottish Government Health & Social Care Directorates National Planning Forum endorsed a report from the National working group on secure care for young people. The report recommended that a National Secure Adolescent Inpatient Service is established for Scotland.

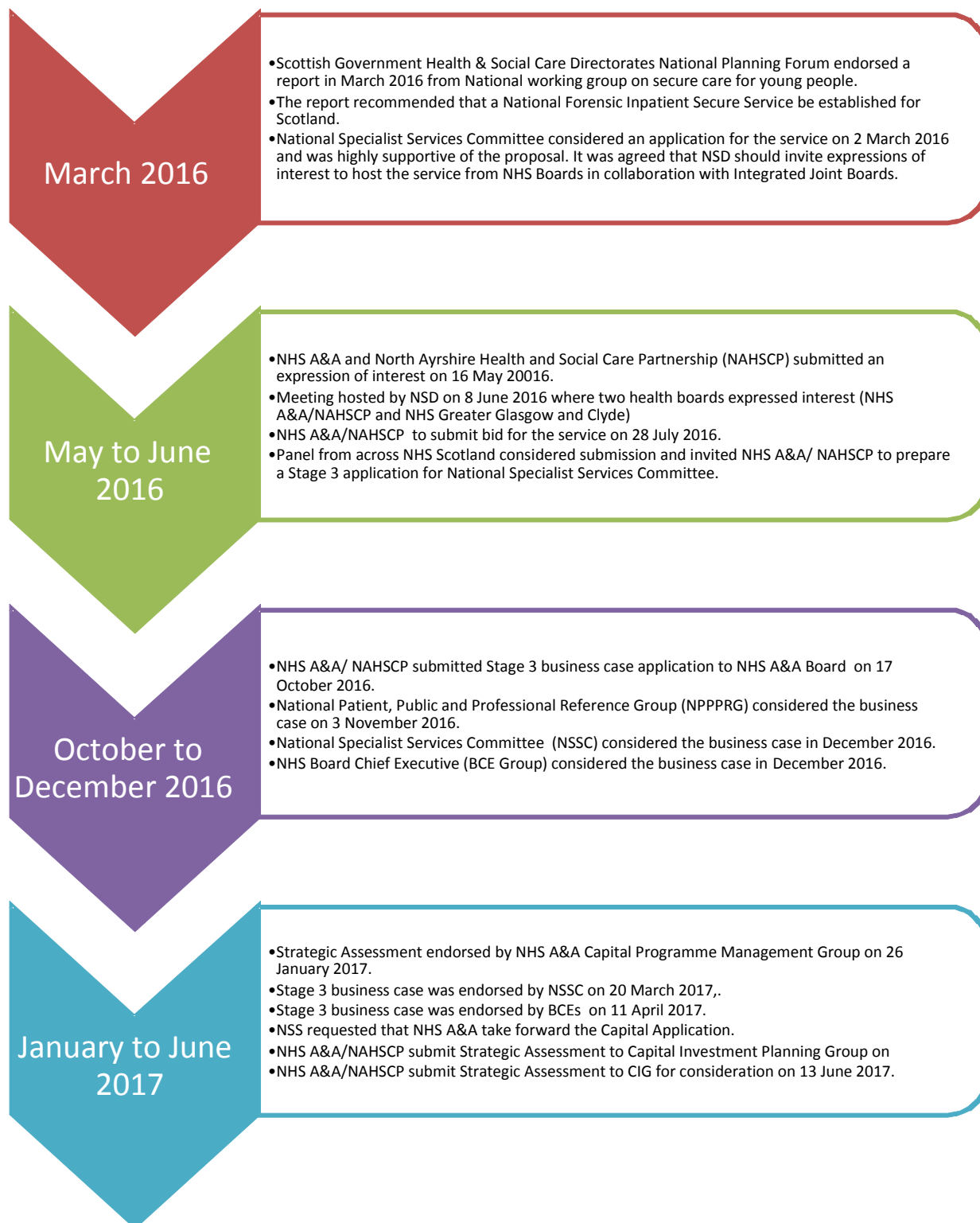
The National Specialist Services Committee considered an application for the service on 2 March 2016 and was highly supportive of the proposal. It was agreed that NSD should invite expressions of interest to host the service from NHS Boards in collaboration with Integrated Joint Boards.

In May 2016, NHS Ayrshire and Arran (NHS A&A) and North Ayrshire Health and Social Care Partnership (NAHSCP) submitted an expression of interest. NHS A&A and NAHSCP met with NSD in June 2016 and were asked to submit a detailed bid. Following an evaluation of the bid by a panel from across NHS Scotland, NHS A&A and NAHSCP were invited to prepare a Stage 3 submission for the National Specialist Services Committee.

In October 2016, Capital Planning and NAHSCP submitted NSS's Stage 3 business case to NHS A&A's Board for approval. The governance route for approval of Stage 3 business case is detailed in the chart below.

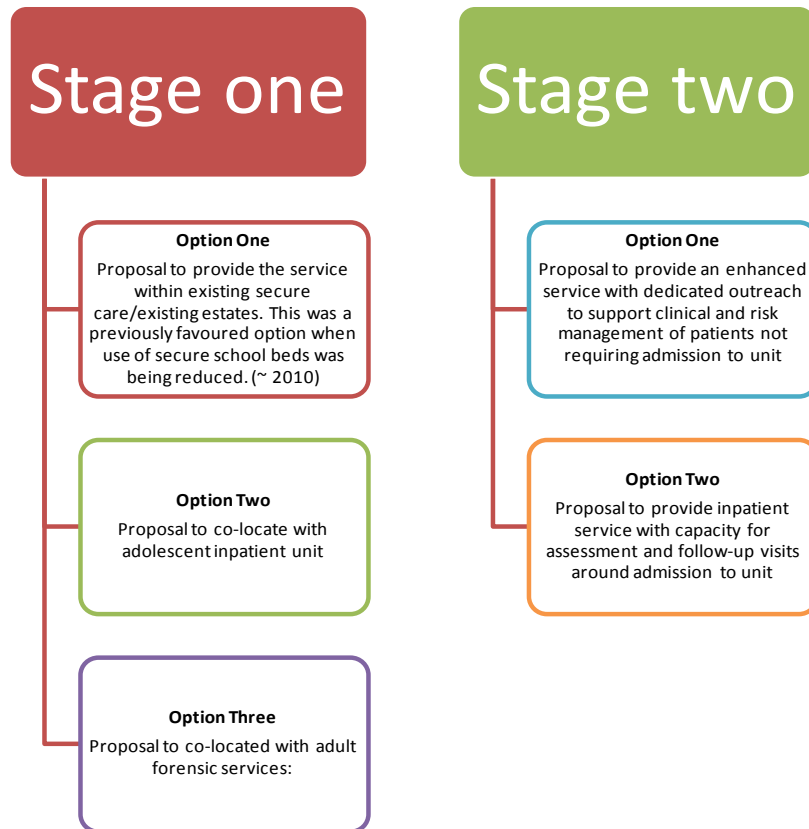
In March/April 2017, the Stage 3 business case was endorsed by both National Specialist Services Committee (NSSC), National Services Scotland (NSS), and the Board of Chief Executives (BCEs). At this time, NSS requested that we take the project forward through Scottish Governments Capital Investment process. Further detail on the decision making process and the NSS Specification Document can be found in Appendix D.

Decision making process



In March 2016, the National working group produced a report on secure care for young people. This was endorsed by Scottish Government Health & Social Care Directorates National Planning Forum. The key recommendation from this report was that a National Adolescent Secure Mental Health Inpatient Service be established for Scotland.

A two stage process was developed to specify the provision of a future adolescent inpatient service for Scotland. This process is described at a high level below.



At Stage 1, the group considered the following options for potential co-location of the proposed service:

1. Within existing secure care/school estate - this was a previously favoured option at a time when use of secure school beds was being reduced (~2010) and there was excess capacity in existing facilities.
 - Advantage = use of purpose-built units of secure specification with developmentally appropriate facilities (school, gym/pool, leisure); access to trained education/care staff; option of transition between "hospital" and "care" units within facility.
 - Disadvantage = lack of proximity to other hospital services, including urgent nursing/medical input to manage medical/psychiatric emergencies; complex commissioning arrangements for secure schools.

2. Co-located with adolescent inpatient unit
 - Advantage = access to developmentally appropriate non-secure facilities and adolescent trained staff.
 - Disadvantage = patient mix; adjacent facilities not secure; no access to expertise.
3. Co-located with adult secure services:
 - Advantage = access to expertise and secure facilities.
 - Disadvantage = patient mix; no access to education or other developmentally appropriate facilities.

Stage 1 favoured either option 2 or 3 as this ensured patient and staff safety by proximity to existing psychiatric hospital services. However, both these options did not provide a suitable care environment for a young person. Therefore, Stage 2 of the process explored further options. These are described below:

1. Enhanced service with dedicated outreach to support clinical and risk management of patients not requiring admission to unit.
 - Advantage = comprehensive national service with integral care pathways; ensure equity of provision across country.
 - Disadvantage = "centre of excellence" with reduced focus on local / regional capacity building.
2. Inpatient service with capacity for assessment and follow-up visits around admission to unit
 - Advantage = clarity of role within care-pathway
 - Disadvantage = relies on local/regional capacity building to meet needs of high risk patients in community and other hospital settings.

Stage 2 identified two options that could be expanded to provide a suitable option.

Stage 3 was then developed by NHS A&A and NAHSCP and a literature review concluded that a scoping exercise, including a possibility of starting a process of direct clinical assessment to ascertain current and future need would require to be undertaken.

Following SCIM guidance options have been measured against the Do Nothing/ Minimum option. A summary of which is presented below.

3.2 Do Nothing/Minimum Option

The Do Nothing/ Minimum Option has been developed as a benchmark against the three options detailed within this section.

Strategic Scope of Option:	Do Nothing
Service provision:	Dependency on resources and facilities within England, including medical/clinical expertise.
Service arrangements:	Complex transfer arrangements over the Border with an impact on cost, risk and legal requirements.
Service provider and workforce arrangements:	NHS England will require investment to provide capacity in the context of increasing demand to support children and young people being transferred from Scotland.
Supporting assets:	There are no supporting assets.
Public & service user expectations:	May result in negative impact on public opinion highlighting lack of provision in Scotland. If we leave things as they are this would result in unsustainable models of care, delivery and increasing demand and complexity of transferring adolescent patients into adult services. This would result in patients and families experiencing high levels of distress and delayed access and treatments. Family breakdown and young people becoming more unwell would be another negative outcome, eg social, physical and mental health deterioration. To Do Nothing would mean that the status quo would remain with all the issues and problems that have been highlighted previously within this document. Key to this is the time taken for a young person with severe mental health problems to access appropriate care.

As previously stated within this Initial Agreement, two Scottish Government reports (2009 & 2014) previously proposed the development of a Scottish Inpatient Service of between 8-12 beds.

Provision of a secure 8-12 bed Inpatient service will respond to the needs of 3 main care groups. These are:

- 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. This will be facilitated by the provision of distinct & discrete areas within the layout of the new facility to provide treatment. Additionally the layout should enable a degree of flexibility to facilitate separation of individuals who present risk for others with particular vulnerabilities.

Three options have been developed and are described in more detail below:

Option 1 – 8 beds

Option 2 – 12 beds

Option 3 – 12 beds and enhanced

Option One

8 Bed unit, most likely made up of 2 x 4 bed units;
Outreach to “community” settings across Scotland

This option enables an 8 bedded service configuration to support the initial launch of the service, assess initial demand and develop expertise, pathways and infrastructure within the context of delivery of this unique service in Scotland.

