London Clinical Senate

FINAL

Advice on proposals for changes to Mental Health Services in Lambeth

14th January 2020

v1.4

Independent advice on proposals for changes to Mental Health Services in Lambeth

Prepared for:	**Denis O Rourke, Assistant Director Mental Health Commissioning (Mental Health), Lambeth CCG**
Approved by:	**Dr Mike Gill, London Clinical Senate Council Chair, on behalf of the London Clinical Senate**
Date:	**14th January 2020**

AIMS OF THE REPORT:

The report responds to the request from commissioners to consider:

a) The strength and appropriateness of the clinical case for change as set out in the pre-consultation business case and assurance that this adheres to optimum best practice and appropriate national guidance;

And to comment specifically on several questions raised by stakeholders in the consultation process to date:

b) The proposed re-provision of services on the Maudsley site adds to an already dense site in terms of number and range of services located there. Does this amount to over saturation of the site and to reducing much needed amenity space for patients, carers and staff?

c) Is the proposed location of inpatient services above ground level in accordance with appropriate practice?

d) Do the proposals for the re-provision of community-based estate currently on the Lambeth Hospital site comply with optimum best practice standards? and

e) Is it well recognised that improvements in the quality of facilities realise better clinical outcomes as suggested in the pre-consultation business case?

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1. Executive summary

Lambeth Clinical Commissioning Group (Lambeth CCG), Lambeth Living Well Network Alliance and South London and Maudsley NHS Foundation Trust (SLaM) are exploring service changes relating to moving the provision of acute inpatient and psychiatric intensive care services from the Lambeth Hospital site in Stockwell, to the Maudsley site at Denmark Hill, between Camberwell and East Dulwich.

The three overarching drivers behind the reconfiguration proposals are:

1. **National and regional policy:** Long term plan, five year forward view for mental health and south east London sustainability and transformation plan strategy.

2. **The local vision and clinical objectives:** set out in the Trusts clinical strategy and the Lambeth Living Well Network Alliance strategy which are to provide care in the least restrictive environments and care closer to home for all but those requiring specialist inpatient care.

3. **Quality of the estate:** to improve the estate to provide care in modern, fit for purpose building to deliver clinical priorities[1]

The London Clinical Senate was asked to advise on the clinical case for change to enable Lambeth CCG and SLaM to decide whether it is reasonable to move forward to a public consultation that is planned for March 2020.

They requested that the London Clinical Senate specifically advised on the following:

a. **The strength and appropriateness of the clinical case for change as set out in the pre-consultation business case and assurance that this adheres to optimum best practice and appropriate national guidance?**

b. **The proposed re-provision of services on the Maudsley site adds to an already dense site in terms of number and range of services located there. Does this amount to over saturation of the site and to reducing much needed amenity space for patients, carers and staff?**

c. **Is the proposed location of inpatient services above ground level in accordance with appropriate practice?**

d. **Do the proposals for the re-provision of community-based estate currently on the Lambeth Hospital site comply with optimum best practice standard?; and**

e. **Is it well recognised that improvements in the quality of facilities realise better clinical outcomes as suggested in the pre-consultation business case?**

To facilitate a structured approach to the review panel's role of exploring, examining, clarifying and challenging where warranted, we held a pre-review telecall for panel members to highlight areas that they considered required attention. We developed four overarching key lines of enquiry

[1] Pre- consultation business case, section 1.3.1, p14

that captured both the request from Lambeth CCG and the output of the panel's discussion, with consideration of the senate's principles. The key lines of enquiry were:

(1) Case for change
(2) Clinical model
(3) Stakeholders
(4) Enablers and the future

A panel was convened on 19th November 2019; it included members of the London Clinical Senate Council as well as individuals with subject matter expertise in mental health care. The review session involved a presentation by Lambeth clinicians and patient representatives who had been involved in developing the proposals and/ or could be affected by them. There was also an opportunity for questions, which enabled the review panel to clarify issues and triangulate what they heard with the supporting documentation.

The findings from the review were documented and shared with the panel to refine during the creation of the report.

The panel concluded that there was a clear case for change and appropriate clinical model to improve the quality of inpatient accommodation. However, they also identified areas where the pre-consultation business case could be strengthened and articulated questions that it would be helpful to address. The panel welcomed the stakeholder engagement and recommended continuing engaging with all key stakeholders throughout the process, also suggesting areas where SLaM and Lambeth mental health commissioners may wish to seek stakeholder views. Finally, the panel raised several areas for consideration to address the future sustainability of the proposals. These findings are described more fully in the document and extracted as 27 key recommendations.

I would like to thank representatives from Lambeth services for sharing their pre-consultation business case, presenting to and discussing with the panel. Thank you also to the review panel who brought substantial knowledge and experience to consider the proposals presented and their thoughtful and constructive approach in developing this report.

Dr Mike Gill
Chair of the Review Panel and Chair of the London Clinical Senate Council

2. Background

South London and Maudsley NHS Trust (SLaM) provides local services to Lambeth, Southwark, Lewisham and Croydon as well as a range of national specialist services. The trust's inpatient services are provided on five sites currently:

- Bethlem Royal Hospital in Beckenham, Bromley;
- Lambeth Hospital in Clapham, Lambeth;
- The Ladywell Unit at University Hospital Lewisham, Lewisham
- The Maudsley Hospital in Camberwell, Southwark; and
- Woodland House in Tonbridge, Kent (Child and Adolescent Mental Health Unit)[2].

The Lambeth Alliance is an Integrated Personalised Support Alliance (IPSA), a partnership aiming to improve outcomes for service users with complex mental health and high support needs in Lambeth. IPSA consists 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[3].

In partnership with the Lambeth Alliance, SLaM is in the process of implementing a service change through the provision of Living Well Centres strategically located within the borough, each of which will provide primary and secondary mental health services through a new care model. This is in keeping with the *SLaM Clinical Strategy* (2014) and the *SLaM Estates Strategy* (2016) of providing services in locations that are well distributed within the communities that they serve and delivering new integrated models of care wrapped around primary care networks. These living well centres support the redistribution of most community and outpatient services from the Lambeth Hospital site into the community and are located at:

- Ackerman House, North Lambeth;
- Gracefield Gardens, Streatham; and
- 332 Brixton Road, Brixton.

