Commercial in Confidence

Capital Full Business Case
Development of a new 123 bedded medium secure unit
July 2017 (version 3)
## Change Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision</th>
<th>Detail</th>
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<tr>
<td>19.04.2017</td>
<td>V1</td>
<td>Excluding Economic and Financial Cases and Guaranteed Maximum Price</td>
</tr>
<tr>
<td>27.04.2017</td>
<td>V2</td>
<td>Inclusion of Economic and Financial Cases Excluding Guaranteed Maximum Price</td>
</tr>
<tr>
<td>18.07.2017</td>
<td>V3</td>
<td>Refreshed Economic and Financial Cases Update on BREEAM Rating Inclusion of Guaranteed Maximum Price</td>
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Foreword by Chief Executive and Chairman of Mersey Care NHS Foundation Trust

As with all mental health trusts, change has been a part of Mersey Care’s organisational life for the last ten years. We have managed significant change from providing care in hospitals to providing most of our care in community settings, in clinics and in people’s homes. Throughout all of this change one thing has remained constant, namely our commitment, from board to ward, to deliver the best possible care for the people and communities we serve.

We work tirelessly to find new ways of providing our services that enable us to reach people in need, prevent and treat mental illness sooner, continuously strive to reduce our costs whilst improving quality and safety for our patients and staff. It is our absolute aim to deliver ‘perfect care’ by making the services we offer more effective, timely, safe and fair to improve patient experience and outcomes as much as possible..

Mersey Care is proud of its history of delivering the promises that it makes to its service users, their carers and our colleagues at the trust. The trust has, in a very short period of time, achieved “good” for service quality from the CQC inspection, became a foundation trust following scrutiny from NHS Improvement and has successfully acquired another foundation trust. The trust carefully considered the obligations and responsibilities that came with that acquisition. We spoke at length with local commissioners and NHS England and agreed the transformational changes to the model of care for learning disabilities.

We welcomed the exciting opportunity to acquire the specialist learning disability trust Calderstones Partnership NHS Foundation Trust on 1 July 2016. This nationally important acquisition gave us the opportunity to focus on the type of future service our service users wanted to receive and how we can deliver ‘perfect care’ in an innovative medium secure and combined learning disability and mental illness environment whilst continually improving the patient experience. This business case therefore provides the rationale for this new service to be provided in a 123 bedded medium secure facility on the Maghull site.

The investment of a new medium secure unit on the Maghull site for service users with mental illnesses and learning disabilities is a significant part of our strategy to continue to deliver the best possible care for the people we serve. Our proposed development will provide a state of the art mental health facility providing each service user with a single room with en-suite bathroom in a therapeutic and healing environment which will lead to improved patient outcomes. This new facility will not be a place to live. Instead it will be a place where the best medical and psychological treatments and therapies can be offered to clients to support recovery within a managed length of stay, thereby offering clearly communicable care plans and value for money to commissioners and the tax payer.

Transforming the secure care pathway will provide the opportunity for fluid and responsive care planning across the spectrum of secure mental health and within existing commissioning frameworks. This exciting development will allow us to radically overhaul the way in which the diversity and complexity of secure mental health care is delivered through consistent innovation underpinned by our aspiration to provide our service users with ‘perfect care’.

This provides us with a significant opportunity to realise our vision to become a world leading provider in the provision of secure mental health, learning disability and autism care.

Joe Rafferty, Chief Executive
Beatrice Fraenkel, Chairman
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Executive Summary

1.1  Synopsis

1.1.1 Mersey Care NHS Foundation Trust (‘Mersey Care’ or ‘the trust’) is a highly regarded provider of the full range of adult mental health services. In addition the trust is in the unique position of being one of only three trusts nationally to provide high secure services.

1.1.2 On 1 July 2016, Mersey Care acquired Calderstones Partnership NHS Foundation Trust (‘Calderstones’; jointly referred to as ‘the trusts’ from when they were separate organisations). Calderstones provided highly specialised residential treatment and community care to individuals with learning disabilities presenting complex behavioural, mental health and social needs. The services provided were: medium secure and low secure services, step down services and an enhanced support service. These services are now provided by Mersey Care.

1.1.3 Mersey Care has prepared this Full Business Case (FBC) for the development of a combined state of the art medium secure unit (MSU) to provide highly specialised care for both service users with learning disabilities (currently cared for on the Whalley and Gisburn sites) and also for service users with a diagnosed mental illness (currently cared for in the Scott Clinic). In March 2017, NHS England’s consultation concluded that NHS England would no longer commission learning disabilities secure services from the Whalley site in the future. In addition the Scott Clinic, which currently cares for mental illness patients, is outdated and deteriorating year on year and NHS England has confirmed that the current facility is unacceptable and needs to be replaced.

1.1.4 It has been agreed between the trust, NHS England, NHS Improvement and the Department of Health that the trust would prepare a single business case, a Full Business Case, which covers the requirements of both an Outline Business Case and an FBC to replace both the Scott Clinic and the MSU at Whalley. This business case was approved by the Mersey Care Board of Directors on 26 April 2017. The Senior Responsible Officer has submitted the business case for external approval. Following requests from NHSI to review the economic and financial cases a revised business case was produced and approved by the Board of Directors on 26 July 2017 and submitted to NHSI.

1.1.5 The preferred option creates a 123 bedded unit: 45 specialist beds for service users with learning disabilities and 78 for service users with severe mental illness. These figures are supported by NHS England in its role as specialist commissioner for 118 beds with a further 5 expected to be filled with service users from Scotland and Wales.

1.1.6 With regard to public consultation, the Joint Overview and Scrutiny Committee who reviewed the public consultation for Scott Clinic considered the consultation to be robust and were fully supportive of the project. The public consultation exercise in Whalley was conducted by NHS England; the outcome of which was that in the future NHS England would no longer commission learning disability
secure inpatient services on the Whalley site and that they should be provided elsewhere.

1.1.7. Planning permission was granted by Sefton Planning Department on 13 January 2017 following a decision by the National Casework Planning Unit not to “call in” the planning application.

1.1.8. The key facts and figures for the preferred solution are:

Table 1.1: Key Facts and Figures

<table>
<thead>
<tr>
<th>Topic</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Bed numbers</td>
<td>123</td>
</tr>
<tr>
<td>Size of the unit</td>
<td>11,103m2</td>
</tr>
<tr>
<td>Capital cost</td>
<td>The total capital cost is £60.7m (inclusive of £9.3m taxes, construction and equipment)</td>
</tr>
<tr>
<td>Source of capital</td>
<td>The project will be funded by a loan from the Independent Trust Financing Facility (ITFF). The application for this loan was submitted in May 2017 and approved in June 2017.</td>
</tr>
<tr>
<td>Affordability</td>
<td>NHS England has agreed to commission 118 beds at an agreed rate. It is expected that the Scotland and Wales Commissioners will continue to purchase the historical 5 learning disability beds.</td>
</tr>
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<td>Procurement route</td>
<td>The new facility will be procured under the Procure21+ (P21+) framework using the appointed partner, Kier.</td>
</tr>
<tr>
<td>Key dates:</td>
<td></td>
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<td>Approvals</td>
<td>November 2017</td>
</tr>
<tr>
<td>Construction</td>
<td>January 2018 – March 2020</td>
</tr>
<tr>
<td>Commissioning</td>
<td>April – May 2020</td>
</tr>
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<td>Operational</td>
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1.2 Case for change

1.2.1. In October 2015, the national policy “Homes not Hospitals for People with Learning Disabilities” was announced by NHS England with the objective of moving people with learning disabilities into “more appropriate community
settings” and to reduce the number of beds in hospitalised care. In addition, Simon Stevens (Chief Executive of NHS England) stated, in relation to the Calderstones’ Whalley site:

“NHS England will [also] cease commissioning secure services on the Calderstones site … all hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close.”

1.2.2. In March 2017, NHS England’s consultation concluded that they will not commission learning disability inpatient secure services from the Whalley site in the future. It is the trust’s intention to fulfil NHS England’s requirements for the future of care and treatment for people with learning disabilities, and as such all learning disabilities beds on the Whalley site will be closed and beds or services will be provided on a case by case basis either in the community or in a new state of the art unit in the North West. This is based on and is fully compliant with the ‘homes not hospitals’ principle of “Building the Right Support”.

1.2.3. In April 2017, Sir Robert Naylor published his report entitled “NHS Property and Estate: Why the estate matters for service users”, in which he stated that “the NHS… [should] rapidly develop robust capital plans which are aligned with clinical strategies, maximise value for money… and address backlog maintenance”. In the cover letter from Lord O’Shaughnessy a similar view was presented, stating that the NHS should “develop and deliver robust, credible capital and estates strategies that are aligned with clinical plans… to ensure that facilities support the very best patient care”.

1.2.3. In addition to this national policy driver, the trust has an urgent and fundamental requirement to re-provide the out-dated medium secure unit at Scott Clinic. This unit does not provide the standard or range of accommodation required to support medium secure service users in their recovery journey. The current accommodation:

- fundamentally breaches building standards;
- requires significant works to improve patient safety by improving sightlines, fire safety and nurse call systems;
- has poor segregation for male and female beds;
- does not have en-suite facilities and has limited toilet facilities within the accommodation;
- has poor access to outside space, especially for those services users accommodated on wards on the second floor;
- does not contain appropriate therapeutic space or space for physical activities;
- has small wards which are not efficient in terms of workforce;
- is geographically isolated and culturally dislocated from the core of clinical provision, leadership and governance.
1.3 Options: do minimum and preferred option

1.3.1. A long list of investment options was identified and reduced to a shortlist which was then subjected to further analysis and scrutiny. The reduction of a long list to a shortlist was achieved by applying the CSF, which consider the feasibility of delivery and the overall investment objectives.

1.3.2. The shortlist was evaluated by undertaking both a qualitative analysis using the benefit criteria derived from Investment Objectives and a quantitative analysis which applied discounted cash-flow techniques. The qualitative analysis involved participation by the stakeholders, together with external scrutiny to ensure objectivity in the process.

1.3.3. The quantitative analysis of the shortlisted options was undertaken on the basis of the HMT’s “Appraisal and Evaluation in Central Government” rules and supplementary guidance which are mandatory for investment appraisal in the public sector. Affordability is considered separately in the Financial Case (Section 5 of this Business Case).

Do minimum

1.3.4. The trust considered a ‘do minimum’ option which consists of a new build for the learning disabilities element (Whalley and Gisburn) on the Maghull site and a refurbishment and extension for the mental illness element (Scott Clinic). This option for Scott Clinic creates a number of issues for the trust and the service users and staff, including:

- it fails to meet the trust’s clinical strategy as the service would remain geographically isolated;
- to provide en-suite bathrooms, the number of bedrooms on each ward would need to be reduced from 12 to 8 bedrooms, resulting in the need for additional wards to meet the bed requirements and requiring additional capital and revenue expenditure;
- these works would create significant disruptions to service users and staff would and present a risk to health and safety as construction work would be taking place adjacent to occupied wards;
- multiple moves would be required for service users as new wards are built and old wards are refurbished, which would be disruptive to service users and staff;
- the available outdoor space for service users would be reduced as a result of the increased accommodation requirements;
- the construction/refurbishment works are likely to prove more expensive as a more phased approach would be required and therefore the programme of works would be longer.

1.3.5. This FBC concludes that this option is wholly unsuitable. It fails to meet the majority of critical success factors and does not support the delivery of the future model of care.

1.3.6. As such this option remains solely as the ‘do minimum’ for comparative purposes in the economic analysis. The trust also needs to re-provide this accommodation elsewhere to satisfy the recommendations from independent inquiries which clearly state that professional isolation of staff at the Scott Clinic was a
contributory factor and could have an impact on patient care.

Preferred option

1.3.7. Through extensive consideration and staff involvement on future models of care, it is proposed that the most effective approach would be to co-locate the two MSUs in a single high quality therapeutic unit on Mersey Care’s existing site in Maghull. To deliver this vision for progressive medium secure learning disability and mental illness care, a new unit is required to care for service users that will bring together the highest quality clinical care in the most effective setting to support proactive case management and a tightly managed but also appropriate length of stay. This will improve recovery rates for service users and ensure that care is cost-effective for commissioners.

1.3.8. The need for the highest quality secure services has never been greater as demand for services continually outstrips supply in this sector. A new and progressive care model, providing intensive care and support regimes alongside tightly managing length of stay of secure service users, is therefore required if the trust is to ensure that people with complex mental illness and learning disabilities are effectively managed in the best accommodation with the right levels of care and security. This is not a place to live, rather it is a highly specialised therapeutic environment aimed at supporting service users to be able to move on through their tightly managed care plan.

1.3.9. This planned MSU unit will bring together the service users benefiting from medium secure services both with a learning disability (currently cared for at the Whalley and Gisburn sites) and mental illness (currently cared for in the inadequate facilities at Scott clinic). This FBC demonstrates that the preferred option is to build a single medium secure unit on the trust-owned Maghull site.

1.3.10 This option would result in a secure campus with other mental illness services as the Maghull site has an existing high secure service (Ashworth hospital) on the site which would result in co-location and eliminate clinical isolation and create the opportunity for efficiency and quality improvements from a workforce perspective.

1.4 Vision and model of care

1.4.1. As with all Mersey Care provision, the service user is at the core, with the model of care wrapped around them. Activities which can take place in the MSU to enhance each patient’s feeling of health and social well-being are then layered around the core treatment plan to ensure that we are assisting individuals in real time to increase readiness for their move to a less secure or community based environment. In addition the trust will then look to how technology can aid in the effectiveness and efficiency of this health care provision to best prepare our clients for a life beyond care. This will be tailored to specifically meet the needs of both the learning disability and the mental illness communities of service users. Once this intensive care plan is developed, the unit is then wrapped around these service plans to ensure that the highest quality therapeutic environment supports the management of individual care pathways.
1.4.2. The proposed clinical model for the medium secure service has been developed with clinical and operational leads from both trusts, in line with best practice and national policy and seeks to address future clinical and workforce challenges. In addition the local and national specialist commissioners have provided input, review and support in the development of the clinical model.

1.4.3. Whilst appreciating that basics, such as patient safety, are paramount, Mersey Care is seeking to use innovative techniques and technology to assist with the treatment and preparedness of service users to move to a less secure or community based environment, in a manner that enables service users to feel ready and comfortable to manage this transition.

1.4.4. The trust has been focused on how patient care will be provided in the new MSU and has been looking internationally – not just in health but in other sectors - for opportunities to bring technological innovation into the design of the building and approaches to the model of care. In a digital age it is imperative that service users have appropriate access to the internet and social media. Mersey Care will ensure service users have the opportunity to successfully prepare for social reintegration. Inclusion and involvement are vital to good and meaningful lives and the trust will ensure service users’ digital rights, are met in a safe manner, whilst supporting therapeutic activity, particularly in the areas of training, vocation and education.

1.4.5. Through innovative thinking, experienced management and investment, the trust will transform the existing secure pathway across high, medium and low secure services. This will create a cohesive and seamless pathway providing access to the appropriate level of secure care for all service users.

1.4.6. In order to ensure that service users are cared for in the most suitable environment, there will be a single overall approach to meeting the needs of people moving between levels of security and into the community as applicable. With this in mind, the trust concluded that best way to achieve this was through the creation of a Secure Campus, with the new MSU co-located with the existing high secure unit on the Maghull site.

1.5 Benefits of the new unit

1.5.1. The development of the new 123 bedded MSU will create a modern therapeutic model of care allowing areas for personal space and opportunities to use the latest technological innovations to assist in the care of service users. This will bring a great range of benefits to these service users, staff and carers:

- **Model of Care**: individualised care plans will allow for high intensity support when this is required by service users. Each person will be equipped with sustainable skills and will take active role in their own care. Delivery of the model of care will be supported by the latest technological innovation to increase effectiveness and efficiency. The anticipated benefits are shorter lengths of stay, limited readmissions, limited disruption to servicer users and carers;
• **Service users**: the trust’s model of care is aimed at creating better life chances for service users, reducing re-offending, improving literacy and numeracy and equipping people for work and a life beyond secure care;

• **Staff**: the trust is working with higher education units to improve training for nursing staff to work across the spectrum of mental illness and learning disability care whilst retaining clinical specialisation, which will create a workforce with multi-disciplinary staff who will be better trained, can offer higher quality services and are easier to recruit and retain, leading to a reduction in use of agency staff;

• **Innovation**: innovation supports the development of the model of care and improvements in environmental conditions;

• **NHS England**: better, locally managed service at an overall lower cost base than the current service through reducing number of out of area treatments. This is in line with the studies on reducing suicide rates (for which a contributory factor is care away from home). NHS England will be commissioning better care and better experiences for the service users and their families and carers.

### 1.6 Costs and financial impact

1.6.1. The capital cost of the MSU build is £60.7m including equipment and VAT (£46.9m capital, £1.1m fees, £1.5m equipment, £1.9m planning risk and £9.3m VAT). The new unit will be procured under the Procure21+ (P21+) framework using the appointed partner, Kier, and funded via loan from the Independent Trust Financing Facility (ITFF). Application to the ITFF was made in May 2017. The trust has incurred £4.1m of costs on the scheme to date for the development of the project and business case including external advisors and internal project support.

1.6.2. The trust has carefully considered the model of care and the associated workforce requirements coupled with the impact of the loan repayment costs all of which are key drivers on the impact of the new development on the MSU service’s as well as the trust’s overall financial position.

### 1.7 Timetable and Implementation

1.7.1. The trust has developed a detailed programme to ensure it is in position to build and operationalise the new MSU as soon as is practical. However, to meet this programme it will require support and action from the trust, approving bodies and the Principle Supply Chain Partner (PSCP) to deliver to the timetable. Current approval and build timetables suggest that completion of the build is expected by March 2020, with occupation by June 2020.
1.7.2. The trust maintains a robust risk management system which is frequently reviewed by individuals responsible for specific elements and reviewed as a whole at the Project Board.

1.7.3. The trust has an agreed management structure for the implementation of the construction programme and the planned commissioning. In addition a transition plan for a smooth transfer of service users and staff into the new unit has been produced.

1.8 Conclusion

1.8.1 Mersey Care views the MSU development as the most exciting and transformational activity it will undertake in the next year. There is true momentum and excitement about this opportunity to create a radically new medium secure service to meet the current and future needs of service users.
2 Strategic Case

2.1 Introduction to the Trust

2.1.1. Mersey Care NHS Foundation Trust (‘Mersey Care’ or ‘the trust’) is a highly regarded provider of the full range of adult mental health and learning disability services. In addition the trust is in the unique position of being one of only three trusts nationally to provide high secure services. The trust has a reputation for delivering on key strategic changes. It has achieved a “good” rating for service quality from the Care Quality Commission (CQC) inspection. On the 29th April 2016, Mersey Care was authorised as a foundation trust and this came into force on the 1st May 2016.

2.1.2. Following this on the 1st July 2016, Mersey Care acquired Calderstones Partnership NHS Foundation Trust (‘Calderstones’; jointly referred to as ‘the trusts’ when separate organisations). Calderstones was a learning disabilities trust and provided highly specialised residential treatment and community care to individuals with learning disabilities, presenting complex behavioural, mental health and social needs.

2.1.3. A comprehensive and open dialogue with stakeholders ensured the ramifications of such changes were fully considered and appraised. Local CCG’s and NHS England were involved in discussions throughout the process of acquisition and agreed the transformational changes to the model of care for learning disabilities.

2.1.4. Mersey Care carefully considered the obligations and responsibilities that came with the acquisition, in particular the changes required to meet guidance and policies regarding care for service users with learning disabilities.

2.1.5. In October 2015 the national policy “Homes not Hospitals for People with Learning Disabilities” (supported by the national plan; Building the Future) was launched by NHS England, in conjunction with the Local Government Association and the Director of Adult Social Services. The objective of this initiative is to transform care and treatment for people with learning disabilities by ensuring services are provided in “more appropriate community settings” with greater emphasis on ensuring access to mainstream services.

2.1.6. This will see a reduction in hospital beds for people with learning disabilities. In line with the future vision, NHS England announced the decision to no longer commission learning disability secure inpatient services at the Whalley site (a site previously managed by Calderstones).

“NHS England will [also] cease commissioning secure services on the Calderstones site … all hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close”. (Simon Stevens Chief Executive of NHS England)
2.1.7. The outcome of the public consultation was announced on 28th March 2017 with
the decision to move all NHS England learning disabilities in patient services off
the Whalley site. This new service direction for learning disability services brings
important consequences for the trust in planning the long term future of secure
services.

2.1.8. Historically Mersey Care has been the preferred provider of medium secure
services for mental illness in the catchment area of Cheshire and Merseyside.
These services are provided at Scott Clinic. The past decade has seen an
unabated increase in referrals to both low and medium secure services nationally.
In parallel the clinical complexity and needs of the needs of this service user group
has increased significantly. As a consequence of these factors and given the
limited capacity at Scott Clinic the need for the high quality secure services has
never been greater at the trust. This is indeed consistent with the picture
nationally as demand continually outstrips supply in this sector.

2.1.9. Moving forward Mersey Care aims to realise our primary objective of becoming a
world renowned leader in forensic mental health. The successful acquisition of
Calderstones has provided the opportunity to expand our expertise and enhance
our international reputation as we broaden service delivery into the field of forensic
learning disability. From the point of the acquisition, Calderstones services (in-
patient) were renamed Specialist Learning Disabilities Division. This
encompasses inpatient services at Whalley, Gisburn, Lancaster and Scott House.
For clarity reference in the FBC to Whalley (or the Whalley site) relates solely to
the Mersey Care Whalley site and not the division as a whole.

2.1.10 A well developed transformation programme has been commenced to effectively,
efficiently and safely bring together two historically distinct forensic services
providing care respectively for patients with mental illness and learning disability.
This is a complex and challenging process. The achievement of this objective
requires a model of care which is innovative, sophisticated, evidence based and
meets the specific needs of all our service users.

2.1.11 A synergy of knowledge and experience from the fields of forensic mental illness
and forensic learning disability services at clinical, operational and strategic levels
will be the foundation for the implementation of our new model of care.

2.1.12 A new and progressive care model, providing intensive and individualised
packages of care and support alongside proactive and targeted management of
length of stay is therefore required. Working collaboratively with service users in
this way, the trust will ensure that people with complex mental illness and learning
disabilities are effectively managed in the best accommodation with the right
levels of care and security.

2.1.13 A cohesive and streamlined secure care pathway (see figure 2.1 below) is built
upon the expectation that service users will always receive treatment within the
lowest level of security appropriate for them. A collaborative approach to
individualised care planning will enhance the service user’s capacity to be a
genuine partner in their care as they progress in their personal recovery.
Therefore while some service users may move down the secure pathway in a
sequence of decreasing levels of security, others may pass over a level or two
depending on individual needs. Progression to community reintegration will be built upon the provision of a step up/step down facility. As well as supporting service users to safely return to independence and community living, it will also provide short term intervention to support individuals and prevent where indicated a return to secure care.

Figure 2.1 Mersey Care’s approach to addressing the future needs of its patients along the secure pathway

2.1.14 The outcome of this national policy over the next few years will be a greater availability and utilisation of community services ensuring people are cared for in the most appropriate level of security. There will be a significant reduction in the requirement for secure beds for people with learning disability.

2.1.15 Despite this however there will remain a cohort of service users who require treatment and care in a secure environment. In order to deliver the closure of services on the Whalley site it will be necessary to relocate low and medium secure inpatient services.

2.1.16 This Full Business Case (FBC) focuses on the proposal for the future of Mersey Care’s medium secure services in their entirety. The requirement to re-provide medium secure care for people with learning disability away from the Whalley and Gisburn sites represents only one facet of the challenge facing the trust. Mersey Care’s Board of Directors are unswerving in their ambition that all service users will be treated in modern, comfortable and well equipped environments which support recovery and enhance the quality of their experience.

2.1.17 There are pressing clinical, operational and strategic imperatives to replace the existing MSU at Scott Clinic. Scott Clinic was opened in 1983 and was among the first tranche of regional secure units. While it was considered to be a ground-breaking design at the time, the structure and configuration are now out-dated and
compromise the delivery of care to vulnerable service users. Year on year, it becomes increasingly challenging to maintain the environment in a condition which meets the minimum standards and facilitates the delivery of excellent care and the privacy and dignity of service users.

2.1.18 Mersey Care holds a long standing commitment to its service users, carers, staff and commissioners to invest in a state of the art environment. This proposal to build a new MSU for service users with a mental illness has been and remains a priority for the Board of Directors.