The staffing complement described below will enable the development of elements of outreach to ensure this new service is embedded within all localities and NHS Board areas, enabling effective, timely transition planning and relocation of young people to their communities of origin.

Option Two

12 bed unit, most likely made up of 3 x 4 bed units;
Outreach to “community” settings across Scotland

This option enables the development of a 12 bedded service configuration to support the full launch of the service.

The staffing complement described below will also enable the development of elements of outreach to ensure this new service is embedded within all localities and NHS Board areas, enabling effective, timely transition planning and relocation of young people to their communities of origin.

Option Three

12 bed unit, most likely made up of 3 x 4 bed units;
With enhanced Outreach to “community” settings across Scotland

This option will enable the development a 12 bedded service configuration to support a full launch of the service with the additional benefits of an enhanced workforce model to deliver a full and comprehensive outreach service to all localities and NHS Board areas.

This model in addition will satisfy future service development requirements and build further capacity in the system to support the development of a specialist Learning Disability unit and the potential of a CAMHS IPCU unit which are currently further significant gaps in the current landscape of existing provision. This model therefore demonstrates the opportunities of future proofing the service for additional potential expansion.

The following table summarises the advantages & disadvantages of each of the proposed solutions previously described.

	Do Nothing: As existing arrangements	Proposed Solution 1	Proposed Solution 2	Proposed Solution 3
Advantages (Strengths & Opportunities)	Existing experience and successful outcomes for young people using English service providers.	Purpose built facility designed around national need. Transportation and access will be improved. Effective use of Mental Health Act Scotland and Legal procedures. Reduce risk of young people going into the wrong care. Highly specialist mental health assessment within Scotland, Development of National resource to offer highly specialist guidance to support consultation. Development centre of excellence for Scotland. Attracting highly specialist staff to Scotland.	Purpose built facility designed around national need. Transportation and access will be improved. Effective use of Mental Health Act Scotland and Legal procedures. Reduce risk of young people going into the wrong care. Highly specialist mental health assessment within Scotland, Development of National resource to offer highly specialist guidance to support consultation. Development centre of excellence for Scotland. Attracting highly specialist staff to Scotland.	Purpose built facility designed around national need. Transportation and access will be improved. Effective use of Mental Health Act Scotland and Legal procedures. Reduce risk of young people going into the wrong care. Highly specialist mental health assessment within Scotland, Development of National resource to offer highly specialist guidance to support consultation. Development centre of excellence for Scotland. Attracting highly specialist staff to Scotland.

Disadvantages (Weaknesses & Threats)	Transportation and access problematic. Lengthy and complicated legal procedures resulting in delays for access to treatment. Different legal jurisdictions.	Young People will be away from their NHS Board area. Insufficient bed capacity in new proposals may result in continued cross border referrals.	Young People will be away from their NHS Board area.	Young People will be away from their NHS Board area.
Does it meet the Investment Objectives (Fully, Partially, No, n/a):				
Investment Objective 1 Existing capacity in England is unable to cope with future projections of demand	No	Partially	Fully	Fully
Investment Objective 2 Existing service arrangements impact access to support and travel arrangements	Yes	N/A	N/A	N/A
Investment Objective 3 Delay in referral to treatment in an inpatient facility may adversely affect the clinical outcome for the young person.	Yes	Yes	Yes	Yes

Improved access and clear patient pathways will improve clinical outcomes.				
Investment Objective 4 Existing service arrangements are not meeting current or future user requirements	Yes	N/A	N/A	N/A
Investment Objective 5 Increased demand and risk on service because of targeted population need	Yes	N/A	N/A	N/A
Are the indicative costs likely to be affordable? (Yes, maybe / unknown, no)				
Affordability	Yes	Yes	Yes	Yes
Preferred / Possible / Rejected	Rejected	Possible	Preferred	Possible

As an example of how the table above should be read, Investment Objective 4 states Existing service arrangements are not meeting current or future user requirements.

The existing service arrangement is that young people are transferred to England. Therefore the existing situation does not meet current or future user requirements as it is not based in the Scottish context.

The table below shows an indication of costs compared to the Do Nothing option.

Costs in £millions	Do Nothing: As existing arrangements	Proposed Solution 1	Proposed Solution 2 Preferred	Proposed Solution 3
Capital cost (or equivalent value)	£1,320m* *Revenue expenditure for Cross Border referrals 15/16	£5.086m	£5.928m	£6.084m
Whole of life capital costs	Not available at this time	Not available at this time	Not available at this time	Not available at this time
Whole of life operating costs	Not available at this time	Not available at this time	Not available at this time	Not available at this time
Estimated Net Present Value of Costs	N/A	£92.400m	£93.087m	£93.253m

More detail on the Net Present Value (NPV) calculations is provided at Appendix K Discounted rate used is 3.5%. The information that is currently not available on the detailed costs of capital/revenue will be provided in more detail within the OBC and finalised at FBC.

The following text details the initial assessment and service details of the proposed solution (Option Two).

3.3 Initial assessment of proposed solution

With regard to the preferred option, the following advantages have been identified.

Advantages:

- Closer to community of origin;
- Can provide treatment under Scottish mental health legislation;
- No need for cross border transfer.

During the bid process NHS A&A undertook a literature review which suggested a wide variety in terms of purpose and source. However some common themes emerged throughout. These were the need for medium secure units for young people, advantages of admission to inpatient CAMHS units, factors that influence the outcome of CAMHS inpatient care, risk assessment in CAMHS medium secure units and clinical outcome measures used in medium secure CAMHS units.

Clearly these themes are all significant whilst discussing Secure Adolescent Inpatient Services.

The proposed service will:

- Address needs quickly, stabilise mental health as quickly as possible and work to promote the skills and needs of young people;
- Reduce time from referral to treatment;
- Reduce risk of young people having to go into care;
- Reduced crime rate and pressure on criminal justice system;
- Reduced in-patient bed stay and likelihood of imprisonment;
- Provide teaching about diet, lifestyle with longer term health problems reduced;
- Improved family therapy, less stress for family when quality of life is improved.

3.3.1 Public protection, cost benefit analysis.

A benefit derived from the National service is that it will provide an overview of an approach for key clinicians to forward plan and deliver psycho-social interventions.

All services will be provided on the one site to deliver an appropriate and comprehensive service. The delivery of anticipatory care will ensure a holistic understanding of the needs of the patient group with improved risk management approaches.

The Clinical Nurse Manager would become the liaison person on a day to day basis with services around Scotland. They will review admission location/source and establish links with referring agencies. This will enable needs to be met effectively and delivering in a timely and as safe way as possible due to the benefits of co-location. The delivery of advice, guidance, support and outreach services will prevent escalation of risk.

3.3.2 Stimulating Research and Innovation

A key function of the proposed national secure service will be the development and dissemination of an evidence base around the needs and interventions for mentally disordered young offenders.

Excellent surveys have been conducted into social backgrounds and mental health problems in young offenders. However, there is little evidence about effective treatments for this population. This is mainly because mentally disordered young offenders represent a disparate group of boys and girls with complex clinical and forensic profiles.

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There will be opportunities for studies of individual cases and wider samples, to improve approaches to assessment and interventions. Such research will be most productive when undertaken across clinical and non-clinical disciplines, including mental & physical health, education and criminal justice. This new National Secure Adolescent Inpatient Service (NSAIS) will provide ample scope for study of mental disorder and offending in young people. A proposed provisional research strategy is summarised in the next section.

3.4 Proposed needs assessment

As previously described, both a five year retrospective and a prospective study of need are underway. This will build upon findings of two recent studies:

- A one day census (14th September 2016) of all under 18's from England who were legally detained in locked facilities within the United Kingdom.
- A needs assessment conducted by National Services Scotland, involving referrals to the Roycroft Clinic (now known as Alnwood Clinic).

As a new service there will be ample scope for study of mental disorder and offending in young people. We would aim to prioritise research of practical relevance, to improve the life chances of mentally disordered young offenders in Scotland. This recognises the particular risks of premature mortality and social exclusion in this population.

We have begun discussions with the following key collaborators, to develop a research strategy:

- Professor Lyndsay Thomson, Forensic Psychiatry, University of Edinburgh;
- Jamie Pitcairn, Research and Development Manager, The State Hospital and Forensic Network;
- Dr Clair Lightowler, Director- Centre for Youth and Criminal Justice, University of Strathclyde;
- Professor Helen Minnis, Child & Adolescent Psychiatry, University of Glasgow;
- Royal College of Psychiatrists Adolescent Forensic Psychiatry Special Interest Group;
- Professor Paul Martin – Depute Principal, University West of Scotland.

3.5 Option 2 - Service Details

3.5.1 Proposed service/activity provision

The preferred option enables the development of a 12 bedded service configuration to support the full launch of the service.

The staffing complement described below will also enable the development of elements of outreach to ensure this new service is embedded within all localities and NHS Board areas, enabling effective, timely transition planning and relocation of young people to their communities of origin.

3.5.2 Proposed functional size of the service or activity

To develop the workforce strategy outlined in the Proposed Model of Care a number of workforce and clinical meetings have taken place. A final workforce workshop was held on the 22nd March 2018 to consider the activity, staffing levels and skill mix required for the proposed service. Also highlighted within this meeting was the directive from the Chief Nursing Officer for Scotland that inpatient nursing services should move to a three shift system. The table below highlights an early indication of the staffing levels required for the proposed service.

Staffing will be subject to further scrutiny and challenge through the next phase of project.

**NSAIS CAMHS Inpatient
Service
REVENUE EXPENDITURE MODEL
Stage 3
12 Beds - No Outreach**

	Original Costed at top of scale		Revised Costed at 2nd top of scale		Modifications to Staffing Costed at 2nd top of scale	
	Forensic CAMHS 12 beds		Forensic CAMHS 12 beds		Forensic CAMHS 12 beds	
	wte	cost £ 16/17	wte	cost £ 16/17	wte	cost £ 16/17
Inflation						
<u>Medical</u>						
Consultant	2.20	292,600	2.20	292,600	2.20	292,600
Paediatrician	0.10	13,300	0.10	13,300	0.10	13,300
Staff Grade	1.00	90,812	1.00	90,812	1.00	90,812
GP	0.10	10,000	0.10	10,000	0.00	0
Higher Trainee (40% supplement)	2.00	46,880	2.00	46,880	2.00	46,880
Sub Total Medical Salaries	5.40	453,592	5.40	453,592	5.30	443,592
<u>Nursing</u>						
Band 8B Nurse consultant	0.00	0	0.00	0	0.00	59,495
ANP B7						
Band 7	1.00	56,304	1.00	54,613	1.00	54,613
Band 6 7 days a week 9-5	6.00	306,702	6.00	292,230	6.00	292,230
Band 5 50% days 50% pm	29.40	1,322,000	29.40	1,269,654	29.40	1,269,654
Band 3						
Band 2 2/3 days 1/3 nights	24.50	736,838	24.50	711,733	24.50	711,733
Flexible Additional Hours	4.00	110,616	4.00	106,836	4.00	106,836
Sub Total Nursing Salaries	64.90	2,532,460	64.90	2,435,066	64.90	2,494,561
<u>AHP</u>						
Psychology - Band 8C						
Psychology - Band 8B	1.00	73,813	1.00	71,816	1.00	71,816
Psychology - Band 8A						
Psychology - Band 7						
Psychology - Band 5	1.00	35,884	1.00	34,454	0.50	17,227
Occ. Therapy - Band 7	1.00	52,668	1.00	50,919	1.00	50,919
Occ. Therapy - Band 6	1.00	44,675	1.00	42,511	1.00	42,511
Occ. Therapy - Band 4	1.60	44,930	1.60	43,971	0.60	16,489
Family Therapist - Band 8A						