The SLaM estate strategy identified investment was required to bring estates up to the standard expected to delivery 21st century care. It identified three key issues to be addressed, including:

- *"Ability to meet service reconfiguration locally aligned to the Sustainability and Transformation Partnership Strategy and South London Mental Health Alliance. This requires an understanding of capability and capacity across those sites and a shared approach to use that capacity;*

- *Sites and buildings maximise the trusts ability to deliver services efficiently and effectively with limited capital to deliver the highest benefits;* and

- *Quality to support better clinical outcomes and improved service user experience facilitated by new technologies*"[4].

[2] Pre-consultation business case, section 1.3.2, p16
[3] Pre-consultation business case, section, 1.2 p14
[4] Pre-consultation business case, section 1.3.2 p17

The estates strategy also outlines an intention to reconfigure adult acute services, consolidating from four hospitals to a minimum of two hospitals, whilst providing the same number of beds in new accommodation. The Lambeth Hospital proposal is seen as the initial phase of an estate transformation programme[5].

It is against this background that the pre-consultation business case proposes transforming mental health services in Lambeth, and that the London Clinical senate has been asked to provide advice.

3. Scope and limitations of advice requested

The London Clinical Senate was asked to review the proposed movement of acute inpatient services for Lambeth residents and to give advice in a formal review of the pre-consultation business case on five issues:

a. The strength and appropriateness of the clinical case for change as set out in the pre-consultation business case and assurance that this adheres to optimum best practice and appropriate national guidance?

b. The proposed re-provision of services on the Maudsley site adds to an already dense site in terms of number and range of services located there. Does this amount to over saturation of the site and to reducing much needed amenity space for patients, carers and staff?

c. Is the proposed location of inpatient services above ground level in accordance with appropriate practice?

d. Do the proposals for the re-provision of community-based estate currently on the Lambeth Hospital site comply with optimum best practice standards? and

e. Is it well recognised that improvements in the quality of facilities realise better clinical outcomes as suggested in the pre-consultation business case?

The advice from this review provides a clinical and service user perspective on the case for change. The review panel's advice is based on the information seen and discussions held with stakeholders from Lambeth. The review team sought to triangulate the two wherever possible but has not explored wider literature.

Linked or associated changes to national inpatient services and most Lambeth community services were outside the scope of the review. This is detailed further below:

National specialist services

The broader reconfiguration proposals include the repatriation of two national specialist services from the Bethlem Hospital site into the Maudsley facility. These services are the Lishman Neuropsychiatry Unit and the Eating Disorders Unit, which were previously displaced from the Maudsley site due to the poor quality of the building. The London Clinical Senate was advised

[5] Pre-consultation business case, section 7.1, p96

that national specialist commissioners have taken a view that these services do not require a formal public consultation for the proposed move, but a full process of engagement is underway.

Community based estate

The pre-consultation business case outlines that community-based services are currently being moved from Lambeth Hospital to three living well centres in the borough. The scope of the panel's review was therefore to consider the inpatient proposals in the context of this wider patient pathway and to advise on whether they supported any residual community services being moved to from the Lambeth hospital site to these centres.

4. Formulation of advice

4.1 Review process

The pre-consultation business case was shared by the Lambeth Alliance and the review terms of reference were mutually agreed (see section 7.5).

It was agreed to hold a desk-based review on 19th November 2019, chaired by Dr Mike Gill, London Clinical Senate Council Chair. A multi-professional panel was secured to include members of the council as well as individuals with specific mental health expertise and public and patient representatives. To ensure independence, care was taken to ensure that members of the review team had not been involved in developing the proposals, that they worked in other areas of London, and had declared any interests. Only individuals without a significant conflict of interest served on the panel (see section 8.4).

The review team considered the pre-consultation business case provided by SLaM, and a teleconference was held on 12th November 2019 to discuss views and findings from the information and evidence provided. During this call members discussed the request of the panel and identified issues that they wished to explore further. These were developed into four overarching key lines of enquiry in line with the London Clinical Senate principles and provided a structure to the review.

The panel were also aware of the Mayor's six tests for major health and care transformation or service reconfiguration proposals in London:

(1) **Health inequalities and prevention of ill health** - the impact of any proposed changes on health inequalities has been fully considered at an STP level. The proposed changes do not widen health inequalities and, where possible, set out how they will narrow the inequalities gap. Plans clearly set out proposed action to prevent ill-health.

(2) **Hospital beds** - given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently scrutinised for credibility and to ensure these demographic factors have been fully taken into account. Any plans to close beds should also meet at least one of NHS England's newly introduced 'common sense' conditions.

(3) **Financial investment and savings** - sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from

hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

(4) **Social care impact** - proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

(5) **Clinical support** - proposals demonstrate widespread clinical engagement and support, including from frontline staff.

(6) **Patient and public engagement** - proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.

This report presents the review teams findings, conclusions and advice.

5. Review findings against key lines of enquiry

This section of the report provides an account of the panel's exploration against the key lines of enquiry, specifically referencing the areas on which Lambeth Clinical Commissioning Group asked for advice.

The exploration is prefaced by key facts and information, derived from either the pre-consultation business case or information that emerged from the slides, presentation and discussion on 19th November 2019.

5.1 Case for change

5.1.1 The strength and appropriateness of the clinical case for change as set out in the pre-consultation business case and assurance that this adheres to optimum best practice and appropriate national guidance.

The panel noted that the case for change to re-provide acute inpatient beds from the Lambeth Hospital to Maudsley site is driven by:

- **National and regional policy** - long term plan, five year forward view for mental health and south east London sustainability and transformation plan strategy;
- **The local vision and clinical objectives** - set out in the Trust's clinical strategy and the Lambeth Living Well Network Alliance strategy which are to provide care in the least restrictive environments, and care closer to home for all but those requiring specialist inpatient care; and
- **Quality of the estate** - to improve the estate to provide care in modern, fit for purpose building to deliver clinical priorities[6].

[6] Pre-consultation business case, section 1.3.1, p14

The quality of estate is a particularly strong driver. Most Lambeth wards were built in the 1990s before modern standards of inpatient accommodation. The proposals aim to:

- Improve access, reduce fragmentation and enhance personalised care;
- Enhance the environment to enable more therapeutic practice. The current environment necessitates more restrictive practice to minimise risk, which is detrimental to optimal care; and
- Reduce the number of sites across the trust, streamline capital spend and achieve best value.