2.1.20 We now have the opportunity to not only build this state of the art environment, but to create a centre of excellence in secure care driven by a wealth of clinical expertise brought together to improve access, treatment and life-long outcomes for patients with mental illness and with learning disability. In addition this will reduce the service inefficiencies and isolation associated with operating three separate MSU sites (see Map below).

![Figure 2.2: Geographical Area](image)

2.1.21 The co-located MSU will sit at the centre of a community to community pathway and our care and treatment will be guided by an explicit focus on the whole person, their needs goals and aspirations. A model of wrap-around care effectively balances risk and recovery. While the reduction of risk is a fundamental treatment priority, individualised care planning will articulate and
explore opportunities to enhance the lives of service users in the longer term. It is our commitment that barriers to a person’s community integration, involvement and future opportunities will be addressed and their abilities to pursue their personal goals enhanced during their time in our care. In essence we consider it a duty to enrich the attributes of each and every service user and equip them with the skills and knowledge to maximise their potential and achieve a productive and satisfying life.

2.1.22 As noted above the re-provision of Scott Clinic has been an objective of the trust for a number of years. This has seen the production of a number of proposals with the development of tentative and formative plans, none of which reached the stage of full business case. In line with the stated intention to close the Whalley site an internal Strategic Outline Case (SOC) was developed to address the re-provision of Scott Clinic while incorporating additional capacity to provide the necessary learning disability beds. This SOC was developed in parallel with the acquisition Outline Business Case and an acquisition Full Business Case. The investment in new accommodation was clearly addressed in the acquisition Full Business Case and in the Transaction Agreement. Due to the time constraints associated with this development, the trust has moved directly to a Full Business Case, which meets both the requirements of an outline business case and a full business case.

2.2 Introduction to this Full Business Case

2.2.1. This Full Business Case (FBC) outlines the strategic rationale and consequences of pursuing a new purpose built, co-located medium secure unit (MSU) with a capital cost of £60.7m for people with mental illness and learning disability. On the 13th January 2017 the trust was granted full planning approval for the development of a 123 bedded unit on the Maghull site. It is the objective of the trust to deliver this in full. We consider this will bring significant benefits to our service users and their families, our staff and our commissioners. These benefits are discussed in detail below.

2.2.2. The trust is however mindful of our responsibilities not only in clinical matters but in terms of excellent financial management in such a challenging economic period. We recognise the complexity of the commissioning landscape and the limited availability of capital funding at this time.

2.2.3. To that end careful and detailed consideration has been given to the development of a range of options which to varying degrees effectively balance the potentially competing factors inherent in the provision of high quality medium secure care for mental illness and learning disability. There are six shortlisted options each of which will encompass a total of 123 beds (78 mental illness and 45 learning disability). These are as follows:

- Do minimum: Refurbish and extend Scott Clinic and build a new learning disability MSU on the Maghull site;
• Integrate learning disability and mental illness in a single unit on the Maghull site;
• Co-locate learning disability and mental illness in a single unit on a generic greenfield site;
• Separate learning disability and mental illness units on the Maghull site;
• Separate learning disability and mental illness units on generic greenfield site;
• Integrate learning disability and mental illness in a single unit on the site of

![Diagram of Model of care]

- Acquisition:
  - brought the two medium secure services together to deliver Perfect Care
- Policy:
  - care closer to home
  - least restrictive environment
  - reduction in learning disability MSU beds by 25%
  - move learning disability services from the Whalley site
- Estates requirement:
  - need to replace Scott clinic
  - need to improve environment for patients
  - move learning disability services from the Whalley site and Gisburn

2.2.4. This development is required in order to address a number of national and local issues as illustrated in the diagram below:

**Figure 2.3: National and Local Issues**

2.2.5. Mersey Care views the MSU development as the most exciting and transformational activity it will undertake in the next year. This is a unique opportunity to shape the future delivery of secure services, to remove many of the barriers to effective and efficient care and place the service user at the centre of it all. The trust expects the co-location of services to provide a step change in the delivery of secure care. Presently the treatment and care on our separate sites is delivered by highly skilled and knowledgeable clinicians; however it can be hampered by geographical and cultural isolation and sometimes by entrenched working practices.

2.2.6. Bringing this extensive expertise and specialism together will undoubtedly create an unrivalled clinical resource to provide comprehensive, specific and targeted treatment for forensic service users with a wide range of complex and often comorbid conditions. These conditions can be life limiting not only as a direct consequence of illness or disability but also due to the stigma, impoverished life chances, and limited opportunities afforded to this group of people. Our
commitment from the top to the bottom of the organisation is to implement a model of care which goes beyond care and treatment of individuals. Our clinical offer will enhance rather than diminish the expectations held of the service user, emphasise their potential and nurture and support their aspirations.

2.2.7. The creation of a secure campus will bring together organisational and operational skills and knowledge of high and medium secure services. It will also facilitate the next step to integrating specialist learning disability services within the trust ensuring the benefits of robust and unified governance for service users, carers and staff. The sharing of best practice and the transformation of clinical care has already begun to bring benefits. The trust’s four major clinical initiatives, Zero Suicide, No Force First, Physical Health and Wellbeing and a Fair and Just Culture are now embedded in clinical care within Mersey Care at Whalley and Gisburn. This has demonstrated a commitment and enthusiasm for change at all levels of the organisation. There is a true momentum and excitement about the opportunity to create a radically new medium secure service to meet the current and future needs of the service users.

2.2.8. The building will offer an innovative design solution creating a therapeutic and healing environment which aids treatment, reduces risk of offending and serious harm, promotes recovery from substance misuse and reduces lengths of stay. The environment will be sufficiently flexible to enable it to respond to changing needs in the model of care or service delivery in the future ensuring exceptional care and treatment is delivered for offenders and high risk patients with severe mental illness, learning disability, neuro-developmental disorders and personality disorder.

2.2.9. In an increasingly challenging health sector our innovative model of care and specialist expertise delivered in a state of the art facility will not only give the trust a competitive advantage, it will allow it to be a leader in the development of treatment which will enhance the life of our services users. It is this investment which will allow the continued delivery of care of the highest quality despite the many challenges facing the NHS over the coming decades.

2.2.10 The investment of a new medium secure unit for these services is a significant part of the trust’s strategy to continue to deliver the best possible care for the people it serves. Transforming the secure care pathway will provide the opportunity for a fluid and responsive care pathway across the spectrum of secure mental health which will be beneficial for patients and attractive to Commissioners. This exciting development will allow the trust to radically overhaul the way in which the diversity and complexity of secure mental health care is delivered through innovations and utilising the trust’s philosophy of providing ‘perfect care’.

2.2.11 Mersey Care is committed to introducing innovative techniques and technology to enhance care and treatment and prepare patients to move to a less secure or community based environment commensurate with their needs.

2.3 Introduction to the Strategic Case

2.3.1. The Strategic Case explains how the medium secure project described within this FBC fits with the strategic direction of the trust and with the commissioning
intentions of the local commissioners as well as NHS England as a specialist commissioner.

2.3.2. The headline content of the remainder of this section is summarised below:

- **General background to the enlarged organisation** - explains high level details regarding the organisation;

- **Commissioners and the Local and National Context** – explains the background to services required locally and the national policy on changing the way care is provided to this cohort of patients, particularly those with learning disabilities;

- **Case for change** – articulates the conclusion that “do nothing” is not an option;

- **Proposed model of care** – depicts the planned model of care incorporating best practice, policy and commissioner requirements;

- **Investment Objectives and Criteria, Constraints and Risks** – describes the concepts used in the option appraisal for the new medium secure unit, list of the constraints surrounding and influencing the business case solution and details of the risks identified and the mitigations planned to address these risks.

Part A: Strategic Context

2.4 Organisational Overview

**Mersey Care, Calderstones and the acquisition**

2.4.1. Mersey Care is now responsible for a full range of primary, secondary and tertiary adult mental health, learning disability, autism and addiction services for the people of Liverpool, Sefton and Kirkby. Further to the acquisition of Calderstones the trust is now in the exciting position of developing and delivering specialist learning disability services for people across the North West of England at a time of significant change. This anticipated transformation in the care of people with learning disability is embraced by the trust and it welcomes the opportunity to shape the whole range of services to meet the needs of this population.

2.4.2. Mersey Care has also recently been commissioned to provide community physical health care services in South Sefton.

2.4.3. The trust is comprised of three clinical divisions: Local, Secure and Specialist Learning Disability (previously Calderstones). These are supported by a Corporate Division. However as the transformational change programme proceeds, the intent is for the Secure and Specialist Learning Disability Divisions to merge under a unified managerial and governance structure.
2.4.4. Mersey Care services are provided from over 38 sites and the local division serves a population of over 1 million. The footprint for secure services is extensive, serving a total weighted population of over 2.5 million (including a male only weighted population of 1.2 million for low secure services) in Cheshire and Merseyside for low and medium secure services.

2.4.5. The trust operates the complete range of secure services extending from community forensic services through low and medium secure to Ashworth High Secure Hospital. As one of only three trusts nationally to provide high secure services it covers a weighted population of 6.5 million (male only for high secure services).

2.4.6. Mersey Care also provides a range of specialist services in partnership with Her Majesty's Prison and Probation Service (HMPPS) commissioned under the Offender Personality Disorder Pathway. This includes the Beacon service at HMP Garth, which is a long term treatment provision for high risk violent offenders, and a number of joint community projects with the National Probation Service (NPS).

2.4.7. Mersey Care is the only trust in the country that has a prison located on its site. HMP Kennet, which is located on the Maghull site, ceased operations in January 2017 and therefore the use of that location is included in the options appraisal for the development of the new medium secure unit.

2.4.8. More than 50\% of the Mersey Care’s income is derived from its secure forensic services, which are currently commissioned by NHS England. Its non-secure clinical services are commissioned by 45 CCGs. Our specialist services for learning disability cover a wide geographical area.

2.4.9. Historically Calderstones was a very small FT with a predicted total annual income of £37.4m for 2016/17. At 30th June 2016 it had approximately 154 service users. Secure inpatient beds numbered 112 with non-secure beds amounting to 42. Overall the trust provided approximately 16\% of NHS consultant led learning disability beds in England. The funded establishment was circa 868 WTE\(^1\) at June 2016. This has undergone a planned reduction to 722 at March 2017 and it is anticipated there will be further efficiencies as the integration of specialist learning disabilities into the wider trust continues.

2.4.10 The majority of Calderstones’ services were provided from its main site in Whalley along with sites in Gisburn, Lancaster and Rochdale as well as in the community. With respect to learning disabilities medium secure services, these will continue to be provided at Gisburn and Whalley until the new MSU is operational.

2.4.11 Mersey Care and Calderstones began working together in April 2014. In September 2014, they agreed a joint clinical strategy. This led to several developments, including joint clinical appointments and an intention by Calderstones to provide some medium secure forensic services from the planned secure recovery campus on Mersey Care’s site in Maghull.

\(^1\) Figures correct as of 2\textsuperscript{nd} June 2016. Source: Calderstones HR Team.
2.4.12 The publication of the second report by Sir Stephen Bubb in November 2014, into the care and treatment of people at ‘Winterbourne View – A Time for Change’, led the board of directors at Calderstones to review future plans for the service in light of emerging changes in the commissioning of inpatient services for people with learning disabilities and challenging behaviours. The board concluded that these changes would be far reaching and fundamental and would impact on the viability of Calderstones as a standalone single speciality trust. As a consequence it would not be able to provide sustainable services that would meet the legal obligations of commissioners under the Mental Health Act (MHA).

2.4.13 In November 2014, the Calderstones’ board agreed that the best way of ensuring sustainable services for its service users was to explore a merger with another NHS body. The board agreed that the partner that could bring most benefit to its service users in the long term was Mersey Care. Mersey Care’s Board approved acquisition in May 2016. The development of the Acquisition Full Business Case (AFBC)² and associated due diligence provided both Boards and Monitor with a basis to formalise that decision. The acquisition was completed in July 2016 with Mersey Care assuming responsibility for the services.

2.4.14 NHS England and the local CCG’s supported the acquisition of Calderstones by Mersey Care and agreed in the Business Transfer Agreement for the transaction that they would support the application for capital funding for the MSU (albeit could not prioritise it over other applications until the business case was submitted).

2.4.15 The acquisition was in line with the Mersey Care vision of ‘striving for perfect care’, and continues to be the focus for the enlarged organisation.

“We will strive for perfect care for the people with complex mental health needs, learning disability, autism and personality disorder. Our collaboration is not based on the perpetuation of a traditional model of large, full—service in patient units, but on integrated pathways of care managed to achieve care in the least restrictive environment possible, and considerable reductions in clinical variation, length of stay and cost.”

2.4.16 Perfect care is made up of four facets: services, people, resources and future, which are summarised in the strategy wheel below.

² AFBC is available from the trust
Figure 2.5: Vision of the enlarged organisation

The goal of the medium secure service is:

“…to provide better managed care pathways so that people in secure services progress through the pathway in the most effective, and least restrictive environment and to care for people as close to their homes and communities as is feasible.”

2.4.17 As part of the acquisition, the trusts agreed a transaction agreement with NHS England and the CCGs that described the support which Mersey Care would receive over the next five years.

2.4.18 The transaction agreement signed by Calderstones, Mersey Care, NHS England, NHS East Lancashire CCG (on behalf of Lancashire CCGs) and NHS Wigan Borough CCG (on behalf of the association of Greater Manchester CCGs) recognised the following overall capital requirement associated with the learning disabilities services, namely:

- £25m for the Learning Disabilities element of the medium secure unit at Maghull;
- 2 x £15m for low secure units; and
- £8m for community bases.

2.4.19 The £25m for the MSU is in addition to Mersey Care’s mental illness element of £35m which already features in Mersey Care’s standalone financial forecasts.
2.4.20 In addition the transaction agreement set out support for double running, integration and transaction along with redundancy costs.

**Current Service Provision**

2.4.21 Mersey Care currently provides medium secure care across three separate sites with a wide geographical spread. Scott Clinic works with individuals with a primary diagnosis of mental illness, while secure care for people with a learning disability is delivered at Whalley and Gisburn sites.

2.4.22 The current mental illness medium secure service has two treatment facilities. Mental health inpatient services are provided from the Scott Clinic. This service provides inpatient assessment, treatment and rehabilitation for both male and female service users suffering from enduring mental health problems and consists of 48 male beds and eight female beds.

2.4.23 Those service users subsequently discharged to the community following successful treatment may come under the responsibility of the Forensic Outreach Service (FOS). The FOS provides intensive risk management, treatment and support.

2.4.24 An additional specialist treatment resource is provided by the Merseyside Forensic Psychology Service. This is an outpatient service provision based at 36 Rodney Street, Liverpool that provides outpatient assessment and treatment and a range of risk assessments. The service also provides specialist sex offender management programmes.

2.4.25 The services support a population in excess of 2.5 million people from within the Cheshire and Merseyside footprint, and with limited wider North West responsibility.

2.4.26 Other services provided from the Scott Clinic site include:

- Reed Lodge – a ten bedded male recovery focused Step Down Facility;
- The Enhanced Care Team – assessment and treatment for patients with more complex needs;
- The Substance Misuse Team - work across both medium and low secure services;
- The Forensic Personality Disorder and Autism Assessment and Liaison Team - assessment of referrals for individuals diagnosed as personality disordered, and when appropriate, recommends inpatient mental health treatment.
- The Psychologically Informed Consultation Service – case management consultation for offender managers, (assessment and formulation) working with high risk violent or sexual offenders with personality disorder.

2.4.27 All of these services with the exception of Reed Lodge and the Forensic Outreach Service (FOS) would transfer to the new MSU. Reed Lodge and FOS will be relocated into an existing trust property situated in a community setting.
2.4.28 The modernisation of the medium secure estate compared to that offered at Scott Clinic will deliver significant improvements in terms of quality for the patients and staff whilst creating reductions to its carbon footprint.

2.4.29 Currently the learning disabilities medium secure services (36 beds) are provided on the Whalley site and with a further 16 bedded MSU facility in the nearby location of Gisburn which is treated as a satellite of Whalley.

**Current MSU Bed Configuration**

2.4.30 Mersey Care currently provides medium secure services across three separate sites.

- **Scott Clinic**, 56 beds for service users with a primary diagnosis of mental illness
  - 4 x 12 bedded male wards
  - 1 x 8 bedded female ward

- **Whalley (Woodview Unit)**
  - 2 x 12 bedded male wards (each ward split into two flats consisting of 6 beds per flat) at
  - 1 x 12 bedded ward (6 male, 6 female separate flats) at Woodview

- **Gisburn**, 1 x 16 bedded male ward

**2.5. The Secure Market**

2.5.1. Mersey Care provides male beds in low and high secure settings, and male and female beds in medium secure settings for both mental illness and learning disability

2.5.2. The national mean occupancy for MSU in July 2015 was 94% which suggests limited availability of empty beds. Between April 2013 and March 2015 the national average number of medium secure bed increased by 6% but there was no increase in the North West.

2.5.3. The table below summarises a national study undertaken in summer 2015 showing the key sources of admissions and location of discharges.

2.5.4. As can be seen from Table 2.1 and Table 2.2 below on a national picture, transfers from the criminal justice system dominate admission patterns (46%), although over half are from other sources.
Table 2.1: Admissions Locations for Mental Illness

<table>
<thead>
<tr>
<th>Location</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penal establishment, Court, or police station</td>
<td>46.0%</td>
</tr>
<tr>
<td>NHS - mental health or LD ward</td>
<td>22.0%</td>
</tr>
<tr>
<td>Non-NHS run hospital</td>
<td>9.1%</td>
</tr>
<tr>
<td>Usual place of residence</td>
<td>8.1%</td>
</tr>
<tr>
<td>NHS - high security psychiatric accommodation</td>
<td>1.5%</td>
</tr>
<tr>
<td>Temporary place of residence</td>
<td>1.4%</td>
</tr>
<tr>
<td>NHS - ward for general patients / A&amp;E</td>
<td>0.7%</td>
</tr>
<tr>
<td>Local Authority residential accommodation</td>
<td>0.4%</td>
</tr>
<tr>
<td>Non-NHS run care home</td>
<td>0.1%</td>
</tr>
<tr>
<td>NHS run care home</td>
<td>0.1%</td>
</tr>
<tr>
<td>NHS - ward for maternity patients or neonates</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

All admissions with known source of admission (Apr 14-Mar 15)

Table 2.2: Discharge Locations for Mental Illness

<table>
<thead>
<tr>
<th>Location</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penal establishment or police</td>
<td>25.2%</td>
</tr>
<tr>
<td>NHS - ward for mental health or LD</td>
<td>19.0%</td>
</tr>
<tr>
<td>Usual place of residence</td>
<td>16.1%</td>
</tr>
<tr>
<td>Non-NHS run hospital</td>
<td>10.8%</td>
</tr>
<tr>
<td>Non-NHS run Care Home</td>
<td>6.4%</td>
</tr>
<tr>
<td>Temporary place of residence</td>
<td>5.8%</td>
</tr>
<tr>
<td>Non-NHS - medium secure unit</td>
<td>3.2%</td>
</tr>
<tr>
<td>NHS - high security psychiatric accommodation</td>
<td>3.0%</td>
</tr>
<tr>
<td>Local Authority residential accommodation</td>
<td>2.9%</td>
</tr>
<tr>
<td>NHS - medium secure unit</td>
<td>1.2%</td>
</tr>
<tr>
<td>Not applicable - patient died or still birth</td>
<td>1.2%</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>0.5%</td>
</tr>
<tr>
<td>Court</td>
<td>0.2%</td>
</tr>
<tr>
<td>Non-NHS run Hospice</td>
<td>0.2%</td>
</tr>
<tr>
<td>NHS - ward for general patients</td>
<td>0.2%</td>
</tr>
<tr>
<td>Repatriation from high secure MH</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

2.5.5. A comparison of the prevalence of mental health conditions indicates that members of the prison population are more likely to have a mental disorder and/or drug and alcohol misuse problems than the general population. Significant referrals come from the prison service and the intention is that the majority of these patients will return to prison upon discharge. In these cases, this arrangement is similar to others being discharged to their home.

2.5.6. Mersey Care provides a gate keeping service on behalf of commissioners that effectively controls the flow of patients into and out of secure hospitals. The trust currently provides less than 50% of the local medium secure market (excluding forensic learning disability). The balance of services is predominantly provided by the independent sector. A considerable proportion of independent sector provision relates to discrete clinical or contextual specialisms such as personality disorder services or long term medium secure care. For clarity in line, with commissioning intention the trust does not propose offering these services. Mersey Care
recognises the important role of a robust independent sector providing specialist care and intervention and wishes to work collaboratively to ensure all service users receive the right treatment at the right time.

2.5.7. However it is evident that Mersey Care currently has insufficient capacity to adequately meet the needs of the mental illness service users who do fit the criteria for admission and for whom treatment in a local MSU would enhance the quality of their experience ensuring they are treated close to home and to their families. A key objective of the “Five Year Forward View” is to eradicate the use of out of area treatments (OATs). The adoption of this objective became a central driver of the planning and design phase of the new build. This approach aligns well with the anticipated outcomes of the Merseyside and Cheshire Sustainability and Transformation Partnership (STP). The local STP has chosen a demonstrable reduction in the use of OATs as a transformational priority. In effect having the capacity to provide timely and responsive care close to home for all our service users is recognised as a critical success factor for the project. A detailed market analysis informed the considerations and decision making of the trust. This is discussed below.

2.6. Estimated Bed Requirements

2.6.1. Nationally, NHS England reviewed commissioning arrangements for secure services and offender healthcare. The Mental Health Task Force\(^3\) identified potential for changes in the care pathway for adult secure care by enhancing out of hospital services supporting the principle of the least restrictive care.

2.6.2. A wide ranging benchmarking review of adult low and medium secure services was undertaken. NHS England are currently considering the implementation of a series of market interventions to ensure the efficient and effective delivery of MSU care nationally with the right bed numbers in the right place.

2.6.3. A national consultation exercise to develop separate service specifications for MSU and LSU is currently on-going. Senior clinicians and managers from Mersey Care have attended a number of reviews and provided comprehensive feedback on the proposals.

Building the right support for Mental Illness Services

2.6.4. In preparation for this business case, the trust modelled its data from the last three years and extrapolated its possible position through until 2017/18. The trend shows a steady increase in occupied bed day requirements. At Mersey Care the occupancy level for the mental illness MSU beds is generally at or around 100% (whereas the capacity target and the Service Level Agreements is 95%).

2.6.5. The lack of available beds constrains the ability to admit patients in a timely manner and often the consequence of this is that patients are place on a waiting list for a period of time. Over the last three years this has been a frequent occurrence. Throughout 2013/14 28 patients deemed suitable for admission were placed on the waiting list. These figures have steadily increased each year with 31 patients having to wait in 2014/15, 38 during 2015/16 and 40 in 2016/17.

Market Analysis

2.6.6. A detailed market analysis was undertaken by Mental Health Strategies on behalf of Mersey Care in April 2016 and the report is included in Appendix: 2.1: Market Analysis. The report outlined the trends in referrals, capacity, waiting times and the use of out of area treatment options for mental illness service users from the Scott Clinic catchment area. Commissioners said that their preference would be to leave patients that will be receiving OATs at the time of opening at that facility, e.g. would not wish to repatriate patients but would however consider sending future referrals to the new local MSU at Maghull.

2.6.7. The key features that were reported in the market analysis were:

- Significant pressure on beds both nationally and locally;
- An opportunity to attract additional business from “Normal Business” mainly from OATs;
- An opportunity to attract “Potential Business” which would be providing services which would require a change to the current model of care to attract additional business;
- The trust’s ability to have contracts moved to deliver the potential business looked challenging;
- Female services are already well established and working well;
- Demand for learning disabilities beds will decline as more services are developed in the community.

2.6.8. The market analysis report concluded that the indications from secure commissioning are that the trust would be in a strong position to secure at least its current commissioned bed base and described a number of opportunities for development and discussed these with commissioners. The outcome suggested opportunities in the order of 45 additional beds over the 96 commissioned.

2.6.9. The trust took a prudent view on this level of opportunity. This exercise was illuminating but revealed a discrepancy with the view of NHS England Specialised Commissioners. The market analysis identified a number of areas of potential expansion and growth. However further detailed discussion with specialised commissioners indicated that a number of these cohorts are not considered as appropriate for the service and their needs would continue to best met by other

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4 “Medium secure mental health and learning disability market review”, Mental Health Strategies, April 2016
providers. In effect what this revealed was that although there was likely to be potential need for expansion for “normal business” service users, the market analysis was too broad to provide sufficient specificity to plan for future service demand.