National Secure Adolescent Inpatient Service
Initial Agreement

Family Therapist - Band 7						
Family Therapist - Band 6						
Speech Language Therapist B6						
Speech Language Therapist B7	1.00	52,668	1.00	50,919	0.50	25,460
Dietetics - Band 6	0.40	17,870	0.40	17,004	0.20	8,502
Physiotherapist - Band 7	0.10	5,267	0.10	5,092	0.00	0
Physiotherapist - Band 6					0.10	4,251
Creative Therapist - Band 7						
Social Worker/MHO	2.00	100,000	2.00	100,000	1.00	50,000
Teachers						
Agency AHP		0		0		0
Sub Total AHP Salaries	9.10	427,774	9.10	416,687	5.90	287,175
Other						
Pharmacy 0.5 B8A + 0.5B5	1.00	48,605	1.00	46,975	0.70	29,126
Security B3 3.7 days 4 fully rotational	7.70	241,520	7.70	236,293	7.70	236,293
Advocacy	1.00	30,000	1.00	30,000	0.50	15,000
Facilities	3.80	109,482	3.80	106,612	3.80	106,612
Sub Total Other Salaries	13.50	429,606	13.50	419,880	12.70	387,031
Admin						
Band 4	1.50	42,122	1.50	41,223	1.50	41,223
Band 3	2.00	50,098	2.00	49,004	2.00	49,004
Band 2	1.00	22,701	1.00	21,919	1.00	21,919
Service Manager - Band 8B	0.00	0	0.00	0	0.00	0
Sub Total Admin Salaries	4.50	114,921	4.50	112,146	4.50	112,146
TOTAL SALARY COSTS	97.40	3,958,353	97.40	3,837,370	93.30	3,724,505
Non-Salary Costs						
Pharmacy		24,000		24,000		24,000
Catering		20,000		20,000		20,000
Domestic		3,000		3,000		3,000
Accommodation		219,489		219,489		219,489
Training		40,000		40,000		40,000
Travel		10,000		10,000		10,000
Transport		15,000		15,000		15,000
Educational Resources		10,000		10,000		10,000
Other		23,000		23,000		23,000
NON-SALARY COSTS		364,489		364,489		364,489
TOTAL COST		4,322,842		4,201,859		4,088,994

Target **4092011** 230,831

120,983

-3,017

3.6 Option 2 - Service Arrangements and Care Pathways

3.6.1 Care Pathways

The pathway developed will deliver consistent and equitable access for all young people in Scotland who have a need to access to a secure health service.

NSAIS will deliver 24/7 mental health care within an acute setting. This is delivered by staff who work both rostered and flexible arrangements, and by a wide range of healthcare professionals depending on the clinical need.

The model of care will continue to be developed, refined and challenged to produce a model that will realise improvements in quality of, and access to care with the ultimate goal that any young person entering the service will be returned to a community setting.

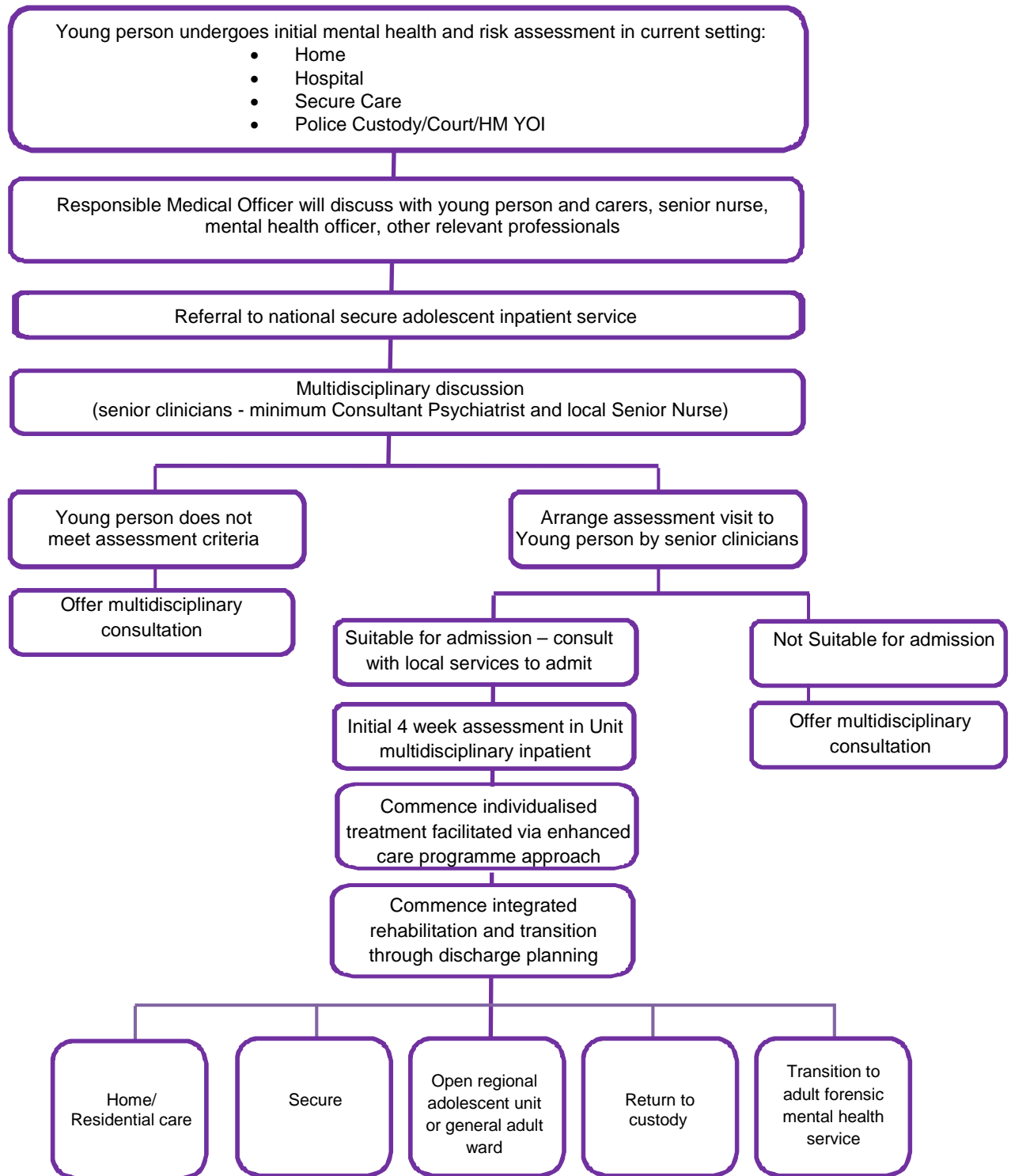
A further challenge for the proposed service is the Chief Nursing Officer for Scotland's directive that inpatient nursing services should move to a three shift system. This will have an impact on the revenue cost already detailed within this IA. However, although revenue costs for the proposed service have been outlined, they will be subject to further robust challenge and refinement as the project progresses to ensure value for money.

NSAIS will be measured against the benefits outlined in the Benefits Realisation Plan, which will be subject to review and refinement until finalised during the OBC/FBC.

CAMHS across Scotland are continually challenged by demand and the capacity to deliver within treatment time guarantees. The lack of a secure inpatient facility is impacting on the successful clinical outcomes for young people for the reasons outlined in the sections above; namely, time from referral to admission, equity of access, leading to care being provided in, what are deemed as inappropriate settings e.g. adult wards or IPCUs.

The methodology to challenge and determine the appropriate demand and capacity for this service in Scotland is outlined in the proposed Model of Care. Gathering the data required is proving a challenge, however, this key piece of work is now commenced. The capacity modelling will be based on the available data and as noted will be further developed during the OBC.

The following chart shows the potential pathway of care.



3.6.2 Improved performance data

As young people are currently using a variety of services in Scotland and elsewhere it is difficult to gather intelligence in terms of outcomes. The proposed service will enable robust data to be gathered and monitored to inform future planning.

The following performance indicators have been identified and will be further developed through a performance framework.

Key Performance Indicators:

- Percentage of young people 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;
- Number 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.).

The list above is indicative only and will be developed further with Regional and National CAMHS.

3.6.3 Proposed or expected service demand

Specialist low volume, high intensity units of this kind, can face difficulties meeting wide fluctuations in demand, impediments to access and/or discharge. This can lead to waiting lists, unmet need, or under use, all of which may risk sustainability of the service. In the proposed service we would aim to mitigate against these risks by:

- aim for minimum 85% bed occupancy;
- act as a national “hub” with an overview of need across Scotland;
- gather data to anticipate demand and intervene in care pathways accordingly;
- use care planning systems and build capacity in care pathways to minimise lengths of stay in unit; and

- Provide a comprehensive package of mental health care which is not currently met by the current service.

3.6.4 Proposed service/activity provision

The proposed inpatient service would serve the needs of young people who require hospital care for their mental health disorders that result in them presenting as a significant risk of harm towards others. The relationship between mental disorder and offending can vary, for example:

Convicted juvenile sex offender who develops bipolar illness; new presentation schizophrenia with violence associated with paranoid delusions;

Compulsive fire setting in adolescent with mild learning disability and Asperger's syndrome.

It is likely that some of the referred young people will be already known to justice services; others will have no previously identified offending risk. Similarly, some will be known to specialist mental health services; others will have undiagnosed or new onset of mental disorder. As a result, young people will be drawn from different settings where their offending or mental health needs will be recognised and managed in various ways.

The primary function of the service is to address mental health needs, and where possible reduce recidivism. However cognisance will also be made of the individual's vulnerability and resilience.

The following is a summary of available information about mental health needs of young offenders in Scotland:

- Youth Justice Pathway;
- Young People in Prison;
- Secure Accommodation.

Secure accommodation

Young offenders aged under 18yrs can alternatively be accommodated in secure care/education establishments.

They might have offence referrals dealt with via the Children's Hearings System resulting in a Compulsory Supervision Order with secure authorisation. Alternatively, they might be remanded or given a custodial disposal by the Court.

In recent years the number of secure units has reduced ('Securing Our Future Initiative' 2009).

There are currently six secure units located across Scotland (Montrose, Edinburgh, Bishopbriggs and Renfrewshire) and together providing 90 beds.

In 2015, there were on average 86 young people (55 boys and 31 girls), in secure care, eight of whom were sentenced. The majority of female authorisations to secure care are due to welfare concerns whereas for males these authorisations are more likely to be on offence grounds.

A study (*Scottish Children's Reporter Association, 2009*) examined the secure authorisations of 100 young people and found that 99% were persistent or frequent offenders, 77% had abused alcohol, 65% had abused drugs and 46% had mental health problems. The young people also had high levels of adverse childhood experiences and family histories of mental illness and criminality.

Children's Social Work Statistics Scotland, 2013-14, published by the Scottish Government, recorded that 94% of young people in secure care accommodation on 31 July 2013 had at least one additional support need and by far the most common category of additional support need was 'other social, emotional and behavioural difficulties', which at 79% is higher than the proportion for other looked-after children or those on the child protection register.

In 2002, researchers in England examined the mental health of a sample of adolescent boys in secure care for persistent offending. They found 27% had an intelligence quotient (IQ) of less than 70. The need for psychiatric help was measured as high on admission to secure units, with the most frequent disorders being depression and anxiety.

