Living Well Network Alliance

NHS Lambeth Clinical Commissioning Group

Improving Inpatient Mental Health Services for Lambeth

Pre-Consultation Business Case

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Glossary of Terms

Term/ Abbreviation	Definition
A&E	Accident and Emergency
ADM	Alternative Delivery Model
AHSC	Academic Health Science Centre
AMHP	Approved Mental Health Professional
CAG	Clinical Academic Group
CAMHS	Child and Adolescent Mental Health Services
CBC	Community Based Care
CBI	Confederation of British Industry
CCG	Clinical Commissioning Group
CE	Compensation Event

CIP	Cost Improvement Programme
CLARHC	Collaboration for Leadership in Applied Health Research and Care
CLN	Clinical Leaders Network
CQC	Care Quality Commission
CSF	Critical Success Factor
CYP	Children & Young People
DEC	Display Energy Certificate
DMBC	Decision Making Business Case
DOH	Department of Health
EI	Early Intervention: First Episode Psychosis
EIA	Equality Impact Assessment
ERIC	Estates Return Information Collection
FBC	Full Business Case
FOMHS	Future of Mental Health Services
FSRR	Financial Sustainability Risk Rating
G&ST	Guy's and St. Thomas' NHS Foundation Trust
GDP	Gross Domestic Product
GLA	Greater London Assembly
HACT	Housing Associations Charitable Trust
HIN	Health Innovation Network
HLP	Healthy London Partnership
IAPT	Improving Access to Psychological Therapies
IEQ	Internal Environmental Quality
IHP	Independent Healthcare Provider
IM&T	Information Management & Technology
IoP	Institute of Psychiatry
IoPPN	Institute of Psychiatry, Psychology & Neuroscience
IPSA	Integrated Personalised Support Alliance
IWG	Integration Working Group
JHOSC	Joint Health Overview and Scrutiny Committees
KCH	Kings College Hospital

KCL	King's College London
KHP	King's Health Partners
LAS	London Ambulance Service
LCN	Local Care Network
LCS	London Clinical Senate
LGBT	Lesbian, Gay, Bisexual, Transgender
LWNA	Living Well Network Alliance
LOS	Length of Stay
LTC	Long Term Condition
LTP	Long Term Plan
LTFM	Long Term Financial Model
LWA	Living Well Alliance
LWC	Living Well Centres
MCP	Multispecialty Community Provider
NBV	Net Book Value
NHSE	NHS England and NHS Improvement
NHSE(L)	NHS England and NHS Improvement (London)
NHSE&I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NPC	Net Present Cost
NPV	Net Present Value
OBC	Outline Business Case
OHSEL	Our Healthier South East London
OPE	One Public Estate
PACS	Primary and acute care system
PCBC	Pre-Consultation Business Case
PDC	Public Dividend Capital
PIA	Privacy Impact Assessment
PICU	Psychiatric Intensive Care Unit
PID	Patient Identifiable Data
PLACE	Patient-Led Assessment of the Care Environment

PMIC	Psychological Medical & Integrated Care
PMO	Programme Management Office
PPE	Post Project Evaluation
PPI	Patient & Public Involvement
PREM	Patient Reported Experience Measures
PRINCE2	Projects In Controlled Environments
PROM	Patient Reported Outcome Measures
PSCP	Principal Supply Chain Partner
PTAL	Public Transport Accessibility Levels
QALY	Quality Adjusted Life Years
QIA	Quality Impact Assessment
SEL	South East London
SLaM	South London and Maudsley NHS Foundation Trust
SLP	South London Mental Health and Community Partnership
SOC	Strategic Outline Case
SOCI	Statement of Comprehensive Income
SoS	Secretary of State
STP	Sustainability and Transformation Partnership
SUAG	Service user Advisory Group
SWL	South West London
SWLStG	South West London and St George's Mental Health NHS Trust
TRACC	Transport Accessibility Calculation
WIC	Ward In Community
WLUG	Workstream Leads Update Group
WTE	Whole Time Equivalent
YTD	Year to Date

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Foreword

Lambeth CCG and South London and Maudsley NHS Foundation Trust (as a provider partner in the Living Well Network Alliance) share a view that people in Lambeth who are experiencing mental illness or distress should receive the support they need to lead full, healthy and independent lives. We are committed to transform the health and care services in Lambeth.

People who use our mental health services tell us they want more options for support when they are in crisis. That's why we're improving our mental health services to be:

- more joined up;
- quicker and easier to access; and
- more focussed on prevention, avoiding crises and unnecessary admissions to hospital.

The new delivery model for the Living Well Network Alliance has been agreed and changes in the way we work has already begun, to join up services around those people who use them to ensure they get the best possible support available as and when they need it.

To deliver our vision we have developed a number of objectives:

- increasing whole person mental and physical health care and wellbeing support provided in the community;
- reducing length of stay;
- offering increased support for people experiencing crisis in their place of residence or alternative setting to A&E where appropriate; and
- reducing inequality in access and experience of mental and physical health care across South East London for people with protected characteristics and experiencing social deprivation.

To deliver our vision, we have designed a programme of clinical transformation based around these key principles:

- delivering new integrated community mental health models of care wrapped around primary care networks;
- increasing capacity to meet national access, recovery and waiting time trajectories;
- providing alternative crisis support working jointly with police, London Ambulance Service and voluntary sector to provide crisis support in alternative least restrictive setting;
- working as a system to enable a minimum of 60% of people with severe mental illness receiving an annual physical health check and follow on support where this is identified; and
- where inpatient care is needed, a commitment to ensuring that individuals are treated in modern, conducive environments, ensuring service users get the best therapeutic care and treatment they need.

We have already commenced the process of developing Living Well Centres, which will enable more care to be delivered in a community setting, right to the heart of our communities so that those needing support remain close to their support networks of families and friends. More accessible community services will mean people are then less likely to be referred to hospital and if they are, more likely to be discharged earlier following periods of illness.

This document describes how we are seeking to transform our inpatient services to align to and enable that model so we can realise our ambition to improve the mental health and reduce the health inequalities of our communities.

South London and Maudsley NHS Foundation Trust, as the lead provider partner in the Living Well Network Alliance is at the forefront of clinical and academic research in mental health. Together we are confident that the proposals outlined in this Pre-Consultation Business Case will enable us to meet the aspirations of mental health for South East London and modernise and improve the quality of care provided to local people, well into the future.

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Chapter 1. Executive Summary

1.1 Introduction

The local health organisations of South London are committed to delivering best possible health outcomes for the local population[1].The Lambeth Living Well Network Alliance and South London and Maudsley NHS Foundation Trust (SLaM) has responded to deliver these through a clinical strategy and quality imperatives that seek to:

- increase whole person mental and physical health care and wellbeing support provided in the community;
- reduce length of stay;
- offer increased support for people experiencing crisis in their place of residence or alternative setting to A&E where appropriate; and
- reduce inequality in access and experience of mental and physical health care across South East London for people with protected characteristics and experiencing social deprivation.

To deliver our vision, a programme of clinical transformation has been designed based around these key principles:

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- where inpatient care is needed, a commitment to ensuring that individuals are treated in modern, conducive environments, ensuring service users get the best therapeutic care and treatment they need.

This programme has seen the development of Living Well Centres, which will enable more care to be delivered in a community setting, right to the heart of our communities so that those needing support remain close to their support networks of families and friends. More accessible community services will mean people are then less likely to be referred to hospital and if they are, more likely to be discharged earlier following periods of illness.

It is recognised, however, that there will always be a need and a place for a much more intensive style of support provided in an inpatient setting and we are committed to ensuring that where this is the case individuals are treated in modern, conducive environments, ensuring service users get the best therapeutic care and treatment they need. Unfortunately, this is not currently possible with the existing, tired and poorly configured facilities at Lambeth Hospital.

This Pre-Consultation Business Case (PCBC) sets out the case for the changes proposed. It is structured using the NHS England and NHS Improvement guidance for delivering service

[1] South East London STP - Integrating Mental Health Services, Page 12, October 2016.

change and sets out a way forward for full public consultation on a preferred option which is demonstrably the best solution in terms of benefits and value for money. The objectives of the PCBC are to:

- Make the case for change for transformation and modernisation of the acute inpatient services currently delivered by the Trust at Lambeth Hospital. This will include setting out the quality of the existing estate and plans for redevelopment against the backdrop of local, regional, and national policy frameworks.
- Detail the process undertaken with stakeholders to inform, develop and evaluate viable options for achieving this.
- Detail the process undertaken to engage the public, staff and other stakeholders in the pre-consultation phase and demonstrate how their feedback has shaped the development and selection of the preferred option.
- Describe the impact on the care delivered to service users and the expected benefits thereof.
- Set out how the development of the preferred options is compliant with the Secretary of State for Health and Social Care's four tests of service reconfiguration and NHS England and NHS Improvement (NHSE) bed test.
- Make the case to NHS Lambeth Clinical Commissioning Group (CCG) and NHS England and NHS Improvement to commence public consultation on the preferred option.

As part of the pre-consultation engagement process thus far we have identified options and will seek to finalise those options through a thorough public consultation considering all views received before making any decision as to the future of inpatient services for Lambeth.

1.2 Context

South East London has a diverse and mobile population with extremes of deprivation and wealth. Four of the six Boroughs (Lambeth, Southwark, Lewisham and Greenwich) are amongst the 15% most deprived local authority areas in England. Of the 1.67 million residents, only one in six people are classified as 'healthy and well' and without risk of poor health. 50% of all people are at risk of having a long term condition. 75% of over 55s have one or more long term condition, while 32% of children are classified as overweight or obese.

The estimated prevalence of psychotic disorder as a percentage of the population aged 16+ (2012 data) is 0.62% for South East London in comparison to 0.40% for England as a whole. The incidence rate for the number of new cases of psychosis per 100,000 population aged 16-64 is 41 for South East London which is significantly higher than the 18.1 incidence rate for England. The Borough of Southwark has the highest prevalence and incident rate of psychosis in South East London [2].

Only 0.3% of psychosis care spells occurring in South East London receive psychological therapy, compared to the 3.4% national average, which suggests that there are access challenges or there are capacity issues in the services currently being provided[3].

The number of people subject to the Mental Health Act in South East London is higher at 43 per 100,000 in South East London compared to the national average of 40.1[4]. The number of

[2] South East London STP - Integrating Mental Health Services, Page 12, October 2016.
[3] Public Health England. Severe Mental Illness – Psychosis Pathway, April 2018.
[4] https://fingertips.phe.org.uk/

admissions per 100,000 is also higher at 351 compared with a national average of 263.

1.2.1 Background of partner organisations

The partner organisations for preparing this case include:

- NHS Lambeth CCG is responsible for commissioning non-specialist hospital and community health services for service users in Lambeth. NHS England and NHS Improvement delegates funding to Lambeth CCG to commission services as required. It is the role of the CCG to spend this money well to ensure that the most needed and effective services are available, and to monitor how well these services are provided, holding Trusts accountable for the quality of service delivery.
- South London and the Maudsley NHS FT (SLaM) provides NHS care and treatment for individuals with mental health problems and services for those who are addicted to drugs and alcohol. Services are provided to those living in the London Boroughs of Croydon, Lambeth, Lewisham and Southwark; and substance misuse services for residents of Wandsworth, Greenwich, Lambeth and Bexley, with a combined population of 2 million people

  Lambeth CCG has six commitments which it tries to adhere to in its operations. These commitments are to be people centred, prevention focused, integrated, consistent, innovative, and to deliver the best value possible.

1.2.2 The Lambeth context

- The Living Well Network Alliance: The Living Well Network Alliance (LWNA) is formed of partners from Lambeth Council, NHS Lambeth CCG, South London and Maudsley NHS Foundation Trust and two voluntary sector organisations – Certitude and Thames Reach. They are responsible for leading, co-ordinating and, in large part, delivering support and services for those experiencing mental health issues in Lambeth. The objectives of the LWNA as follows:

  i) Improve access to support - including easier early access and a rapid crisis response.

  ii) Integrate and coordinate care and support for people and their networks across Lambeth.

  iii) Reduce the inequalities experienced by people experiencing mental health problems.

  iv) Manage demand and resources effectively.

  v) Drive culture change - including leadership and models of working.
- Kings Health Partners (KHP): Kings Health Partners is an Academic Health Science Centre for South London. Its aim is to be a leader in improving health and wellbeing locally, nationally and globally. Four partner organisations fund the centre's work through equal contributions. The Trust is one of these partners alongside Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and King's College London.
- NHS England and NHS Improvement (Specialist Commissioning): Specialist care services are commissioned directly by NHS England and NHS Improvement, rather than through local CCGs, and are planned on a national and regional basis. Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to service users with rare cancers, genetic disorders or complex medical or surgical conditions. Care delivered is cutting edge and these services are a catalyst for medical innovation. NHS England and NHS Improvement commissioned the Eating Disorders and Neuropsychiatry services from the Trust, which proposed to move

into the new inpatient facility from Bethlem Royal Hospital however this will be subject to a separate consultation process led by NHS England.

1.2.3 Overview of the clinical transformation programme and estate strategy

With local partners, we have continued to make progress on clarifying our clinical strategy, which aims to move care closer to home and manage inpatient admission as a specialist intervention – recognising that the service user experience of modern, therapeutic environments is a key determinant of effective recovery.

In line with the clinical strategy and subsequent estates strategy, this envisages moving local community services to better equipped local hubs and consolidating inpatient activity in new, better equipped facilities that can be co-located where possible with other acute services. Due to the scale of this programme of change it will take a significant investment in multiple phases over some 12 years to fully realise with Lambeth inpatient services being the first of these phases.

The following guiding principles underpin our future aspirations:

- community care focus, moving away from reliance on bed based and institutional care;
- improve accessibility of services for its users addressing barriers such as locality, timeliness, capacity and quality;
- integration across care providers and partnerships/alliances to deliver more efficiently and effectively;
- integration of physical and mental healthcare for service users;
- economically sustainable mental health services; and
- high quality and therapeutic environments for service users and staff.

The aspiration is to move local community services to better equipped local hubs and consolidate inpatient activity into new, better equipped facilities. This will help ensure a service user-centric approach and support the health of the community, as well as support the sustainability of SLaM as a world-leading mental health service. Services are currently provided from 72 locations – 66 community sites and six acute sites – across the London Boroughs of Croydon, Lambeth, Lewisham and Southwark.

Lambeth is the furthest ahead of all SLaM's boroughs in determining its local, community care blueprint and the Lambeth Alliance has consulted extensively on this with changes starting in July 2019. To support this service change, investment is already being made in the fabric of Lambeth's community estate. Three community hubs are:

(i) 332 and 308-312 Brixton Road (In Lambeth Borough);

(ii) Akerman Health Centre, (In Lambeth Borough); and

(iii) Gracefield Gardens, (In Lambeth Borough).

As a result, the Lambeth community estate will be refurbished to deliver much greater levels of usability and functionality than currently present. Embedding services in the community in this way, appropriately distributed across the borough, will allow our teams to help people earlier, closer to their homes, preventing people from becoming unwell so that they require fewer hospital referrals. By delivering more responsive care in community settings, we can prevent crisis for some people and provide and provide a 'least restrictive' offer for those who might currently be detained under the Mental Health Act. Our aim being to avoid admitting those people who do not require hospital treatment.

It will support the further de-stigmatisation of mental health services as the ambition for the Living Well Centres is to move to a neighbourhood care mode in line with the primary care network model, where care and support will be delivered in community locations such as GP practices and community centres to provide wider access to care and reduce the reliance on a one-place community mental health centre approach.

Overall, our approach would be to provide a robust community and acute interface, with staff and partners across the community and acute pathways working together to ensure people receive the least restrictive treatment and care, as close to a person's home as practically possible, with community connections maintained if an admission is required. It is also expected that this will reduce the need to access inpatient care with quicker, easier access to support and care in the community.

1.3 Case for Change, Care Model and Expected Benefit

1.3.1 Drivers for change

There are three primary drivers of our case for change. They are:

1. **National and regional policy** – this proposal is fully aligned with, and supports the delivery of the NHS Long Term Plan, Five Year Forward View for Mental Health and the South East London STP strategy.

2. **The local vision and clinical objectives set** out in the Trust's Clinical Strategy and the Lambeth Living Well Network Alliance Strategy to provide care in the least restrictive environments and move care closer to home for all but those requiring specialised inpatient care.

3. **Quality of the estate** – its impact on service provision, outcomes and service user and carer experience. In order to be able to deliver our clinical priorities, the estate must be improved so that care is provided in modern, fit for purpose estate both in the Driver 2: Strong local and clinical vision

These drivers of change have informed the clinical case for change as outlined below.

1.3.2 Clinical Case for Change

Investment is already being made in the fabric of Lambeth's community estate, and we are now proposing to enter into a process of engagement on service changes regarding Lambeth Hospital to support this direction of travel. Through an extensive engagement process with stakeholders, it is hoped that the following can be delivered in a bid to serve local populations:

- improving the estates quality through investment in modern, fit for purpose environments for services both in the community and at inpatient sites across all the boroughs we serve; and
- the consolidation of acute inpatient services which will allow:
    - investment in new acute inpatient facilities where service users requiring specialist care in an inpatient environment are treated in state-of-the-art, therapeutic environments and safe; and
    - more robust staffing models through co-location of services which could help reduce the use of bank and agency staff that currently contribute to existing financial strain and clinical risk. Conservative assumptions have been made at this stage to test affordability and a further assessment of financial benefits will be made by the Trust as part of the business case process for capital investment that would follow a successful consultation process.

1.3.3 Improving estates quality

The Trust's estates strategy identified that the estate requires extensive investment to bring it up to the standard expected to deliver 21st century care. The development of the strategy identified three key estate issues that need to be addressed including:

- Investment in modern, fit for purpose environments for services both in the community and at inpatient sites across all the boroughs we serve.
- Ability to meet service reconfiguration that is locally aligned to the Sustainability and Transformation Partnership strategy. This requires an understanding of capability and capacity across sites and a shared approach to use of that capacity.
- Ensuring sites and buildings are used to maximise their ability to deliver services efficiently and effectively, focused on the assets of the Trust and limited capital where it delivers the highest benefits.
- Quality to support better clinical outcomes and improved service user experience facilitated by new technologies.

The ongoing work as part of that strategy has identified that the inpatient services at Lambeth Hospital are not fit for purpose and require very significant modernisation in order to deliver the Trust Clinical Strategy. Sites are generally in poor condition and too small to offer a good environment of care.

Lambeth Hospital has particular estates challenges which impact on the delivery of our clinical transformation programme and impact on service user safety, experience and outcomes include:

- The acute inpatient wards at Lambeth (Luther King, Nelson, LEO and Eden) were built in the 1990s (some of which originally as offices) and, therefore, do not align with modern accommodation standards, for example they do not have ensuite facilities. The general environment in these wards is cramped, especially at Nelson and Luther King wards.
- In their inspection (July 2017) of the Trust accommodation, the Care Quality Commission (CQC) identified a number of specific issues with the current accommodation:
  - All inpatient units were found to have blind spots which necessitated the use of convex mirrors to mitigate.
  - All wards were found to exclude a dedicated seclusion room which required staff to improvise when seclusion was required.
  - At Nelson ward and others on the Lambeth site, there are potential ligature risks following the recent attempted suicide of a service user by using the ceiling as a ligature point.
- Nelson and Luther King wards are in the poorest condition and due to their age and configuration, deviate from the most from latest planning standards. Patient safety is impacted due to poor observational lines of sight, ligature risks, ward lighting controls being located in areas that are accessible to patients and the general cramped nature of the wards make service users feel cramped which can sometimes cause aggression.

  Whilst measures are in place to maintain privacy and dignity as much as possible, issues remain that cannot be addressed because of the design of the ward templates including the lack of ensuite facilities and the fact that all bedrooms are located off one busy ward street thoroughfare. Toilets and showers often become blocked due to structural issues with the drainage system which further reduces the number of facilities available for use.
- There are no purpose designed facilities on the wards for the delivery of therapeutic activities. Whilst workarounds are in place, the design constraints limit the extent to which a wide range of therapy can be delivered.

- The wards do not comply with the Royal College of Psychiatrists standards relating to “a physical environment that is fit for purpose” due to:
    - Lack of bathroom and showering facilities – only 18 beds out of the entire bed base have ensuite facilities.
    - Tired and worn decoration and furnishings.
    - Insufficient on and off ward therapy spaces.
    - Luther King, Nelson and Eden wards are essentially long narrow corridors with bedrooms, communal space and staff facilities running off them.
    - Poor natural light and ventilation.

The Lambeth Hospital lacks the expected features of high-quality acute inpatient mental health facilities and to address this we propose to consolidate inpatient care and modernise Trust acute inpatient bed stock.

1.3.4 Consolidation of inpatient services

Currently the Trust’s inpatient services are provided at five sites; Bethlem Royal Hospital in Beckenham, Lambeth Hospital in Clapham, the Ladywell Unit at University Hospital Lewisham, the Maudsley Hospital in Camberwell and Woodland House in Tonbridge.

Outpatient and psychiatric liaison services are also provided from sites including; Croydon University Hospital, Guy’s Hospital, King’s College Hospital, University Hospital Lewisham and St Thomas’s Hospital.

National and specialist services are also provided from Bethlem and Maudsley, Trust staff also deliver services from numerous community locations in Lambeth, Southwark, Lewisham and Croydon as well as visiting service users in their homes.

Inpatient admissions, where they are necessary, will be focused specialist interventions in modern environments that are conducive to effective recovery. For example, enabling all staff to safely respond to service users as they will be consolidated on fewer sites. This will also allow greater workforce flexibility as well as the cross-fertilisation of ideas and best practice.

The acute care pathway programme for the Trust will continue to be developed through standardising pathways and reducing variation in care across sites, which will over time be achieved by consolidating acute inpatient mental health services creating closer relationships with local acute physical health services.

Our existing investment in community services and earlier access to care will reduce the dependency on inpatient services for a far greater number of service users reducing their need to access a hospital site. This will have the consequence that acute inpatient care is more available to those who truly need specialist interventions.

The acuity of service users accessing inpatient care is likely to create a demand for more specialist clinical interventions and access to specialist clinical expertise. Geographical aggregation of inpatient services on fewer sites reduces the dilution of these specialist clinical resources allowing more agile and responsive intervention where needed.

New inpatient units, with an improved environment, would positively impact on staff morale and the recruitment and retention of staff. It is anticipated that a higher quality environment would reduce aggression and violence, with the result being that patients and staff feel safer.

More robust staffing models through the consolidation of acute inpatient services would also support a reduction in the use of bank and agency staff that currently contribute to existing financial strain and clinical risk. This would also help manage staffing on the acute wards as there would be an increased pool of staff on one site which will have the added advantage of increasing the number of available staff for the emergency response teams. Additionally, there may also be productivity and efficiency improvements so that staff can spend more time supporting service users.

With any strategy including consolidation concerns may be felt that this will lead to a reduction in the capacity of services. In the context of this proposed service reconfiguration the intention is to maintain the same number of beds across the four boroughs for which services are provided.

In addition, any future growth in demand for mental health services will be managed through improved early intervention services in the community, thus reducing the reliance on periods as an inpatient coupled with a reduction in the length of stay as people respond and recover quicker in better therapeutic environments and there are improved community services to support them when they leave.

1.3.5 Care Model

Looking forward, we recognises that care should be provided in the least restrictive setting. As outlined above, this includes developing the support available within the community to ensure that the care, support and interventions that support people to recover and stay well are available and accessible, and that an asset based approach supports service users to take a more central role in their care.

The reorganisation of community services through the implementation of Living Well Centres should help to deliver care in the least restrictive setting and should prevent readmissions to hospital. There will however always be a need to treat the most acute cases in an inpatient setting and delivery of this project will provide an inpatient environment for Lambeth service users that promotes recovery and accommodation that is configured in a way that is flexible to cope with changes in demand.

As inpatient care becomes a more specialised intervention, it will become more complex and acute. The consolidation of our wards will not affect the care model which will remain unchanged under this proposal. Rather, this proposal seeks to improve the existing care model by providing a new clinical environment that is modern and purpose designed to promote recovery. Further, the consolidation of our wards on less sites will support this through ensuring proximity to physical health hospitals and care, the ability to flex our staffing as needed and rapidly scale learning to improve outcomes and experience.

1.4 Governance

The service change and re-provision of community services in Lambeth is being overseen by the Programme Board and the Lambeth Hospital Oversight Group supported by the Workstream Leads Update Group (WLUG). The Programme Board will, under the instruction of the Chair and Senior Responsible Owner (SRO), prepare quarterly updates and assurance reviews for the Finance and Performance Committee and Trust Board, as activities move forward. A communications steering group is jointly chaired by the Trust and NHS Lambeth CCG. This steering group will provide oversight to delivery of the public consultation.

The document has been developed with NHS Lambeth CCG and the Lambeth Alliance in addition to providing assurances to NHS England and NHS Improvement. NHSE&I representatives also have positions within a number of the groups relevant to the redevelopment to ensure adherence to rigorous NHSE guidelines for consultation.

In order to proceed to public consultation, the process requires approval from Lambeth CCG. To support this decision, Lambeth CCG will approve the proposed consultation document, consultation methodology including, the Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) and financial modelling.

Approval to move to public consultation has been granted by Lambeth CCG, South London and Maudsley NHS Foundation Trust, Lambeth and Southwark Joint Health Overview and Scrutiny Committees (JHOSC) and NHS England and Improvement.

1.5 Stakeholder Engagement

Under s.242 and s.14Z2 of the NHS Act 2006, NHS Trusts and CCGs have a legal duty to make arrangements for individuals to whom the services are being or may be provided, to be involved throughout the process Individual involvement includes participation in consultation, information sharing, or in other ways, such as:

- Planning of the provision of those services;
- Developing and considering proposals for changes to the way services are provided; and
- Influencing decisions which affect operation of those services.

Due to the substantial nature of the proposed changes in the PCBC there is also a separate duty for the relevant CCG to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 made under s.244 NHS Act 2006. Lambeth CCG has engaged with Lambeth Local Authority Health Oversight and Scrutiny Committee (Lambeth HOSC) to review the terms of this process.

All public consultations should adhere to the Gunning Principles, which are:

- consultation must take place when the proposal is still at a formative stage;
- sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
- adequate time must be given for consideration and response; and
- the product of consultation must be conscientiously taken into account prior to launch.

1.6 Pre-Consultation Engagement on the Case for Change

We have engaged with inpatient service users, community service users, carers and staff as part of pre-consultation engagement work for the development of the plans.

We have engaged regularly with the Stakeholder Group, which is made up of senior representatives from the Trust, Lambeth CCG and local HealthWatch. Appendices [11 & 12] provide a full list of meetings conducted and pre-consultation engagement activities undertaken to date.

We have held a number of pre-consultation engagement events to listen to the views of existing and previous service users and carer representation groups as well as governors. This has included meetings with service users, their families and carers most affected by any proposed change**,** gathering views on what people view as the key benefits and challenges/potential negative impacts with the proposed options.

Due to the potential workforce implications, we have also completed initial consultations with staff impacted and governors. This includes meetings with all the local managers and Directorate leaders, onsite community teams, social care teams and onsite voluntary services.

As a part of the pre-consultation engagement, a wide array of stakeholders from South East London STP were engaged that included CCG Chairs, CCG Members, Clinical Cabinet, GPs, Local Healthwatch, Local Authorities (Health and Wellbeing Boards, relevant Councillors), Lead Officers and Members, Provider Trusts and voluntary and community groups. Appendices [11 & 12] set out how these parties were engaged with and continue to contribute to the development and implementation of the STP.

1.7 Option Development

1.7.1 Identification and Evaluation of the options

The local health organisations have developed a process for the identification of a preferred option from a long list of options. This includes:

1. An initial study of organisation wide estate options to identify the optimum sequence to progress the objectives of the clinical and estate strategies;

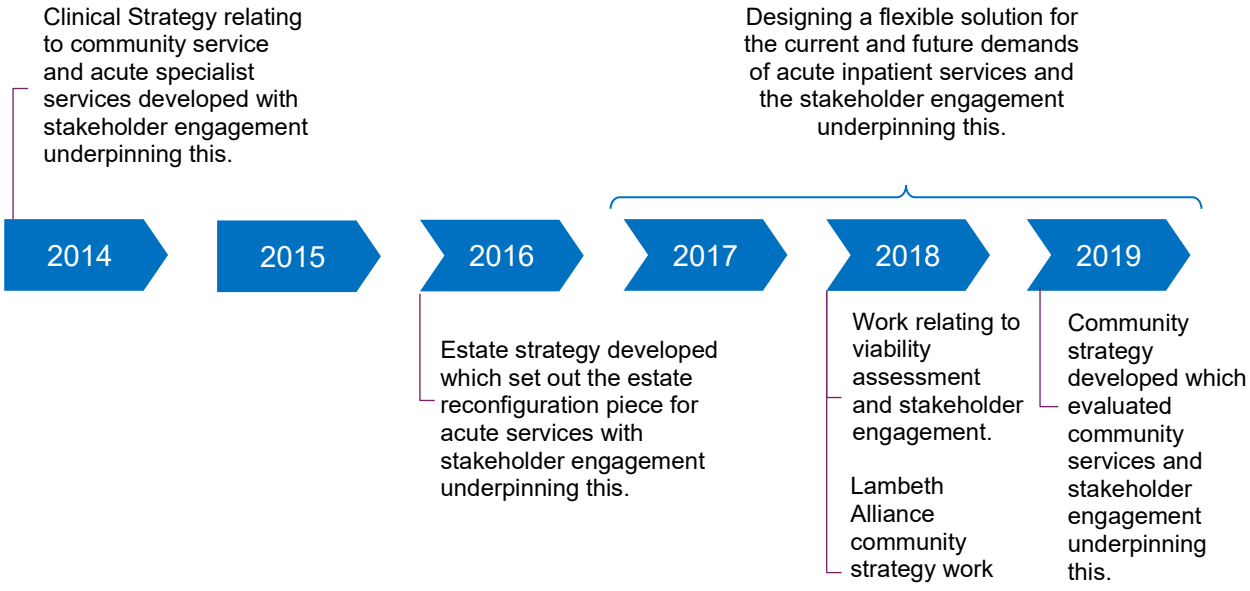
2. The development of feasibility studies and the application of a set of Critical Success Factors (CSF) to evaluate a short list of options for this specific proposal and detail the preferred option; and

3. An economic and impact assessment of the preferred option.

In Chapter 4 of this document the case for change and the clinical model are described. These underpin the identification and evaluation of the estate-based options that can support the realisation of the clinical strategies and their benefits.

In looking to establish the most appropriate options to move forwards, a number of key issues relating to the various sites that the Trust owns and operates had to be assessed and an estate strategy was identified as the correct vehicle to undertake this analysis.

The timeline below shows how this estate strategy, developed in 2016, sits between the definition of clinical strategy in 2014 and the design and engagement process undertaken through 2017 onwards to come up with the detail of the preferred option being described later in this pre-consultation business case.



Given the significance of the planned expenditure and importance of the clinical reconfigurations to the future of service delivery of the Trust the first item that was evaluated was how the four main hospital sites would be utilised and developed over time.

A number of options were considered that aimed to maximise clinical and operational benefits as well as address the long-term sustainability. These ranged from maintaining all four major

inpatient sites through to consolidating on to fewer sites whilst improving the quality of care and efficacy of services.

Ultimately, through detailed engagement with the Local Authority and Clinical Commissioning Group stakeholders, it was recognised that the most practically and economically feasible model was to look at options as to how Lambeth hospital services can be improved through the provision of new wards whilst still supporting a broader investment programme across the other boroughs .

As such, the short list within this pre-consultation business case focusses specifically on the options for the re-provision of inpatient services for wards on the Lambeth Hospital site into new, fit for purpose accommodation. This would require the capacity to meet the demands of the case for change, and be viable should a decision be taken to move forwards with the service change proposal. The following short list of options sets out those which have been identified as viable options for progression to full evaluation within this case:

1) Do Nothing – Lambeth Hospital would remain as is.

2) Relocation to Maudsley Hospital – the acute inpatient wards including a PICU would move to the Maudsley Hospital Site which is located on the border of Lambeth and Southwark.

3) In-situ Redevelopment – Acute inpatient wards and a PICU would be re-provided on the Lambeth Hospital Site.

In identifying the list of options set out above consideration was also given to the potential to refurbish the existing wards or select an alternative site in the borough but these failed to meet the needs of the case for change or lacked an identifiable location and as such were not proposed as options for evaluation in this case for the following reasons:

- A refurbishment option would have required lesser investment which would be advantageous but would never fully mitigate the clinical risks inherent in the existing buildings and could not provide the level of accommodation (en-suite bathrooms, good lines for sight for staff and direct, unsupervised access to outside space from each ward) that are felt to be important in the design of a new facility that is compliant with modern standards.

- Other sufficiently large and vacant sites in the borough demand a premium due to the current demand for new residential developments. These options would mitigate significant risk associated with a redevelopment in-situ by allowing a new facility to be built without a protracted decant plan for the wards. However, through discussion with key partners it has been recognised that there are currently no available sites and the cost of purchasing the land would make the scheme unaffordable.

The three options shortlisted above are described in full along with a thorough appraisal of their conformance with a series of Critical Success Factors, and broader economic analysis in Chapter 7 of this pre-consultation business case.

Through this evaluation we have worked with staff, service users and a number of key public representative groups (such as Lambeth Healthwatch, Black Thrive, and the Living Well Network Alliance) to review the short-list options and identify a preferred option for consultation. Part of this also included assuring ourselves that the options presented for public consultation are viable, reasonable and sustainable and thus fit to be taken forwards.

Option 2, which would involve the move of inpatient services to the Maudsley Hospital site has been identified as the preferred option. The purpose-built, modern, safe and therapeutic environment that would be created will work well alongside the existing investment that the Living Well Network Alliance is already making in new, accessible community services. We also

feel it will provide the high quality therapeutic environment for services users in the event a more specialist intervention is required.

Through the public consultation process we will seek to finalise these options with full consideration of all views received before making any decision as to the future of inpatient services for Lambeth.

1.7.2 Travel Time

We recognise that we have a responsibility to address the current issues raised by climate change and the increasing levels of congestion on the local transport network. Our Sustainable Travel Plan, produced in 2015, sets out the approach to achieving this.

6.7% (354) of our employed staff are based at Lambeth [Figure 4.11] and a significant proportion of these will relocate to the Maudsley site when this project is delivered. It is anticipated that these staff will use public transport to travel to and from work. The majority of these staff are ward based, and as, such there is no requirement for a car to undertake work duties.

We are aware that the Sustainable Travel Plan needs updating and it is anticipated that an updated version will be available for inclusion as an Appendix to the Full Business Case (FBC). The current Sustainable Travel Plan can be found in Appendix [6].

Methodology

The travel time analysis and presentation has been developed out into maps. It sets ranged output areas using the Transport for London travel tool. Analysis and maps will be presented in the form of heat maps to demonstrate the impact on service users and populations for the change in travel times by differing modes of transport. Appendix [12] is a map showing the change in time due to relocation of beds from Lambeth to the Maudsley site.

Travel time analysis

In addition to the postcode mapping, an analysis of the expected journey time from postcode zones to each of the Lambeth and Maudsley Hospitals has been undertaken. The origin destination for each postcode zone has been based on the approximate centre point of each zone and journey times have been calculated using public transport analysis tool (TRACC). Appendices [7 & 8] provide a summary of the journey times to Lambeth and Maudsley Hospitals, along with the expected change in journey times for inpatients.

An Accessibility Study review for SLaM conducted by Motion [5] demonstrates that both Lambeth and Maudsley Hospitals are well located with regard to the local highway networks as well as benefitting from access to a range of more sustainable transport opportunities including a good pedestrian network, cycle network and access to a range of public transport options.

Whilst both sites are well located with regard to the surrounding transport network, Maudsley Hospital benefits from slightly higher Public Transport Accessibility Levels (PTAL) demonstrating a greater level of accessibility by public transport.

Public transport journey time analysis further shows that there are some areas to the west of the sites which are currently within a 45-minute journey time of the Lambeth site but would be in excess of a 45-minute journey time of the Maudsley site. In comparison, there are larger areas to the east of the sites, including around Lewisham, Kidbrooke, Charlton and Bromley which are

[5] Maudsley and Lambeth Hospitals, Accessibility Study for South London and Maudsley NHS Foundation Trust. Motion, August 2019.

current in excess of a 45-minute journey of Lambeth Hospital but within a 45-minute journey of the Maudsley site.

An analysis of inpatient postcode information demonstrates that around 82% of inpatient postcodes provided by the Trust are within a 45-minute journey time of Lambeth Hospital and around 90% of inpatient postcodes are within a 45-minute journey time of the Maudsley Hospital site.

1.7.3 Public Sector Equality Duty

The Equality Impact Assessment (EIA), Appendix [17], is designed to ensure that a project, policy or scheme does not discriminate against any disadvantaged or vulnerable people or groups. This ensures CCGs pay 'due regard' to the Public Sector Equality Duty.

Two EIAs were completed prior to consultation; one to assess the impact of all services and the other to assess the impact for all staff and consider whether the proposal met the following objectives:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

As such, the EIAs focused on:

- how the services will impact on protected and vulnerable groups in the community;
- the staff affected by proposed relocations;

The EIA was completed as a broader piece of work to support wider decisions about the clinical transformation programme, incorporating the impact of all the proposed changes at the Lambeth Hospital including:

a) the relocation of adult acute wards (Eden Ward, Luther King ward, Nelson Ward, Rosa Parks Ward and ES2 - currently operating on Maudsley Hospital site) from Lambeth Hospital to the Maudsley Hospital (in the new inpatient unit);

b) the relocation of LEO ward from Lambeth Hospital to the Maudsley Hospital (ES2);

c) The relocation of Tony Hillis Unit from Lambeth Hospital to the Maudsley Hospital (in the new inpatient unit);

d) The relocation of the Ward in the Community (a four Borough service) from Lambeth Hospital to the Bethlem Royal Hospital as a result of the wider proposal for the preferred option; and

e) The relocation of Lambeth community and outpatient services (directly due to this project) from Lambeth Hospital to either Brixton Road or another community living well centre (Gracefield Gardens or Akerman Road),

However, as noted previously, only items (a) and (b) above form part of this PCBC and proposed consultation.

The majority of vulnerable or protected groups identified as part of the EIA have been judged as achieving greater equality, improved outcomes or increased accessibility through the proposal. For example, inpatient developments will provide improved disabled access for service users, staff and visitors. For many other groups, the purpose built facilities offer an improvement in therapeutic environment, access to outdoor space and care delivered closer to home.

The EIA identified that the majority of vulnerable or protected groups identified as part of the EIA have been judged as achieving greater equality, improved outcomes or increased accessibility through the proposal. At this stage, the EIA identified a number of potential issues that will be explored further through the public consultation and mitigated in terms of impact on groups or individuals with protected characteristics. The main issues identified were:

- Improving understanding of travel implications of the change in location of services for service users, carers, community members of different ages, disabilities, ethnicities, gender identity, sexes and sexual orientation
- Improving understanding of how to mitigate potential risks of social isolation at proposed new location for service users who are older, who are disabled, who are transgender, who are Black, who are from other ethnic minority backgrounds, who have places of worship in Lambeth, who are gay, lesbian or bisexual

The EIA action plan has identified key groups who should be consulted with as part of the public consultation and these actions are being built into the public consultation plan.

Quality Impact Assessment

A Quality Impact Assessment (QIA) was developed and led by the Clinical & Operational Workstream for the preferred option (relocation of inpatient services currently located at Lambeth Hospital) to evaluate the impact on quality of care, Appendix [14]. This was developed in partnership with clinicians at the Trust to ensure it provides an accurate reflection of the changes to service delivery.

In line with our clinical strategy, the driver for change is the consolidation of the inpatient bed base due to the realisation that acute inpatient care is becoming increasingly specialised.

The risks that are identified affecting clinical services are:

- Reduction in service user satisfaction due to new service location - relocating services outside of the Lambeth Borough may lead to a reduction in service user satisfaction due to the perception that services are less accessible. The relocation may result in less service user interaction with familiar surroundings and their local community. Mitigation: the Maudsley Hospital is located on the border of Lambeth and Southwark. It is expected that the quality of the new build accommodation will offset any reduction in service user satisfaction of moving the service to a busier site.
- Reduction in carer/visitor satisfaction - there is a risk that travelling to the Maudsley for visitors/carers rather than Lambeth or the Bethlem may be more difficult/timely/costly which may lead to less patient/visitor interaction. Mitigation: Initial findings from the travel impact assessment identifies the Maudsley as being more accessible by public transport. Lambeth is only better connected by underground. It is worth noting that visitors/carers residing in the Loughborough Junction / Brixton area should find that it is quicker and easier to access the Maudsley when compared to Lambeth. Visitors / carers may offset the potential disadvantage of travelling further with the benefit that their loved ones will be accommodated in a higher quality environment which should lead to a more timely recovery.
- Increase in the number of Serious Incidents - there is a risk of an increase in errors / serious incidents for a period of time after relocation due to changes in working practices, service reconfiguration and changes to the physical working environment. Mitigation: During the mobilisation and transition phases, ward based staff will require thorough induction and orientation to the new facilities prior to service go live to reduce the risk of SIs occurring / complaints increasing.

Operational Risks - Inpatients at Lambeth currently access physical health services at either GSTT (St Thomas') or King's College Hospital (KCH). There is a risk that there will be additional demand for KCH for emergency admissions due to the Lambeth beds being relocated closer to

KCH (the Maudsley) and further from St Thomas'. This could impact on KCH A&E performance and may put additional pressure on service demand. With regard to blue light conveyances of Lambeth inpatients to A&E, there were only 20 cases (DATIX Jan 18- Dec 18) and all of these patients were conveyed to KCH A&E. It is therefore expected that there will no additional pressure for KCH from these patients.

1.8 Finance Case

Although this PCBC focuses specifically on the re-provision of acute inpatient services to new facilities, the financial case has been developed to encompass the broader changes to the services currently delivered at the Lambeth Hospital site as part of the clinical transformation programme and estate strategy as described in section 1.2.3.

The impact of service changes in Lambeth have been recognised to have no financial impact on Lambeth CCG as the majority of the Trust activity is on the basis of block contracts such that income does not vary in accordance with activity changes. The assessment of affordability has then focused on the Trust.

Below is a financial forecast summary for the do nothing and preferred option.

Forecast Summary – 'Do Nothing' Option											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Surplus / (Deficit)			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CIP Requirement (Recurrent)			6.6	7.1	7.6	8.2	8.8	9.5	7.5	8.2	8.8
CIP %			1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.1%	1.1%	1.1%
Statement of Financial Position - Total Net Assets	275.6	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0
Cash Flows - End of period Balance	84.0	73.2	62.6	64.6	66.7	70.9	71.4	71.9	72.3	72.6	72.8

Forecast Summary – 'Preferred' Option											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Surplus / (Deficit)			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CIP Requirement (Recurrent)			6.6	6.9	9.5	10.5	8.7	9.4	7.5	8.2	8.8
CIP %			1.6%	1.6%	2.0%	2.1%	1.6%	1.6%	1.1%	1.1%	1.1%

Statement of Financial Position - Total Net Assets	275.6	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0	276.0
Cash Flows - End of period Balance	84.0	73.2	66.5	30.4	41.1	47.5	49.9	52.2	54.4	56.3	58.0

Table [1.1] – Forecast Summary of Do Nothing and Preferred Option.

From a cash balance perspective, the preferred option is affordable. Throughout the forecast period, the cash balance is projected to range between £30.4m to £66.5m and there are sufficient funds of circa £10.0m to cover for working capital in each year. Planned CIP targets are also built into the proposed option. However, if the CIP targets were not achieved, the additional cash values would deteriorate. In a 'do nothing' scenario 1.6% CIP (dropping to 1.1% in the last three years) is required in order to address the underlying deficit and this increases to a one off CIP of 2.1% in 2023/24 for the preferred option.

In the preferred option, from 2020/21, a deficit is projected on the SOCI resulting from higher depreciation charges and an additional dividend charge associated with the assumed receipt of Public Dividend Capital (PDC). This will further have an impact on cash to implement the investment, while maintaining sufficient headroom for the working capital requirements over the long term.

Sensitivity scenarios have been modelled to show the financial impact of different project risks to the Trust.

Sensitivities - Impact on SOCI											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
30% CIP Reduction (New Inpatient Unit)			0.0	0.0	(0.6)	(1.3)	(1.3)	(1.4)	(1.4)	(1.5)	(1.5)
30% CIP Reduction (Whole Organisation)			(2.0)	(4.0)	(6.8)	(9.9)	(12.4)	(15.1)	(17.2)	(19.5)	(21.9)
0.5% Increase in Pay			(1.6)	(3.3)	(5.1)	(7.0)	(9.1)	(11.3)	(13.8)	(16.4)	(19.3)
10% increase in the cost of new inpatient unit			0.0	(0.1)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
1 Year delay in building new inpatient unit			0.0	0.7	1.3	1.4	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)

Sensitivities - Impact on Cash Balance											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
30% CIP Reduction (New Inpatient Unit)			66.5	30.4	40.6	45.9	46.9	47.9	48.7	49.1	49.3
30% CIP Reduction (Whole Organisation)			64.8	24.9	29.0	25.9	16.2	3.7	(11.1)	(28.4)	(48.4)
0.5% Increase in Pay			65.0	25.6	31.2	30.7	24.0	14.9	3.4	(11.1)	(28.7)
10% increase in the cost of new inpatient unit			64.6	24.6	34.4	40.6	42.7	44.8	46.8	48.4	49.9
1 Year delay in building new inpatient unit			85.6	69.3	49.8	49.0	51.4	53.6	55.8	57.8	59.6

Table [1.2] – Forecast sensitivity analysis on SOCI and Cash Flows.

These sensitivities focus on assessing the SOCI and cash position with respect to increases in pay costs that are driven by annual inflation, compounding growth, reduction in planned CIP, increases in site costs and a delay in building the new inpatient unit.

Building the new inpatient unit will impact operating expenditure by circa £3.0m, offset by CIP savings. With regards to CIPs (for the new inpatient unit and for the Trust) there will be a negative impact on the SOCI position ranging from a breakeven position to a £21.9m (deficit). With the exception of pay costs rising at an additional 0.5% and 30% CIP reductions per annum, all sensitivities show a favourable cash balance ranging from £24.6m to £85.6m indicating the preferred option is feasible with respect to forecast cash flows.

As projected costs for the new inpatient unit increase on a yearly basis, this increases risk for the project overall. However, in comparison to the 'preferred' option, in table 1.1, the cash balance position reduces to a minimum point of £30.4m in 2021/22 in contrast to the £64.6m cash position for the 'do nothing' scenario in the same year reflecting the capital investments being made to improve the standard of care.

The sensitivities that measure a 10% increase in the cost of the new inpatient unit and a one year delay carry less risk to the financial position in comparison to other sensitivities. A one year delay adversely impacts the cash balance from 2021/22. The Trust will see a maximum difference of £21.9m in cash reduction resulting from the delay in 2028/29. Similarly, a 10% increase in the cost of building will have a minimum negative impact on the SOCI from 2022/23 and a cash balance range of £24.6m to £64.6m.

1.9 Implementation

Following the close of public consultation and decision-making process responsibility will hand back to SLaM who will, should the proposal remain appropriate, implement the service changes, having already factored in considerations from the consultation process.

We have implemented a robust programme management and governance structure which ensures accountability through clear allocation of responsibilities, and provides assurance through regular reporting, enabling quick identification and addressing of issues as they arise.

This section describes the following programme management arrangements:

- programme management approach;
- project implementation budget;
- risk Management Arrangements; and
- benefits management.

We have established a Programme Board to ensure that the programme achieves its objectives in full and on time. The Programme Board is chaired by the Senior Responsible Owner who takes executive responsibility for decisions relating to the programme. The membership of the Programme Board includes an individual who represents each group of those senior managers who have an interest in the programme and whose activity will be affected by the programme.

Our implementation team will comprise approximately 4-6 people on a whole time equivalent (WTE) basis to be engaged at various points during the implementation. The function requirements during the implementation include: Programme Director, Project Director, Project Manager, Finance Support, HR Workforce Support, Clinical Support and Administration.

A detailed project plan with key milestones is provided in Appendix [4].

Through discussion with NHS England and NHS Improvement an agreed process has been identified with SLaM which is aligned to the regulatory guidance for Transactions[6].

The guidance for capital investment describes a two stage process of an Outlie Business Case and Full Business Case for capital investment transactions where the regulator is able to risk assess the investment as low risk.