2.6.10 A further analysis of the data was conducted by specialist commissioners which reviewed the level of medium secure mental illness activity for North West resident patients across all settings of delivery. This identified “a consistent cohort of circa 20 patients who are, at any one time, placed on a cost per-case basis in other facilities that are of a similar case mix to those currently receiving treatment at the Scott Clinic who would have been admitted there through your gatekeeping service should a bed have been available at the time”.

2.6.11 The specialised commissioning team reported “It is our view that these patients would receive optimal care in a local medium secure facility linked to the gatekeeping service, where established discharge arrangements are in place to effectively manage the patient’s treatment journey effectively”.

**Building the right support for Learning Disability Services**

2.6.12 NHS England North Regional specialised commissioners have indicated an intention to purchase 40 learning disabilities beds in future. This is a proposed reduction from the current figure of 48 and represents a decrease of 25% which is consistent with the aims of national policy drivers for such a reduction by 2020.

2.6.13 Until recently, the occupancy level for the learning disabilities MSU beds was in the order of 96-98%. This has dropped in recent times due to a number of factors, e.g.: presumption that the service at Whalley was not admitting new patients following the announcement of its closure and reduction in nursing staff due to closure has meant fewer patients were admitted. However, work is underway to address this with the resumption of referrals. Again, until recently there was a local waiting list of 3-4 males and 1 local female in prison. An additional five women are currently placed out of area.

**Other Commissioners: Wales and Scotland**

2.6.14 Mersey Care at Whalley is a recognised provider of specialist LD services commissioned on a bespoke basis for service users from Wales. The service is on the framework agreement.

2.6.15 The specialised commissioning team for Wales have expressed their satisfaction with the service and stated their intent to continue procuring services from Mersey Care in future. Continued access to these beds is an important component of their commissioning arrangements and they recognised the detrimental impact on their capacity if the beds were no longer available.

2.6.16 Data over the past five years reveal on average a small and consistent cohort of 2/3 medium secure patients from Wales being cared for at Whalley. The commissioners suggested that over the last two years this has represented a probable under-use of the resource and they considered it likely that in the absence of the uncertainty about the future of the services at Whalley up to four more service users would have been referred.
2.6.17 A similar service is provided to NHS Scotland commissioners and since 2014 there have consistently been a minimum of two service users placed in MSU at Gisburn. The commissioning team for Scotland has also stated their intention to continue using this service.

2.6.18 Mersey Care has adopted a conservative approach in planning to meet this need and has taken the current occupancy figures from Wales and Scotland as indicative of future need. To continue to provide this important resource up to five places have been incorporated in the design for Welsh and Scottish patients. Therefore the trust is planning to build 45 LD beds and is confident there will be sufficient demand to fill these while benefitting from additional flexibility and contingency.

**Future commissioning intentions**

2.6.19 The North Regional Specialised Commissioning Team wrote to Mersey care on 22nd March 2017 to confirm their commissioning intentions and provide support for the development of a 123 bedded unit **Appendix 2.2a: Letter of Support**. They will directly commission a combined total of 118 mental illness and learning disability beds.

2.6.20 In addition to these 118 beds commissioned under the NHS England block contract the trust will also provide specialist medium secure learning disability beds to a small cohort of service users from Wales and Scotland.

2.6.21 The bed numbers and funding streams for the planned development are shown in the table below.

**Table 2.3: Bed Numbers**

<table>
<thead>
<tr>
<th>BED TYPE</th>
<th>NHS England</th>
<th>Devolved Administration</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 MSU learning disability beds</td>
<td>40</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>5 spot purchase MSU learning disability beds (Wales/Scotland)</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>56 MSU mental illness beds</td>
<td>56</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>22 Additional MSU mental illness beds following review of patient numbers</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>118</strong></td>
<td><strong>5</strong></td>
<td><strong>123</strong></td>
</tr>
</tbody>
</table>

**Planned functional content and design**

2.6.22 The design of the new MSU at Maghull has 123 beds. This will encompass 118 beds funded by NHS England Specialised Commissioning and a further 5 beds provided on the NHS Wales and NHS Scotland commissioning frameworks on a case by case basis **Appendix 2.2b: Email confirmation from NHS Wales**.
2.6.23 The diagram below shows the strategy in determining the total bed number for the new facility.

![Diagram of strategy for bed numbers]

Figure 2.4: Strategy for Bed Numbers

**Outcome of this process**

2.6.24 The FBC assumes a 123 bedded facility which will contain 118 core beds (78 mental illness and 40 learning disability) plus 5 beds commissioned under devolved arrangements. The trust anticipates operating at a 95% occupancy level going forward.

2.6.25 In terms of the managing the increase in capacity, the additional beds (the 4<sup>th</sup> male mental illness ward) would be opened and funded on a phased basis. This will be jointly planned and agreed by NHS England and Mersey Care. A description of how the opening of this ward will be operationalized and managed is provided in the commercial case.

**National Policy and Strategic Context**

2.6.26 National policy has mandated the closure of institutional inpatient facilities for people with learning disabilities in favour of a radical transformation and expansion of community learning disabilities provision:

- In December 2012, the Department of Health published “Department of Health Winterbourne View Review – concordat: Programme of Action” (Department of Health, December 2012)<sup>6</sup>. It highlighted widespread failure to commission and provide safe, appropriate and high quality services for people with learning disabilities.
disabilities and autism that allowed for them to remain within their local communities. The Concordat mandated that health and care commissioners put in place plans that would allow people with learning disabilities and/or autism that were inappropriately placed in hospital-based care to move into community care by June 2014.

- Despite this mandate, “Winterbourne View - A Time to Change” (December, 2014)\(^6\) found that not only had there been a failure to achieve the required movement of people out of inpatient settings, but there were still more people being admitted to hospital than being discharged. The report called for a “closure programme of inappropriate hospital-based inpatient facilities” alongside an “expansion of community provision”.

- In January 2015 NHS England and its partners\(^7\) set out its commitment to strengthen the Transforming Care delivery programme in “Transforming Care for People with Learning Disabilities and/or Autism”. It outlined plans to empower people and families, tighten regulation and inspection, raise workforce capability, make data and information more accessible and ensure individuals receive care in the right place at the right time.

- On the 30\(^{th}\) October 2015, NHS England in conjunction with the Local Government Association and the Director of Adult Social Services, announced the introduction of a £45m transformation plan “Building the Right Support”\(^8\). Six “Fast Track” areas were identified, of which Greater Manchester and Lancashire were two. The planning assumptions detailed within the plan are:
  - “At a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed;
  - 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision;
  - Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community”.

- In February 2016 the Independent Mental Health Taskforce to the NHS in England prepared a document entitled “The Five Year Forward View for Mental Health”\(^9\). This document describes current experiences of Mental Health Care and contains 58 recommendations of where action is required. The trust has considered these recommendations when reviewing its planned model of care to ensure consistency.

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\(^6\) [Winterbourne View - A Time to Change](https://www.england.nhs.uk/.../transforming-commissioning-services.pdf)

\(^7\) Association of Directors of Adult Social Services, Care Quality Commission, Department of Health, Health Education England and Local Government Association

\(^8\) [Building the Right Support: A national implementation plan to develop community services and close inpatient facilities](https://www.england.nhs.uk/.../transforming-commissioning-services.pdf), NHS ENGLAND & partners, October 2015

\(^9\) [The Five Year Forward View for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf)
• From 2010 – 2013 a confidential inquiry was tasked with investigating the avoidable or premature deaths of people with learning disability. This report focused on pattern of care people received, in the period leading up to their death to identify errors or omissions. The inquiry also sought to elicit examples of good practice: **Confidential inquiry into premature deaths of people with learning disability (CIPOLD) 2013.** Norah Fry Research Centre, University of Bristol.

• In 2013 the Department of Health published their response to the confidential inquiry outlining 18 recommendation aimed at reducing the rates of premature mortality in people with a learning disability. The report was “**Government response to the confidential inquiry into premature deaths of people with learning disabilities**” (2013). The recommendations have informed and guided the development of the model of care, the proposed design and configuration of the new MSU and the future workforce plan.

2.6.27 In addition, NHS England explicitly announced the intention to no longer commission learning disability secure inpatient services from the Whalley site subject to public consultation which has since been concluded, as discussed in Section 2.1.

2.6.28 Mersey Care has very positive relationships with commissioners. The strategic change programme in secure services reflects significant commissioner involvement and the changes that are being implemented are supportive of commissioners as well as the trust’s own organisational requirements for the future.

2.6.29 As such commissioners have welcomed the trust’s plans to develop and enhance medium secure services and have recognised the need for the trust to consider future capacity needs in developing its plans - encompassing the inclusion of learning disability/autism services, market position, future demand and financial aspects and also the planned relocation to the Maghull site adjacent to high secure services.

**Cheshire and Merseyside Sustainability and Transformation Plan**

2.6.30 The national planning guidance for 2017/19 is clear that the planning and contracting round will be built upon each local sustainability and transformation plan (STP). Mersey Care must deliver its financial control totals, with our finance, activity and workforce plans being consistent with the STP. Mersey Care is part of the Cheshire and Merseyside STP footprint and, within this, the North Mersey Local Delivery System. The Cheshire and Merseyside STP is still at a developmental stage and is in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations. The trust is adopting a lead role in the implementation of many of the identified targets for implementation particularly in the area of secure care.

2.6.31 The illustration below provides key facts regarding Cheshire and Merseyside STP.
2.6.32 The three mental health trusts in the STP have developed a mental health work plan to support delivery of the Five Year Forward View for Mental Health. Additional funding to support the transformation of mental health services will include centrally-held transformation funding and allocations via CCGs. It is assumed that an appropriate share of national monies will be made available and that this investment will rise to at least £57.9m in Cheshire and Merseyside by 2020/21. Mersey Care specialist learning disability services delivered from the Whalley and Gisburn sites form part of the Greater Manchester and Lancashire STP.

2.6.33 Evidence provided within the Centre for Mental Health Economic Report indicates that significant savings across the health and care system will outweigh the investment needed to deliver services.

2.6.34 Three priorities have been identified for early implementation across Cheshire and Merseyside:
- Eliminate out-of-area placements
- Develop integrated clinical pathways for those with a personality disorder
- Enhance Psychiatric Liaison provision across the footprint and establish a Medically Unexplained Symptoms (MUS) service

2.6.35 The STP priorities for mental health will be taken forward through a Chief Executive-led programme group. Mersey Care is a member of this group, working in collaboration with Cheshire and Wirral Partnership NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust and at local level, a Mental Health Transformation Board has been established to take forward implementation of the Five Year Forward View for Mental Health in North Mersey.
2.6.36 Of particular relevance and import to this case is Recommendation 23 which is wholly consistent with the development of the proposed MSU, the new model of care and creation of a seamless secure care pathway.

Recommendation 23: NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

2.6.37 A number of specific and important work-streams falling from the STP priorities have direct links to recommendation 23 and are connected to and generate interdependencies with the new co-located MSU and the secure care pathway. These innovations and areas of transformation are being led by Mersey Care:

Table 2.4: STP Work Streams

<table>
<thead>
<tr>
<th>Project</th>
<th>Impact</th>
<th>Workstream</th>
<th>Lead trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Care Pathway</td>
<td>Prevent avoidable admissions and support “step-down” and on-going recovery</td>
<td>Improve pathways in and out of secure care</td>
<td>Mersey Care</td>
</tr>
<tr>
<td>Health and Justice</td>
<td>Fewer GP consultations, hospital admissions &amp; inpatient MH treatment</td>
<td>Expand access to liaison and diversion services</td>
<td>Mersey Care</td>
</tr>
<tr>
<td>Sustaining Transformation</td>
<td>Prevent avoidable admissions, reduce length of stay, improve community access and eliminate out of area placements</td>
<td>Care pathways Workforce MH</td>
<td>Mersey Care</td>
</tr>
</tbody>
</table>

2.6.38 In relation to specialist learning disability services the STP provides the vehicle for commissioners and providers to respond to Sir Stephen Bubb’s report (Winterbourne View – A Time for Change 2014) and make provision for a significant number of patients to transfer from Whalley and Gisburn sites to settings closer to their home. This objective is a guiding principle of the Mental Health Act 1983 and articulated in the code of practice “If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (e.g. their home or close to a family member or carer). In cases where the patient lacks capacity to make a decision about the location they would like to be close to, a best interest’s decision on the location should be taken. This will promote recovery and enable the patient to maintain contact with family, friends, and their community”.
QUIPP

2.6.39 The principles of the QUIPP agenda are embedded in the new model of care and have been at the heart of the planning and design process for the new MSU. It is a stated aspiration that our use of clinical and technological innovation will support improvements in quality for service users and their carers. The workforce plan articulates the efficiencies to be gained from the co-location on a single site and the advantages of new ways of working. A programme of training and staff development will result in a workforce which is more flexible and which has a greater range of skills and depth of knowledge. It is our view that this will lead to increased productivity across the secure pathway and contribute to the prevention of unnecessary admissions to higher level of security.

Health & Social Care

2.6.40 The whole pathway approach opens up access for service users to a more integrated health and social care system. The model of care is predicated on early recognition of treatment needs and discharge options. For service users and their families this will bring many benefits. It will involve social care and local authorities at a much earlier stage of their care and allow appropriate planning for their future needs. Points of transition in the pathway will be well managed and supported by specialist services to facilitate a greater emphasis on positive risk taking and community integration.

Capital investment and NHS Property and estates

2.6.41 Ensuring the best use of the NHS estate is now regarded as a priority by the government, health commissioners and NHS trusts. The publication of the review by Sir Robert Naylor (NHS Property and Estates March 2017) highlights the importance of a system wide approach to providing an NHS estate which is configured to maximise the benefits to patients and taxpayers. The report clearly articulates the interdependency between a fit for purpose estate and the success of the programme of transformation of clinical services

“Without investment in the NHS estate the Five Year Forward View cannot be delivered, the NHS estate will remain unfit for purpose and will continue to deteriorate”.

2.6.42 The report charges each STP with the responsibility to “rapidly develop robust capital plans which are aligned with clinical strategies, maximise value for money (including land sales) and address backlog maintenance”.

2.6.43 It is anticipated that the programme will bring about opportunities for running cost savings, and allow better utilisation of existing premises. It is recognised that potential savings are likely to be subsumed in the costs of re-provision. Even so it is likely to see a dramatic reduction in the need for backlog maintenance and will
result on cost efficient, fit for purpose environments which will enhance the quality of care.

2.6.44 Mersey Care’s plans for the new MSU are wholly consistent with the objectives above and will result in the rationalisation of our secure estate providing high quality care environments while also facilitating the release of land for other purposes.

Clinical and Operational dependencies

2.6.45 The new MSU project fits within the wider transformational landscape of secure and community forensic services. An effective and seamless care pathway can only be built upon a clear and well defined appreciation of the dependencies each service has on another. The MSU is a pivotal part of the pathway and therefore the achievement of its stated outcomes for service users is reliant upon the responsivity, engagement and collaboration of all secure services. The primary interdependencies are:

- LSU-Mental Illness: There are a number of separate low secure units in the Cheshire and Merseyside STP region provided by different health trusts. These trust are currently working together to develop practices, principles and policies to enhance the flow of service users through the secure care pathway.

- LSU-Learning Disability: The strategic partnership board is currently evaluating a range of options for the relocation of low secure learning disability services from the site at Whalley. At an operational level the timely and appropriate provision of low secure services for learning disability is a critical component to allow progress from MSU for service users. However the re-provision of LSU learning disability services is not considered to be a critical interdependency in terms of the construction of the new MSU.

- Forensic Outreach Services: The role of community forensic services has been given greater emphasis in the planning of future service specifications for MSU and LSU. There is a recognised need for these services to be considered an essential component of the secure care pathway with a specific remit to prevent unnecessary readmissions and support transition to non forensic services.

- Specialist Support Teams: In line with the aims outlined in Homes not Hospital specialist support teams (SST) across Greater Manchester and Lancashire will provide a range of services to assist in the pathway and discharge planning for people with learning disability from secure services.

Part B: Case for Change

2.7 Rationale for Change

2.7.1 This section looks at the case for change separately for mental health and learning disability and autism medium secure services. In doing so it recognises and
highlights the current challenges facing the mental health medium secure services in the trust, and is reflective and supportive of the national strategy for reducing reliance on inpatient services for learning disability and autism patients (NHS England, 2015).

The Case for Change in Mental Illness Services

2.7.2. The diagram below highlights a few key factors in the case for change.

![Figure 2.6: Case for Change in Mental Illness Services](image)

Patient Experience

2.7.3. The views of service users in Scott Clinic have been sought through a comprehensive process of engagement. A number of themes were consistently raised by service users which they considered to seriously compromise the quality of their experience. This included a lack of personal private space, difficulty in accessing outside space and fresh air and importantly the inadequate facilities for visits from their family and friends. The issue of privacy and dignity is a recurring theme raised not only by service users but by their families and carers. Twelve male patients have to share two toilets, and the location of these facilities on the ward is regarded as affording little privacy to service users. In 2016 an outbreak of novo-virus on a male ward highlighted the inadequacy of this provision and posed a significant health risk.

2.7.4. Each ward has a single bath and a separate shower room which understandably is seen by service users and their families to be grossly inadequate given the likelihood of length of stay of approximately two years. The communal spaces are cramped and are the location for multiple activities often delivered simultaneously throughout the day. This is both unproductive and at times chaotic for service users.

2.7.5. In terms of environmental improvement, service users requested en-suite bedrooms to provide privacy and dignity, larger bedrooms with bigger beds, a space of their own away from their peers, more discrete space for activities on the ward, a comfortable chair in their bedrooms, and freedom to access open space directly from the ward (therefore reducing barriers in terms of escort availability).
In terms of access to therapeutic spaces, the provision of a skills for life room and a music room were seen as an option to improve access to activities and prevent boredom.

2.7.6. The overall lack of space on and off the wards, and limited centralised areas continues to limit the ability to engage with and involve families in the care of their loved ones in the ways, or to the degree we would like, or indeed they have a right to expect.

**Isolation and workforce issues**

2.7.7 The trust recognises the significant risks associated with services which are geographically isolated and culturally dislocated from the core of clinical provision, leadership and governance. The eradication of such risks is a primary driver in the endeavour to develop a cohesive care pathway spanning from the highest level of secure services through to the community. Uniting the full range of services under a single governance structure with consistent ways of working will support the changes necessary to deliver our aim of perfect care and address many of the barriers which impinge upon the quality of experience for service users.

2.7.8. The current geographical isolation of the Scott Clinic to the Secure Division limits the ability to conceptualise a service user’s treatment in its entirety across the whole pathway rather than in silos. Inevitably this contributes to pronounced transition points between levels of security which can be hard to negotiate and confusing for service users. At an operational and clinical level joint working, liaison, training and research opportunities and activities have also been limited. The wealth of very experienced, highly trained clinicians within the secure division is not being used as effectively or efficiently as it could be as a result of this geographical isolation, and the opportunity for sharing expertise amongst highly qualified staff will be greatly enhanced should the clinic be re-located nearer to the high secure site.

2.5.9. Scott Clinic has been subject to internal and independent inquiries as a consequence of domestic homicides committed by patients under the care of the service. The potential impact of its geographical, clinical and cultural isolation has been a recurring theme in the investigations. The co-location of secure services provides the opportunity to eradicate this factor which otherwise would continue to present a risk going forward to the safety of the public and to the trust.

2.7.10 The trust also recognises that the small ward sizes at the clinic prevent it benefiting from economies of scale in relation to nursing, management, training, administration, support services, out of hours cover and emergency response. Detailed workforce plans are being developed based on future staffing requirements for each service area.

**Estate**

2.7.11 A number of independent reviews over the last few years have raised significant concerns about the environmental quality at Scott Clinic. The Scott Clinic undergoes an annual inspection and review from the Forensic Quality Network
2.7.12 Consistently the findings of the independent reviewers have highlighted concerns about the condition, utility and comfort of the unit. In essence the successful outcomes achieved for service users are a testament to the commitment and endeavour of the clinical staff. In terms of recovery and well being there is no “therapeutic premium” from the building for service users.

2.7.13 This ability to ensure a positive experience for service users despite significant environmental constraints was recognised in the most recent CQC inspection at Scott Clinic in October 2015. The service caring rating was 'good' for a number of reasons:

- Our staff interact with patients in a polite and caring way;
- The atmosphere on all of our the wards is calm and friendly;
- Service users had opportunities to be involved in decisions regarding their care; Families and carers were encouraged to attend their relative’s annual care programme approach review;
- Staff were observed knocking on service users’ doors prior to entering their rooms and service users told the CQC that staff respected their privacy;
- Staff at all levels were able to demonstrate a good knowledge of the needs of individual patients;
- The CQC saw there was a clear pathway through the Scott clinic from admission to discharge. They inspected and met with all the teams involved in this process. They also case tracked three patients through the pathway and saw how care planning and transfer arrangements were made effectively. However, they noted there were delays to discharge planning caused by very limited housing options in the community for patients. With the exception of Reed Lodge, all wards had been operating at 100% bed occupancy.

2.7.14 These points demonstrate the message this business case wants to convey. Mersey Care understands the needs of its patients, involved them in their care and seek to move people through the process towards discharge.

2.7.15 However this becomes increasingly difficult in the context of an aging and out-dated building which requires continuous maintenance and restructuring just to keep it at a habitable and clinically appropriate condition. In November 2014 the Forensic Quality Network made a number of observations about the quality of the estate at Scott Clinic, namely:

- The staff continue to ensure physical security measures, such as key management, are in place despite the difficult environment of the reception area and airlock space;

- The staff at Scott Clinic are working well to overcome the challenges faced by the lack of therapy space and have as a result established strong community links to continue to allow service users to progress along their care pathway;
The main challenge faced at Scott Clinic is the building environment. There is limited space for therapeutic activities to take place both on the wards and in the off-ward shared areas. Therapy sessions are often held in the multi-purpose rooms on each ward, which are used for meetings, 1:1 sessions and activities. The staff acknowledged that this is problematic and some sessions have to be cancelled or be held elsewhere. The peer review team felt this needs to be addressed in order to continue to provide a meaningful timetable of activities within the secure perimeter;

The location of the seclusion room on each ward continues to be problematic for service users’ privacy and could be distressing for visitors onto the ward who have to walk past the seclusion facilities to reach the communal ward space.

2.7.16 A further review conducted by the Royal College of Psychiatrists’ Forensic Quality Network Review dated November 2015 identified a number of key challenges but specifically focused on estate issues at the Scott Clinic:

“The main challenge for Scott Clinic is the building environment. The building is nearly 30 years old and becoming unfit for purpose with a lack of dedicated spaces for therapies and activities with rooms being multi-purpose, and no ward level access to fresh air for patients other than those on Myrtle Ward. All other patients have to access the internal courtyard on a rota system.

There is a dedicated family room at the Scott Clinic which was well decorated and bright however, it was unfortunate that due to the design of the building children have to walk through the unit to access the room and that the wards have to go onto lockdown until the visit is in place”.

2.7.17 It is important to note that over the course of these assessments reassurance has been given to the reviewing team that the development of a new unit was progressing and when complete would alleviate these concerns.

2.7.18 In November 2016 the unit was again reviewed by the Forensic Quality Network and again the feedback focused on the poor environmental conditions. It was evident from the reviewers’ comments that their considerations were tempered by the prospect of the service being moved to a new state of the art building. The review team highlighted the improved environmental conditions they considered to be vital to ensure a sufficient standard of care. This included adequate bathroom and toilet facilities, improved seclusion areas and the introduction of de-escalation rooms “The review team recognise that a new build has been commissioned for and would encourage that dedicated spaces should be available for the following:

- Education
- OT, psychology and therapy
- Tribunal suite
- Library/reading
- Multi-faith room
- Physical exercise
- Primary health provision
• Self-catering/cooking
• Dining
• Shop/café

Poor environmental quality and an inflexible configuration

2.7.19 As referred to above there is unequivocal evidence from a variety of independent sources which states that Scott Clinic falls well below the minimum environmental standards. In its current state it is becoming increasingly untenable to consider it fit for purpose. The environment has been pro-actively maintained but facilities are poor and deteriorating, and the unit does not comply with Department of Health (DOH) environmental guidelines. The 12 bedded male wards are physically too small and inflexible for the service users being cared for. Limitations in the building design hinder the provision of therapeutic interventions and activities and are not conducive in aiding the recovery process. Similarly, the eight bedded female ward is physically too small and inflexible to treat women with a range of illnesses from admission through to discharge; from those who are well, stable and in recovery, to those who present as complex, challenging and in crisis.