Secure schools usually have "in house" nursing and psychological services, with in-reach from local CAMHS as required.

From available information, around two thirds of young people in secure accommodation have input from specialist mental health services, including CAMHS or psychological services.

Community

A larger number of young offenders are in the community as a result of reduced detentions, including family homes and residential care.

If a young person cannot be effectively assessed or treated in secure care, they may be transferred to hospital, usually to an adult locked psychiatric service. From current estimates, each secure school would have at least two young people each year requiring, (but not necessarily accessing) hospital admission.

References

Scottish Children's Reporter Association (2009) Secure authorisations in Scotland's Children's Hearings System: *An exploration of decision-making, placements, outcomes and social backgrounds*.

Moodie, K, (2015) Secure Care in Scotland, a Scoping Study: Developing the measurement of outcomes and sharing good practice. Glasgow: Centre for Youth & Criminal Justice

Mental Welfare Commission for Scotland. (2015). *Visit and Monitoring Report Visits to young people in secure care settings*. Edinburgh: Mental Welfare Commission for Scotland.

Gough, A (2016)

3.6.5 Services or activities to be delivered by this solution

The core function of the facility will be to provide safe effective multi disciplinary inpatient care for presenting mental disorder and risk towards others. Every young person will have a individually tailored mental and physical health care plan. In order to support their treatment and meet developmental and welfare needs, young people will also have access to the following:

- wide range of outdoor activities and pursuits;
- family involvement;
- Educational programmes;
- Vocational opportunities.

3.6.6 Proposed location of these services/activities

The proposed site currently includes the new Ayrshire Mental Health and Community Hospital, Woodland View. In addition, the campus hosts the North Ayrshire Community CAMHS Team, North Ayrshire Specialist Health Community Learning Disability Team, Community Paediatric Developmental Disability Service and out of hours doctors response service ADOC.

The development of Woodland View includes all aspects of specialist mental health provisions within an innovative purpose built facility and is uniquely placed to further develop integrated specialist responses to children and young people with highly complex needs. The campus affords the opportunity to deliver co-located/integrated services including:

On site physician support with access to paediatric expertise;

Developmental disability service including Psychology, Occupational Therapy, Speech and Language Therapy and nursing; North CAMHS community team base, inclusive of all aspects of multidisciplinary team: and North CLDT and potential development of inpatient learning disability service you people with very complex needs.

In addition, the campus model allows for:

- Creating close connections and identity across specialism's;
- Distributed leadership, mutual support and expertise across clinical groups;
- A shared identity across lifespan informing history and future planning child, young person and adult;
- Supports education, training and research without boundaries;
- Broader and deeper capacity and capability to support complex patient presentation and associated risk;
- Ability to recruit, manage and develop workforce across specialism's; and
- Agility to adapt to changing environment and delivery models from a local and national perspective.

The proposed build site is in close proximity to Woodland View. The red construction boundary is clearly shown on the following aerial photo. The building will be standalone and will not be attached to any other building.



Co-location with existing adult forensic inpatient services

NHS Ayrshire and Arran and the Health and Social Care Partnership has a rich history of developing a community based forensic service and the associated redesign of in-patient low secure services. This activity has been further built on through the development of the new mental health provision - Woodland View.

In January 2016/17, a purpose built eight bedded low secure forensic in-patient service at Woodland View opened. In preparation for this the management team developed a full business case including staffing profile and skill mix.

This focus on quality, commitment and a desire to develop a progressive outward looking service will play a critical role in influencing the development of the children's/young person's secure inpatient facility, appreciating the need for a high quality living environment, dedicated and knowledgeable skill mix but critically an understanding of the need for security, risk management and safety.

3.6.7 Changes to expected location of service users associated catchment areas.

The new service is a national service and will benefit all NHS Scotland and their communities.

3.6.8 Description of any changes to or impact on service providers

NHS Boards will have access to a National Secure Adolescent Inpatient Service (NSAIS) that will provide assessment and treatment in a timely manner.

3.6.9 Description of expected improvements

We are planning improvements in the following critical areas and continue to listen, discuss, collaborate with staff, stakeholders and people who use our services and their carers including with local people on the best way forward. We will ensure that North Ayrshire Health and Social Care Partnership services use our combined resources to best effect to ensure the highest possible quality of person-centred care available:

- To address the ongoing rising demand for services by implementing early intervention and prevention approaches;
- To make services available closer to people's homes and in an appropriate setting;
- To allocate resources so that there are fewer gaps in services; and
- To make sure that if hospital stays are necessary, that these are the best quality of care for the shortest period of time.

3.7 Indicative costs

Indicative costs for each of the proposed solutions have been prepared and added to the table below.

Costs in £millions	Do Nothing: As existing arrangements	Proposed Solution 1	Proposed Solution 2 Preferred	Proposed Solution 3
Capital cost (or equivalent value)	N/A	£5.086m	£5.928m	£6.084m
Whole of life capital costs		Not available at this time	Not available at this time	Not available at this time
Whole of life operating costs		Not available at this time	Not available at this time	Not available at this time
Estimated Net Present Value of Costs		£92.400m	£93.087m	£93.253m

Assumptions made are as follows:

- Optimism Bias is based on a figure of 10%;
- VAT is deemed to be non recoverable until the project has been reviewed by the Board's VAT advisors;
- Equipment allowance of 6.3% used in calculation;
- Revenue costs are calculated using baseline year 17/18;
- Lifespan of the building is based on 40 years.

The optimism bias figure of 10% is based on detailed knowledge of the site, familiarity with the proposed procurement route and NHS Ayrshire & Arran's long standing relationship with the statutory approval body. The Board accept that this may be deemed to be low, however, this will be monitored and continually assessed throughout the business case process to ensure value for money.

Sensitivity analysis will be further developed at OBC stage, with cognisance taken of possible movement in known Government indices (i.e. RPI, CPI etc). Cognisance will also be taken on available information of interest rates.

3.8 Service change proposals

Two meetings have taken place with relevant representatives from the Scottish Health Council, who has offered guidance about patient and public participation in this proposed development.

The Scottish Health Council has been instrumental in assisting with the setting up of a Public Reference group for this project.

3.8.1 Stakeholders identified

This section summarises the range of stakeholders affected by this proposal, details what engagement has taken place, outlines any concerns expressed, and confirms the level of support for the proposal.

A National Stakeholder group has been established, with the express remit that the group will provide expert advice on the development, planning, implementation and evaluation of the National Secure Adolescent Mental Health Inpatient Service for Scotland (NSAIS). The Terms of Reference and membership for the group are included at Appendix M.

Stakeholder engagement has been undertaken as follows:

1. NHS / professional bodies

- Discussions at Scottish Government CAMHS Lead Clinicians Group (2015–17) including communications regarding proposed “outreach” function of service;
- Presentation and discussion at SEAT Tier 4 CAMHS consortium (31 Aug 17);
- Correspondence to Forensic Network – for discussion at inter-regional group meeting (August 17);
- Correspondence to Chair, Royal College of Psychiatrists in Scotland – for consideration by Forensic and Child/Adolescent Executives (August 2017);
- Presentation at Royal College of Psychiatrists Adolescent Forensic Psychiatry Special Interest Group (20 March 2017; update 13 Sept 17).

2. Other agencies

- Presentation to Secure Care Screening Group, 23 Feb 17, updates planned;
- Discussion with Centre for Youth & Criminal Justice.

3. Patient & Public

With guidance from Scottish Health Council, we have commenced active engagement with patients, carers and members of the local community in design of the proposed service. So far, we have:

- met NHS A&A Mental Health Patient Reference Group (04 July 17); updates planned;
- Interviews with young people and families with lived experience of secure inpatient care- ongoing with completion anticipated within the next few months.

4. Stakeholder Engagement to assist in preparation of Initial Business case:

- Benefits & Risks workshop – involved colleagues from National Forensic Network, Alnwood Clinic, secure care providers, SACRO, “Stepdown”, Violence Reduction Unit, North Ayrshire Education and NHS A&A mental health services (12 Sept 17).
Clinical workshop held on 19 April 2018 at Stirling Court.

Other public engagement activities are proposed in keeping with governance and advice from Scottish Health Council.

In additional to the above stakeholders, Community Councils had also been identified as a good route to informing/engaging with local communities. We are liaising with North Ayrshire Council Connected Communities colleagues regarding the development of this new facility.

The following partnership groups will be informed and engaged during the development of the facility.

Locality Planning Partnerships

The locality planning partnerships have a standing item on the Agenda for the Health and Social Care Partnership. It is envisaged that presentations and briefings will be provided to this group.

Community Councils

The Community Councils have a statutory duty to ascertain, coordinate and express (ACE) the views of the local community to the Council and its partner agencies.

There are 17 Community Councils across North Ayrshire but only 11 are currently active. The Chair of each Community Council has a right to sit on the Locality Planning Partnership (see above).

The involvement in Youth Services and Community Development teams will assist informing and engagement.

Informing and engaging events attendees will be expected to ensure that information is cascaded widely and appropriately in order to achieve community feedback.

The following table provides a further list of identified stakeholders, a summary of their engagement and an indication of their support.

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
National Stakeholder Group	1 st meeting held in the Clyde Room, Grand Central Hotel, Glasgow. Presentation and discussion on progress so far.	All in attendance support the proposed service.
Patients / service users	Views and wishes were obtained from a patient with lived experience of secure inpatient care and a carer of a patient. Both were supportive of the proposal. There is a proposal to obtain views from a wider group of patients and carers with relevant experience.	Patient / service user groups were consulted on the proposal to provide a National Service in Scotland and were both supportive of the proposal.
Mental Health Public Reference Group	Views and wishes were obtained from the NHS Ayrshire & Arran Mental Health Public Reference Group. All were supportive of the proposal. We have agreed to provide regular updates and obtain feedback.	The Public Reference Group was consulted in July 2017 on the proposal to provide a National Service in Scotland and were all supportive of the proposal. The questions that were raised by group members will be developed to inform other public events in the future.
Scottish Health Council	Two meetings have taken place with relevant representatives from the Scottish Health Council. They offered guidance about patient and public participation in this proposed development.	Their guidance from these discussions will be followed.
General public	At all stages of development of Woodland View campus the general public were involved and this will continue.	Discussions to take place.
Expert collaborators	Colleagues from Forensic Network are being consulted.	Broadly the Forensic Network support improved access to developmentally appropriate inpatient care for young people from Scotland.