This investment requires no external capital borrowing or other such support and is not of a complex or contentious manner. As such NHS England and Improvement have indicatively identified this as a low risk investment and agreed the following process:

- This Pre-Consultation Business Case along with a detailed financial model will act as the Outline Business Case and, if appropriate to proceed; and

- A Full Business Case will be then be developed for organisational due diligence purposes.

1.10 Key Tests

The 2014/15 mandate from the Secretary of State to NHS England and NHS Improvement outlines that proposed service changes should be able to demonstrate evidence to meet four tests. These are set out below. More recently the Mayor of London has created an additional

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[6] https://improvement.nhs.uk/documents/1983/Transactions_guidance_2017_Final.pdf

framework of tests for service changes in the capital. These have a level of alignment to the NHS tests as noted below:

1. **Strong public and service user engagement:**

   Mayor's Test 6 – Patient and public engagement

   The robust stakeholder engagement undertaken to date, and that which is proposed over the course of the development of the PCBC, incorporates methods and approaches such as presentations, discussions, surveys, meetings and emails. There has been a relatively strong engagement with stakeholders to deliver the engagement plan given the stage in the pre-consultation process.

2. **Consistency with current and prospective need for service user choice:**

   Mayor's Test 1: Health inequalities and the prevention of ill health

   Mayor's Test 4: Impact and Social Care

   The entry pathway will remain the same for service users following the proposed redevelopment as SLaM are relocating services. As the clinical model remains unchanged, with the majority of services continuing to be delivered in the community and via primary care, the range of service user choice is unaffected.

3. **A clear clinical evidence base**:

   Mayor's Test 1: Health inequalities and the prevention of ill health

   Mayor's Test 4: Impact and Social Care

   Our most recent CQC report was published in July 2019, where we received an overall rating of "Good" for the second year running (August 2018 – we received an overall rating of "Good"). The report published in August 2017 identified the overall rating as "Requiring Improvement". This was due to incidents where service users identified as in need of a Mental Health Act assessment were not assessed properly. This was driven by a lack of hospital beds and complicated further by issues beyond our control including the availability of AMHPs and the police.

   There has been broad and varied communication with a range of clinical staff to ensure proposals have service user outcomes central to plans. Feedback provided from consultations demonstrated a strong level of support for the proposal with a consensus that the changes identified would improve services for service users.

   There is also evidence showing that there is a relationship between the quality of the physical environment and mental health clinical outcomes[7]. Environmental features which have been shown to produce positive mental health outcomes include corridors with a homely feel, lots of natural light, access to outdoor space and single rooms with en-suite facilities.

4. **Support for proposals from clinical commissioners:**

   Mayor's Test 5: Clinical Support
   Mayor's Test 3: Funding

   Lambeth CCG has been involved and provided their support for the proposed redevelopment as joint commissioners of the Trust. They have also led the hospital redevelopment oversight group, providing guidance over the communication and engagement workstream.

From 1 April 2017, NHSE introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures; this also relates to the Mayor's test 2. As the

[7] Standards for Inpatient Mental Health Services, P.18, 2nd Edition, 2017

proposed development will focus on relocating services rather than closing beds, the entry pathway will remain the same for service users. The total bed stock will also be the same under the proposed option and so the bed test is considered not applicable to this PCBC.

1.11 Decision Making and Next Steps

The purpose of this PCBC is to seek approval by the Lambeth CCG to commence formal public consultation on the proposed service changes outlined in this document.

Following consultation, the Lambeth Hospital Oversight Group and Programme Board will receive consultation responses from members of the public and organisations. The Programme Board will then consider the views of the participants and the effect these may have on the decision-making process.

At this stage of the development of options, it is not possible to fully detail the timescales in which decisions will be taken and when subsequent implementation could take place. This is due to a number of factors, including:

- the quantity and detail of consultation responses received, and timescales required to analyse those responses;
- the consideration of consultation responses by the Lambeth Hospital Oversight Group and Programme Board will update the analysis and evaluation of options as required;
- the development of a decision making business case and confirmation by the Lambeth Hospital Oversight Group and Programme Board; and
- the development of detailed implementation plans between providers and commissioners on the basis of the decision made by the Lambeth Hospital Oversight Group and Programme Board.

However, with a view to deliver the required service changes by September 2022, the Programme Board expects the following milestones for this process. These may be subject to change, as described above:

- Pre-consultation Business case (development, review & approval) – May 2019 to February 2020.
- Service change public consultation – late March 2020 to late-May 2020.
- Decision making Business Case (approval) – July 2020.
- Final Business Case (approval) – October 2020

Chapter 2. Introduction

This section provides an overview of the purpose and development of the Pre-Consultation Business Case (PCBC), as well as a description of its contents.

2.1 Overview

The local health organisations of South London are committed to delivering best possible health outcomes for the local population[8]. South London and Maudsley NHS Foundation Trust (SLaM) has responded to deliver these through a clinical strategy and quality imperatives that seek to:

- increase whole person mental and physical health care and wellbeing support provided in the community;
- reduce hospital bed-based care and length of stay;
- offer increased support for people experiencing crisis in their place of residence or alternative setting to A&E where appropriate; and
- reduce inequality in access and experience of mental and physical health care across South East London for people with protected characteristics and experiencing social deprivation.

To deliver our vision, we have designed a programme of clinical transformation based around these key principles:

- delivering new integrated community mental health models of care wrapped around primary care networks;
- increasing capacity to meet national access, recovery and waiting time trajectories;
- providing alternative crisis support working jointly with police, London Ambulance Service and voluntary sector to provide crisis support in alternative least restrictive setting; and
- working as a system to enable a minimum of 60% of people with severe mental illness receiving an annual physical health check and follow on support where this is identified.

This clinical strategy in turn has driven the development of the estates strategy that sets out how that model could feasibly be delivered in light of the existing infrastructure and assets of the Trust, which has led to the development of the proposals set out in this document.

2.2 PCBC Objectives

The objectives of this PCBC are to:

- Make the case for change for transformation and modernisation of the acute inpatient services currently delivered by the Trust at Lambeth Hospital. This will include setting out the quality of the existing estate and plans for redevelopment against the backdrop of local, regional, and national policy frameworks.
- Detail the process undertaken with stakeholders to inform, develop and evaluate viable options for the service change.
- Detail the process undertaken to engage the public, staff and other stakeholders in the pre-consultation phase and demonstrate how their feedback has shaped the development and selection of the preferred option.

[8] South East London STP - Integrating Mental Health Services, Page 12, October 2016.

- Describe the impact on the care delivered to service users and the expected benefits thereof.
- Set out how the development of the preferred option is compliant with the Secretary of State for Health and Social Care's (SoS or Secretary of State) four tests of service reconfiguration and NHSE bed test.
- Make the case to NHS Lambeth Clinical Commissioning Group and NHS England and NHS Improvement to commence public consultation on the preferred option.

2.3 Background

With local partners, we have continued to make progress on clarifying our clinical strategy, which aims to move care closer to home and manage inpatient admission as a specialist intervention – recognising that the service user experience of modern, therapeutic environments is a key determinant of effective recovery. This envisages moving local community services to better equipped local hubs and consolidating inpatient activity in new, better equipped facilities that can be co-located where possible with other acute services.

The estates strategy, a multi-phased reconfiguration programme over some 12 years, has been developed to support the clinical strategy. The ongoing work as part of that strategy has identified that the inpatient services at Lambeth Hospital are not fit for purpose and require very significant modernisation. Sites are generally in poor condition and too small to offer a good environment of care. The Lambeth Hospital lacks the expected features of high-quality inpatient mental health facilities and to address this our estates strategy proposes to rationalise and consolidate inpatient care and modernise our inpatient bed stock as the first phase of this long term strategy.

The following guiding principles underpin our future aspirations:

- Community care focus, moving away from reliance on bed based and institutional care.
- Improve accessibility of services for its users addressing barriers such as locality, timeliness, capacity and quality.
- Integration across care providers and partnerships/alliances to deliver more efficiently and effectively.
- Integration of physical and mental healthcare for service users.
- Economically sustainable mental health services.
- High quality and therapeutic environments for service users and staff.

The Lambeth Living Well Network Alliance (LWNA) provides the overall governance (commissioning and provision) for Adult Mental Health service provision in Lambeth. This Alliance Agreement sets out the aim, vision, outcomes and principles to which all parties have signed up to. The Alliance is also responsible for acute in patient provision and community services and as such will need to sign off the business case. The Alliance will need to be satisfied that the overall, funding package across service change at the Maudsley site and re-provision of community services, is both affordable and sustainable.

2.4 Proposal Development

Our proposal set out in this document is to consolidate acute inpatient activity to new, better equipped facilities, ensuring improvements in outcomes and quality of care.

The aspiration is to transform our places and spaces into 21st century mental health facilities that support the health of the community, as well as the sustainability of SLaM as a world-leading mental health service. Services are currently provided from 72 locations – 66

community sites and six acute sites – across the London Boroughs of Croydon, Lambeth, Lewisham and Southwark.

Lambeth is the furthest ahead of all SLaM's boroughs in determining its local, community care blueprint and the Lambeth Alliance has consulted extensively on this with changes starting in July 2019. To support this service change, investment is already being made in the fabric of Lambeth's community estate, and we are now proposing to enter into a process of engagement on service changes regarding Lambeth Hospital to support this direction of travel. Through an extensive engagement process with stakeholders, it is hoped that the following can be delivered in a bid to serve local populations:

- New acute inpatient facilities where service users requiring specialist care in an inpatient environment are treated in state-of-the-art, therapeutic environments.
- More robust staffing models through co-location of services which could help reduce the use of bank and agency staff that currently contribute to existing financial strain and clinical risk. Conservative assumptions have been made at this stage to test affordability and a further assessment of financial benefits will be made by the Trust as part of the business case process for capital investment that would follow a successful consultation process.
- Modern, fit for purpose environments for services at inpatient sites across the entire service user population we serve.

2.5 PCBC Scope

In identifying the scope of this public consultation, a number of key stakeholders have been drawn in to understand the needs for services that they have responsibility for including NHS Lambeth CCG, NHS England, and Southwark and Lambeth Health Oversight and Scrutiny Committees.

Within the NHS England guidance for service reconfiguration, and the requirements of the NHS Act, we are provided with criteria to identify those services that require a formal public consultation (those which are deemed a material service change) and those others for which we would seek to engage and involve the public but do not require a formal public consultation. This decision is made by the commissioner of the specific services.

Services on the Lambeth Hospital Site can be categorised as either:

- Being commissioned directly by Lambeth CCG for service users in Lambeth
- Being commissioned on behalf of multiple Boroughs by a lead commissioner (in the case of services on the Lambeth Hospital site this lead commissioner is Lewisham CCG)
- Specialist services commissioned nationally by NHS England National Specialist Commissioning team

On reviewing the key services provided on the Lambeth Hospital site it has been identified that there are a minority of services commissioned nationally or on behalf of multiple boroughs, including:

- Specialist inpatient services provided in Bridge House
- The Tony Hillis Rehabilitation Unit
- Ward in the Community

The commissioning leads for these services have been engaged with in order to ensure that the requirements of consultation and engagement are appropriately met should any changed to their current provision be made. These services will not form part of this consultation process.

Of the remaining services which are commissioned by Lambeth CCG on behalf of Lambeth Borough residents these can also be broken down into two further categories:

- Those services where decisions have already been made about their improvements, development and reprovision (which includes outpatient services and community services); and
- Those services where there are still decisions to be taken and we feel it is appropriate to undertake a formal public consultation process (which includes the main acute inpatient wards)

Lambeth CCG along with the Living Well Network Alliance have already engaged publicly around the future model of community outpatient services and the development of three Living Well Centres. As this is a planned change to services which is already being implemented this will not form part of this public consultation. It is worth noting however that the changes proposed within this consultation form part of an integrated approach to improve all aspects of the care pathway and complement each other well.

The proposed change to inpatient services on the Lambeth Hospital site is viewed as a material change in service provision requiring public consultation; not in terms of the scope of the services provided or number of beds available, but in terms of where the services may be located in the future. As such the future location of following wards will form the basis of proposed public consultation:

- Rosa Parkes Ward (Acute Admission Ward)
- Nelson Ward (Acute Admission Ward)
- Luther King Ward (Acute Admission)
- Leo Ward (Early Interventions Ward)
- Eden Ward (Psychiatric Intensive Care Ward)

Throughout this pre-consultation business case we will provide the necessary context, outline the case for change and offer background to the various potential options to support a meaningful consultation on the future of the inpatient services on the Lambeth Hospital site.

2.6 Parties involved in the production of this PCBC

The PCBC has been produced following engagement throughout the process with the following parties:

- NHS England and NHS Improvement (NHSE&I);
- The Lambeth Living Well Network Alliance (LWNA);
- The local CCGs, specifically NHS Lambeth CCG;
- The local Health Trusts, specifically South London and the Maudsley NHS Foundation Trust (“the Trust” or “SLaM”); and
- Local Authorities, these are the London Borough councils of Lambeth and Southwark.

2.7 PCBC Structure

This PCBC was developed in line with the NHSE guidance “Planning, assuring and delivering service change for service users” published in December 2013, and updated March 2018, as

well as the HM Treasury Green Book guidance in relation to the capital investment decisions involved to support that service change. It includes the following sections:

Executive summary: Summarises the key findings from the PCBC.

Introduction (this section): Provides an overview of the project's objectives, background, scope, parties involved in the production and the proposal.

Context: This section sets the background of the parties involved, the current healthcare challenges faced by the commissioners and providers, and the commissioning arrangements between the CCGs and Trust.

Case for change: This section details the rationale and key drivers for changing the way services are delivered including from a national and local strategic context. This section also sets out the model of care, details how the model of care is changing and how the proposal facilitates delivery of this. The model further highlights the expected benefits and how it meets the needs identified in the Case for Change section.

Governance: This section documents the governance structure that has been put in place to ensure the consultation process is robust, accommodates relevant stakeholder views and identifies who is responsible for making decisions and who is responsible for approvals.

Stakeholder engagement: This section sets out the engagement undertaken to date, how this has informed the consultation proposed and how the consultation will be run.

Options development: This section documents the process for options generation and evaluation.

Finance case: This section sets out the financial impact of the selected option on the CCGs, Trust and any other relevant parties.

Implementation: This section sets out the practice steps needed to deliver the option identified in the Options for consultation, including project team, governance, risk management and timelines.

Key Tests: This section sets out how the consultation process has met the Secretary of State's four tests and NHSE bed test.

Decision making and next steps: This section identifies next steps for the consultation process and wider development programme.

Context

This section sets the background of the parties involved, the current healthcare challenges faced by the commissioners and providers, and the commissioning arrangements between the CCGs and Trust.

Chapter 3. Context

3.1 The Population and Healthcare Challenges

This section sets out the background of the local population and the healthcare profile of this population.

3.1.1 Health Profile

South East London has a diverse and mobile population with extremes of deprivation and wealth. Four of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) are amongst the bottom 15% of the most deprived local authority areas in England. 26% of children in South East London are classified as living in poverty, concentrated in certain areas within the region.

Of the 1.67 million residents, only one in six people are classified as 'healthy and well' and without risk of poor health. 50% of all people are at risk of having a long term condition. 75% of over 55s have one or more long term condition, while 32% of children are classified as overweight or obese.

The estimated prevalence of psychotic disorder as a percentage of the population aged 16 and over (2016 data[9]) is 0.62% for South East London, which is more than 50% higher than the average for England of 0.40%. The incidence rate for the number of new cases of psychosis per 100,000 population aged 16-64 in South East London is 41, which is also significantly higher than the 18.1 incidence rate for England. The Borough of Southwark has the highest prevalence and incident rate of psychosis in South East London. Only 0.51% of psychosis care spells are receiving psychological therapy in South East London, compared to the 0.24% national average, which suggests that there are barriers for accessing services or there are capacity issues in the services currently being provided.

The number of people subject to the Mental Health Act in South East London is higher than the national average at 43 per 100,000 compared with 40.1 nationally. The number of admissions per 100,000 is also higher at 351 compared with a national average of 263.

3.2 Background to the CCG, the Living Well Network Alliance and the Trust

This section sets out the background of the Trust and its relationship between other entities such as Kings Health Partners, the Lambeth Alliance, Lambeth CCG and NHS England and NHS Improvement.

3.2.1 Background of Partner Organisations

NHS Lambeth CCG

NHS Lambeth CCG is responsible for commissioning non-specialist hospital and community health services for service users in Lambeth. NHS England and NHS Improvement delegates funding to Lambeth CCG in order for it to perform its functions. It is the role of the CCG to spend this money well to ensure that the most needed and effective services are available, and to monitor how well these services are provided, holding Trusts accountable for the quality of service delivery.

[9] Psychosis Data Report; Describing Variation in Numbers of People with Psychosis and their access to care in England, https://assets.publishing.service.gov.uk/government/.../Psychosis_data_report.pdf, September 2018

Lambeth CCG has six commitments which it tries to adhere to in its operations. These commitments are to be people centred, prevention focused, integrated, consistent, innovative, and to deliver the best value possible.

The Living Well Network Alliance

The Living Well Network Alliance (LWNA) was formed in July 2008 with key objectives being:

- Improve access to support - including easier early access and a rapid crisis response.
- Integrate and coordinate care and support for people and their networks across Lambeth.
- Reduce the inequalities experienced by people experiencing mental health problems.
- Manage demand and resources effectively.
- Drive culture change - including leadership and models of working.

The Lambeth Alliance builds upon the Integrated Personalised Support Alliance (IPSA), which was formed in April 2015, a partnership aimed at improving outcomes for service users with complex mental health difficulties and high support needs in Lambeth.

IPSA consisted of key partners from Lambeth Council, NHS Lambeth CCG, South London and Maudsley NHS Foundation Trust and two voluntary sector organisations; Certitude and Thames Reach. The Alliance Rehabilitation Team was created (comprising voluntary sector staff, social workers, nurses, occupational therapists and consultant psychiatrists) to provide intensive support for people in their homes who would otherwise require hospitalisation.

Identifying alternatives to mental health inpatient admission led to a 60% reduction in admission rates to inpatient rehabilitation wards in Lambeth. 65% of service users in rehabilitation and residential care placements have been supported to move to alternative accommodation or to go back home with support.

Additionally, IPSA reduced entry to residential care by over half and has increased the number of discharges from residential care by a third when compared to before IPSA was in place. The IPSA provided evidence to partners (and respective governing bodies and trustees) of the value and effectiveness of “alliance contracting” as a means of supporting service integration and transformation.

The IPSA prototype paved the way for the much wider whole system LWNA encompassing the majority of NHS and local government investment on adults of working age and a 7 year (and option to extend by 3 years) contractual term.

Working age adult mental health services for Lambeth are contracted to the Lambeth Alliance by the commissioners rather than directly to the multiple service providers involved in the services along a service user’s pathway. This is a new approach, where all organisations within the alliance have agreed to collectively work together to achieve the desired outcomes and to deliver the required services within the funding envelope provided by the commissioners. This is the first contract of its kind in the country.

South London and Maudsley NHS Foundation Trust

SLaM provides NHS care and treatment for individuals with mental health problems and services for those who are addicted to drugs and alcohol. Services are provided to those living in the London Boroughs of Croydon, Lambeth, Lewisham and Southwark; and substance misuse services for residents of Wandsworth, Greenwich, Lambeth and Bexley, with a combined population of 2 million people.

SLaM Profile:

The total hospital and community area comprises of 153,000 m^2. This is split between Southwark (49,000 m^2), Lambeth (27,000 m^2), Croydon (53,000 m^2) and Lewisham (24,000 m^2).

Within the total hospital and community area across the four boroughs, there are 80 community sites that have 50 wards and 813 beds.

This enables the community to treat 45,000 outpatients and admit 5,000 service users per year. Additionally this provides the capacity to manage 400,000 individual appointments, 30,000 group appointments and 200,000 care related phone calls.

The Trust employs around 4,800 staff (2018/19), servicing a population of 1.3 million people. SLaM provides 4,000 people with inpatient care from 755 beds across 8 inpatient sites [10].

Approximately 50 national and specialist services for children and adults are provided by the Trust nationwide and the Trust also has a partnership with the Macani Medical Centre in Abu Dhabi to transfer its knowledge and expertise to the Middle East and North Africa [11].

Inpatient services are provided at five sites; Bethlem Royal Hospital in Beckenham, Lambeth Hospital in Clapham, the Ladywell Unit at Lewisham University Hospital, the Maudsley Hospital in Camberwell and Woodland House in Tonbridge.

Outpatient and psychiatric liaison services are provided from sites including; Croydon University Hospital, Guy's Hospital, King's College Hospital, Lewisham University Hospital and St Thomas's Hospital. Services are also provided from Bethlem and Maudsley.

Trust staff also provide services at numerous community locations in Lambeth, Southwark, Lewisham and Croydon as well as visiting service users at their homes.

SLaM's organisational structure is clinically led with a strong focus on Clinical Academic Groups (CAGs) that were formed to bring together clinical and academic expertise that could develop and deliver care pathways across the whole spectrum of mental health conditions.

Recently, SLaM has further built on this organisational structure to improve efficiency and efficacy. This improved structure consists including operations directorates, the Quality Centre (including includes seven CAGs), and corporate services.

There is a longstanding clinically led strategy in place, which was initiated in 2014. The focus relates to community and acute specialised services, underpinned by stakeholder engagement. Two years later, in 2016, an estates strategy was developed in support of this clinical strategy, which looked to set out the estate reconfiguration piece for acute services.

From 2017 a scheme was advanced to develop a new facility as a flexible solution for the current and future demands of adult mental health services. This will be the new inpatient unit and is proposed to be located on the Maudsley Hospital site in the preferred option of this consultation.

In 2019, a community strategy which looks to evaluate community services was also developed by Lambeth CCG and the Living Well Network Alliance. The evolution of this process is explained in more detail in Chapter 7.

Inpatient services at Lambeth and Lewisham were both considered as a starting point for phase 1 of the estate reconfiguration strategy by the Trust in consultation with the CCGs but the existing co-location with emergency physical health services at Lewisham hospital alongside a stakeholder consultation with key health economy parties meant Lambeth was preferred from a health economy perspective.

The Lambeth Alliance has also spent a significant amount of effort looking at the development of community services in the context of the local One Public Estate work in partnership with

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10 https://www.SLaM.nhs.uk/about-us, Annual Report 2018/19

11 https://www.kingshealthpartners.org/latest/1125-maudsley-health-in-the-middle-east
https://www.SLaM.nhs.uk/our-services/maudsley-abu-dhabi

local government. SLaM are building on this further to draw out a broader range of services distributed within the communities that require access. As such the Trust is looking to move non-bedded clinical services into the community facilities that have either already been acquired or where feasible sites have been identified.

It is also recognised that any changes across the sites need to be flexible and responsive to future change in demand and capacity requirements.

Kings Health Partners

Kings Health Partners is an Academic Health Science Centre for South London. Its aim is to be a leader in improving health and wellbeing locally, nationally and globally. Four partner organisations fund the centre's work through equal contributions. The Trust is one of these partners alongside Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and King's College London.

Collaboration through an Academic Health Science Centre is designed to break down barriers between health and academic institutions, to increase cooperation and focus on improving care. These centres aim to create world-leading improvements in healthcare and to speed up the time it takes the NHS to access new and better-quality treatments through combining health research with clinical care and education.

NHS England and NHS Improvement (Specialist Commissioning)

Specialist care services are commissioned directly by NHS England and NHS Improvement, rather than through local CCGs, and are planned on a national and regional basis. Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to service users with rare cancers, genetic disorders or complex medical or surgical conditions. Care delivered is cutting edge and these services are a catalyst for medical innovation.

Currently there are 146 specialised services commissioned by NHS England and NHS Improvement which collectively have a 2018/19 budget of £17.7bn (NHSE&I Funding and Resource 2018/19: Supporting Next Steps for the NHS FYFV). These services are delivered in hospitals which are properly equipped and staffed to provide necessary quality. NHS England and NHS Improvement has a legal duty to commission medicines and devices recommended by the National Institute for Health and Care Excellence (NICE), in addition to a number of other novel treatments which are funded each year following appraisal for safety, effectiveness, affordability and value for money.

NHS England and NHS Improvement commissioned the Eating Disorders and Neuropsychiatry services from the Trust, which are moving into the new inpatient facility from Bethlem Royal Hospital.

3.3 Overview of the clinical transformation programme and estate strategy

Together with our local partners, we have continued to make progress on clarifying our clinical strategy, which aims to move care closer to home and manage inpatient admission as a specialist intervention – recognising that the service user experience of modern, therapeutic environments is a key determinant of effective recovery.

In line with the clinical strategy and subsequent estates strategy, this envisages moving local community services to better equipped local hubs and consolidating inpatient activity in new, better equipped facilities that can be co-located where possible with other acute services.

The following guiding principles underpin our future aspirations:

- Community care focus, moving away from reliance on bed based and institutional care.

- Improve accessibility of services for its users addressing barriers such as locality, timeliness, capacity and quality.
- Integration across care providers and partnerships/alliances to deliver more efficiently and effectively.
- Integration of physical and mental healthcare for service users.
- Economically sustainable mental health services.
- High quality and therapeutic environments for service users and staff.

The aspiration is to move local community services to better equipped local hubs and consolidate inpatient activity to new, better equipped facilities, ensuring it is service user-centric and supports the health of the community, as well as the sustainability of SLaM as a world-leading mental health service. Services are currently provided from 72 locations – 66 community sites and six acute sites – across the London Boroughs of Croydon, Lambeth, Lewisham and Southwark.

Lambeth is the furthest ahead of all SLaM's boroughs in determining its local, community care blueprint and the Lambeth Alliance has consulted extensively on this with changes starting in July 2019. Investment is already being made in the fabric of Lambeth's community estate within three community hubs:

(i) 332 and 308-312 Brixton Road (In Lambeth Borough);

(ii) Ackerman Health Centre, (In Lambeth Borough); and

(iii) Gracefield Gardens, (In Lambeth Borough).

As a result, the Lambeth community estate will be refurbished to deliver much greater levels of usability and functionality than currently present. Embedding services in the community in this way, appropriately distributed across the borough, will allow our teams to help people earlier, closer to their homes, preventing people from becoming unwell so that they require fewer hospital referrals. By delivering more responsive care in community settings, we can prevent crisis for some people and provide and provide a 'least restrictive' offer for those who might currently be detained under the Mental Health Act. Our aim being to avoid admitting those people who do not require hospital treatment.

It is hoped that this investment will help support the further destigmatisation of mental health services as the ambition for the Living Well Centres is to move to a neighbourhood care mode in line with the primary care network model, where care and support will be delivered in community locations such as GP practices and community centres to provide wider access to care and reduce the reliance on a one-place community mental health centre approach.

Overall, this change will provide a robust community and acute interface, with staff and partners across the community and acute pathways working together to ensure people receive the least restrictive treatment and care, as close to a person's home as practically possible, with community connections maintained if an admission is required.

The development of Living Well Centres and associated move to a primary care model is expected to reduce the need for people to access inpatient care with quicker, easier access to support and care in the community.

There will however always be a need to treat the most acute cases in an inpatient setting. As inpatient care becomes a more specialised intervention, it will be become more complex and acute.

We are now proposing to enter into a process of engagement on service changes regarding Lambeth Hospital to support this direction of travel. Through an extensive engagement process with stakeholders, it is hoped that the following can be delivered in a bid to serve local populations:

- New acute inpatient facilities where service users requiring specialist care in an inpatient environment are treated in state-of-the-art, therapeutic environments.
- More robust staffing models through co-location of services which could help reduce the use of bank and agency staff that currently contribute to existing financial strain and challenge. Conservative assumptions have been made at this stage to test affordability and a further assessment of financial benefits will be made by the Trust as part of the business case process for capital investment that would follow a successful consultation process.
- Modern, fit for purpose environments for services both in the community and at inpatient sites across the entire service user population we serve.

Chapter 4. Case for Change, Care Model and Expected Benefit

4.1 Introduction

This section details the rationale and case for changing the way that our services in Lambeth are delivered. It covers:

- Drivers for change.
- Clinical case for change (community services; consolidation of inpatient services).
- Care Model.
- Expected benefits.
- Impact on service users.
- Travel time.
- Public sector equality duty.

4.2 Drivers for Change

There are three primary drivers of our case for change. They are:

1. **National and regional policy** – this proposal is fully aligned with, and supports the delivery of the NHS Long Term Plan, Five Year Forward View for Mental Health and the South East London STP strategy.

2. **The local vision and clinical objectives** - set out in the our Clinical Strategy and the Lambeth Living Well Network Alliance Strategy to provide care in the least restrictive environments and move care closer to home for all but those requiring specialised inpatient care.

3. **Quality of the estate** – its impact on service provision, outcomes and service user and carer experience. In order to be able to deliver our clinical priorities, the estate must be improved so that care is provided in modern, fit for purpose estate both in the community and across inpatient sites.

4.2.1 Driver 1: National and regional policy

There are a number of relevant national policies and guidelines for mental health or healthcare more broadly that have guided and informed the proposal in a number of ways, including (see Appendix [3] for full list):

National policy

NHS Long Term Plan

This sets out a series of changes to the NHS to be implemented over the next decade. The Plan describes in six chapters, how the NHS will improve care for patients over the next ten years. It describes how we can tackle the challenges face by the NHS by:

- Doing things differently – introducing new service models that will encourage collaborative working such as the formation of primary care networks and integrated care systems;

- Tackling health inequalities - the NHS will increase its contribution to tackling some of the most significant causes of ill health, with a particular focus on the communities and groups of people most affected by these problems;
- Improving care outcomes - the NHS has committed to increasing funding for mental health, focusing on expanding community and crisis support, and improving mental health services for children and young people. Additionally, there is a commitment to research and innovation, with the benefits of these fed back directly into the NHS;
- Backing our workforce - there are plans to increase recruitment to the NHS by introducing incentive schemes which make qualifying for clinical roles more achievable, cheaper and worthwhile;
- Creating a digital NHS – making better use of data and digital technology, giving service users access to a wide range of digital services, including e-consultations and online follow-up appointments, and greater control over their care; and
- Financial sustainability – The 3.4% five-year funding settlement, announced in the most recent budget, will enable the NHS to improve its financial position and the Long Term Plan sets out the objectives which are necessary for this to happen, including making better use of capital investments and existing assets to drive transformation.

The first stage in implementing the Long Term Plan is to create Integrated Care Systems (ICSs), facilitating the integration of primary care, specialist care, and physical and mental health services who will work with local authorities to provide the best care to local populations.

This scheme is supports delivery of the Long Term Plan through its focus on:

- improving local and national specialist mental health services and facilitating collaboration with academic research to improve the quality of care; and
- supporting financial sustainability through maximising the productivity of the Trust's estate.

Five Year Forward View for Mental Health

This national policy was published by NHS England and sets out a target to achieve high quality care for an additional one million service users by 2020/21. This is a decisive step forward towards closing the treatment gap for mental health.

The forward view highlighted several actions they will take by 2020/21, in order to achieve this:

- A significant expansion in access to high quality mental healthcare for children and young people. At least 70,000 additional children and young people each year will receive evidence based treatment.
- Increased access to specialist perinatal mental health support in all areas in England, in the community or in inpatient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it.
- Increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year.
- Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors.
- NHS England and NHS Improvement should lead work to increase access to high quality care that prevents avoidable admissions and supports recovery for people who have severe mental health problems and significant risk or safety issues in the least restrictive setting as close to home as possible.

- Evidenced improvement in mental healthcare pathways across the secure and detained settings.
- An ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.

This scheme is fully aligned with the NHS Five Year Forward View for Mental Health with its support for improving adult community mental health services as part of the proposed changes, and preventing avoidable admissions.

The Carter Review

Examines the operational productivity and efficiency of NHS hospitals focusing on workflow, workforce, pharmacy, medicines optimisation and estates and procurement management. The report identified significant and unwarranted variation in costs and practice which, if addressed, could save the NHS £5bn.

The report recommends that every Trust has a strategic estates and facilities plan in place based on the model hospital data and benchmarks. This will aid a plan for long term estate investment and reconfiguration. Following this in May 2018, Lord Carter published a more detailed review of unwarranted variations in Mental Health and Community Services identifying a savings opportunity of £1bn.

The key recommendations that are consistent with the aims of this scheme include recommendations to:

- optimise inpatient services by making significant improvements to better manage the workforce. The review also recognised the significant challenges facing Trusts around the infrastructure to support the deployment of medicines in the community and inpatient facilities;
- improve quality and efficiency across the mental health pathway and bring parity of esteem with physical health services; and
- optimise non-clinical resources including improving the efficiency of estates and facilities management by rationalising estate and identifying opportunities for consolidation.

The Naylor Review

Sets out recommendations on how the NHS can make best use of its property and estate and, by doing so, generate money to reinvest in service user care and deliver the reforms set out in the Five Year Forward View. It emphasises the importance of ensuring that NHS property and estates support clinical need by aligning clinical and capital plans.

In order to encourage the NHS to rationalise their estate and move towards affordable, sustainable and long-term estates solutions, the Review sets out plans for capital receipts of surplus land to be reinvested in local services. The review places emphasis on the importance of long-term capital investment strategic planning which is an outcome of implementing the preferred option.

The scheme supports the recommendations of the Naylor Review by consolidating in-patient services and moving facilities to the Maudsley Hospital site allowing the generation of £38.2m of funds from the Lambeth Hospital site which can be used towards to next phases of the estate strategy.

Modernising the Mental Health Act

The document builds on the Five Year Forward View for Mental Health and identifies what issues the NHS has faced with its implementation. The report is in favour for the retention of a Mental Health Act with both compulsive power and total commitment to a right-based approach.

The document proposes some key principles which should be adopted when implementing the Mental Health Act. These principles act to improve choice/decision making within a setting of compulsion, an essential element to upholding dignity. Additionally, it is a key objective to support people of ethnic backgrounds in order to tackle the profound inequalities for black men of African and Caribbean descent by responding to objectives in the Public Sector Equality Duty, setting up an Organisation Competency Framework.

These principles are:

- Providing service users with the highest level of choice and autonomy;
- Providing care in the least restrictive way;
- Maximise therapeutic benefit to service users; and
- Adopt a person-centered approach – the person as an individual.

Our broader clinical transformation programme and estate strategy support delivery of the recommendations through the emphasis on care in the least restrictive environment, and the need to develop therapeutic environments.

Regional policy

Our programme is fully aligned with, and supports, delivery of the South East London STP strategy and mental health strategy.

Our Healthier South East London (OHSEL)

This is the NHS Sustainability and Transformation Partnership (STP) for South East London 12, and includes collaborations between commissioners and providers, across health and social care, with the voluntary sector and citizens, and with education and research institutions and networks. The six South East London CCGs included in this STP (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) have in place a well-established collaborative approach, and work with NHS England and all of London's 32 CCGs to enable transformation across the capital, including through the Healthy London Partnership (HLP).

STP plans across South London show an emerging plan for 14 integrated care networks and early work through the Trust's Integration Group identified that there are a range of services that may be appropriate to be provided from local care network (LCN) hubs in the future. These include some of the early detection services, low intensity teams, primary and secondary care liaison services and mental health promotion teams.

Providers work together as part of formal and informal clinical networks, including specialised services supported by King's Health Partners (KHP) Academic Health Science Centre. Organisations in the footprint also contribute to and use resources developed by support infrastructures such as the Health Innovation Network (HIN) and Collaboration for Leadership in Applied Health Research and Care (CLARHC).

OHSEL was first established in 2013, by local health commissioners, to promote and develop more integrated, out-of-hospital and preventative care, and so has well-established transformation programmes with integrated service user, public and clinical involvement.

The STP is driven to address the following three problems in local healthcare:

1. The health and wellbeing gap – people should be helped to lead healthier and longer lives

[12] South East London STP - Integrating Mental Health Services, Page 12, October 2016.

2. The care and quality gap – variation in the accessibility and quality of care should be improved
3. The funding and efficiency gap – the NHS must become more efficient and make better use of the money available

Key aims

The STP aims by 2021 to:

- Support people to be in control of their physical and mental health and have a greater input to their own care;
- Help people to live independently and understand what to do when they need support;
- Help communities to support each other;
- Make sure primary care services are sustainable and consistently excellent, with an increased focus on prevention;
- Reduce variation in outcomes and address inequalities by raising standards in the health service;
- Develop integrated care so that people receive the support they need more efficiently;
- Ensure services are benchmarked to ensure a uniformity across the Board in delivering high quality standards; and
- Spend money more effectively, to deliver better outcomes and avoid waste.

The SEL STP lists five priority areas, that are identified as having the greatest impact to collectively address the three gaps of health, quality and finance;

1. Developing consistent and high quality community based care (CBC) and prevention.
2. Improving quality and reducing variation across both physical and mental health.
3. Reducing cost through provider collaboration.
4. Developing sustainable specialized services.
5. Changing how we work together to deliver the transformation required.

There has been significant progress made in South East London since the STP was written with the Boroughs on track to deliver the STP vision.

Progress in Lambeth in delivering STP priorities

Lambeth has been radically transforming mental health services since 2010, with a vision to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. This was initially led by the Living Well Collaborative, a collaboration of commissioners, providers and people with lived experience, and has now moved to an alliance model of commissioning which has seen the integration of services. This is the first Alliance Outcome based contract for a whole system.

Lambeth Together is a plan to put in place a new health and social care system for Lambeth, this in turn will make services better and easier to access for everyone who lives or works in the Borough. Lambeth together consists of a number of different public bodies including Lambeth Council, NHS Lambeth CCG and South London and Maudsley NHS Foundation Trust as well as voluntary bodies e.g. Thames Reach and Certitude community groups and local sports clubs.

Lambeth Together aim to help individuals with their own health and wellbeing to reduce the need to access services and provide services in a better way so when individuals require them,

they are convenient and easy to access. With a growing population, people living longer and having less money available nationally for health and social care, pressure will be created on services in the future. Lambeth Together hope to address that by doing the following:

- Staff working in health and social care to work in a similar way as far as possible which is referred to as 'The Lambeth Together Way'.
- Organising services by people and places – instead of by the organisations that hosts those services, these will be called 'Delivery Alliances' (including for example the Lambeth Living Well Network Alliance).
- Set up one group of people to make sure Lambeth Together is managed effectively. This group will be responsible for looking after finances, workforce and digital and is called the 'Strategic Alliance'.

4.2.2 Driver 2: The local vision and clinical objectives

The second key driver is our clinical vision and the local policy framework for Lambeth – specifically, the clinical outcomes set out for the borough by the Lambeth Living Well Network Alliance.

Improving the quality of care provided by the Trust is at the heart of our clinical vision outlined in the Changing Lives strategy (published 2018).

We are experiencing a fundamental shift, towards a model of healthcare delivery where service users are encouraged to take ownership of their health and wellbeing, with a focus on enabling self-care, autonomy, and independence and encouraging them to be at the forefront when decisions are made about their care. Our strategy places a greater emphasis on asset-based healthcare delivery that works with service users strengths, which means resources should be managed more efficiently, to support the best quality outcomes.

As a borough, Lambeth has a long history of innovation and co-production in mental health. The Living Well Network Alliance is the first Alliance Outcome based contract for a whole system and is therefore responsible for transforming the way that adult mental health services are delivered in Lambeth and embedding these changes across the system. This forms part of the wider Sustainability and Transformation Plan (STP) that covers South East London.

Lambeth CCG and South London and Maudsley NHS Foundation Trust (as the main provider partners in the Living Well Network Alliance) share a view that people in Lambeth who are experiencing mental illness or distress should receive the support they need to lead full, healthy and independent lives. The Alliance is committed to transforming health and care services in Lambeth.

The three main outcomes that the Alliance is seeking to achieve for Lambeth residents are to:

- recover and stay well;
- have choice in their care and support; and
- have the ability to participate on an equal footing in their daily lives.

Feedback received from people who use mental health services in Lambeth has identified that they want more options for support when they are in crisis. This has led to a focus on improving mental health services to be:

- more joined up;

- quicker and easier to access; and
- more focussed on prevention, avoiding crises and unnecessary admissions to hospital.

The new delivery model for the Living Well Network Alliance has been agreed and changes in the way the system works have started to be implemented with a focus on joining up services around those people who use them to ensure they get the best possible support available as and when they need it.

A number of objectives have been developed to support delivery of the vision:

- increasing whole person mental and physical health care and wellbeing support provided in the community;
- reducing length of stay;
- offering increased support for people experiencing crisis in their place of residence or alternative setting to A&E where appropriate; and
- reducing inequality in access and experience of mental and physical health care across South East London for people with protected characteristics and experiencing social deprivation.

In order to deliver these objectives, a programme of clinical transformation has been developed around the following key principles:

- delivering new integrated community mental health models of care wrapped around primary care networks;
- increasing capacity to meet national access, recovery and waiting time trajectories;
- providing alternative crisis support working jointly with police, London Ambulance Service and voluntary sector to provide crisis support in alternative least restrictive setting; and
- working as a system to enable a minimum of 60% of people with severe mental illness receiving an annual physical health check and follow on support where this is identified.

A key plank of this programme is the development of three Living Well Centres in 19/20, which are new integrated community mental health models of care, wrapped around primary care networks. These will enable more care to be delivered in a community setting, right to the heart of our communities so that those needing support remain close to their support networks of families and friends.

4.2.3 Driver 3: Quality of the estate

The third main driver for change is the current condition of the Trust's estate, particularly in Lambeth. Improving the quality of the estate links directly to their ability to deliver our overall clinical vision and evidence shows that the provision of a high-quality inpatient environment is conducive to recovery and the wellbeing of mental health service users.

In comparison to some other Trusts, who have invested more in modernising their estate in recent years, much of the current hospital estate is outdated with over 58% being built before 1990 and the release of modern design guidance in Mental Health and recommendations for ensuite bathrooms, social and family space, and direct access to outside space from recreational areas to facilitate improved service user care. There is therefore a significant need for investment on inpatient sites.

In relation to Lambeth specifically, in its inspection in 2017, the CQC identified a number of specific issues with our current inpatient provision, with all inpatient units found to have blind

spots which necessitated the use of convex mirrors. Acute inpatient wards on the Lambeth Hospital site do not meet modern standards as they do not have ensuite bathroom facilities and cramped environment. Violence and aggression on the Lambeth wards is an issue due to poor lines of sight, ventilation and an environment which is in effect a long corridor. People not feeling safe in the environment also impacts on recovery. We know that where recovery is aided through an improved environment this will have a positive impact on length of stay.

4.3 Clinical Case for Change

Lambeth is the furthest ahead of all SLaM's boroughs in determining its local, community care blueprint and the Lambeth Alliance has consulted extensively on this with changes starting in July 2019. To support this service change, investment is already being made in the fabric of Lambeth's community estate through the development of Living Well Centres which support the move towards a primary care model.

There will however always be a need to treat the most acute cases in an inpatient setting. As inpatient care becomes a more specialised intervention, it will become more complex and acute and we are now proposing to enter into a process of engagement on service changes regarding Lambeth Hospital to support this direction of travel.

Through an extensive engagement process with stakeholders, it is hoped that the following can be delivered to serve local populations:

Consolidation of inpatient services

- New acute inpatient facilities where service users requiring specialist care in an inpatient environment are treated in state-of-the-art, therapeutic and safe environments.
- More robust staffing models through co-location of services which could help reduce the use of bank and agency staff that currently contribute to existing financial strain and challenges. Conservative assumptions have been made at this stage to test affordability and a further assessment of financial benefits will be made by the Trust as part of the business case process for capital investment that would follow a successful consultation process.

Improving estates quality

- Investment in modern, fit for purpose environments for services both in the community and at inpatient sites across the entire service user population we serve.

Any proposals will maintain the number of beds for Lambeth services users

We recognise that there is a need for a much more intensive style of support provided in an inpatient setting and we are committed to ensuring that where this is the case individuals are treated in modern, conducive environments so that service users get the best therapeutic care and treatment they need.

Unfortunately, this is not currently possible with the existing, tired and poorly configured estates facilities at Lambeth Hospital, which as highlighted above is a key driver for change.

4.3.1 Consolidation of inpatient services

Currently our inpatient services are provided at five sites; Bethlem Royal Hospital in Beckenham, Lambeth Hospital in Clapham, the Ladywell Unit at University Hospital Lewisham, the Maudsley Hospital in Camberwell and Woodland House in Tonbridge.

Outpatient and psychiatric liaison services are also provided from sites including; Croydon University Hospital, Guy's Hospital, King's College Hospital, University Hospital Lewisham and St Thomas's Hospital. National and specialist services are also provided from Bethlem and Maudsley, Trust staff also deliver services from numerous community locations in Lambeth, Southwark, Lewisham and Croydon as well as visiting service users in their homes.

Developing a modern and therapeutic inpatient facility
Proposals are being reviewed to invest in a new acute inpatient facility for those Lambeth service users requiring specialist inpatient care. This will be done by providing a new modern facility that will offer a safer environment for services and staff, in state-of-the-art therapeutic settings that will significantly improve individuals' privacy and dignity.

Offering service users an open and inviting ward that has the flexibility to offer both social spaces and areas for privacy where needed will have a material improvement on service users and staff. The new facilities would support meeting modern guidelines for staff including the ability to be able to observe patients by line of sight, ensuring natural lighting and ventilation are available throughout.

It is important to note that there is no intention to reduce the availability of beds through the development of the proposals in this pre-consultation business case.

Consolidation with a focus on specialist interventions
The acute care pathway programme for the Trust will continue to be developed through standardising pathways and reducing variation in care across sites.

The ongoing investment in community services and earlier access to care will reduce the dependency on inpatient services for a far greater number of service users reducing their need to access a hospital site. This will have the consequence that inpatient care is more available to those who truly need specialist interventions.

The acuity of service users accessing inpatient care is likely to create a demand for more specialist clinical interventions and access to specialist clinical expertise and we need to be able to respond in a more agile and responsive manner where needed.

Staff recruitment and retention
A new inpatient unit with an improved environment would undoubtedly positively impact on the recruitment and retention of staff. In the new environment it is anticipated that a higher quality environment would reduce aggression and violence, with the result being that patients and staff feel safer.

More robust staffing models would also support a reduction in the use of bank and agency staff that currently contribute to existing financial strain and clinical risk. We can also help manage staffing on the acute wards by developing an increased pool of staff that can be deployed more effectively. Additionally, there may also be productivity and efficiency improvements so that staff can spend more time supporting service users.

4.3.2 Improving estates quality

The Trust's estates strategy identified that their estate requires extensive investment to bring it up to the standard expected to deliver 21st century care. The development of the strategy identified three key estate issues that need to be addressed including:

- Ability to meet service reconfiguration that is locally aligned to the Sustainability and Transformation Partnership strategy and South London Mental Health Alliance. This requires an understanding of capability and capacity across sites and a shared approach to use of that capacity.
- Ensuring sites and buildings are used to maximise our ability to deliver services efficiently and effectively, focused on the assets of the Trust and limited capital where it delivers the highest benefits.
- Quality to support better clinical outcomes and improved service user experience facilitated by new technologies.

The ongoing work as part of that strategy has identified that the inpatient services at Lambeth Hospital are not fit for purpose and require very significant modernisation in order to deliver the

Trust Clinical Strategy. Sites are generally in poor condition and too small to offer a good environment of care.

Lambeth Hospital's particular estates challenges which impact on the delivery of our strategy and impact on service user safety, experience and outcomes include:

- The acute inpatient wards at Lambeth (Luther King, Nelson, LEO and Eden) were built in the 1990s (some of which originally as offices) and, therefore, do not align with modern accommodation standards, for example they do not have ensuites. The general environment in these wards is cramped, especially at Nelson and Luther King wards.
- In their most recent inspection (July 2019) of the Trust, the Care Quality Commission (CQC) identified a number of specific issues with the current accommodation:
    - All inpatient units were found to have blind spots which necessitated the use of convex mirrors to mitigate;
    - All wards were found to exclude a dedicated seclusion room which required staff to improvise when seclusion was required.
    - At Nelson ward and others on the Lambeth site, there are potential ligature risks following the recent attempted suicide of a service user by using the ceiling as a ligature point.
- Nelson and Luther King wards are in the poorest condition and due to their age and configuration, deviate away the most from latest planning standards. Patient safety is impacted due to poor observational lines of sight, ligature risks, ward lighting controls being located in areas that are accessible to patients and the general cramped nature of the wards make service users feel cramped which can sometimes cause aggression. Whilst measures are in place to maintain privacy and dignity as much as possible, issues remain that cannot be addressed because of the design of the ward templates including the lack of ensuite accommodation and the fact that all bedrooms are located off one busy ward street thoroughfare. Toilets and showers often become blocked due to structural issues with the drainage system which further reduces the number of facilities available for use.
- There are no purpose designed facilities on the wards for the delivery of therapeutic activities. Whilst workarounds are in place, the design constraints limit the extent to which a wide range of therapy can be delivered.
- The wards do not comply with the Royal College of Psychiatrists standards relating to "a physical environment that is fit for purpose" due to:
    - Lack of bathroom and showering facilities – only 18 beds out of the entire bed base have ensuite facilities.
    - Tired and worn decoration and furnishings.
    - Insufficient on and off ward therapy spaces.
    - Luther King, Nelson and Eden wards are essentially long narrow corridors with bedrooms, communal space and staff facilities running off them.
    - Poor natural light and ventilation.