2.7.20 The wards within the clinic lacked discrete medication dispensing areas, which necessitated the dispensing of medications from a busy office. In late 2015 small dispensing rooms were created to try and improve this, but the physical environment limited what has been achieved and this issue remains of great concern. The provision of these rooms, although a relatively minor undertaking, was a logistical challenge and the construction work had a deleterious impact on the care, treatment and quality of life for service users.

2.7.21 The current control room does not conform to the standards set out in medium secure unit environmental guidance. Forensic Quality Network reviews have consistently highlighted the lack of separate entrances and exits for patients, staff and visitors. This has led to a reduction in scoring for the quality of the environment and is also a concern as lack of separate entrances creates unnecessary risk. Scores were also low for the ASPECT survey.

2.7.22 Three of the wards are located on the first floor. This can at times limit access to fresh air for patients who are unwell and unable to leave the ward, and can increase risk in the movement of some patients through and around the clinic.

2.7.23 The current facilities struggle to meet modern infection control standards with limited shared toilet facilities on most wards which are of real concern in the event of an outbreak.

Poor service user privacy and dignity

2.7.24 Throughout their time in the unit service users can experience periods of distress, a relapse of illness and sometimes they can exhibit behaviours which put them and others at risk. Therefore the facility to provide care and treatment separate from other service users is often necessary. Undoubtedly at such times of emotional and psychological crisis the needs of the service user are many and exacerbated. It is reasonable to hold an expectation that they are cared for in a
setting which prioritises privacy and dignity, reduces additional noise and stressors and allows staff to undertake meaningful assessment with space to provide association and re-integration. Under current circumstances however this is a critical failing of the ward environment. Seclusion rooms are on the main corridor of each ward which can give rise to noise and privacy/dignity issues for patients who are very unwell. Seclusion reviews and periods of association need to be scheduled frequently throughout the day. This gives rise to the need to restrict access and egress to areas of the ward (laundry, bathroom, medication dispensing) at these times, which significantly compromises the care of other service users.

**Poor therapeutic environment**

2.7.25 It is worth emphasising that throughout the unit there is an absence of dedicated therapeutic space which severely inhibits the ability to consistently deliver a full range of individual and group interventions. While occupational and vocational activities can be accommodated in the workshop and the therapy kitchen areas, there is no provision for psychological or speech and language therapy. The centrality of these interventions to an individual’s recovery, progress and their future safety is universally recognised. Our clinicians consistently demonstrate a commitment and adaptability to overcome these constraints and continue to achieve positive outcomes. Yet there is no doubt the lack of space and therefore ease of access to appropriate intervention at the right time is a significant impediment to service users. It can result in unnecessarily extended lengths of stay which is both demoralising and demotivating.

2.7.26 For those service users who are at an early point in the admission and treatment and who don’t have leave from the ward, the situation is worse. The small, crowded wards can limit the ability of staff to provide meaningful therapeutic interventions. The wards do not have dedicated therapy space reducing upon the ability to provide intensive 1-1 psychological interventions due to lack of privacy and the need for confidentiality. Often the mix of new admissions and more settled patients on the wards can disrupt the recovery process for some, with the lack of space at times leading to crowding and increasing risks within the clinical environment.

**Trust Estate Framework**

2.7.27 The trust’s Estates Framework was approved at the November 2016 Board of Directors. The key points of the framework are to develop and maintain a modern fit for purpose flexible estate that supports the delivery of the care strategies across the clinical divisions. The framework will provide 100% en-suite bedrooms with all patients being cared for in new or refurbished building by the end of the current decade. The estate framework is designed to ensure parity across the organisation and to meet NHS 6 facet survey condition B as a minimum. Information on the framework is included as **Appendix 2.3a: Trust Estates Framework**. The re-provision of Scott Clinic into a modern efficient, flexible unit is an integral part of the estates framework.

2.7.28 Currently the MSU (mental illness service) estate is classified as condition C/D on the 6 facet survey which means repair or replace.
2.7.29 A revised estates framework has been developed to take into account the enlarged estate resulting from the acquisition. The Development Control Plan is attached at Appendix 2.3b: Development Control Plan

2.7.30 The trust has a Sustainable Development Management Plan providing details around how the trust will measure, monitor and reduce carbon emissions. See Appendix 2.3c: Sustainable Development Management Plan

**Limited bed capacity**

2.7.31 The medium secure unit at Scott Clinic has consistently run at capacity for many years. As a consequence many patients have been placed in out of area treatment (OAT) in hospitals a significant distance from their home and families which does not create the best outcome for patients and their families and is not in line with policy of caring for patients close to home.

2.7.32 The new unit will bring a meaningful increase in bed numbers for service users with a diagnosis of mental illness. There will be benefits to patients and their families, it will optimise their involvement and provide access to a unified care pathway with treatment closer to home. Commissioners will benefit from an increased throughput of service users who will have rapid access to excellent treatment and progress more quickly, while retaining links to their local community.

**Sub Optimal Care Pathway**

2.7.33 The acquisition of Calderstones in July 2016 provided the opportunity to develop a unified medium secure service for patients with mental illness and learning disabilities and fits with the wider secure care strategy resulting from the creation of the secure division in 2014. A stated imperative of this strategy is to restructure the care pathway across secure services. It is accepted that previously the pathway has been fragmented, with each component working in isolation whereas the aim is to have a single admission panel and smooth transfer between settings.

2.7.34 This MSU project has provided a timely opportunity to revisit the model of care for the mental illness medium secure unit with the aim of ensuring a clear and cohesive secure pathway, in order to deliver future services and to create a clear pathway for patients to move through the system to be cared for in the most appropriate and least restrictive environment.

2.7.35 The co-location of MSU services is the catalyst for the development of a more fluid and collaborative approach to care planning and transition characterised by a shared responsibility falling upon both the referring and the receiving service in the pathway. It is clear that the effective operationalisation of the pathway will be dependent on the integration of all secure services. From the perspective of the MSU it will be essential that effective ways of working alongside low secure services are implemented with a view to enhancing recovery and allowing ease of transition and progression into the community.
Policy imperatives / Strategic fit

2.7.36 The imperative to treat patients as close to home as possible is mandated in the Five Year Forward View and also a priority for the Cheshire and Merseyside STP. This objective has been and remains elusive. Mersey Care has highlighted how some local patients are receiving treatment outside the catchment area due to the current lack of capacity. This can have significant consequences for them in terms of recovery, access and connection to families and friends, and the ability for them to reintegrate into the community once they move out of medium secure care.

2.7.37 In addition the goal is to care for people in the least restrictive environment as possible and as highlighted above, care pathway coordination is more difficult with geographically isolated units.

2.7.38 As medium secure bed provision is a condition of the trust’s high secure licence, this plan outlines how Mersey Care will minimise the risks to this service. It is imperative that Mersey Care retains its current business for both medium secure services in order to retain the licence to provide high secure services.

The Case for Change in Learning Disability and Autism medium secure services

![Diagram showing national context, local context, patient experience, isolation, workforce]

Figure 2.7: Case for Change in Learning Disability Services

Patient Experience

2.7.39 The proposed model of care and relocation of the secure unit will ensure that patients only enter secure care if absolutely necessary and enter it at the appropriate level of security commensurate to risk. Also patients will have their needs fully assessed with robust plans formulated and acted upon to return them to levels of lesser security at the earliest opportunity. The patient is central to the care process and a co-contribution to their pathway through services and back to community living.

National context / strategic fit
2.7.40 In October 2015 NHS England launched their national plan to reduce reliance upon inpatient services for patients with learning disabilities and autism. It was informed and developed in line with recent reviews of learning disability and autism services which recommended the closure of large hospitals, and the re-provision of care into either community or smaller units.

2.7.41 As noted above the NHS England led public consultation on the provision of learning disability services on the Whalley site reported in March 2017. The outcome is that NHS England will no longer commission learning disability secure inpatient services on this site. The final date of closure for the services will be agreed between NHS England and Mersey Care in line with the development of community and secure services.

2.7.42 The organising principle of the plan is the recognition that people are best placed in the community with family, friends and with the appropriate level of support. However, it also recognises that there will remain a small cohort of patients for whom the most appropriate care and treatment will require a period of time as an in-patient; including those in low and medium secure services. In line with the vision articulated by NHS England the future provision of MSU care for people with learning disability and autism medium will be delivered in a state of the art facility.

Regional / Local Context

2.7.43 The new clinical environment and model of care will enable the trust to meet the aspirations of the NHS England national plan of providing opportunities for patients to live satisfying and valued lives and being treated with dignity and respect.

2.7.44 Clearly the provision of MSU services at Maghull needs to be viewed in the context of the broader work being undertaken to re-provide more regionalised low secure services and enhanced community placements. There is recognition that the relocation of medium secure patients forms only a part of the national plan to provide a comprehensive and robust care pathway for all patients with learning disability/autism.

Workforce

2.7.45 The closure of MSU services on the Whalley and Gisburn sites brings significant challenges not least in ensuring the continuation of positive relations with the workforce. At an early stage of the project to relocate services to a single site in Maghull the impact on staff recruitment and retention was identified as a significant future risk. There is little doubt that the additional distance and travelling time will act as a disincentive for a significant cohort of staff which may lead to them pursuing other employment opportunities. This risk is well articulated in the workforce plan which has adopted conservative assumptions about the likelihood of staff at each level and band moving to the new site. The workforce plan outlines a series of mitigations to ensure appropriately qualified, skilled and experienced staff are in place to deliver specialist care and treatment for people
with learning disability and autism. Mersey Care is adopting a “grow our own” approach to the future workforce. This includes the development of:

- MSc in Nursing (the first cohort will complete in 2019, 15 learning disability and 5 mental illness MSc);
- Apprentice Nursing Programme (cohort of 20 each year);
- Awareness modules for mental illness and learning disability in conjunction with Edge Hill University;
- Nurse associate programme.

2.7.46 In addition the trust continues to use a number of opportunities and different approaches to work collaboratively with staff on the Whalley site in line with the detailed communication and engagement strategy developed as part of the acquisition planning process and for this MSU project.

Isolation

2.7.47 It is our view that the co-location and unification of MSU services brings many benefits to service users, their families and carers as well as commissioners and the trust which are simply unachievable on separate sites. Alongside the economic advantages and increased efficiency, a unified MSU would allow robust governance provided by a single management structure which can guide, inform and fundamentally sculpt the emerging culture to enhance safety and deliver treatment of the highest quality.

2.7.48 Should the learning disabilities MSU remain on the Whalley and Gisburn sites, it would be clinically and operationally isolated from the rest of the secure care services. Services isolated in this way increase risk of developing atypical and localised practices which diminish clinical effectiveness and increase risk to patients and public safety. This would result in potential recreation of the geographical and cultural isolation which has been acknowledged as key risk at Scott Clinic in the past.

2.7.49 It is difficult for the trust to contemplate operating three separate MSU at distant locations particularly when the current and future funding constraints are considered. The economic impact would be serious with additional costs due to the loss of economies of scale and the need for full workforce on site for a single unit. Such additional expenditure would have to be found from within the existing trust finances and therefore may be detrimental to other patient groups.

Part C: Plans for the Future

2.8 Model of Care

Overview

2.8.1 As the trust moves forward towards realising its objective of becoming a world renowned leader in forensic mental health, there is the opportunity to expand expertise and enhance its international reputation as service delivery is broadened into the field of forensic learning disability and autism.
2.8.2 As with all Mersey Care provision, the service user is at the core, with the model of care wrapped around them. Activities which can take place in the MSU to enhance each service users’ feeling of health and social well-being are then layered around the core treatment plan to ensure that we are assisting individuals in real time to increase readiness for their move to a less secure or community based environment.

2.8.3 In addition the trust will then look to how technology can aid in the effectiveness and efficiency of this health care provision to best prepare our clients for a life beyond care.

2.8.4 Mersey Care is uniquely placed to provide an authentic and seamless secure care pathway for a broad range of patients with diverse mental health needs and learning disability who have committed serious offences and are considered a risk to others. The MSU will be strategically, operationally and clinically integrated within the comprehensive and complete secure model. It will maintain operational consistency and coherence with the principles and procedures of the secure pathway with clearly defined interfaces to high secure and low secure. It will reflect the value and vision of Mersey Care and its commitment to Perfect Care.

2.8.5 The unified medium secure service for mental illness and learning disability creates the context and opportunity to develop an innovative model of care which fits with the secure division strategy for care. The Model of Care for medium secure services, attached in Appendix 2.4: Model of Care, has been developed through a structured series of collaborative planning meetings attended by a clinical consultation group comprising senior clinicians and managers from both trusts. It has been reviewed by the NHS England specialist commissioning team and adapted to reflect their position and views. It sets out how the trust will deliver exceptional care and treatment for offenders and high risk patients with severe mental illness, learning disability and autism, neuro-developmental disorders and personality disorder.

2.8.6 Going forward service delivery will ensure the right care is provided in the right location with an emphasis on caring for people in the lowest level of security as possible and with a preference to care closer to home and in the community setting.

2.8.7 An innovative approach to clinical care is structured around six pillars of effective practice which provide flexibility and responsive care consistent with national guidance and Mersey Care’s vision and values. It will drive a shift in focus from service delivery structured around clinical input to care and treatment which is outcome oriented and emphasises quality of life for patients. The six pillars are discussed in detail in the Model of Care and summarised below.
Figure 2.8: Six Pillars of Effective Practice

2.8.8. The model of care recognises the expansive range of mental and physical health and social needs of this broad group of patients. Service users will receive specialist care and treatment on dedicated wards from trained and qualified staff in response to their holistic needs. There will be specialist wards for those service users with learning disabilities and for those with severe mental illness.

2.8.9. It is likely that the clinical presentations of a small number of individual patients will reveal significant comorbidity with multiple diagnoses and functional difficulties such as severe mental illness, learning disabilities, personality disorder and substance misuse. The resultant complex and sometimes contradictory pattern of health and social care requirements for these service users means care and treatment planning will be based upon an individualised assessment of their needs, risk and vulnerability as well as diagnosis. This whole system approach will combine clinical care of the highest quality with a dedicated research, development and education centre for perfect care.

2.8.10 Service users will be provided with timely, efficient, specific and effective care of the highest quality. Once referred to the service they will be admitted quickly when they need to be, will remain in hospital for the shortest period safely possible and will receive care in the least restrictive environment commensurate with their needs. The care programme approach will guide the planning and delivery of treatment.

2.8.11 Care planning for those service users with learning disability will use the CCARM (Complex Case & Autism Recovery Model). This is a person centred framework coproduced with individuals to plan and achieve their recovery. It is an evidence based model which allows individual service user outcomes to be measured in the context of best practice for their care. The framework incorporates individual toolkits to formulate treatment and care and focuses on reducing risk and increasing skills building.
2.8.12 Excellent care and treatment is a combination of high quality personalised clinical intervention, effective operational procedures and robust governance. The model of care integrates these aspects to avoid delay, prevent treatment drift, and reduce variance in cost and activity across clinical care teams. This will ensure equality of access for all service users and ensure they benefit from the service commitment to the following four major objectives:

Table 2.5: Objectives

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced length of stay in hospital</td>
<td>Fundamental objective of the model of care is to reduce the average length of stay for service users within MSU. Our aspiration is to decrease this by 5% aiming to be the lowest nationally. Achievement of this will ensure service users receive care and treatment in the least restrictive environment possible.</td>
</tr>
<tr>
<td>Clear and well-articulated plans for discharge</td>
<td>Discharge options will be identified on admission, providing clarity for service users. Identifiable “therapeutic milestones” which will trigger progress to the next stage on their personal pathway will be articulated.</td>
</tr>
<tr>
<td>Proactive risk management</td>
<td>The risk service users pose to others will be expertly assessed, managed and reduced facilitating a timely return to the community or to a lower level of restriction.</td>
</tr>
<tr>
<td>Shared care planning</td>
<td>Service users, carers and families will be integrally involved in care planning which will be outcome focused with an emphasis on quality of life measures for service users.</td>
</tr>
</tbody>
</table>

Case Planning

2.8.13 A whole system model will deliver robust clinical governance, a consistent approach to clinical care and a cohesive and shared understanding of patient’s multiple and complex needs as they progress through the clinical pathway. A single admission panel traversing the secure pathway will see service users are admitted to the appropriate level of secure care and will identify their broad treatment needs. The on-going care and treatment of all service users will be assured by a clinical oversight group.

2.8.14 Care planning for each service user will be driven by comprehensive multi-disciplinary clinical formulation. A continued focus on the whole range of service users’ health and social needs will provide opportunity for appropriate access to mainstream activities while maintaining the necessary specificity of treatment and intervention.

2.8.15 The service will deliver care and treatment consistent with these principles through a comprehensive model of care planning which will result in individualised person centred programmes of clinical care for all patients. This will be guided by a formulation of their functioning and needs and will incorporate their strengths and aspirations.

2.8.16 The model of care will facilitate a shift in emphasis to ensure that all treatment goals for service users are outcome focused. Clarity of therapeutic objectives and anticipated outcomes for the service user, agreed at an early point in their treatment will increase their motivation and mitigate treatment drift and the additional risks this introduces.
2.8.17 Care of the highest quality will be driven by clear and auditable service standards. Clinical care standards for admission, interventions, discharge planning, risk management and care programme approach (CPA) will propel continuous improvement, providing explicit guidance for clinical teams to inform decision making and forming a contract between the team and the service user.

Physical health and wellbeing

2.8.18 The integration of physical and mental health is a defining aspect of the model of care. It is our intent to eradicate the health inequalities experienced by people with learning disability and mental illness who are in secure care. The evidence base reveals an unacceptable position. Nationally access to and uptake of routine screening, annual health checks and the treatment of long term conditions is inadequate and requires improvement. Reducing the rates of mortality and premature death in these groups of service users is a priority and has been a primary factor in the design of the unit and the development of the future workforce.

2.8.19 The physical health care provision within the new MSU will be consistent and compliant with national guidance. It has been informed by the following:

- Improving the Physical Health of People with Serious Mental Illness: A Practical Toolkit (May 2016);
- Improving the Physical Health of People with Mental Health Problems (DOH, May 2016);
- Confidential inquiry into premature deaths of people with learning disability (CIPOLD) 2013. Norah Fry Research Centre, University of Bristol;

Triangle of Care

2.8.20 Mersey Care recognise and acknowledge that carers, families and friends are key partners and consider their role to be integral to the delivery of perfect care. This is expressed in the concept of the triangle of care where the service user, the clinical care team and their carers, families and friends are seen as stakeholders in treatment planning, delivery and outcomes.

2.8.21 This collective approach will enhance the care and support service users receive as they progress through the secure care pathway.

2.8.22 Establishing the appropriate role for carers, families and friends can be a complex and challenging task given the nature of the service user’s presentation and ongoing risk and requires a significant investment in time and resource. For many carers and family members, continued involvement with the patient may carry grave danger. They are placed in an often intolerable dilemma. They have a desire to continue caring for the person but have previously been, or may be in future, a victim of serious violent offending. The risk in such circumstances is extremely high and therefore requires a collaborative and comprehensive
approach to risk management. Clinical care teams will apply the interventions for potential familial victims set out in the Carer families and friends engagement standards.

**Benefits of the model of care**

2.8.23 The adoption of a unified model of care will facilitate excellence, in the care and treatment of forensic service users who have a diagnosis of mental illness, learning disability and autism. A significant minority of this group may also have a co-morbid personality disorder.

2.8.24 The model of care will bring the following major benefits for service users, families and carers, commissioners and stakeholders:

- A whole service ethos across the secure pathway will provide clarity of function and task for each facility in the secure division. This will facilitate a cohesive and seamless process of admission treatment and transition reducing duplication of assessment and delay and uncertainty. Mersey Care will be the only local provider able to deliver this and one of three nationally;
- A single admission and pathway planning panel will manage all referral to the secure division and ensure service users are admitted to the correct level of secure care;
- Early identification of personalised outcomes and pathway options for service users will enhance engagement and motivation and reduce treatment drift;
- Compliance with the principle of least restriction with service users moving to lower levels of restrictions and security as soon as possible with well managed and efficient transition processes;
- A reduction in recovery times and occupied bed days: as a result of streamlined assessment and treatment delivery, Mersey Care anticipate lengths of stay to reduce by 5%);
- Personalised intervention plans which will be co-constructed with service users' families and carers;
- Service users’ care, treatment and progress against identified therapeutic objectives will be formally monitored by a clinical oversight group. This will fit with the care and treatment review (CTR) process for patients with a diagnosis of learning disability/autism;
- There will be a more effective allocation of resources with the workforce sharing skills, services and expertise across a larger range and number of services. This shared specialism will reduce duplication in terms of training and decrease the cost of the service. Staff will be skilled and experienced in the treatment of a broad range of forensic patients working with service users with mental illness or learning disability and autism.
- There will be a greater and more appropriate range of therapies across the whole pathway. This will include increased access to psychological and occupational therapy to reduce risk/offending behaviours and increase engagement in meaningful activity.
- A high standard of physical health care through the sharing of physical health resources across the secure campus.
• A high standard of provision compliant with clinical guidelines, monitoring frameworks and service specification. This will include Department of Health guidance with the national policy aims for forensic service users with a diagnosis of learning disability/autism.
• Meet national standards for safety and security through co-location and sharing resources across the secure division.

A small number of these benefits can be realised within the existing environment and will be implemented in the near future.

2.9 Physical, mental and social well-being and technology

2.9.1. The model of care provides a unique opportunity to embrace and embed the innovative use of technology throughout clinical care. At a high level the trust is seeking to instil new way of delivering perfect care to the patients in the medium secure unit and this addresses the following:

2.9.2. Health and social well being: the trust has embedded in its plans for the future service aspects which will aid the health and social well being of its service users. An articulated principle of the planning process was to ensure the environment supported a synergy of physical, social and mental wellbeing. In line with this objective the following were considered to be integral aspects of the design:

• Dedicated indoor and outdoor space for exercise including an astro turf sports area
• Access to gardens from the ward
• music room
• multi-functional rooms
• Sensory rooms

2.9.3. Readiness and preparedness: the key ethos of the model of care is to try to encourage people through the system as quickly as appropriate and to be ready for a less secure environment or life in the community. The trust has been considering typical areas of education with respect to numeracy and literacy as well as using technology and other skills for daily living. The trust is looking to incorporate features such as:

• GP visits
• dentist visit
• bank features
• shop
• café

In addition, the trust is seeking to create an environment as similar to the community as possible on the wards and is looking to include study and writing areas in the bedrooms along with access to TV, movies, Skype and computer games. The trust is looking to technology to allow service users more freedom of movement and control of their daily lives, for example wearables.
2.9.4 **Health care provision**: the trust is also working to allow service users to be more involved in their care and to utilise technology to provide a more efficient and effective services, for example:

- paperless patient records
- electronic prescribing
- silent alarms
- menu ordering

These areas are discussed in the following paragraphs.

2.9.5 Six innovation arenas are being considered, these are:

<table>
<thead>
<tr>
<th>Innovation Arenas</th>
<th>How these are being considered in the model of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The General Environment</td>
<td>How Mersey Care as care providers and service users interact with the building in general and transitory spaces, i.e. any hallways, lobbies or atria's within the building</td>
</tr>
<tr>
<td>The Specific Environment</td>
<td>The particular use of rooms to facilitate activity or provide respite or stimulation for service users, including their own private spaces</td>
</tr>
<tr>
<td>Personal Preferences</td>
<td>An innovative approach to self-regulation, improved access to technology in line with service users’ needs</td>
</tr>
<tr>
<td>Therapeutic Tools</td>
<td>Making best use of current tools and developing solutions for the future, enabling co-production and engaging the service user population</td>
</tr>
<tr>
<td>Education</td>
<td>Providing a person centred approach to education based on risk and function, preventing further alienation due to lack of skills or knowledge when service users progress to non-secure environments</td>
</tr>
<tr>
<td>Digital Rights</td>
<td>With the increasing prevalence of digital technology in daily life, the trust will seek ways to enable service users access to tools that will help maintain their skills and knowledge or prepare them for the technological demands of our current culture</td>
</tr>
</tbody>
</table>

2.9.6 Collectively the application of technological innovations will increase the scope to enhance service user autonomy, safety and participation. Solutions can include the facilitation of unescorted movement through an approved area for service users and the capacity to moderate the environment by changing lighting, making music available or presenting imagery within the service user’s immediate environment.