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
	<p>We have begun discussions with the following key collaborators, to develop a research strategy:</p>	<p>Professor Lyndsay Thomson, Forensic Psychiatry, University of Edinburgh & Jamie Pitcairn, Research & Development Manager, The State Hospital and Forensic Network</p> <p>Professor Helen Minnis, Child & Adolescent Psychiatry, University of Glasgow</p> <p>Royal College of Psychiatrists Adolescent Forensic Psychiatry Special Interest Group</p> <p>Professor Paul Martin – Depute Principal, University West of Scotland</p>
Staff / Resources	<p>We are actively involving colleagues on a regular basis from Adult Mental Health and Forensic Services in NHS A&A. Their involvement in its development includes attendance at Project Group meetings, risk workshop, benefits workshop, steering group and Project Board.</p> <p>They currently provide services for NHS A&A patients in the community and Woodland View. The proposed service will share expertise and resources.</p>	<p>Staff representatives are involved on a regular basis and support this development.</p>
North Ayrshire Council Education Department	<p>We are actively involving colleagues on a regular basis from the local Education Department. Their involvement in its development includes attendance at Project Group meetings, risk workshop, benefits workshop. There will be an education sub group to plan provision for patients.</p>	<p>Broadly North Ayrshire Council Education Department support improved access to developmentally appropriate inpatient care for young people from Scotland.</p>
North Ayrshire Council Children's/ Youth	<p>We are actively involving colleagues on a regular basis from the local Children's/ Youth</p>	<p>Broadly North Ayrshire Children's/ Youth Justice Social Work Services support improved</p>

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
Justice Social Work Services	Justice Social Work Services. Their involvement in its development includes attendance at Project Group meetings, risk workshop, benefits workshop.	access to developmentally appropriate inpatient care for young people from Scotland.
Providers of Secure Accommodation	The proposal was presented to the Scottish Government Secure Care Screening Group; further discussion has been held with Heads and key professionals from four Secure Accommodation facilities. Representatives from the sector participated in the Risk and Benefits workshop.	
Other key stakeholders and partners		
Violence Reduction Unit including Medics Against Violence, Police Scotland	The Violence Reduction Unit, Police Scotland contributed to the risk and benefits workshop. They will be engaged in participation.	Violence Reduction Unit including Medics Against Violence are keen to participate in the improved access to developmentally appropriate inpatient care for young people from Scotland.
Voluntary Groups and Third Sector	Step Down and SACRO contributed to the risk and benefits workshop. They and other providers of intensive community Youth Justice service will be engaged in participation.	Step Down and SACRO are keen to participate in the improved access to developmentally appropriate inpatient care for young people from Scotland.
Members of Parliament	Following press release articles local Members of Parliament have spoken about the proposals. Central Ayrshire MP Dr Philippa Whitford	Central Ayrshire MP Dr Philippa Whitford has stated: "From a healthcare perspective, this is very specialised work and I welcome the decision to build a dedicated facility in Scotland and to co-locate it beside the award winning mental health facility at Woodland View. This will be hugely beneficial for both patients and their families, who won't have to travel such long distances for visits".
Member of Parliament	Cunninghame South MSP Ruth Maguire	Ruth Maguire MSP intimated:

Stakeholder Group:	Engagement that has taken place	Confirmed support for the proposal
		<p>“Even though it is at a very early stage, I am supportive of this project in principle and believe it would be an important addition to Scotland’s mental health care facilities.</p> <p>Having facilities specifically for young people who require this specialised mental healthcare located here and thus avoiding the need for them to travel to England or be treated in adult facilities is something I welcome, and I look forward to following the process of these plans closely over the coming months.”</p>
Member of Parliament	Jamie Greene, West of Scotland MSP	<p>Jamie Green MSP stated: “This is an extremely welcome proposal from NHS Ayrshire and Arran. As it stands children and teenagers often must travel down to England to receive psychiatric treatment as Scotland doesn’t currently have this much-needed facility.</p> <p>The long distance makes it difficult for their families to visit them leaving them feeling isolated and in some cases, delaying their recovery.</p> <p>Having our own facility will allow patients to be treated closer to home, improving their chances at a full recovery. Moreover, this will send a clear message that Scotland is serious about tackling mental health issues. I’m aware campaign groups have been pushing for a dedicated facility for children and teenagers for some time now so this will certainly be seen as a step in the right direction.”</p>

3.9 Design Quality Objectives

In partnership with Architectural Design Scotland and Health Facilities Scotland, NHS Ayrshire & Arran undertook Design Statement workshops on 3 and 31 October 2017.

Develop the NDAP design statement.

There was recognition early on that the NDAP Design Statement would be a crucial piece of work. The Design Statement allows NHS A&A to use good design to get the most out of the project.

Initial workshops were organised in October 2017. These mapped out what the physical and environmental solution must do in order to deliver success.

The stakeholders agreed a series of statements of intent. Demonstrable benchmarks were then defined. Finally, an action plan was agreed which stated how the Design Statement would inform key decision-making throughout the project.

Appendix H contains the National Design Assessment Process (NDAP) – Design Statement.

AEDET Workshop (Achieving Excellent Design Evaluation Toolkit)
A multi-stakeholder AEDET review took place on 13 December 2017.

4.0 Commercial Case

The Commercial Case will consider the procurement strategy for the preferred option and will include:

- Proposed Procurement Route;
- Programme;
- Design & Design Development;
- Outline Main Procurement steps.

The bullet points listed above will be outlined in more detail in the sections that follow.

4.1 Procurement Strategy and Timetable

4.1.1 Proposed procurement route

This chapter will provide a high level assessment of the proposed procurement route.

In order to determine the most appropriate procurement vehicle for delivery of the proposed National Secure Adolescent Inpatient Service (NSAIS) NHS Ayrshire & Arran have evaluated the two available procurement routes for the design and construct of NSAIS, these are, hub Scotland and Frameworks Scotland 2.

Framework Scotland 2

Frameworks Scotland 2 is a procurement method which provides a wide variety of construction-related services for both new build and refurbishment projects and consists of five Principal Supply Chain Partners (PSCP) appointed to a framework that will deliver capital projects on pre-agreed rates.

Scotland 2 PSCP and Professional Services Contract (PSC) is engaged with the development of a High level Information pack which is issued to all Framework Scotland 2 PSCPs and PSCs. A mini competition is then held to determine the most economical supplier.

hub Scotland – Tier 1 Contractor

Hub Scotland involves Public sector organisations across a hub territory working in partnership with each other and a private sector delivery partner in a joint venture delivery company called a HubCo to deliver public sector projects.

Hubco is engaged with development of New Project Request (NPR). This will include developing a brief for the project that will then be submitted to the HubCo board for approval. Once approved a Tier 1 contractor can be appointed from the HubCo supply chain.

In order to identify at an early stage the preferred procurement route NHS Ayrshire & Arran's Capital Planning department in conjunction with the Child and Adolescent clinical team commissioned and developed a feasibility study solely for the purposes of determining the most appropriate procurement route (attached at Appendix E).

The feasibility study included:

- Draft Schedule of Accommodation;
- Location plan including 2 potential sites;
- Site Analysis;
- Adjacency diagram;
- Site Services and Ground conditions;
- Programme.

The feasibility study was submitted to both Frameworks 2 and hub South West with the brief to develop an elemental cost plan and the associated fees for their procurement vehicle.

The elemental cost spreadsheets from both hub and F2 have been used to provide a range for the anticipated capital cost of £5.9M -£6.5M. A high level breakdown of the capital cost and the elemental breakdown is provided at Appendix I (i) and (ii).

Conclusion

It should be noted that although cost has influenced the decision on procurement, it is not the only factor considered by Capital Planning and the wider project team. Other factors that were considered included:

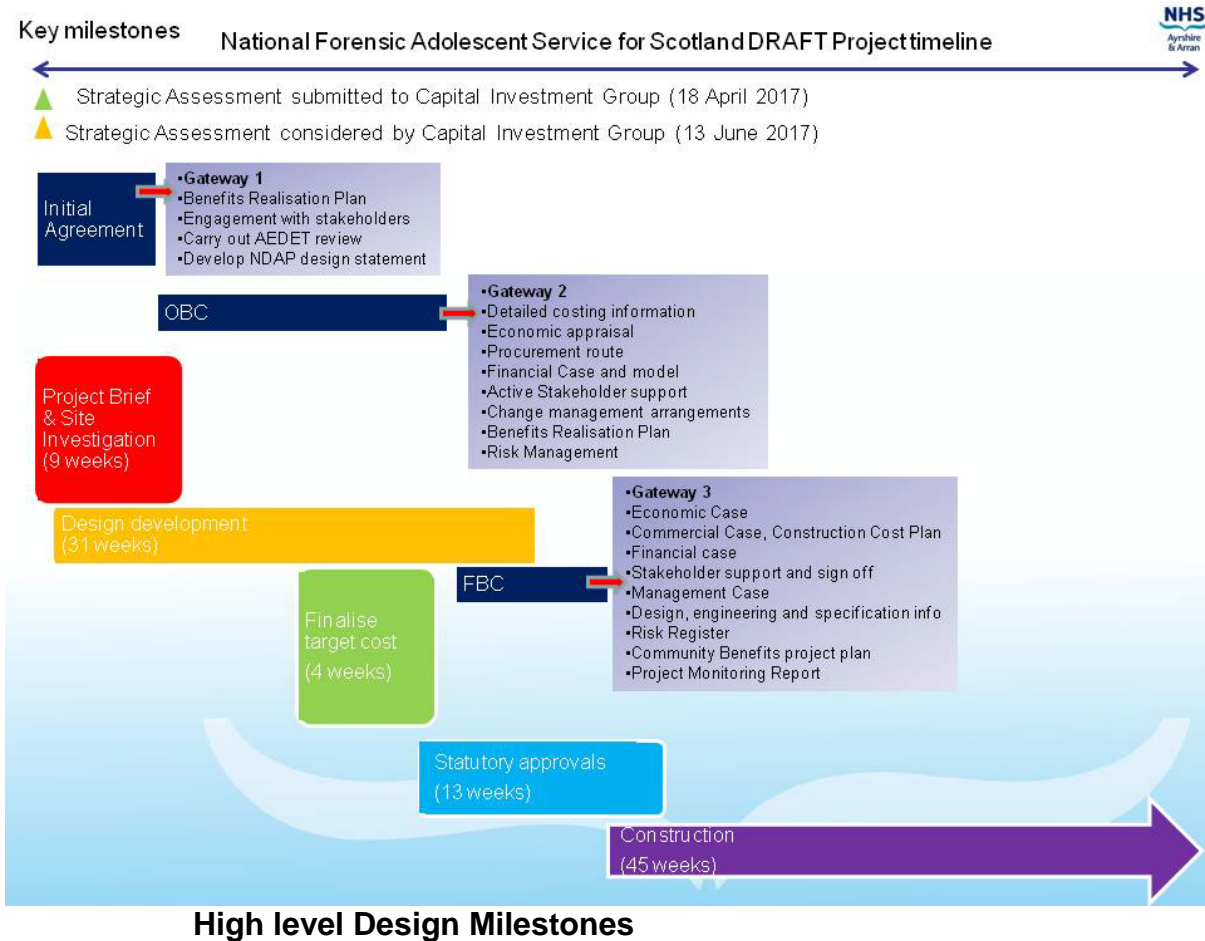
- Acute healthcare experience;
- Healthcare planning experience;
- Relevant design & construction experience.

The group concluded, firstly that given the importance of the unit, it is essential that designers have extensive knowledge of Child & Adolescent Mental Health Services. Secondly that the contractor has experience of design and build and more importantly has constructed similar secure units. Taking into consideration all of the factors noted within this section it is the conclusion of NHS Ayrshire & Arran's Capital Planning Department that Frameworks 2 presents the most economic procurement route.

The costs and Schedule of Accommodation will be developed in conjunction with the Model of Care and will be further refined during the Outline Business Case.

4.1.2 Timetable covering key business case stages

This section sets out the timetable from submission of IA to Full Business Case (FBC). Design, procurement and construction/commissioning are covered in the next section(s).



Activity	Commence	Completion
NDAP review	August 2018	November 2018
Development of Clients Construction Requirements	November 2017	March 2018
Development of Clinical Brief	November 2017	May 2018
Design Development	June 2018	January 2019
OBC	June 2018	April 2019
Loaded 1:50's and Market Testing	December 2018	June 2019
FBC	May 2019	August 2019
Construction	September 2019	August 2020

The above timescales noted above are indicative. A draft programme is included at Appendix N.

4.1.3 Business Case timescales

The table below details the proposed business case timetable.