The Lambeth Hospital lacks the expected features of high-quality inpatient mental health facilities and to address this the Trust's estates strategy proposes to rationalise and invest in community sites, consolidate inpatient care and modernise Trust inpatient bed stock.

The following sections provide further details on the current quality of the estate and key issues that this proposal seeks to address.

Community Properties

Community properties account for 36% of the estate by area and represent 36% of freehold space. Of the 93 properties, 18% of these are not utilised by SLaM, being leased out to others or currently vacant. Appendix [13] shows the properties that have been sold or vacated based on the 2017 estates strategy.

Geography

The geographic location of properties is an important consideration in accessibility of services for service users and location of workspace for staff providing home treatment services. The Trust's Integration Working Group (IWG) identified gaps in service provision in Kennington and Rotherhithe/Canada Water areas in February 2018.

Size

The size of the properties is also an indicator of likely future strategic fit as smaller properties are unlikely to be big enough to accommodate hub models or provide sufficient critical mass for staff safety. Properties which fall below these sizes have been considered too small to support efficient and safe service provision and, therefore, should not be retained by the Trust.

We have identified 25 properties smaller than 250sqm. Consideration has been given to properties with service agreements in place requiring the service provision to continue within this location, and so when the existing service agreements are taken into account, 12 of these properties should be retained and the remaining 13 should be exited.

Condition

Based on an assessment of building conditions, 45 properties are considered to be in Condition C or worse, indicating that the building will require major repair or replacement within three years for building elements and one year for engineering elements. 32% (30) properties, are ranked as sound, operationally safe and exhibit only minor deteriorations. The condition of the remaining 18 properties has not been classified.

Age

Building age is used as a proxy for functional suitability, the building date is an indicator of the design suitability and the general condition of the building. Of the 93 community properties investigated, 30 (32%) have been built in the last 30 years, and 34 pre-date 1948.

Hospital Sites

The pie charts in Figure [4.3] illustrate how space is currently used across the combined hospital sites. Non-service user areas account for 64% of the total space in use.

Overall 58% of the estate by area is over 30 years old. As noted above, the typical life of hospital buildings is considered to be 30 years after which significant replacement investment is required. Older buildings are generally costly to maintain and to refurbish to modern standards.

Facilities Management Budget

Below is a summary of the current estates and facilities management financial plan[13] for Lambeth Hospital.

[13] Lambeth Hospital Management Accounts – Estates, Porters, Rates and Energy YTD, May 2019

Cost Centre	Expense Type	Full Year Budget (FY19/20) (£)
Estates	Pay	309,117
	Non-Pay	342,097
	Income	(20,843)
Porters	Pay	421,442
	Non-Pay	3,482
Rates	Non-Pay	133,025
Energy	Non-Pay	424,363
	Income	(32,000)

Figure [4.2]: Facilities Management Budget

The table above shows the combined full year budget across facilities for pay and non-pay costs to be £731k and £910k respectively. Combined revenue for facilities is £53k.

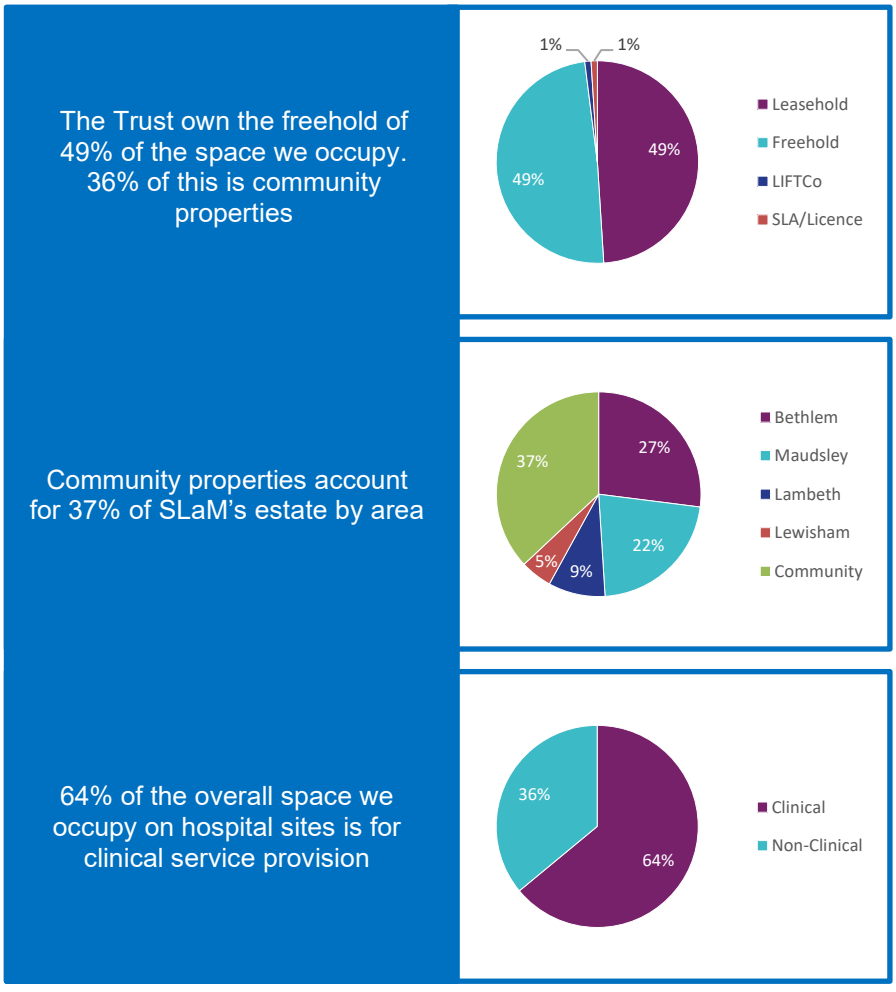

Figure [4.3]: Distribution of space

Utilisation

Space utilisation is assessed on a series of judgements made on the intensity of use i.e. the number of people using it and the frequency with which they use it. Currently the Trust's inpatient bed occupancy levels are around 100% with overspill of capacity resulting in service users being transferred to private providers at a cost to the Trust.

Current activity data suggests 920,000+ service user contacts were undertaken across the Trust in 2016. Of this, an estimated 507,000 were held in consultation rooms either in the community or hospital sites with the remaining undertaken in service user homes or via telemedicine.

The Trust's property base currently accommodates an estimated 3,300 desks in workspace across community properties and hospital sites. In comparison to the number of staff (4,254 permanent full time equivalent and 983 temporary) employed by the Trust this suggests an overprovision of workspace where agile working principles and ratios are applied.

Physical Condition and Backlog Maintenance

Of the current hospital estate 35% of the area is ranked as Condition B or higher. This is reflected in the Trust's risk adjusted backlog maintenance currently £18/sqm across all inpatient sites. As illustrated in Figure [4.4] SLaM's backlog maintenance costs are higher than the median for mental health Trusts in England which is £13/sqm and significantly higher than the top 10th percentile of £2/sqm. The backlog costs vary significantly across the hospitals with high costs on the Maudsley site which are largely attributable to Mapother House. While Bethlem is below the national median, the average value masks the very poor accommodation in the older estate on that site. Investment in the estate will reduce the Trust's backlog maintenance liability.

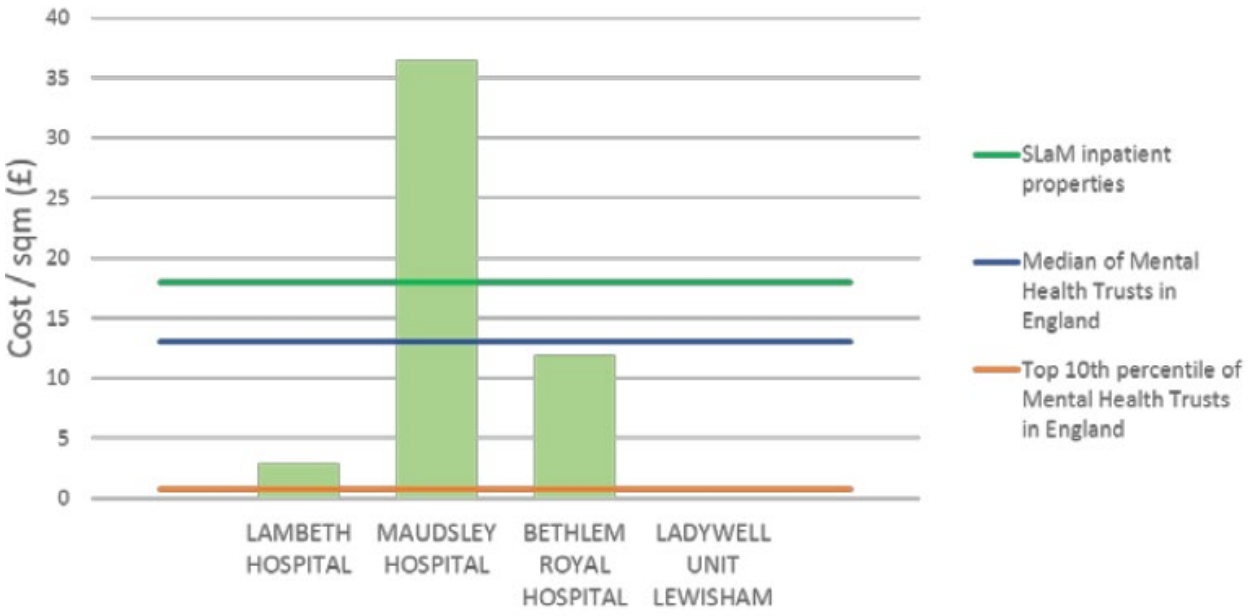

Figure [4.4]: Risk adjusted backlog costs per sqm

Quality measure

The quality measure is focused on the inpatient environment as it has the most impact on service user experience. The Quality measure relates to design rather than operational effectiveness

		Bethlem	Maudsley	Lambeth
Beds		375	117	143
Single room (%)		100%	97%	100%
Ensuited rooms		43%	0%	20%
Size of bed rooms (m^2)	Range	5.9-18.2	7.0-17.7	8.4-16.7
	Mode	11	10	12
Av no. beds per ward		15	17	16
Independent access to outdoor space (%)		67%	35%	52%

Figure [4.5]: Summary of key quality indicators across hospital sites

All beds across the Trust are provided within single bedroom accommodation. However, the level of ensuite accommodation is poor. At Maudsley and Ladywell no en-suite facilities are available. The Bethlem site has the best provision at 43%, which reflects the more recent developments on that site. Lambeth has been ranked 2nd on the table as accommodation and facilities fall below regulatory standards.

All inpatient beds are in single rooms. However, some wards have shared bathrooms and others are en-suite. Below is a summary of ensuite and shared facilities in Lambeth wards:

Ward	Facility
Rosa Park Ward	Ensuite
Nelson Ward	Shared
Tony Hillis Unit	Shared
Ward in the Community	Shared
Eden Ward	Shared
Luther King Ward	Shared
LEO Ward	Shared

Estate Performance Summary

It is evident that the Trust's estate requires extensive investment to bring it up to the standard expected to deliver 21st century care. Key estate issues that need to be addressed include:

- Ability to meet service reconfiguration locally aligned to the STP strategy. This requires an understanding of capability and capacity across sites and a shared approach to use of that capacity.
- Asset productivity ensuring sites and buildings are used to maximise the Trust's ability to deliver services efficiently and effectively, ensuring investment focused on releasing benefits.

- Quality to support better clinical outcomes and improved service user experience facilitated by new technologies.

Performance measure	Current Performance		Target Performance	
	Now	Post Preferred Option	2022	2027+
% beds in single rooms with ensuite accommodation	26%	42%	60%	100%
% bedrooms of a size meeting recommended guidelines	36%	51%	60%	100%
% inpatient units with direct access to safe therapeutic outdoor space	50%	66%	75%	100%
% of estate by area dedicated to non-clinical use	36%	36%		Carter target tbc
Risk Adjusted backlog £/m^2	£18/m^2	-	£13/m^2	£2/m^2
% of hospital estate by area ranked as Condition B or higher	35%	43%	80%	100%
Consulting room utilisation: service user contact per room	~955	-	2,000	2,300
Agile working: % reduction of workstations	4,254 staff occupy 3,300 desks	-	20%	40%

Figure [4.6]: SLaM's estate performance measures and targets

The performance measures are intended to be Trust wide. These are average performance rates, therefore, there is likely to be variances in performance across some services with regards to consulting room utilisation.

CQC

In most recent inspection (July 2019), the CQC identified a number of specific issues with the current accommodation. All inpatient units were found to have blind spots which necessitated the use of convex mirrors to mitigate. Additionally, some bedroom doors did not give patients the option to close vision into their bedrooms, therefore staff and patients passing by could see into their bedrooms. On one rehabilitation ward it was found that there was insufficient storage space in the clinic room for patients' medicines.

The acute inpatient wards at Lambeth (Luther King, Nelson, LEO and Eden) were built in the 1990s (some of which originally as offices) and, therefore, do not align with modern accommodation standards, for example they do not have en-suite facilities. The general environment in these wards is cramped, especially at Nelson and Luther King wards. In the Southwark, Lambeth and Lewisham perinatal community teams there are insufficient rooms available to meet with patients.

The CQC also highlighted the lack of purpose designed seclusion facilities on the wards which results in staff having to improvise when needed. Extensive consideration has been given in the

proposed designs on how patients who experience an episode of violence or aggression are managed. Patients on the adult acute wards will have access to a de-escalation/sensory room where they can be taken to without restraint until the episode has passed. The use of seclusion rooms for acute wards is an outdated model. The PICU, due to the acuity of patients, will have a seclusion room.

Royal College of Psychiatrists Standards

In 2011, the Royal College set out ten standards for adult inpatient mental healthcare in their report 'OP79 – Do the right thing: how to judge a good ward'. The recommendations were distilled from agreed existing standards and the College recommends that these standards are used by Trusts as a check on the quality they provide.

Our services meet the majority of the standards set with the exception of the following:

1 Bed occupancy rates of 85% or less.

High bed utilisation can lead to a detrimental effect on quality and safety of inpatient care. The Lambeth Adult Acute service is currently running at an occupancy of around 98%. Running at such a high occupancy leads to problems in the timely admission of service users when they most need acute intervention.

The capacity modelling in this case is based on running at an 85% occupancy rate which will, therefore, provide capacity to meet peaks in demand. This is an aspiration that is assumed to be worked towards in the coming years as the impact of earlier intervention, additional investment in the Borough (as a direct result of the additional funds derived from the disposal or development of the Lambeth Hospital site) and other such improvements in non-inpatient care take hold.

2 A physical environment that is fit for purpose.

There is recognition in the report, that a relaxed, comfortable, safe and predictable environment is essential to service user recovery and wellbeing. The Lambeth inpatient accommodation does not provide accommodation that is in line with latest standards and recommendations. The deficiencies with the current accommodation include:

- Lack of bathroom and showering facilities – only 18 beds out of the entire bed base have ensuite facilities.
- Tired and worn decoration and furnishings.
- Insufficient on and off ward therapy spaces.
- Luther King, Nelson and Eden wards are essentially long narrow corridors with bedrooms, communal space and staff facilities running off them.
- Poor natural light and ventilation.

3 The ward as a therapeutic space

A lack of regular activities can lead to boredom, frustration and inactivity which not only impedes recovery but can also instigate unsafe, violent and erratic behaviour and can lead to distress and agitation that can manifest in violence and aggression. Access to a wide range of therapy activities inside and outside the ward is recommended and the ability to provide this is dependent on the availability of physical space and occupational therapy workforce. Limited communal spaces on the wards can increase people's agitation and can impede privacy and dignity.

PLACE Assessment Score

PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. Assessments are undertaken by a team of trained assessment teams consisting of staff and members of the public.

Site Name	Cleanliness (CLN) Score %	Ward Food Score %	Privacy, Dignity & Wellbeing Score %	Condition, Appearance and Maintenance Score %	Dementia Score %	Disability Score %
Maudsley Hospital	95.30%	67.74%	86.09%	91.98%	93.31%	83.57%
Bethlem Royal Hospital	98.20%	76.14%	96.54%	97.28%	95.93%	86.21%
Lambeth Hospital	99.30%	81.20%	84.17%	92.63%		76.20%
Trust Average	98.07%		90.89%	95.36%	95.06%	84.53%

Figure [4.7]: The 2018 PLACE scores for the relevant sites

Lambeth Hospital scores lowest when compared to other large Trust sites in regard to Privacy, Dignity and Wellbeing, and how well the needs of service users with a disability are met.

A review of the ward level qualitative feedback from the PLACE assessments undertaken at Lambeth Hospital highlights that the inpatient accommodation is generally in good condition and is fit for purpose for the time it was constructed.

Standards have changed over time and there are two wards at Lambeth which fall short of an acceptable standard. Ensuite facilities are only provided at Rosa Parks. The other wards do not provide all bedrooms with ensuite accommodation. Providing inpatients with access to their own toilet and washing facilities is a definitive requirement for modern mental health inpatient facilities.

On most of the wards at Lambeth, the PLACE surveys did reveal issues with the maintenance of the environments and a number of service user assessors did suggest that redecoration is required to ensure that the inpatient spaces provide a high quality environment.

Therapeutic environment

As outlined previously evidence suggests that the provision of a high-quality inpatient environment is conducive to service user wellbeing and recovery.

Currently, the wards do not provide all these environmental features. However, the new facility has been designed specifically to provide an environment which is most conducive to the recovery of mental health service users.

Parity of esteem for mental health

Parity of esteem for mental health is widely supported as a concept across the health and social care system, reflecting the fact that mental health can be more debilitating than most physical conditions as well as the enormous social and economic costs of untreated conditions (only 25% of those with depression are diagnosed).

Similarly, for inpatients that are admitted to the service at the Trust, there is an associated stigmatism with the facility which could be addressed through moving to a new, modern site. This supports the wider new Model of Care as set out in Section [5] and STP goals for mental health provision that is integrated and viewed as equal to physical health provisions.

4.4 Care Model

This section sets out the model of care and details how the model of care is changing and the proposal facilitates delivery of this. It highlights the expected benefits and also how the model meets the needs identified in the Case for Change section.

Currently, service users are admitted into an inpatient setting where there is a need to provide intensive clinical intervention. Service users access inpatient services through either a mental health act assessment or informal/voluntary admission. The assessment to determine admission can take place in a number of locations including physical health A&E, a persons home, a health based place of safety or policy custody. Once a decision to admit has been made a request for a bed is made through the acute referral centre (ARC). The admission premise considers the least restrictive environment to admit a person to (default is an adult acute ward) however there may be some instances where service users may be admitted straight to PICU and this is guided by the individual's absent without leave (AWOL) risk or levels of violence and aggression.

The ARC then determines the availability of a bed nearest to their geographic location with the aim of keeping people close to their family and community.

The inpatient capacity for Lambeth residents comprises four working age adult acute wards which are single sex and a mixed sex early intervention in psychosis unit. For those service users who have a high AWOL risk or a high risk of violence or aggression a 10 bedded male PICU is part of the inpatient offering. Female service users for PICU are made to the nearest female PICU unit which is either in Southwark or Croydon. Within Lambeth, the demand for PICU by males is much greater than females.

Treatment on the ward is provided by a multidisciplinary team comprising of nursing staff, psychiatry, psychology, occupational therapy and healthcare support workers. Once admitted, service users will undergo an extended assessment to understand distinct needs for their disorder. Each service user will have an individual care plan and risk assessment. Service users will receive pharma logical and psychosocial interventions which are designed to reduce the impact of symptoms the individual is experiencing and to promote recovery. Individual and group therapy programmes are offered at ward level for service users and there are options for service users to exercise and access outside space.

Each individual's dedicated care coordinator maintains strong relationships with the individual and the multidisciplinary clinical team through the individuals pathway. They work with community and residential providers to ensure that once an individual is ready for discharge, an appropriate location is identified which enables the right level of care to be provided in the least restrictive setting.

Looking forward, we recognise that care is increasingly shifting from secondary care, towards primary and community care, in a move encouraged by facilitating service users to take a more central role in their care – through self-management and peer support, when it is safe to do so.

The reorganisation of community services through the implementation of Living Well Centres should help to deliver care in the least restrictive setting and should prevent readmissions to hospital. There will, however, always be a need to treat the most acute cases in an inpatient setting and delivery of this project will provide an inpatient environment for Lambeth service users that is promotes recovery and accommodation that is configured in a way that is flexible to cope with changes in demand.

We are seeking to consolidate the provision of inpatient services to encourage greater integration and partnership and facilitate the future increasing acuity and specialisation of mental health inpatient care. This is especially true in the delivery of holistic care, joining up physical and mental healthcare, and organising hospitals around specialist services including acute admission.

However, within the new facility proposed the clinical model remains unchanged rather, this proposal seeks to improve the existing care model by providing a better inpatient environment. The new clinical environment will be modern and purpose designed to promote recovery. The facility will provide an environment that is less institutionalised and an environment that can be controlled by service users which will lead to an improved feeling of safety (service users being able to lock bedroom doors).

The new facility will also mean that:

- Patient transfers between the health based place of safety and the female PICU and an inpatient bed will be streamlined because in the future the bed base will be located on the same site as the health based place of safety and female PICU.
- Relocation of the inpatient bedbase to the Maudsley site also provide opportunities to strengthen collaboration between front line clinical service delivery and the Institute of Psychiatry, Psychology and Neuroscience – supporting clinical research.

We would like to be a global model of excellence in healthcare provision, and the above predictions are captured in the below five shifts that we have identified.

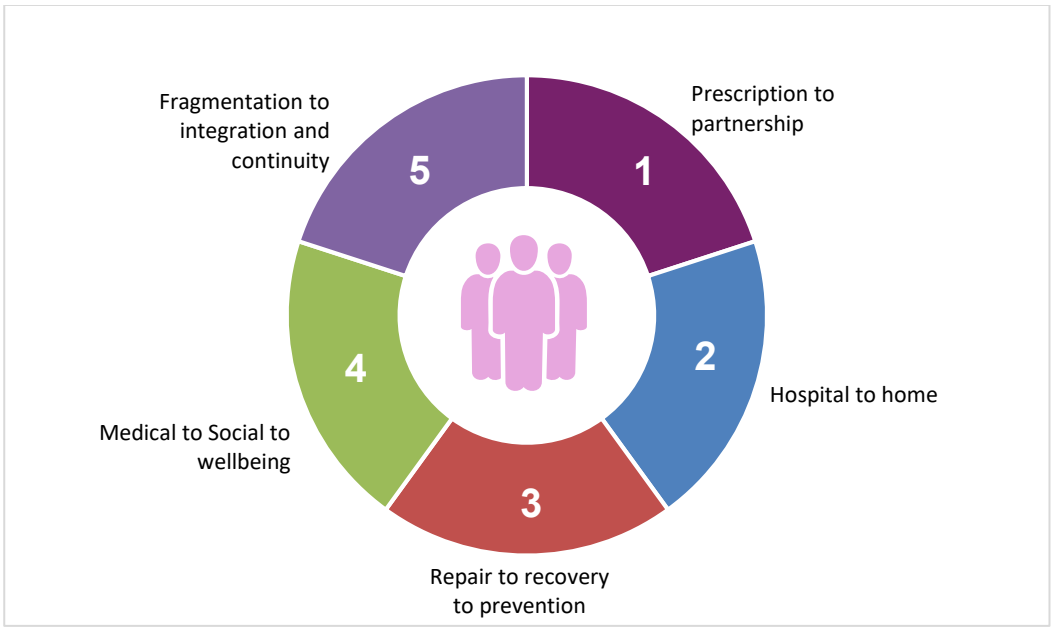

Figure [4.8]: Five shifts

Our strategic plan (2014-19) sets out the future objectives for the Trust and a number of initiatives that are being delivered to achieve an integrated model of care for South London.

The clinical strategy also aims to shift care from treatment to prevention and building high quality specialist services for those with complex needs in line with the Five Year Plan Forward View for mental health, Mental Health Taskforce 2016. This is further supported by Changing Lives, our five year (2017-2022) strategy to improve the lives of the people and communities.

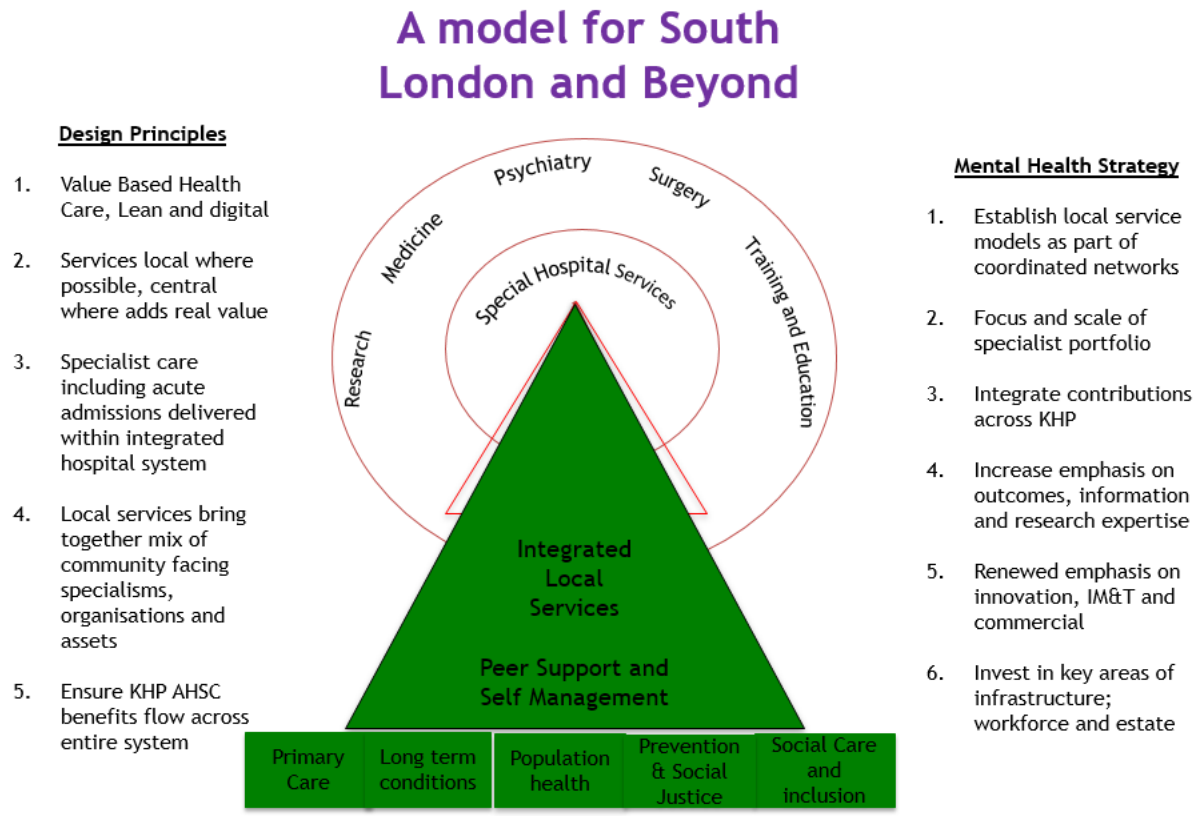

Figure [4.9]: Summary of design principles and features of SLaM's model

We have set out an economic plan, to capture the outlined objectives, and this project focuses on the following key points:

1 Secure existing income streams

a) Stabilise and transform local service provision.

b) Integrate health and social care, built around the needs of individuals and communities.

c) Focus and scale of specialist portfolio.

Build on existing high quality specialist services, and encourage specialist research that's translated into practice, in partnership with Institute of Psychiatry (IoP).

2 Effective cost management

a) Identifying opportunities to streamline workforce models specifically around nursing.

b) Ensure efficient use of the estate asset base disposing of buildings that are not fit for purpose and consolidating inpatient services to ensure long term viability.

3 Enablers

The Trust's strategic plan documents a series of enablers that are critical to the delivery of the economic plan. The enablers identified focus on five key areas:

Enabler	Description
Workforce	Engage, support and develop staff to enable them to work to the top of their skill set.
IM&T	Deployment of mobile working technologies, cloud based productivity apps, service user facing record systems.
Estates	Provision of fit for purpose community hubs. Rebuilding hospital buildings to be more accessible, therapeutic and sustainable.
Commercial capability	Invest in commercial capability and capacity Embedding commercial practice and cost awareness into operations.
Partnership strategy	Building relationships with those who have complementary skills and values in areas such as learning and education, technology and innovation, research and fundraising

To expand further on the workforce enabler, the vacancy rate summary is outlined below:

Area	Funded WTE	Actual WTE	Vacancy Rate
Lambeth Directorate	752.71	535.71	29%
Southwark Directorate	812.62	610.72	25%
Croydon Directorate	1095.74	832.01	24%
Lewisham Directorate	560.24	435.68	22%

Following changes to the current care model, the demands on existing workforce will change in line with the proposal in relation to greater expansion of community staff. Some key issues have been highlighted as:

- portability to enable staff to work across traditional boundaries;
- improving staff experience of providing care; and
- career planning/development to support a lifetime career.

The aims of the proposal around vacancies will be:

- to provide analytical support in designing the workforce elements across workstreams including providing an understanding of the impacts and benefits of introducing new roles and ways of working;
- to provide a common approach to recruitment which will cover common recruitment policy and process that will support collaborative recruitment and retention initiatives for provider Trusts; and

- to enable ‘portability’ of staff between providers and into primary and community care settings.

To deliver these aims and address the issues, a range of operational measures are outlined which will impact the workforce will be undertaken in order to support a smooth transition and implementation of the proposed service change:

- recruitment initiatives;
- retention initiatives;
- development and use of new roles;
- upskilling current staff.

4.5 Expected Benefits of the Service Reconfiguration

Potential benefits have been identified for the proposed clinical reconfiguration of Lambeth mental health services through a series of stakeholder engagement sessions, stakeholders include clinical teams, managerial teams, corporate services and service user advisory groups. These sessions have encompassed the changes proposed in this document as well as the broader changes under our clinical transformation programme and estate strategy. The stakeholders are listed in Appendix [10].

Since the time of the initial workshops, there has been a change in the scope of the project. Under the new scope, the key estate based enablement areas were identified as:

- Creating healing environments;
- Creating environments that improve inpatient experience;
- Creating environments that help promote health & safety for service users and staff;
- Developing a flexible bed base to support operational management;
- Aggregating inpatient activity into correct clinical setting;
- Rebalancing the provision of services into the correct setting; and
- Utilising technology and facilities to enable agile working.

The estates strategy highlights the development priorities as:

1) an urgent need for fit for purpose community estate that promotes integration, care closer to home and early intervention reducing excess demand for acute services;

2) an urgent need to modernise inpatient estates and to improve on key estate quality indicators across the sites; and

3) a material change in the delivery of acute services sufficient to mitigate significant capital investment and enable other efficiency benefits of a modern and consolidated estate.

In moving forward with the exploration of the proposal, a number of variables changed which had a material impact on this strategic evaluation. Although not the subject of this proposal, the redevelopment of the Ladywell replacement building at the Lewisham site which was originally proposed as part of the broader estate strategy cannot be progressed without the Lewisham and Greenwich Trust completing their clinical and estate strategies – something that they

estimate will take circa. 18 months. Therefore, a desktop review has been carried out to ensure benefits identified remain relevant to the new scope.

Where possible, research to evidence these benefits has been provided. Suggested approaches to quantification of these benefits have also been proposed. During the sessions, 25 characteristics of the new scheme at the inpatient unit were identified to deliver benefits. In addition, the team also identified 5 specific drawbacks and 8 risks of the scheme which were captured for reference and for future input into the risk register respectively.

Following the workshops, a number of benefits were identified as the most significant for this scheme. For these benefits, further research has been undertaken to substantiate the evidence behind the points raised by the project team, and understand how these benefits are realised in light of the our Care Model and future objectives.

Benefits were classified into benefit types as detailed in the definition table below:

Type	Definition
Societal benefit (SB)	A benefit which is quantifiable in monetary terms but the benefit is realised by society outside the Department for Health/NHS. For example, getting a sick person back to work earlier saves the economy money but doesn't impact the Department for Health or NHS.
Qualitative benefit (QB)	A benefit which cannot be quantified in terms of money.
Non cash releasing benefit (NCRB)	A benefit which is quantifiable in monetary terms but no money is actually released in a budget. For example, these may be productivity savings whereby small elements of time are saved, which is not sufficient to make headcount savings.
Cash releasing	A benefit that releases cash from an existing budget. A cash releasing benefit may be used as a funding mechanism to fund a business case if funds are genuinely released.
Quantified risk	Economic measure of the qualitative or quantitative value of the risk associated with an investment should things not go to plan.

Figure [4.10]: Benefits classified into benefit types, and definitions.

4.5.1 Societal benefits

Social value is inherently about outcomes and should have a measurable impact on reducing inequalities and improving the wellbeing of individuals.

Societal benefits include outcomes such as employment, job creation, apprenticeships and young people taking work-experience, life-long learning opportunities for employees, programmes of engagement with schools, colleges, universities, local residents, community groups and local charities. These can be hard to quantify and quantification relies on statistics from external sources.

The characteristics identified that would bring about societal benefits are listed below.

Characteristic(s)	Access to therapeutic activities for inpatient service users, in shared therapy space in new building.

Description of benefit it could bring	Earlier access to treatment which will lead to quicker recovery, improved wellbeing and reduced reliance of high acuity support. Service users will be re-introduced into the local community sooner to participate in community, contribute to the economy and build personal social networks. This will provide social benefits from more economically active people. Overall, the number of service users successfully treated may increase over a defined period of time.
Quantification and evidence	QALYs – quality adjusted life years are often used to measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a service user following a treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the person's ability to carry out the activities of daily life, and freedom from pain and mental disturbance.
Measurement	Trust to quantify the impact on the number of service users treated over a period of time. Then it will be possible to allocate a change in total QALYs and associated gains to society in £s. i.e. number of days of relief from depression + speed of returning to work

Characteristic(s)	Construction and local infrastructure spending.
Description of benefit it could bring	Economic improvement to Camberwell with increased spending in the Lambeth Borough. The procurement method for the construction works should include requirements for contractors to achieve targets with regards to the local economy to maximise the development benefit realised locally.
Quantification and evidence	In 2010, benefits to local economy from construction were £2.84 for every £1 spent according to research by CBI. Where the construction value is known, the benefits could be estimated using this ratio. Consideration of the reduction in local economy benefits at the existing sites from the move to the new inpatient unit.
Measurement	Total construction spend

Other relevant references

Government savings:

- Effective mental health treatment can also generate other large savings to the government, for example by increasing employment. As one example, The Centre for Economic Performance reports that the Improving Access to Psychological Therapies programme has almost certainly paid for itself through reduced disability benefits and extra tax receipts.

- From a policy point of view the important figure is the cost of mental illness to the Exchequer. If we focus on non-employment, this costs the Exchequer £8 billion in benefits for the 1.3 million people on incapacity benefits. And the total non-NHS cost of adult mental illness to the Exchequer may be around £28 billion[14].
- The wider costs of mental illness – taking all these phenomena into account, the Centre for Mental Health estimates that mental illness reduces GDP by 4.1% or £52 billion a year.

Mental illness within the working population:

- Mental Illness is by far the most important illness for people of working age – from an economic point of view, it is particularly interesting to focus on morbidity among people of working age, since this has such an impact on the economy and thus on the public finances. Morbidity from physical illness rises steadily throughout life, whereas mental illness especially affects people aged 15-44. Taking together all ages up to 65, mental illness accounts for nearly as much morbidity as all physical illnesses put together. It is by far the most important illness for people of working age.

Reintroduction to the economy:

- Reintroduction to community sooner could add benefits to the local economy. The HACT value calculator indicates that the value of 1 person moving from unemployed to full time employment is £14,380, part time employment is £1,966. Regular attendance at a voluntary or local organisation is £1,064. The same calculator indicated that relief from depression/anxiety (adult) is equivalent to £35,563.
- These HACT figures are prepared specifically for housing associations to measure the social impact of community investment and valuing wellbeing. Whilst they are not designed to advise on the impact of healthcare interventions, they do give an indication of the value that can be realised from qualitative societal benefits such as introducing an individual back into work and the community.
- To robustly use the HACT values, we would need to gather the statistics on numbers of individuals moving from unemployment to full time/part time employment.

4.5.2 Qualitative benefits

Generally qualitative benefits include improved clinical quality of care. Some benefits can be directly attributable to the redevelopment, such as improvements in service user privacy and dignity. In other instances, there may be evidence that the redevelopment will contribute, but not be fully responsible for, the outcome – such as reductions length of stay. The characteristics identified that would bring about qualitative benefits are listed below:

- Improved internal environmental quality (IEQ) for service users and staff;
- Safer service users, carers, visitors and staff;
- Provision of useful space – ensuite facilities and communal spaces;
- Standard design and fit-out;
- External appearance – aesthetically pleasing and supports the de-stigmatisation of mental health;
- Close to the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) – sharing knowledge between staff; potential partnerships between wards; and

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[14] http://www.centreformentalhealth.org.uk/pdfs/mental_health_at_work.pdf **Centre for Mental Health, 2007**, *p.2.*

- Governance and staff development.

Characteristic(s)	• Improved internal environmental quality (IEQ) for service users and staff. • Safer for service users and staff. • Provision of useful, fit for purpose spaces.
Description of benefit it could bring	Current accommodation is not fit for purpose and not in line with modern standards. The new facility will meet privacy and dignity requirements and provide modern & fit for purpose accommodation. Ensuring the ward environments are fit for purpose will positively impact on safety, privacy and dignity. New spaces will provide an improvement on the current poor estate and safely respond to service user needs, of which benefits include; improved indoor air quality, temperature, light and visual comfort, and open space with natural light and good ventilation. The current layout of the wards are inefficient. The optimum layout of the new wards will promote safety through good de-escalation pathways, variety of activity zones, increased socialising, managed escape routes, improved one to one spaces, high specification rooms and single bedrooms with ensuite facilities for all service users. It also allows us to meet modern guidelines for staff to be able to monitor and observe service users by improved visibility and 'line of sight', and to support appropriate levels of staff cover. Modern design for safety – secure ligature/wristbands rather than locks and keys which improve the service user experience. Furthermore, there is no danger of ligatures in the new wards. As part of the broader estate strategy, Psychiatric Intensive Care Units are being consolidated on to one site, Eating disorders (specialist service) is moving from Bethlem, and Neuro psychology, Psychiatry, Geriatric, Physical exercise, International thinking (research centre) and Cardiac units are being consolidated onto the main site. This allows cross fertilisation and support in clinical delivery, as well as reducing travel times. This is especially important in Mental Health, where service users are particularly vulnerable, and thereby requiring closer supervision by clinicians.
Quantification and evidence	**Independent Healthcare Provider (IHP)** – to provide research from the previous project (St Anne's) where simply having a 'new' well designed space saw improvements in the service – the clinicians are spending more time giving service users therapy rather than dealing with operational tasks. This resulted in increased focus time with service users. One study[15] shows that design features such as more 'total private space per service user', a higher 'level of comfort' and greater 'visibility on the ward', decreased the risk of being secluded. The findings suggest that the physical environment of the ward had a significant effect on the risk of being secluded during admission, even after service user, staff and general ward characteristics were taken into account. This emphasises the

[15] McCuskey Shepley et al. 2017

	importance of reassurance, identity, privacy and normality, when designing wards for intensive psychiatric care. The study also asked staff to evaluate the effectiveness and importance of environmental features in mental and behavioural health environments. Respondents typically supported private rooms, open nurse stations, and the presence of positive distraction as effective in these environments.
Measurement	De-escalation incidents – current vs. projected Seclusion incidents – current vs. projected Service user surveys – dignity and privacy Staff surveys – satisfaction High dependency service user waiting times – linked to clinical outcomes so there could be a measurable health benefit Change in SLaM PLACE scores – service user-led assessments of the care environment

Other relevant references

One study[16] shows that in UK adult acute inpatient psychiatric wards the estimated mean annual cost for conflict is £145,177, and for containment £212,316. The total estimated annual costs in England for all conflict is £72.5 million and for containment is £106 million. The most expensive conflict behaviour to manage was verbal abuse with a mean cost per ward of £21.2k and a total of £10.5 million nationally. Self-harm had a mean cost of £8.2k per ward and £4 million nationally in England. Intermittent and special observation cost £45 million and £35 million respectively (see Table 1). This study also suggests that approximately half of all nursing resources are expended in managing conflict and deploying containment. (Flood, C. at all 2008)

Where we can demonstrate that good design leads to a reduction in the number of conflict instances and containment, these could be quantified with an average cost saving.

- Gabor et al. found that total sleep time was 9.5 hours in single rooms vs 8.2 hours in multi-bed bays, despite a similar number of disturbances. The noise level was 43 dB vs 51 dB.
- Improved quality of sleep is associated with faster recovery rates, reduced stress and anxiety and reduced physiological changes such as elevated heart rate and blood pressure.

Clinician Rated Outcome Measures (CROM) and experience measures (PREM) are now being routinely used across health services. The Warwick and Edinburgh Wellbeing Scale and a range of social adjustment scales can provide useful ways of assessing impact which is not related to financial proxies.

4.5.3 Non-cash releasing

The characteristics identified as giving rise to non-cash releasing benefits included:

[16] https://www.researchgate.net/publication/23447119_Estimating_the_Costs_of_Conflict_and_Containment_On_Adult_Acute_Inpatient_Psychiatric_Wards

https://www.ncbi.nlm.nih.gov/pubmed/18979699

Service Location	Services located close to acute Trust. Variety of related services co-located.
Robust construction	A building that is fit for purpose (staff focused).
Environment	Modern & Safe.

Measurement

Characteristic(s)	• Services close to Acute Trust
Description of benefit it could bring	There may also be the ability to widen remit of service users coming in; develop relationships between wards e.g. doctors transferring to different wards instead of service users. This may also support staff retention and reduce turnover. However, this is part of a wider compound effect of other characteristics such as a modern and safe environment that is fit for purpose. It will also ensure that our emergency teams are more robust, and allows services to be interdependent of one another. For example, the number of service user blue light transfers from Lambeth hospital for medical attention over the last 2 years was 18.
Quantification and evidence	A reduced number of escorts and transports – small time savings. Reduce the number of staff away from the ward – time saving. Time saving to London Ambulance Service (LAS) in emergencies – shorter travel time to A&E, therefore, saving ambulance time and providing small benefit to the LAS. The total cost per ambulance call for face to face attendance in London is £272 One hour of ambulance time is estimated to be £100, therefore, saving 20 minutes of ambulance travel time per call out could equate to £33 worth of freed resources to LAS.
Measurement	Change in time taken for escorts and transports. Number of escorts & transports – will there be a change in these numbers from current to projected or will these stay consistent? Staff turnover – current vs. projected. Staff satisfaction surveys. Overall staff expenditure vs. planned expenditure.
Characteristic(s)	• Modern and safe environment • A building that is fit for purpose (staff focused)
Description of benefit it could bring	The current wards have been identified as not fit for purpose and this can lead to staff being unhappy due to the environment they provide care in. The benefit of a new functional space to staff wellbeing and happiness will

	also feed through into service user care, as ward staff are better able to support one another. Staff retention may be improved and reduced turnover realised through a better designed environment. Staffing would also be easier to manage as there would be a pool of 15/16 wards. There will be a reduction on the dependency on bank/agency staff too, which plays a critical role in financial savings. The new scheme will have single sided corridors, maximising the potential visual connections across the floor plate and creating a better place to work for the staff. Lambeth Hospital was built in the 1990s and, therefore, does not meet current DH guidelines for mental health accommodation. Much staff resource is allocated to mitigating environmental and operational risk instead of providing care to service users. The new space will be designed for the service requirements and see benefits in operational efficiencies. There are current limitations to staff and service users with regards to car parks and general site capacity.
Quantification and evidence	Evidence suggests that an improved working environment improves employee satisfaction. Improved satisfaction and engagement leads to better organisational performance, including reduced turnover and sickness absence, higher productivity and patient/customer satisfaction, and improved service user outcomes (MacLeod, D. and Clarke, N., 2012). By improving sickness absence by just 1%, the NHS will recuperate £280m in staff costs. In 2016/17, Trust staff turnover has been proportionally highest across the Trust in the medical staffing group at 23.10% followed by psychology/psychotherapy professional group at 22.69%% in 2017/18. The sickness absence level for 2016/17 was 5.00% which has slightly decreased from 5.04% in the previous year. In other sectors and industries, it can cost up to £30,000 to replace one employee. This includes the time to recruit and get new joiners up to a productive level of output.
Measurement	Improved staff retention could be quantified through savings from staff turnover costs. Trust to estimate the reduction in turnover and the cost average cost of turnover per position if known. Overall staff expenditure vs. planned expenditure. Measure staff absence. Survey staff satisfaction and engagement – specifically related to the working environment.

4.5.4 Cash releasing

The benefits identified as cash releasing include:

Operational Cost Savings	Reduction in carbon emissions. Hard FM Efficiencies.

Construction & Build Ability	Standard and repeated ward layouts across the floors reducing costs and fees associated with design.
Robust Infrastructure	Better utilisation of technology and the implementation of MRI at Denmark Hill.

Measurement

Operational Energy costs of Current vs New Space	ERIC (Estates Return Information Collection) for existing services (GJ/100m^3/annum); Metering and monitoring of new building
Hard FM – Current vs Planned project costs	Current inpatient unit hard FM cost per head; current Lambeth Hard FM cost per head.
The Design Team	Time saving on design and construction efficiencies; IHP calculated the savings from standardised design on another project. They were able to estimate the % of construction cost saved (e.g.1%) and could do the same on the inpatient unit.
The Design Team	Potential to do a risk adjusted backlog maintenance calculation saving.
DEC	Display Energy Certificate Rating – current vs planned.

4.5.5 Service user Choice and Accessibility

Inpatient services are organised by Borough and are geographically located close to or within the Borough served. Service users and their carers' choice is always respected and considered. The organisation as a whole has the ability to adopt service user and care choice as to the location of an admission through admitting service users onto other Borough wards if this is preferred and there is availability to do so.

Initiatives are in place to reduce bed occupancy rates which should shorten waiting times for an admission and increase access to services. In addition, we have reorganised all services to be Borough based and managed which will improve initial local access to services and make the transition between service smoother and more seamless.

Regarding service user accessibility, the purpose designed wards in the new inpatient unit will improve accessibility for those service users in wheelchairs and for those with mobility problems. The new ward designs will comply with the latest building regulations for disability access and there are larger rooms on each ward to provide enough space for staff to provide care and support for those requiring mobility assistance.

The current ward layouts at Lambeth are not conducive to wheelchair users or those with mobility problems.

4.5.6 Service Quality

Delivering services from a new, purpose-built environment will deliver direct benefits to the quality of care. There is evidence showing that there is a relationship between the quality of the physical environment and mental health clinical outcomes[17]. Environmental features which have been shown to produce positive mental health outcomes include corridors with a homely feel, significant natural light, access to outdoors and single rooms with en-suite facilities. Current facilities do not provide all of these features. Additionally, this scheme presents an opportunity to tailor the environment to the specific needs of each service, producing associated improvements in quality and clinical outcomes.

A recent case on improved outcomes and speed of recovery from reconfigured mental health services is evident in Sheffield Health and Social Care NHS Foundation Trust.

We have identified several themes such as reducing length of stay, development of crisis care and establishing effective bed management within their care pathway and improvement of facilities. One theme in specifically was to develop a purpose built, 10 bedded Psychiatric Intensive Care Unit. The aim of the new unit (Endcliffe Ward) is to accommodate service users and to avoid out of area admissions and treatments. In addition, the new layout provides an open, therapeutic and a safe space environment for service users. The redevelopment further comprised of improved facilities for staff including separate staff rooms away from the ward, shower rooms and individual alarm systems to be able to request immediate assistance from anywhere on the unit. For their design, the unit won the prestigious 'Refurbishment Project of the Year', Design in Mental Health Awards' in January 2016.