The pre-consultation business case explains that the wards do not meet Royal College of Psychiatrists standards due to inadequate bathroom facilities, dilapidated furnishings and decoration, insufficient on and off-ward therapy space, inappropriate 'corridor' style layouts and poor natural light and ventilation[7]. As a result, the safety and dignity of patients is impacted.

The pre-consultation business case also articulates that concerns regarding the quality of Lambeth Hospital estate have been highlighted in Care Quality Commission (CQC) reports since 2015, and that in July 2017 the CQC identified specific issues with the current accommodation:

- Inpatient units with blind spots necessitating the use of convex mirrors;
- A lack of a dedicated seclusion room requiring staff to improvise when seclusion was required; and
- At Nelson ward and others in the Lambeth site, there are potential ligature risks and a recent attempted suicide by a service user using the ceiling as a ligature point[8].

SLaM advise that due to the structure of the buildings, improvement can only go so far and costly maintenance is required due to the age of the site and general fabric of the buildings. They explained that the trust has been engaging with CQC sharing the estate's strategy and responding with a managed approach to risk. The plans shared and their responsiveness in managing risk have meant that action has not been taken by the CQC to date[9].

Upon reviewing the pre-consultation business case and following discussion the review panel were persuaded that there was an appropriate case for change articulated in the pre-consultation business case. They agreed that:

- The case is consistent with many of the principles of the London Clinical senate: it addresses parity of esteem, improves standards and ensures good value from resources;
- Service users gave a highly compelling case for change in their presentation;
- The overarching model outlined by commissioners and providers is consistent with optimum best practice. The proposed inpatient wards would better enable a clinical model with increased psychology, occupational therapy and ancillary support; and
- The community care pathway is consistent with providing care closer to home, supporting prevention and early intervention and reducing stigma.

[7] Pre-consultation business case, section 1.3.2, p18
[8] Pre-consultation business case, section 1.3.2, p17
[9] Slides presented to review panel, 19th November 2019

However, the review panel also reflected that further information would give clarity to the process undertaken and strengthen the case for change. This could be addressed by:

a) Fuller articulation of the options appraisal that concluded that the Denmark Hill site was the preferred option.

b) Providing further detail on the clinical model, including quantifying and evidencing the bed base that is required with an enhanced community offer.

c) Demonstrating the pathway with Accident and Emergency (A&E) and other services, given the emergence of Integrated Care Systems.

d) Articulating more fully the social care pathway and support alongside the community offer.

e) Responding in more detail to the voice of stakeholders in the business case: service users, staff and Lambeth and Southwark councils.

Each of these areas is expanded upon and discussed below:

a) Fuller articulation of the options appraisal that concluded that the Denmark Hill site was the preferred option

The review panel noted that the pre-consultation business case gives some context as to why the Denmark Hill site was considered the preferred option for the re-provision of Lambeth inpatient services.

Firstly, it articulates there is a need to rationalise estates, from 66 community and 6 acute sites across the boroughs of Croydon, Lambeth, Lewisham and Southwark, to ensure best value for money from capital investment[10]. It also explains that a range of options were considered looking at how to consolidate four hospital sites to a minimum of two hospital sites whilst providing the same number of beds[11]. Whilst the panel recognises that the pre-consultation business case notes alternative options and the critical success factors for shortlisting the preferred option, this is at a high level.

A fuller articulation of how the criteria were applied would strengthen the business case and give better context to other key questions e.g. the wards being above ground level and consideration as to whether the Denmark Hill site is over saturated. This recommendation is also consistent with the feedback from local stakeholders who have "*highlighted the need for full and contextual information to be provided alongside the options"*[12].

The panel considered that as well as understanding the application and outcome of the selection criteria, it would be helpful to position the business case within the wider Sustainability and Transformation Plan (STP) context. The re-provision is based on the premise that funds from the sale of the Lambeth hospital site are combined with wider capital from SLaM funds. The panel would welcome the wider STP's perspective about whether they endorse this and the most effective use of the capital available and indeed whether additional capital across the STP might also underpin the development.

[10] Pre-consultation business case. Section 2.6, p36
[11] Pre-consultation business case, section 7.1, p96
[12] Slides presented to review panel, 19th November 2019

R1.	Articulate why the Denmark Hill site was proposed as the preferred location for inpatient services, showing the process undertaken and the evaluation criteria applied.
R2.	Articulate the STP perspective on the use of the available capital

b) Providing further detail on the clinical model, to include predicting the bed base required with an enhanced community offer

Commissioners presented a whole system commitment to ensuring an effective community offer, which was being rolled out in Lambeth during October 2019. They articulated an integrated model with benefits to patients in improving flows through the system, increasing the speed and ease of transfers and reducing inpatient length of stay. The panel were impressed with this description and recommend including these planning assumptions and early findings in the business case to strengthen the case for change.

The panel observed that the pre-consultation business case proposes re-providing beds from the Lambeth site onto the Maudsley site. They recognised that multiple factors would interplay in determining the bed base required including: demographic changes, current system pressures, benefits of working as an integrated system and the community service model.

The pre-consultation business case outlines some of the calculations at a relatively high level and the bed requirement was explored during the review. The panel were advised that:

- Work has been undertaken with North East London Commissioning Support Unit this year to develop projections, and work is being undertaken across London to determine the bed requirements;
- There is no intention to reduce bed capacity;
- There are currently three male and one female 10 bedded Psychiatric Intensive Care Units (PICU) across SLaM which have only very rarely run out of capacity;
- The current length of stay is outside the national average;
- Co-location with Southwark would give flexibility to manage variation in demand because beds will be managed between the boroughs; and
- Notwithstanding work to date, the true demand of beds is not currently known.

The review panel would like to see more detail regarding the predicted future bed requirements and how these will be delivered by the proposed model. This would include:

- Articulating the current bed occupancy rates including the numbers and rationale if any patients from Lambeth and South East London are placed privately or out of area;
- Estimating the maximum and minimum reduction in admissions and reduction in length of stay and delayed transfers of care by the changes to the community model including the home treatment team;
- Assessing how the readmission rates impact on bed numbers; and
- Articulating how fluctuation of demand can be managed and requirements future proofed.