	Proposed submission date	Approved
Strategic Assessment	18 April 2017	*
Initial Agreement	28 June 2018	TBC
Outline Business Case	April 2019	TBC
Full Business Case	August 2019	TBC
Anticipated Construction start date	Late Summer 2019	TBC
Anticipated handover	Late Summer 2020	TBC

* Note: CIG do not approve Strategic Assessments.

4.1.4 Implementation period

It is anticipated that the construction phase should take approximately 45 weeks.

This includes mobilisation, construction, completion and handover. Commissioning of the building will take a further six weeks.

5.0 Financial Case

The Financial Case considers the affordability analysis for the preferred option based on the overall capital and revenue costs of the preferred option.

NHS Ayrshire & Arran's Financial and Senior Capital Planning Team consistently deliver the Board's capital plan, meeting its financial targets and predicting financial out-turns for Capital projects, ensuring that the board meets the 2017/18 Revenue & Capital Resource Limits. The Proposal to design and construct a 12 bedded secure adolescent inpatient facility is seen as a much needed resource and asset to deliver part of the Mental Health Strategy 2017-2027. Nationally it is recognised that this project represents a challenge not only in the delivery of the strategy but also ensuring that this is achieved within the Revenue Resources made available nationally.

While NHS Ayrshire & Arran recognise that the proposed National Secure Adolescent Inpatient Service new build at Ayrshire Central Hospital, Irvine, is a significant undertaking it is a key requirement to support the delivery of the National mental health strategy. Between now and the development of the OBC there will be several key issues which will need to be considered to allow the successful delivery of this project and to ensure that the project remains affordable within the revenue resources available nationally. These will include:

- Ability to deliver the clinical model;
- Ability to reduce length of stay;
- Bed numbers required within the new hospital;
- Single Room requirements;
- Link to national initiatives;
- Impact on potential regional centres and private sector suppliers;
- Development of Health & Social Care Partnerships.

Resourcing of the project is key to successful delivery and the PID will identify key support across a range of disciplines to support the process. Full provision for the funding of this resource is contained within the Initial Agreement.

The financial case for NSAIS envisages significant improvement in adolescent secure mental health inpatient services throughout Scotland in a new state-of-the-art/environmentally friendly facility with 100% single room provision.

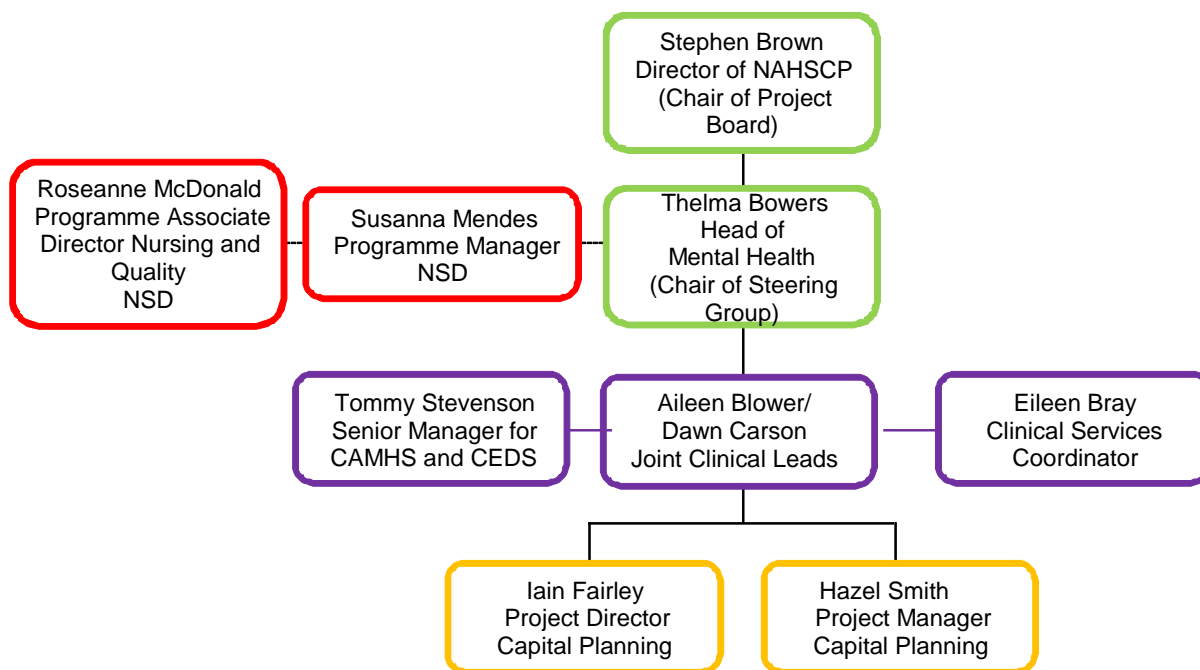
5.1 Organisation's financial situation

NSS and NHS Scotland Board Chief Executives have considered the proposal from NHS Ayrshire & Arran and recommended the continuation of the suggested governance route to facilitate the development within NHS Ayrshire & Arran.

5.2 Identification of resources

The chart below summaries the Project Team for the delivery of the National Secure Adolescent Inpatient Service (NSAIS)

Each of the roles listed is described in more detail in Appendix F.



The initial Capital Cost estimates have determined that the capital requirement to complete this development is within the range of £5.8m – £6.5m for.

5.3 Capital or revenue constraints

Capital and revenue consequences are outlined within this document. These will be further developed during the Outline Business Case and Full Business Case.

5.4 Financial contributions to be made by external partners and the current status of their commitment

The table below provides a breakdown of the finances by NHS Board.

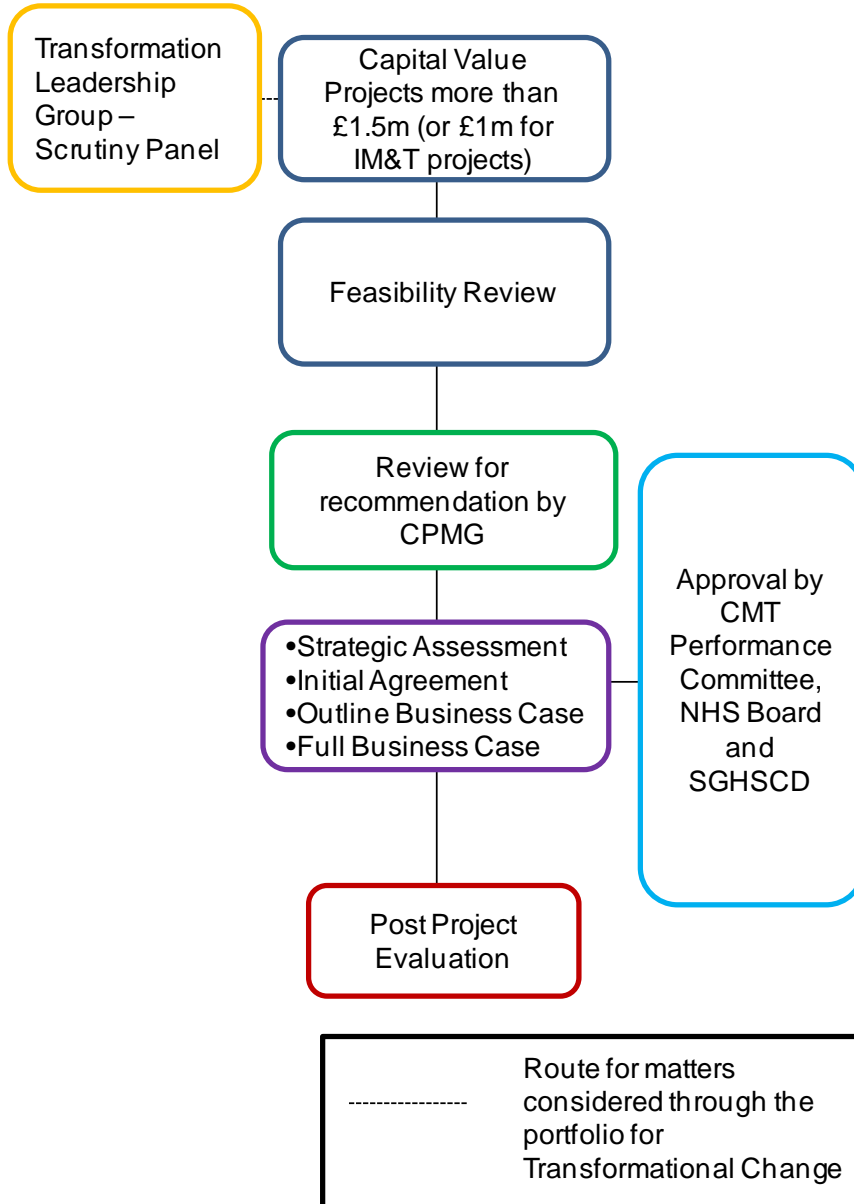
Reference period is from 2013-2016		New Service Costs Required Top-Slice £	Already Directly Funded by HBs (3yr Avg) £	Already Funding thru' Risk Share (3yr Avg) £	Already Funding Total (3yr Avg) £	Potential Change to Costs (Gain)/Loss £
A&A	7.43%	303,861	166,000	156,454	322,454	-18,593
Borders	2.15%	88,115	0	45,369	45,369	42,746
D&G	3.10%	126,904	0	65,341	65,341	61,563
Fife	6.71%	274,474	0	141,324	141,324	133,150
Forth Valley	5.39%	220,424	0	113,494	113,494	106,930
Grampian	9.63%	393,883	538,333	202,806	741,139	-347,256
GG & C	23.09%	944,239	224,800	486,178	710,978	233,261
Highland	6.40%	261,847	32,333	134,822	167,155	94,692
Lanarkshire	12.29%	502,710	273,620	258,840	532,460	-29,750
Lothian	14.33%	585,784	203,823	301,613	505,436	80,348
Orkney	0.48%	19,576	0	10,080	10,080	9,496
Shetland	0.47%	19,349	0	9,963	9,963	9,386
Tayside	7.77%	317,578	294,667	163,517	458,184	-140,606* previously (-295,606)
Western Isles	0.74%	30,250	0	15,575	15,575	14,675
Total		4,088,994	1,733,576	2,105,377	3,838,952	250,042

NB The figures above derived from a three year reference period which is up to and including 2015/16.