Prior to the redevelopment a CQC report, in 2015, found that the care environment was found to be 'unsafe' as not all parts of the ward could be observed which meant patient safety could not be ensured at all times. The current design also meant that the large nursing office in the centre of the ward was accessible from each male and female corridor but did not enable staff to observe patients in all parts of the ward. As a result, the report concluded the environment 'required improvement'. Following successful completion, the impact of the re-design substantially reduced length of stay from 56 to 31 days and greatly improved pathway management. This is largely due to effective daily bed management. Service users and staff both agreed that the redevelopment was easy to maintain, offered more open spaces for the community and promoted environmental and sustainable solutions. Moreover, the post completion CQC inspection report in 2017 rated the re-designed ward as 'Good', potentially striving towards the services being 'Outstanding'[18].

[17] Standards for Inpatient Mental Health Services, P.18, 2nd Edition, 2017,

[18] http://positivepracticemhdirectory.org/adults/transforming-acute-mental-health-care-sheffield/.

Chapter 5. Governance

This section documents the governance structure that has been put in place to ensure the consultation process is robust, accommodates relevant stakeholder views and determines who is responsible for making decisions and approvals.

5.1 Governance Structure

The Programme Board has agreed the following governance and resource structure for this programme of work, see figure [5.1]. The Programme Board will, under the instruction of the Chair and SRO, prepare updates and assurance reviews for the Finance and Performance Committee and Trust Board quarterly as activities move forward.

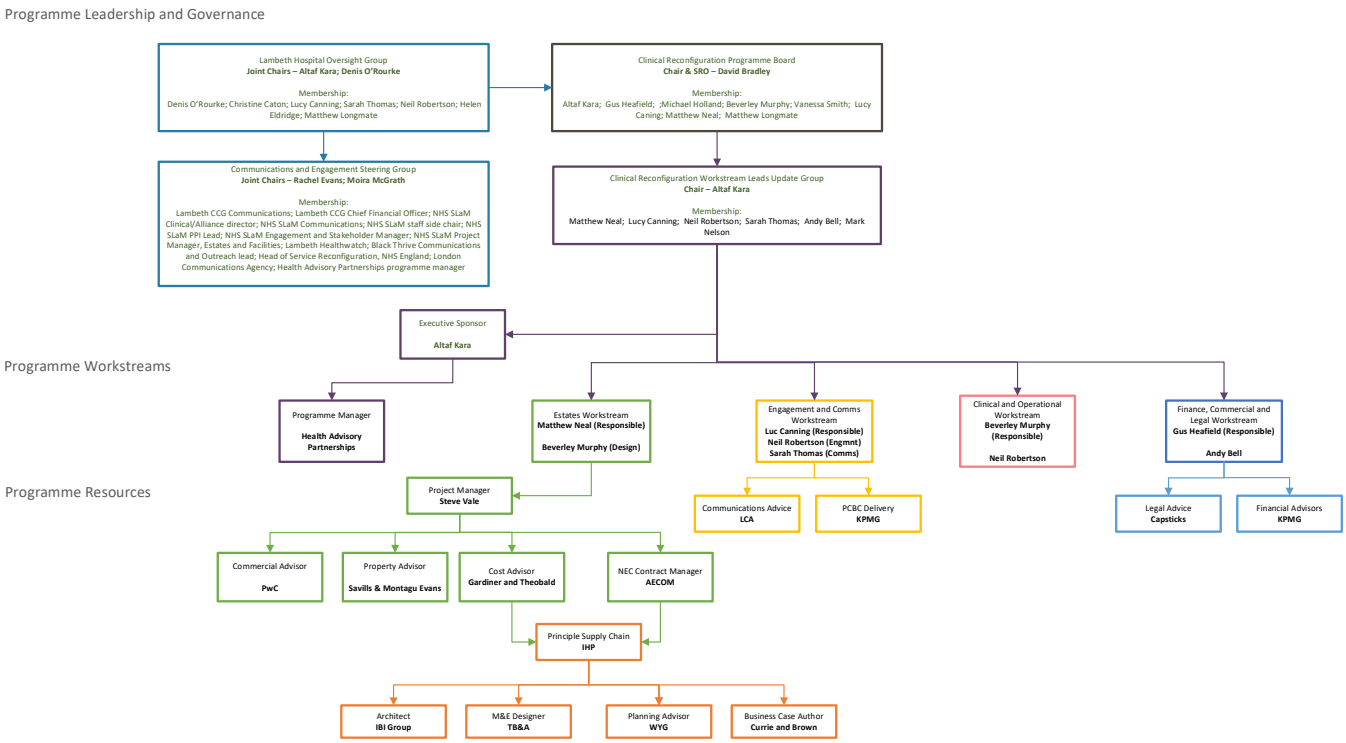


Figure [5.1]: Governance Structure

The key elements of the programme governance structure include:

- a clear governance and delivery structure from operational workstreams to the Trust Board;
- the structured relationship between programme management and delivery;
- the interface between the Programme Board and its assurance mechanism; and
- the interface between the Trust Board and its assurance mechanism.

The day to day development of the case is delivered by a series of project workstreams within which the membership will vary in line with the specific needs of the workstream and the phase of the business case.

Estates

The Estates workstream will review the proposals for estates issues and advice and to provide solutions. This will further include a working relationship with the principal supply chain lead and procurement. Procurement should advise on best practice for contracts and equipping new schemes.

Engagement & Communications

The Engagement & Communications workstream will set out the communication strategy to deliver and monitor the plan.

Clinical & Operational

The Clinical & Operational workstream will review the clinical implications of the design proposals.

Finance, Commercial & Legal

The Finance, Commercial & Legal team will monitor the development expenditure and advice on elements such as cash flow, VAT and compliance with finance requirements.

5.2 Role and responsibilities

The consultation phase of the service change and re-provision of community services in Lambeth is being overseen by the Programme Board and supported by the Workstream Leads Update Group (WLUG). The Programme Board will, under the instruction of the Chair and SRO, prepare quarterly updates and assurance reviews for the Finance and Performance Committee and Trust Board as activities move forward.

The consultation phase of this redevelopment is being led by the Chief Executive Officer, who also oversees the strategic output, and builds the environment and commercial output streams of the project. The document has been developed with Lambeth CCG and the Lambeth Alliance in addition to providing assurances to NHS England and NHS Improvement. NHSE&I representatives also have positions within a number of the groups relevant to the redevelopment to ensure adherence to rigorous NHSE guidelines for consultation.

In order to proceed to public consultation, the process requires approval from all the CCG Governing Bodies. To support this decision, the CCG Governing Bodies will review the proposed consultation document, consultation methodology (including the Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) and financial modelling). Following approval by all the CCG Governing bodies, Lambeth and Joint Health Overview and Scrutiny Committees (JHOSC) will also be provided an opportunity to review and approve the consultation prior to launch.

5.3 Use of external advisors

Special advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance.

The external advisors have been contracted to provide the services outlined below:

- Legal Advisor.
- Programme Manager.
- Project Manager.
- Management Consultancy.
- Accountancy Consultancy.
- Communications Consultancy.

- Property Advisor.

5.4 Information Governance Issues

South London and Maudsley NHS Foundation Trust is committed to providing world-class and efficient mental health and substance misuse services in a new landscape. It is of paramount importance to ensure that clinical and corporate information is effectively managed whilst utilised to their maximum potential to benefit service users and the public. The effective management of information requires appropriate policies, procedures, management accountability and structures to provide a robust governance framework.

We support the principles of Corporate Governance and recognises its public accountability, but equally places importance on confidentiality of personal data, commercially sensitive information and the security arrangements to safeguard sensitive information.

We store data about its patients that could identify each patient. This Patient Identifiable Data (PID) can be classed as any information, electronic or paper format that would allow a third party to identify the patient.

As a part of the proposed relocation, we are not proposing to change the use, storage or accessibility of any PID it holds. A Privacy Impact Assessment (PIA) screening questions form was completed by the Trust, seen in Appendix [2] whereby the result indicated that a PIA was not required.

The principal reasons include:

1. Trust staff will continue to access data in line the Trust's Information Governance Policy and current operational processes.

2. The Trust patient medical records are electronic so the relocation will not lead to any change in the accessing of patient records.

Should there be any changes to information privacy as a part of this proposal in the future, we will recomplete the PIA screening questions form to determine whether a PIA is needed. The Trust's Chief Information Officer will be consulted closer to the relocation period to discuss shredding bins, privacy displays, and photocopier/scanner/medical device locations.

Chapter 6. Stakeholder Engagement

This section sets out the engagement undertaken to date, how this has informed the consultation proposed and how the consultation will be run.

6.1 Legal Context

Under section 242 and section 14Z2 of the NHS Act 2006, NHS Trusts and CCGs have a legal duty to make arrangements to involve individuals to whom the services are being or may be provided. Individual involvement includes participation in consultation, information sharing, or in other ways, such as:

- planning of the provision of those services;
- developing and considering proposals for changes to the way services are provided; and
- influencing decisions which affect operation of those services.

In order to meet these legislative requirements and the 'four tests' outlined in the mandate from the Secretary of State to NHS England, public involvement must be an integral part of the service change process. Engagement should be early and on-going throughout the process using a broad range of engagement activities.

The Clinical Commissioning Group must make arrangements to ensure that individuals whom the services are being provided for are involved (either by being consulted or provided with information in various ways):

- in the planning of the commissioning arrangements by the group;
- in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and
- in decisions made by the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Due to the substantial nature of the proposed changes in the PCBC there is also a separate duty for the relevant CCG to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 made under s.244 NHS Act 2006. Lambeth CCG has engaged with Lambeth Local Authority Health Oversight and Scrutiny Committee (Lambeth HOSC) to review the terms of this process.

All public consultations should adhere to the Gunning Principles, which are:

- consultation must take place when the proposal is still at a formative stage;
- sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
- adequate time must be given for consideration and response; and
- the product of consultation must be conscientiously taken in to account.

6.2 Pre-Consultation Engagement on the Case for Change

To help design and steer our engagement work, we have formed a Lambeth Communications and Engagement Steering Group, which includes senior representatives from the Trust and the

Lambeth CCG as well as Lambeth Healthwatch and Black Thrive. Since its first meeting in June the Steering Group has overseen engagement work for this programme.

Appendices [11 & 12] set out how stakeholders were engaged with and continue to contribute to the development and implementation of the proposals.

6.2.1 Overview of pre-consultation engagement overseen by the Communications and Engagement Steering Group

The following table sets out the timeline of the stakeholder engagement activity for the Pre-consultation Business Case, for review and feedback from the Communications and Steering Group.

Date	Activity
w/c 20 May 2019	• Staff team briefings and ward visits ahead of Trust Board on 21 May. • Stakeholder letters ahead of Trust Board on 21 May, offering meetings. • Joint staff side meeting to discuss proposals
w/c 17 June 2019	• Preparation for Communications and Engagement Steering Group. • Developing the content for the staff/stakeholder pre-consultation workshops and meetings.
w/c 24 June 2019	• First meeting of Communications and Engagement Steering Group to discuss pre-consultation approach. • Sending out further information to staff and inviting them to attend workshops in July. • Organising workshops with other stakeholders including service users, their families and carers.
w/c 1 July – w/c 15 July 2019	• Service User and Carer Advisory Group (SUAG) stakeholder workshops. • Staff engagement workshops.
w/c 22 July 2019	• Governors workshop to consider proposals • Workshop with senior clinicians and operational leads to review key findings from staff/stakeholder workshop discussions and agree content for PCBC. • Second meeting of Communications and Engagement Steering Group.
24 July 2019 25 July 2019 31 July 2019	• Lambeth Service User Advisory Group engagement meeting • Further Lambeth ward team visits (Luther King and Nelson ward) • Discussion meeting held open to all Lambeth staff (not limited to clinical) • Second meeting of Communications and Engagement Steering Group
29 August 2019	• Third meeting of Communications and Engagement Steering Group
12 September 2019 18 September 2019	• Presentation on proposals at Lambeth Collaborative Breakfast • Meetings with Lambeth Councillors - Chair of Health and Wellbeing Board and Cabinet Member for Health.

	• Meeting with Paul Bates, Director of Communications, Lambeth Council • Primary care localities (SW, SE and North Lambeth) presentation and discussion (three meetings during September)
26 September 2019	• Fourth meeting of Communications and Engagement Steering Group.
11 October 2019 16 October 2019	• Lambeth OSC briefing and discussion with Chair and members • NHS Lambeth CCG board meeting
11 November 2019 19 November 2019 20 November 2019	• Further meetings with staff groups (Rosa Parks ward, Tony Hillis Unit) • Presentation to Clinical Senate • Engagement with Lambeth Leadership team meeting to discuss proposals
27 November 2019	• Lambeth Committees in Common meeting
28 November 2019	• Lambeth Healthwatch-led discussion on about proposals with carers
December 2019	• Lambeth Healthwatch begins engagement with service users and staff – tailored face to face engagement. Detailed report being prepared by Healthwatch to inform consultation.
13 December 2019 16 December 2019 19 December 2019	• Meeting with Lead Governor to further discuss proposals • Lambeth Executive Team engagement • Further SUCAG engagement meeting
14 January 2020	• David Bradley, Chief Executive SLaM review of proposals and discussion with David Quirke-Thornton, Strategic Director for Children and Adults Southwark Council

Figure [6.1]: Timeline of engagement activity

6.2.2 Pre-consultation engagement with service users and carers

We met with the Lambeth and Southwark Service User and Carer Advisory Groups (SUAGs) in July 2019 to outline the proposals and hear the feedback from existing and former service users and carers who are part of the SUAGs.

This included meetings with service users, their families and carers most affected by any proposed change**,** gathering views on what people view as the key benefits and challenges/potential negative impacts with the proposed options.

Further meetings are planned to continue discussions around the development of the proposals.

6.2.3 Pre-consultation engagement with employees

On 21 May 2019, a paper went to the Trust Board meeting to ask for the Board members' approvals to start engaging with staff, patients and all other relevant stakeholders on proposed service changes to the Lambeth Hospital.

Prior to the Public Board meeting in May, a number of activities were carried out to begin a pre-engagement phase:

a) Initial face-to-face briefings were held with affected staff at Lambeth Hospital, led by local managers at staff meetings.

Due to the potential workforce implications, we undertook initial discussions with those staff teams who may be impacted by the proposals. This included meetings with local managers and Directorate leaders, on site community teams, social care teams and onsite voluntary services. More meetings with staff about the proposals are planned for Autumn 2019 and engagement with this stakeholder group will be ongoing.

Separately, a discussion about the proposals took place at the Council of Governors Strategy and Planning Sub Committee - the Lambeth Clinical Director and the Director of Nursing attended on 18 July 2019 to brief members and listen to their feedback.

b) Letters were also issued to key external to make them aware of the paper and its contents and to offer a meeting.

Appendix [10] provides a full list of meetings conducted and pre-consultation engagement activities undertaken to date.

6.2.4 Building design engagement

In addition to workshops about the service change proposals, engagement has also taken place with clinicians, other staff and service users in the design of the new building at the Maudsley Hospital over a number of years.

The original proposal was to refurbish the inpatient unit rather than develop a new building. These plans were granted planning permission by Southwark Council in April 2016.

We conducted a further review of the proposals and decided to fully redevelop the building in December 2016.

In May 2017, the Trust and IBI architects worked closely with Southwark Council on the initial plans for a new building on the site. In order to shape the design proposals, IBI architects have held a series of engagement workshops with clinicians, the Trust estates team and service users to develop a preferred design which would accommodate eight wards. The architects have also taken inspiration from other successful mental health developments.

Since submitting a planning application in early 2019, further design changes have been made following feedback from design and conservation officers at the Council. Some elements of the design have been resubmitted as a result. The Planning Committee at Southwark Council will make a decision on the design in due course.

The workshops, which included presentations and discussions, were led by senior clinical staff from the Trust. In March and April 2019, a series of 6 group workshops were held with clinicians, other staff and service users in order to get feedback on what is important in a mental health inpatient environment. This included:

- the requirement for the wards to have private, ensuite bedrooms to meet current needs and viability, and ensure privacy and dignity;
- the need to have single side corridors, where possible, with good bedroom observation;
- the importance of natural light and open spaces;
- the need for a tribunal suite and administrative offices;

- the importance of having the neuropsychiatry ward on the ground floor, for easy access; and

- the shape of the building and the shift from the H shaped existing building, to more of a bow-shape, with two internal courtyards. Service users highlighted the need to achieve a place at the heart of the ward where service users could approach staff, sit next to them on a sofa or define a treatment plan with them at a desk space, but at the same time give staff a private/retreat space. This has been done on each level of the building design.

We is proposing to hold further engagement sessions with staff and service users in early 2020 to focus on the detail of the internal spaces and interior design of the new building proposed for Windsor Walk.

There has also been public engagement around the planning in the form of public exhibitions. We met with neighbours and listened to comments from people who attended the public exhibitions, resulting in changes to the design plans.

As part of the planning process, comments and input from the conservation architects at the Council has contributed to an improved look and feel of the building that complements the local Conservation Area. These changes to the design have been captured both internally and externally and re-submitted to the local planning authority. The new facility proposed for the Maudsley Hospital site received a resolution to grant planning permission by Southwark Council, in November 2019, subject to legal agreements.

6.2.5 Pre-consultation engagement with GPs

Our work as part of the Lambeth Living Well Network Alliance has allowed us to communicate with a wide array of stakeholders across South London.

An example of this is the Lambeth Living Well Collaborative Breakfast on 12 September 2019. During this event, GP's were engaged in the pre-consultation business case. Presentations circulated in advance to a membership list of approximately 100 stakeholders, including Commissioners, GPs, Social Care, SLaM, VCS, Service users and carers. Our presentation was shared in advance with the full list of possible attendees and feedback and comments were gathered from the event about the proposed plans, staffing and process. There will be broader clinical engagement as part of the next phase of work including the Primary Care Network of Clinical Directors.

6.2.6 Pre-consultation engagement with Lambeth Overview and Scrutiny Committee (OSC)

We have engaged with Lambeth OSC and discussions have been held with OSC Chair and Vice Chair. No specific concerns were raised. Lambeth OSC will be kept up to date as the PCBC develops.

Given that the proposals for change include the movement of clinical services from the Borough of Lambeth to the Borough of Southwark, engagement is being undertaken with Southwark stakeholders including the OSC as well as officers at Southwark Local Authority. A joint Lambeth and Southwark OSC has been established.

6.2.7 Pre-consultation engagement with local people

We have shared our proposals with local people by setting out the context and early details of the proposed changes and requesting meetings with external stakeholders at an early stage to seek their views on the proposals, the plans for engagement and how best to involve local people and, where relevant, the appropriate committee / Board / organisation.

Letters were sent on the week of 24th June 2019 to the following:

- Chair of Lambeth Council's Overview and Scrutiny Committee;
- Chair of Lambeth Council's Health and Wellbeing Board;
- Lambeth Council's Cabinet Member for Health and Adult Social Care;
- Larkhall Ward Councillors;
- Chair Healthwatch Lambeth; and
- Chief Executive Healthwatch Lambeth.

Follow up meetings are being arranged with each stakeholder. A meeting with Cllr Ed Davie, Cabinet Member for Health and Adult Social Care and Councillor Jim Dickson, Chair Health and Wellbeing Board took place on 18 September 2019.

Letters have also been sent to local MPs in Lambeth and Southwark to inform them and offer an early meeting.

6.2.8 Pre-consultation engagement with other local stakeholders

Together with the CCG, we have established a Communications and Engagement Steering Group to oversee and input into the proposed approach to pre-consultation engagement for the proposed changes to mental health services at Lambeth Hospital, and work together to design the full public consultation. The group will ensure a consistent approach and deliver timely and effective engagement activity that will involve all our staff and key stakeholders.

The Group is jointly chaired by Liz Clegg, Interim Director, Integrated Commissioning, Adults Lambeth CCG and Lambeth Council and Lucy Canning, Associate Director of Strategy South London and Maudsley NHS Foundation Trust (SLaM). The following organisations have been invited to take part:

- Lambeth CCG Communications Lead;
- NHS SLaM Clinical/Alliance Director, Communications Lead, Staff Side Chair, PPI Lead, Engagement and Stakeholder Lead, Estates and Facilities Project Manager;
- Lambeth Healthwatch;
- Black Thrive Communications and Outreach lead;
- London Communications Agency; and
- Considered Analytics programme manager.

Terms of Reference have been drafted and agreed and the Group has already met monthly between June and January 2020 with further meetings planned. Agreed actions and detailed minutes are taken. To help achieve the objectives set out above the Group has agreed to:

- Work together to design the staff, public and patient engagement in the programme;
- Act as an information exchange between members of the Group about the proposals and consultation;
- Agree the approach to engaging with external stakeholders including local Councillors and MPs;

- Review documents and plans prepared for the public consultation;
- Bring forward questions or concerns to discuss as a group and address;
- Discuss if engagement is working well and sufficient and how well we're responding to any concerns raised; and
- Review the findings of the engagement and consultation.

6.2.9 Results, feedback and analysis

A series of pre-consultation workshops have been held (dates below). These workshops have been based on a presentation and discussion led by senior clinical staff from the Trust. The presentation explained our clinical vision and case for change, and set out the two options under consideration. Attendees were asked to give their feedback on the pros and cons of the current environment, the benefits, challenges and mitigation around each of the options and what needed to be considered in order to implement the community model.

The workshops held to date comprise of:

- Lambeth Council Overview and Scrutiny Committee – 21 May, 5 attendees
- Council of Governors, Planning and Strategy Working Group meeting –18 July, 5 attendees
- Lambeth Hospital, Luther King ward staff workshop – 24 July, 5 attendees
- Lambeth Hospital, Nelson ward staff workshop – 24 July, 3 attendees
- Lambeth & Southwark Service User Advisory Group (SUAG) - 24 July, 10 attendees
- Lambeth Hospital staff workshop, 25 July, 15 attendees
- Clinical Lead workshop – 8th August, 5 attendees
- Lambeth Hospital Community Mental Health Team – September 2019

Feedback following the PCBC engagement activity will inform the content of the formal consultation and the consultation approach. Formal public consultation activity is expected to begin in February 2020.

Staff and service users' comments on the current environment are addressed below:

- Staff and service users alike agreed that the current condition of the wards were not fit for purpose;
- Staff and service users agreed that Option 2 was preferable than 'stay as we are' ('do nothing');
- Nelson Ward and Eden Ward in Oak House were mentioned by the SUAG members as substandard with poor ventilation and poor soundproofing that distressed service users can be heard through the corridors, shared and not enough bathrooms, long dark corridors, not enough natural light, nurses offices poorly positioned and far away rather than in a central hub; and
- The staff of Luther King Ward also raised issues such as lack of daylight, tight on space, no room for activities such as table tennis leaving service users bored, restrictive bedroom door locks which can only be operated by staff, shortage of clinic rooms and poor ventilation. The staff of Nelson Ward highlighted that it is not fit for purpose as the long corridor is not practical, the lack of toilets (three toilets between 18 people on the ward), security issues and blind spots, lack of fresh air and restrictive bedroom door locks which can only be operated by staff.

Staff and service users identified the benefits of the proposal:

- Governors said that they were reassured to hear that the number of inpatient beds for Lambeth would remain should the proposals be enacted.
- All workshop attendees agreed that the preferred option offered a high-quality inpatient environment – with its floor layout, outside spaces, ensuite bedrooms, single sex wards, rooms for staff, etc.
- All workshop attendees agreed that the new facilities will be better than the existing facilities for staff and service users.
- All voiced agreement of the need for wards with ensuite bathrooms, with Lambeth hospital staff adding that they would be easier to keep clean.
- Nelson Ward staff thought that the changes would help to reduce violence and aggression on the ward, especially if there are no long corridors.

Conversely, the following concerns were highlighted:

- Lambeth Hospital will lose its identity in the move to the new inpatient unit;
- The lack of green and outdoor space at the Maudsley site;
- Parking, as several members of the SUAG voiced how important it is for inpatients to be visited by family, some of whom have to drive;
- Several members of the SUAG group voiced concerns that this would lead to the NHS selling off more prime real estate and asked why the land could not be rented rather than sold;
- A governor was concerned that the new building on the Maudsley site should provide rooms that have adequate temperature control, following some concerns that the ORTUS building, although award-winning, is not always sufficiently cool during the Summer and that this would be a concern to service users and their families as well as staff working on the new wards; and
- Some concern from Governors that, if the total Lambeth site is sold off, there will be a loss of offices and community facilities.

To address concerns above, potential mitigations have been highlighted as:

- As part of the broader programme, the Lambeth Alliance is developing three Living Well Hubs now. Some of the current services will be moving into these community hubs giving Lambeth a new identity in the community;
- As the Maudsley campus has limited outside areas, the designs for the inpatient unit have a range of outdoor spaces planned comprising of internal courtyard gardens, balconies and a roof terrace; and
- The need to make the most of the existing car park at the Maudsley site.

6.2.10 Overview

Key findings included:

- The new proposals offer a high-spec acute environment;
- New facilities will be better than what they currently have for staff and patients;
- Security will improve thus reducing theft and improving safety;
- The proposed wards with ensuite bathrooms will be easier to keep clean;

- The changes will help to reduce violence and aggression on the ward, especially if there are no long corridors; and
- More open space will benefit staff on the wards.

Stakeholders identified that service users felt strongly that there needed to be a focus on consulting with current and ex-service users.

6.2.11 Community care delivery

Whilst not in scope of the PCBC or the proposed public consultation it was felt important to listed to other comments which focused on community care delivery from staff and service user groups included the following:

- Governors stressed that community staff will need to see the improvements in the proposals that apply to them if they are not going into purposely designed new buildings, as the staff working in the inpatients wards would do.
- Governors have been concerned for some time that current community facilities are not adequate – both for adults and CAMHS. It is not going to be easy to find new and suitable accommodation for all the services.
- Staff commented that they like the Alliance model and the more collaborative way of working but added that they need plenty of space “to be able to work well and make it work”, adding that we potentially needed to invest in “bigger or extra buildings”.
- Staff were pleased that the new Living Well Centres currently being created by the Alliance will be well-established by the time services will be moved from the hospital site into the community, so the model will have had time to bed in.
- Staff commented that we had to invest in the community to help the flow of service users out of inpatient wards.
- A request for the public consultation to be promoted more widely e.g. on-site posters so that more staff are aware when workshops are taking place.
- Staff have enquired why services at the Ladywell site could not be brought onto the Maudsley site. This was discussed at some length in the Governors and staff meetings, and it was explained that to bring Lewisham service users to the Maudsley site would be challenging for service users and their families, given the geographical distance is further than the Lambeth site.
- The Lead Governor has raised the issue of the need to properly accommodate those support staff / non-clinical staff who would be moved onto other sites. It has been asked whether office space would be found elsewhere in Lambeth.

6.3 Applying pre-consultation engagement findings to options appraisal

As part of the formal consultation process, the group of stakeholders who will be engaged will be widened to include commentators and influencers such as local media, ward councillors, NHS pressure groups and heritage bodies, as well as the wider local community, including residents and businesses. Furthermore, we are exploring with Healthwatch whether they will carry out some independent work to inform the process. We will use the EIA to identify any groups who may be affected but are considered hard to reach, to proactively ensure they have the opportunity to find out about and understand the proposals and provide feedback to the consultation. This may be in the form of focus group sessions. Stakeholder mapping has been completed to ensure all interested and relevant groups are captured.

The concerns raised through the pre-consultation engagement highlight the requirement for full and contextual information to be provided alongside the options when undertaking the formal consultation. Specific concerns raised will be incorporated into the consultation.

6.4 Consultation Plan

A Consultation Plan has been developed to support the design and implementation of a public consultation- see Appendix [15]. This plan is in the process of review and is subject to change.

6.4.1 Overview of the consultation plan

In line with statutory duties, the CCG is required to publicly consult on the redevelopment proposals, ensuring local people are given the opportunity to share their views on the proposed service changes at Lambeth Hospital.

6.4.2 Summary of planned activities

In light of these plans, we will run a public consultation for 12 weeks starting in March 2020. This is outlined in Appendix [4].

A consultation document, questionnaire and Frequently Asked Questions will be developed. The consultation will aim to understand the views of the local community on the relocation and development of the new site and its impact on mental health inpatient services.

As part of a public consultation, we will speak to as many people in the local community as possible, ensuring we hear from a wide range of service users of all of the services proposed for relocation, the local community, local voluntary organisations and local Healthwatch, as well as other key stakeholders such as local Councillors and MPs.

6.4.3 Consultation communications and engagement channels

The channels which will be used during the consultation to gather as many views as possible are set out in Figure [6.2].

Channels	Implementation assumptions
Websites/online media	A full consultation document containing a survey about the proposals is available on our website. Prompts placed on our social media channels will advise on how to leave feedback and join the public consultation meetings.
Paper copies	Copies of the full consultation is available at each service affected by the change, our sites and upon request. Posters and leaflets in our sites will advise on the consultation and opportunities for feedback. Paper copies of the survey will also be available at each site. All paper publications is in an easy to read format, with copies available in large print, easy read, community languages, braille and audio on request. There will be a dedicated telephone line for local people either requesting the consultation documents or to ask any questions they may have.
Public meetings	Held at easily accessible sites for people in Lambeth and Southwark to discuss and provide feedback on the consultation.

Channels	Implementation assumptions
	There are drop-in sessions with our clinicians.
Focus groups	Focus groups are commissioned to undertake targeted research with groups that face barriers to access services and do not traditionally have their views heard in service redevelopment.
Staff Engagement	Trust and CCG staff are updated on the consultation via staff meetings and staff newsletters. GP member practices will also receive regular updates in GP forums and GP newsletters via the CCG.
Targeted Interventions	Using the EIA to identify disadvantaged or vulnerable groups, we are supporting the CCG to consult with these groups. Further targeted engagement using the consultation survey with service users across all directorates.
Local networks	The consultation document and survey is shared with local groups for distribution amongst their members, including service user and Community Groups, our service user Groups, service user representatives, local voluntary and community sector groups.

Figure [6.2]: consultation communications and engagement channels

6.4.4 Consultation Timeline

To progress with the preferred option there are a number of phases of engagement that have put us in the best position of being able to carry out a public service change consultation led by Lambeth CCG.

A summary of key phases is listed below:

Phase	Time Frame	Description
1	Dec-18 to Mar-19	SLaM Trust Board Meeting; Meetings with Lambeth CCG, Lambeth Alliance and others.
2	Apr-19 to May-19	Meetings with staff and key stakeholders ahead of SLaM Trust public Board meeting.
3	Jun-19 to Sep-19	Pre-Consultation engagement on options relating to Lambeth Hospital, staff workshops and service user group meetings; meetings with key external stakeholders.
4	Oct-19 to Dec-19	Continued pre-consultation engagement.

Phase	Time Frame	Description
		Development of consultation document and questionnaire with Steering Group.
5	Jan-20	Amendments to consultation documents following assurance process. Review and sign off process of consultation documents.
6	Mar-20 to May-20	CCG launch 12 week Public Consultation.
7	May-20 to June-20	Consultation analysis. Recommendation to LWNA Leadership Team, Lambeth Together Strategic Board Recommendation of Lambeth Together Strategic Board to go to South East London CCG for decision (note: South East London CCG will replace NHS Lambeth CCG from 1st April 2020)

Figure [6.3]: Pre-consultation and consultation timeline

Chapter 7. Options Development, Analysis and Evaluation Process

This section documents the range of options identified, and the process for the generation of these options as well as their subsequent evaluation.

The local health organisations have developed a process for the identification of a preferred option from a long list of options. This includes:

1. An initial study of organisation wide estate options to identify the optimum sequence to progress the objectives of the clinical and estate strategies;
2. The development of feasibility studies and the application of a set of Critical Success Factors (CSF) to evaluate a short list of options for this specific proposal and detail the preferred option; and
3. A economic and impact assessment of the preferred option.

The outcome of this process is to enable the local health organisations, through the Programme Board, chaired by the Chief Executive Officer, to determine the preferred option for each area that will be subject to a full public consultation.

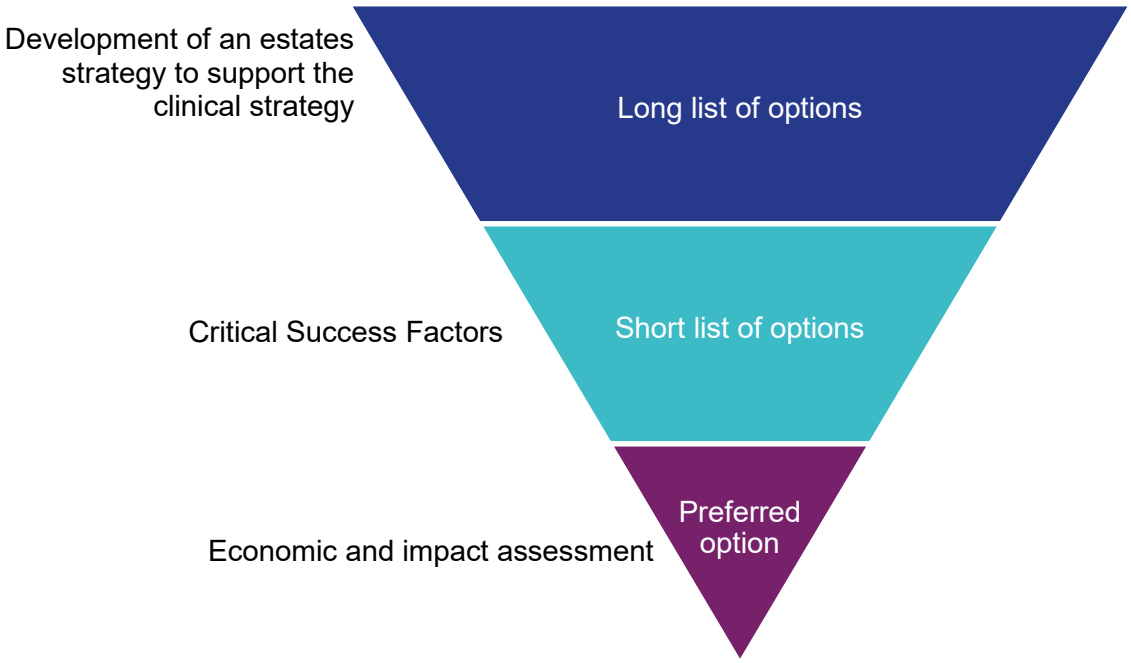


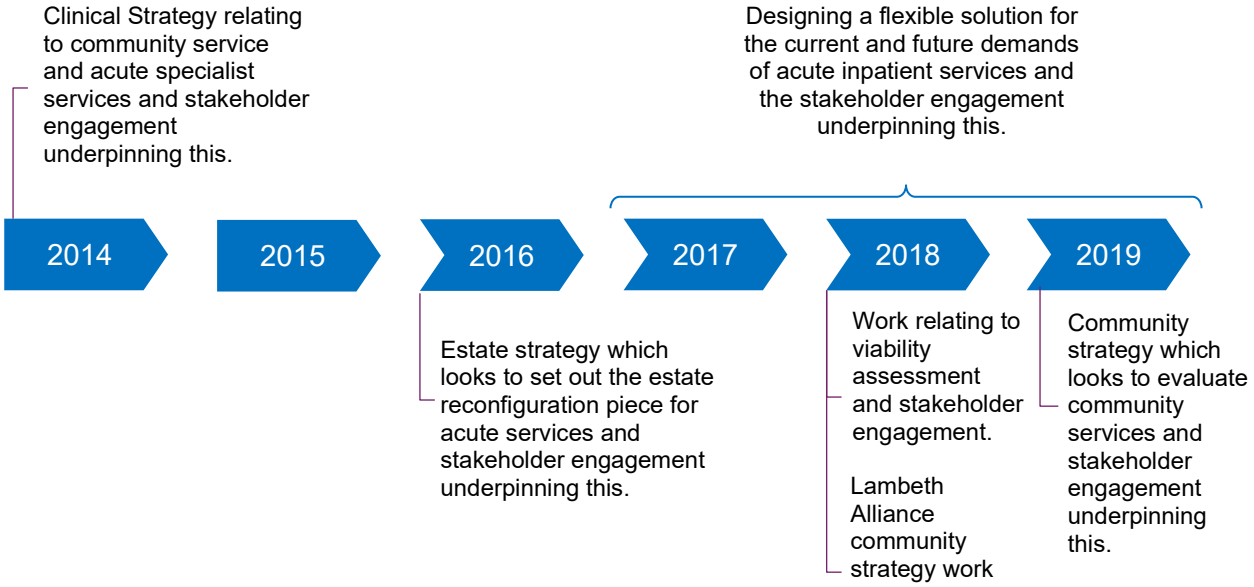
Figure [7.1]: Overview of options evaluation process

7.1 Long List of Options

In Chapter 4 of this document the case for change and the clinical model are described. These underpin the identification and evaluation of the estate-based options that can support the realisation of the clinical strategies and their benefits.

In looking to establish the most appropriate options to move forwards, a number of key issues relating to the various sites that the Trust owns and operates had to be assessed and an estate strategy was identified as the correct vehicle to undertake this analysis.

The timeline below shows how this estate strategy, developed in 2016, sits between the definition of clinical strategy in 2014 and the design and engagement process undertaken through 2017 onwards to come up with the detail of the preferred option being described here.



Given the significance of the planned expenditure and importance of the clinical reconfigurations to future of service delivery the first item that was evaluated was how the four main hospital sites would be utilised and developed over time.

This evaluation, whilst not a focus of this pre-consultation business case, has been described below to set the context of why Lambeth Hospital has been selected as the initial phase of a much greater estate transformation programme across all boroughs of SLaM services.

A range of options were considered looking at the consolidation from four hospital sites to a minimum of two hospital sites and how these might be achieved to provide the same number of beds in new accommodation staged over a number of phases. These options included:

1. **Maintain 4 sites ('Do Nothing')**
   This would include the retention of all existing main hospital sites and require multiple temporary decants, a significant and complex redevelopment model. This would be extremely expensive, time consuming and complex to coordinate.

2. **Consolidate to 3 sites (retaining Lambeth)**
   This included the retention of the Maudsley, Bethlem and Lambeth hospital sites with the re-provision of services from the Lewisham site onto the Maudsley Hospital Site permanently.

3. **Consolidate to 3 sites (retaining Lewisham)**
   This included the retention of the Maudsley, Bethlem and Lewisham hospital sites with the re-provision of services from the Lambeth site onto the Maudsley Hospital Site. This would also enable the redevelopment of the Lambeth Hospital Site to generate funds that can be reinvested in future phases of the estate redevelopment programme.

4. **Consolidate to 2 sites (retaining Maudsley and Bethlem only)**
   This included the retention of the Maudsley and Bethlem sites with the disposal of both

Lambeth and Lewisham hospital sites which would both be re-provided on the Maudsley site. The density of development required on the Maudsley and Bethlem sites to accommodate this made the option unrealistic.

Ultimately, through detailed engagement with the Local Authority and Clinical Commissioning Group stakeholders in Lambeth and Lewisham, it was recognised that the most practically and economically feasible model was to consolidate to three sites with the Lambeth inpatient facility being redeveloped on the Maudsley Hospital Site.

The South London and Maudsley Trust Board reviewed and agreed that the initial phase of the clinical reconfiguration programme and related estate strategy should focus on Lambeth at their Board meeting on 17th December 2018.

As such, the short list within this pre-consultation business case focusses specifically on the options for the re-provision of inpatient services for Lambeth service users to new facilities.

It is important to recognise that our intent is to undertake a managed and phased redevelopment of all of their inpatient facilities so that, in time, all service users have a comparable quality of facility. The ability to continue with future phases is supported by the ability to dispose of the Lambeth Hospital site and reinvest the funds received from that process in better quality estate.

7.2 The Short List of Options

7.2.1 A new inpatient facility

Having established that the short list of options should be those that focused on the re-provision of inpatient facilities sited at Lambeth Hospital, irrespective of which option was ultimately selected, a new facility would be required.

A great deal of engagement and design work has been undertaken to design a facility that is a viable and affordable solution irrespective of where it may be located; a blueprint for future inpatient accommodation for SLaM.

Below are some indicative representations of what the ward spaces will be like in terms of their openness, space, light and vibrancy.

The following images show what the facility might look like from the outside in a typical residential location and with an attractive and inviting main entrance.

This view shows the proposed facility in the context of a street scene and shows how it tries to ensure that it can be sympathetic to the surrounding buildings even in a conservation area.

This view shows the facility from the side with its main entrance and how this would be complemented by open space and landscaping.

The following image highlights how the proposed wards would be configured with each bedroom and communal area having natural daylight and access to open space from each ward's lounge area allowing for unescorted access to open space and fresh air direct off the ward.

Each main floor is proposed to have two wards comprising of 18 bedrooms each and a large lounge and dining area, all of which are on an external wall thus bringing in natural ventilation and light which is so important to the feel and ambiance of the facility. The floor is split diagonally with the purple area to the top left and blue area to the bottom right making up the two wards.

The cost of the facility is estimated to be £68.7m although this is inclusive of further space in the building for two specialist services that will be transferring from the Bethlem Hospital site as part of another concurrent clinical reconfiguration scheme. The equivalent value for the like-for-like re-provision of the Lambeth Hospital Wards is estimated to be £55m.

7.2.2 Selection of a preferred site location

A feasibility study was conducted to ensure that the redevelopment of inpatient services, either at the Maudsley Hospital Site or on the Lambeth Hospital Site, was viable or could be evaluated against a series of critical success factors and economic analysis.

The Lambeth Hospital site has a number of acute wards, a psychiatric intensive care unit (PICU) and a rehabilitation unit. These are as follows:

- Acute Wards
  - Luther King Ward
  - LEO Ward
  - Rosa Parks Ward
  - Nelson Ward
- Eden PICU Ward
- Tony Hillis Unit Rehabilitation Ward

Whilst, externally, these seem relatively new they were designed and developed before modern standards of accommodation were created and fall far behind in terms of privacy, dignity and good lines of observation which are critical to the wellbeing of service users.

This feasibility study reviewed two opportunities which were the re-provision of inpatient facilities on the Maudsley Hospital site or their re-provision in-situ on the Lambeth Hospital site.

Re-provision on the Maudsley Hospital Site

This opportunity is to accommodate these services in a fit for purpose new build facility on the Maudsley Hospital Site that would resolve the current issues with the existing wards and be fully suited to deliver modern, high quality and safe care for service users when they are most in need.

The consolidation of inpatient services onto a site with our existing acute services not only would improve the clinical care for the population of Lambeth but would also mean that the Lambeth Hospital site is then vacant. This creates an opportunity to work with the Lambeth Local Authority planning teams to look at what might be the best use for that site in the future.

It is well recognised that various forms of affordable and social housing are in great demand and it would be a valuable asset to the Borough to be able to have that type of accommodation available. It is estimated that the site, with the assumption of the Greater London Assembly (GLA) target for affordable housing being included in a development, could have a value of around £38.2m.

We need to be mindful that this significant investment in Lambeth services of some £55m means that only one of the Trust's four main hospital sites providing inpatient beds has been improved to the level which is felt appropriate for all service users to expect.

The remaining three sites (Lewisham, Maudsley and Bethlem) will also require an equivalent level of investment in the coming years and this needs to be funded within the limited capital envelope that is available nationally. This capital requirement is likely to be well in excess of £165m just for the remaining three adult acute inpatient facilities.

The capital receipt available from development of residential accommodation in Lambeth is absolutely vital to be able to progress forwards with these next phases and help support further improvements in our other local Boroughs.

Re-provision on the Lambeth Hospital Site

This opportunity is to accommodate these services in this fit for purpose new build facility on the Lambeth Hospital Site and, as with the previous opportunity, would resolve the current issues with the existing wards and be fully suited to deliver modern, high quality and safe care for service users when they are most in need.

What is immediately apparent when looking at how the facility might be delivered on the site is that, wherever on the Lambeth Hospital site the building is placed (as indicated by the scale sized orange blocks on the site map), existing services are impacted to allow for the construction of the new facility.

The least disruptive of these indicative areas would affect a single ward and the most disruptive would affect four wards each requiring a decant location for the duration of the works.

There are two wards available at the Bethlem Hospital site and a further ward available at the Maudsley site, but they are not in use at present and would require refurbishment costs of between £2.5 and £3.2m to make them habitable for that period.

Furthermore, being a stand-alone inpatient unit (which is unable to use the support facilities of an existing wider campus such as the Maudsley Site) it is estimated a further £8.2m investment in infrastructure (catering, offices, utilities and plant) would be required as well.

This would adversely affect the cost of the scheme adding between £10.7 and £16.4m to the £55m investment in the building itself.

Alongside this additional cost of a decant location and infrastructure, the ability to dispose of the full site is also not possible as around half would be taken up with the new building and its support spaces. As such the £38.2m disposal opportunity would therefore be reduced, at best, to half of that value causing a further strain on the future of the reconfiguration programme of around £19m which would have to be funded through additional borrowing.

This would bring the overall additional financial impact of this potential opportunity to between £29.7m and £35.4m greater than the opportunity on the Maudsley Hospital site.

7.2.3 Short Listed Options

As noted previously the short list within this pre-consultation business case is intended to focus specifically on the options for the re-provision of inpatient services for wards on the Lambeth Hospital site into new, fit for purpose accommodation. The option would need to have the capacity to meet the demands of the case for change and be viable in practice should a decision be taken to move forwards with the service change proposal.

The following series of options sets out those which have been identified as viable options for progression to full evaluation within this case:

1. Do Nothing: Lambeth Hospital would remain as is.
2. Relocation to Maudsley Hospital: the acute inpatient wards including a PICU would move to the Maudsley Hospital which is located on the border of Lambeth and Southwark.
3. In-situ Redevelopment: inpatient wards and a PICU would be re-provided on the Lambeth Hospital Site.

In identifying the list of options set out above consideration was also given to the potential to refurbish the existing wards or select an alternative site in the borough for a new inpatient facility but these failed to meet the needs of the case for change or lacked an identifiable location and as such were not proposed as options for evaluation within this case. The reasons for this are set out below.

Refurbishment of the existing site

Alongside the assessment of the potential to create a new facility on the existing Lambeth Hospital site, as in option 3 above, we also considered refurbishment of the existing wards as a 'lighter touch' solution to see if there was a viable alternative to a full new build solution.

The key areas which would need to change on the current wards which relate to the safety of service users, the most therapeutic experience when in the ward, and offering the dignity and respect one would expect in a modern healthcare environment are:

- Lines of sight along corridors to allow for good staff observation away from the nurse stations
- Sufficient clinical and treatment spaces to ensure group and individual therapy can be undertaken effectively
- Ensuite facilities in every bedroom and bedrooms of sufficient size that service users have dignity and do not feel confined during longer spells on the ward
- A good level of communal and day space with direct, unsupervised access to outside space and fresh air without requiring leave from the ward
- The general fabric and infrastructure of the building to ensure its lifespan can extend sufficiently to warrant the investment required.

On looking at how these key items may be incorporated through refurbishment of the existing wards it is clear their structure and size would not be able to offer even the most basic of these such as en-suite bathrooms and sufficient space in the bedrooms to avoid the feeling of confinement that has been expressed by many service users.

To accommodate the improvements to bedrooms, adequate day spaces and improve the availability of therapy space would require the wards to reduce the bed numbers significantly; thus, making them unworkable clinically and operationally.

For this reason, it was felt this did not offer a credible solution to meet the needs of the case for change and was not proposed as an option for full evaluation within the pre-consultation business case.

Alternative sites in the Borough

Another area that was reviewed in looking for a solution to improve the acute inpatient services was to identify if there were any other alternative locations within the Borough of Lambeth where a new facility could be located.

A standalone hospital requires a large sized plot of land with good access links and the ability to obtain planning permission to build a significant sized building where shape and density of the designs are constrained by the nature of an inpatient ward.

Further to these design constraints the site needs to be affordable to purchase as this has a bearing on the feasibility and financial sustainability of a new facility.

In discussion with the Local Authority and other key partners it was recognised that there were no appropriate locations available within the necessary timeframe or that were affordable. This largely related to the premium price attached to sites that have the ability to support large residential development.

Given no alternative, affordable locations could be found this was not seen as a credible solution to meet the needs of the service change and as there is no certainty as to whether a site may become available in a suitable timeframe which would be affordable. As such this was not included as a viable option for full evaluation within the pre-consultation business case.

7.3 Critical Success Factor Assessment

In order to reach a preferred option for consultation the three viable options presented in the short list were assessed against a series of criteria to establish their credibility as the option that best meets the intentions of the clinical reconfiguration of inpatient services.

To support this assessment process five key areas which are critical to the success of the scheme were identified which help comparatively appraise what we are looking to gain, how it works across the health economy and if it is the best value at the lowest risk. These are:

1. Delivery of Benefits; these benefits are those identified in the case for change and ensuring as many of these are delivered in order to ensure that any investment made provides the highest level of benefit to our service users.