2.9.7 In a digital age it is imperative that service users have appropriate access to the internet and social media. Mersey Care will seek to ensure service users have the opportunity to prepare for social reintegration. Inclusion and involvement are vital to good and meaningful lives and we will ensure service users’ digital rights are met whilst supporting therapeutic activity, particularly in the areas of training, vocation and education.

2.9.8 In 2015/16 Mersey Care developed its five year digital strategy that explicitly set out its intention to put service user and patient empowerment as the centre piece of its purpose. In doing so, Mersey Care naturally aligned its approach with the
The vision of the IT strategy is to enable service and user empowerment through the delivery of digital services which allows our staff and service users to have interoperable access to health and social care information and allows service users to be in control of their own health and well-being.

For the medium secure unit, there will be an implementation of modern technology to support care and support service user and carer empowerment.

We will be building on digital technologies for the new build of the MSU which will incorporate innovations such as:

- **Wearables:** We will be increasing the use of wearables to support service users to monitor physical activities and sleep patterns. We are planning for service user apps which data from wearables will link into and allow clinicians to use the data to support care. We will be investing in technologies such as breathing monitors to support the service users and allow our staff to work in a more efficient manner. We are working with organisations such as Sensor city to develop this further.

- **Apps:** The trust has developed a number of app technologies to support well-being, physical health and mental health co-designed with our service users and will continue to develop for the MSU.

- **For service user empowerment:** In partnership with South London and Maudsley, the trust has been developing a ‘digital care record’. Much of the development has already been completed for the London trust and we are working with service users in our Recovery College to co-design a bespoke version for Mersey Care. The principle of the digital care record is that it is accessible on smartphone or web; it enables individuals to record details of their mental and physical health and well-being; it connects service users to their clinicians and carers through a ‘care circle’; it provides information and signposting; it will give access to the clinical records; and for clinicians provides additional and valued data centred on the service user’s own experiences and feelings. Alongside this development, the trust is also developing a programme of digital inclusion to enable service users to have access to digital devices and connection to services. It is also starting a programme with the workforce to develop their digital skills to enable them to support and empower service users in their use of digital skills.

- **Access:** The plan is to remove the need for keys by using wearable devices to allow movement around the facility through wearables which can allow patients to have access to specific areas without the need for an escort.

- **Calming environments:** through the use of technology we will use designated areas to provide areas of calm using visuals and sound that are pre-programmed by the individual that will assist them to regain control and to allow virtual visits for patients whose relatives are unable to visit in person.
This will support the trust’s focus on reduced restraint and on its commitment to zero suicide in its services.

2.9.12 IM&T is an important enabler to fully align with and support the organisational strategy and the delivery of ‘perfect care’. Mersey Care aspires to be a technology led and intelligent organisation and will deliver this through initiatives:

- A roadmap for business intelligence;
- Data sharing with health and social care colleagues;
- A clinically led information and management technology organisation with the recruitment of a Chief Clinical Information Officer;
- The deployment of more mobile technology and Wi-Fi enabled sites to increase productivity.

2.9.13 Mersey Care recognises the importance of the need to invest and maintain technical infrastructure and device management. This includes the development of the community of interest of networks (COIN) which supports the sharing of information across the local health economy and supports the use of technologies such as wireless and exploitation of mobile devices to support effective delivery of care. This will support service users and carers and the staff in ensuring Mersey Care has service users that come first, empowered teams and supported staff.

2.9.14 Mersey Care will also continue to work towards seamless electronic records inclusive of learning disability and autism services.

2.9.15 The trust has a roadmap for business intelligence that will provide ward to board information with a focus on health outcomes and performance improvement. Mersey Care is working to ensure that data is captured once at source. The trust’s governance of information assets ensure that they manage data and information safely and securely in a way Mersey Care patients and carers would expect.

2.9.16 Mersey Care are working to ensure they engage effectively in data and information sharing with the local health economy where Mersey Care colleagues work, allowing quicker and better access to information and that the trust use their data to report on outcomes of care.

2.10 Planning Sessions

2.10.1 The proposal to relocate medium secure services to a state of the art unit on a single site for people with mental illness and for those with learning disability brought significant challenges both clinically and operationally. A carefully considered and comprehensive programme of engagement and planning has provided the opportunity to elicit the views and ideas of a wide range of staff from all disciplines. This facilitated a well informed analysis of the environmental requirements in order to support the delivery of the model of care and optimise opportunities for recovery.

2.10.2 In April 2016, when Mersey Care was confident the acquisition of Calderstones was likely to take place, an away day was organised and about 40 people attended from Mersey Care and Calderstones, supported by advisors. The attendees were fully aware of service user and staff feedback about the environment the trust wanted to create and the model of care envisaged.
2.10.3 The main purpose of the session, which reflects the main purpose of this business case, was to:

- Discuss, debate and enhance the care model described above and focus on how the service can be provided in a different and better way to support the ethos of recovery and transition to less secure environments;
- inspire ideas of how technology could aid service users with management of their care as well as prepare them for life in a community setting;
- agree the commonality and differences required in the care of these two groups of service users;
- consider the practical requirements of the building to deliver this model of care in an effective and efficient manner.

2.10.4 The outputs produced in this session were used to update the model of care and to prepare this FBC.

Part D: Strategic Appraisal

2.11 Alignment of Organisational Aims and the FBC

2.11.1 This additional investment in the trust medium secure estate will allow Mersey Care to realise its strategic aims, as shown in table one below:

<table>
<thead>
<tr>
<th>Trust Strategic Aim</th>
<th>Detail</th>
<th>How will the FBC deliver this objective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Resources</td>
<td>Will ensure that people's experience of their services is recognised nationally as best in class.</td>
<td>The new care environment will deliver high quality service user outcomes, public protection and be best practice.</td>
</tr>
<tr>
<td>Our Services</td>
<td>Will grow and differentiate their secure services from those provided by others.</td>
<td>The trust will offer a rapid response and a holistic care pathway (and not just single treatment episodes). The trust will also expand the number of beds provided and the range of service user needs / diagnosis treated.</td>
</tr>
<tr>
<td>Our Future</td>
<td>Will use intelligence and information to identify need and to target interventions more effectively.</td>
<td>Clinicians will work in and out of offender health organisations supporting them to address need. Support the medium secure markets for learning disabilities, women's mental health and Out of Area Treatments.</td>
</tr>
<tr>
<td>Our Future</td>
<td>Will have a new emphasis on research and development.</td>
<td>The co-location of staff will further strengthen the delivery of internationally renowned R&amp;D.</td>
</tr>
<tr>
<td>Our Future</td>
<td>Will build new partnerships to improve quality and support recovery and wellbeing outcomes for people with mental health needs.</td>
<td>Establish new partnerships with prisons and other criminal justice organisations, offering instant liaison and expertise. Improve quality and support for mental health and learning disabilities community provisions.</td>
</tr>
</tbody>
</table>
2.12 Investment Objectives

2.12.1 The trust recognises that the investment objectives are crucial for making a convincing argument for this business case. It is important that any objective delivers tangible results which achieve one or all of the following:

- A reduction in costs (enhancing economy);
- An increase in throughput (increasing efficiency);
- An improvement in quality (enhancing effectiveness).

2.12.2 There are five Investment Objectives for the MSU project:

- Improved service user outcomes
- Secure Care Pathway
- Improved environment
- Service growth and differentiation
- Effective and efficient workforce

2.12.3 The investment objectives were selected following a workshop which was attended by a number of Project Board members and other senior staff.

2.13 Benefits Criteria

2.13.1 A long list of benefits associated with each investment objective was identified as per the table below:

### Table 2.8: Investment Objectives and Benefit Criteria

<table>
<thead>
<tr>
<th>Ref</th>
<th>Investment Objective</th>
<th>Benefits Required from Investment</th>
</tr>
</thead>
</table>
| 1   | Improved outcomes         | • Reduced length of stay  
|     |                            | • Reduced frequency in use of seclusion and alternatives such as de-escalation                      |
|     |                            | • Reduction in duration of seclusion                                                                |
|     |                            | • Improved dental care for patients                                                                 |
|     |                            | • Improvement in physical health and wellbeing                                                     |
|     |                            | • Wider range of skills for independent living                                                     |
|     |                            | • Quicker admission of service users to the appropriate level of security through the co-location of secure services |
2. A seamless secure care pathway

- Reduced duplication of assessments through the creation of a single admission panel across the Secure Division.
- Treatment in the least restrictive environment as service users will be treated in the most appropriate environment.
- Reduction in transfer times across different levels of the trust Secure Services
- Reduction in professional and geographical isolation through co-location of services onto a single site

3. Effective and efficient workforce

- Reduction in staffing costs for commissioned mental illness ward which is financially better due to the reduction in wards and co-location onto one site.
- Reduction in restrictive practice (use of supportive observations) which can slow down care pathway and is a very intrusive experience for the patient
- With the integration of learning disability/mental illness services on one site there will be an increased need for a cross-skilled workforce, creating opportunities for professional development

4. Improved environment

- Increased access to a full range of therapies by the provision of designated psychological and occupational therapeutic spaces/rooms
- Improve privacy & dignity for service users by the provision of single en-suite bedrooms
- Increased access to outside space and fresh air for patients
- Improved access to medical treatment following increased availability of treatment rooms on individual wards
- Improved environment for patients whilst in seclusion
- Greater autonomy and independence for service within the unit
- Enhanced opportunities for family contact through digital technology
- Increased therapy and social spaces will provide greater opportunities for social interaction for service users
- Facilitating patient access to therapy on a 24/7 basis by providing therapeutic content to be accessed by service users, especially during times when provision is limited

5. Service growth and differentiation

- Greater flexibility to respond to demand for beds

2.11.2 The benefits identified were then refined to the evaluation criteria ensuring that all investment objectives were being assessed as part of the evaluation. The participants in the workshop then ranked and weighted each criterion to sum to 100%, to reflect the relative importance of the delivery to the specific service.

2.14 Constraints

2.14.1 The following constraints were identified against key elements of the project:

**Design & Build**

- **Planning constraints and time delays** – Planning permission was granted by Sefton planning dept. on the 13th January 2017
- **Department of Health standards for medium secure facilities** – The building has been designed in accordance with the required standards and regulations

**Economic**
• **Availability of capital monies** – confirmation from Department of Health / NHS Improvement is awaited regarding the allocation of funding for capital projects;  

• **The need to achieve cost improvement plans to support a sustainable service** – the affordability may impact on the service achieving cost improvement plans, although cost improvement plans have been built into the economic case.

**Strategy**

• **Commissioner support:** Formal support has now been confirmed by North regional specialised commissioning team

• **NHS England’s statement referring to the closure of the Whalley site (subject to the outcome of the public consultation)** – the requirement for regulators to have sight of a programme business case for the re-provision of LSU prior to approving the FBC for MSU may impinge on the timescale for the project;  

• **NHS Public consultation process in Whalley** – *The outcome of the public consultation was announced on 28th March 2017 with the decision to no longer commission Learning Disability services on the Whalley site.*

### 2.15 Dependencies

2.15.1 The key dependencies are shown below:

• **Special environment and planning considerations for mental health** – mental health patients will require specific environmental/planning considerations related to the consultation and maintaining neighbourhood relations;  

• **Land sales** – will contribute to the funding for the project;  

• **Successful loan application to the ITFF** - funding support is required to pay for the capital costs of the development.
Economic Case

3.1 Introduction

3.1.1 In accordance with the Capital Investment Manual and requirements of HM Treasury (HMT) this section of the FBC:

- sets out the long list of investment options to be considered in response to the Investment Objectives identified within the Strategic Case;
- documents the reduction to a shortlist;
- conducts an evaluation of the qualitative performance of each of the shortlisted options using a weighted benefits assessment;
- describes the outcome of a quantitative appraisal, adjusted for risk assessment and optimism bias;
- selects a Preferred Option, based on overall Value for Money (VfM).

3.1.2 A long list of investment options was identified and reduced to a shortlist which was then subjected to further analysis and scrutiny. The reduction of a long list to a shortlist was achieved by applying the CSF, which consider the feasibility of delivery and the overall investment objectives.

3.1.3 The shortlist was evaluated by undertaking both a qualitative analysis using the benefit criteria derived from Investment Objectives and a quantitative analysis which applied discounted cash-flow techniques. The qualitative analysis involved participation by the stakeholders, together with external scrutiny to ensure objectivity in the process.

3.1.4 The quantitative analysis of the shortlisted options was undertaken on the basis of the HMT’s "Appraisal and Evaluation in Central Government" rules and supplementary guidance which are mandatory for investment appraisal in the public sector. Affordability is considered separately in the Financial Case (Section 5 of this Business Case).

3.2 Critical Success Factors

3.2.1. Critical success factors (CSF) relate to the deliverability of the option. They provide a rationale to discard long list options before any detailed review.

3.2.2 The CSFs were developed and confirmed at a workshop held in May 2016 and were re-confirmed in March 2017. The attendees at the workshop are detailed at in Table 3.5. The agreed CSFs are as follows:

### Table 3.1: Critical Success Factors

<table>
<thead>
<tr>
<th>Key CSFs</th>
<th>Broad Description</th>
<th>Translated to MSU CSF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Fit and Business Needs</strong></td>
<td>How well the option:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• meets agreed spending objectives, related business needs and service requirements</td>
<td>Does the investment fit with the trust’s clinical strategy?</td>
</tr>
<tr>
<td></td>
<td>• provides holistic fit and synergy with other strategies, programmes and projects.</td>
<td>Does the option remove the requirement for beds on the Whalley site (as required by NHSE)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does the option provide integration of learning disabilities and mental illness care?</td>
</tr>
<tr>
<td><strong>Potential VfM</strong></td>
<td>How well the option:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• maximises the return on the required spend (benefits optimisation) in terms of economy, efficiency and effectiveness from both the perspective of the organisation and wider society.</td>
<td>Is the option likely to provide improved benefits to the service users?</td>
</tr>
<tr>
<td></td>
<td>• minimises associated risks.</td>
<td></td>
</tr>
<tr>
<td><strong>Potential achievability</strong></td>
<td>How well the option:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• is likely to be delivered in view of the organisation’s ability to assimilate, adapt and respond to the required level of change.</td>
<td>Is the option likely to adversely impact on the well-being of patients due to difficulties of implementation?</td>
</tr>
<tr>
<td></td>
<td>• matches the level of available skills which are required for successful delivery.</td>
<td>Can the option be delivered in line with the programme requirements set by the trust?</td>
</tr>
<tr>
<td><strong>Supply-side capacity and capability</strong></td>
<td>How well the option:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• matches the ability of the service providers to deliver the required level of services and business functionality</td>
<td>Is the land available for development of the option?</td>
</tr>
<tr>
<td></td>
<td>• appeals to the supply-side.</td>
<td></td>
</tr>
<tr>
<td><strong>Potential affordability</strong></td>
<td>How well the option:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• meets the sourcing policy of the organisation and likely availability of funding</td>
<td>Is the option likely to be affordable?</td>
</tr>
<tr>
<td></td>
<td>• matches other funding constraints.</td>
<td></td>
</tr>
</tbody>
</table>

3.2.3 Achieving the critical success factors will be a key part of delivering a successful project and all options have been assessed against them. Alongside the
3.2.4 For each Investment Objective, the benefit criteria has been determined which will be used in the qualitative and quantitative analysis presented below. The values associated with each type are on the basis of full benefit, however all options may not offer 100% of the benefit and this is taken into account within the Capital Investment Appraisal modelling undertaken as part of section 3.9.

Table 3.2: Benefits Classification

<table>
<thead>
<tr>
<th>Ref</th>
<th>Investment Objective</th>
<th>Benefits</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Improved outcomes</td>
<td>Reduced length of stay</td>
<td>Non-Cash £0.49m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced frequency in use of seclusion and alternatives such as de-escalation, and reduction in duration of seclusion</td>
<td>Non-Cash £0.06m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved dental care for patients</td>
<td>Societal £0.00m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement in physical health and wellbeing</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wider range of skills for independent living</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quicker admission of service users to the appropriate level of security through the co-location of secure services</td>
<td>Qualitative</td>
</tr>
<tr>
<td>2</td>
<td>A seamless secure care pathway</td>
<td>Reduced duplication of assessments through the creation of a single admission panel across the Secure Division.</td>
<td>Non-Cash £0.00m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment in the least restrictive environment as service users will be treated in the most appropriate environment.</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction in transfer times across different levels of the trust Secure Services</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction in professional and geographical isolation through co-location of services onto a single site</td>
<td>Qualitative</td>
</tr>
<tr>
<td>3</td>
<td>Effective and efficient workforce</td>
<td>Reduction in staffing costs for commissioned MI ward which is financially better due to the reduction in wards and co-location onto one site.</td>
<td>Cash releasing £0.55m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction in restrictive practice (use of supportive observations) which can slow down care pathway and is a very intrusive experience for the patient</td>
<td>Cash releasing £0.07m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With the integration of LD/MI services on one site there will be an increased need for a cross-skilled workforce, creating opportunities for professional development</td>
<td>Non-Cash £0.13m</td>
</tr>
<tr>
<td>4</td>
<td>Improved environment</td>
<td>Increased access to a full range of therapies by the provision of designated psychological and occupational therapeutic spaces/rooms</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve privacy &amp; dignity for patients by the provision of single en-suite bedrooms</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased access to outside space and fresh air for patients</td>
<td>Societal £0.16m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved access to medical treatment following increased availability of treatment rooms on individual wards</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved environment for patients whilst in seclusion</td>
<td>Non-Cash £0.01m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater autonomy and independence for service within the unit</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced opportunities for family contact through digital technology</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased therapy and social spaces will provide greater opportunities for social interaction for patients</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitating patient access to therapy on a 24/7 basis by providing therapeutic content to be accessed by patients especially during times when provision is limited</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Ref</td>
<td>Investment Objective</td>
<td>Benefits</td>
<td>Type</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>5</td>
<td>Service growth and differentiation</td>
<td>Greater flexibility to respond to demand for beds</td>
<td>Societal</td>
</tr>
</tbody>
</table>

3.2.5 Key stakeholders from both clinical and non-clinical fields were invited to participate in a benefits realisation workshop which identified a number of benefits that the project would seek to deliver. Following the identification of the benefits a core group of staff, including both clinicians and non-clinicians, were invited to an option appraisal meeting to assess the relevant importance of the benefit criteria against the different options for the project and agree a ranking and weighting of the benefits (section 3.6.2).

3.2.6 Cash releasing and non-cash releasing benefits have been quantified where baseline data is available. The values associated with those benefits are set out in table 3.2 above. The methodologies for calculating each of the benefit values are set out below in table 3.3, the total benefit is shown below with discounted benefits for all options over the 64 year analysis period of between £20.7m and £35.6m.
Table 3.3: Summary of Benefit Savings

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cash Releasing (CR) / Non Cash Releasing (NCR)</th>
<th>Methodology</th>
<th>Benefit Saving £k000</th>
<th>Option 2 - Do Minimum</th>
<th>Option 5 - Maghull 2 Build</th>
<th>Option 6 - Greenfield 2 Build</th>
<th>Option 7 - Maghull 1 Build</th>
<th>Option 8 - Greenfield 1 Build</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced length of stay</td>
<td>NCR</td>
<td>Reducing length of stay by 5% will result in patients being discharged to community, prison or LSU sooner resulting in lower costs to commissioners</td>
<td>488</td>
<td>5.9</td>
<td>5.3</td>
<td>11.8</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>Reduced frequency in use of seclusion and reduced duration of seclusion</td>
<td>NCR</td>
<td>Reduction in use and length of seclusion releases non-qualified staff time.</td>
<td>58</td>
<td>0.7</td>
<td>0.7</td>
<td>1.4</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Improved dental care for patients</td>
<td>SB</td>
<td>Offering 100% of dental checks to Mi patients, will result in less emergency dental treatment required</td>
<td>4</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Reduction in staffing costs for commissioned mental illness ward which is financially better due to the reduction in wards and co-location onto one site.</td>
<td>CR</td>
<td>56 Mi patients currently on 5 Mi wards, this will change to 62 Mi patients on 4 Mi wards in the new MSU</td>
<td>552</td>
<td>9.3</td>
<td>9.3</td>
<td>13.4</td>
<td>12.0</td>
<td></td>
</tr>
<tr>
<td>Reduction in restrictive practice (use of supportive observations) which can slow down care pathway and is a very intrusive experience for the patient</td>
<td>CR</td>
<td>10% reduction in the use of bank staff (Band 2 and 3) required to enable unplanned supportive observations</td>
<td>67</td>
<td>0.8</td>
<td>0.8</td>
<td>1.6</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>With the integration of learning disability/mental illness services on one site there will be an increased need for a cross-skilled workforce, creating opportunities for professional development</td>
<td>NCR</td>
<td>Reduction in staff sickness as a result of being a better place to work from 6.96% (2016/17) to target 4.8%</td>
<td>133</td>
<td>1.9</td>
<td>1.6</td>
<td>3.2</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Increased access to outside space and fresh air for patients</td>
<td>SB</td>
<td>DEFRA report (UK National Ecosystem Assessment 2011) suggests that view of outside space equates to value of £300 per year per person</td>
<td>157</td>
<td>2.8</td>
<td>2.8</td>
<td>3.8</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Greater autonomy and independence for service within the unit</td>
<td>NCR</td>
<td>Reduction in the time spent by non qualified staff escorting patients through the building</td>
<td>13</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td><strong>Total Benefit Saving</strong></td>
<td></td>
<td></td>
<td><strong>1,472</strong></td>
<td><strong>21.6</strong></td>
<td><strong>20.7</strong></td>
<td><strong>35.6</strong></td>
<td><strong>30.1</strong></td>
<td></td>
</tr>
</tbody>
</table>

Sub totals by Type of Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cash Releasing Benefits</th>
<th>Non Cash Releasing Benefits</th>
<th>Societal Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR</td>
<td>619</td>
<td>10.1</td>
<td>10.1</td>
</tr>
<tr>
<td>NCR</td>
<td>692</td>
<td>8.7</td>
<td>7.8</td>
</tr>
<tr>
<td>SB</td>
<td>161</td>
<td>2.9</td>
<td>2.9</td>
</tr>
</tbody>
</table>

**Total Benefit Saving by Type of Benefit** | 1,472 | 21.6 | 20.7 | 35.6 | 30.1 |

3.3 Long-listed Options

3.3.1 Due to the various iterations of this project (both before and after the acquisition of Calderstones) there have been a number of long listed options which have included differing bed number requirements. A list of those options considered within different documents is included at Appendix 3.1: Options considered in the past

3.3.2 The trust has far greater clarity on the service requirements that drive the MSU project, having now:

- Achieved FT status;
- Completed the acquisition of Calderstones;
- Designed and agreed the future model of care; and
Obtained support letter from Commissioners in relation to bed numbers.

3.3.3 The long list of options for the project was generated and evaluated as part of the Strategic Outline Case (SOC). This list was based on a number of physical solutions and locations and included Do Nothing and Do Minimum options in accordance with planning guidance. The long listed options from the SOC were reviewed and refined in March 2016. Further discussions with Commissioners resulted in different bed numbers being considered until a final position was confirmed in March 2017. The long list of options includes for completeness those options for 96 beds and 107 beds that were previously considered but these have not been shortlisted given the recent commissioner support letter for 123 beds.