R3.	Describe and quantify where possible the planning assumptions and early findings of an enhanced community offer in the pre-consultation business case.
R4.	Provide predictions of future bed requirements and how these will be delivered by the proposed model.

c) Demonstrating the pathway with A&E and other services, given the emergence of Integrated Care Systems

At the review session Lambeth representatives presented plans for a clinical model designed to support patients closer to home and, in the community, supported through crisis cafes in community hubs. Lambeth living well centres would act as the single point of entry to a new integrated community mental health model of care wrapped around primary care networks. Anticipated benefits were described as:

- Improving access and reducing the mortality gap for people with serious mental illness by increasing whole person mental and physical health care and wellbeing support provided in the community;
- Reducing hospital bed-based care and 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 of access and experience of mental and physical health care across South East London for people with protected characteristics and experiencing social deprivation[13].

Lambeth representatives suggested that the placement of the inpatient unit on the Maudsley hospital site would improve access for service users to a broader base of clinical support services including physical urgent and acute care due to the close location with King's College Hospital Accident and Emergency department. However, they also clarified that the pathway for patients in extreme crisis was the 136- suite at the Maudsley site, not King's Emergency Department. The panel were advised that the 136- suite has increased its availability and reached capacity only once since opening in January 2017 but queried whether demographic and anticipated prevalence rates would mean that this capacity was enough for the future.

The panel reflected that the proposals alongside the introduction of Integrated Care Systems offered enhanced opportunities for partnership work between health and social care as well as mental health and physical care. They recognised that the Lambeth Alliance is at the forefront of this integrated work.

The panel welcomed these new models of care to enable prompt and effective responses to patients in crisis. However, they also noted that some patients in crisis are still likely to attend SE London Emergency Departments and may need acute mental health assessment and support either in the community or as an inpatient.

The panel suggest articulating the acute assessment pathway in the context of new community services and planned inpatient facilities. Multi-agency agreement to this, e.g. with King's and London Ambulance Service, would be particularly powerful.

[13] Slides presented to review panel, 19th November 2019

The panel also heard about a mental health triage alongside Emergency Department triage in Lewisham that that is now being rolled out. They recommend articulating the findings from this, showing the impact on future need and requirements.

Finally, the panel noted that there is potential increased demand for ambulance journeys for patients in mental health crisis who require admission to the Denmark Hill site (the distance of some of these journeys could be greater than to the Lambeth hospital site). Including modelling of this and clarifying whether this is handled by London Ambulance Service NHS Trust or a contracted provider from the acute hospital site/s would also strengthen the case. The panel recommendations are below:

R5.	Describe what is known of the demographic changes, articulating whether this suggests that the 136- suite will continue to have adequate capacity.
R6.	Describe the pathway for crisis care in the context of community services and the planned inpatient facilities, showing the support of partners where possible. Ensure that the link with King's College Hospital and the emergency pathway is clearly articulated given the close proximity.
R7.	Share modelling regarding transport to the Denmark Hill site for individuals in crisis requiring a mental health assessment.
R8.	Describe how access / availability of supportive housing might be achieved through the partnership and the effects of this on length of stay.

d) Articulating more fully the social care pathway and support

The panel noted that the proposal for moving the Lambeth beds onto the Maudsley site moves the provision of inpatient care from Lambeth to the borough of Southwark. The panel also noted the plan to have wards that are not designated to community catchment areas. This raised questions that the panel would like to see addressed in the business case.

R9.	Articulate any difference between Lambeth and Southwark populations and the impact that this may have on the model.
R10.	Detail how the social care input and pathway will be developed to facilitate a seamless patient journey, particularly arrangements for Lambeth services to "inreach" into beds within Southwark.

e) Responding in more detail to the voice of stakeholders in the business case: service users, staff and Lambeth and Southwark councils

The panel were strongly persuaded of the need for change by the service users who attended the review meeting and encourage ongoing listening to service users and staff in ongoing development of plans and the business case. As part of the equality assessment, the panel encourage attention to all groups including young people (18-25 years) transferring from children's services. The panel would like to see responses to stakeholder questions that were raised in the pre-consultation business case included in the consultation business case.

R11.	Include response and actions of the points raised by stakeholders in the consultation business case

5.2 Clinical model

5.2.1 Is the proposed location of inpatient services above ground level in accordance with appropriate practice?

The panel heard proposals to combine a building that housed both local Lambeth inpatient services and national specialised inpatient services.

The accommodation for those wards relocating from the Lambeth Hospital site are as follows:

- Ground Floor: National neuropsychiatry unit
- First Floor: Psychiatric Intensive Care Unit (PICU); Rehabilitation ward
- Second Floor: Two male acute wards
- Third floor: Two female acute wards
- Fourth floor: National eating disorder unit.

During the presentation, Lambeth representatives recognised that common practice would be to place the PICU on the ground floor but identified that it would not be possible in this building due to the need to incorporate a specialist neuropsychiatry unit where accessibility restrictions for service users means that a ground floor location is necessary for evacuation and safety. They advised that the first-floor placement of the PICU has been risk assessed and reviewed for derogations against DH Health Building Notes and Technical Memorandums and is compliant[14].

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.

To ensure that appropriate practice is maintained, the panel stressed that there needed to be due consideration to outside space that could be accessed without an escort. They also considered that enough light and ventilation should be included in the building design; the initial artist impressions of the wards suggest this is being considered from the outset. The panel also would like articulated how the dignity of patients will be maintained if they are admitted in severe distress or crisis, e.g. is there a discreet entrance to the wards.

The panel reflected that safe management of emergency evacuation for fire is essential for all buildings and requires particular consideration for a multi-tiered building. They were advised that discussions had taken place with the London fire brigade as well with fire officers within the trust, and that an operational plan sits behind the pre-consultation business case. Consideration has been given to access for fire engines and emergency access vehicles, horizontal and vertical evacuation and the creation of a secure environment outside.

Finally, the panel observed that wards should not be accommodated on more than one floor, and that any overspill would need to be across and not down. Therefore, consideration would need to be given to ensure wards could flexibly respond to different gender mix.

[14] Slides presented to review panel, 19th November 2019

R12. Include more detail about the outside space in the business case such as dimensions, visuals and whether it can be accessed without escort.

R13. Articulate how the dignity of patients will be maintained if they are admitted in severe distress or in crisis.

R14. Reference managing fire risk within the business case and continue dialogue with fire experts to ensure that all necessary standards are met.

5.2.2 Do the proposals for the re provision of the community-based estate currently on the Lambeth hospital site comply with optimum best practice standards?