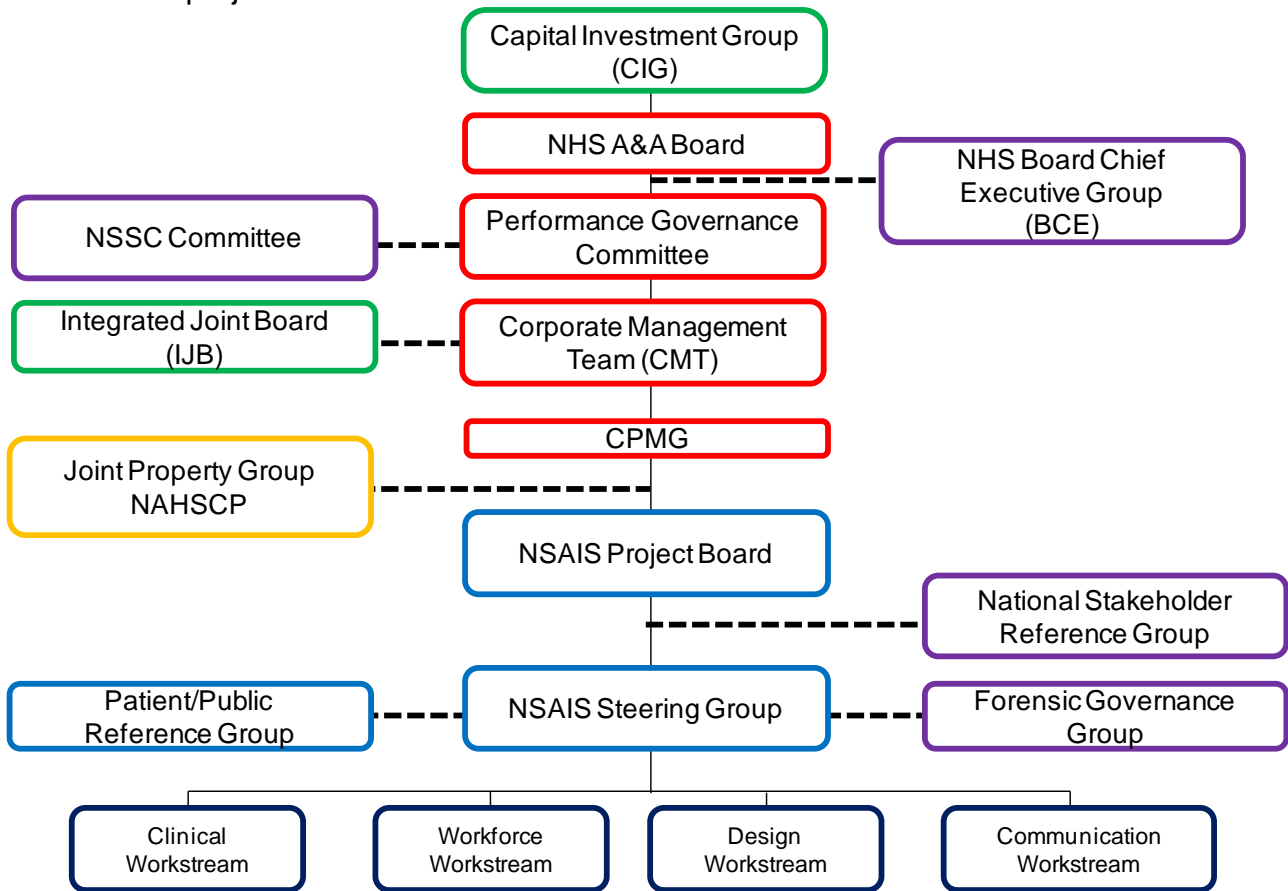
6.0 Management Case

6.1 Governance & Project Management Arrangements

The chart below shows the NHS A&A Capital Approval process.



The chart below shows the governance arrangements in place for this project.



NHS Ayrshire & Arran has a governance structure in place which ensures that there is a dedicated management focus and capacity for the programme, visibility and accountability at the highest levels in the organisation and the involvement of a wide range of stakeholders in the programme process.

The two previous charts outline the link between the Project Structure and the Board’s existing governance arrangements for capital projects.

The following text describes the responsibilities of the governance groups. The NHS Board has responsibility for approving capital investments. It fulfils the role of investment decision maker and exercises this at key points such as the approval of Initial Agreement, OBC and FBC in advance of submission to the Scottish Government.

The Performance Governance Committee is a formal committee of the NHS Board chaired by the Board Chairman. It has a key scrutiny role on behalf of the NHS Board in relation to all aspects of the financial case for capital projects and related matters.

The Corporate Management Team has the responsibility at a strategic level for the successful delivery of the project. Their role is to provide strategic leadership and to manage the political dimensions associated with the project.

The NHS Board Chief Executive Group allows strategic policy and operational discussions to take place between the Scottish Government Health Directorates and the Chief Executives of NHS Scotland Health Boards.

The Capital Programme Management Group (CPMG) is chaired by the Director of Corporate Support Services and is responsible for ensuring cohesive strategic alignment and prioritisation of capital programmes. The CPMG comprises a number of senior Executive Directors (Finance/ Planning and Performance/ Nurse Director) who provide robust and independent scrutiny of the project. The National Secure Adolescent Inpatient Service (NSAIS) is a standing item on the agenda of the CPMG and a regular report is provided to the Group.

The National Stakeholder Reference Group will comprise of NHS and other partners from across the regions and sectors. Due to its unique nature, it will be important that a range of stakeholders have input into the development of this proposed national secure service. A National Stakeholder Reference Group will be established to consider care pathways, elements of design, function and other issues which arise during the project development.

This Group will comprise key stakeholders from NHS Boards, regional NHS services (such as adolescent inpatient units, Forensic CAMHS and intensive community treatment teams), the Forensic Network, secure accommodation and other bodies who commission and provide services for young people with offending risk and mental health needs. The group would also ensure patient/carer participation. Representatives from the stakeholder group would sit on the Project Board. Terms of reference and membership would be clarified early in project development.

Joint Property Group (NAHSCP) is a formal group of the North Ayrshire Health and Social Care Partnership. It is chaired by the Director of NAHSCP. This group is responsible for driving forward the partnerships premises and accommodation requirements in line with addressing partnership objectives. Prioritising partnership requirements to ensure best use of NHS and NAC property portfolio's. Also responsible for early identification of new projects for possible inclusion in NHS and NAC Capital programmes. Group comprises partnership senior management from across range of services, together with Council and NHS Corporate Property Services and Partnership and Trade Union representatives.

The NSAIS Project Board is chaired by the SRO who is the Director of NAHSCP. They will ensure that the Project realises the specified benefits. The Project Board provides a key element of governance for the project ensuring that it is running to time, cost and quality. Core membership includes the Project Director (who provides the report to the Project Board), the Assistant Director of Finance, the Health Care Managers (in the role of business change managers), the Project Manager. In attendance Project Manager, Clinical Services Co-ordinator etc. The Project Board reviews and endorses key decisions as proposed by the Project Director and the Steering Group. For example, the sign off of the Initial Agreement, OBC; the Project Risk Register; the response to gateway reviews; the design and the workforce plan etc.

The NSAIS Steering Group is chaired by the Head of Mental Health Services NAHSCP. The Head of Mental Health Services has the responsibility for driving the project forward on a day to day basis. They are the conduit to all of the supporting project structures such as the interface with the Design Team. The Steering Group supports the Head of Mental Health Services to drive the project forward, ensuring rapid decision making on issues of detail rather than strategy. Associated work streams will be developed over the coming months and will have identified leads who sit on the Steering Group.

6.1.2 Project Team

The Project Team is responsible for controlling and managing all matters relating to the day to day development of the project. The Project Team is led by the Project Director, a Senior member of the NHS Ayrshire & Arran's Capital Planning team. The Project Director provides expert project management skills to successfully deliver the proposed National Secure Adolescent Inpatient Service (NSAIS), The Project Director also has extensive knowledge of project procurement, construction, commissioning and post project evaluation.

The Project Director will support the Senior Responsible Officer (SRO) specifically in the day- to-day project management of NSAIS and for ensuring that NSAIS meets its objectives and delivers its projected benefits. The Project Director will ensure, that on a day-to-day basis that the frameworks put into place for accountability and governance are actively implemented and that defined project management components covering business case development, project organisation, plans, controls, risk management, project quality, configuration management and change control covering all of the activities of the multi-disciplinary project team members are actively managed. In addition the Project Director will also ensure that all relevant stakeholders are fully engaged in the project through the delivery of an agreed strategy for communication across the Board and nationally.

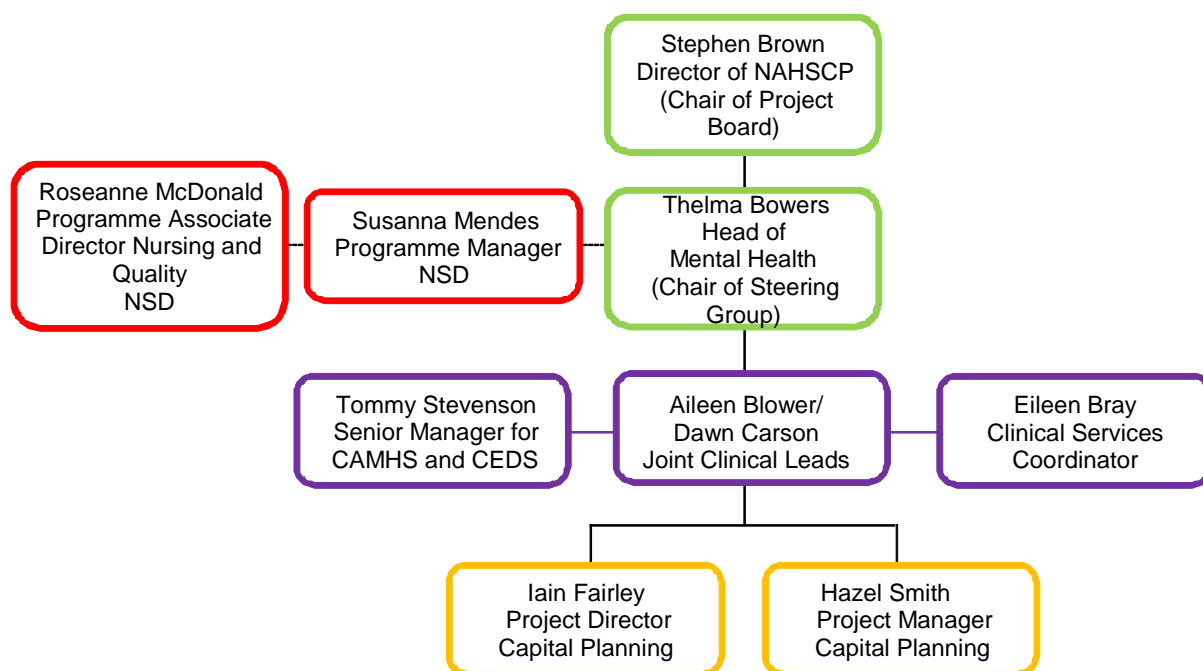
Critically during the project, the Project Director aided by a member of the Capital Planning team (Project Manager) will provide the necessary day to day project management, of a multi-disciplinary project team. This includes responsibility for:

- Clinical modelling;
- User engagement and consultation;
- Design and technical development;
- Commercial Procurement;
- Programme management;
- Communications;
- Key Project Issues;
- Risk management.

The Project Team incorporates the necessary mix of skills and experience required to deliver the project, incorporating clinical advisors, leads in key operational areas, planners and communications leads. The Project Team meets fortnightly.

The following diagram shows a summary of those identified within the Project Team. Further details of their roles are described in Appendix F.

Baseline Skills Matrix is also included at Appendix F for the Project Director and Project Manager. The level of complexity for this project measured against Scottish Government and Scottish Future Trust baseline skill set for construction procurement is level 4.



6.1.3 Summary of organisational involvement

The table below summarises how the key stakeholders have been involved in the development of the proposed solution together with an indication of their support.

Governance Group:	Engagement that has taken place	Confirmed support for the proposal
National Services Specialist Committee	NSS is fully supportive of this proposal.	Correspondence received on 30 November 2017 from Fiona Murphy, Director, National Specialist and Screening Directorate (NSD), stated the following:- “The Cabinet Secretary has endorsed the National Specialist Services Committee (NSSC) recommendation to designate the Secure Care Adolescent Inpatient Unit as a National Specialist Service. NSD will now work with NHS Ayrshire and Arran to put in place arrangements to establish this National Service”.
NHS A&A Board	NHS A&A Board is fully supportive of this proposal.	This Initial Agreement will be considered by the NHS A&A Board on 29 January 2018.