2. Strategic Fit; to look more broadly about how mental health services are best configured for our local health economy and that any investments made in Lambeth do not stop SLaM also supporting the other Boroughs they provide services for.

3. Service User Centred; to make sure that the service user is held at the heart of all our decisions and that any change we make is in the best interest of those using our services

4. Value for Money; money for investment in service changes and developments can be scarce and where we have the ability to make improvements, they need offer the best value for the money that is spent

5. Deliverability; significant service changes usually require large sums of money to implement and have complex decant and transitional stages. In undertaking these schemes, we want to avoid undue risk to service users, operational continuity or financial sustainability.

The table below identifies whether each of the options is aligned with each of these areas drawing out specifically how the options are able to deliver the benefits we are looking to achieve.

Delivery of Benefits		Option 1: Do Nothing	Option 2: Redevelopment at Maudsley	Options 3: In-situ Redevelopment
Wards	The wards are purpose-built, with a modern, safe and therapeutic environment for service users.	✗	✓	✓
	The wards are fit for purpose and meet the requirements of our regulator, the Care Quality Commission (CQC), which monitors the quality of our services.	✗	✓	✓
	Wards are light, bright and are safer, with good lines for sight for staff.	✗	✓	✓
	All bedrooms have their own ensuite bathrooms giving service users more dignity.	✗	✓	✓
	All wards have direct, unsupervised access to large outdoor balconies and fresh air.	✗	✓	✓
	All wards have access to supervised outdoor, garden space.	✓	✗	✗
	Wards are adaptable to provide single sex accommodation.	✗	✓	✓
	Private areas are available for staff.	✗	✓	✓
	No disruption for services users and staff as a result of moving the wards.	✓	✗	✗
Staff	Staff morale, recruitment and retention is improved by working in a modern, safe and therapeutic environment.	✗	✓	✓
	Access on one site to a larger pool of staff reducing the use of bank and agency staff	✗	✓	✗
Journeys	Journeys to and from the inpatient wards remain familiar for service users, families, carers and staff as there is no change in the location of the wards.	✓	✗	✓
	Journey times and access via public transport to and from the inpatient wards is better for the majority of service users, families, carers and staff.	✗	✓	✗
Buildings	Buildings are energy efficient, and sustainable and need less maintenance.	✗	✓	✓
	The Lambeth Hospital site can be developed for housing, providing funds to modernise other wards and clinical environments for service users in Croydon, Lewisham, Lambeth and Southwark.	✗	✓	!
Strategic Fit		✗	✓	✗
Service User Centered		✗	✓	✓
Value for Money		✗	✓	✗
Delibverability		✓	✓	✗

Within this appraisal it was clear that both of the options to reprovide the wards have a good level of alignment to the benefits anticipated from the scheme. The differences between the options are those areas relating to benefit arising from consolidation of the wards onto an existing site rather than maintaining a standalone site. These include access to a more robust staffing pool and the better connections that the Denmark Hill location provides in terms of improved public transport access for service users and carers.

Both of these redevelopment options also support the opportunity for the Trust to use the value of vacant space created on the Lambeth Hospital site to support further investment directly into the facilities and services across their other Boroughs. As noted in the review of the option for redevelopment on the Lambeth Hospital site that opportunity is reduced by between £29.7m and £35.4m, due to decant and other infrastructure required, and as such is not optimal.

The areas of the assessment looking at strategic fit, value for money and deliverability reflect the greater complexity of the redevelopment on the Lambeth Hospital site. Significant disruption would be caused to staff and service users as wards would need to be decanted and services split between other sites for the duration of the demolition and construction works and this would also create a level clinical and operational risk and as such reduces the deliverability of the option.

The option to reprovide the ward accommodation at the Maudsley Hospital site maximises the value available to reinvest as the entire Lambeth Hospital site would be available for disposal.Operational efficiencies could also be realised as the Lambeth wards would no longer be isolated reducing duplication of support services and infrastructure. This helps this option offer better value for money and also ensures its alignment to the broader estate and clinical reconfiguration strategies.

7.4 The preferred option

Throughout this evaluation of the potential options for reprovision of the inpatient wards currently located on the Lambeth Hospital site it has been apparent that a new build facility is the best option for delivering the clinical and quality benefits we are looking to achieve as part of this service reconfiguration.

Also apparent is that there is a significant level of additional complexity, disruption and cost associated with building this facility on the Lambeth Hospital site and that no other suitable or affordable sites have been identified within the Borough.

We have a duty to ensure we are prudent in our approach to service change and investment. We also have a responsibility to ensure that the proposals we put forward to public consultation are viable, reasonable and ultimately sustainable.

In light of the additional costs identified in the feasibility and poorer appraisal against the success criteria it was felt that there is a need to examine the option for reprovision of the wards on the Lambeth Hospital site further by applying these principles.

1. It is viable to deliver a solution on the Lambeth Hospital site; however
2. It is unrealistic to conclude that it is appropriate or proportionate to spend c£30m more for the same outcome should the development be provided on the Lambeth site coupled with the fact that it is unrealistic to take on the inherent clinical and operational risks associated with decant and disruption to the site during construction; and
3. It is unsustainable for the Trust to afford the increased level of charges that it would have to pay every year if the cost of the scheme were to be increased by £30m. These charges would have to be funded from the existing Trust annual budget putting further pressure on services and care.

As such the options which we will be taken forward to public consultation are:

i. Do nothing: Lambeth Hospital would remain as is.

ii. Relocation to Maudsley Hospital: the acute inpatient wards including a PICU would move to a new, high quality building on the Maudsley Hospital which is located on the border of Lambeth and Southwark.

Of these options (ii) Relocation to Maudsley is the preferred option as it delivers the greatest level of additional benefit for service users.

7.5 Economic analysis of the preferred option

7.5.1 Lambeth CCG Impact

The financial appraisal was undertaken by the Financial Modelling Workstream which is led by the Chief Financial Officer of NHS Lambeth CCG.

The impact was found to be insignificant, as the commissioning arrangement between the CCGs and the Trust is not one that is related to activity (such as Payment by Results arrangements), rather being based on an agreed settlement ('block' payments).

Therefore, there is no change expected in the financial forecast of the CCG as a result of these proposals.

7.5.2 Trust Impact

A significant piece of work was undertaken to quantify the financial benefits and consequences of the proposed preferred scheme in order to fully appreciate the implications of moving forwards. An independent accountancy and advisory firm worked alongside the Trust Finance Department in a comprehensive and robust modelling exercise based on a broad range of assumptions.

A base case model was created that described the organisational position going forward as if this reconfiguration programme were not to be undertaken. This set a position onto which a scenario for the preferred option (in patient facility on the Maudsley Hospital site) to be layered.

Outcome of quantitative assessment of options

For the quantitative assessment, the project costs (capital, revenue and lifecycle), benefits and risks were calculated for the Trust cash flows under the different options.

Net present cost (NPC) assumptions

The Department of Health and Social Care template Generic Economic Model was used to generate the Net Present Cost ("NPC") and Equivalent Annual Value ("EAV").

Operating costs and lifecycle

A LTFM has been produced for each option that covers the period from 2019/20 to 2028/29. This was used as the basis of the operating cost assumptions for that period. Beyond that period it was assumed that costs were flat in real terms.

Quantifiable benefits

We have sought to quantify the public benefits that the proposed development will deliver to the local and wider community as well as to the NHS. To do this, members of the project team reviewed the benefits identified to set out those that were able to be quantified. We worked through the list of potential benefits with input from clinicians delivering the services.

Once benefits were identified as quantifiable, they were considered either as a reduction in cost or an increase in income. Where benefits were reducing costs, full consideration was given to the cost at present and to the impact that the change would have on that cost. Where an additional income stream was identified, this was valued based on past experience and current benchmarks. Once the benefit was identified, the period when it is most likely to have an impact

was agreed and applied to the model. The benefit was then discounted where appropriate in the model.

7.5.3 Southwark Impact

Alongside the assessment of impact to Lambeth CCG and the Trust it is important to be aware of any impact on the Borough of Southwark as the preferred option would see wards from Lambeth Hospital moving into the Borough.

Individuals with 'No Fixed Abode'

It was identified that there may be a potential issue for the inheritance of costs and implications relating to individuals with no fixed abode which would have previously been associated with the Borough of Lambeth were the beds to remain on that site.

However, there are already established protocols in place to manage this issue via the Trust's Place of Safety Suite at the Maudsley which covers four boroughs, and the existing Lambeth ward on the Maudsley site (ES2) as follows:

- If service users have No Fixed Abode are seen in the Place of Safety suite and require inpatient admission, they are allocated to a ward within the borough where they were picked up prior to being taken to the Place of Safety. This determinant would be the basis for any operational arrangements to be agreed with the CCG and Local Authority regarding provision for patients with No Fixed Abode.
- Service users who have No Fixed Abode that are admitted to ES2 are most likely to have been picked up in Lambeth and gone through the Trust's Place of Safety suite, and the ward operates discharge pathways in accordance with Lambeth local pathways.

In addition, Lambeth CCG has developed homelessness services within borough which Lambeth service users at the Maudsley can access as part of discharge pathways as follows:

- Over the last four years, Lambeth has developed service models that support people with no fixed abode to access the right housing support and accommodation at the point of discharge from Lambeth wards. The KHP Homelessness Team provides a robust package of care that places people in the locality where they have connections or a preference to live.
- For people who are connected to Lambeth or known to services, Lambeth Council has a dedicated mental health housing coordinator who can access supported and independent housing or access to hostel accommodation through the vulnerable person pathway.
- In addition, Lambeth has been awarded NHSE mental health funding for the next five years to support rough sleepers and hostel in-reach.
- Finally, for decades there have been Lambeth wards based at the Maudsley Hospital. This history goes back to the 1990's when the Maudsley's catchment area included East Lambeth. Eileen Skellern Two (ES2) at the Maudsley Hospital, is a 20-bed inpatient unit mainly serving Lambeth men and operates discharge pathways in accordance with Lambeth local pathways.

Implications on Kings College Hospital Emergency Pathway

There were concerns that there would be a risk of increased numbers of transfers from mental health to physical health beds for mental health inpatients who require physical health interventions due to the close proximity of the beds. Currently is it assumed that some transfers

from Lambeth go to St Thomas. However, SLaM data regarding blue light conveyances of Lambeth inpatients to A&E identified there were only 20 cases (DATIX Jan 18 Dec 18) and all of these patients were conveyed to KCH A&E.

KCH forecast 2019 data for A&E attendances resulting in referrals to mental health was c4200 compared to 4100 in 2018; a marginal increase and a pattern that is not anticipated to change going forwards.

It is therefore expected that there will no additional pressure for KCH from these patients transferring from Lambeth to Maudsley Hospital.

Excessive density of the Maudsley Hospital Site

The issue of additional density on the Maudsley Hospital Site is one of concern to a number of stakeholders and as such this was identified as a line of enquiry for the London Clinical Senate to review as part of their review of the proposed scheme.

A number of benefits were describes to the Clinical Senate including:

- As acuity of inpatient services increases there will be a greater dependence on specialist interventions and clinical input.
- Reducing the number of inpatient sites will allow for a more efficient and effective use of resources to improve access to specialist clinical resources.
- The proposed inpatient facility would make use of a building on the Maudsley Hospital campus which has been vacant for a number of years and is in a state of disrepair following many years of disuse including a period of occupation by squatters.
- Demolishing the building and redeveloping the site will have a very positive effect by rejuvenating the heart of the Maudsley campus.

The report stated that "*the panel were persuaded by the benefits, although noted that there is no evidence for the consolidation of mental health care on single sites as there is for acute care"*.

The Panel also noted in response to a review of the placement of the PICU in the unit that *"The panel considered that although ground floor accommodation was preferable, it would not be unreasonable to house wards above the ground floor in a capital city given the availability and affordability of land space. The panel felt that a multi floored building had the potential to offer better value for money and that the proposed configuration of services was a logical arrangement"*.

With any proposal to move services onto an existing site there can be concerns that this will create an environment that is too cramped, with little open space making it feel oppressive and unwelcoming.

Alongside the new inpatient accommodation the Trust have developed a longer-term strategy to open up green walkways through the site between the Denmark Hill station and Camberwell and also from the main aspect of the site through towards the new buildings with a view to allow better access to Camberwell and create an inviting campus for service users, staff and the broader public.

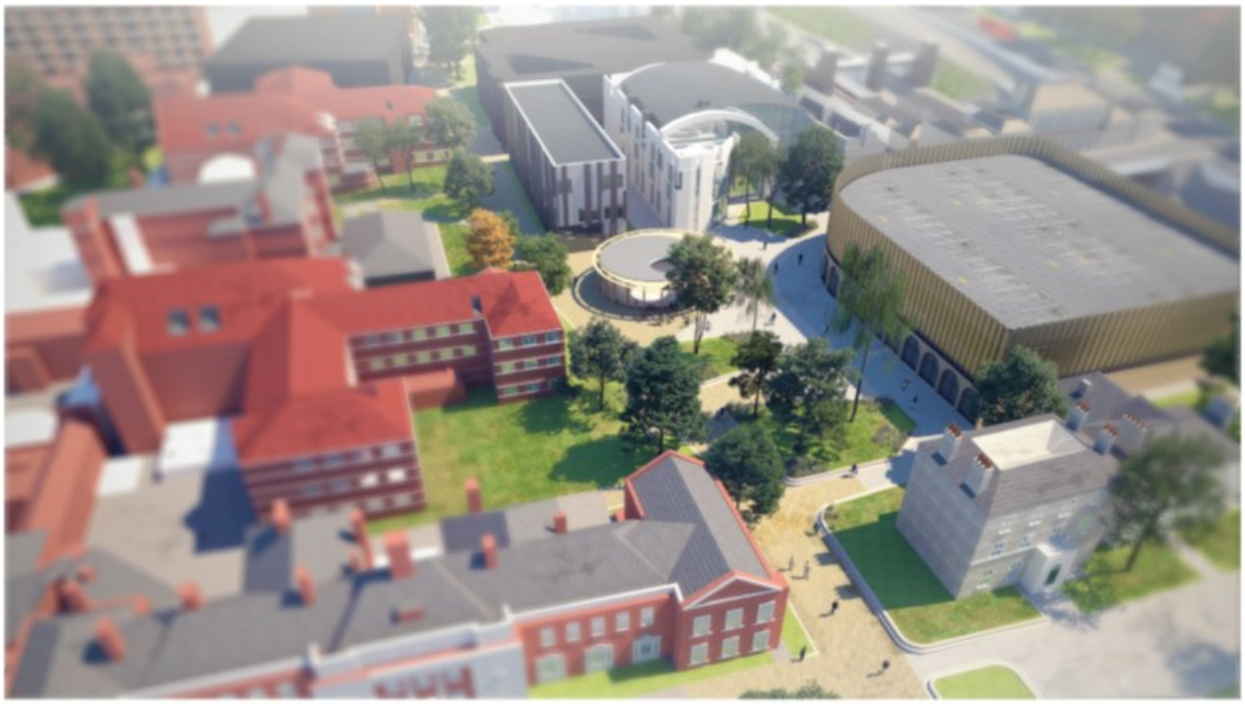
Not only will this give the site a vibrant and fresh feel, but it will be sympathetic to the grand listed entrances which speak to the sites deep rooted history in clinical and research excellence.

Around these large public areas will be shops and leisure space to provide amenities whilst visiting the site, something that is lacking at present.

There is also a real desire to destigmatise mental health and it is hoped that making the site accessible and open to all will help to achieve that goal.

Below are some representations of what the masterplan for the Maudsley Hospital Site may be in the future.

On this image you can see how light, open and accessible the site will be in the future for service users, visitors and staff.



Here one can visualise more clearly how that would look with a birds eye view looking from the main entrance on Denmark Hill across to the rear of the hospital site.

Investment in Southwark Mental Health Estate

There is a need to invest in all four Boroughs where we have a material inpatient estate (Lambeth, Southwark, Lewisham and Croydon) and as such there is a recognised estate strategy that looks to work across all of these estates in a phased programme of reconfiguration and improvement.

Critical to this is the ability to manage the necessary cashflow which underpins this very significant investment. This is managed through the ensuring that the programme is scheduled in such a way as to ensure that the ability to undertake developments is linked both to the ability to release value from vacated estate and to ensure that the Borough is itself ready to make the necessary investments into community services to best maximise the clinical and operational returns.

The proposed Lambeth reconfiguration supports a significant improvement in the inpatient estate and is aligned with the imminent completion of the Borough investment in community services through the Living Well Network Alliance. This coalesces in the ability to receive further funds through the disposal of the Lambeth Hospital site which can be reinvested in Southwark and the other Boroughs.

Implications for Local Infrastructure

In October 2019 Network Rail secured funding from the Department for Transport to continue with design work for improvements to Denmark Hill station. Network Rail and Govia Thameslink Railway (GTR) is now drawing up detailed proposals for enhancements at Denmark Hill, including a new station entrance on Windsor Walk.

The proposals aim to reduce congestion and provide easier access for patients and staff to Kings College Hospital and Maudsley Hospital, as well supporting the growth of both the Denmark Hill and Camberwell areas. This will be a material improvement for those using this important local amenity

and is complimented by the fact that the majority of staff who work in Clinical environments, such as the transferring Lambeth wards, travel to work out off rush hour, due to the shift system.

Both the Lambeth and Maudsley Hospital sites are well served by public transport networks and as such both are equally accessible to service users and their visitors with only a 2.5 mile distance between the two hospital sites.

7.5.4 Sensitivity analysis

We have run a number of sensitivities, shown in section 8.5, to understand the impact of different risks on the project:

1. **A 30% reduction in yearly CIP for new inpatient unit** – There will be a negative impact on the SOCI position ranging from a breakeven position in 2020/21 to £1.5m (deficit) in 2028/29. Furthermore, as pay and operating expenditure costs increase on a yearly basis, this builds more risk for the project and reduces the cash / cash equivalent balance to £49.3m in 2028/29 compared to the 'do nothing' option at £72.8m for the same year.

2. **A 30% reduction in yearly CIP for the Trust** – There will be a negative impact on the SOCI position ranging from £2.0m (deficit) in 2020/21 to £21.9m (deficit) in 2028/29. In comparison to the first sensitivity, measuring a 30% reduction in CIP for the new inpatient unit, there is a breakeven position to a £1.5m (deficit) for the same time period. This shows that the financial risk is limited for the new inpatient unit. Furthermore, if the Trust does not achieve their CIP target, there will be an adverse impact on cash flows in 2026/27 of £11.1m (deficit) and this trend will continue to adversely impact the cash flows and reduce them to £48.4m (deficit) by 2028/29 compared to the surplus in the 'do nothing' option at £72.8m for the same year.

3. **A 0.5% increase in pay costs each year** – This variable shows that a slight increase in pay costs each year (on top of the assumed 2.9% pay inflation) will have a maximum impact on the SOCI by £19.3m (deficit) in 2028/29. An adverse cash / cash equivalent balance is also forecast from 2027/28 (£11.1m (deficit)) and will reduce to £28.7m (deficit) by 2028/29 compared to the 'do nothing' option at £72.8m for the same year, a movement of £44.1m. This demonstrates a growing risk year on year both on the SOCI and cash flow balance. Note that it is 0.5% in addition to the already assumed pay inflation.

4. **A 10% increase in the cost of new inpatient unit** – From a SOCI perspective, there will be a negative impact from 2022/23 until the end of 2028/29 ranging between £0.1m to £0.3m. The deficit in the SOCI is projected to reduce by £0.3m each year from 2023/24. The impact on cash flow will see a decrease of £2.0m in 2020/21, compared to the 'do nothing' option. However, the cash balance will be within the range of £24.6m to £64.6m in the sensitivity measure.

One year delay in building the new inpatient unit – A one year delay will adversely start to impact cash flows from 2022/23 by £16.9m compared to the 'do nothing' option. The Trust will see an adverse difference of (£13.2m (deficit)) in cash reduction compared to the 'do nothing' option by the end of 2028/29.

7.6 Pre-consultation feedback

As laid out in Section 6, the Trust has completed a range of pre-consultation engagements with key stakeholder groups, listed in Appendix [15], and will continue to do so throughout the pre-consultation phase. The findings of these preliminary consultations will be used to further shape options, as they will be a good indicator of user and public acceptability of options.

The key themes identified during the consultation are outlined in section 6.2.9 of this document. These are summarised as:

- The importance of having easy access, natural light and open / green spaces to create vibrancy. The current condition of the wards are not fit for purpose;
- Creating space for sport and social activities. This would benefit both staff and service users;
- Making effective use of the existing car park at the Maudsley site;
- The new building on the Maudsley site should provide rooms that have adequate temperature control, good ventilation and soundproofing; and
- The new proposal should offer a re-designed high quality patient environment to provide a better floor layout, ensuite bedrooms, single sex wards and rooms for staff. This would be easier to manage and would help reduce violence and aggression.

7.7 Equality and Quality Impact Analysis

7.7.1 Independent review

The London Clinical Senate was established as part of the pre-consultation phase to ensure proposals are independently reviewed and guided. The London Clinical Senate provides independent strategic advice and guidance to commissioners and stakeholders regarding healthcare provision. A request for advice was sought on 11th August 2019 from the London Clinical Senate, with support from both the Trust and CCG. The London Clinical Senate sought guidance on:

- The impact of the environment change on clinical care;
- If the proposal is justified in terms of clinical and quality of care for local service users and the evidence for this; and
- If the investment in mental health community services was sufficient to absorb the predicted rise in demand for inpatient services and the evidence for this assumption.

A panel was convened on 19 November 2019 and included members of the London Clinical Senate Council as well as individuals with subject matter expertise in mental health care. The panel concluded that there was a “clear case for change and appropriate clinical model to improve the quality of inpatient accommodation”. Further, they stated that they were “The review panel were convinced that action needs to be taken to address the Lambeth inpatient estate. This was clear from Royal College Guidelines, Care Quality Commission Reports and Service User feedback”.

NHSE&I has also completed a series of assurance tests including financial assurance and has stated that no further reviews are necessary.

7.7.2 Travel Time

We recognise that we have a responsibility to address the current issues raised by climate change and the increasing levels of congestion on the local transport network. Our Sustainable Travel Plan, produced in 2015, sets out the approach to achieving this.

6.7% (354) of Trust employed staff are based at Lambeth [Figure 4.11] and a significant proportion of these will relocate to the Maudsley site when this project is delivered. It is

anticipated that these staff will use public transport to travel to and from work. The majority of these staff are ward based, and as, such there is no requirement for a car to undertake work duties.

We are aware that our Sustainable Travel Plan needs updating and it is anticipated that an updated version will be available for inclusion as an Appendix to the Full Business Case (FBC). The current Sustainable Travel Plan can be found in Appendix [6].

We currently operate five main hospital and community sites:

- Bethlem Royal Hospital.
- Lambeth Hospital.
- The Maudsley Hospital.
- The Ladywell Unit (at Lewisham Hospital).
- Jeanette Wallace House, Croydon.

In addition, we operate from over 100 community sites across South East London, located within the Boroughs of Lambeth, Southwark, Lewisham, Croydon, Bromley, Bexley and Greenwich. Over 5,000 individuals are treated in their hospitals every year, whilst there are 32,000 individuals on the care programme approach.

Because of the large number of community sites operated by the Trust, we have developed twelve geographical based areas, to which all our sites have been allocated, alongside six main sites. This has been done to help develop area based travel plans as well as make our survey assessments more effective.

Site/Clusters	No. of Sites	No. of Staff	% of all staff
Main Sites			
Maudsley Hospital (inc. KCH)	/	1020	19.3%
Bethlem Royal Hospital	/	1224	23.1%
Lambeth Hospital	/	354	6.7%
Ladywell Unit (Lewisham Hospital)	/	192	3.6%
Guys Hospital (inc. Munro)	/	342	6.5%
St Thomas's Hospital	/	63	1.1%
Clusters			
Croydon Central (inc. Jeanette Wallace House)	11	448	8.5%
Croydon Outer	5	73	1.4%
Bromley	3	83	1.6%
Streatham/West Norwood	6	171	3.2%
Camberwell	6	187	3.5%

Lewisham	15	441	8.3%
Brixton	11	248	4.7%
Sydenham/Forest Hill	4	73	1.4%
Stockwell/Kennington	6	135	2.6%
Bermondsey/Deptford	9	199	3.8%
East Dulwich/Peckham	4	63	1.2%
Outer Remote Sites	3	79	1.5%

Table [4.11]: SLaM Sites by Clusters[19]

Across the whole Trust, we employ 4,200+ members of staff. As well as hospital and clinic based services there are also a large number of community based staff who are required to make home visits. Further, since we cover a large geographical area and population, a number of staff provide clinics and services on a number of different sites, necessitating increased travel patterns.

Methodology

The travel time analysis and presentation has been developed out into maps. It sets ranged output areas using the Transport for London travel tool. Analysis and maps will be presented in the form of heat maps to demonstrate the impact on service users and populations for the change in travel times by differing modes of transport. Appendix [12] is a map showing the change in time due to relocation of beds from Lambeth to the Maudsley site.

Travel time analysis

In addition to the postcode mapping, an analysis of the expected journey time from postcode zones to each of the Lambeth and Maudsley Hospitals has been undertaken. The origin destination for each postcode zone has been based on the approximate centre point of each zone and journey times have been calculated using TRACC. Appendices [7 & 8] provide a summary of the journey times to Lambeth and Maudsley Hospitals, along with the expected change in journey times for inpatients.

[19]SLaM Estates Strategy, 2017

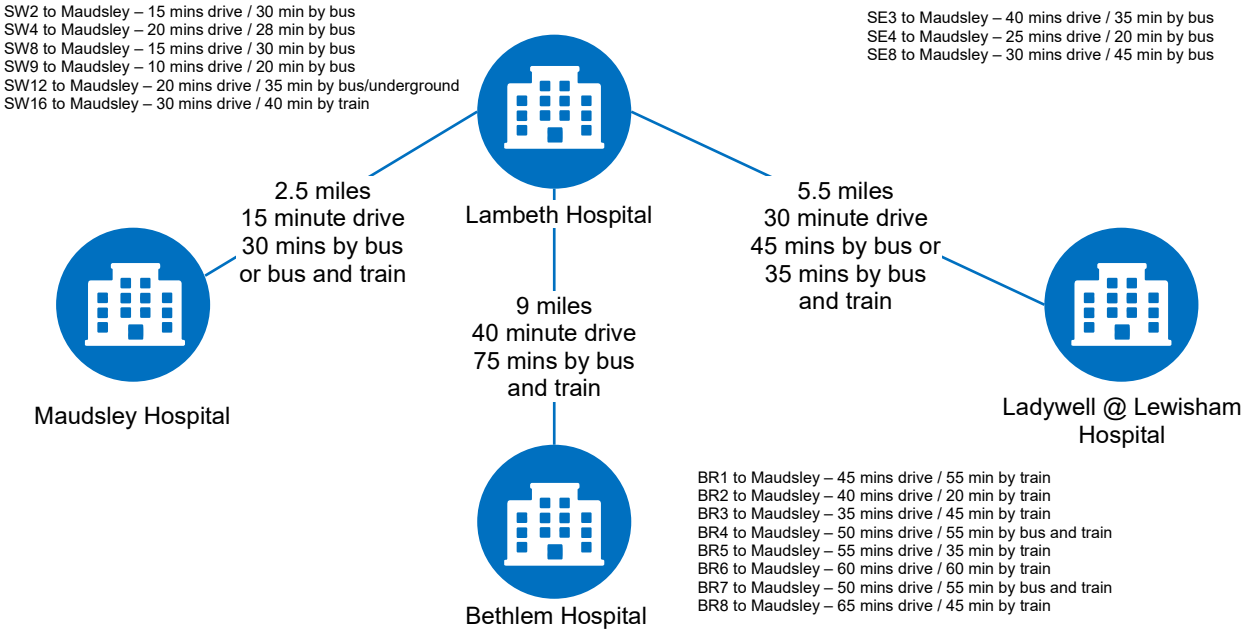


Table [4.12]: Travel time analysis

An Accessibility Study review for SLaM conducted by Motion [20] demonstrates that both Lambeth and Maudsley Hospitals are well located with regard to the local highway networks as well as benefitting from access to a range of more sustainable transport opportunities including a good pedestrian network, cycle network and access to a range of public transport options.

Whilst both sites are well located with regard to the surrounding transport network, Maudsley Hospital benefits from slightly higher Public Transport Accessibility Levels (PTAL) demonstrating a greater level of accessibility by public transport.

Public transport journey time analysis further shows that there are some areas to the west of the sites which are currently within a 45-minute journey time of the Lambeth site but would be in excess of a 45-minute journey time of the Maudsley site. In comparison, there are larger areas to the east of the sites, including around Lewisham, Kidbrooke, Charlton and Bromley which are current in excess of a 45-minute journey of Lambeth Hospital but within a 45-minute journey of the Maudsley site.

An analysis of inpatient postcode information demonstrates that around 82% of inpatient postcodes provided by the Trust are within a 45-minute journey time of Lambeth Hospital and around 90% of inpatient postcodes are within a 45-minute journey time of the Maudsley Hospital site.

7.7.3 Equality Impact Assessment

The Equality Impact Assessment (EIA), Appendix [16], is designed to ensure that a project, policy or scheme does not discriminate against any disadvantaged or vulnerable people or groups. This ensures CCGs pay ‘due regard’ to the Public Sector Equality Duty.

[20] Maudsley and Lambeth Hospitals, Accessibility Study for South London and Maudsley NHS Foundation Trust. Motion, August 2019.

Two EIAs were completed prior to consultation; one to assess the impact of all services and the other to assess the impact for all staff. The EIAs looked at the all the changes proposed in relation to the provision of services within the Lambeth Borough including:

a) The relocation of LEO ward from Lambeth Hospital to the Maudsley Hospital (ES2);

b) The relocation of adult acute wards (Eden Ward, Luther King ward, Nelson Ward, Rosa Parks Ward and ES2 - currently operating on Maudsley Hospital site) from Lambeth Hospital to the Maudsley Hospital (in the new inpatient unit);

c) The relocation of Tony Hillis Unit from Lambeth Hospital to the Maudsley Hospital (in the new inpatient unit);

d) The relocation of the Ward in the Community (a four Borough service) from Lambeth Hospital to the Bethlem Royal Hospital as a result of the wider proposal for the preferred option; and

e) The relocation of Lambeth community and outpatient services (directly due to this project) from Lambeth Hospital to either Brixton Road or another community living well centre (Gracefield Gardens or Akerman Road),

however it is noted that items (c) – (e) fall outside the scope of this PCBC and will be considered via separate engagement processes for those services.

The EIAs focused on:

- how the services will impact on protected and vulnerable groups in the community; and
- the staff affected by proposed relocations.

The majority of vulnerable or protected groups identified as part of the EIA have been judged as achieving greater equality, improved outcomes or increased accessibility through the proposal. For example, both inpatient and community developments will provide improved disabled access for service users, staff and visitors. For many other groups, the purpose built facilities offer an improvement in therapeutic environment, access to outdoor space and care delivered closer to home.

At this stage, the EIA identified a number of potential issues that will be explored further through the public consultation and mitigate in terms of impact on groups or individuals with protected characteristics. The main issues identified were:

- Improving understanding of travel implications of the change in location of services for service users, carers, community members of different ages, disabilities, ethnicities, gender identity, sexes and sexual orientation
- Improving understanding of how to mitigate potential risks of social isolation at proposed new location for service users who are older, who are disabled, who are transgender, who are Black, who are from other ethnic minority backgrounds, who have places of worship in Lambeth, who are gay, lesbian or bisexual

The EIA action plan has identified key groups who should be consulted with as part of the public consultation and these actions are being built into the public consultation plan.

7.7.4 Quality Impact Assessment

A Quality Impact Assessment (QIA) was developed and led by the Clinical & Operational Workstream for the preferred option to evaluate the impact on quality of care, Appendix [14]. This was developed in partnership with clinicians at the Trust to ensure it provides an accurate reflection of the changes to service delivery.

Specifically, the QIA of the proposed redevelopment will provide assurance that any resultant reconfiguration services will not adversely affect the quality of service user care. This is defined by NHS England and NHS Improvement as care that is clinically effective, safe and that provides as positive an experience for service users as possible.

The risks that are identified affecting clinical services are:

- Reduction in service user satisfaction due to new service location - Relocating services outside of the Lambeth Borough may lead to a reduction in service user satisfaction due to the perception that services are less accessible. The relocation may result in less service user interaction with familiar surroundings and their local community. The Maudsley Hospital is located on the border of Lambeth and Southwark. It is expected that the quality of the new build accommodation will offset any reduction in service user satisfaction of moving the service to a busier site.

- Reduction in carer/visitor satisfaction - There is a risk that travelling to the Maudsley for visitors/carers rather than Lambeth or the Bethlem may be more difficult/timely/costly which may lead to less patient/visitor interaction. Initial findings from the travel impact assessment identifies the Maudsley as being more accessible by public transport. Lambeth is only better connected by underground. It is worth noting that visitors/carers residing in the Loughborough Junction / Brixton area should find that it is quicker and easier to access the Maudsley when compared to Lambeth. Visitors / carers may offset the potential disadvantage of travelling further with the benefit that their loved ones will be accommodated in a higher quality environment which should lead to a more timely recovery.

- Increase in the number of Serious Incidents - There is a risk of an increase in errors / serious incidents for a period of time after relocation due to changes in working practices, service reconfiguration and changes to the physical working environment. During the mobilisation and transition phases, ward based staff will require thorough induction and orientation to the new facilities prior to service go live to reduce the risk of SIs occurring / complaints increasing.

- Operational Risks - Inpatients at Lambeth currently access physical health services at either GSTT (St Thomas') or KCH. There is a risk that there will be additional demand for KCH for emergency admissions due to the Lambeth beds being relocated closer to KCH (the Maudsley) and further from St Thomas'. This could impact on KCH A&E performance and may put additional pressure on service demand. With regard to blue light conveyances of Lambeth inpatients to A&E, there were only 20 cases (DATIX Jan 18- Dec 18) and all of these patients were conveyed to KCH A&E. It is therefore expected that there will no additional pressure for KCH from these patients.

Chapter 8. Finance Case

8.1 Introduction

This section sets out the financial impact of the selected option on the CCGs, Trust and any other relevant parties.

The purpose of the financial case is to set out the impact of the preferred option on the CCGs and Trust's financial performance and position and to show the impact of the key financial risks. This is important as it demonstrates the options being considered for consultation are financially sustainable.

Although this PCBC focuses specifically on the re-provision of inpatient services to new facilities, the financial case has been developed to encompass the broader changes to the services currently delivered at the Lambeth Hospital site as part of the clinical transformation programme and estate strategy as described in section 1.2.3.

8.1.1 CCG Impact

The CCG Chief Financial Officer for Lambeth CCG has reviewed the activity and financial assumptions applied by the Trust. The CCG has confirmed these assumptions on activity and income are consistent with both the STP expectations and the CCG forecast. The commentary provided in this Finance Case, therefore, focuses on the impact on the proposals to South London and the Maudsley as a provider Trust.

The CCG current spending plans with the Trust will not significantly change as a result of the changes in the care model because of the contract arrangements in place between the CCG and the Trust. Specifically, the Trusts receive a fixed amount per period from the CCG to provide a range of services to the local population. Unlike tariff arrangements this is not directly correlated to changes in activity by volume or type, therefore, any service expansion requiring investment would be separately agreed in advance between the CCGs and the Trust outside of this business case.

8.1.2 Provider Impact

In terms of providers, the system affordability of the proposals can be shown by setting out the position for the Trust. This section sets out what those impacts are from a financial perspective and that the preferred option is affordable for the Trust. For the purposes of this analysis, affordability is defined as:

- Ensuring that we have the cash required to complete the estates programme;
- Having sufficient cash to cover the Trust's working capital requirement throughout the period (assumed to be £10m); and
- The Financial Sustainability Risk Rating (FSRR) will be at least 2 in all years when appropriate adjustments are made for the impact of bridge financing.

This section of the business case includes a financial summary of the preferred option.

8.2 Basis of Preparation

The projections in this section have been prepared on the following basis:

- We have completed the NHSE&I Long Term Financial Model (LTFM).

- A combined service development model was populated for the 'do nothing' option and the preferred option and a comparison of the outputs was used to assess the incremental impact.
- The assumptions proposed are set out in the tables below.

All assumptions set out below were approved by the Trust Director of Finance.

<table>
<tr><th>Category</th><th>Assumptions</th></tr>
<tr><td>Capital costs</td><td>The capital costing for the preferred option is assumed to be £68.7m for the building.
The building has been depreciated over a 60 year period.
Ongoing lifecycle costs have also been included within the model.
Inflation is included in this financial case.</td></tr>
<tr><td>Disposals</td><td>The following disposal values have been assumed:
Disposals valued related to 'preferred option' are assumed to be £38.2m received in two tranches 60% in 2020 and 40% in 2022. This relates to the Lambeth site and has been assumed that the proceeds on disposal will equal the NBV of the asset at the time of the disposal.</td></tr>
<tr><td>Revenue costing</td><td>Additional Revenue Costs:
Additional revenue costs for the 'preferred option' in 2022/23 are £0.5m. These are expected to increase to £1.9m in 2023/24. This relates to additional operating expenditure of the new inpatient facility and lease expenses on expanded community space.
The PDC payable will also increase due to an increase in the net relevant assets (which differs to the total net assets). The PDC has been calculated at 3.5% of the net relevant assets.
Inflation:
The following inflation rates have been assumed for all income and expenditure:
<table>
<tr><th>Element</th><th>2019/20</th><th>2020/21</th><th>2021/22</th><th>Ongoing</th></tr>
<tr><td>Income Inflation</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Block Income</td><td>3.5%</td><td>3.5%</td><td>3.5%</td><td>3.5%</td></tr>
<tr><td>Non-Clinical Income</td><td>-</td><td>0.9%</td><td>2.0%</td><td>2.0%</td></tr>
<tr><td>Expenditure Inflation</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Staffing</td><td>1.6%</td><td>2.9%</td><td>2.9%</td><td>2.9%</td></tr>
<tr><td>Drugs</td><td>4.1%</td><td>4.1%</td><td>4.1%</td><td>4.1%</td></tr>
<tr><td>Other</td><td>1.9%</td><td>2.0%</td><td>1.9%</td><td>1.9%</td></tr>
</table>
The expenditure has been derived from NHSI economic forecast assumptions. The income is based on what the Trust is likely to receive from Block CCG contracts.</td></tr>
<tr><td>Activity/ growth assumptions</td><td>Activity assumption is that activity will grow circa 2% per year, as per NHSI Economic Forecast Assumptions, July 2019.</td></tr>
<tr><td>Lifecycle Costs</td><td>In the 'do nothing' scenario, the Lambeth site is not disposed. It is assumed that there will be £556k of Lifecycle costs each year for that site. £556K came from what has been spent on the Lambeth site on average over the past few years.
In the preferred option, however, Lambeth is disposed and these lifecycle costs are not incurred. New lifecycle costs are assumed for the preferred option. These are:</td></tr>
</table>

Category	Assumptions
	Year 1 - (2023/24): £100k Year 2 - (2024/25): £200k Year 3 - (2025/26): £200k Year 4 - (2026/27): £300k Year 5 - (2027/28): £400k Year 6 - (2028/29): £600k

8.3 Financial Projections

8.3.1 Income and Expenditure

In both the 'do nothing' and 'preferred' option the Trust is forecasting a breakeven I&E position in all years with cost efficiencies across the whole of the Trust's cost base proposed at a level to deliver this (CIP requirement). The preferred option contains a requirement for additional efficiency savings of £3.6m using this approach. At this stage it has been assumed that this will be principally delivered over two years in 2022-23 and 2023-24 respectively. This leads to a total CIP requirement in each of those years of close to 2%, which is in line with delivery of over 2% in 2018/19[21] and will be explored in further detail as part of the next stages of the business case process.

'Do Nothing' (pre service development) Position											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(314.7)	(325.4)	(336.4)	(347.8)	(359.6)	(371.9)	(385.1)	(400.0)	(415.5)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.7)	(118.9)	(120.4)	(121.9)	(123.8)	(126.0)	(128.2)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(429.8)**	**(441.8)**	**(454.1)**	**(466.7)**	**(479.9)**	**(493.8)**	**(508.9)**	**(526.0)**	**(543.7)**
Operating Surplus / (Deficit)	1.9	5.9	6.3	6.7	6.6	6.5	6.3	6.3	6.3	6.3	6.3
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.7)	(6.6)	(6.5)	(6.3)	(6.3)	(6.3)	(6.3)	(6.3)
Surplus / (Deficit)	**4.2**	**(0.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CIP requirement (Recurrent)			6.6	7.1	7.6	8.2	8.8	9.5	7.5	8.2	8.8
CIP %			**1.6%**	**1.6%**	**1.6%**	**1.6%**	**1.6%**	**1.6%**	**1.1%**	**1.1%**	**1.1%**
Surplus / (Deficit) if CIP not achieved			**(6.6)**	**(7.1)**	**(7.6)**	**(8.2)**	**(8.8)**	**(9.5)**	**(7.5)**	**(8.2)**	**(8.8)**

[21] SLAM Management Accounts, Board Paper, April 2019

As set out above the 'do nothing' I&E shows the CIP requirement for the Trust to break even in the period to March 2029 and therefore also the deficit that would result if no CIP was delivered. Within the 'do nothing' forecast the highest requirement for CIP delivery in a year is £9.5m in 2025/26, which remains close to 1.6% of the cost base and is in line with historical levels of CIP delivery.

'Preferred' Option											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(314.7)	(325.5)	(335.2)	(344.7)	(356.5)	(368.9)	(382.1)	(397.1)	(412.5)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.8)	(121.1)	(122.6)	(124.2)	(126.2)	(128.4)	(130.7)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(429.8)**	**(442.0)**	**(452.9)**	**(465.8)**	**(479.1)**	**(493.0)**	**(508.3)**	**(525.5)**	**(543.2)**
Operating Surplus / (Deficit)	1.9	5.9	6.3	6.5	7.8	7.4	7.1	7.0	6.9	6.8	6.7
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.5)	(7.8)	(7.4)	(7.1)	(7.0)	(6.9)	(6.8)	(6.7)
Surplus / (Deficit)	**4.2**	**(0.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CIP requirement (Recurrent)			6.6	6.9	9.5	10.5	8.7	9.4	7.5	8.2	8.8
CIP %			**1.6%**	**1.6%**	**2.0%**	**2.1%**	**1.6%**	**1.6%**	**1.1%**	**1.1%**	**1.1%**
Surplus / (Deficit) if CIP not achieved			**(6.6)**	**(6.9)**	**(9.5)**	**(10.5)**	**(8.7)**	**(9.4)**	**(7.5)**	**(8.2)**	**(8.8)**
Additional CIP to be achieved with preferred option.			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Building the new inpatient unit ('preferred' option) has an increase in expenditure of circa £3.6m (£1.1m for depreciation, £0.5m for PDC, £2.0m for building expenditure running costs and other leases). This is being offset by additional CIP savings. The highest forecast CIP requirement would be £10.5m in 2023/24 to deliver break even financial performance, indicating a slightly higher level of risk to the Trust to deliver cost improvements in the preferred option (the highest CIP requirement in 'do nothing' was £9.5m). This is a short term risk for delivery and, as shown by comparing the forecasts for the two options above, the underlying financial performance is comparable in both options.

For the 'do nothing' option, the SOCI is projected to breakeven each year assuming CIP requirements are achieved. In the preferred option there are additional PDC and deprecation charges due to an increase in non-current assets and net relevant assets. However, the required CIPs have been increased to bring the Trust to breakeven even after these cost pressures arise.

From 2020/21 the Trust has a deficit SOCI position, as a net result of the following:

- Increased expenditure on staff and operating costs driven by annual inflation and compounding growth;
- Higher depreciation charge to reflect the additional assets; and
- Additional PDC charge.

The impact of this will increase total operating expenditure from £429.8m (deficit) in 2020/21 to £543.2m (deficit) in 2028/29.

8.3.2 Statement of Financial Position

The Trust's current statement of financial position is shown below.

'Do Nothing' (pre service development) Position											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Non-current assets	236.5	238.0	249.2	247.5	245.8	242.1	242.1	242.1	242.1	242.1	242.1
Current assets	109.3	98.0	87.4	89.7	91.9	96.3	96.9	97.6	98.4	99.3	100.3
Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.5)	(55.1)	(55.8)	(56.4)	(57.3)	(58.2)	(59.2)
Total assets less current liabilities	**281.5**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)
Total net assets employed	**275.6**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**
Total taxpayers and other equity	**275.6**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**
'Preferred' Option											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29

	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Non-current assets	236.5	238.0	245.2	281.7	271.5	265.8	264.0	262.1	260.4	258.8	257.3
Current assets	109.3	98.0	91.3	55.5	66.3	72.9	75.4	77.9	80.5	83.1	85.5
Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.5)	(55.4)	(56.1)	(56.8)	(57.6)	(58.6)	(59.6)
Total assets less current liabilities	**281.5**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**	**283.3**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)
Total net assets employed	**275.6**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**
Total taxpayers and other equity	**275.6**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**	**276.0**

In both cases, 'do nothing' and 'preferred option', there is no impact on total net assets to the Trust. This is because the Trust is assumed to break even every year and therefore no movements are carried over to the statement of financial position. Additionally the building is assumed to be funded by cash reserves and disposals so the movements are between categories of assets as opposed to total assets overall. Furthermore, any increase to the assets due to capital expenditure is offset by the reduction in cash that is used to pay for the capital expenditure. The LTFM has assumed that all capital expenditure is paid in cash in year (there are no capital creditors assumed each year). As a result of building the new inpatient unit, the Trusts non-current assets increase in 2020/21 from £245.2m to 257.3m in 2028/29.

8.3.3 Cash Flows

The Trust's current cash flow position is indicated in the table below.

'Do Nothing' (pre service development) Position											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Operating surplus/(deficit)	1.9	5.9	6.3	6.7	6.6	6.5	6.3	6.3	6.3	6.3	6.3
Net cash generated from / (used in) operations	10.2	9.5	16.8	16.8	16.8	16.6	16.4	16.4	16.4	16.1	16.1
Net cash generated from/(used in) investing activities	8.9	(14.5)	(20.7)	(7.8)	(7.8)	(5.6)	(9.2)	(9.2)	(9.2)	(9.2)	(9.2)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(7.0)	(6.9)	(6.9)	(6.7)	(6.7)	(6.7)	(6.7)	(6.6)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(10.6)**	**2.1**	**2.1**	**4.2**	**0.5**	**0.4**	**0.4**	**0.3**	**0.3**
Cash and cash equivalents at start of period	70.2	84.0	73.2	62.6	64.6	66.7	70.9	71.4	71.9	72.3	72.6

Cash and cash equivalents at end of period	84.0	73.2	62.6	64.6	66.7	70.9	71.4	71.9	72.3	72.6	72.8
'Preferred' Option											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Operating surplus/(deficit)	1.9	5.9	6.3	6.5	7.8	7.4	7.1	7.0	6.9	6.8	6.7
Net cash generated from / (used in) operations	10.2	9.5	16.8	16.7	18.0	19.0	18.4	18.3	18.2	17.9	17.8
Net cash generated from/(used in) investing activities	8.9	(14.5)	(16.7)	(46.0)	0.8	(4.7)	(8.5)	(8.5)	(8.6)	(8.7)	(8.8)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.9)	(8.1)	(7.8)	(7.6)	(7.5)	(7.4)	(7.3)	(7.2)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(6.6)**	**(36.1)**	**10.7**	**6.4**	**2.4**	**2.3**	**2.2**	**1.9**	**1.7**
Cash and cash equivalents at start of period	70.2	84.0	73.2	66.5	30.4	41.1	47.5	49.9	52.2	54.4	56.3
Cash and cash equivalents at end of period	**84.0**	**73.2**	**66.5**	**30.4**	**41.1**	**47.5**	**49.9**	**52.2**	**54.4**	**56.3**	**58.0**

The movements in cash generating activities between both scenarios are a combination of:

1. Capital expenditure the new inpatient unit.
2. The reduction in lifecycle costs due to the Lambeth disposal.
3. An increase in lifecycle costs due to building of the new inpatient unit.

For the preferred option, cash is forecast to be at least £30.4m over a 10 year period, increasing to £58.0m by 2028. The risk to cash is therefore seen as low at this stage and this will be considered in further detail as part of the business cases process to follow the consultation process. At this stage, what is shown is that the Trust has sufficient cash based on the assumption they can achieve the CIP values and disposal of Lambeth as set out in the assumptions above. If additional CIPs were not achieved, the cash values would deteriorate as shown in the sensitivities below. However, due to the Trusts cash reserves, the cash balance would not be reduced to the level where financial support would not be required.