3.3.4 Table 3.4 sets out the bed numbers indicated in the letters.

### Table 3.4: Commissioned Beds

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>NHS England</th>
<th>Devolved Administration</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 MSU learning disability beds</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>5 Spot Purchase MSU learning disability beds (Wales/Scotland)</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>56 + 6 MSU mental illness beds</td>
<td>62</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>16 Additional MSU mental illness beds</td>
<td>16</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>TOTAL</td>
<td>118</td>
<td>5</td>
<td>123</td>
</tr>
</tbody>
</table>

3.3.5 A description of the options explored and rationale for exclusion of options (where applicable) is provided in the table below:

### Table 3.5: Long list of options

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Shortlist</th>
<th>Reason for Inclusion / Exclusion on shortlist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Do Nothing</strong>&lt;br&gt;Do nothing (services remain at Scott Clinic on the site and Whalley sites, as currently configured). Capital spend limited to backlog maintenance and funded by current budgets.</td>
<td>No</td>
<td>Does not meet the majority of the CSFs or Investment Objectives including:&lt;br&gt;• requirement of freeing up Calderstones site&lt;br&gt;• commissioner demand</td>
</tr>
<tr>
<td>2A</td>
<td><strong>Do Minimum A</strong>&lt;br&gt;New build MH unit on Scott Clinic site (56 beds) to replace current building and new build LD unit on Maghull site</td>
<td>No</td>
<td>This option only partially meets CSFs and Investment Objectives. The Scott Clinic is of insufficient size to accommodate a new build of the scale and scope to meet the new model of care requirements.</td>
</tr>
<tr>
<td></td>
<td>Option Description</td>
<td>Recommendation</td>
<td>Comments</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2B</td>
<td>Do Minimum B</td>
<td>Yes</td>
<td>This option only partially meets CSFs and Investment Objectives. However included as a baseline option for economic evaluation as it is practically deliverable as opposed to Option 2A.</td>
</tr>
<tr>
<td>3</td>
<td>Refurbishment of Scott Clinic and Whalley site</td>
<td>No</td>
<td>Does not meet number of CSFs or Investment Objectives including:</td>
</tr>
<tr>
<td></td>
<td>Per option 2, but in addition would upgrade buildings to a Category B standard throughout, which would address items such as space standards, privacy and dignity, en-suites.</td>
<td></td>
<td>• doesn’t meet the commissioner decision following consultation to no longer commission LD services from the Whalley site</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• doesn’t allow for pathway integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• doesn’t contribute to longer term sustainability</td>
</tr>
<tr>
<td>4</td>
<td>New Build 1 building Maghull 96 beds</td>
<td>No</td>
<td>Does not meet commissioner demand</td>
</tr>
<tr>
<td></td>
<td>96 bed provided in single building on Maghull site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>New Build 2 buildings Maghull site</td>
<td>Yes</td>
<td>Meets the Investment Objectives, CSFs and does not breach a project constraint</td>
</tr>
<tr>
<td></td>
<td>123 bed provided in 2 buildings split between learning disabilities and mental illness on Maghull site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>New Build 2 buildings Greenfield site</td>
<td>Yes</td>
<td>Meets the Investment Objectives, CSFs and does not breach a project constraint</td>
</tr>
<tr>
<td></td>
<td>123 bed provided in 2 buildings split between learning disabilities and mental illness on Greenfield site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>New Build 1 building Maghull site</td>
<td>Yes</td>
<td>Meets the Investment Objectives, CSFs and does not breach a project constraint</td>
</tr>
<tr>
<td></td>
<td>123 bed provided in single building on Maghull site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>New Build 1 building Greenfield site</td>
<td>Yes</td>
<td>Meets the Investment Objectives, CSFs and does not breach a project constraint</td>
</tr>
<tr>
<td></td>
<td>123 bed provided in single building on Greenfield site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Mental illness beds only Maghull</td>
<td>No</td>
<td>Does not meet number of CSFs or Investment Objectives including:</td>
</tr>
<tr>
<td></td>
<td>56 bed development at Maghull</td>
<td></td>
<td>• pathway integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• longer term sustainability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• doesn’t facilitate closure of Whalley</td>
</tr>
<tr>
<td>10</td>
<td>New Build 1 building at HMP Kennet site</td>
<td>No</td>
<td>Does not meet CSF as the site will not become unavailable as the Ministry of Justice intend to continue using as a training facility.</td>
</tr>
<tr>
<td></td>
<td>123 bed development at Mersey Care owned HMP Kennet site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>New Build 1 building at Maghull 107 beds</td>
<td>No</td>
<td>Does not meet commissioner demand</td>
</tr>
<tr>
<td></td>
<td>96 bed + 11 spot purchase beds provided in single building on Maghull site.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.4 Short-listed Options

Option 2B - Do Minimum B (123 beds)

3.4.1 Services at the Scott Clinic remain at current site with capital spend to refurbish the existing building and extend to enable additional bed capacity. Learning disability services move from the Whalley site to a standalone building comprising a 46 bed unit (40 beds + 6 Wales and Scottish beds) on a Maghull site.

3.4.2 The revenue costs of providing the mental illness service increase due to the change in ward size that is required and there are non-recurrent costs associated with the decant process during the build/refurb phase. The revenue costs of providing the learning disabilities service increase due to the larger footprint, different functional content (e.g. more en-suite bathrooms) and improved facilities provision (e.g. “cook fresh” rather than “cook chill” food service, gym, outdoor space).

Option 5 – 2 buildings on Maghull site (123 beds)

3.4.3 New two-building MSU facility at Maghull comprising 77 bed mental illness (56 beds + 21 additional beds) and 46 bed learning disabilities (40 beds + 6 spot purchase beds).

3.4.4 The revenue costs increase due to the workforce changes, larger footprint, different functional content (e.g. more en-suite bathrooms) and improved facilities provision (e.g. “cook fresh” rather than “cook chill” food service). Some economies of scale of co-locating the two services in one building are lost.

Option 6 – 2 buildings on generic greenfield site (123 beds)

3.4.5 New two-building MSU facility on a generic greenfield site comprising 77 bed mental illness (56 beds + 21 spot purchase beds) and 46 bed learning disabilities (40 beds + 6 spot purchase beds). The option includes the costs of the land purchase and associated legal fees.

3.4.6 The revenue costs increase due to the workforce changes, larger footprint, different functional content (e.g. more en-suite bathrooms) and improved facilities provision (e.g. “cook fresh” rather than “cook chill” food service). Some economies of scale of co-locating the two services in one building are lost.

Option 7 – Single integrated building on Maghull site (123 beds)

3.4.7 New integrated 123 Bed MSU facility at Maghull comprising 77 bed mental illness (56 beds + 21 spot purchase beds) and 46 bed learning disabilities (40 beds + 6 spot purchase beds).

3.4.8 The revenue costs increase due to the workforce changes, larger footprint, different functional content (e.g. more en-suite bathrooms) and improved facilities provision (e.g. “cook fresh” rather than “cook chill” food service).

Option 8 – Single integrated building on Greenfield site (123 beds)

3.4.9 New integrated 123 Bed MSU facility on a generic greenfield site comprising 77 bed mental illness (56 beds + 5 spot purchase beds + 16 additional beds for future
potential use) and 46 bed learning disabilities (40 beds + 6 spot purchase beds). The option includes the costs of the land purchase and associated legal fees.

3.4.10 The revenue costs increase due to the workforce changes, larger footprint, different functional content (e.g. more en-suite bathrooms) and improved facilities provision (e.g. “cook fresh” rather than “cook chill” food service).

3.5 Economic Appraisal

3.5.1 The trust has undertaken an economic analysis combines the results of:

- a qualitative appraisal of options, which looks at how each performs against the organisation’s investment objectives; and
- a quantitative analysis i.e. the Net Present Cost (NPC) cash-flow implications of investing in these options.

3.5.2 HMT requires that certain adjustments are made against the NPC calculations to reflect optimism bias and risk. The trust has incorporated these adjustments in the analysis of each option.

3.6 Qualitative Appraisal

3.6.1 An evaluation of the qualitative performance of each of the shortlisted options has been undertaken using a weighted benefits assessment. This is the methodology recommended by the Capital Investment Manual and HFMA Toolkit guides. The analysis involves assessing how much the investment in a given option will allow it to improve the service’s performance against each of the investment objectives. It is therefore an incremental and not an absolute analysis of the performance against an objective.

Methodology

3.6.2 A qualitative appraisal of options was undertaken in a facilitated workshops held in March 2016 and revisited in March 2017. The workshop involved the following participants:

12http://www.hm-treasury.gov.uk/media/3/4/greenbook_toolkitguide170707.pdf
http://www.hm-treasury.gov.uk/media/D/3/greenbook_toolkittemplates170707.pdf
Table 3.6: Option Appraisal Workshop attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elaine Wilkinson</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Dr Frank McGuire</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Clinical Lead</td>
</tr>
<tr>
<td>Mina Patel</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Senior Assistant Director of Finance</td>
</tr>
<tr>
<td>Dr Melanie Higgins</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Associate Medical Director / Consultant / Forensic Psychiatrist</td>
</tr>
<tr>
<td>Vicki Wilson</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>HR Business Partner</td>
</tr>
<tr>
<td>Bridget Clancy</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Head of Nursing and Patient Experience</td>
</tr>
<tr>
<td>Anne-Marie Davies</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Project Manager</td>
</tr>
</tbody>
</table>

3.6.3 Each of the options was discussed with the participants and a score against each investment objective agreed by consensus. An average score from participants is unreliable due to differing assumptions and the possibility of distortion by outliers, hence the approach taken.

Evaluation Criteria

3.6.4 Each option was considered with respect to its performance against the agreed investment objectives, by way of the benefits criteria which had been identified and weighted as agreed by the participants in the workshop. The criteria for scoring was based on an assessment of the benefits identified for each of the investment objectives as set out in the table below:

Table 3.7: Criteria and Weightings

<table>
<thead>
<tr>
<th>Ref</th>
<th>Investment Objective</th>
<th>Benefits Required from Investment</th>
<th>Rank</th>
<th>Weighting</th>
</tr>
</thead>
</table>
| 1   | Improved outcomes   | • Reduced length of stay  
• Reduced frequency in use of seclusion and alternatives such as de-escalation  
• Reduction in duration of seclusion  
• Improved dental care for patients  
• Improvement in physical health and wellbeing  
• Wider range of skills for independent living  
• Quicker admission of service users to the appropriate level of security through the co-location of secure services | 1    | 31.25%    |
<table>
<thead>
<tr>
<th>Ref</th>
<th>Investment Objective</th>
<th>Benefits Required from Investment</th>
<th>Rank</th>
<th>Weighting</th>
</tr>
</thead>
</table>
| 2   | A seamless secure care pathway | • Reduced duplication of assessments through the creation of a single admission panel across the Secure Division.  
• Treatment in the least restrictive environment as service users will be treated in the most appropriate environment.  
• Reduction in transfer times across different levels of the trust Secure Services  
Reduction in professional and geographical isolation through co-location of services onto a single site | 2=   | 25%       |
| 3   | Effective and efficient workforce | • Reduction in staffing costs for commissioned mental illness ward which is financially better due to the reduction in wards and co-location onto one site.  
• Reduction in restrictive practice (use of supportive observations) which can slow down care pathway and is a very intrusive experience for the patient  
With the integration of learning disability/mental illness services on one site there will be an increased need for a cross-skilled workforce, creating opportunities for professional development | 4    | 12.5%     |
| 4   | Improved environment | • Increased access to a full range of therapies by the provision of designated psychological and occupational therapeutic spaces/rooms  
• Improve privacy & dignity for patients by the provision of single en-suite bedrooms  
• Increased access to outside space and fresh air for patients  
• Improved access to medical treatment following increased availability of treatment rooms on individual wards  
• Improved environment for patients whilst in seclusion  
• Greater autonomy and independence for service within the unit  
• Enhanced opportunities for family contact through digital technology  
• Increased therapy and social spaces will provide greater opportunities for social interaction for patients  
Facilitating patient access to therapy on a 24/7 basis by providing therapeutic content to be accessed by patients especially during times when provision is limited | 2=   | 25%       |
| 5   | Service growth and differentiation | • Greater flexibility to respond to demand for beds | 5    | 6.25%     |

**TOTAL 100%**

**Scoring**

3.6.5 Following the agreement on the relative importance of each criterion, the workshop scored each option against each criterion. The rationale for each score is described in table below:
Table 3.8: Approach to Scoring

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets trusts requirements / Very Good</td>
<td>5</td>
</tr>
<tr>
<td>Meets most of trust’s requirements / Good</td>
<td>4</td>
</tr>
<tr>
<td>Partially meets trust’s requirements / Fair</td>
<td>3</td>
</tr>
<tr>
<td>Meets a few of trust’s requirements / Poor</td>
<td>2</td>
</tr>
<tr>
<td>Does not meet trust’s requirements / Very Poor</td>
<td>1</td>
</tr>
</tbody>
</table>

3.6.6 The results of the analysis are provided in the table below:

Table 3.9: Scoring of Each Shortlisted Option

<table>
<thead>
<tr>
<th>Ref</th>
<th>Investment Objective</th>
<th>Weighting</th>
<th>Option 2B Do Min</th>
<th>Option 5 2 buildings Maghull (123 bed)</th>
<th>Option 6 2 buildings Greenfield (123 bed)</th>
<th>Option 7 1 building Maghull (123 bed)</th>
<th>Option 8 1 building Greenfield (123 bed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Improved outcomes</td>
<td>31.25%</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>A seamless secure care pathway</td>
<td>25%</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>3</td>
<td>Effective and efficient workforce</td>
<td>12.5%</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Improved environment</td>
<td>25%</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Service growth and differentiation</td>
<td>6.25%</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>Total Raw Scores (out of 25)</strong></td>
<td></td>
<td>11</td>
<td>15</td>
<td>12</td>
<td>22</td>
<td>20.5</td>
</tr>
<tr>
<td></td>
<td><strong>Rank (raw scores)</strong></td>
<td></td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>Weighted Score</strong></td>
<td></td>
<td>10.9</td>
<td>15</td>
<td>11.6</td>
<td>21.9</td>
<td>20.6</td>
</tr>
<tr>
<td></td>
<td><strong>Rank (weighted score)</strong></td>
<td></td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

3.6.6 The Do Minimum (Option 2) was considered by the workshop as a baseline for the qualitative scoring and scored lower than the other options.

3.6.7 There is a reasonable difference in scores between the options which have two buildings (option 5 and 6) and those with one building (option 7 and option 8). There was a clear consensus that two separate buildings would impact the ability to implement the new model of care and deliver the level of integration planned. This was backed up by the trust’s experience from Ashworth when there was two buildings on a site and the care model was very different in each and improved when moved to a single building. In addition, the view was that while there would be greater opportunities for staff (in terms of personal development etc.) these
would not be as significant as under a one building option and the overall staff perception of the solution would be poorer.

3.6.8 Option 7 (one building at the Maghull site) was the highest scoring option with a total weighted score of around 6% higher than Option 8 (one building on a Greenfield site) which was the next best option. While the one building option on the Greenfield site scored highly in terms of the criteria and would be able to deliver significant clinical improvements it was considered not to score as highly as the build at Maghull due to the likely benefits of the build on Maghull site where there is existing Mersey Care service provision.

3.6.9 The qualitative appraisal therefore selected option 7 i.e. the building of a 123 bed unit on the Maghull site (one building) as the preferred option.

Sensitivities

3.6.10 In order to test the robustness of the non-financial option appraisal outcome, a number of sensitivity tests were carried out, which involved the identification of how the weightings could be differently allocated. Three sensitivities were considered:

- Sensitivity 1 – equalise the weightings (100% split five ways i.e. 20% each);
- Sensitivity 2 – give the patient-focused objectives (i.e. 1-3) equal highest weightings of totalling 3/5th of weights, followed by equalising on the other criterions;
- Sensitivity 3 – reverse the weightings.

3.6.11 The results of the sensitivities are summarised below. It was found that changing the weightings does not alter the order in of the rankings, as seen in the table below:

Table 3.10: Ranking of Options

<table>
<thead>
<tr>
<th>Ranking of options</th>
<th>S1 – equal weighting</th>
<th>S2 – greater merit to those impacting upon “patients”</th>
<th>S3 – reverse weightings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2B</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Option 5</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Option 6</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Option 7</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Option 8</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Preferred Option</td>
<td>Option 7</td>
<td>Option 7</td>
<td>Option 7</td>
</tr>
</tbody>
</table>
3.7 Quantitative Appraisal

3.7.1 A quantitative analysis of the shortlisted options was undertaken in accordance with HMT Green Book, which sets out the rules that should be followed for the treatment of costs and benefits:

- the relevant costs and benefits to government, the public sector and society of all the (short-listed) options should be valued and the net benefit and costs calculated. ‘Relevant’ in this instance means all those costs and benefits that can be affected by the decision at hand;
- the costs and benefits should cover the useful lifetime of the assets; or the contractual period for the purchase of the service outputs and outcomes;
- the costs and benefits should be based on market prices, wherever possible, and reflect the best alternative uses (the ‘opportunity cost’) that the goods, assets and services could be put to;
- the wider social and environmental costs – for which there is no market price – should also be taken into account;
- the sources and assumptions underlying each cost and benefit line in the economic appraisals must be explained in full;
- all cost and benefit estimates must be stated in the same base year at a common price level. The base year should be the same for all options. The base year is defined as ‘year 0’.

Modelling Principles

3.7.2 The modelling principles adopted for this analysis were as follows:

- Sign Convention: The trust is required to use the Treasury sign convention. This means that costs are shown as positive and income or surpluses, which are a benefit, as negative;

- An Economic Model (specifically the DH Capital Investment Appraisal Model (CIA)) which is consistent with the Green Book rules has been used to analyse each of the options under review;

- All amounts are expressed in £m rounded to one significant figure;

- All transfer payments between Government departments are excluded from this analysis e.g. VAT is excluded, as is clinical income;

- An analysis period equal to the longest potential development period (five years under the do minimum option) plus 60 years has been used, equating to 65 years;

- A price base of 2017/18 has been used for all operating and lifecycle costs;
• A price base calculated on fixed pricing basis for capital adjusted to 2017/18 has been used for all construction cash flows;

• The trust has quantified the estimated transitional costs associated with the establishment of the new MSU. These relate to the cost of service relocation, training staff and other issues;

• The first year (year zero) is 2017/18;

• Trust year-ends (March) are assumed;

• The HMT discount rate is 3.5% for the first 30 years then 3.0% thereafter;

• All economic cash flows (impacts of the investment decision) have been modelled.

**Opportunity Costs**

3.7.3 Opportunity Costs represent the benefits foregone from alternative options and generally relate to the benefits accruing from land sale enabled by one or more of the options under consideration.

3.7.4 The benefit of disposing of the Scott Clinic site is foregone under the Do Minimum Option (as the site is not vacated) and £2.6m (the projected land sale value) has therefore been included under this option as an opportunity cost.

3.7.5 The benefit of disposing of the Maghull site is foregone under Options 5 and 7 as the site is not vacated. The Maghull site proposed has been valued by the District Valuer in March 2017 at £1.4m. This is therefore included as the opportunity cost of these options.

3.7.6 The opportunity cost is calculated as the difference from the highest potential land sale value e.g. under Options 6 and 8.

**Table 3.11: Opportunity Costs**

<table>
<thead>
<tr>
<th></th>
<th>Real (2017/18)</th>
<th>Option 2 Do Minimum</th>
<th>Option 5 2 buildings Maghull (123 bed)</th>
<th>Option 6 2 buildings Greenfield (123 bed)</th>
<th>Option 7 1 building Maghull (123 bed)</th>
<th>Option 8 1 building Greenfield (123 bed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott Land Sale Value</td>
<td>£2.6m</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Can the site be sold under this option? × / ✓</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>✓</td>
</tr>
<tr>
<td>Maghull Land Sale Value</td>
<td>£1.4m</td>
<td>×</td>
<td>×</td>
<td>✓</td>
<td>×</td>
<td>✓</td>
</tr>
</tbody>
</table>
### Capital Costs and Lifecycle Costs

#### 3.7.7 Capital costs have been generated by the trust’s Cost Planning advisors, Rider Hunt, on the basis of a concept design for each of the options under consideration with the exception of Option 7 (1 building at Maghull) which is based on firm costs provided by Kier. A lifecycle profile for each option has also been generated which would allow the trust to maintain its resulting estate at a standard consistent with its operating obligations.

#### 3.7.8 These costs are summarised below and a full breakdown is provided in Appendix 3.2: Capital and Lifecycle Costs.

#### 3.7.9 Capital costs have been calculated in 2017/18 prices and are based on the construction start programme start date. The quantitative assessment calculation is performed using real cashflows (i.e. in 2017/18 prices), and so the general level of inflation (at 2.5%) has been stripped out of the nominal cashflow (i.e. including construction inflation).
Table 3.12: Capital Costs

<table>
<thead>
<tr>
<th></th>
<th>Option 2</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
<th>Option 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do Min</td>
<td>Maghull</td>
<td>Greenfield</td>
<td>Maghull</td>
<td>Greenfield</td>
</tr>
<tr>
<td></td>
<td>2 buildings</td>
<td>2 buildings</td>
<td>1 building</td>
<td>1 building</td>
<td>1 building</td>
</tr>
<tr>
<td></td>
<td>123 beds</td>
<td>123 beds</td>
<td>123 beds</td>
<td>123 beds</td>
<td>123 beds</td>
</tr>
<tr>
<td>Cost components</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Works Cost</td>
<td>44.1</td>
<td>50.6</td>
<td>50.6</td>
<td>43.5</td>
<td>43.5</td>
</tr>
<tr>
<td>Design Fees</td>
<td>1.5</td>
<td>2.1</td>
<td>2.1</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Trust Fees</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Land Purchase</td>
<td>0.0</td>
<td>0.0</td>
<td>5.0</td>
<td>0.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Non-works Costs</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Equipment</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Planning Contingencies</td>
<td>2.4</td>
<td>1.7</td>
<td>1.7</td>
<td>1.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Optimism Bias (Note 1)</td>
<td>2.7</td>
<td>3.0</td>
<td>3.6</td>
<td>0.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Inflation adjustment (Note 2)</td>
<td>(1.9)</td>
<td>(1.7)</td>
<td>(1.7)</td>
<td>(1.3)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>Total (per Economic Model - Real)</td>
<td>51.3</td>
<td>58.2</td>
<td>63.8</td>
<td>47.6</td>
<td>55.2</td>
</tr>
<tr>
<td>Sunk costs (Note 3)</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Inflation (Note 2)</td>
<td>1.9</td>
<td>1.7</td>
<td>1.7</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Forecast Outturn (excl VAT)</td>
<td>55.7</td>
<td>62.3</td>
<td>67.9</td>
<td>51.3</td>
<td>58.9</td>
</tr>
<tr>
<td>VAT</td>
<td>10.1</td>
<td>11.3</td>
<td>12.5</td>
<td>9.4</td>
<td>10.9</td>
</tr>
<tr>
<td>Forecast Outturn (incl VAT)</td>
<td>65.8</td>
<td>73.7</td>
<td>80.4</td>
<td>60.7</td>
<td>69.8</td>
</tr>
<tr>
<td>Net Present Cost (Note 4)</td>
<td>48.8</td>
<td>56.0</td>
<td>61.6</td>
<td>45.9</td>
<td>53.4</td>
</tr>
</tbody>
</table>

Notes

Note 1: 0% Optimism Bias applied to Option 7 as costs are based on current Guaranteed Maximum Price. Other options include optimism bias to reflect the initial costing basis of these options.

Note 2: Inflation at 2.5% per annum has been stripped out to reflect a real position.

Note 3: The Trust has already incurred £2.5m of costs during 2016/17 related to design fees on the project. While related to the total cost of the project, these are considered sunk and so have been removed from the economic analysis.

Note 4: Net present costs at 2.5% of the Total per Economic Model (Real).
Table 3.13: Lifecycle Costs

<table>
<thead>
<tr>
<th></th>
<th>Option 2</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
<th>Option 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do Min</td>
<td>Maghull</td>
<td>Greenfield</td>
<td>Maghull</td>
<td>Greenfield</td>
</tr>
<tr>
<td>Lifecycle Cost (Total)</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td></td>
<td>25.0</td>
<td>28.1</td>
<td>28.1</td>
<td>23.5</td>
<td>24.8</td>
</tr>
<tr>
<td>Lifecycle Cost (Net Present Cost)</td>
<td>8.3</td>
<td>9.3</td>
<td>9.3</td>
<td>7.8</td>
<td>8.2</td>
</tr>
</tbody>
</table>

**Operating Costs**

3.7.10 Operating costs have been generated on the basis of a detailed assessment of the clinical model under each option and the additional facilities management (FM) maintenance costs required as a result of additional floor space. A more detailed breakdown is provided in Appendix 3.3: Operating Costs.

3.7.11 The trust is currently providing 96 beds but based on Commissioner demand this will increase to 123 beds. The trust has modelled the impact of this movement for each option dependent on a number of assumptions as to when the relevant buildings will be complete.