NHS A&A Corporate Management Team	NHS A&A Corporate Management Team is fully supportive of this proposal.	This Initial Agreement was approved by the NHS A&A Corporate Management Team on 19 December 2017.
NHS A&A Performance Governance Committee	NHS A&A Performance Governance Committee is fully supportive of this proposal.	This Initial Agreement was approved by the NHS A&A Performance Governance Committee on 4 December 2017.
NAHSCP Joint Property Group	NAHSCP Joint Property Group is fully supportive of this proposal.	This Initial Agreement will be considered by the NAHSCP Property Group on 9 January 2018.
Governance Group:	Engagement that has taken place	Confirmed support for the proposal
NHS A&A Capital Programme Management Group	NHS A&A Capital Programme Management Group is fully supportive of this proposal.	This Initial Agreement was approved by the NHS A&A Capital Programme Management Group on 23 November 2017.
NSAIS Project Board:	<p>Project Board is fully supportive of this proposal, with Director Stephen Brown, taking the lead role in its development.</p> <p>This proposal is also incorporated into NHS A&A Board's 2017 PAMS document, which has been submitted through local and national governance.</p>	This Initial Agreement was approved by the NSAIS Project Board on 9 October 2017.
NSAIS Steering Group:	Steering Group is fully supportive of this proposal, with Thelma Bowers, Head of Mental Health Services taking the lead role in its development.	This Initial Agreement was approved by the NSAIS Steering Group on 27 September 2017.
Service or Department	<p>The Service Director(s) involved in this project is/are</p> <p>John Wright (CPMG, CMT)</p> <p>Stephen Brown (Project Board, Joint Property Group, IJB, CMT)</p> <p>Thelma Bowers (Steering Group, Project Board, IJB, Joint Property Group)</p> <p>Aileen Blower (Steering Group, Project Board and National Stakeholder groups)</p>	This Initial Agreement has followed the governance route detailed in the organogram above.
	Scottish Health Council have	

<p>Scottish Health Council</p>	<p>been informed of the impact of any proposed service change on patient care.</p>	<p>Scottish Health Council have provided confirmation of the level of engagement expected. Further details on such engagement will be developed and shared.</p>
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6.1.4 Capability

Careful thought has been given to the composition of the project team. There is a mix of clinical and capital experience throughout the team. The Senior Responsible Officer will be the Director of NAHSCP.

Within the project team are two joint clinical leads who between them, have extensive knowledge and experience of the functional and operational requirements of both a Child and Adolescent Mental Health services and Forensic/secure mental health services. The joint clinical leads are supported by three key team members who are responsible for the interface of all clinical operational services involved in the procurement, development and commissioning of the project.

The Project Director has extensive experience for the delivery of large, complex NHS capital projects. The Project Director is supported by a Capital Planning Team who have a wide range of capital planning experience. In addition, the Project Director will be supported by the Senior Finance Manager for Partnerships who will lead on the financial aspects of the project.

The Terms of Reference including membership for the Project Board and Steering Group are attached in Appendix G.

During the Outline Business Case, the Project Team will engage with a number of consultants, as part of the PSCP supply chain. For the OBC the key consultants will be Healthcare Planner, PSCP and PSCs.

A profile of the Project Team experience and time input to the development is attached as Appendix F.

6.1.5 Statement of the organisation's readiness

NHS A&A and NAHSCP are in the process of detailing the next stages of the project. This will include the inception of a number of work streams to support and complement the OBC.

There is recognition within NHS Scotland, NHS A&A and NAHSCP that there is a need for this key service and commitment has been made to support this project.

6.1.6 Specialist external advisors

NHS A&A will appoint a Healthcare Planner to assist the Clinical teams to develop a clinical brief, including a comprehensive model of care.

6.1.7 Project Plan

The following key activities are detailed below:

	Anticipated duration
Initial Agreement	22 weeks
Outline Business Case	
Clinical brief and Authorities Construction Requirements	12 weeks
Detailed design	15 weeks
Commercial management	12 weeks
Full Business Case	
Finalise design	8 weeks
Commercial management	8 weeks
Statutory Approvals	12 weeks
Mobilisation and Construction	45 weeks

6.1.8 Next Steps

Stakeholder engagement

NHS A&A recognises that the new facility will serve Scotland and as such there is a need for efficient, timely and relevant communication across a broad range of stakeholders throughout Scotland. To this end, a robust Communication Plan is being developed and many of the key stakeholders are already being engaged. This process is ongoing as the project progresses.

Clinical brief

As previously described, a model of care is being developed in collaboration with key stakeholders and will continue to evolve as the needs analysis results emerge.

Authorities Construction Requirements

NHS A&A will develop Authorities Construction Requirements that will set out the key design and construction requirements of the Authority for the provision of the new facility. This will include the use of BIM Level 2 which is now mandatory for all capital projects with a value of £2m or over.

Workforce Planning

A number of specific regulatory and policy drivers will have an impact on both the shape and size of the workforce for this new facility. This will include the European Working Time Directive and the impact of Modernising Medical Careers. These coupled with complexity of the patient group will directly influence the workforce.

The overall vision is to ensure we have the right staff, in the right place with the right skills and competences to deliver high quality care and services to the young people of Scotland.

In order to realise this vision, the workforce needs to be aligned with both service and financial plans to ensure affordability and sustainability over the long term. In forecasting the workforce element of the project, NHS Ayrshire & Arran will utilise the 6 steps methodology, the common workforce planning framework for the NHS in Scotland.

The review and redesign of models of care, coupled with the development of existing and new roles will be a benefit arising from this National facility.

Design Development

The key driver for the design development of the proposed facility is, ensuring timely access to treatment and support for young people across Scotland. The focus of the design of the facility will be to meet the differing needs of this complex group of young people, who will be accommodated in wards which support activity, reflection and treatment.

Choice of environment, such as spending time as part of the ward community or choosing quieter areas with more privacy will be balanced through a range of activity areas from day spaces to treatment rooms, further enhanced by 100% single occupancy bedrooms with en-suite shower rooms and easy access to a range of outdoor space.

This requirement for current and future health care provision for young people is in stark contrast to the current policy of transferring young people to NHS England for treatment.

Commercial Management

As stated in the Commercial Case, the preferred option for procurement of the proposed facility is Frameworks 2. A Professional Services Consultants (PSC) advisors and Principal Supply Chain Partners (PSCP) will be appointed to advise, design and build the new facility.

These appointments will ensure the delivery of a Design and associated costs for the OBC. The Project Team will ensure that this work will align with the outcomes noted in the National Design Assessment Process.

7.0 Strategic Assessment template

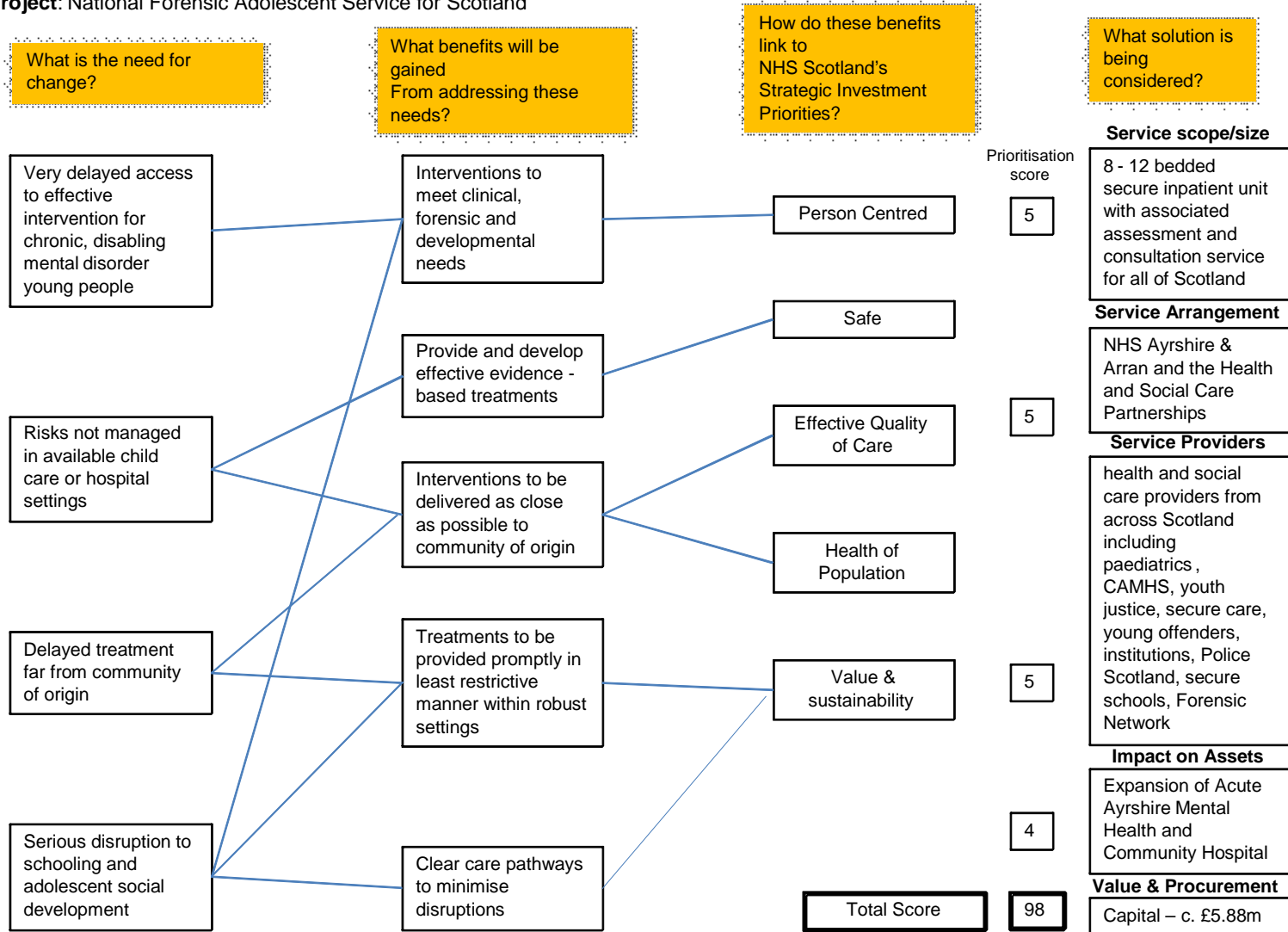
7.1 Updated strategic assessment

The Strategic Assessment template has been scored and can be referred to on the next page. The reports generated by the capital planning tool are included at Appendix Q.

Strategic Assessment

Project: National Forensic Adolescent Service for Scotland

What are the current arrangements: There are no arrangements for this service within Scotland. NHS England National Secure Forensic Mental Health for Young People service provide the current service.



8.0 Conclusion

This Initial Agreement (IA) sets out a robust case for the provision of a new National Secure Adolescent Inpatient Service (NSAIS). The proposed new facility will transform care pathways for young people by reducing the time taken from referral to treatment, and by providing that assessment and treatment in an appropriate health and care setting.

The capital investment in this proposed facility reflects and responds to National Strategies, such as The National Clinical Strategy for Scotland and The Scottish Mental Health Strategy 2017 – 2027. It will transform the way in which health care for young people will be delivered in a secure setting and will address a major gap within current mental health care delivery. The development will provide enhanced services in an appropriate setting and enable staff to work more efficiently and effectively, in modern, safe and sustainable facilities located in the heart of the Scottish community.

The IA outlines the management planning and the governance structure established by key stakeholders to take the project forward on an affordable basis, monitored at every stage. In submitting the IA, approval and support is sought to move to the OBC stage of this essential development.

NHS Ayrshire & Arran would like to acknowledge the effort, energy and enthusiasm of everyone who has been involved in the development of this IA.