The panel understand that many of the changes regarding the community-based estate have already been implemented and are, therefore, out of the scope of this review. However, they noted that it was logical for the community services remaining at Lambeth to move to other community facilities, especially if inpatient services are moved off the Lambeth hospital site.

The panel welcomed the increased focus on community provision, providing care closer to home and support at an earlier point in the patients' journey. From the information provided, the panel felt that the proposals were in keeping with best practice standards. However, they considered that more detailed information would be valuable in describing the community services and how these integrate within the wider system in the context of Sustainability and Transformation Plans.

The panel suggest including more information on the living well centres, and how they fit and support the wider system approach to developing the community offer and reduce the anticipated demand for inpatient care. This would include:

- How do living well centres interface with the primary care networks and/ or GP practices. How is duplication avoided if there are similar personnel?
- How do living well centres fit into the pathway? Are they open 7 days a week, and if so, during which hours?
- How would living well centres reduce demand on inpatient services? Can this be modelled?

R15. Describe how the community offer sits within the wider integrated care system and STP plans

R16. Describe and quantify how living well centres interface with the wider system, support the patient pathway and are intended to reduce demand on inpatient services

5.2.3 Will the improvements in the quality of facilities realise better clinical outcomes as suggested in the PCBC?

There was powerful feedback from service users to suggest that improved quality of facilities would realise better clinical outcomes. It was noted that the improved facilities would enable a clearer line of sight across the wards, enable less restrictive patient care and provide the opportunity for a more therapeutic model to be implemented.

SLaM presented the quality improvements realised and measured in the following areas:

- **Safety** - reduction in violence and aggression, use of restraint, use of one to one or enhanced observations, incidents of self-harm;
- **Experience Measures** - improved Patient Experience Data Intelligence Centre (PEDIC) feedback and health of the national outcome scales (HONOS) in relation to experience and recovery; and
- **Staff Satisfaction - Measures** - Improved staff survey and listening in action, improved recruitment and retention, improved delivery of care as assessed through *Perfect wards*.

The panel acknowledge the association between the quality of facilities and improved patient outcomes. They recommend specific analysis is undertaken to confirm exactly which indicators will be measured with a view to the development of a dashboard against which these can be evaluated.

> **R17.** Identify the specific indicators or metrics against which change will be measured and use this to inform ongoing evaluation and feedback loop.

5.3 Stakeholder consultation

The panel were advised that the new ways of working in the community in Lambeth have already been extensively consulted on by the Alliance and its predecessors. This includes a communications and engagement steering group which has been in place since June 2019 and is jointly chaired by the CCG and Trust, including clinicians, staff side, PPI and communications leads, Lambeth Healthwatch and Black Thrive.

The panel heard that meetings and workshops have taken place with staff, service users and their families, commissioners, governors and local stakeholders to discuss the case for change and options to inform the pre-consultation business case. They were informed that the Trust has also engaged with the Lambeth Overview and Scrutiny Committee (OSC) including Chair and Vice Chair, and engagement is ongoing with Southwark Council. This pre-consultation engagement is continuing with Healthwatch carrying out an independent piece of work interviewing staff and service users who have experience of the services[15].

The review panel welcomed this basis for stakeholder consultation and encourage that this continues with an ongoing feedback loop as the business case is further developed and refined.

5.3.1 Consultation with service users / patients

The panel explored with the Lambeth representatives how the community would respond to losing a hospital from the borough, particularly when the Lambeth and Southwark wards will be mixed and there will not be a relationship between the borough and an inpatient ward.

The slide pack indicated that this had been raised by stakeholders and that Lambeth are seeking to establish community hubs to mitigate against some of this impact as well as undertaking focus group sessions to engage with particular communities[16]. The Lambeth representatives advised

[15] Slides presented to review panel, 19th November 19
[16] Slides presented to review panel, 19th November 19

that the proposals have broadly been well received with many carers describing their priority for inpatient services as being a high-quality inpatient environment, with location of lesser concern.

The panel were advised that councillors have been supportive of the change, which may be as there is no proposed reduction of beds, and there is potential opportunity for the development of social housing on the Lambeth hospital site.

The panel were pleased to hear that the Health Inequalities Impact Assessment had been undertaken and was being used to identify other groups that should be involved in consultation. They considered that this work should be ongoing.

The panel also explored the impact of the proposal on travel time for service users. The presentation identified that both the Lambeth and Maudsley Hospital sites were well served by public transport networks, and that a transport analysis has found Maudsley Hospital benefits from a greater level of accessibility by public transport[17].

The pre-consultation business case states 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 of the Maudsley hospital site*"
>
> "*At this stage, the EIA has identified the potential increased travel time for some disabled service users as the only vulnerable group that may experience a reduction in accessibility. In order to minimise this risk, route planning to the new site will be provided and shared with local community groups for individuals with disabilities*" [18]

The panel welcomed the work which had been undertaken to date, and commitment to ongoing action. They also recommend demonstrating the correlation between postcode and population density or numbers requiring care from this postcode area. For example, a 45-minute drive from SE9 may affect 1 or 20 people depending on the population density and need.

The panel also recommends clarifying the transport method by which journey times are calculated, for example there will be a difference between public transport, off peak car travel and car travel during rush hour. They also would like to see articulated the implications for disabled parking spaces and parking charges.

Finally, the panel recommend sharing the implications of the impact on leave for patients living more than 45 minutes travel from the ward. Given that leave ordinarily begins at 2 hours, the panel considered that this may allow for an unsatisfactory amount of time at home.

R18. Maintain engagement listening and discussing with the local community including gaining more feedback from seldom heard voices. This should feature strongly in the business case and approach to consultation.

R19. Provide fuller explanation of the likely impact of the movement of the inpatient wards, giving consideration not only to the postcode but the population numbers living in those postcodes who may be likely to require inpatient services.

R20. Provide further details on the calculation of travel times by transport method and the impact of this.

[17] Slides presented to review panel, 19th November 2019
[18] Pre- consultation business case, section 4.12, p 76-77

R21. Address how short periods of ward leave will be impacted for patients living more than 45 minutes travel from the ward, how this is currently managed and future plans especially if numbers increase.

5.3.2 Consultation with the workforce

The panel considered that there was a case for consolidating care from a workforce perspective, agreeing that there were clear opportunities from a centralised, flexible workforce. "*More robust staffing models can also be formed where co-location can help reduce the use of bank and agency staff that currently contribute to existing financial strain and clinical risk*"[19].