3.7.12 The key dates for each option are summarised below:

**Option 2B – Do Minimum**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 April 2017</td>
<td>Start of Economic modelling</td>
</tr>
<tr>
<td>1 October 2019</td>
<td>LD building complete and occupy</td>
</tr>
<tr>
<td>1 December 2021</td>
<td>Scott refurb complete and 61 beds established</td>
</tr>
<tr>
<td>1 June 2022</td>
<td>Establishment of additional 16 bed ward (6 months after completion)</td>
</tr>
<tr>
<td>2022/23</td>
<td>First full year of 123 bed cost</td>
</tr>
</tbody>
</table>

LD costs per current (40 beds)  
MI costs per current (56 beds)

**Option 5 and Option 6 – 2 Building solution**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 April 2017</td>
<td>Start of Economic modelling</td>
</tr>
<tr>
<td>1 March 2020</td>
<td>Building complete and occupy</td>
</tr>
<tr>
<td>1 November 2020</td>
<td>Establishment of additional 16 bed ward</td>
</tr>
<tr>
<td>2021/22</td>
<td>First full year of 123 bed cost</td>
</tr>
</tbody>
</table>

LD costs per current (40 beds)  
MI costs per current (56 beds)
Option 7 and Option 8 – 1 Building solution

3.7.13 The Current Cost figures (£18.9m per annum), are based on clinical costs for 96 beds. Workforce costs would increase as further beds are occupied firstly to 107 beds and then to the 123 beds.

3.7.14 Table 3.13 sets out the costs once the full 123 beds are established for each option. The Cash Releasing benefits are those shown in table 3.3.

Table 3.14: Revenue costs

<table>
<thead>
<tr>
<th></th>
<th>Annual 2017/18 price base = 123 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Option 1</td>
</tr>
<tr>
<td></td>
<td>Do Min</td>
</tr>
<tr>
<td>123 beds</td>
<td>£m</td>
</tr>
<tr>
<td>Clinical Staff - Mental Illness</td>
<td>8.6</td>
</tr>
<tr>
<td>Clinical Staff - Learning Disabilities</td>
<td>3.8</td>
</tr>
<tr>
<td>Other Staff</td>
<td>6.1</td>
</tr>
<tr>
<td>FM Costs</td>
<td>2.6</td>
</tr>
<tr>
<td>Overheads</td>
<td>2.8</td>
</tr>
<tr>
<td>TOTAL Gross Cost @ Steady State</td>
<td>23.9</td>
</tr>
<tr>
<td>Cash Releasing Benefits</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTAL Net cost @ Steady State</td>
<td>23.9</td>
</tr>
<tr>
<td>Total NPC over evaluation period</td>
<td>620.6</td>
</tr>
</tbody>
</table>

Transitional Costs and Double Running Costs

3.7.15 The project will also require a transitional cost budget to support the non-recurring costs incurred as a consequence of moving services to the new MSU. These transitional costs include the cost of double-running services for a period of time, mandatory and statutory training of staff and costs associated with the clinical commissioning of the new facilities. The total forecast transitional costs have been estimated at £0.4m for each option, with the exception of Do Minimum which is estimated at £0.3m.

3.7.16 These transitional costs have been allowed for in the trust’s overall assessment of affordability, as demonstrated in Section 5 – the Financial Case.
Income

3.7.17 Clinical income is a transfer payment so excluded from the Economic Appraisal.

Procurement of Equipment

3.7.18 In each of the options under consideration equipment is expected to be provided by traditional capital procurement. However the VfM offered by other procurement routes will be kept under review as the project progresses and will be tested against traditional procurement.

3.7.19 The estimated cost of the provision of the equipment and furnishings for the options is £1.5m. The options that are provided by a single building and those provided via two buildings have very similar gross internal floor area (GIFA) and similar functional content. It is therefore assumed that there will be no significant differential cost of equipping and furnishing them.

Cash and Non Cash Releasing Benefits

3.7.20 Each of the benefits identified in section 3.2.4 and table 3.2 has been assessed for qualitative and quantitative impact on the project across the analysis period, for each of the options assessed. The impact of the qualitative benefits are set out within section 3.6.

3.7.21 The methodology to quantify the cash and non-cash releasing financial benefits are shown in table 3.3.

3.8 Adjustments Required by HMT

Optimism Bias

3.8.1 Optimism Bias reflects the tendency for scope change to affect capital cost between estimated capital costs and commissioning. The Mott McDonald Supplement to the Green Book has been used by Rider Hunt to generate an appropriate adjustment to the Net Present Cost of capital for each option. The calculation of the percentage adjustment to capital for each of the shortlisted options, is included in the Estates Annex.

Risk

Risk identification and measurement

3.8.2 There is always likely to be some difference between what is expected and what eventually happens, because of biases unwittingly inherent in the appraisal, and the risks and uncertainties that materialise during the design, build, and operational phases of the project.
Risk quantification

3.8.3 It is good practice to add a ‘risk premium’ to provide the full expected value of the base case and alternative options. In the early stages of an appraisal, this risk premium may be encompassed by a general uplift to a project’s NPV to offset and adjust for undue optimism. But as the appraisal proceeds, more specific risks will be identified, thus reducing the more general optimism bias.

3.8.4 The guidance identifies three main categories of risk:

- Business related risks - The risk that the organisation cannot meet its business imperatives. These risks have not been quantified;
- Service related risks - The risk that the service is not fit for purpose. These may occur in the design, build and operational phases of a project. These risks have been quantified;
- External environmental risks - The risks faced by society as a whole. These risks have not been quantified.

3.8.5 The generic types of service related risks i.e. those that are quantified, are set out in broad terms below:

Table 3.15: Risk Categories

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Design risk</td>
<td>The risk that design cannot deliver the services to the required quality standards.</td>
<td>Quantified</td>
</tr>
<tr>
<td>2</td>
<td>Planning risk</td>
<td>The risk that the implementation of a project fails to adhere to the terms of the planning permission or that detailed planning cannot be obtained; or, if obtained, can only be implemented at costs greater than in the original budget.</td>
<td>Quantified</td>
</tr>
<tr>
<td>3</td>
<td>Build risk</td>
<td>The risk that the construction of physical assets is not completed on time, to budget and to specification.</td>
<td>Quantified</td>
</tr>
<tr>
<td>4</td>
<td>Project intelligence risk</td>
<td>The risk that the quality of initial intelligence (for example, preliminary site investigation) will impact on the likelihood of unforeseen problems occurring.</td>
<td>Covered in overall construction risk</td>
</tr>
<tr>
<td>5</td>
<td>Decant risk</td>
<td>The risk arising in accommodation projects relating to the need to decant staff/clients from one site to another.</td>
<td>Quantified</td>
</tr>
<tr>
<td>6</td>
<td>Environmental risk</td>
<td>The risk that the nature of the project has a major impact on its adjacent area and there is a strong likelihood of objection from the general public.</td>
<td>Covered in overall construction risk</td>
</tr>
<tr>
<td>Ref</td>
<td>Risk</td>
<td>Description</td>
<td>Comments</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Procurement risk</td>
<td>The risk that can arise from the contractual arrangements between two parties – for example, the capabilities of the contractor when a dispute occurs.</td>
<td>Covered in overall construction risk</td>
</tr>
<tr>
<td>8</td>
<td>Operational risk</td>
<td>The risk that operating costs vary from budget and that performance standards slip or that a service cannot be provided.</td>
<td>Quantified</td>
</tr>
<tr>
<td>9</td>
<td>Availability &amp; performance risk</td>
<td>The risk that the quantum of service provided is less than that required under the contract.</td>
<td>Not applicable – no service contract included</td>
</tr>
<tr>
<td>10</td>
<td>Demand risk</td>
<td>The risk that the demand for a service does not match the levels planned, projected or assumed.</td>
<td>Quantified – but not included for VfM calculation – clinical income is a transfer payment and therefore excluded.</td>
</tr>
<tr>
<td>11</td>
<td>Volume risk</td>
<td>The risk that actual usage of the service varies from the levels forecast.</td>
<td>Not applicable – no service contract included</td>
</tr>
<tr>
<td>12</td>
<td>Occupancy risk</td>
<td>The risk that a property will remain untenanted – a form of demand risk.</td>
<td>Covered in risk 10 – demand risk</td>
</tr>
<tr>
<td>13</td>
<td>Maintenance risk</td>
<td>The risk that the costs of keeping the assets in good condition vary from budget.</td>
<td>Quantified</td>
</tr>
<tr>
<td>14</td>
<td>Technology risk</td>
<td>The risk that changes in technology result in services being provided using sub-optimal technical solutions.</td>
<td>Quantified</td>
</tr>
<tr>
<td>15</td>
<td>Funding risk</td>
<td>The risk that the availability of funding leads to delays and reductions in scope as a result of reduced monies.</td>
<td>Quantified – but not included for VfM calculation – clinical income is a transfer payment and therefore excluded.</td>
</tr>
<tr>
<td>16</td>
<td>Residual value risk</td>
<td>The risk relating to the uncertainty of the values of physical assets at the end of the contract period.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Methodology**

3.8.6 A quantitative appraisal of options was undertaken in a facilitated workshop held on 13th June 2016. The workshop involved the following participants:

**Table 3.16: Risk Workshop attendees**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alison Jordan</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Deputy Director of Estates</td>
</tr>
<tr>
<td>2</td>
<td>Elaine Wilkinson</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Strategic Project Manager</td>
</tr>
<tr>
<td>3</td>
<td>Dr Frank McGuire</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>Consultant Clinical Psychologist</td>
</tr>
</tbody>
</table>
3.8.7 Each of the quantifiable risks was discussed with the workshop participants and the exact meaning for each risk agreed following a robust debate.

3.8.9 The trust decided that the most appropriate methodology to apply to the quantification was a multi-point probability analysis i.e. for each risk, a range of possible outcomes was estimated. An output probability distribution provides a more complete picture of the possible outcomes and recognises that some of these outcomes are more likely to occur than others. The ‘expected outcome’ is the average of all possible outcomes, taking into account their different probabilities.

3.8.10 For each risk and for each option the group then discussed and agreed on the following parameters:

- the appropriate cost driver (e.g. cost of FM services, or cost of decanting the services);
- the likely impact if a risk occurs - low, medium, high (e.g. +10%, +2%, -2% of cost driver);
- the likelihood of occurrence – low, medium, high (total 100%);
- the years for which the risk could occur and therefore for which it should be quantified.

3.8.11 The group set out the key considerations and rationale that led to the particular values chosen for the above parameters for each risk, and for the relative differences in the scoring for the different options. These justifications were captured in a detailed risk register Appendix 3.4: Risks for Options Appraisal
Net Present Cost of Risk

3.8.12 The outcome of the risk quantification is summarised in the table below:

**Table 3.17: Risk Summary**

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
<th>Option 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do Min</td>
<td>Maghull</td>
<td>Greenfield</td>
<td>Maghull</td>
<td>Greenfield</td>
</tr>
<tr>
<td></td>
<td>123 beds</td>
<td>2 buildings</td>
<td>1 building</td>
<td>123 beds</td>
<td>123 beds</td>
</tr>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Design</td>
<td>1.8</td>
<td>2.0</td>
<td>2.0</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Planning</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Construction</td>
<td>0.8</td>
<td>1.0</td>
<td>1.0</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Construction Risk</strong></td>
<td><strong>2.6</strong></td>
<td><strong>3.0</strong></td>
<td><strong>3.0</strong></td>
<td><strong>2.6</strong></td>
<td><strong>2.6</strong></td>
</tr>
<tr>
<td>Operational</td>
<td>1.4</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Demand</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Maintainance</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Funding</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Operational Risk</strong></td>
<td><strong>1.5</strong></td>
<td><strong>1.3</strong></td>
<td><strong>1.3</strong></td>
<td><strong>1.3</strong></td>
<td><strong>1.3</strong></td>
</tr>
<tr>
<td><strong>TOTAL Risks</strong></td>
<td>4.2</td>
<td>4.3</td>
<td>4.3</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Net Present Cost</strong></td>
<td><strong>2.5</strong></td>
<td><strong>2.9</strong></td>
<td><strong>2.9</strong></td>
<td><strong>2.5</strong></td>
<td><strong>2.5</strong></td>
</tr>
</tbody>
</table>

3.8.13 In general the risks are considered similar across the options with the differential of less than £0.5m net present cost across the options.

3.8.14 Where differences have been noted these mainly relate to the view that a 2 building solution would create more risks as compared to a single building solution.

3.8.15 The Net Present Costs for each of the options have been adjusted for the risk values in the table above.

**Risk appraisal unquantifiable**

3.8.16 The trust has robust risk management systems in place which are set out as part of the Management Case, paragraph 6.11.

**3.9 Results of Quantitative Analysis**

3.9.1 The costs and income related to the options have been evaluated using the HMT rules. The HMT test shows the Net Present Cost of the total costs of the option discounted over the analysis period required by the Treasury. The analysis period is the development period plus the estimated life of the assets; this is assumed to be 65 years. This test is undertaken at the HMT cost of capital which is 3.5% (first 30 years) and 3.0% (31 years to 65 years).
3.9.2 The VfM calculation has been performed using the DH Capital Investment Appraisal Model (CIAM). The outcome of which is shown in Table 3.18 below.

**Table 3.18: Quantitative Analysis Summary**

<table>
<thead>
<tr>
<th>Option</th>
<th>Do Min</th>
<th>Maghull</th>
<th>Greenfield</th>
<th>Maghull</th>
<th>Greenfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Opportunity Cost</td>
<td>3.8</td>
<td>1.3</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Capital Cost</td>
<td>48.8</td>
<td>56.0</td>
<td>61.6</td>
<td>45.9</td>
<td>53.4</td>
</tr>
<tr>
<td>Lifecycle Cost</td>
<td>8.3</td>
<td>9.3</td>
<td>9.3</td>
<td>7.8</td>
<td>8.2</td>
</tr>
<tr>
<td>Revenue Cost</td>
<td>620.6</td>
<td>555.5</td>
<td>555.5</td>
<td>552.1</td>
<td>550.3</td>
</tr>
<tr>
<td>Transitional Costs</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Risk</td>
<td>2.5</td>
<td>2.9</td>
<td>2.9</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Risk Adjusted Net Present Cost (NPC)</strong></td>
<td><strong>684.3</strong></td>
<td><strong>625.4</strong></td>
<td><strong>629.7</strong></td>
<td><strong>610.0</strong></td>
<td><strong>614.8</strong></td>
</tr>
<tr>
<td>CR Benefits</td>
<td>0.0</td>
<td>10.1</td>
<td>10.1</td>
<td>15.0</td>
<td>13.2</td>
</tr>
<tr>
<td>Non-CR Benefits</td>
<td>0.0</td>
<td>8.7</td>
<td>7.7</td>
<td>16.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Societal Benefits</td>
<td>0.0</td>
<td>2.9</td>
<td>2.9</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>TOTAL BENEFITS</strong></td>
<td><strong>0.0</strong></td>
<td><strong>21.7</strong></td>
<td><strong>20.8</strong></td>
<td><strong>35.6</strong></td>
<td><strong>30.2</strong></td>
</tr>
<tr>
<td><strong>Net Present Value (NPV)</strong></td>
<td><strong>-684.3</strong></td>
<td><strong>-603.7</strong></td>
<td><strong>-608.9</strong></td>
<td><strong>-574.4</strong></td>
<td><strong>-584.6</strong></td>
</tr>
<tr>
<td>Rank</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

3.9.3 The option with the lowest risk adjusted net present cost is Option 7 – Single building at Maghull. The second lowest option is Option 8 – Single building at a Greenfield site.

3.9.4 The two 123 bed “single building” options – Options 7 and 8 – are similar in terms of NPC, but the single building on the Maghull site has the lowest overall cost. The revenue costs for the options are similar, as the building would be practically the same for each, and would therefore offer the same benefits and workforce efficiencies. The greenfield site bears the cost of land purchase (£5.0m) and due to less certainty around costing optimism bias has been applied, whereas the Maghull option is adjusted for the opportunity cost of potential land disposals which would be foregone (£1.3m).

3.9.5 The Do Minimum option has a much higher revenue cost implication due to the inefficiencies of the 2 building solution and the refurbished Scott Clinic. This is further demonstrated in the Value for Money section 3.11 below.

**3.10 Benefits Appraisal**

3.10.1 The trust has developed a detailed Benefits Plan [Appendix 6.4: Benefits Plan](#) which sets out the benefits to patients, to the trust workforce, to clinical outcomes and to the physical environment.

3.10.2 The benefits have not been quantified for the economic appraisal, however they have been considered in arriving at the qualitative scoring set out in Section 3.6.
In order to combine the quantitative and qualitative scoring the following methodology has been used.

3.10.3 The Net Present Cost (quantitative analysis) for each option has been combined with the qualitative scoring against the selection criteria to provide a comparator of Net Present Cost per quality point. This assumes a linear relationship between cost and quality which is not always the case (for example, the Government would not pay an infinite amount for infinite quality) but is a fair indicator if options are not over specified against the requirement.

Table 3.19: Quantitative Analysis Summary

<table>
<thead>
<tr>
<th>Option</th>
<th>Do Min</th>
<th>Maghull</th>
<th>Greenfield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>123</td>
<td>123</td>
<td>123</td>
</tr>
<tr>
<td>£m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Present Value (NPV) of all cash flows</td>
<td>-684.3</td>
<td>-603.7</td>
<td>-608.9</td>
</tr>
<tr>
<td>Qualitative Score (weighted)</td>
<td>10.9</td>
<td>15.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Net Present Value per Quality Point</td>
<td>-62.8</td>
<td>-40.2</td>
<td>-52.5</td>
</tr>
<tr>
<td>Rank</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

3.10.4 The conclusion of this analysis is that the single building option at Maghull (Option 7) is the best value for money on a combined benefits and cost analysis. It is the preferred option both from a Qualitative and Quantitative assessment.

3.11 Value For Money Analysis

3.11.1 The economic analysis undertaken through the Capital Investment Appraisal model demonstrates the net present value of each of the options as outlined in table 3.18 above.

3.11.2 In order to demonstrate Value for Money it is necessary to complete additional analysis comparing the net present value of each of the future options, with the net present value of the current cost of the service.

3.11.3 The current cost of the service takes into account the costs of 96 beds provided at Scott Clinic, and Whalley, plus the additional costs of out of area beds which are an external cost to the scheme as these are currently funded separately by NHS England.

3.11.4 The analysis below takes into account the marginal costs and benefits of each of the options to arrive at a risk adjusted Value for Money ratio. It can be seen that Option 7 provides the greatest Value for Money of all the options.
### Table 3.20: Marginal Cost Benefit Analysis

<table>
<thead>
<tr>
<th></th>
<th>Current Costs</th>
<th>Option 1</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
<th>Option 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>123 beds</td>
<td>Do Min</td>
<td>Maghull 2</td>
<td>Greenfield 2</td>
<td>Maghull 1</td>
<td>Greenfield 1</td>
</tr>
<tr>
<td><strong>TOTAL COSTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Trans ional</td>
<td>-</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Externality</td>
<td>165.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue costs</td>
<td>500.7</td>
<td>620.6</td>
<td>555.5</td>
<td>555.5</td>
<td>552.1</td>
<td>550.3</td>
</tr>
<tr>
<td><strong>MARGINAL COSTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>53.3</td>
<td>61.6</td>
<td>67.1</td>
<td>50.0</td>
<td>57.8</td>
</tr>
<tr>
<td>Marginal costs - transitional</td>
<td>-</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Marginal costs - externality</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Marginal costs - revenue</td>
<td>-</td>
<td>120.0</td>
<td>64.9</td>
<td>64.9</td>
<td>66.4</td>
<td>62.9</td>
</tr>
<tr>
<td>Opportunity costs</td>
<td>-</td>
<td>3.8</td>
<td>1.3</td>
<td>-</td>
<td>1.3</td>
<td>-</td>
</tr>
<tr>
<td>Total marginal costs</td>
<td>-</td>
<td>173.6</td>
<td>126.9</td>
<td>132.5</td>
<td>116.7</td>
<td>121.1</td>
</tr>
<tr>
<td><strong>MARGINAL BENEFITS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Societal benefits</td>
<td>-</td>
<td>-</td>
<td>2.9</td>
<td>2.9</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Non-cash releasing benefits</td>
<td>-</td>
<td>-</td>
<td>8.7</td>
<td>7.7</td>
<td>16.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Cash releasing benefits/marginal savings - externality</td>
<td>-</td>
<td>165.6</td>
<td>165.6</td>
<td>165.6</td>
<td>165.6</td>
<td>165.6</td>
</tr>
<tr>
<td>Cash releasing benefits/marginal savings - revenue</td>
<td>-</td>
<td>-</td>
<td>10.1</td>
<td>10.1</td>
<td>15.0</td>
<td>13.2</td>
</tr>
<tr>
<td>Total marginal benefits</td>
<td>-</td>
<td>165.6</td>
<td>187.2</td>
<td>186.3</td>
<td>201.1</td>
<td>195.7</td>
</tr>
<tr>
<td><strong>NPV</strong> = total marginal benefits - total marginal costs</td>
<td>-</td>
<td>-</td>
<td>8.0</td>
<td>60.3</td>
<td>53.8</td>
<td>84.4</td>
</tr>
<tr>
<td>Risk</td>
<td>-</td>
<td>2.5</td>
<td>2.9</td>
<td>2.9</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Risk Adjusted NPV</td>
<td>-</td>
<td>10.5</td>
<td>57.5</td>
<td>51.0</td>
<td>82.0</td>
<td>72.1</td>
</tr>
<tr>
<td><strong>VFM ratio</strong> = (total marginal benefits) ÷ (total marginal costs)</td>
<td>-</td>
<td>1.0</td>
<td>1.5</td>
<td>1.4</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Risk Adjusted VFM ratio = (total marginal benefits) ÷ (total marginal costs + risk)</td>
<td>-</td>
<td>0.9</td>
<td>1.4</td>
<td>1.4</td>
<td>1.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

### 3.12 Sensitivity Analysis

3.12.1 Sensitivity tests have been considered in relation to the Land Purchase cost assumptions and the Opportunity cost assumptions as these are considered the key areas of potential variance and differentiators between the options.
3.12.2 The trust has received a GMP for Option 7 and therefore no further movement in the capital cost is expected unless the trust seeks to achieve further cost reductions and therefore a sensitivity relating to movements on capital costs has not been undertaken.

**Sensitivity Test 1: Changes in Land Purchase Costs assumptions**

3.12.3 Land purchase costs apply to some options (Options 6 and 8 – the Greenfield site options) but not others and therefore represent a differentiator in establishing the best VfM option.

3.12.4 The cost of the land purchase would have to be reduced by 50% to make Option 7 more expensive than Option 8. Option 7 would still score higher on a cost per quality point basis.

3.12.5 It is considered to be unlikely that the land values would fall to this level.

**Sensitivity Test 2: Changes in Opportunity Costs assumptions**

3.12.6 Opportunity costs apply to some of the options but not others so are again considered a differentiator in establishing the best value option.

3.12.7 A professional valuation of the Maghull site indicates a value of £1.4m. Sensitivity analysis indicates that this valuation would need to rise to £8.4m to result in a comparable NPV with Option 8. An increase of land value from £1.4m to £8.4m is considered unrealistic.

3.13 Preferred Option

3.13.1 The combination of the above analyses shows that the best overall option is Option 7, the development of a 123 bed unit, housed in a single building, on the Maghull site.

3.13.2 This option scores best on the combined benefits and cost analysis. It has the advantage that the completion of the construction phase is earlier than the options on a Greenfield site or the Do Minimum option, allowing the early delivery of the quality benefits. The preferred option not only delivers on all the CSF and Investment Objectives but also addresses all the requirements of the Strategic Case for change.

3.13.3 The preferred option has been selected on the basis of the combination of its economic impact and its ability to achieve Mersey Care’s Investment Objectives. The trust recognises that the output developed using the Net Present Cost per Quality point algorithm is consistent with a high-level evaluation of the factors involved in the decision-making process.

3.13.4 The preferred option, Option 7, provides a Value for Money ratio of 1.7, with £116.7m marginal costs, compared to £201.1m marginal benefits achieved.

3.13.5 Sensitivity analysis demonstrates that significant changes in capital cost elements would be required to change the overall ranking of the options, when considered in line with other elements and that the highest ranked option is not sensitive to reasonable changes in cost assumptions or benefits scores.
3.13.6 The case for the preferred option is further strengthened by consideration of additional health benefits it would bring compared to the other shortlisted options. Benefits realisation has been considered as part of the Management Case at Section 6 of this OBC.