8.4 Impact on Financial Sustainability Risk Rating (FSRR)

The financial sustainability risk rating (FSRR) is the NHSE&I assessment of financial risk that a Trust is exposed to and is, therefore, a key metric to consider for this transaction. Ratings go from 1 to 4, where 4 is the highest risk and 1 is the lowest risk.

The current risk rating within the Trust is a 1. Assuming that the preferred option position is achieved this risk rating will likely be reduced to level 2. This is due to the slight deficit within the surplus/ deficit position as a result of the increased depreciation and PDC charge.

8.5 Sensitivities

The Trust has run a number of sensitivities to understand the impact of different risks on the project:

8.5.1 30% Reduction in CIP (New Inpatient Unit only)

Impact on Income & Expenditure											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(314.7)	(325.5)	(335.6)	(345.7)	(357.5)	(369.9)	(383.2)	(398.1)	(413.6)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.9)	(121.4)	(122.9)	(124.5)	(126.5)	(128.8)	(131.1)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(429.8)**	**(442.0)**	**(453.5)**	**(467.1)**	**(480.4)**	**(494.4)**	**(509.7)**	**(526.9)**	**(544.7)**
Operating Surplus / (Deficit)	1.9	5.9	6.3	6.5	7.2	6.1	5.8	5.7	5.5	5.4	5.2
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.5)	(7.8)	(7.4)	(7.1)	(7.0)	(6.9)	(6.8)	(6.7)
Surplus / (Deficit)	**4.2**	**(0.3)**	**0.0**	**0.0**	**(0.6)**	**(1.3)**	**(1.3)**	**(1.4)**	**(1.4)**	**(1.5)**	**(1.5)**

Impact on Statement of Financial Position											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Non-current assets	236.5	238.0	245.2	281.7	271.5	265.8	264.0	262.1	260.4	258.8	257.3
Current assets	109.3	98.0	91.3	55.5	65.8	71.2	72.4	73.5	74.7	75.9	76.8
Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.6)	(55.6)	(56.2)	(56.9)	(57.8)	(58.8)	(59.8)
Total assets less current liabilities	**281.5**	**283.3**	**283.3**	**283.3**	**282.7**	**281.4**	**280.1**	**278.8**	**277.4**	**275.9**	**274.4**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)

Total net assets employed	**275.6**	**276.0**	**276.0**	**276.0**	**275.5**	**274.2**	**272.9**	**271.6**	**270.2**	**268.7**	**267.2**
Total taxpayers and other equity	**275.6**	**276.0**	**276.0**	**276.0**	**275.5**	**274.2**	**272.9**	**271.6**	**270.2**	**268.7**	**267.2**

Impact on Cash Flows											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Operating surplus/(deficit)	4.2	(0.3)	0.0	0.0	(0.6)	(1.3)	(1.3)	(1.4)	(1.4)	(1.5)	(1.5)
Net cash generated from / (used in) operations	10.2	9.5	16.8	16.7	17.5	17.8	17.1	16.9	16.8	16.4	16.3
Net cash generated from/(used in) investing activities	8.9	(14.5)	(16.7)	(46.0)	0.8	(4.8)	(8.5)	(8.5)	(8.6)	(8.7)	(8.9)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.9)	(8.1)	(7.8)	(7.5)	(7.4)	(7.4)	(7.3)	(7.2)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(6.6)**	**(36.1)**	**10.2**	**5.2**	**1.0**	**1.0**	**0.8**	**0.5**	**0.2**
Cash and cash equivalents at start of period	70.2	84.0	73.2	66.5	30.4	40.6	45.9	46.9	47.9	48.7	49.1
Cash and cash equivalents at end of period	**84.0**	**73.2**	**66.5**	**30.4**	**40.6**	**45.9**	**46.9**	**47.9**	**48.7**	**49.1**	**49.3**

A 30% reduction in yearly CIP for new inpatient unit – There will be a negative impact on the SOCI position ranging from a breakeven position in 2020/21 to £1.5m (deficit) in 2028/29. Furthermore, as pay and operating expenditure costs increase on a yearly basis, this builds more risk for the project and reduces the cash / cash equivalent balance to £49.3m in 2028/29 compared to the 'do nothing' option at £72.8m for the same year.

8.5.2 30% Reduction in CIP (Whole Organisation)

Impact on Income & Expenditure											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(316.2)	(328.6)	(340.3)	(352.2)	(365.8)	(380.2)	(395.1)	(411.8)	(429.1)
Other operating expenditure	(118.3)	(114.4)	(115.6)	(117.5)	(119.6)	(123.7)	(125.8)	(128.0)	(130.5)	(133.2)	(136.0)

Total Operating Expenditure	**(404.4)**	**(419.6)**	**(431.8)**	**(446.1)**	**(459.8)**	**(475.8)**	**(491.6)**	**(508.2)**	**(525.6)**	**(545.0)**	**(565.1)**
Operating Surplus / (Deficit)	1.9	5.9	4.3	2.4	0.9	(2.6)	(5.4)	(8.2)	(10.4)	(12.7)	(15.2)
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.5)	(7.7)	(7.3)	(7.0)	(6.9)	(6.8)	(6.7)	(6.7)
Surplus / (Deficit)	**4.2**	**(0.3)**	**(2.0)**	**(4.0)**	**(6.8)**	**(9.9)**	**(12.4)**	**(15.1)**	**(17.2)**	**(19.5)**	**(21.9)**

Impact on Statement of Financial Position											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Non-current assets	236.5	238.0	245.2	281.7	271.5	265.8	264.0	262.1	260.4	258.8	257.3
Current assets	109.3	98.0	89.6	49.9	54.2	51.3	41.6	29.4	15.0	(1.6)	(20.9)
Current liabilities	(64.3)	(52.8)	(53.5)	(54.4)	(55.3)	(56.5)	(57.5)	(58.4)	(59.5)	(60.7)	(61.9)
Total assets less current liabilities	**281.5**	**283.3**	**281.3**	**277.2**	**270.4**	**260.5**	**248.1**	**233.1**	**215.9**	**196.5**	**174.6**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)
Total net assets employed	**275.6**	**276.0**	**274.1**	**270.0**	**263.2**	**253.3**	**240.9**	**225.9**	**208.7**	**189.3**	**167.4**
Total taxpayers and other equity	**275.6**	**276.0**	**274.1**	**270.0**	**263.2**	**253.3**	**240.9**	**225.9**	**208.7**	**189.3**	**167.4**

Impact on Cash Flows											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Operating surplus/(deficit)	4.2	(0.3)	(2.0)	(4.0)	(6.8)	(9.9)	(12.4)	(15.1)	(17.2)	(19.5)	(21.9)
Net cash generated from / (used in) operations	10.2	9.5	15.0	12.9	11.4	9.3	6.2	3.3	1.1	(1.5)	(3.9)
Net cash generated from/(used in) investing activities	8.9	(14.5)	(16.7)	(46.0)	0.8	(4.8)	(8.6)	(8.7)	(8.8)	(9.0)	(9.3)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.8)	(8.0)	(7.6)	(7.3)	(7.1)	(7.0)	(6.9)	(6.8)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(8.4)**	**(39.9)**	**4.2**	**(3.1)**	**(9.8)**	**(12.5)**	**(14.8)**	**(17.3)**	**(20.0)**
Cash and cash equivalents at start of period	70.2	84.0	73.2	64.8	24.9	29.0	25.9	16.2	3.7	(11.1)	(28.4)
Cash and cash equivalents at end of period	**84.0**	**73.2**	**64.8**	**24.9**	**29.0**	**25.9**	**16.2**	**3.7**	**(11.1)**	**(28.4)**	**(48.4)**

A 30% reduction in CIP for the Trust in **every year** – There will be a negative impact on the SOCI position ranging from £2.0m (deficit) in 2020/21 to £21.9m (deficit) in 2028/29. In comparison to the first sensitivity, measuring a 30% reduction in CIP for the new inpatient unit, there is a breakeven position to a £1.5m (deficit) for the same time period. This shows that the financial risk is limited for the new inpatient unit. Furthermore, if the Trust does not achieve their CIP target, there will be an adverse impact on cash flows in 2026/27 of £11.1m (deficit) and this trend will continue to adversely impact the cash flows and reduce them to £48.4m (deficit) by 2028/29 compared to the surplus in the 'do nothing' option at £72.8m for the same year.

8.5.3 0.5% increase in pay costs each year.

Impact on Income & Expenditure											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(316.3)	(328.8)	(340.3)	(351.8)	(365.6)	(380.2)	(396.0)	(413.5)	(431.8)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.8)	(121.1)	(122.6)	(124.2)	(126.2)	(128.4)	(130.7)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(431.4)**	**(445.3)**	**(458.0)**	**(472.9)**	**(488.3)**	**(504.4)**	**(522.1)**	**(541.9)**	**(562.5)**
Operating Surplus / (Deficit)	1.9	5.9	4.7	3.2	2.7	0.4	(2.0)	(4.4)	(6.9)	(9.6)	(12.6)
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.5)	(7.7)	(7.4)	(7.1)	(7.0)	(6.9)	(6.8)	(6.7)
Surplus / (Deficit)	**4.2**	**(0.3)**	**(1.6)**	**(3.3)**	**(5.1)**	**(7.0)**	**(9.1)**	**(11.3)**	**(13.8)**	**(16.4)**	**(19.3)**

Impact on Statement of Financial Position											
	Historic	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Non-current assets	236.5	238.0	245.2	281.7	271.5	265.8	264.0	262.1	260.4	258.8	257.3
Current assets	109.3	98.0	89.8	50.6	56.4	56.0	49.4	40.6	29.5	15.6	(1.2)
Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.5)	(55.4)	(56.1)	(56.8)	(57.6)	(58.6)	(59.6)
Total assets less current liabilities	**281.5**	**283.3**	**281.7**	**278.4**	**273.4**	**266.4**	**257.3**	**246.0**	**232.2**	**215.8**	**196.5**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)

Total net assets employed	**275.6**	**276.0**	**274.5**	**271.2**	**266.2**	**259.2**	**250.1**	**238.8**	**225.0**	**208.6**	**189.3**
Total taxpayers and other equity	**275.6**	**276.0**	**274.5**	**271.2**	**266.2**	**259.2**	**250.1**	**238.8**	**225.0**	**208.6**	**189.3**

Impact on Cash Flows											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Operating surplus/(deficit)	4.2	(0.3)	(1.6)	(3.3)	(5.1)	(7.0)	(9.1)	(11.3)	(13.8)	(16.4)	(19.3)
Net cash generated from / (used in) operations	10.2	9.5	15.2	13.4	12.9	11.9	9.3	6.9	4.3	1.4	(1.5)
Net cash generated from/(used in) investing activities	8.9	(14.5)	(16.7)	(46.0)	0.8	(4.8)	(8.6)	(8.6)	(8.8)	(8.9)	(9.2)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.8)	(8.1)	(7.7)	(7.4)	(7.3)	(7.1)	(7.0)	(6.9)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(8.2)**	**(39.4)**	**5.6**	**(0.5)**	**(6.7)**	**(9.0)**	**(11.6)**	**(14.5)**	**(17.6)**
Cash and cash equivalents at start of period	70.2	84.0	73.2	65.0	25.6	31.2	30.7	24.0	14.9	3.4	(11.1)
Cash and cash equivalents at end of period	**84.0**	**73.2**	**65.0**	**25.6**	**31.2**	**30.7**	**24.0**	**14.9**	**3.4**	**(11.1)**	**(28.7)**

A 0.5% increase in pay costs each year – This variable shows that a slight increase in pay costs each year (on top of the assumed 2.9% pay inflation) will have a maximum impact on the SOCI by £19.3m (deficit) in 2028/29. An adverse cash / cash equivalent balance is also forecast from 2027/28 (£11.1m (deficit)) and will reduce to £28.7m (deficit) by 2028/29 compared to the 'do nothing' option at £72.8m for the same year, a movement of £44.1m. This demonstrates a growing risk year on year both on the SOCI and cash flow balance. Note that it is 0.5% in addition to the 2.9% inflation already assumed in the base case scenario and it assumes both that this additional growth would occur in each and every year as well as the fact that this would not be funded by commissioners.

8.5.4 10% increase in the cost of new inpatient unit.

Impact on Income & Expenditure											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**

Staff costs	(286.1)	(305.3)	(314.7)	(325.5)	(335.2)	(344.7)	(356.5)	(368.9)	(382.1)	(397.1)	(412.5)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.8)	(121.2)	(122.7)	(124.3)	(126.3)	(128.5)	(130.8)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(429.8)**	**(442.0)**	**(452.9)**	**(465.9)**	**(479.2)**	**(493.1)**	**(508.4)**	**(525.6)**	**(543.3)**
Operating Surplus / (Deficit)	1.9	5.9	6.3	6.5	7.8	7.3	7.0	6.9	6.8	6.7	6.6
Non-operating expenditure	2.3	(6.2)	(6.3)	(6.6)	(8.0)	(7.6)	(7.4)	(7.3)	(7.1)	(7.0)	(6.9)
Surplus / (Deficit)	**4.2**	**(0.3)**	**0.0**	**(0.1)**	**(0.2)**	**(0.3)**	**(0.3)**	**(0.3)**	**(0.3)**	**(0.3)**	**(0.3)**

Impact on Statement of Financial Position											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Non-current assets	236.5	238.0	247.1	287.4	277.8	272.1	270.2	268.2	266.4	264.7	263.2
Current assets	109.3	98.0	89.4	49.7	59.6	66.0	68.2	70.5	72.8	75.2	77.4
Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.5)	(55.4)	(56.1)	(56.8)	(57.6)	(58.6)	(59.6)
Total assets less current liabilities	**281.5**	**283.3**	**283.3**	**283.2**	**283.0**	**282.6**	**282.3**	**282.0**	**281.7**	**281.3**	**281.0**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)
Total net assets employed	**275.6**	**276.0**	**276.0**	**276.0**	**275.8**	**275.4**	**275.1**	**274.8**	**274.4**	**274.1**	**273.8**
Total taxpayers and other equity	**275.6**	**276.0**	**276.0**	**276.0**	**275.8**	**275.4**	**275.1**	**274.8**	**274.4**	**274.1**	**273.8**

Impact on Cash Flows											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Operating surplus/(deficit)	4.2	(0.3)	0.0	(0.1)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
Net cash generated from / (used in) operations	10.2	9.5	16.8	16.7	18.0	19.0	18.4	18.3	18.2	17.9	17.8
Net cash generated from/(used in) investing activities	8.9	(14.5)	(18.6)	(49.8)	0.2	(4.8)	(8.5)	(8.5)	(8.6)	(8.7)	(8.9)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.9)	(8.4)	(8.0)	(7.8)	(7.7)	(7.6)	(7.5)	(7.4)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**(8.5)**	**(40.0)**	**9.8**	**6.2**	**2.1**	**2.1**	**2.0**	**1.7**	**1.4**
Cash and cash equivalents at start of period	70.2	84.0	73.2	64.6	24.6	34.4	40.6	42.7	44.8	46.8	48.4

Cash and cash equivalents at end of period	**84.0**	**73.2**	**64.6**	**24.6**	**34.4**	**40.6**	**42.7**	**44.8**	**46.8**	**48.4**	**49.9**

A 10% increase in the cost of new inpatient unit – From a SOCI perspective, there will be a negative impact from 2022/23 until the end of 2028/29 ranging between £0.1m to £0.3m. The deficit in the SOCI is projected to reduce by £0.3m each year from 2023/24. The impact on cash flow will see a decrease of £2.0m in 2020/21, compared to the 'do nothing' option. However, the cash balance will be within the range of £24.6m to £64.6m in the sensitivity measure.

8.5.5 One year delay in the building of new inpatient unit.

Impact on Income & Expenditure											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Income from service user care activities	342.3	354.4	366.8	379.6	392.9	406.7	420.9	435.7	450.9	466.7	483.1
Other Operating Income	63.9	71.2	69.3	68.8	67.8	66.5	65.3	64.4	64.3	65.6	66.9
Total Income	**406.2**	**425.6**	**436.1**	**448.5**	**460.7**	**473.2**	**486.3**	**500.1**	**515.2**	**532.3**	**549.9**
Staff costs	(286.1)	(305.3)	(314.7)	(325.5)	(335.2)	(344.7)	(356.5)	(368.9)	(382.1)	(397.1)	(412.5)
Other operating expenditure	(118.3)	(114.4)	(115.1)	(116.4)	(117.8)	(120.0)	(122.6)	(124.2)	(126.2)	(128.4)	(130.7)
Total Operating Expenditure	**(404.4)**	**(419.6)**	**(429.8)**	**(442.0)**	**(452.9)**	**(464.7)**	**(479.1)**	**(493.0)**	**(508.3)**	**(525.5)**	**(543.2)**
Operating Surplus / (Deficit)	1.9	5.9	6.3	6.5	7.8	8.6	7.1	7.0	6.9	6.8	6.7
Non-operating expenditure	2.3	(6.2)	(6.3)	(5.9)	(6.5)	(7.2)	(7.2)	(7.1)	(7.0)	(6.9)	(6.8)
Surplus / (Deficit)	**4.2**	**(0.3)**	**0.0**	**0.7**	**1.3**	**1.4**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**

Impact on Statement of Financial Position											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Non-current assets	236.5	238.0	226.2	243.5	264.8	267.7	265.8	264.0	262.1	260.4	258.8
Current assets	109.3	98.0	110.4	94.3	75.0	74.3	76.8	79.3	81.9	84.6	87.1

Current liabilities	(64.3)	(52.8)	(53.3)	(53.9)	(54.5)	(55.4)	(56.1)	(56.8)	(57.6)	(58.6)	(59.6)
Total assets less current liabilities	**281.5**	**283.3**	**283.3**	**283.9**	**285.3**	**286.6**	**286.6**	**286.5**	**286.4**	**286.4**	**286.3**
Non-current liabilities	(5.9)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)	(7.2)
Total net assets employed	**275.6**	**276.0**	**276.0**	**276.7**	**278.1**	**279.4**	**279.4**	**279.3**	**279.2**	**279.2**	**279.1**
Total taxpayers and other equity	**275.6**	**276.0**	**276.0**	**276.7**	**278.1**	**279.4**	**279.4**	**279.3**	**279.2**	**279.2**	**279.1**

Impact on Cash Flows											
	Historic	**Outturn**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	31-Mar-19	31-Mar-20	31-Mar-21	31-Mar-22	31-Mar-23	31-Mar-24	31-Mar-25	31-Mar-26	31-Mar-27	31-Mar-28	31-Mar-29
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Operating surplus/(deficit)	4.2	(0.3)	0.0	0.7	1.3	1.4	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Net cash generated from / (used in) operations	10.2	9.5	16.8	16.7	18.0	19.0	18.4	18.3	18.2	17.9	17.8
Net cash generated from/(used in) investing activities	8.9	(14.5)	2.3	(26.8)	(30.7)	(12.2)	(8.4)	(8.5)	(8.5)	(8.6)	(8.6)
Net cash generated from/(used in) financing activities	(5.3)	(5.9)	(6.7)	(6.2)	(6.8)	(7.6)	(7.6)	(7.5)	(7.4)	(7.4)	(7.3)
Increase/(decrease) in cash and cash equivalents	**13.8**	**(10.8)**	**12.4**	**(16.3)**	**(19.5)**	**(0.8)**	**2.4**	**2.2**	**2.2**	**1.9**	**1.9**
Cash and cash equivalents at start of period	70.2	84.0	73.2	85.6	69.3	49.8	49.0	51.4	53.6	55.8	57.8
Cash and cash equivalents at end of period	**84.0**	**73.2**	**85.6**	**69.3**	**49.8**	**49.0**	**51.4**	**53.6**	**55.8**	**57.8**	**59.6**

One year delay in building the new inpatient unit – A one year delay will adversely start to impact cash flows from 2022/23 by £16.9m compared to the 'do nothing' option. The Trust will see an adverse difference of (£13.2m (deficit)) in cash reduction compared to the 'do nothing' option by the end of 2028/29.

8.6 Affordability of the preferred way forward

With the exception of sensitivities that measure a 30% CIP reduction (for the new inpatient unit and Trust) and pay costs rising at an additional 0.5% per annum (on top of the 'do nothing' option level assumed of 2.9%), the proposal is affordable in terms of overall cash balance. The main risk to affordability is overarching CIP delivery and this is also the case in the 'do nothing' scenario.

Sensitivities that measure a 0.5% pay and 30% CIP reduction (for both the new inpatient unit and Trust) are projected to have a negative impact on the SOCI position ranging from £0.6m (deficit) to £21.9m (deficit). As forecast costs increase on a yearly basis, this builds risk for the project and also reduces the cash equivalent balance to £48.4m in 2028/29. In comparison to the 'preferred' option, the cash balance position reduces to a minimum point of £30.4m in 2021/22 in contrast to the £62.6m cash position for the 'do nothing' scenario in 2020/21.

Neither option is likely to have an impact on activity. Expenditure on staff and operating costs is forecast to increase, driven by annual inflation and compounding growth. The overall impact to the SOCI projections is at a non-operational level, with the largest impact being additional depreciation and PDC, offset by savings.

Broader commercial proposals are also being developed by the Trust which, if approved, would enable the Trust to generate additional efficiency savings from management of the estate and the capital programme alongside generating additional income from commercial sources which would mitigate some of the risks of delivery of the additional affordability challenge.

8.7 Conclusions

From a cash balance perspective, the proposed option is affordable. Although the cash balance ranges from £30.4m to £66.5m, there are sufficient funds of circa £10.0m to cover for working capital. Planned CIP targets are also built into the proposed option. However, if the additional CIP of £3.6m was not achieved, the cash position would deteriorate.

The potential for the Trust to deliver recurring financial benefits as a result of the changes will be considered in greater detail as part of the future business cases required for this programme following the consultation.

There is also no substantive financial impact assumed on any other parties, including both of the CCGs due to the block-payment contract provided to the Trust.

Chapter 9. Implementation

This section sets out the practical steps needed to deliver the option identified in the Options for consultation, including project team, governance, risk management and timelines. It sets out what happens after the consultation phase, namely, how we plan to manage the project and sets out in more detail the actions that will be required to ensure the successful delivery of the scheme in accordance with best practice.

9.1 Post-consultation process

Following the close of the consultation and decision-making process as set out at the end of Section [6], the CCGs will hand back decision making responsibility to the Trust, SLaM. Dependent on the outcome of the consultation and decision making process, SLaM will implement the proposal.

9.2 Programme management arrangements

We have implemented a robust programme management and governance structure which ensures accountability through clear allocation of responsibilities, and provides assurance through regular reporting, enabling quick identification and addressing of any issues as they arise. This section describes the following programme management arrangements:

- Programme management approach;
- Project implementation budget;
- Risk Management Arrangements; and
- Benefits management.

9.2.1 Project management approach

We will follow the PRINCE2 principles in their approach to project management to ensure the delivery of the project. This is the de facto standard in use in the public sector in the UK.

9.2.2 Project implementation budget

The project implementation costs for the project are expected to be £1.7m as shown in Appendix [8]. This is over the project implementation period and are inclusive of costs associated with the programme team, town planning and technical support. The implementation costs will also cover Programme Director and management costs, a small proportion to cover back fill, financial modelling, support with writing the PCBC and full business case. A summary breakdown of the project implementation budget can be found in Appendix [8]. Furthermore, a cost plan summary for the preferred option and can be found in Appendix [9].

9.2.3 Risk Management

Our approach to risk management, in accordance with its own board assurance framework, the Capital Investment Manual and the Treasury Green Book, is designed to ensure that the risks and issues are identified, assessed, and mitigation plans are developed in a risk management plan. All risks have a responsible owner identified. Our risk rating process is shown below. The risks associated with the preferred option continue to be reviewed to monitor the development of risks and implementation of mitigation actions, as well as identifying new risks as they arise.

There is an existing risk management process in place for the Programme, and this process will continue throughout the implementation and delivery phase of the programme. The overarching risk management policy is based on an iterative process of:

- Identifying and prioritising the risks to the achievement of the programme aims and objectives;
- Evaluating the likelihood of those risks being realised and the impact should they be realised; and
- Managing the risks efficiently, effectively and economically.

Consequence		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Figure [9.1]: The Trust's Risk Rating process

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

The Programme Office maintains the Risk Register for the Programme. Project risk registers are maintained by the project manager/workstream lead and risks escalated where necessary via reporting.

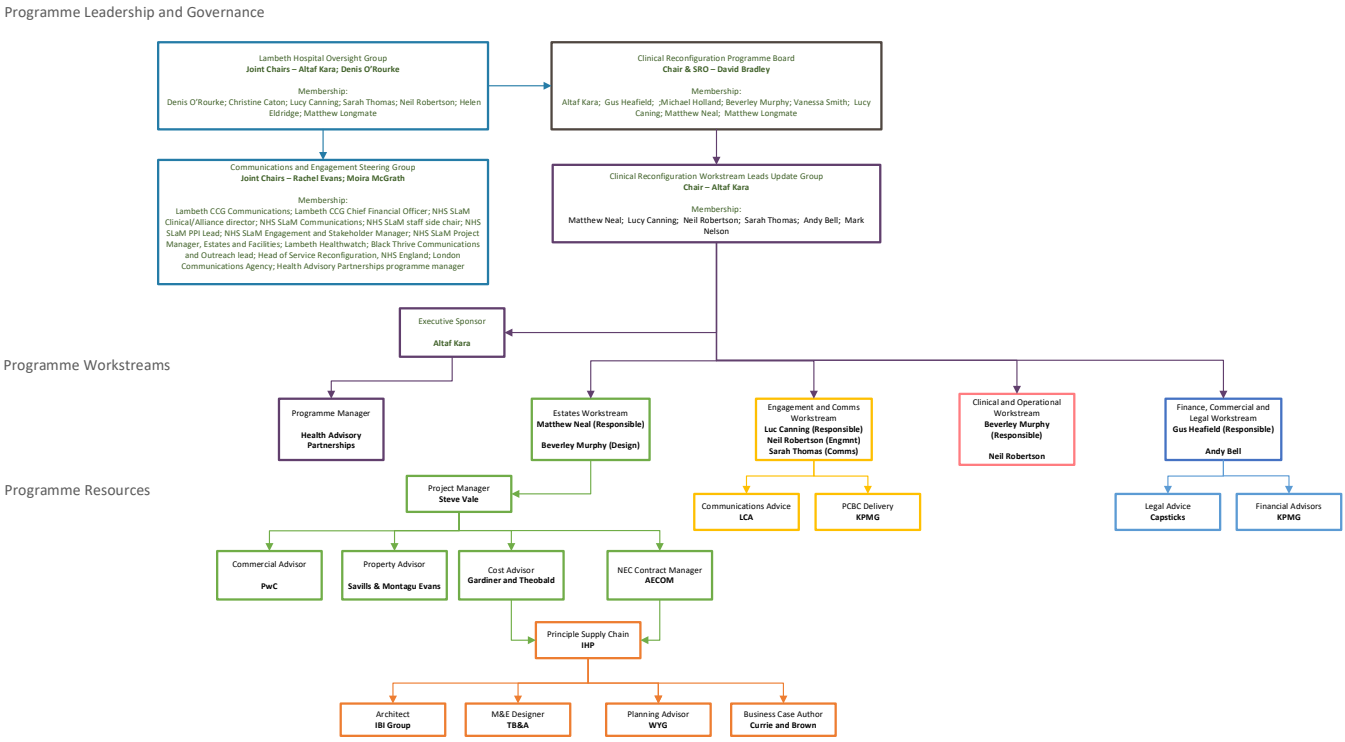
The risk register is outlined in Appendix [5]. All risks in the table have been assessed based on their probability and impact to provide a risk rating. Risks provided are classified as 'moderate' while only a few have a 'high' rating. All risks identified have a mitigating action to describe how they will be managed.

9.2.4 Programme governance structure

Figure [9.2]: Governance Structure

9.3 Project Roles and Responsibilities

The core roles and responsibilities are described below.



9.3.1 Trust Board

The programme is owned by the Board of South London and Maudsley NHS Foundation Trust. The Senior Responsible Owner reports on progress and management of risk to the Trust Board at regular intervals as required.

Members of the Trust Board:

June Mulroy	Interim Chair
Beatrice Butsana-Sita	Non-Executive Director
Professor Ian Everall	Non-executive Director
Mike Franklin	Non-executive Director
Duncan Hames	Non-executive Director
Dr Geraldine Strathdee	Non-executive Director
Anna Walker	Non-executive Director
David Bradley	Chief Executive
Dr Michael Holland	Medical Director
Beverley Murphy	Interim Chief Operating Officer

Gus Heafield	Chief Financial Officer
Vanessa Smith	Interim Director of Nursing
Altaf Kara	Director of Strategy and Commercial

9.3.2 Programme Board

We have an established a Programme Board to ensure that the programme achieves its objectives in full and on time. The Programme Board is chaired by the Senior Responsible Owner (SRO) who takes executive responsibility for decisions relating to the programme. The membership of the Programme Board includes an individual who represents each group of those senior managers who have an interest in the programme and whose activity will be affected by the programme.

Senior Responsible Owner		David Bradley
Financial Responsible Owner		Gus Heafield
Strategic Responsible Owner (Executive Sponsor)		Altaf Kara
Senior User Group Representatives	Interim Chief Operating Officer	Beverley Murphy
	Interim Director of Nursing	Vanessa Smith
	Medical Director	Dr Michael Holland

9.3.3 Project Team

The roles of the project team are summarised below:

Chair & SRO	The Chair and SRO is recognised as a key role in existing programme and project management methodologies such as Managing Successful Programmes and PRINCE2 and, for construction procurement projects, Achieving Excellence. As owner of the business change, the SRO is the chair of the Programme Board or Project Board.
Executive Sponsor	An Executive Sponsor provides the leverage needed to promote, defend and enhance the success of the business initiative.
Project Manager	The Project Manager (PM) has the responsibility to administer and manage the contract and engage stakeholders while being responsible for the day to day progress of the scheme's activities. The Project Manager implements and maintains the project's Risk Register, ensures the processes and procedures of the NEC Contract are being followed by all parties and advises the Project Director of contract matters. The Project Manager is the point of direct contact for the Contractor. The PM reports to the Project Director and seeks approval for additional expenditure and change.
Programme Manager	The Programme Manager is responsible, on behalf of the Senior Responsible Owner, for delivering change. The role requires effective co-ordination of the programme projects and management of their inter-

	dependencies including oversight of any risks and issues arising. It also includes the co-ordination of the new capability for the business to enable effective change and realisation of projected benefits.
Commercial Advisor	The role of the Commercial Advisor involves developing and initiating contracts, tender evaluation and contracts negotiation. They will bring good knowledge of legal aspects in the supply chain and contracts. They also are responsible for financial reporting involving projects and contracts.
Property Advisor	A Property Advisor has deeper knowledge in a specific area and cross-functional and multidisciplinary expertise. The advisor's role is that of a mentor or guide and differs categorically from that of a task-specific consultant. An advisor is typically part of the leadership group.
Cost Advisor	The Cost Advisor supports the Project Manager and the Project Director and collaborates in the development of business cases, design option appraisal, review of assessments submitted for payment, open book audit and control of expenditure.
NEC Contract Manager	The role of the NEC Contract Manager is to offer useful guidance and practical tips to ensure that projects are successfully managed and delivered.
Principal Supply Chain Partner	The PSCP is the Principal Contractor. They are responsible for the management and delivery of the development of design options and associated costings, detailed design and activity schedules, risk management, cost control and reporting, and all activities associated with construction, commissioning and handover.
Architect	Architects in construction play an important role and they are responsible for visual appearance of the buildings and structures before final structural design. They develop a facility as per the design concept and the requirements specified by the client.
Mechanical and Electrical (M&E) Designer	The M&E professional plays a key role in facilitating the input of project staff, partners and other stakeholders in project design and measurement activities. Responsibilities include: providing expertise in M&E planning and methodology. They also participate in and provide support to project design activities including development of project theories of change and strategic frameworks (Results Frameworks and Log Frames).
Planning Advisor	The Planning Advisor provides consultancy and peer support, learning events and online resources to help stakeholders understand and respond to planning reform.
Business Case Author	A Business Case Author captures the reasoning for initiating a project or task. They help present a well-structured written document, aligned to the scope of the proposal.
Communications Advisor	The Communications Advisor will work with the project manager to research information, review & prepare documents and attend meetings.
Legal Advisor	The Legal Advisor is primarily responsible for providing high quality advice to the organisation or the client on major legal issues and problems. They

	are responsible for formulating the best possible legal solution after analysing the legal problem in depth.
Financial Advisor	The Financial Advisor can provide many different services such as investment management, income and indirect tax preparation and advice and estate planning.

9.3.4 Trust implementation team

Our implementation team will comprise of approximately 3.5 whole time equivalents (WTE) to be engaged at various stages during the implementation phase. The functional requirements during the implementation include:

- Programme Director;
- Project Director;
- Project Managers:
- Finance Support;
- HR and Workforce Support;
- Clinical Support; and
- Administration.

Figure [9.3]: Trust implementation team

Role	2019/20	2020/2021	2021/22	2022/23
Programme Management Office	WTE	WTE	WTE	WTE
Leadership	1	1	1	1
Management	0.5	0.5	0.75	1
Activity Modelling	0.5	0.25		
Financial	0.5	0.5	0.25	0.25
HR support			0.25	0.5
Project Support	1	1	1	1
Total	**3.5**	**3.25**	**3.25**	**3.75**

This proposed staffing profile for the implementation team has been informed by the recommendations of the Project Director based on experience of similar schemes. Please note the table above is subject to change.

a) Project implementation plan

A detailed project plan is provided in Appendix [4] and the key milestones from this project plan is set out in Figure [9.4] below.

This project implementation plan covers a period from October 2019 to September 2022 when construction is completed. This sets out the project initiation stage through to project

completion. There is a caveat around the project implementation plan changing, therefore, the milestones below will be updated on a regular basis as more information becomes available and the project develops.

Figure [9.4]: Project milestones

Task Name	Item Type	Milestone Date
PCBC (Assurance Release Draft) Submitted	Document	31/10/19
Clinical Senate Review Panel	Assurance	19/11/19
National Specialist Commissioning Review Complete	Assurance	by 30/11/19
Lambeth CCG Financial Review	Assurance	by 30/11/19
NHSEI Strategy Review Complete	Assurance	by 30/11/19
Clinical Senate Report Received	Assurance	by 23/12/19
NHSEI Financial Review Complete	Assurance	by 31/12/19
PCBC (Release Document) Submitted	Document	by 31/12/19
NHSEI Regional Review Panel Approval	Approval	w/c 13/01/20
Lambeth CCG Board Approval	Approval	15/01/20
SLaM Trust Board Approval	Approval	29/01/20
Lambeth Oversight and Scrutiny Committee	Approval	30/01/20
Lambeth CCG Public Consultation Launch Meeting	Consultation	04/03/20
Public Consultation Start	Consultation	04/03/20
Public Consultation End	Consultation	31/05/20
DMBC Complete	Document	18/06/20
DMBC Approvals Complete	Approval	by 30/06/20
FBC Complete	Document	by 19/08/20
FBC SLaM Board Approval	Approval	17/09/20
Construction Start Date	Build	21/10/20
Construction End Date	Build	19/09/22

9.4 Reporting Structure

The reporting structure, in Section 5.1, starts by outlining the leadership and governance structure at the top which is supported by an oversight group (providing steering and direction as well as aligning CCG and SLaM objectives). The Communications and Engagement Steering Group is responsible for public engagement in Lambeth. The workstream leads update group manage individual project workstreams and their responsible owners. The respective project teams then report to the workstream leads on granular progress.

9.5 Change Management Plan

Day-to-day decisions are made by workstreams and the Steering Group. Any changes against the ‘do nothing’ option (schedule of accommodation, capital cost, and programme) are first

assessed to determine their impact on the cost plan and programme. The following approvals process is then undertaken:

Change	Process approval required
• Design proposal/change – finalisation and any subsequent changes to the schedule of accommodation, adjacencies, room layouts or choice of finishes or equipment, or any delay to 'sign-off' programme dates for design stages.	1. Confirmation of cost by the cost manager 2. Project team define the impact and review 3. Clinical Reconfiguration Programme Board to approve designs
• Any other day to day decisions/changes.	1. Identification of risk and changes to programme by project manager 2. Confirmation of cost by the cost manager
• Decisions/changes affecting clinical operations.	1 Identification of clinical risk and changes to programme by project manager and clinical and operational workstream lead 2 Clinical Reconfiguration Programme Board to approve changes proposed by clinical and operational workstream lead
• Significant decisions – such as directing major exceptions to the plan or halting significant elements of the plan.	1. Programme Manager to identify and assess the impact of material changes 2. Clinical Reconfiguration Programme Board to propose changes proposed by Programme Manager to the Trust Board or committee 3. Trust Board or committee to approve material change

9.6 Post-project Evaluation

We are committed to ensuring that a thorough and robust post project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project.

A thorough and robust post project evaluation will:

- Facilitate continual learning from the project to be implemented at subsequent stages as well as future projects;
- Ensure that the project adheres to the project plan/milestones and review of project risks;
- Enable measuring of project performance against project aims including the realisation of benefits; and
- Provide useful feedback and knowledge that can be shared with key stakeholders as well as the NHS as a whole.

Evaluation will be undertaken through the following investigations:

- A review of the project implementation to learn lessons for future;
- A review of the benefits detailed within this business case and confirmation that the benefits have been met;

- A review of the capital and revenue costs to confirm that the capital costs were robust and adhered to and that the actual and projected revenue costs were realistic; and
- A review of the Project Programme and adherence to it throughout the life of the project.

These investigations will focus on the perspectives of service users, staff and the project team, using stakeholder consultation meetings, staff focus groups and evaluation of data around the benefits realisation.

The arrangements for the Post Project Evaluation will be established in accordance with best practice. In addition, the Principal Supply Chain Partner (PSCP) must have a number of post contract activities to aid customer satisfaction and capture learning for future projects. These involve the activities described below:

- Lessons learned – based on feedback and a workshop arranged for this purpose;
- KPI review involving analysis and the collation of a KPI workbook; and
- Satisfaction surveys will be undertaken and the results issued to the Trust.

The planned participants in the evaluation will be as follows:

- Project Manager;
- Senior Responsible Officer;
- Director of Finance;
- Director of Nursing;
- Clinical lead;
- Staff Groups; and
- Service users Representatives.

In accordance with the Department of Health's Good Practice Guide Learning Lessons from Post Project Evaluation, the PPE will be conducted in accordance with the following activities:

Stage	Activity
1	Undertake interim reviews of processes, handover and communication to learn from works at each phase
2	Produce detailed plan for undertaking the PPE
3	On completion of the works, evaluate initial outputs and undertake review of the processes followed to identify lessons learned
4	Undertake initial evaluation of the project outputs following completion of the works
5	Evaluation of achievement of benefits and project objectives for entire project one year post completion

This will be carried out by the Project Manager with support as appropriate.

Going forward, service users, staff and the project team will be asked to evaluate the project through the use of questionnaires, stakeholder consultation meetings, staff focus groups and benefits realisation data.

The arrangements for the Post Project Evaluation will be established in accordance with best practice. We will identify responsibilities and resource requirements for management of the Post Project Evaluation during the PCBC development period, and Post Project Evaluation will be an integral part of the post implementation operating model.

9.7 Approval process for investment by the Trust

Through discussion with NHS England and NHS Improvement, an agreed process has been identified with South London and Maudsley NHS Foundation Trust which is aligned to the Regulatory Guidance for Transactions22.

The guidance for capital investment describes a two stage process of an Outline Business Case and Full Business Case for capital investment transactions where the regulator is able to risk assess the investment as low risk.

This investment requires no external capital borrowing or other such support and is not of a complex or contentious manner. As such NHS England and NHS Improvement have indicatively identified this as a low risk investment and agreed the following process:

- This Pre-Consultation Business Case along with a detailed financial model will act as the Outline Business Case and, if appropriate to proceed;

- A Full Business Case will be then be developed for organisational due diligence purposes.

[22] https://improvement.nhs.uk/documents/1983/Transactions_guidance_2017_Final.pdf

Chapter 10. Key Tests

This section sets out how the consultation process has met the Secretary of State's four tests and NHSE Bed Closures tests. The NHS England 'Planning and delivering service changes for service users' published in December 2013, outlined good practice for commissioners on the development of proposals for major service changes and reconfigurations.

Building on this, the 2014/15 mandate from the Secretary of State to NHS England and NHS Improvement, outlines that proposed service changes should be able to demonstrate evidence to meet four tests:

- Strong Public and service user Engagement;
- Consistency with Current and Prospective need for service user choice;
- A clear clinical evidence base; and
- Support for proposals from clinical commissioners.

Reconfiguration proposals must meet the four tests before they can proceed. These tests are designed to demonstrate that there has been a consistent approach to managing change, and therefore, build confidence within the service, and with service users and the public.

From 1 April 2017, NHSE introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures, and this will be an additional test included in this document.

Alongside these tests required by NHSE the Mayor of London has released a framework for major hospital reconfigurations which has an independent series of six tests. To ensure alignment with both of these regulatory frameworks whilst avoiding duplication we have assessed both schemes and aligned the questions as closely as is possible, as follows:

NHS England 5 Tests	Mayor's 6 Tests
Test 1: Strong Public and Service User Engagement	Test 6: Patient and public engagement
Test 2: Consistency with Current and Prospective need for service user choice	Test 1: Health inequalities and the prevention of ill health Test 4: Impact and Social Care
Test 3: A clear clinical evidence base	
Test 4: Support for proposals from clinical commissioners	Test 5: Clinical Support Test 3: Funding
Test 5: NHSE's Bed Closures Test	Test 2: Hospital bed capacity

10.1 Test 1: Strong Public and Service User Engagement

Mayor's Test 6 – Patient and public engagement

This test evaluates how service users and the public have been involved in the development of the proposals for the redevelopment of the site. The extensive stakeholder engagement undertaken to date and that which is proposed over the course of the project is laid out in detail

in Chapter [6] of this document. The methods and approaches for consultation have included presentations, discussions, surveys, meetings and emails.

There has been strong engagement with stakeholders to deliver the engagement plan. A summary of activities and methods of approach for consultation include:

- Establishing a Communications and Engagement steering group - responsible for developing the communications and engagement activity required to support the programme.
- Developing key messages and FAQs - to accurately capture and explain the benefits that are foreseen for people using the services and the process for engaging staff and stakeholders in developing a Pre-consultation Business Case and preferred option for consultation.
- Stakeholder Mapping - as part of the PCBC all clinical and non-clinical staff, service user representative groups, service users, families and carers involved in the proposed changes will be mapped out. Through identifying specific groups, this will ensure their roles in the programme are considered, their level of engagement understood, and how they will influence the development of the proposals.
- Communication and Engagement activity with Lambeth Hospital - On 21 May 2019 a paper was sent to the SLaM Public Board Meeting to ask for the Board member's approval to start engaging with staff, service users and all other relevant stakeholders on proposed service changes to the Lambeth Hospital. The paper recognised the urgent need to improve community and inpatient facilities in order to be able to deliver SLaM's clinical priorities. A number of activities were carried out as part of the pre-engagement phase. These included face-to-face briefings with staff and letters were issued to key stakeholders at Lambeth Council and Healthwatch.
- Staff Engagements - A series of face-to-face briefing sessions were held with affected staff at Lambeth Hospital in 2019 ahead of Trust Board meetings. Meetings were with local managers and directorate leaders, ward staff, onsite community teams, social care teams and onsite voluntary services. Overall the feedback from these sessions has been positive. To follow up, a further briefing note was provided and a series of workshops were arranged in early July 2019 for teams to review and record the likely impact of the various options.
- External Stakeholder engagement – Letters have been sent to key stakeholders setting out the context and early details of the proposed changes. This was then followed by a meeting to seek their views on the proposals, plans for engagement and how best to involve them and where relevant. Letters were also sent to local MPs and local Southwark stakeholders.

A staff and service user engagement correspondence log in Appendix [10] further illustrates staff feedback from the consultation. In addition to this, a stakeholder log in Appendix [11] outlines the stakeholders that were engaged, their correspondence and methods of follow up.

10.2 Test 2: Consistency with Current and Prospective need for service user choice

Mayor's Test 1: Health inequalities and the prevention of ill health
Mayor's Test 4: Impact and Social Care

This test is to illustrate whether the proposed redevelopment will maintain the availability of service user choice.

The entry pathway will remain the same for service users following the proposed redevelopment. As the clinical model remains unchanged, with the majority of services

continuing to be delivered in the community and via primary care, the range of service user choice is unaffected. Due to improved access to early interventions, the acuity of service users requiring inpatient care is expected to rise. This rise will result in higher demand for specialist clinical interventions and a greater need for clinical expertise. Geographical aggregation of inpatient services reduces the dilution of access to these specialist clinical resources, allowing more agile and responsive intervention where needed.

The proposed changes will have minimal impact on the choices available to service users due to the fact that there is no change in the number of providers serving the local area. Maudsley Hospital services will be delivered 2.5 miles further away from the current inpatient service delivery for Lambeth residents.

Service user choice would also be improved from a quality perspective as with the proposed redevelopment, service users would receive care from a purpose-built, higher quality, and safer facility. This increase in quality is in line with the shared vision of the CCG and Trust to deliver excellence in the area of mental health and wellbeing; “everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all”.

10.3 Test 3: A clear clinical evidence base

Mayor’s Test 1: Health inequalities and the prevention of ill health
Mayor’s Test 4: Impact and Social Care

This test is to demonstrate sufficient clinical evidence and clarity on the case for change. This is clearly outlined in Chapter [3]. The independent verification of this case for change will be gained through submission for consideration by the London Clinical Senate, engagement with a range of clinicians as detailed below, and using reports from the CQC reports.

- CQC report - Our most recent CQC report was published in July 2019, where the Trust received an overall rating of “Good” for the second year running. The report published in August 2017 identified the overall rating as “Requiring Improvement”. This was due to incidents where service users identified as in need of a Mental Health Act assessment, were not assessed properly. This was driven by a lack of hospital beds, complicated further by issues beyond our control including the availability of AMHPs and the police. This placed service users and others at potential risk, and a significant responsibility on care coordinators in managing their needs in the community. After publication of the 2017 report, the CQC was briefed on our plans to review these risks.

- The King’s Fund report – This identified key drivers in why mental health services have moved from a model of institutional care and long term acute facilities to care delivered by community mental health teams. The National Service Framework, published by the Department of Health in 1999 placed great emphasis to strengthen and develop community service infrastructure in order to prevent admission to hospital, reduce length of admission and improve service user experience. More recently, demand for specialist mental health services increased by 47% to 1.6 million service user contracts, while the average number of available mental health beds fell by 28%. Falling bed availability is mirrored by an overall decline in the percentage of service users with mental health problems receiving inpatient care, from 10.4% in 2003/04 to 6.4% in 2012/13[23].

  The following evidence is taken into account when reconfiguring inpatient mental health services:

  1. Quality – Access to outdoor space, single sex environments or single rooms can prevent suicide, reduce violence and aid recovery and discharge.

[23] The Kings Fund – Reconfiguration of Clinical Services, Page 33-37 (Nov 2014)

2. Workforce – In 2010, there were 2,132 FTE consultants in general (adult) psychiatry in England and the supply of consultants is expected to increase by 35% to 2,870 FTE over the next 10 years. The growth is needed but may not be achieved, increasing the number of trainees moving to private sector[24].
3. Finance – Closing inpatient settings can generate one-off savings by generating capital receipts from land sales.

10.4 Test 4: Support for proposals from clinical commissioners

Mayor's Test 5: Clinical Support
Mayor's Test 3: Funding

This test is to provide assurance that the proposals have the approval of local commissioners.

SLaM, Lambeth CCG and the Local Authority have created an alliance to oversee all services provided in Lambeth. This alliance has been involved and provided their support for the proposed redevelopment as joint commissioners of the Trust. The alliance has also led the hospital redevelopment oversight group, providing guidance over the Consultation workstream, with representation from NHS Lambeth CCG.