The panel were pleased to note that the ward designs increase the opportunity for educational activity with the provision of rooms for Multi-Disciplinary Team meetings and seminar rooms. They would like to see further stakeholder engagement with the workforce to enable the cultural change necessary to move into a new working environment and ensure that the highest quality service can be provided. To date, little detail has been provided about the impact for staff and consequences for recruitment and retention.

R22. Consult and co-produce with the workforce actions that might be required to enable the cultural change needed with moving sites and the actions that may be required to deliver optimal service.

R23. Engage with the workforce on the amenities required.

5.3.3 Does the proposed re-provision of services on the Maudsley site add to an already dense site in terms of number and range of services located there? Does this amount to over saturation of the site and to reducing much needed amenity space for patients, carers and staff?

The Lambeth alliance argue for the benefits of re-provision on the Maudsley site for several reasons:

- 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[20].

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.

Regarding the question of saturation or density, they considered that staff and service users were best placed to advise on this, therefore detailed and extensive consultation with

[19] Slides presented to review panel, 19th November 2019
[20] Slides presented to review panel, 19th November 2019

stakeholders should be undertaken to effectively address this question. In addition they advise that addressing recommendations 12-14 regarding outside space, amenities, privacy and dignity would support answering this question.

R24.	Explain fully the benefits of consolidation and use the dialogue with staff and community to explore ways to mitigate any over saturation of the site.

5.4 Enablers and the future

5.4.1 Workforce, digital and sustainability

The panel reviewed the proposals with consideration of enablers and future sustainability. The proposals regarding workforce have been included in section 5.3.2.

The panel explored the configuration of the wards and how the design could be future proofed. They noted that the building was designed to flex according to gender balances, variable sized rooms would allow usage for difference purposes and therapeutic work as well as opportunities to modify the PICU into a standard ward. The panel also noted partnership with Microsoft and Apple being explored for digital interface for the building. The panel would like to see this more fully worked through. They also recommend looking at sustainability in the wider context, considering the guidance and recommendations in *Clean Air Hospital Framework*, co designed by Great Ormond Street Hospital and Global Action Plan.

R25.	Articulate the attention to future proofing to accommodate changes in demand
R26.	Provide fuller workup of the digital offer within the building, progressing from current conversations with Microsoft and Apple.
R27.	Consider sustainability in the broadest sense, considering the guidance and recommendations in Clean Air Hospital Framework, co designed by Great Ormond Street Hospital and Global Action Plan.

6. Conclusion

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.

The panel were in broad support of the proposed changes.

However, they also considered that further information would help to develop the most robust case for change possible. This includes:

- Fuller articulation of the options appraisal that concluded the Denmark Hill site was the preferred option;
- Additional detail on the clinical model including social care support, interface with the community offer and management of patients in crisis. The panel considered that this articulation could be used to predict the bed base required and how this would be met. Associated with this, the panel would like to see greater attention given to the future proofing and sustainability of the building; and

- Maintaining engagement with service users and staff to understand the impact of the relocation on vulnerable patients e.g. extending the postcode mapping to gain fuller understanding of potential numbers of people affected in each postcode as well as discussing outside space and amenities.

The panel acknowledged the work undertaken to date in these areas and welcome seeing the further progress on this and on the recommendations made.

7. Supporting information

7.1 Information submitted to the review

The panel review was based on the:

- Pre-consultation Business Case, Reconfiguration of Mental Health Services for Lambeth, South London and Maudsley NHS Trust - November 2019
- Clinical reconfiguration programme for Lambeth. An overview for the London Clinical Senate. Slide pack 19th November 2019

7.2 Review panel members

The review panel was comprised of:

Name	**Role**
Senate Council and PPV Members	
Dr Mike Gill	Chair, London Senate Council
Dr Mark Spencer	Vice Chair, London Clinical Senate, General Practitioner, Medical Director Northwest London Clinical Commissioning Groups
Richard Ballerand	Chair, London Clinical Senate Patient and Public Voice Group
Geoff Bellingan	Medical Director, Surgery and Cancer Board and Consultant in Critical Care, University College London Hospitals NHS Foundation Trust and Professor in Intensive Care Medicine, University College London
Adrian Capp	Head of Therapy, The National Hospital for Neurology & Neurosurgery, University College London Hospitals NHS Foundation Trust
Jane Clegg	Interim Joint Regional Chief Nurse and Director of Nursing Professional and System Development NHS England and NHS Improvement, London
Elaine Cloutman-Green	Principal Clinical Scientist within Infection Prevention and Control and Lead Healthcare Scientist, Great Ormond Street Hospital (Telecall and remote contribution to write up)

Tim Edwards	Consultant Paramedic, London Ambulance Service NHS Trust
Jo Emmanuel	Divisional Medical Director, Central and North West London NHS Foundation Trust
Deepak Hora	General Practitioner and North Central London Primary Care Lead for Planned Care
Diane Jones	Director of Quality & Safety, NHS Brent, Harrow & Hillingdon Clinical Commissioning Groups
Richard Leigh	Consultant Podiatrist, Royal Free NHS Foundation Trust
Martin Machray	Interim Joint Regional Chief Nurse and Clinical Quality Director NHS England and NHS Improvement, London
Janet Murat	Deputy Chief Nursing Officer , Princess Grace Hospital, Central London, HCA Healthcare
Nnenna Osuji	Medical Director, Croydon Health Services NHS Trust
David Parkins	Optometrist and Chair of the London Eye Health Network, NHS England
Julian Redhead	Medical Director, Imperial College Healthcare NHS Trust
Inder Singh Uppal	Vice Chair, London Clinical Senate Patient and Public Voice Group
Laura Stuart-Neil	Director of Quality Improvement and Director of Allied Health Professions, NELFT
Julia Whiteman	Postgraduate Dean, Health Education England, North West London
Fenella Wrigley	Executive Medical Director, London Ambulance Service
Additional Experts	
Vincent Kirchner	Medical Director Camden and Islington NHS Foundation Trust
Charlotte Harrison	Deputy Medical Director and Consultant Psychiatrist, Phoenix Unit and Wandsworth Rehabilitation Team, South West London and St George's NHS Mental Health Trust
Bill Tiplady	Psychologist and Clinical Director for Brent Mental Health Services, Central Northwest London NHS Foundation Trust

Carly Lynch	Psychiatrist Nurse and lead for London Ambulance Service
Sally Kirkpatrick	PPV representative, London Clinical Senate Patient and Public Voice group

Supported by

- **Emily Webster**
  Clinical Senate Programme Lead (Interim), NHS England and NHS Improvement, London
- **Katie Humphreys**
  Clinical Senate Senior Project Manager, NHS England and NHS Improvement, London

7.3 Review panel enquiry sessions

The review panel held a pre-meet telecall on Tuesday 12th November 2019 at which the approach to the review session, areas for further questioning and the key lines of enquiry were discussed. This resulted in agreed key lines of enquiry that were shared with the Lambeth representatives, to enable them to focus their presentation on these key areas.

The review session took place on Tuesday 19th November 2019. It was attended by the below representatives from Lambeth Mental Health services. They provided the panel with a 15-minute presentation and answered questions from the panel:

- **Dr Michael Holland,** Medical Director, South London and Maudsley NHS Foundation Trust
- **Dr Robert Harland,** Clinical Director, South London and Maudsley NHS Foundation Trust
- **Denis O'Rourke,** Assistant Director Integrated Commissioning, Lambeth Clinical Commissioning Group
- **Neil Robertson,** Managing Director, Living Well Network Alliance
- **Sarah Thomas,** Head of Communications, South London and Maudsley NHS Foundation Trust
- **Antonia Knifton,** Engagement Manager, Lambeth Clinical Commissioning Group
- **2x Service User Representatives (SLaM)**
- **Matthew Longmate,** Lambeth Reconfiguration Programme Director – Health Advisory Partnerships
- **Emma Crowe,** Communications Advisor, London Communications Agency

7.4 Declarations of interests

The London Clinical Senate provides independent and impartial advice.

The review panel did not include anyone who has been involved in the development of the proposals on which we are giving advice or who has been involved in, or is likely to be involved in, any part of NHS England's assurance process for these proposals.

All review panel members formally declared their interests and no conflicts existed.

7.5 Review terms of reference

[see next page]

London Clinical Senate

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title:	Advise on proposals for a series of proposed service changes which will impact the delivery of Mental Health services within the borough of Lambeth in advance of progression to a formal Public Consultation.
Sponsoring Organisation:	NHS Lambeth Clinical Commissioning Group
Clinical Senate:	London Clinical Senate
NHS England regional or team:	NHS England and NHS Improvement (London)
Terms of reference agreed by:	Dr Mike Gill, Chair, London Clinical Senate Council on behalf of the London Clinical Senate Neil Robertson, Alliance Director, Lambeth Living Well Network Alliance on behalf of Lambeth Denis O Rourke, Assistant Director Integrated Commissioning (Mental Health)
Date:	6th November 2019

1. Aims of the review and advice requested

South London and Maudsley NHS Foundation Trust (SLaM), Lambeth Clinical Commissioning Group (Lambeth CCG) and Lambeth Living Well Network Alliance are looking to publicly consult on a series of service change relating to the provision of the following key services in the borough of Lambeth, which are currently based on the Lambeth Hospital site:

- Acute inpatient mental health services;
- Psychiatric Intensive Care Unit services; and
- Community outpatient services.

The drivers behind the reconfiguration proposals include: SLaMs clinical strategy; aggregation of expertise and capacity; improved access and the responsiveness of community-based care; quality of estate and capability to move at scale and pace; and an opportunity to invest more broadly in updated estate.

Advice is sought on the clinical case for change to enable Lambeth CCG and SLaM to decide whether it is reasonable to move forward to Public Consultation, which is planned for March 2020.

The Clinical Senate has been asked to consider a series of proposed service changes, and has specifically been requested to advise on the following:

a) *The strength and appropriateness of the clinical case for change as set out in the PCBC and assurance that this adheres to optimum best practice and appropriate national guidance;*

Comment specifically in relation to a number of questions raised by stakeholders in the consultation process to date;

b) *The proposed re-provision of services on the Maudsley site adds to an already dense site in terms of number and range of services located there. Does this amount to over saturation of the site and to reducing much needed amenity space for patients, carers and staff;*

c) *Is the proposed location of inpatient services above ground level in accordance with appropriate practice;*

d) *Do the proposals for the re-provision of community-based estate currently on the Lambeth Hospital site comply with optimum best practice standards; and*

e) *Is it well recognised that improvements in the quality of facilities realise better clinical outcomes as suggested in the PCBC?*

2. Scope of the review

Planning, assuring and delivering service change for patients (NHS England, November 2015) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

1) Strong public and patient engagement;
2) Consistency with current and prospective need for patient choice;
3) Clear, clinical evidence base; and
4) Support for proposals from commissioners.

The Clinical Senate's advice focuses mainly, but not exclusively, on the third test. In 2017 the NHS Chief Executive introduced a fifth new patient care test for hospital bed closures, which if relevant will also be reviewed clinically.

The timing of the review of the PCBC is critical; the review will be undertaken by considering a draft of the PCBC as opposed to the final document submitted for NHSE and NHSI assurance. Focus will be predominantly on the clinical elements. This planned approach will enable Lambeth CCG and SLaM to make best use of Clinical Senate advice and recommendations, revising and integrating them where appropriate into the final version of the PCBC, prior to the assurance process.

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides. The issues are:

a) Promoting **integrated working across health and social care** and ensuring a seamless patient journey;

b) Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services);

c) Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population);

d) Demonstrating **parity of esteem between mental and physical health** for people of all ages;

e) Supporting **self-care** and **health and wellbeing**;

f) Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation); and

g) Ensuring **value** (achieving the best patient and population outcomes from available resources).

3. Review Panel

The Chair of the London Clinical Senate Council (Dr Mike Gill) will chair the review.

The review will take place following a Senate Council meeting and include members of the Senate Council and Senate Patient and Public Voice Group. Membership will therefore be a multi-professional panel and, subject to agreement with the Chair, membership will include clinical experts with specific subject matter expertise. Advice on membership will be sought from the London Clinical Senate Council and Forum members with relevant expertise, professional bodies and the Mental Health Clinical Networks as necessary.

The review panel will seek advice from other independent experts on specific issues if indicated. The review panel may also seek input/ advice from clinical and patient experts in advance of the review panel. It will not include anyone who has been involved in the development of the proposals being considered.