Meeting / Approach	Date	How the participants were informed	Target Audience
1 Primary Care Localities SE / SW & North	September 2019 (3x sessions)	Presentation and discussion	GPs and Practice Leads
2 Lambeth OSC Briefing	September 2019	Presentation and discussion	OSC Chair and CCG Commissioners
3 Lambeth Living Well Collaborative	October 2019	Presentation and discussion	Users, Carers, Statutory and non-statutory providers Clinicians, GPs, Clinical Commissioners
4 NHS Lambeth Board Meeting	October 2019	Presentation and discussion	Clinical Commissioners, GPs
5 Committee in Common	October 2019	Presentation and discussion	Clinical Commissioners, Local Authority Members

10.5 NHSE's Bed Closures Test

Mayor's Test 2: Hospital bed capacity

From 1 April 2017, NHSE introduced a new test to evaluate the impact of any proposal that includes a significant number of bed closures. This is to ensure commissioners are able to evidence that one of the following three conditions have been met:

[24] Royal College of Psychiatrists research unit and healthcare commission, 2005

1. Sufficient alternative provisions have been made, such as increased GP or community services;
2. New treatments or therapies will reduce specific categories of admissions; or
3. Where a hospital has been using beds less effectively than the national average, that there is a credible plan to improve performance without affecting service user care.

This test is only applied where the proposal includes plans to significantly reduce bed numbers. The proposed development will focus on relocating services to improve quality rather than closing beds. Thus, the entry pathway will remain the same for service users and the bed numbers will remain the same.

Chapter 11. Decision Making and Next Steps

Following consultation, the Lambeth Hospital Oversight Group and Programme Board will receive consultation responses from members of the public and organisations. The Committee will then consider the views of the participants and the effect these may have on the decision-making process.

At this stage of the development of options, it is not possible to fully detail the timescales in which decisions will be taken and when subsequent implementation could take place. This is due to a number of factors, including:

- The quantity and detail of consultation responses received, and timescales required to analyse those responses;
- The consideration of consultation responses by the Lambeth Hospital Oversight Group and Programme Board will update the analysis and evaluation of options as required;
- The development of a decision making business case and confirmation by the Lambeth Hospital Oversight Group and Programme Board; and
- The development of detailed implementation plans between providers and commissioners on the basis of the decision made by the Lambeth Hospital Oversight Group and Programme Board.

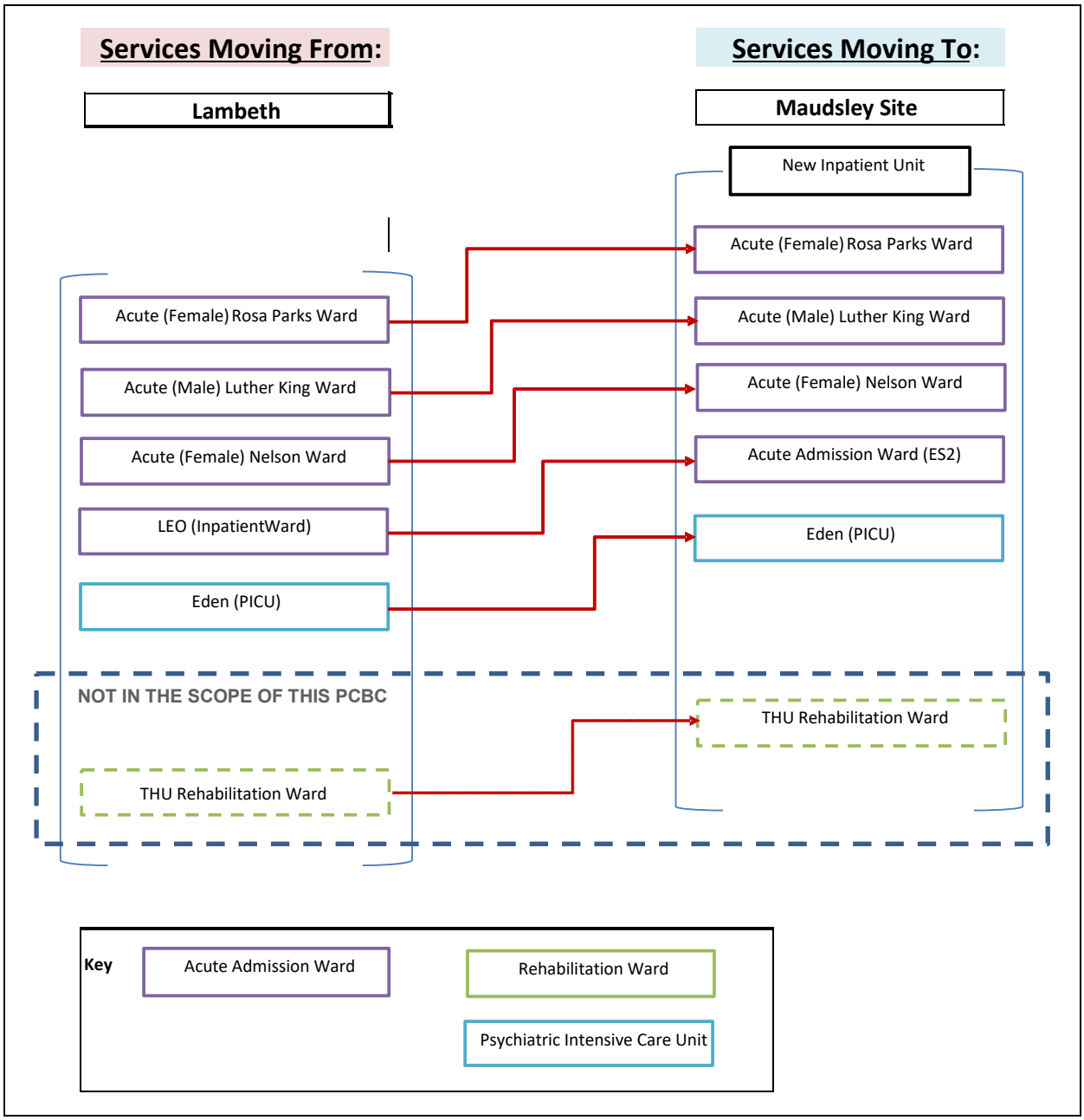
However, to give an indicative timeline, the programme expects the following milestones for this process. These may be subject to change, as described above:

- Pre-consultation Business case (development, review & approval) – 27/05/19 to 04/03/2019.
- Service change public consultation – 04/03/2020 to 31/05/2020 (12 weeks).
- Decision making Business Case (development & assurance) – 31/05/20 – 30/06/20.

Chapter 12. Appendices

Appendix Number	Name
1	Proposed Relocations – PCBC Scope
2	Privacy Impact Assessment (PIA) Screening Questions
3	National, Regional and Local Policies
4	Preferred Option Milestones
5	Risk Register
6	Travel Time Analysis – Impact on service users
7	Travel Time Analysis – Summary of Inpatient Journey Times
8	Project Implementation Budget
9	Preferred Option – Cost Plan Summary
10	Staff & service user Engagement Correspondence Log
11	Stakeholder Engagement Log
12	Comparison Accessibility Maudsley & Lambeth – Travel time analysis
13	Properties sold or vacated (2017 Estates Strategy)
14	QIA – Movement of Services for Preferred Option
15	Communication & Engagement Consultation Plan
16	Equality Impact Assessment Action (EIA) plan for proposed changes
17	Community Estates Strategy (2019 Roadmap)
18	Living Well Network Alliance Model

Appendix 1– **Proposed Relocations – PCBC Scope**



Appendix 2 – **Privacy Impact Assessment (PIA) Screening Questions.**

Q	Category	Screening question	Yes/No
1.1	Technology	Does the project introduce new or additional information technologies that can substantially reveal an individual's identity and has the potential to affect that person's privacy?	No
1.2	Technology	Does the project introduce new or additional information technologies that can substantially reveal business sensitive information, specifically: have a high impact on the business, whether within a single function or across the whole business?	No
1.3	Identity	Does the project involve new identifiers, re-use or existing identifiers e.g. NHS or NI number, or will use intrusive identification or identity management processes?	No
1.4	Identity	Might the project have the effect of denying anonymity and pseudonymity, or converting transactions that could previously be conducted anonymously or pseudonymously into identified transactions?	No
1.5	Multiple organisations	Does the project involve multiple organisations, whether they are public sector agencies i.e. joined up government initiatives or private sector organisations e.g. outsourced service providers or business partners?	No
1.6	Data	Does the project involve new process or significantly change the way in which personal and/or business sensitive data is handled?	No
1.7	Data	Does the project involve new or significantly changed handling of a considerable amount of personal and/or business sensitive data about each individual in a database?	No
1.8	Data	Does the project involve new or significantly change handling of personal data about a large number of individuals?	No
1.9	Data	Does the project involve new or significantly changed consolidation, inter-linking, cross referencing or matching of personal and/or business sensitive data from multiple sources?	No
1.10	Data	Will the personal data be processed out of the U.K?	No
1.11	Exemptions and Exceptions	Does the project relate to data processing which is in any way exempt from legislative privacy protections?	No
1.12	Exemptions and Exceptions	Does the project's justification include significant contributions to public security and measures?	No
1.13	Exemptions and Exceptions	Does the project involve systematic disclosure of personal data to, or access by, third parties that are not subject to comparable privacy regulation?	No

Appendix 3 – **National, Local and Regional Policy**

National Policy:

NHS Long Term Plan (January 2019)	The NHS Long Term Plan (LTP) sets out a series of suggested changes to the NHS to be implemented over the next decade. There are three key factors which have enabled the NHS to plan in this way: • A secure and improved funding path set out by government; • A wide consensus between stakeholders about what changes are needed; and • Effectiveness based on the outcomes of vanguard schemes across the country. Changes are presented in six chapters, each with its own theme, with a seventh chapter assessing how the current – and potential future – legal frameworks facilitate the implementation of the plan. **Introduce** new service models: The NHS has committed to increase funding for primary and community care services in order to support the formation of community health teams, involving GPs and incorporating social prescribing. Reforms in urgent and emergency care and create urgent treatment centres will relieve pressures on A&E. Additionally, new clinical standards for major trauma, stroke and other critical illnesses will be implemented. **Chapter 1** Tackle health inequalities: NHS England and NHS Improvement will improve the accuracy of their assessments of health inequalities and unmet need and will allocate funding accordingly. In order to avoid wastage, local areas must set out specific and measurable goals and mechanisms in order to receive funding. Additionally, NHS England and NHS Improvement will roll out nationwide prevention programmes for known causes of disease and track progress against a set of specific population health objectives. **Chapter 2** Improve care outcomes: The NHS has committed to increasing funding for mental health, focusing on expanding community and crisis support, and improving mental health services for children and young people. Additionally, there is a commitment to research and innovation, with the benefits of these fed back directly into the NHS. *This scheme responds to this objective by improving local and national specialist mental health services and by facilitating collaboration with academic research to improve the quality of care delivered to service users.* **Chapter 3** Tackle workforce pressure and provide support to staff: There are plans to increase recruitment to the NHS by introducing incentive schemes which make qualifying for clinical roles more achievable, cheaper and worthwhile. Additionally, there will be changes to the way the NHS acts as an employer, improving employees' work-life balance, giving them flexibility and supporting their personal development by providing multi-disciplinary qualification opportunities. **Chapter 4** Create digital NHS: The NHS plans to digitise care as much as possible. This will give service users access to a wide range of digital services, including e-consultations and online follow-up appointments, and will give service users and carers

	greater control over their care. Improvements in NHS digital infrastructure will improve clinicians' access to service user records and facilitate predictive techniques to support local Integrated Care Systems. **Chapter 5** Put NHS back onto a sustainable financial path: The 3.4% five-year funding settlement, announced in the most recent budget, will enable the NHS to improve its financial position and the Long Term Plan sets out five objectives which are necessary for this to happen: 1 Return to financial balance by reducing the deficit of individual Trusts and NHS Property Services providers. 2 Support cash releasing productivity growth by reducing waste, inefficiency, prescription processing and estate management. *This scheme supports this by improving the efficiency of services and management of Trust estate.* 3 Reduce growth in demand by service integration and prevention of common diseases. 4 Reduce unjustified variations in performance between Trusts. *5* Make better use of capital investments and existing assets to drive transformation. *This scheme responds to this objective by maximising the productivity of the Trust's estate.* **Chapter 6** Next Steps… The first stage in implementing the Long Term Plan is to create Integrated Care Systems (ICSs), facilitating the integration of primary care, specialist care, and physical & mental health services who will work with local authorities to provide the best care to local populations. The LTP sets out a number of recommendations for changes to the law that will facilitate the production of the ICSs. *This scheme responds most significantly to Chapter 6 of the NHS LTP as it sets out plans to improve the management of the Trust's estate. The scheme addresses and negates the current issues associated with having a disused building, improving the use of capital investments, and improving facilities management efficiency by co-locating multiple services. Additionally, the relocation of specialist Eating Disorder and Lishmann Units to the Maudsley site supports Chapter 3 by facilitating collaboration between clinical and academic teams, a key priority for SLaM.*
5YFV for Mental Health, NHS England and NHS Improvement (July 2016)	The *Five Year Forward View For Mental Health* was published by NHS England and its partners. It reported that there will be an additional one million people receiving high-quality care by 2020/21: a decisive and unprecedented step towards closing the treatment gap for mental health. The forward view highlighted several actions they will take by 2020/21, in order to achieve this: • A significant expansion in access to high quality mental healthcare for children and young people. At least 70,000 additional children and young people each year will receive evidence based treatment. • Increased access to specialist perinatal mental health support in all areas in England, in the community or in inpatient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it. This includes procurement of additional mother and baby units to increase capacity in areas with particular access issues and review of capacity in existing units.

	• Increased access to psychological therapies, so that at least 25% of people (or 1.5m) with common mental health conditions access services each year. • Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors. • NHS England and NHS Improvement should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people who have severe mental health problems and significant risk or safety issues in the least restrictive setting as close to home as possible. • Evidenced improvement in mental healthcare pathways across the secure and detained settings. • An ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. From 2016/17, NHS England and NHS Improvement led a programme which aimed to put local clinicians and managers in charge of both managing tertiary budgets and providing high-quality secondary care treatment, giving Mental Health providers and CCGs the incentive and responsibility to strengthen care pathways. In March 2016, NHS England and NHS Improvement introduced a £450m financial incentive focused on improving staff health and wellbeing.
Mental Health Promotion and the National Service Framework, The Mental Health Foundation	The National Service Framework focuses on the mental health needs of working age adults up to 65 in England and Wales. The Framework intends to: • Set national standards and define service models for promoting mental health and treating mental illness. • Put in place underpinning programmes to support local delivery. • Establish milestones and a specific group of high-level performance indicators against which progress within an agreed time will be measured. It sets standards in five areas: primary care and access to services; severe mental illness; carers; suicide; and mental health promotion. The Framework sets out interventions to target: • Action across whole populations; • Programmes for individuals at risk and for vulnerable groups; • Combating discrimination and social exclusion. The Framework aims to move beyond the goal of simply preventing specific mental illness and recognise the benefits of promoting positive mental health strategies on a national level by identifying and promoting factors that can contribute to general mental well-being. The implementation of The National Service Framework will have important challenges for mental health services and society as a whole. These include: • An emergence and acceptance of a broader model of mental health based on the principles of physical public health promotion • Specific provision for individuals and groups most at risk, aimed at increasing people's ability to manage emotional distress.

	• An increased recognition of the importance of public education, and the need to build understanding of mental health problems in order to reduce the stigma and discrimination faced by people who experience mental health problems.
Mental Health and new models of care (May 2017), and Quality Improvement in Mental Health (July 2017) The King's Fund	The King's Fund produced the former report to present the findings of their research on the vanguard sites in England. This was undertaken in partnership with the Royal College of Psychiatrists. The main finding was that new care models which removed barriers between mental health and other parts of the health economy are perceived to be highly valuable in improving care for service users. The report identifies the development of a multispecialty community provider (MCP) and primary and acute care system (PACS) models further, and recognises areas of significant scope in this context: • Making new forms of mental health support a core component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice, and to meet the physical healthcare needs of people with long-term mental health problems. • Further strengthening mental health components of urgent and emergency care pathways in accident and emergency (A&E) departments and elsewhere. • Making public mental health and wellbeing central to population health management approaches, including through a focus on perinatal mental health, children and young people, where some of the greatest opportunities for prevention lie. The latter report identifies a strong emphasis on co-production and service user involvement in mental health as a powerful asset in quality improvement work. This is one aspect of quality improvement where there is considerable potential for mental health providers to innovate and to share learning with others across the health system.
Starting Today: the future of mental health services, Mental Health Foundation, 2013	This report explores the Inquiry into the Future of Mental Health Services (FOMHS) in the UK considering the current and future health and socio-economic development to ensure the services are fit to deal with challenges 20-30 years in the future. Mental Health services face a number of future challenges, including continuously high levels of psychiatric morbidity, increasing levels of comorbidity and multiple morbidity, an ageing population with high health and social care needs with barriers to providing good integrated care and significant constraints on public spending. It is estimated that if prevalence rates for mental disorders stay the same (at around one in four) then there will be around 2m more adults and 100,000 more children and young people with mental health problems in the UK by 2030. Much of what needs to be done is implementing existing known good practice. Personalisation was one of the key messages highlighted, with the need to provide a personalised service to service users and involvement of them, their family and carers as equal partners in mental health service design and delivery decisions through early training of all staff and continuation of their professional development. Attention was also drawn to the need of building service users' capacity to safely manage their own condition. Future GPs need to become leaders in mental healthcare, knowing as much as much about mental health as they do about physical health to allow future mental health services to be primary care led with a more accessible and holistic care regime for individuals.

	The need for crisis care and community support was also highlighted as a key message, to help individuals cope with the problems and challenges of daily living. It was evidenced that it is people and relationships that secure good integrated care and the future of effective integrated care lies primarily in recruiting, training, maintaining and developing a workforce which is passionate and committed to the principles and practice of holistic care and partnership working. Investment in early years support and initiatives to address later life challenges such as dementia need to be pursued. The future mental health workforce needs a balance of generalist and specialist staff, with defined roles and skills. The workforce should be able and willing to work collaboratively, along with the knowledge of the best evidence-based clinical and social interventions they can offer. This can be made possible through significant investment in mental health research over the coming years.
The Carter Review	The Carter Review, published in 2016, reviewed the operational productivity and efficiency of NHS hospitals focusing on workflow, workforce, pharmacy, medicines optimisation and estates and procurement management. The report identified significant and unwarranted variation in costs and practice which, if addressed, could save the NHS £5bn. The report acknowledges that although there is exceptional practice already happening in the NHS, the overall average is not sufficient and more needs to be done to bring poor performance up to meet the best. It concluded that there is the potential for efficiency savings of £1bn from better management of estates, such as lighting, heating and utilising floor space. The report recommends that every Trust has a strategic estates and facilities plan in place based on the model hospital data and benchmarks. This will aid a plan for long term estate investment and reconfiguration. The report also sets out the aim for all Trusts' estates and facilities departments to operate at or above the median benchmarks for the operational management of their estates and facilities functions. All Trusts to have a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017. This benchmark needs to be delivered by April 2020, so that estates and facilities resources are used in a cost effective manner. Following this in May 2018, Lord Carter published a more detailed review of unwarranted variations in Mental Health and Community Services identifying a savings opportunity of £1bn. The key recommendations that are consistent with the aims of this scheme include recommendations to: • Optimise inpatient services by making significant improvements to better manage the workforce. The review also recognised the significant challenges facing Trusts around the infrastructure to support the deployment of medicines in the community and inpatient facilities. • Improve quality and efficiency across the mental health pathway and bring parity of esteem with physical health services. • Optimising non-clinical resources including improving the efficiency of estates and facilities management by rationalising estate and identifying opportunities for consolidation.
The Naylor Review (2017)	The Naylor review, published March 2017, sets out recommendations on how the NHS can make best use of its property and estate and by doing so, generate money to reinvest in service user care and deliver the reforms set

	out in the Five Year Forward View. Naylor sets out the importance of ensuring that NHS property and estate support clinical need by aligning clinical and capital plans; this will enable the NHS to build capacity and capability across their estate. In order to encourage the NHS to rationalise their estate and move towards affordable, sustainable and long-term estates solutions, the Naylor review sets out plans for capital receipts of surplus land to be reinvested in local services. The review places emphasis on the importance of long-term capital investment strategic planning.
Modernising the Mental Health Act (2018)	This document builds on the Five Year Forward View for Mental Health and identifies what issues the NHS has faced with its implementation. The report develops the priorities set out in the Interim Report, arguing for the retention of a Mental Health Act with both compulsive power and total commitment to a preferred approach. This can be delivered by improving respect and dignity for service users and ensuring greater attention is paid to a person's freely expressed wishes and preferences. There is a serious fault with the current system. Dignity is a basic right and is essential for proper recovery and Trust in the system. However, dignity is often stripped from people who are detained. Furthermore, a lack of Trust in the system causes people not to seek help immediately which, in turn, increases their chance of experiencing crisis and, therefore, requiring detention. Black African and Caribbean men are affected most negatively affected by these shortcomings. The document proposes some key principles which should be adopted when implementing the Mental Health Act. These principles act to improve choice/decision making within a setting of compulsion, an essential element to upholding dignity. Additionally, it is a key objective to support people of ethnic backgrounds in order to tackle the profound inequalities for black men of African and Caribbean descent by responding to recommendations in the Public Sector Equality Duty, setting up an Organisation Competency Framework. These principles are: • Providing service users with the highest level of choice and autonomy; • Providing care in the least restrictive way; • Maximise therapeutic benefit to service users; and • Adopt a person-centered approach – the person as an individual.

Regional Policy:

South East London (SEL) STP Background	'Our Healthier South East London' (OHSEL) is the NHS Sustainability and Transformation Partnership (STP) for South East London [25], and includes collaborations between commissioners and providers, across health and social care, with the voluntary sector and citizens, and with education and research institutions and networks. The six South East London CCGs included in this STP (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) have in place a well-established collaborative approach, and

[25] South East London STP - Integrating Mental Health Services, Page 12, October 2016.

work with NHS England and all of London's 32 CCGs to enable transformation across the capital, including through the Healthy London Partnership (HLP).

STP plans across South London show an emerging plan for 14 integrated care networks and early work through the Trust's Integration Group identified that there are a range of services that may be appropriate to be provided from local care network (LCN) hubs in the future. These include some of the early detection services, low intensity teams, primary and secondary care liaison services and mental health promotion teams.

Providers work together as part of formal and informal clinical networks, including specialised services supported by King's Health Partners (KHP) Academic Health Science Centre. Organisations in the footprint also contribute to and use resources developed by support infrastructures such as the Health Innovation Network (HIN) and Collaboration for Leadership in Applied Health Research and Care (CLARHC).

OHSEL was first established in 2013, by local health commissioners, to promote and develop more integrated, out-of-hospital and preventative care, and so has well-established transformation programmes with integrated service user, public and clinical involvement.

The STP is driven to address the following three problems in local healthcare:

6. **The health and wellbeing gap** – people should be helped to lead healthier and longer lives
7. **The care and quality gap** – variation in the accessibility and quality of care should be improved
8. **The funding and efficiency gap** – the NHS must become more efficient and make better use of the money available

Key aims

The STP aims by 2021 to:

- Support people to be in control of their physical and mental health and have a greater input to their own care;
- Help people to live independently and understand what to do when they need support;
- Help communities to support each other;
- Make sure primary care services are sustainable and consistently excellent, with an increased focus on prevention;
- Reduce variation in outcomes and address inequalities by raising standards in the health service;
- Develop integrated care so that people receive the support they need more efficiently;
- Ensure services are benchmarked to ensure a uniformity across the Board in delivering high quality standards; and

	• Spend money more effectively, to deliver better outcomes and avoid waste.
SEL STP: Plan for Mental Health	One in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is £105bn a year [26]. People with mental health problems receive poorer physical healthcare, and in South East London serious mental illness is predicted to reduce a person's life expectancy by 15-20 years, with a three-fold increase in the likelihood they will need to attend A&E throughout their lifetime, and an almost five-fold increase in the likelihood of being admitted as an emergency. The SEL STP lists five priority areas, that are identified as having the greatest impact to collectively address the three gaps of health, quality and finance; 9. Developing consistent and high quality community based care (CBC) and prevention 10. Improving quality and reducing variation across both physical and mental health 11. Reducing cost through provider collaboration 12. Developing sustainable specialised services 13. Changing how we work together to deliver the transformation required Current initiatives to address these priorities include: **1 Prevention, wellbeing and inequality** There is good evidence to suggest that those people who have a severe mental illness, are less able to engage in diet and lifestyle aspects that can help them to stay well. Hence they are more likely to develop physical health conditions too. Identifying any adverse health complications by screening and then ensuring timely access to good evidence-based care, which are known to improve outcomes for people, is essential. It is recognised that the mental health needs of people living in South East London are higher than average. There are many reasons for this including, deprivation, population mobility, sexuality and ethnicity. South East London also has a large lesbian, gay, bisexual, transgender (LGBT) population, who also experience poorer mental health outcomes than the general population[27]. Other people at higher risk of mental illness are those with long term physical health conditions, older people, pregnant women or new mothers who are socially isolated and people who are unemployed or in poor housing. Therefore, there is a focus to steer health and care services to target those most at risk of developing a mental health problem, provide preventative care, identify issues early, and give timely access to specialist assessment and advice when needed. Currently, access to certain evidence based

[26] South East London STP, Projects and mental health sections, October 2016.
[27] https://www.ourhealthiersel.nhs.uk/projects/what-we-are-doing.htm

treatment needs to be significantly improved and needs to be available across all Boroughs.

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor physical health significantly and can improve mental health too. The STP strategy, therefore, encourages utilising every contact with health and care services, as an opportunity to use day-to-day interactions to support behavior change.

2 Integrating mental health services

Thirty per cent of people with a long-term condition also suffer from poor mental health and so a repetitive theme in the STP's plan is the creation of a culture whereby mind and body are not treated as distinct entities, but rather, clinicians should be encouraged to assess and treat mental health disorders or conditions on a par with physical illnesses. In order to achieve this culture, mental health services need to become more integrated in all health and care services.

There is a move to the development of a consistent approach to recognise and support people with mental health needs, including more screening and timely access to evidence-based care.

3 Urgent and emergency care

Access to crisis mental health services needs to be easier and faster.

One of the biggest impacts on urgent and emergency care will be felt through the development of out-of-hospital care and by helping residents avoid emergency admissions with better care planning and on-going support.

For those service users who do need to use urgent or emergency care, there must be an assurance of access to consistent, high quality services, better advice on where to go for urgent care, and access to specialist care at the earliest point, including mental health emergency services.

4 Adult mental health

(i) Talking therapies can help people with a range of mental health conditions such as mild to moderate depression, anxiety, panic attacks, obsessive compulsive disorder, anger, eating and relationship difficulties. In South East London they are part of Improving Access to Psychological Therapies (IAPT) services.

(ii) Nationally, one in five mothers suffers from mental health problems during pregnancy or in the first year after childbirth. Yet fewer than 15% of areas have the necessary perinatal mental health services and more than 40% provide none at all.

(iii) Women need to have access to high quality maternity services close to home before and after birth, with a plan to support women to have a normal birth, with as little medical intervention as possible. There should be a move toward midwife-led maternity care with a named midwife before and after birth for every woman, with consultant-led support at hospital when necessary.

	(iv) Specialised services are provided in a small number of hospitals and are used by relatively small numbers of service users. They cover more than 170 services, including things like pediatrics, neuroscience, cardiac, HIV and kidney. They tend to be provided in large hospitals by teams of highly trained, experienced staff and are often associated with academic research and innovation. The STP is working with NHS England and its NHS partners in South West London to support a review of specialised services across the whole of South London. The aim is to make sure that specialised services in South London and are efficient and effective in the way they are provided as well as being sustainable in the future, with the right mix of clinicians and support staff delivering the highest quality care from the most appropriate locations. **5 Children and young people's mental health** The STP aims to provide support closer to home for families – to help keep children physically, mentally and emotionally well – and more joined-up health and care services that are easy for service users and their families to understand and navigate. They encourage an ease of access to the right services, and an assurance that children admitted as inpatients on specialist wards, are dealt with quickly, in order for them to get home and participate in school as quickly as possible. Another priority is making the transition into adult services more straightforward for young people with long-term conditions.
Progress on STP Initiatives in South East London.	There has been significant progress made in South East London since the STP was written with the Boroughs on track to deliver the STP vision. **Prevention, Wellbeing & Inequality** There are some good examples in South East London of preventative mental healthcare, particularly focused on children, young people, families and the wider determinants of mental health. However, most mental health services are treatment rather than prevention focused and so there is an absence of a consistent way to making sure there is uniformity in the advice and care service users receive. This is being addressed by collaborating across South East London to develop a consistent approach to recognise and support people with mental health needs. Many of the initiatives within community based care, urgent and emergency care and maternity projects are focused on preventative care and making sure everyone has the same experience when accessing services. **Integrating mental health Services** With partners in Southwark, a Joint Mental Health and Wellbeing Strategy has been developed with a vision of how integrated care will be delivered. The strategy aims to improve the mental health and wellbeing outcomes of Southwark residents. It sets out how the Trust will focus on prevention and early intervention to deliver a sustainable mental health system in Southwark and will help better understand the population in this Borough and the challenges people face.

In Lewisham, the Trust is working with local partners on the Lewisham Alliance (Partnership Lewisham), where they are advancing the design for the delivery of better care closer to home. **Lewisham Community Wellbeing** is a new integrated service for people with mental health and wellbeing problems, which will support people to manage their mental health and wellbeing problems, stay well, recover, achieve their personal goals and connect with their local community.

In Croydon, work is being undertaken with partners to agree how the clinical strategy described above is advanced with SLaM's Borough partners there.

Lambeth has been radically transforming mental health services since 2010, with a vision to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. This was initially led by the Living Well Collaborative, a collaboration of commissioners, providers and people with lived experience, and has now moved to an alliance model of commissioning which has seen the integration of services. This is the first Alliance Outcome based contract for a whole system.

Lambeth Together is a plan to put in place a new health and social care system for Lambeth, this in turn will make services better and easier to access for everyone who lives or works in the Borough. Lambeth together consists of a number of different public bodies including Lambeth Council, NHS Lambeth CCG and South London and Maudsley NHS Foundation Trust as well as voluntary bodies e.g. Thames Reach and Certitude community groups and local sports clubs.

Lambeth Together aim to help individuals with their own health and wellbeing to reduce the need to access services and provide services in a better way so when individuals require them, they are convenient and easy to access. With a growing population, people living longer and having less money available nationally for health and social care, pressure will be created on services in the future. Lambeth Together hope to address that by doing the following:

- Staff working in health and social care to work in a similar way as far as possible which is referred to as 'The Lambeth Together Way';
- Organising services by people and places – instead of by the organisations that hosts those services, these will be called 'Delivery Alliances'; and
- Set up one group of people to make sure Lambeth Together is managed effectively. This group will be responsible for looking after finances, workforce and digital and is called the 'Strategic Alliance'.

Urgent & Emergency Care

SEL STP is working to ensure there is access to mental health support and liaison teams for people of all ages in A&E departments 24 hours a day, 7 days a week – known as the 'core 24' standard, with a commitment to making it easier for South East London residents to access community based crisis response teams and intensive home treatment as an alternative to hospital based care.

Adult Mental Health

	Better access to talking therapies The aim is that by 2020/21, more people can access talking therapies, so that at least 25 per cent of people with common mental health conditions are supported in this way each year. **Maternity** There should be greater lifestyle support to help the mother and baby and in South East London, women should have access to perinatal (the time, usually a number of weeks, immediately before and after birth) mental health services. This is already underway in Lambeth, Southwark and Lewisham after funding was secured to expand specialist perinatal services, and more staff are being recruited with the service evaluated in 2018/19. **Specialist services** The aim is to make sure that if someone is in crisis, they can access a health-based place of safety. The police can use the law to take people from a public place to a 'place of safety' or '136 suite' if they seem to have a mental illness and are in distress and in need of immediate care. This is a place where mental health professionals can assess a person's needs and work out the best next steps. **Children & young people's mental health** Half of all mental health problems have been established by the age of 14, rising to 75 per cent by the age of 24. It is essential that young people receive timely access to evidence-based care in order to improve their life chances. Many of the initiatives within community based care and urgent and emergency care projects are focused on minimising the need for children and young people to be admitted to hospital through illness or mental health crisis. Clinicians need to be better at supporting families to keep children and young people physically and mentally well, and out of hospital – offering advice on things like healthy lifestyles, better access to talking therapies and more health and care staff being trained to recognise mental ill health at an earlier stage.

Local Policy:

The Trust's Clinical Strategy	SLaM's clinical vision and strategy is at the heart of the Trust strategy to improve the lives of the people and communities they serve. The Trust is experiencing a fundamental shift, towards a model of healthcare delivery where service users are encouraged to take ownership of their health and wellbeing, with a focus on enabling self-care, autonomy, and independence and encouraging them to be at the forefront when decisions are made about their care. This is driven by the strategic priorities outlined in the Trust's Changing Lives Strategy document (published October 2018), where a partnership is encouraged between service providers and service users. Further, the Trust's strategy places a greater emphasis on asset-based healthcare

delivery, which means resources should be managed more efficiently, to support the best quality outcomes.

The aims of the clinical strategy are well envisaged in the proposed service changes in Lambeth, where the central focus is to move more care, where it is safe to do so and closer to home. This will offer service users greater autonomy and to manage resources more effectively, to fully integrate community and inpatient services. A crucial aspect of the model of care is that there will be a key person who will provide trusted and consistent support for the service user and the co-location of services in three 'Living Well Centres' (LWC). These LWCs will form the organisational basis of most community based mental health services in Lambeth and will assist access and integration as well as delivering efficiencies and improving services. The remaining LWCs are opening in 2019/2020.A crucial aspect of the proposed system is the key worker or person, who will provide trusted and consistent support for the service user and the co-location of services in three 'Living Well Centres' (LWC) which will form the organisational basis of most community based mental health services in Lambeth. This will assist access and integration as well as delivering efficiencies and improving services. The first LWC opened in October 2019.

Another component of the strategy is the development of a robust community and acute interface, with staff and partners across the community and acute pathways working together to ensure people receive the least restrictive treatment and care, as close to a person's home as practically possible, with community connections maintained if an admission is required.

There is still further progress to be made before mental health and physical health are given the same priority. Lambeth Together is the vehicle that will support the delivery of this through creating a new, integrated health and social care system in Lambeth. In order to seek parity of esteem, key elements of the Trust's strategy that are directly relevant to this case for change include:

- Improving the overall population health with reduced stigma for mental health.
- Focus on better out of hospital care providing care closer to home for service users, which will be achieved by upgrading the community infrastructure.
- Continuing to develop the acute care pathway programme through standardising pathways and reducing variation in care across sites, which will be achieved by consolidating the inpatient mental health services delivered at Lambeth Hospital and the Maudsley site as well as closer location to physical acute services.
- Maintaining market leading position in respect of specialist services for mental health and maintaining clinical edge and research focus.
- Productivity and efficiency improvements so that staff can spend more time supporting service users.
- Developing strategic partnerships in South London to improve access and quality for service users and maximise efficiency.
- Developing a culture of Quality Improvement to deliver these goals.

The Trust's Estate Strategy (that supports Clinical Strategy)	The clinical strategy informed the development of the estate strategy by identifying the clinical objectives and service needs to which the estate needs to respond. The Community Estates Strategy roadmap is in Appendix [18] and illustrates the short, medium and long term plans for development. One of the greatest challenges that local healthcare economies and organisations face is that of enhancing the quality of outcomes and service user experience in the face of increasing demand and expectations within a context of funding that is not increasing at the same rate. In responding to this, the Trust's clinical strategy seeks to employ a value based healthcare approach that ensures that resources are deployed at the right time, in the right place and by the right people. The estate strategy meets the fifth strategic aim outlined in the Trust's Changing Lives Strategy (the other 4 aims include quality, partnership, a great place to work, and innovation), which encourages the best use of assets and resources, in a manner that is deemed the most efficient. This brings the Trust closer to its ambition to be a leader in the design and provision of the best and most appropriate locations, buildings and spaces for mental healthcare and wellbeing. In addition, investment in the estate will improve quality of service provision for our service users which will assist the Trust in meeting the quality element of the Changing Lives Strategy. The estates strategy sets out that all new builds and refurbishments are to be 'future-proofed' to enable changes to be made without large reconfiguration and expenditure to encourage sustainability, based on a long-term view of delivery of mental health services. This takes into account how mental healthcare will evolve in the future, particularly as articulated in the document 'Starting Today: where we can anticipate a future where financial resources will be scarcer (NHS at 75, Towards a Healthy State). In comparison to some other Trusts, who have invested more in modernising their estate in recent years, much of the current hospital estate is outdated with over 58% being built before the release of modern design guidance in Mental Health (1990). This included recommendations for ensuite bathrooms, social and family space, and direct access to outside space from recreational areas to facilitate improved service user care. The community estates are overly fragmented, in poor condition and mostly comprised of buildings that are too small to ever offer effective use. There is, therefore, a significant need for investment in new, high quality estate in the community as well as on inpatient sites. The estates strategy sets out the Trust's vision to meet key longstanding priorities envisaged by local and national policies, and covers the period 2017 to 2027. For example, the Trust's strategic plan identifies 'key enablers' crucial to the successful delivery of transformational change, of which include the following priorities: • The aim is to modernise and develop 'fit for purpose' community hubs for use by the Trust and key partners, that are situated appropriately, are cost effective and cost efficient on a whole life basis. This is with the focus to develop a network of highly accessible facilities in local communities that support mental healthcare (termed 'community hubs') and meets the urgent need for fit for purpose community estate that promotes integration, care closer to home and early intervention with the effect of reducing demand for acute services. There is an urgent need to modernise the inpatient estate, in order to raise the standard of and improve the flexibility and effectiveness of existing secondary/tertiary

facilities, which at present lack the functional suitability of a modern, 'world class' mental health provider.

- There has been significant progress made in South East London since the Sustainability & Transformation Partnership (STP) was written, with the Boroughs on track to deliver the STP vision. Most mental health services are treatment rather than prevention focused and so there is an absence of a consistent approach in the advice and care service users receive. This is being addressed by collaborating across South East London to develop a consistent approach to recognise and support people with mental health needs. There are some good examples in South East London of preventative mental healthcare, particularly focused on children, young people, families and the wider determinants of mental health.
- The need to improve on key estate quality indicators across the sites such as:
    1. Percentage of ensuite bedrooms
    2. Percentage of standards compliant size bedrooms
    3. Percentage of inpatient areas with safe outdoor access

The key estate-based enablement areas identified are:

- Creating healing environments;
- Creating environments that significantly improve service user experience;
- Creating environments that promote health and safety for service users and staff;
- Developing a flexible bed base to support operational management;
- Aggregating inpatient activity into the correct clinical setting;
- Rebalancing the provision of services into the correct setting; and
- Utilising technology and facilities to enable agile working.

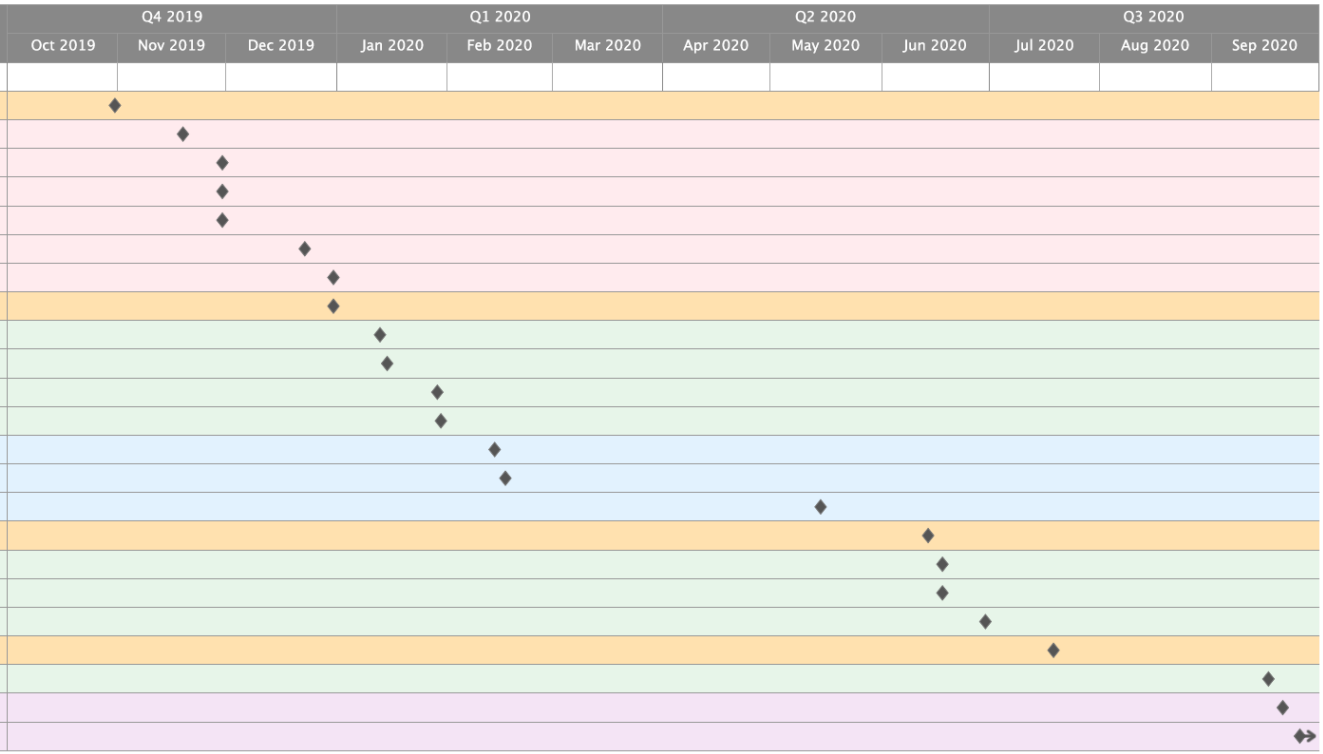
Under the above proposals it is anticipated that, on average, the need for inpatient provision will reduce in each of the next five years as more activity becomes community based.

In terms of community estate, the refreshed strategy is to reduce the number of sites including clinical rooms and workstations. The community estate will be made up of community hubs and spokes. The community hubs represent larger bases and accommodate several community mental health services alongside provider and voluntary sector partner organisations. Each community hub will have more than 10 clinic rooms and more than 50 workstations. The spoke element of the refreshed community strategy relates to a small or single use community site where services are delivered, with presence in wider healthcare buildings.

Although activity is due to increase by 8% per year, through more effective use of space, longer service opening hours and the use of other locations to deliver care, e.g. GP surgeries, it is envisaged that in overall terms the Trust has sufficient capacity. The intent, however, is to consolidate activity within two to three hubs per Borough with a network of satellite provision for crisis services, drop in clinics and similar.

Appendix 4 – **Preferred Option Milestones**

	Task Name	Item Type	Milestone Date
1			
2	PCBC (Assurance Release Draft) Submitted	Document	31/10/19
3	Clinical Senate Review Panel	Assurance	19/11/19
4	National Specialist Commissioning Review Complete	Assurance	30/11/19
5	Lambeth CCG Financial Review	Assurance	30/11/19
6	NHSEI Strategy Review Complete	Assurance	30/11/19
7	Clinical Senate Report Received	Assurance	23/12/19
8	NHSEI Financial Review Complete	Assurance	31/12/19
9	PCBC (Release Document) Submitted	Document	31/12/19
10	NHSEI Regional Review Panel Approval	Approval	13/01/20
11	Lambeth CCG Board Approval	Approval	15/01/20
12	SLaM Trust Board Approval	Approval	29/01/20
13	Lambeth Oversight and Scrutiny Committee	Approval	30/01/20
14	Lambeth CCG Public Consultation Launch Meeting	Consultation	14/02/20
15	Public Consultation Start	Consultation	17/02/20
16	Public Consultation End	Consultation	15/05/20
17	DMBC Complete	Document	14/06/20
18	DMBC Lambeth CCG Approval	Approval	18/06/20
19	DMBC SLaM Board Approval	Approval	18/06/20
20	DMBC OSC Approval	Approval	30/06/20
21	FBC Complete	Document	19/07/20
22	FBC SLaM Board Approval	Approval	17/09/20
23	Construction Start Date	Build	21/09/20
24	Construction End Date	Build	19/09/22



Appendix 5– **Risk Register**

No.	Description of Risk	Probability	Impact	Risk Rating	Owner	Mitigation Action Description	Status
1	Risk that local patient groups do not support proposals leading to the requirement to rescope project	2	3	6	Comms Workstream Lead	Undertake pre consultation engagement. Develop a detailed comms plan for public consultation exercise. Undertake a stakeholder mapping exercise to identify all affected stakeholders. Analyse stakeholder map and develop plans to target particular stakeholders	Open
2	Risk that local patient groups do not support proposals leading to the delay in completion of the DMBC which will lead to a delay of programme completion	2	3	6	Comms Workstream Lead	Undertake pre consultation engagement. Develop a detailed comms plan for public consultation exercise. Undertake a stakeholder mapping exercise to identify all affected stakeholders. Analyse stakeholder map and develop plans to target particular stakeholders	Open
3	Risk that local health economy leaders including CCG and STP do not support proposals	1	3	3	Programme SRO	Ensure continued engagement with CCG and STP throughout the public consultation process. Report regularly to CCG on consultation progress and any key issues being raised.	Open
4	Risk that public consultation timescales slip due to inadequate resource to deliver consultation activities	2	2	4	Comms Workstream Lead	Comms workstream lead to identify resources. Develop detailed public consultaiton implementation plan. Idenfify budget.	Open
5	Risk that local stakeholder groups are not identified leading to the lack of support of proposals during public consultation	2	2	4	Comms Workstream Lead	Undertake a stakeholder mapping exercise to identify all affected stakeholders.	Open
6	Risk that Trust strategy changes leading to the requirement of a service scope review which will lead to the replanning of public consultation	1	3	3	Programme SRO	Early indication of any change in Trust strategic direction by SRO.	Open
7	Risk that Trust strategy changes leading to the requirement of a service scope review which will render the proposed designs unsuitable	2	3	6	Programme SRO	Early indication of any change in Trust strategic direction by SRO.	Open
8	Risk that Trust strategy changes to not involve the disposal of Lambeth Hospital leading to termination of the project	1	3	3	Programme SRO	Early indication of any change in Trust strategic direction by SRO.	Open
9	Risk of a shortage of programme resource leading to the inability to delivery in line with the programme	2	2	4	Programme Director	Identify programme resources and identify budget.	Open

Appendix 6 - **Travel Time Analysis – Impact on service users**

Consideration has been given to the number of users after by the change to services.
The table below summaries the information provided by the Trust on change to service users.

Name of service	Current location service provided	Proposed new location	Number of service users affected	Number of disabled users
Inpatient				
Eden Ward	Lambeth Hospital	New Inpatient Unit	11	TBC
Luther King Ward	Lambeth Hospital	New Inpatient Unit	18	TBC
Rosa Parks Ward	Lambeth Hospital	New Inpatient Unit	18	TBC
Nelson Ward	Lambeth Hospital	New Inpatient Unit	18	TBC

Appendix 7 - **Travel Time Analysis – Summary of Inpatient Journey Times**

Postcode Zone	Journey Time to Lambeth Hospital (mins)	Journey Time to Maudsley Hospital (mins)	Change in Journey Time (mins)	Co-ordinates of Postcode	
				Easting	Northing
CR0	81	75	-6	539052	162028
CR2	58	59	+1	533144	162715
CR4	35	36	+1	528947	169557
CR5	55	57	+2	529983	158838
CR7	45	52	+7	531185	167833
CR8	63	59	-4	531703	161632
N4	46	51	+5	531605	188249
SE1	23	20	-3	531869	179427
SE11	17	25	+8	531348	177981
SE13	47	24	-23	538629	175288
SE14	33	18	-15	535741	176906
SE15	31	17	-14	534257	177086
SE18	37	34	-3	533176	170843
SE21	24	32	+8	533196	172317
SE23	55	32	-23	535668	173448
SE24	24	9	-15	532559	175617
SE25	47	50	+3	533924	168718
SE26	52	36	-16	535929	171896
SE27	25	24	-1	531789	172519
SE28	69	51	-18	545754	179495
SE5	29	12	-17	532351	177667
SW1	19	15	-4	529150	179131
SW11	23	21	-2	527588	175552
SW12	22	31	+9	529180	173778
SW13	45	44	-1	521713	176218
SW15	38	39	+1	523544	175404
SW16	27	38	+11	530019	172701
SW2	17	30	+13	530767	174534
SW4	15	23	+8	528747	175256
SW8	14	26	+12	530731	177208

Appendix 8 – **Project Implementation Budget**

South London and Maudsley NHS Foundation Trust

CASHFLOW FORECAST SUMMARY

Month	STAGE 3 - GMP AND FBC	DEMOLITION	MAIN WORKS	Fees £ 1,765,000
Previously				0
Jul 19	1	1		49,000
Aug 19	2	2		49,000
Sep 19		3		49,000
Oct 19		4		49,000
Nov 19		5		49,000
Dec 19		6		49,000
Jan 20		7		49,000
Feb 20		8		49,000
Mar 20		9		49,000
Apr 20		10	1	49,000
May 20			2	49,000
Jun 20			3	49,000
Jul 20			4	49,000
Aug 20			5	49,000
Sep 20			6	49,000
Oct 20			7	49,000
Nov 20			8	49,000
Dec 20			9	49,000
Jan 21			10	49,000
Feb 21			11	49,000
Mar 21			12	49,000
Apr 21			13	49,000
May 21			14	49,000
Jun 21			15	49,000
Jul 21			16	49,000
Aug 21			17	49,000
Sep 21			18	49,000
Oct 21			19	49,000
Nov 21			20	49,000
Dec 21			21	49,000
Jan 22			22	49,000
Feb 22			23	49,000
Mar 22			24	49,000
Apr 22			25	49,000
May 22				49,000
Jun 22				50,000
Rounding				
				1,765,000

Appendix 9 – **Proposed Option – Cost Plan Summary**

Client:	South London and Maudsley NHS Foundation Trust	Base Date:	3Q2019
Project	DOUGLAS BENNETT HOUSE	Issue Date:	17-Sep-19
Report:	Cost Plan Summary.12	Gross internal floor area m²:	**10,164**

1	EXECUTIVE SUMMARY	£	£/m²	%
1	**Construction Cost**	50,840,000	*5,002*	*74%*
2	**Associated Costs**	2,483,000	*244*	*4%*
3	**Non Works Costs**	225,000	*22*	*0%*
4	**Professional Fees**	1,765,000	*174*	*3%*
5	**Risk and Optimism Bias**	3,541,000	*348*	*5%*
6	**Trust Inflation Allowance**	90,000	*9*	*0%*
7	**Total**	58,944,000	*5,799*	*86%*
8	**Value Added Tax**	11,789,000	*1,160*	*17%*
9	**Recovery of Value Added Tax**	(1,993,000)	*(196)*	*(3%)*
10	**Project Team Allowance**	0	*0*	*0%*
11	**Decant Scheme**	**Excluded**		
12	**TOTAL COST ESTIMATE**	**68,740,000**	**6,763**	***100%***

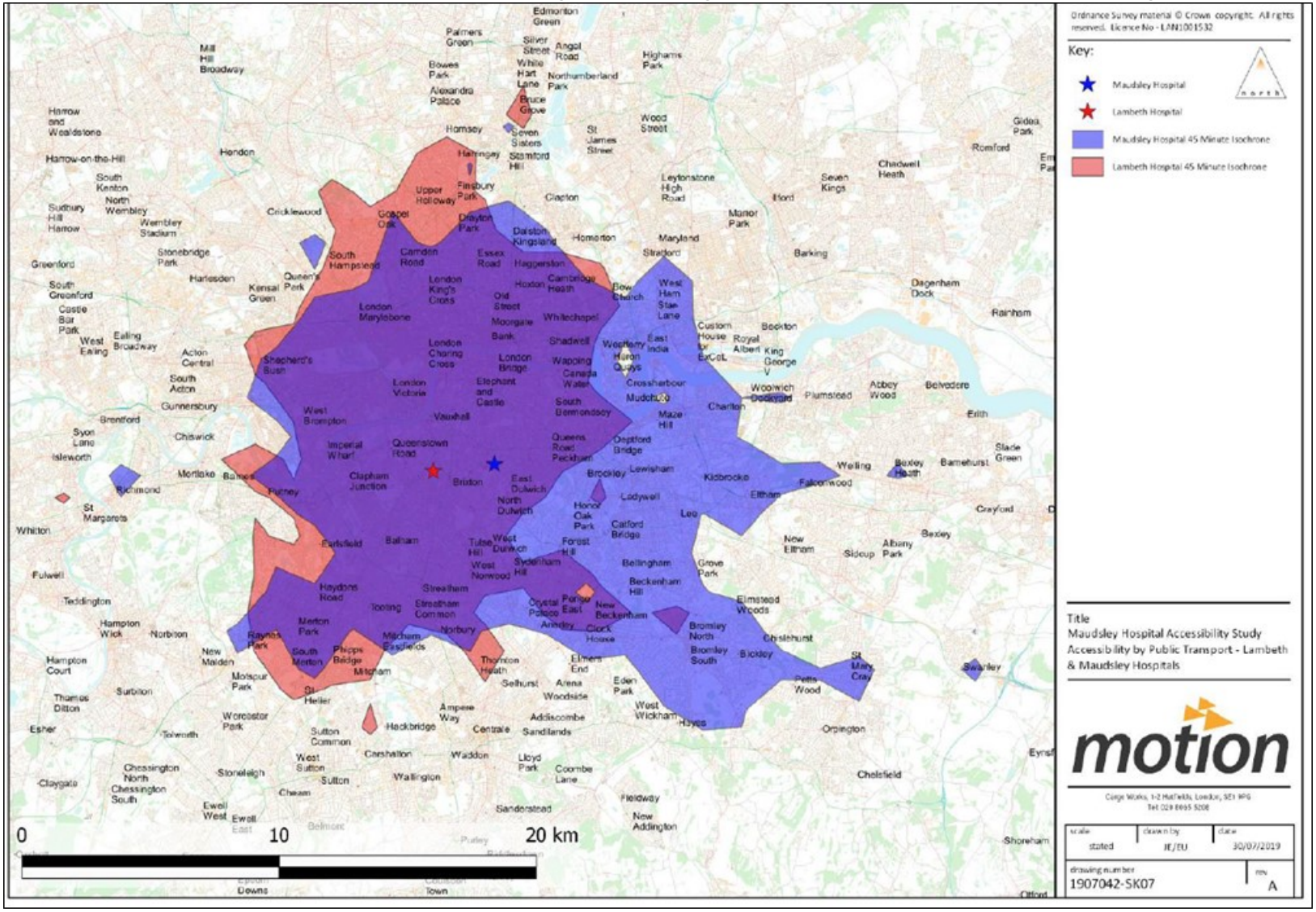
Appendix 10 – **Staff & service user Engagement Correspondence Log**

	Date	Team / Service	Borough / Directorate	Who ran briefing	Staff feedback
1	15th - 17th May 2019	Senior Leaders in Croydon briefed	Croydon & BDP	Faisil Sethi (Interim Service Director)	None
2	17th May 2019	**Clinical and managerial colleagues** (Bridge House inpatient forensic ward): Criminal Justice Mental Health Team, FIPTS, Lambeth and Southwark Community Forensic Teams, Ward in the community	Croydon & BDP	Faisil Sethi (Interim Service Director)	None
3	20th May 2019	Trust Estates Manager, Trust Site Services Manager, Hotel Services Manager (Southwark & Lambeth), Estates Officer (Lambeth), Estates Team Leader (Lambeth)	Estates	Graham Richards	None
4	20th May 2019	**Lambeth Estates Team**: Agency Electrician, Agency Assistant Plumber, Agency Painter, Agency Painter, Agency Carpenter	Estates	Graham Richards	None
5	20th May 2019	Lambeth Portering Team	Estates	Graham Richards & Gillian Kumar	None
6	20th May 2019	Older Adults	Lambeth	Cha Power	Queries about the options if they move offsite
7	20th May 2019	Luke King, Eden, ES2, HTT, Nelson, Leo, THU, Hospital Social Work Team, Lambeth Directorate back office, Reay House, Lambeth Advocacy Team, Approved Mental, Health Practitioners Team, Lambeth Inpatient	Lambeth	Neil Robertson	None
8	21st May 2019	Trust Estates Manager, Trust Site Services Manager, Hotel Services Manager (Southwark & Lambeth), Estates Officer (Lambeth), Estates Team Leader (Lambeth), Lambeth Estates Team.	Estates	Follow up visit from Matthew Neal	some concerns from them about the future and from an estates perspective that staff might have a different attitude
9	22nd May 2019	JSC	Trust-wide	Mark Maynard	None
10	24th July 2019	Lambeth Service User Advisory Grouip engagement meeting	Lambeth	Neil Robertson	Nelson ward and Eden ward in Oak House we're both mentioned as substandard. Raey House has issues with sound proofing. AL2 ward has narrow and crampt corridors with very little natural light. Worried about lack of meeting room space when needed. Group agreed outpatients shouldn't necessary be on a hospital site- community & outpatients relocated within Lambeth community.
11	24th July 2019	Lambeth ward team visits (Luther King Ward & Nelson V	Lambeth	Neil Robertson	**Luther King Ward:** It would be good to have a room for a ward round not directly off the corridor, Access to a gym for patients, Bike storage for staff. Issues with current ward: a lack of daylight, ward is small, Poor ventilation.
12	24th July 2019	Lambeth ward team visits (Luther King Ward & Nelson V	Lambeth	Neil Robertson	**Nelson Ward:** staff feel very positive about the proposed changes. Issues with current ward: blind spots on the ward, not enough space, Environment can negatively impact aggression, often security issues, 3 toilets between 18 people, lack of fresh air.
13	25th July 2019	Lambeth staff (all, not just clinical)	Lambeth	Beverley Murphy	**Comments on the current environment**: Wards not fit for purpose, Problems with plumbing, Poor staff facilities, **Concerns about the proposed change**: Lambeth identity loss, loss of outdoor space, Parking for staff & family,

Appendix 11 – **Stakeholder Engagement Log**

	Date	Stakeholder	Correspondence	Follow up
1	21st May 2019	Cllr Liz Atkins, Chair of Lambeth Council's Overview and Scrutiny Committee, Cllr Jim Dickson, Chair of Lambeth Council's Health and Wellbeing Board, Cllr Edward Davie, Lambeth Council's Cabinet Member for Health and Adult Social Care, Larkhall Ward Councillors, where Lambeth Hospital is located: Cllr Timothy Windle, Cllr Andy Wilson and Cllr Tina Valcarcel, Sarah Corlett. Chair Healthwatch Lambeth and Catherine Pearson, Chief Executive Healthwatch Lambeth.	Letters were sent to a number of key stakeholders setting out the context and early details of the proposed changes ahead of the Public Board meeting and asking for a meeting with them at this early stage to seek their views on the proposals, our plans for engagement and how best to involve them and where relevant, their committee/board/organisation.	
2	21st May 2019	Cllr Liz Atkins	Email and letter informing them of proposed service changes to Lambeth Hospital	
3	21st May 2019	Cllr Jim Dickson	Email and letter informing them of proposed service changes to Lambeth Hospital	Follow-up email and letter sent on 08/07/19 by ST
4	25th June, 2019	Steering Group meeting held Attendees: • Moira McGrath (MM) – Director of Integrated Commissioning NHS Lambeth CCG & London Borough of Lambeth (chair) • Denis O'Rourke (DOR) – NHS Lambeth CCG & London Borough of Lambeth • Helen Eldridge (HE) – Lambeth CCG Communications • Antonia Knifton (AK) – Engagement Manager, NHS Lambeth CCG • Rachel Evans (RE) – Director of Corporate Affairs, NHS SLaM • Sarah Thomas (ST) – Head of Communications, NHS SLaM • Chithmini De Silva (CDS) – NHS SLaM Engagement and Stakeholder Manager • Catherine Pearson (CP) – Lambeth Healthwatch • Daniela Kazuko (DK) – Lambeth Healthwatch • Mark Maynard (MMay) – NHS SLaM staff side chair • Sadiki Harris (SH) – Black Thrive • Emma Crowe (EC) – London Communications Agency • Matthew Longmate (ML) – Considered Analytics		Minutes from the meeting sent to attendees on 04/07/19
5	3rd July 2019	Meeting with Alice Glover re PPI engagement		
6	9th July 2019	Cllr Jim Dickson	Responded to Sarah's email sent on 8/7/19 requesting meeting be arranged with Cllr Davie included	ST responded on 9/7/19 requesting availbility. LC followed up on 22/7/19 to Cllr Dickson, Davie and Dyer
7	23rd July 2019	Gary O'Key (support officer for Lambeth OSC)	Responded to LC's email sent on 22/7/19 to Cllr Liz Atkins following Sarah Thomas' letter offering a meeting to discuss the OSC's involvement	
8	23rd July 2019	Cllr Liz Atkins	Followed up from Gary O'Key's email providing upcoming availability	
9	31st July 2019	Steering Group meeting held Attendees: • Rachel Evans (RE) – Director of Corporate Affairs, NHS SLaM (Chair) • Denis O'Rourke (DOR) – NHS Lambeth CCG & London Borough of Lambeth • Antonia Knifton (AK) – Senior Engagement Manager, NHS Lambeth CCG • Chithmini De Silva (CDS) – NHS SLaM Engagement and Stakeholder Manager • Sarah Corlett (SC), Lambeth Healthwatch • Neil Robertson (NR) – NHS SLaM Service Director/Alliance Director • Ed Williams (EW) – London Communications Agency • David Mallet (DM) – Head of Strategy and Reconfiguration, NHS London		Minutes sent to attendees
10	20th August 2019	Cllrs Atkins, Dickson & Dyer	Email arranging meeting	

Appendix 12 – **Comparison Accessibility Maudsley & Lambeth – Travel time analysis**



Appendix 13 – **Properties sold or vacated (2017 Estates Strategy)**

Building Name	Borough	Status
1. 80, 82 & 84 London Road	Croydon	Leased out
2. Broad Green Centre	Croydon	Leased out
3. Jeanette Wallace House	Croydon	Vacant
4. Lena Peat House	Croydon	Leased out
5. 108a Landor Road	Lambeth	Vacant
6. Abbevilles Restaurant	Lambeth	Leased out
7. The Masters House and Gate Lodge	Lambeth	Leased out
8. The Turrets	Lambeth	Leased out
9. Woodlands Nursing Home	Lambeth	Vacant
10. Elmfield House	Lambeth	Leased out
11. 33-35 Wildfell Road	Lewisham	Leased out
12. 42 Newstead Road	Lewisham	Leased out
13. Domus Dilwyn Close	Lewisham	Vacant
14. Domus Inglemere	Lewisham	Vacant
15. Edward Street	Lewisham	Leased out
16. Lee Centre	Lewisham	Leased out
17. 184-186 Rye Lane	Southwark	Vacant
18. Land at the former St Giles Hospital Site	Southwark	Leased out

Appendix 14 – **QIA – Movement of Services for Preferred Option.**

Date of QIA …….	Completion tips	Complete each section below
Scheme Name		Vacation of Lambeth Hospital and the relocation of inpatient accommodation from the Lambeth Hospital and the Bethlem Royal Hospital. This QIA relates to the relocation of inpatient services only which are currently located at Lambeth Hospital, and Bethlem Royal.
Scheme Overview	Aim of the scheme clarifying clinical components affected and whether due to CIP, QUIPP or other financial saving related scheme, e.g. removal of band 6 CPN role to save money due to CIP requirements.	In line with the Trust's clinical strategy, the driver for change is the consolidation of the inpatient bed base due to the realisation that acute inpatient care is becoming increasingly specialised and delivery of services will be in the least restrictive environment including the reconfiguration of community service models. Only those that can't access care in this way will be admitted into an inpatient bed. ADULT ACUTE The project consists of the relocation of all Lambeth acute inpatient wards to the Maudsley Hospital. The majority of which will be located in new build accommodation. The adult acute wards affected by this proposal are: Nelson, Martin Luther King and Rosa Parks. All of these wards will relocate to the new inpatient unit at the Maudsley. The male Lambeth ward already at the Maudsley in Eileen Skellern 2 will move to the new inpatient unit. LEO ward (currently in Reay House at Lambeth) will move to Eileen Skellern 2. ADULT PICU The Male PICU (Eden Ward) currently a Lambeth will relocate to a purpose built ward in the new inpatient unit. This means that the Lambeth and Southwark PICUs will be located on the same site. REHAB The Tony Hillis Unit currently located at Lambeth will relocate to the new inpatient unit. FORENSIC The Ward in the Community currently located in McKenzie House at Lambeth will relocate to Dennis Hill at Bethlem Royal Hospital. SPECIALIST SERVICES The proposal involves the relocation of the Eating Disorders Unit and the Lishman Unit (Neuropsychiatry) from the Bethlem Royal Hospital to the Maudsley Hospital Neuropsychiatry inpatient capacity will have the capacity to increase in the future from 15 to 18 beds. The current service is contracted for fifteen beds at present (contract based on occupied bed days not block) and this is expected to remain consistent initially when the service relocates. The new ward template has 18 beds.
Project Lead	Operational lead	Vanessa Smith, Service Director – Director of Nursing (Interim)
Service	Team/CAG etc	Specialist Services – Eating Disorders and Neuropsychiatry Adult acute – Southwark, Lambeth and Croydon Forensic – McKenzie House Ward in the Community Adult rehabilitation – Lambeth
QIA completed by	Clinical director	Dr Rob Harland, Dr Emily Finch and Dr Dan Harwood
Potential risks arising from scheme	Brief summary from risk assessment below, e.g. risk	RISKS AFFECTING ALL SERVICES

	of increased waiting list, risk of increased adverse incidents from slower response times, etc.	1/ Reduction in service user satisfaction Relocating services outside of the Lambeth Borough may lead to a reduction in service user satisfaction due to the perception that services are less accessible. The relocation may result in less service user interaction with familiar surroundings and their local community. Lambeth services are currently piloting a service to offer visits for inpatients to their local community. If this is proven successful, the plan would be to roll out to all Lambeth wards once relocated to the Maudsley. The environmental qualities of Bethlem may be seen as desirable to service users when compared to the busy, inner city location of the Maudsley. ED and Neuropsychiatry are moving back from Bethlem to the Maudsley. It is expected that the quality of the new build accommodation will offset any reduction in service user satisfaction of moving the service to a busier site. 2/ Reduction in carer/visitor satisfaction There is a risk that travelling to the Maudsley for visitors/carers rather than Lambeth or the Bethlem may be more difficult/timely/costly which may lead to less patient/visitor interaction. A time travel analysis is being carried out to understand further. Initial findings from the travel impact assessment identifies the Maudsley as being more accessible by public transport. Lambeth is only better connected by underground. It is worth noting that visitors/carers residing in the Lough Borough Junction / Brixton area should find that it is quicker and easier to access the Maudsley when compared to Lambeth. Visitors / carers may offset the potential disadvantage of travelling further with the benefit that their loved ones will be accommodated in a higher quality environment which should lead to a more timely recovery. Ward in community relocation to the Bethlem Royal is a Trust wide service so the relocation may benefit some visitors/carers as well as disadvantage others but there is no requirement for it being located at/in Lambeth. Visitor/carer access for specialist services which have a larger catchment is expected to be easier when the services relocate because the Maudsley is more accessible by public transport than the Bethlem Royal Hospital. 3/ Increase in the number of Serious Incidents There is a risk of an increase in errors / serious incidents for a period of time after relocation due to changes in working practices, service reconfiguration and changes to the physical working environment 3/ Operational Risks *Kings College Hospital NHS FT* Inpatients at Lambeth currently access physical health services at either GSTT (St Thomas') or KCH. There is a risk that there will be additional demand for KCH for emergency admissions due to the Lambeth beds being relocated closer to KCH (the Maudsley) and further from St Thomas'. This could impact on KCH A&E performance and may put additional pressure on service demand. In addition, there is a risk that service users will self-present / community health professionals will refer to KCH A&E directly because they know that it is close to the inpatient beds and the support the Maudsley can offer. There is also a risk that there will be an increase in the number of transfers from mental health to physical health beds for mental health inpatients who require physical health interventions due to the close proximity of the beds. Currently is it assumed that some transfers from Lambeth go to St Thomas'. Forecast 2019 KCH A&E attendances (forecast by KCH) resulting in referrals to mental health is c4200 compared to 4100 in 2018 With regard to blue light conveyances of Lambeth inpatients to A&E, there were only 20 cases (DATIX Jan 18- Dec 18) and all of these patients were conveyed

		to KCH A&E. It is therefore expected that there will no additional pressure for KCH from these patients. In 2018, ED and Neuropsychiatry inpatients were conveyed to with KCH or CUH so there may be a potential increase in demand to KCH of seven attendances. *Length of stay* There is a risk of an increased LOS due to the distance impacting on ability of care coordinators and families to maintain contact with inpatient service users (for Lambeth adult acute and rehabilitation wards). This risk is expected to be minimal due to the fact that the Maudsley is well connected by public transport. The current CMHT in Brixton can access with Lambeth or the Maudsley by foot or bus. *Operational pressures for the Maudsley* The delivery of these proposals (and the resultant relocations of other services associated with the beds) will significantly increase the number of beds on the Maudsley site which could put pressure on support services such as catering, portering, pharmacy. There is a risk that these services will need to expand or will require investment to enable them to deliver services to the additional 118 beds, associated therapy and clinical office space on the site. *Pressures on local public services and the local community* With the additional 118 beds comes additional staff needing to travel to the site to work. This will put pressure on car parking spaces onsite and also on the local public transport infrastructure which is already over-crowded at rush hour. The additional bed base relocating to the Maudsley is also expected to impact on the demand for other public services such as the police and fire service due to call out by Trust staff regarding inpatient incidents. There is a risk that local community organisations will provide significant opposition to the proposals due to the sheer scale of the increase in mental health beds and the resultant impact on public infrastructure. SPECIALIST SERVICES Eating Disorders Minimal risk which is outweighed by multiple gains from the Maudsley site. Relocating Eating Disorders to the Maudsley will: • Co-locate the inpatient element of the service with the day and outpatient service and • Improve the ability to attract staff to work for the service • Ensure the Trust adheres with commissioner requirement to relocate the service back to the Maudsley • Provide more, purpose designed appropriate accommodation for a mixed sex ward There will however be a cost of transferring staff from outer London to inner London (pay weightings). There is some concern that staff may leave due to relocation. Access to therapeutic spaces and activities may reduce when the service is relocated to the Maudsley. ED inpatients are popular users of the site wide therapy and social services provided by the OT department at the Bethlem. There is concern that the range of therapy services will not be as diverse at the Maudsley due to constraints in available space ie. No evening film clubs or pottery However, the inpatient facility has been purpose designed to meet the needs of eating disorders service users with a range of dining rooms, ensuite bathrooms, a gym and café Neuropsychiatry Minimal risk which is outweighed by multiple gains from the Maudsley site. Relocation of the service to the Maudsley will:

		• Return the service back to the Maudsley (moving the service to Bethlem was only meant to be temporary) • Co-locate the inpatient element of the service with the day and outpatient service and • Improve the ability to attract staff to work for the service There will however be a cost of transferring staff from outer London to inner London (pay weightings). There is some concern that staff may leave due to relocation. Ward in Community(WIC) – from Lambeth to Bethlem There is a risk that staff may choose to leave due to the fact that inner London weighting will be removed from their salary after a period of time and also because access to Bethlem will be more difficult for staff (as few live close to Bethlem) . WIC has built strong community connections with local organisations in Lambeth such as the Effra Day Centre and Raw Sounds. There is a risk that these relationships may deteriorate or be lost due to the service not being located close by/within the Borough of Lambeth.
Planned actions that will reduce/mitigate risk	Brief summary from risk assessment below, e.g. weekly monitoring of waiting list by management team, monthly monitoring of incidents, increased hours for duty workers, etc	Service user and carer engagement during planning, design and implementation Engagement with commissioners and other relevant partners. Detailed development of the new unit's operational policy during Full Business Case development Staff familiarisation visits prior to service transfer. Engage with KCH to assess the impact on physical health demand impact and keep them updated on project timescales. Consultation and engagement with the local community at key stages through the project. The Specialist services being located at the Maudsley will mean that they will be closer to their respective operational management teams which should improve working relationships and the escalation/management of issues.
Measures to assess/monitor risk outcomes	e.g. complaints, waiting lists, incidents of self -harm etc	Service user satisfaction surveys Friends and Family Test PLACE surveys Complaints Compliments Waiting Lists Delayed Mental Health Act Assessments Regular monitoring of progress of QIPP implementation Number of Sis A - C Safer Staffing QuesTT Absenteeism Number of DToCs
Monitoring of quality measures ()	e.g. 3 monthly for review at CAG Quality Committee	Monthly and Operational Directorates Performance and Quality Meeting. Monthly Performance & Quality Compliance Meetings with DoN, COO & MD. Quality Sub Committee.

South London and Maudsley NHS Foundation Trust

LAMBETH HOSPITAL PROPOSALS &
DEVELOPMENT OF FORMER INPATIENT UNIT:

DRAFT COMMUNICATIONS AND ENGAGEMENT PLAN

(for review by Communications and Engagement Steering Group, 25 June)

1. INTRODUCTION

Key elements of SLaM's clinical strategy can be found within a number of recent documents produced by the Trust, including Changing Lives and the Quality Improvement driver diagrams. These documents make it clear that the Trust's clinical focus is on prevention, increasing out of hospital care, developing strategic partnerships to improve access and quality for patients, supported by innovation/digital/informatics and moving towards population scale interventions.

The Trust's vision is to 'improve the lives of the people and communities we serve' and we aim to do this by ensuring that everyone who is experiencing mental health difficulties is supported to recover, stay well, make their own choices and participate on an equal footing in everyday life. The impact of this clinical direction will be a reduced reliance on bed based in-patient care and sometimes inappropriate stays in hospital to provision of joined-up services at home and within the community.

Achieving this vision will require significant investment to modernise our estate. Consolidating our community sites will help us to fund this investment, through capital receipts and operational savings. The urgent need for additional quality, modern facilities has been recognised, and the redevelopment of the new inpatient unit on the Maudsley site has already been agreed by the Board. A new building on the site of the former inpatient unit will provide eight new wards of accommodation.

The Trust Board at its meeting on 21 May 2019 reviewed options for the consolidation of Trust sites – including an option for the relocation of community services from Lambeth Hospital into modernised local community estate, alongside the relocation of Lambeth's acute services to the Maudsley hospital site - largely into the new inpatient unit development.

The Trust is committed to engaging, informing and listening to our stakeholders, including staff, throughout the development and delivery of these proposed changes.

2. SCOPE AND BACKGROUND

This document sets out proposals for the process of engagement that will need to take place jointly with key stakeholders including Southwark CCG and Lambeth CCG (given the proposed changes to the Lambeth Hospital site). Pre-consultation engagement is needed with staff, service users, families and carers, MPs, Councillors. Any decision about changes to services will be taken following a public consultation.

This document suggests an overarching timeline for communications and engagement up until a 12 week public consultation with a focus on the engagement and communications activity that will need to be delivered on the Lambeth Hospital site.

This document sets out a programme of internal and external communications activity to increase understanding of the Trust's clinical direction and the plans for major changes to our estate that aim to support the delivery of this clinical vision.

The programme is wide and complex in terms of its scope and strands requiring communications and engagement support:

- Demolition of the existing inpatient unit
- The planning, design and development of a new inpatient unit on the Maudsley Hospital site (Southwark)
- Options for service change including:
  - The consolidation of inpatient services into the new unit
  - Moving community services from Lambeth Hospital into new community locations
  - Re-location of non-Lambeth services currently on the Lambeth Hospital site
- The possible planning, marketing and sale of the Lambeth Hospital site
- Impact of decision on other Trust locations, e.g. Bethlem Hospital, Ladywell Unit, Lewisham

3. OBJECTIVES

Our overarching communications objectives for the preferred option is:

1. Raise service user, staff and stakeholder awareness of the Trust's clinical focus on **receiving the right care, in the right place, at the right time and aligned with the right values** - and impact of this direction on our plans and proposals for developing our future estate;
2. Identify and implement a plan to engage, and where required, involve and consult with specific service user, staff and other stakeholder groups who may be affected by, or who are integral to the programme;
3. Generate mechanisms to listen to any concerns raised by these stakeholder groups in relation to the plans and feedback views to the programme Board; and
4. Deliver effective and timely communications and engagement activity and materials (including a narrative and key messages) that support the milestones of the estates programme, for example the development of the PCBC.

4. COMMUNICATIONS AND ENGAGEMENT APPROACH

To progress with the preferred option it is recommended that there are a number of phases of engagement needed to put the Trust in the best position of being able to carry out a public service change consultation led jointly with Lambeth CCG.

Summary of key phases:

Phase	Date	Description
1	Dec 2018-Mar 2019	SLaM Trust Board Meeting; Meetings with Lambeth CCG, Lambeth Alliance and others.
2	Apr-May 2019	Meetings with staff and key stakeholders ahead of SLaM Trust public Board meeting.
3	Jun-Sep 2019	Pre-Consultation engagement on options relating to Lambeth Hospital, staff workshops and service user group meetings; meetings with key external stakeholders.
4	Sep-Nov 2019	Public consultation on preferred option.
5	Dec 2019-Jan 2020	Consultation analysis, Lambeth OSC agreement.

5. CORE MECHANISMS:

In order to deliver these objectives, the following core mechanisms are required:

5.1 ESTABLISHING A COMMUNICATIONS AND ENGAGEMENT STEERING GROUP

To ensure a consistent approach across the Lambeth Alliance and other stakeholders, and deliver timely and effective engagement activity that will increase understanding and buy-in across all parties, we have established a communications and engagement steering group.

This group is responsible for developing the communications and engagement activity required to support the programme. It includes planning a programme of engagement, developing a narrative and key messages, cascade briefings and presentations for staff and other stakeholders.

Working to the proposed option programme Board, the group brings together our individual communications and engagement activity into one coordinated plan. This provides greater oversight and assurance for the programme Board, and enable ongoing delivery to agreed milestones.

Going forward, the communications and engagement steering group will ensure coordinated activity and consistent messaging. Membership of the steering group is:

- Lambeth CCG Communications
- Lambeth CCG Chief Financial Officer
- NHS SLaM Clinical/Alliance Director
- NHS SLaM Communications
- NHS SLaM staff side chair
- NHS SLaM PPI Lead
- NHS SLaM Engagement and Stakeholder Manager
- NHS SLaM Project Manager, Estates and Facilities
- Lambeth Healthwatch
- Black Thrive Communications and Outreach lead
- Head of Service Reconfiguration, NHS England and NHS Improvement
- London Communications Agency
- Considered Analytics programme manager

5.2 KEY MESSAGES/CORE SCRIPT AND FAQ

One challenge is to accurately capture and explain the benefits that we foresee for people using our services and local people more generally, and the process for engaging staff and stakeholders in developing a Pre-Consolation Business Case and preferred option for consultation.

However, the programme also presents an opportunity to deliver a clear vision for the future direction of our mental health services, especially in the Borough of Lambeth, from which to galvanise support from staff and stakeholders.

To support this, it is recommended that we develop a strong overarching narrative that, once agreed, will form the basis of consistent messaging for staff and will provide a reference point for team leaders when briefing their teams.

The narrative should be supported by a robust FAQ, covering the likely questions or issues of concern for staff, such as what does this mean for me, as well as the detail of the process and what will be included in the PCBC such as the Quality Impact Assessment and the Equalities Impact Assessment.

This narrative would need to be reviewed and refreshed over time, to make sure the information is being received as intended and adapted as necessary. The narrative will need to be tested and refined in discussion with the communications working group and, in particular, in discussion with identified clinical and service leads involved.

5.3 STAKEHOLDER MAPPING

- Stakeholder mapping is an important step to understanding who is likely to be impacted by the proposed changes and a first step towards gathering perspectives on what is being proposed.

- As part of the PCBC we will need to map out all those clinical and non-clinical staff, service user representative groups, patients, families and carers involved in the proposed changes. Patient and service user involvement will provide valuable direction and support (the patient voice is powerful).

- The communications and engagement steering group will be a source of information to help identify groups of patients, staff and others who may have important viewpoints on the proposals that will need capturing as part of the PCBC and Consultation process.

- Once mapped, we will ensure that we consider their role in the programme, what level of engagement they require and how they will influence the development of the proposals.

6. LAMBETH HOSPITAL - COMMS AND ENGAGEMENT ACTIVITY TO DATE

On 21 May a paper went to the SLaM Public Board Meeting to ask for the Board member's approval to start engaging with staff, patients and all other relevant stakeholders on proposed service changes to the Lambeth Hospital. The paper recognised the urgent need to improve our community and inpatient facilities in order to be able to deliver our clinical priorities.

Prior to the Public Board a Staff and Stakeholder Communications and Engagement Paper was prepared setting out what needed to be delivered in May 2019 to increase key staff and stakeholder groups understanding of the Trust's clinical vision and make them aware of the Board paper which set out proposed major changes to our estate that aim to support the delivery of this clinical vision.

A number of activities were carried out as part of this pre-engagement phase:
a. Initial face-to-face briefings were held with affected staff at Lambeth Hospital, led by local managers staff meetings (See staff engagement below)
b. Letters were issued to key stakeholders at Lambeth Council and Healthwatch in advance of the Board meeting to make them aware of the paper and its contents and to offer a meeting. We are now following up these letters and arranging these meetings. (See stakeholder engagement below)

6.1. STAFF ENGAGEMENT

A series of face-to-face briefing sessions were held with affected staff at Lambeth on 20 May ahead of the Trust Board meeting on 21 May. Between all the local managers and Directorate leaders all the wards, onsite community teams, social care teams and onsite voluntary services were met with. There was also engagement with teams at Lewisham to ensure they were made aware.

Service Directors met with all the wards, onsite community teams, social care teams and onsite voluntary services on the Lambeth site. They started the morning meeting on 20 May with ward managers and consultants and then back office staff based at Raey House, finishing with ES2 staff at the end of the day.

Overall the feedback from these sessions has been positive. Information from the meetings will be available on Maud.

Nothing controversial was raised and staff on Nelson, Luther King and Eden are pleased with the preferred option.

It was stressed that this is a pre-consultation phase and the importance of staff involvement going forward. There were some questions raised which we will ensure we address in our future communications activity.

A number of staff asked why a new build is not possible on the Lambeth site. Neil Robertson responded was that we will struggle logistically to rebuild the site as there is nowhere for wards to be decanted and also that financially, the disposal of the site (or part of it) is key to future plans.

Although the consultants affected were generally in support of the ideas, a couple did reflect on how it could appear that the Maudsley was becoming a "big asylum" and the messages associated with this.

Next Steps:
A further briefing note will be provided for Service Directors / Deputy Directors (including SLP) in June to share with staff on the Lambeth site.

Following this, a series of 1 hr workshops are being arranged in early July with teams to review and record the likely impact of the various options. Feedback will be included in the Pre-Consultation Business Case.

It is recommended that the communications workstream agree the required feedback loop to evaluate impact and track any issues arising. This will help to make sure our messaging is kept up-to-date and continuously refined, and ensure that the programme Board is sighted and informed.

6.2 EXTERNAL STAKEHOLDER ENGAGEMENT

Letters were sent to a number of key stakeholders setting out the context and early details of the proposed changes and asking for a meeting with them at this early stage to seek their views on the proposals, our plans for engagement and how best to involve them and where relevant, their committee/Board/organisation.

Letters were sent (from Andrew Eyres and Matthew Patrick, cc Andrew Travers) to:

- Cllr Liz Atkins, Chair of Lambeth Council's Overview and Scrutiny Committee
- Cllr Jim Dickson, Chair of Lambeth Council's Health and Wellbeing Board
- Cllr Edward Davie, Lambeth Council's Cabinet Member for Health and Adult Social Care
- Larkhall Ward Councillors, where Lambeth Hospital is located: Cllr Timothy Windle, Cllr Andy Wilson and Cllr Tina Valcarcel,
- Sarah Corlett. Chair Healthwatch Lambeth and Catherine Pearson, Chief Executive Healthwatch Lambeth

Follow up meetings are now being arranged with each stakeholder.

Letters are also being sent to local MPs to inform them and offer an early meeting.

Local Southwark stakeholders will be sent a letter informing them of developments on the Maudsley site in the coming weeks.

7. PLANS FOR PRE-CONSULTATION

A draft Pre-Consultation comms and engagement plan is being developed. As detailed in the NHS England and NHS Improvement guidance it will support the development of a pre-consultation business case (PCBC) and set the foundation for planning formal public consultation.

Our pre-consultation and consultation activities will need to demonstrate compliance with the four tests which form part of the NHS England and NHS Improvement assurance processes:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear clinical evidence base
4. Support for proposals from clinical commissioners

The purpose of the pre-consultation phase is to inform and prepare for the potential full public consultation by discussing the case for change, our formative proposals and draft evaluation criteria, with local stakeholders.

At this stage we are **intending to hold a series of meetings and focus our engagement with key stakeholders including staff, service users, their families and carers most affected by any proposed change,** gathering views on what people view as the key benefits and challenges/risks with the proposed options.

We will do this by asking a number of questions. The material for the workshop is currently being developed.
We will ensure that the outputs of these discussions are captured in the PCBC and influence the final options taken forward to consultation.

Timeline of engagement activity

Date	Activity
20 May	• Staff team briefings ahead of Trust Board on 21 May • Stakeholder letters ahead of Trust Board on 21 May, offering meetings.
w/c 17 June	• Prep for Communications and Engagement Steering Group • Developing the content for the staff/stakeholder pre-consultation workshops
w/c 24 June	• First meeting of Communications and Engagement Steering Group to discuss pre-consultation approach • Sending out further information to staff and inviting them to attend workshops in July. • Organising workshops with other stakeholders inc service users, their family's and carers
w/c 1 July 15 July	• Staff/service users, family & carer/stakeholder workshops
w/c 22 July	• Governors workshop (18 July) • Workshop with senior clinicians and operational leads to review key findings from staff/stakeholder workshop discussions and agree content for PCBC • Second meeting of Communications and Engagement Steering Group (tbc)

8. PLANS FOR CONSULTATION

The feedback following the PCBC engagement activity will inform the **content** of our formal consultation and the consultation **approach**. We expect the formal public consultation activity to begin in the autumn.

We wish to work jointly with Healthwatch Lambeth to develop a joint approach to service user involvement as part of the consultation activity.

9. EVALUATION OF ACTIVITY

Measuring the impact of our communications and engagement activity would include evaluation of:
- Staff feedback via dedicated email and during briefing sessions
- Service users feedback on proposals
- Ability for timely response, managing and escalating issues and concerns raised by staff and other stakeholders

Appendix 16 – **Equality Impact Assessment Action (EIA) plan for proposed changes**

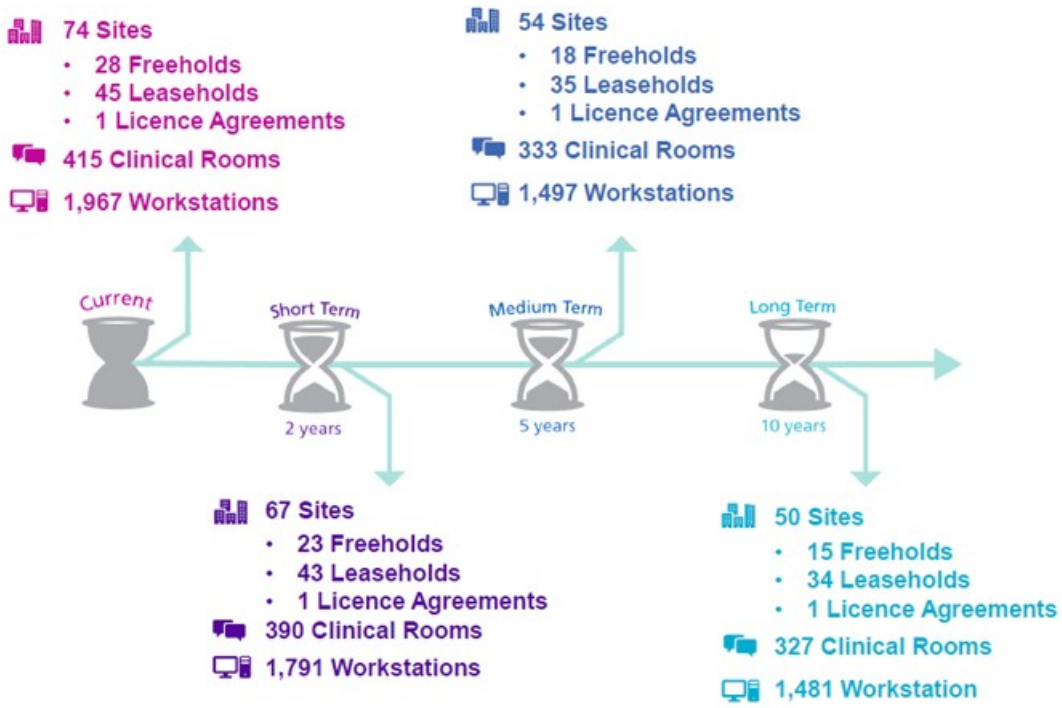
Potential impact	Proposed actions	Responsible/ lead person	Timescale	Progress
SERVICE DELIVERY				
Improve our understanding of the potential equality implications and required actions of the proposed changes	Identify appropriate stakeholders for all protected characteristics to involve in all future consultations	Head of Communications	Nov 2019	
	Share initial EIA in as part of future consultations	Head of Communications	Nov 2019	
	Ensure that EIA is fully coordinated with QIA	Clinical and Operational leads	Dec 2019	
	Update EIAs as required to incorporate equality-related evidence of the potential risks and benefits that emerge from evidence from future consultations, assessments or QIAs	Clinical and Operational leads	Ongoing (1 year before any future moves)	
	Ongoing engagement with wider clinical teams to share initial equality analysis and to seek views on potential risks opportunities and accompanying actions	Clinical and Operational leads	Ongoing (1 year before any future moves)	
Improve understanding of the travel implications of change in location of services in relation to service users, families, carers, supporters and community members of different ages, disabilities, ethnicities, gender identity, sexes and sexual orientations.	Undertake further detail assessment of the travel impact by age to understand quantum of when travelling for: • Young people, in particular those at risk of violence outside their area of residence • Older people with mobility issues • Disabled people • People from ethnic minorities, in particular from Black and Latin American communities. • People living in the Clapham Park Estate. • Ward in the Community service users	Director of Estates	Feb 2020	
Improve understanding of how to mitigate potential risks of social isolation at the proposed new locations of services of service users who are older, who are disabled, who are transgender, who are Black, who are from other ethnic minority back grounds (e.g. Latin American), who have places of worship in Lambeth, who are gay, lesbian or bisexual.	Ask how to do this in future consultations. In particular with stakeholders in relation to: • People aged 26-35 • Older people • Black Thrive and Black people • Latin American people • Lesbian, gay and bisexual people • Pregnant people • Trans and non-binary people	Clinical and Operational leads	Ongoing (1 year before any future moves)	

	• Females and males • Different religions and beliefs • Ward in the Community service users			
Maximise the potential positive disability-related environmental impacts of the proposed new building	• Ensure disabled service users, carers and stakeholders are involved in consultation process for the proposed new building	Director of Estates	Ongoing (1 year before any future moves)	
	• Ensure that all appropriate disability aids are procured for use in the building (mobile induction hearing loops, hoists, etc.)	Director of Estates	6 months before building opening	
	Commission an Accessible assessment disability access report for the new building and wards	Director of Estates	On completion of new building	
	Promote any learning on disability access identified in delivery of Southwark equality objective	Equality Manager & Southwark Equality Lead	Apr 2020	
Improve understanding of estate-related equality risks of proposed relocation of LEO and Ward In the Community	Engage with clinical teams and service users in identifying and delivering estates works required at ES2 and Dennis Hill Unit.	Director of Estates	Ongoing (1 year before any future moves)	
	Commission an Accessible assessment disability access report for ES2 and Dennis Hill Unit.	Director of Estates	TBC – after any building/ adaptions complete	
	Promote any learning on disability access identified in delivery of Southwark equality objective	Equality Manager & Southwark Equality Lead	Apr 2020	
Improve service delivery to transgender service users	Deliver transgender policy sessions to all ward managers and ward staff	Lambeth Service Director & Equality Manager	Apr 2020	
Improve understanding of potential sex-related implications of the proposals for single sex adult acute ward provision	Understand ward designs from estates and their suitability to have mixed sex wards in the future if required.	Director of Estates	Nov 2019	
	Obtain activity data on Lambeth private patients and analyse by age, ethnicity and sex	Lambeth Service Director	Nov 2019	
Improve understanding of potential sexual orientation-related implications of the proposals	Understand further why LGBT+ service users have a poor service user experience to be able to understand whether the relocation will positively or negatively impact this	Lambeth Service Director & Equality Manager	Apr 2020	
Monitor actual equality impacts of proposed changes	Engage with the Lambeth Development of Cultural Appropriate Services Forum on proposals and to identify	Lambeth Service Director	Feb 2020	

	mitigation measures to the impacts identified for Black service users.			
	Put measure in place to monitor length of stay and performance after the move by age, gender and ethnicity to assess whether the environment leads to improved experience and a reduction in length of stay.	Lambeth Service Director	TBC – after any potential changes are implemented	
	Adapt these to consider disability, religion and sexual orientation as demographic recording of these characteristics improves	Lambeth Service Director	TBC – after any potential changes are implemented	
WORKFORCE				
Improve our understanding of the potential equality implications and required actions of the proposed changes	Ongoing engagement with wider clinical teams to share initial equality analysis and to seek views on potential risks opportunities and accompanying actions	Service Director – Lambeth Service Director - Croydon & BDP	Complete by Feb 2020	
Improve understanding of potential disproportionate impacts for Black and older Ward in the Community staff	• Engage with BME staff forums to share plans and understand impact • Engage with staff groups at ward level to update on plans and to understand the impact • Develop mitigation actions where possible.	Human Resources & Croydon & BDP Director	Complete by Feb 2020	

Date completed 23rd August 2019
Name of person completing: Dr Rob Harland – Clinical Lead & Vanessa Smith – Operational Lead
Directorate: Lambeth Directorate
Service: Lambeth Hospital site services

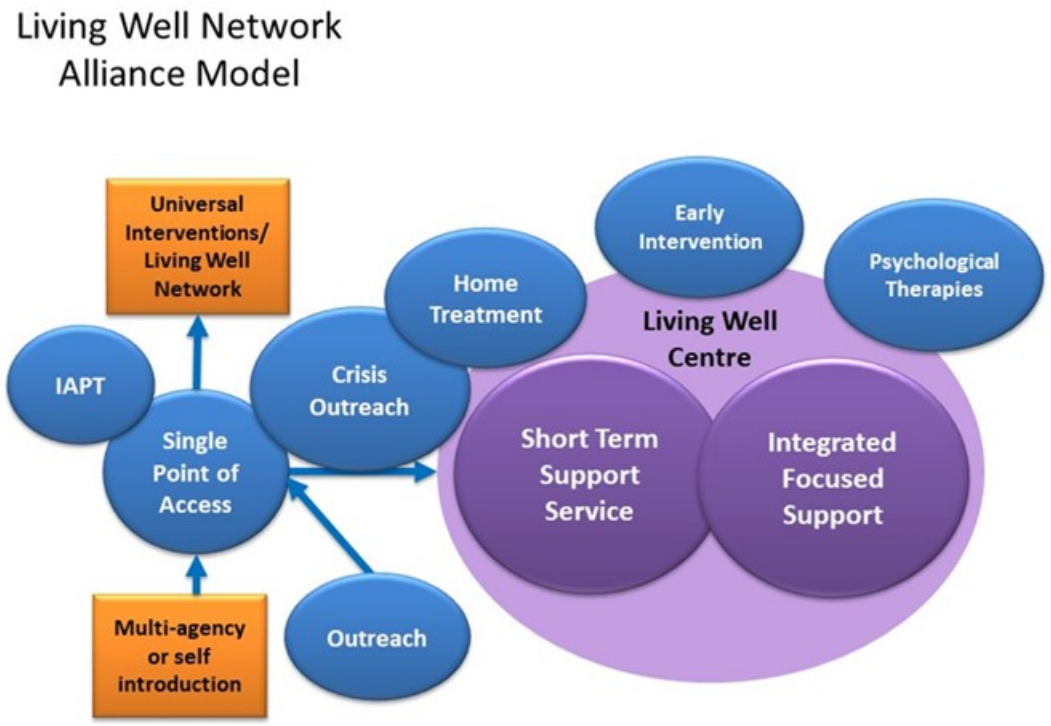
Appendix 17 – **Community Estates Strategy (2019 Roadmap)**



*Clinical and Workstation Analysis has only been undertaken for Croydon, Lambeth, Lewisham and Southwark excludes 7 properties which sit outside of the four main boroughs

South London and Maudsley NHS
NHS Foundation Trust

Appendix 18 – **Living Well Network Alliance Model**



Each Living Well Centre is supported by a Borough wide Single Point of Access Team, a Crisis Outreach Service and an Outreach Service.

The Single Point of Access team screens and triages all new referrals into the service and directs them to the most suitable team to provide personalised care and support. People that have been discharged within the previous 12 months are directed to a separate team which avoids the need to go through the triage process again.

The Crisis Outreach team provides a response with four hours. The Outreach service provides culturally appropriate support and advocacy for those that need it.