All Senate Council members will be requested to formally declare any interests in advance, and again at the start of the review panel. Conflicted council members will be excluded from the review.

All addition panel members, contributing will be asked to complete and sign a declaration of interests form and sign a confidentiality agreement.

4. Method

In determining the review approach and formulating advice, the Clinical Senate Council and review panel will draw on the following, which include guidance on testing an evidence base:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014
- NHS England's Service Change Toolkit
- Planning, assuring and delivering service change for patients, NHS England, March 2018

The review is expected to involve the following steps:

Step 1: **Establish the review panel**

Step 2: **Brief the review panel** and circulate key documentation for desktop assessment (see section 5 for the proposed schedule of documentation)

Step 3: **Hold a review panel meeting / teleconference** to:

a. agree the overall methodology that will be applied to formulate the advice
b. share desktop assessment findings
c. identify issues that need to be explored, clarified or validated to assist in formulating the advice
d. agree any further information/documentation that the review panel members agree to be required to inform the review

Step 4: **Hold an expert review panel** (1.5 hours) to:

a. meet and discuss the proposals / solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
b. provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
c. debate findings within the review panel and finalise conclusions
d. identify any outstanding issues and agree the process for following-up (and further review panel discussion agreed as necessary)

Step 5: **Prepare a report** setting out overall findings, conclusions, advice and any recommendations; this will be circulated to the review panel.
Hold a meeting / teleconference with the review panel to discuss the draft report content and agree any amendments.

Step 6: Once agreed by the review panel**, share the report with the Clinical Senate Council** who will:

- ensure the terms of reference have been met
- comment on any specific issues where identified by the review panel
- agree that the report can be issued

Subject to the schedule of Council meetings, the Senate Council Chair may undertake this on the Council's behalf.

Step 7: **Issue the report and advice**

5. Documentation required

In formulating advice, the review panel will review documentation that has both informed and been developed by commissioners and the providers.

The documentation that will inform this review is anticipated to be as follows.

1) The draft pre-consultation business case (PCBC) which will include:
    a) the Case for Change (rationale for the proposed change and evidence base);
    b) proposed clinical models (description, rationale and evidence base);

c) supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance against key quality indicators and benchmarking data / patient experience data;

d) schedule of evidence and best practice that have informed the proposals;

e) relevant Trust Clinical Strategies; and

f) process used to develop the proposals including staff, service user and public involvement. Summary of outcomes of stakeholder and patient and public engagement;

g) programme risk log

h) connection to STP plans

The review panel will formulate the advice requested based on consideration and triangulation of the documentation provided, discussion with key stakeholders and panel members' knowledge and experience. The advice will be provided as a written report.

6. Timeline

The figure below details the milestones in the review process.

	October				November				December			
	4	14	21	28	4	11	18	25	2	9	16	23
Convene Review Panel												
Submission of required documentation					31-Oct							
Terms of reference agreed					04-Nov							
Pre panel telecall						12-Nov						
Review Panel							19-Nov					
Report drafted and shared with review panel												
Final draft report shared with sponsoring organisaiton for factual accuracy check										13-Dec		
Feedback from sponsoring organisation on factual accuracy											20-Dec	
Final report												14-Jan

7. Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the appropriately experienced review panel members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

8. Reporting arrangements

The review panel will report to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report.

The Clinical Senate Council will submit the report to the sponsoring organisation and this advice will be considered as part of the NHS England assurance process for service change proposals.

9. Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracy prior to completion. Comments / corrections must be received within 5 working days.

10. Communication and media handling

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided - e.g. at a key stakeholder meeting subject to discussion and availability of review panel members.

- Disclosure under the Freedom of Information Act 2000

  The London Clinical Senate is hosted by NHS England and NHS Improvement and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

11. Resources

The Clinical Senate will recruit review panel members and cover members' reasonable expenses. It will also provide management support to the review panel, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level.

If, during the course of the review, the review panel identifies any additional requirements to formulate the advice requested, the review Chair or Clinical Senate Senior Project Manager will, where considered necessary, discuss these with the sponsoring organisation and may seek additional resources for this.

12. Accountability and Governance

The review panel is part of the London Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate a risk to patients, it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that, depending on the nature of the issues identified, the Clinical Senate Council

may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

13. Functions, responsibilities and roles

1) The **sponsoring organisation** will:

   a) provide the review panel with the case for change, draft PCBC, options / solutions appraisal and relevant background and current information, identifying relevant best practice and guidance and other documentation requested. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projections, evidence of alignment with national, regional and local strategies and guidance (e.g., NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, Sustainability and Transformation Plan, CCG delivery plans and commissioning intentions). Information requested for this review is detailed on page 4. Additional requests may be made as the review progresses;

   b) respond within the agreed timescale to the draft report on matters of factual inaccuracy;

   c) undertake not to attempt to unduly influence any members of the review panel during the review; and

   d) submit the final report to NHS England for inclusion in its formal service change assurance process.

2) The **London Clinical Senate Council and the sponsoring organisation** will:

   a) agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

3) The **London Clinical Senate Council** will:

   a) appoint a review panel which may be formed of members of the Senate, external experts, and/or others with relevant expertise;

   b) endorse the terms of reference, timetable and methodology for the review;

   c) consider the review recommendations and report (and may wish to make further recommendations);

   d) provide suitable support to the review panel; and

   e) submit the final report to the sponsoring organisation.

4) The **review panel** will:

   a) undertake its review in line with the methodology agreed in the terms of reference;

   b) submit the draft report to the London Clinical Senate Council for comment, consider any such comments made and incorporate relevant amendments into the report. Review panel members will subsequently submit a final draft of the report to the London Clinical Senate Council; and

c) keep accurate notes of meetings.

5) The **review panel members** will undertake to:

a) commit fully to the review and attend / join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology);

b) contribute fully to the process and review the report;

c) ensure that the report accurately represents the consensus of opinion of the review panel;

d) comply with the confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it; and

e) declare to the review panel Chair any conflict of interest prior to the start of the review and / or any that materialises during the review.

14. Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Emily Webster
Senior Programme Manager, London Clinical Senate (Interim)
emilywebster@nhs.net

For Lambeth Clinical Commissioning Group:

Denis O'Rourke
Assistant Director - Integrated Commissioning (Mental Health)
NHS Lambeth CCG / Lambeth Council