3.13.7 The development of the new 123 bedded MSU will:

- resolve current limitations in service delivery associated with the physical configuration and environment of at Scott Clinic;
- create a modern therapeutic model of care allowing areas for personal space and opportunities to use the latest technological innovations to assist in the care of individuals;
- allow improved training and opportunities for nursing staff to work across the spectrum of care whilst retaining clinical specialisation;
- bring opportunities for sharing best practise in the care of people requiring medium secure facilities;
- allow the organisation to share planning, patient management and back office support;
- address the national policies of changing the manner of care provided to people with learning disabilities and or autism who require inpatient care as set out in NHSE’s policy on 'Transforming Care for People with Learning Disabilities and or Autism – Next Steps';
- deliver on Simon Stevens’ requirement for the closure of Calderstones’ Whalley site as Commissioners state they will not be purchasing services from the Whalley site after 2018.
4. Commercial Case

4.1 Introduction

4.1.1. This section outlines the proposed procurement route and contractual arrangements associated with the preferred option. It further provides an explanation of how the commercial elements of the project have developed.

4.1.2. The project brief is to build a state of the art MSU facility from which Mersey Care can deliver modern and innovative medium secure services ensuring that care is delivered as close to home and in as timely a way as possible. The new unit will be built on an existing trust site at Maghull to enable co-location with High Secure Services which are delivered from Ashworth Hospital.

4.1.3. The unit has been designed to accommodate 123 beds across eight wards. These are made up of specialist wards for service users with mental illness and learning disabilities, the unit will offer services to male and female service users in single sex ward environments providing 100% single rooms with en-suite facilities.

4.1.4. Offering an innovative design solution, the unit will create a therapeutic and healing environment to support high quality care, treatment and recovery. This will contribute to a range of positive service user outcomes: including improved levels of recovery, a reduction in the risk of offending or re-offending and serious harm, and reduced lengths of stay. The unit will be sufficiently flexible to enable a rapid respond to any changing needs in the model of care or service delivery in the future.

4.1.5. The procurement will be for capital works only. The project will be delivered under a Principal Supply Chain Partner under the 'Procure21+ National Framework Agreement' using an NEC3 (ECC Option C) contract.

4.2 Procurement Route

4.2.1. Mersey Care considered the different procurement routes available for the capital development of the MSU with a summary of the considerations set out in the table below:
<table>
<thead>
<tr>
<th>Option</th>
<th>Benefits</th>
<th>Disadvantages</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional competitive tendering, standard form of building contract (NEC or JCT)</td>
<td>The trust retains control over design and quality. Good price certainty. Easier to accommodate trust changes. Value for money through competitive procurement. Could be open book (NEC Option C target cost and activity schedule).</td>
<td>Significant design risk remains with the trust. This route has a poor track record of delivering projects on time and within budget. A risk of claims if design information is not issued in time by the design team. Time consuming as a full set of documents/design is to be produced before the works can be tendered and then the Official Journal European Union (OJEU) tendering process takes additional time, although time spent during the tender process should be seen as an investment.</td>
<td>Discarded due to trust retention of risk and potential for programme and cost over-run.</td>
</tr>
<tr>
<td>Detailed design and Construct</td>
<td>Trust retains some control over the design (to the point of novation) as the design team can be novated to the contractor. Value for money to an extent (1st stage) through competitive procurement.</td>
<td>The OJEU process applies although time spent during the tender process should be seen as an investment. The contractor may price the risks involved and therefore the employer could be paying a premium for risk transfer. Value for money of final costs.</td>
<td>Discarded due to length of time to complete procurement process.</td>
</tr>
<tr>
<td>Conventional Design &amp; Build Contracting</td>
<td>Risks are transferred to the contractor. Faster than traditional competitive tendering. A single point of responsibility for design. Much of the detailed design work can be carried out in parallel with the construction thus a start on site can be achieved quickly. Better cost certainty than traditional. Value for money through competitive procurement.</td>
<td>The OJEU process applies although time spent during the tender process should be seen as an investment. The trust lacks control over detail. The trust QS has little negotiating room with respect to changes. The contractor may price the risks involved and therefore the employer could be paying a premium for risk transfer.</td>
<td>Discarded due to trust losing control of design.</td>
</tr>
<tr>
<td>Option</td>
<td>Benefits</td>
<td>Disadvantages</td>
<td>Conclusion</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Measured term Contract</td>
<td>Speed once contract in place.</td>
<td>Could tender without design. Design and unknown work item risks would remain with the trust. Quantum risk remains with the trust. Not suited to larger contracts and infrastructure works as unknown work items would not be priced.</td>
<td>Discarded due to risk of cost increase if works rates and quantum are unknown.</td>
</tr>
<tr>
<td>The trust appoints a contractor purely on the basis of rates for identified building elements / items following a competitive procurement</td>
<td>Value for money on rates through competitive procurement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management Contracting</td>
<td>Suited to large, complex and fast moving projects where early completion is desirable. Integration between design and construction is achieved as the Management Contractor is involved during the design phase. Much of the detailed design work can be carried out in parallel with the construction thus a start on site can be achieved quickly. Value for money through competitive procurement.</td>
<td>The OJEU process applies although time spent during the tender process should be seen as an investment. Cost certainty will not be achieved until late in the project. Risk lies mainly with the trust. The trust will require considerable in house expertise and resources to undertake the high degree of involvement needed. The trust lacks control over detail. Multiple packages not suited to refurbishment due to clashes between work packages – trust retains risk.</td>
<td>Discarded due to lack of cost certainty, trust retention of risk and the considerable in-house input required by the trust</td>
</tr>
<tr>
<td>The trust appoints and manages the design team. A Management Contractor is incorporated into the team to procure and manage the construction works packages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procure21+</td>
<td>The PSCP which includes a full design team and contractor are already preselected through OJEU selection therefore the procurement time and input is minimised. Cost certainty based on Guaranteed Maximum Price partly due to the early involvement of the supply chain. The PSCP would hold the majority of the project risks. Time savings are achievable due to robust planning in the early stages.</td>
<td>Benchmarking is recommended to verify price competitiveness in the absence of a competitive tender. Build quality may suffer to achieve the GMP in the event of an affordability issue. Contractor – led design may affect functionality.</td>
<td>Shortlisted option due to the reduced procurement time scales and cost certainty.</td>
</tr>
</tbody>
</table>
### Option Benefits Disadvantages Conclusion

**Private Finance Initiative (PFI)**

Trust undertakes a competitive procurement process to select a private sector partner to deliver the construction and provide associated Hard FM services and lifecycle.

- Significant risk transfer from trust to private sector.
- Long term managed solution for estate.

- Length of time to complete procurement process is longer than other options.
- Loss of control of FM provision

Discarded due to timescales for delivery of project and the size which may have impacted the market interest option.

**Local Improvement Finance Trust (LIFT)**

Trust utilises the LIFT to deliver a managed solution similar to PFI above.

- Significant risk transfer from trust to private sector.
- Long term managed solution for estate

- Length of time to complete procurement process is longer than other options.
- Cost of finance

Shortlisted due to trust experience of use on other projects.

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4.2.2. In November 2013 the Trust Board, following a comparison of the shortlisted procurement routes in the table above, agreed to proceed with a Procure21+ solution for the scheme. The Board considered that the project is commercially feasible and deliverable. These decisions were based on a number of factors, the main three reasons being:

- Speed to site
- Cost of finance
- Funding availability

4.2.3. Mersey Care has selected the standard P21+ contract documentation. The P21+ selection process was run fully in line with the P21+ guidance and was fully monitored by the Department of Health’s Implementation Advisor along with senior trust level involvement.

4.2.4. Following a competitive process Rider Hunt were appointed and contracted under the Scape Framework. Working in collaboration with the Department of Health P21+ advisor and Rider Hunt, Mersey Care undertook a robust tender process resulting in the shortlisting of three suppliers. The assessments for each of the shortlisted suppliers are attached at **Appendix 4.1a: Tender Process**. Following interview the selection of the Principal Supply Chain Partner (PSCP) to develop
the scheme was completed and in line with P21+ rules Kier was appointed for Stage 2 OBC on the 3rd February 2014. Given that the procurement route is identified at P21+ there is no requirement for an OJEC notice to be issued.

4.2.5. The original brief provided to Kier was based on the provision of a 90 bed MSU with future proofing to 120 beds. Considerable design work was undertaken and fees expended on this level of scheme. Following the acquisition of Calderstones by Mersey Care, the project brief was expanded to 123 beds to incorporate the additional learning disability beds. The trust sought advice from P21+ representatives at the Department of Health in relation to the potential need to re-tender for a PSCP given the changes to the original brief. Following consideration approval was given for Kier to retain the contract and to retain the procurement route of P21+. The main drivers for this decision was the resultant increase in timescales to the programme, extensive additional costs, a loss of knowledge of the scheme and the design development should an alternative procurement route be selected.

4.2.6. P21+ is the recommended procurement method for publicly funded NHS capital projects and is the “default” procurement option for NHS trusts. This procurement route provides NHS clients with the ability to appoint approved PSCPs, and their supply chain of designers and sub-contractors, using an agreed commercial arrangement. Trusts and their PSCP supply chain work collaboratively to develop the scheme using the framework processes and tools, which have been shown to deliver quality schemes on time and budget.

4.2.7. P21+ offers a ready-made selection of experienced health-focused contractors, delivers rapid mobilisation of the team, achieves a quick start on site, significantly reduces the risk to trusts and the trusts have protections if things do not go to plan.

4.2.8. Value for money is achieved through the usual P21+ mechanisms including competitive tendering of sub-contract packages and cost certainty is obtained once the Guaranteed Maximum Price (GMP) is agreed. The key advantages to this trust of using the P21+ framework are:

- Speedy selection process which does not involve OJEU. This allows rapid mobilisation, early contractor involvement and input to the business cases, along with a reduced pre-construction period;
- A GMP will be agreed between the trust and the PSCP, which will only be adjusted if the trust issues a post-contract variation;
- There is an agreed mechanism for any changes to the client brief and a process for agreeing any cost and programme implications in a non-adversarial environment;
- The trust passes design responsibility to the PSCP at an early stage and then works with them and their designers to develop the design, business case and GMP;
- The framework is commercially lean and rigorously managed;
- Value is generated by market testing the sub-contract packages (generally, at least 90% of the GMP to be competitively tendered);
- The PSCPs have agreed margins and hourly rates for designers and PSCP staff;
The trust has the comfort of working within a framework endorsed by Department of Health and Office of Government and Commerce (OGC), the support of the P21+ Unit, and the benefit of lessons learnt from other schemes;

The PSCPs and their supply-chains are all health experts with extensive experience of delivering similar schemes, and bring experience, learning, and innovation.

Value for Money from the P21+ Contract

4.2.9. The P21+ contract between Mersey Care and Kier will deliver value for money for the trust’s investment via the usual P21+ mechanisms. In the current tendering climate, the agreed contract price (GMP) is commensurate with a lump sum tender price if the scheme were tendered to the open market; and P21+ will deliver a much closer final outturn cost, with far less risk to the trust. Value for money is achieved through the P21+ contract by:

- Market testing/ competitive tendering of contract works packages;
- Using pre-tendered rates, which were obtained at the bottom of the market;
- Allocation of risk on a best value basis;
- One point of responsibility for design and construction;
- Reduced pre-contract time period, and the benefit of early contractor involvement;
- Fully open book and partnering approach, which reduces the risk of dispute and litigation;
- Agreement of a GMP prior to the trust committing to commencing construction;
- An agreed post-contract process for change.

4.2.10 As the project will be delivered as a P21+ National Framework Agreement the trust will follow an agreed approach for project management and there is no intention to derogate from the standard contract documentation.

4.2.11 The level of special advisors is kept to a minimum with appointments to provide project management, cost consultancy and construction design and management support. These costs are included within the capital costs set out in the Financial Case.

4.2.12 Specialist legal or financial advisor support is provided from the Department of Health P21+ team. However, there may be occasions when external opinion is favoured and in these cases the trust will seek advice from its current advisors.

4.2.13 To ensure value for money an independent review of the mechanical and engineering (M&E) specification has been undertaken from an independent M&E engineer.

4.3. Appointment of P21+ Partner

4.3.1. The diagram below shows the process used with P21+ from appointment through to completion of the unit:
Stage 1 Initial Appointment of Kier

4.3.2. Mersey Care undertook a selection process following the standard selection tool for P21+ contracts. Kier was selected ahead of two other companies, Integrated Health Projects and Balfour Beatty Group, scoring higher in all categories:-

- strength of team/leader;
- delivery confidence;
- care quality and productivity;
- cost management;
- and innovation;
- sharing information.

4.3.3. In February 2014 Kier was issued with a Letter of Appointment. The letter covered Kier’s initial period of activity prior to agreeing the Stage 2 contract and specified the total value of the scheme, the approximate end date, a description of the works, and a high-level programme for delivery of the scheme.

4.3.4. Preparatory work was undertaken by Kier to establish the scope, resources and programme to support the P21+ entry form of proposal for the project for Stage 2.
This included detailed reviews of the proposed resource to complete the design and costing work up to commencement of Stage 3.

4.3.5. A copy of the Letter of Appointment is included in Appendix 4.1b: Kier’s Offer of Appointment Letter and Appendix 4.1c: Kier’s Acceptance Letter.

Stage 2 Contract

4.3.6. Once the initial work was completed, Mersey Care entered into the P21+ Stage 2 Form of Agreement in April 2014 which authorised Kier to progress the development of the design and costs up to the OBC. This contract covered the period from Kier’s appointment in February through to the completion and approval of the OBC by the Board of Directors in December 2014. Kier’s services for Stage 2 include but are not limited to:

- Assist the Project Manager to update the Scheme brief;
- Update of the Employer’s affordability review;
- Review the Employer’s life cycle cost exercise;
- Develop design/option studies;
- Produce design to level required for Outline Business Case presentation to the NHS Client;
- If instructed prepare and submit a detailed Planning Permission Application (agreed in Stage 3);
- Review the equipment strategy;
- Update the environmental assessment using BREEAM for Healthcare;
- Update the design quality review, e.g. using AEDET (Achieving Excellence Design Quality Evolution Toolkit);
- Participate in the Scheme risk and value management process;
- Undertake financial analysis including Optimism Bias;
- Prepare strategic Scheme contract documents for Stage 3 entry;
- Enact enabling works where identified in the scope of the works or instructed by the Project Manager;
- Participate in Stakeholder review workshops;
- Review Procurement Strategy;
- Provision of Risk Manager/Facilitator to assist the Project Manager in administration of the P21+ Risk process;
- Undertake User Engagement and Workshops;
- Site Surveys.

4.3.7. The form of contract for all P21+ schemes is an amended version of the NEC3 Option C: Target Contract with Activity Schedule. The trust has used this standard form of contract for the agreement with Kier, supported by project-specific information (works information, site information, Priced Activity Schedule, target programme etc.).

4.3.8. Under the Stage 2 contract, Mersey Care funds for work undertaken by Kier against the agreed Priced Activity Schedule, using pre-agreed rates. These rates have been market tested by the Department of Health as part of Kier’s tender
return for the P21+ framework and reflect the competitive market conditions at the time of tender.

**Stage 3 Contract**

4.3.9. In May 2016, Kier were instructed to proceed with the initial work on the new MSU scheme, for an agreed upper limit of £164,456.51 excluding VAT. These works are aligned to the design and pre-contract work and include tree felling and service diversion works. It should be noted that these works are not “project specific” however, more the clearing of the site for future development.

4.3.10 On 28 July 2016 Mersey Care signed the formal Stage 3 agreement with Kier authorising the remaining FBC stage work, including further detailed design work, submitting the full planning application and developing the costs to a GMP stage to be undertaken.

4.3.11 It is important to note that the trust is only committed to Kier for the work undertaken to date up to the point when the Stage 4 (GMP) agreement has been signed.

4.3.12 Timescales for completion of design elements are as follows:
- The 1:200 layouts signed off on 15th June 2016;
- RIBA Stage 2 design was completed in July 2016;
- The GMP design was completed on 31 March 2017 (RIBA Stage 3);
- RIBA Stage 4 design is estimated to be complete December 2017

4.3.13 Design details are contained in the Estates Annexe, **Appendix 4.2: Estates Annexe**. Please note that Kier are currently finalising their full Stage 4 design submission which will take this design to a full pre-construction stage by April 2017.

**Stage 4 Contract and Guaranteed Maximum Price (GMP)**

4.3.14 Once the FBC is approved and the GMP has been agreed, Mersey Care will enter into a Stage 4 Agreement with Kier authorising the complete final design and construction of all the works being completed under the P21+ contract. The GMP or ‘target price’ in the NEC3 Contract, is the agreed maximum outturn cost between the trust and Kier for all Kier’s costs, including Stage 4 construction works and all design work, based on the defined scope of work at the time the GMP is agreed.

4.3.15 The GMP is the most accurate forecast of outturn cost based on the information available to the team, together with joint assessment and agreed allocation of risk. The GMP has been developed in collaboration between the trust and Kier through the project development stages and will be signed into the Stage 4 Contract prior to construction commencing. The process is completely transparent, conforms to ‘open book’ principles and contains safeguards to ensure governance and value for money for the NHS client.
4.3.16 Mersey Care acknowledges that the GMP is only ‘guaranteed’ and ‘maximum’ for the defined scope of work at the time of the GMP agreement and includes no client direct costs or risks (these reside above the GMP agreement and are managed by the trust). If the scope of work is subsequently altered or a client risk comes to fruition then the GMP will be changed accordingly via the NEC3 compensation event process (either positively or negatively).

4.3.17 The Stage 4 Agreement will use the standard P21+ Form of Agreement, complemented by a full set of project specific information and the agreed GMP.

4.3.18 Following extensive negotiation, the trust and Kier have agreed a GMP of £46.922m for the capital works.

**Actual Cost**

4.3.19 The P21+ Form of Agreement specifies that Mersey Care reimburses Kier on an actual cost basis for all of their works completed on the project. This cost is calculated based on actual cost incurred by Kier, work done against the pre-agreed Bid Return Document (BRD) rates (as provided when Kier tendered for the framework), and staff rates. These rates have been market tested by the Department of Health as part of Kier’s tender return for the P21+ framework, and reflect the competitive market conditions at the time of tender.

4.3.20 The final outturn cost (i.e. total actual cost paid by the trust to Kier) cannot ever exceed the agreed GMP (adjusted for any trust-led variations).

**Gainshare**

4.3.21 The P21+ framework agreement incentivises Kier to make on-going efficiencies through the later design and construction phases, by providing them with a share of any savings achieved (a “gainshare”), in line with the contractually agreed process.

4.3.22 The Stage 4 contract between the trust and Kier will therefore specify that if the final outturn cost is below the agreed GMP then the savings will be shared between the trust and Kier on a 50/50 basis (up to a maximum of 5%).

4.3.23 Any additional savings which are made below 95% of the GMP will also be retained 100% by the trust.

4.3.24 If on completion of the project, the outturn cost is higher than the agreed GMP (adjusted for any trust changes), then 100% of the additional cost is payable by Kier, hence why it is a GMP and the trust will not pay more than the agreed GMP.

4.3.25 To be a legitimate gainshare, it must be as the result of more efficient methods of construction or alternative materials or designs that do not affect the quality or functionality of the completed project. A gainshare must not result from setting the GMP too high. Equally, further market testing of works packages after the agreement of the GMP without any changes to the design or specification will cause 100% of the savings to be returned to the trust as provided for by P21+. 
Open Book Accounting

4.3.26 P21+ requires the contract to be agreed and administered on an ‘open book’ basis. The trust and its external advisors (Rider Hunt as Cost Advisor) and Kier have therefore agreed to adhere to this throughout the life of the project.

4.3.27 All PSCPs and their supply chains have signed up with the Department of Health to total disclosure of information, cost and processes.

Design Responsibility

4.3.28 All design responsibility was passed to Kier at the point of their appointment in February 2014. Kier and their supply chain are therefore fully responsible for carrying out all design requirements to meet the trust’s brief. Strategic Healthcare Planning has been commissioned by Kier and worked in collaboration with both Kier and the trust around the Schedule of Accommodation and the legal requirements. Throughout the design process Kier, IBI and Strategic Healthcare Planning have sought guidance from the following documents:-

- Environmental Design Guide: Adult Medium Secure Units
- Health Building Note 03-01: Adult Acute Mental Health Units
- Health Building Note 00-09: Infection Control in the Built Environment (as appropriate to mental health)
- General Suite of Health Technical memoranda for Healthcare Buildings

4.4 Potential for Risk Transfer

4.4.1. The general principle is that risks are passed to ‘the party best able to manage them’, subject to value for money.

4.4.2. These risks have been definitively allocated to the most appropriate party, after much rigorous review, mitigation and negotiation. The Risk Register for the main works has been reviewed regularly and the trust has concluded that it will apportion service risks in the design, build and operational phases as shown in Table 4.2 below.

Table 4.2: Risk Allocation

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Potential Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
</tr>
<tr>
<td>Design</td>
<td></td>
</tr>
<tr>
<td>Construction and Development</td>
<td>✓</td>
</tr>
<tr>
<td>Transition and Implementation</td>
<td>✓</td>
</tr>
<tr>
<td>Availability and Performance</td>
<td>✓</td>
</tr>
<tr>
<td>Operating</td>
<td>✓</td>
</tr>
<tr>
<td>Variability of revenue</td>
<td>✓</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Potential Allocation</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td>Public</td>
</tr>
<tr>
<td>Termination</td>
<td>✓</td>
</tr>
<tr>
<td>Technology and Obsolescence</td>
<td>✓</td>
</tr>
<tr>
<td>Control</td>
<td>✓</td>
</tr>
<tr>
<td>Residual value</td>
<td>✓</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
</tr>
<tr>
<td>Legislative</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>✓</td>
</tr>
</tbody>
</table>

4.4.3. The apportionment of risks reflects that the assets underlying the works will remain in the trust’s ownership throughout, which is in line with works procured under an NEC3 ECC contract. Regular review of the risk and allocation will be undertaken collaboratively between Kier and the trust.

4.5 Proposed Charging Mechanisms

4.5.1. Under NEC3 option C Mersey Care and Kier agree a Target Cost at the outset of the construction stage which will be distributed into an activity schedule prepared by Kier. This target cost was agreed on 17 March 2017 following tendering of the work packages as described in section 4.3.4.

4.5.2. With this arrangement, there is no concept of a ‘contract sum’; the target cost is determined by the accuracy of the cost plan produced. The cost consultants Rider Hunt are responsible for advising on this, taking into account risk analysis and risk management, in order to get to an agreed target cost and agreed pain / gain share allowances with Kier.

4.5.3. Kier are also closely involved with this process since much of the cost information comes from their tendering process; they are also in the best position to offer options for value engineering.

4.5.4. The pain/gain share percentages allocated between the construction client and Kier are agreed rather than imposed, as any potential benefit will be lost if excessive risk is priced as a contingency item, which in reality may never materialise. A thorough assessment of the party best placed to carry the risk will be undertaken in order to allocate the appropriate share percentage. It is not unusual therefore for the agreed percentages to be unequal.

4.5.5. The proposal is to enter into a Standard P21+ construction contract for the design and construction of the proposal. Payments will be made on a monthly basis based on proven actual costs up to the amounts specified within the GMP (subject to any disallowed costs associated with any non-compliant works). Amounts due will be reviewed and validated by an independent Project Manager prior to any payments being made.
4.6 Surplus Land

4.6.1. Plans for the redevelopment/disposal of the Scott Clinic site and the Whalley site are at an early stage.

4.6.2. The Scott Clinic site, valued at £2.625m by the Valuation Office Agency, will be cleared and sold for residential development (in excess of 15 dwellings, 30% of which should be affordable housing).

4.6.3. Discussions are on-going with the Department of Health regarding the redevelopment of the Whalley site. Plans include opportunities to meet the local LIFT plans for an elderly care village and with the MoD in respect to accommodation to support veterans.

4.7 Procurement of Services

4.7.1. Mersey Care seeks value for money in all its investments. This is achieved through competitive pricing and use of frameworks where applicable and within the context of the trust’s Standing Financial Instructions and obligations under the Public Procurement Regulations. The procurement team tests the market for all purchases and supplier frameworks are monitored so that new entrants are given opportunities to bid.

Equipment

4.7.2. Group 1 equipment will be procured as part of the P21+ contract GMP. This includes fitted items which have a direct bearing on the final design and operation of the building, for example: kitchen units, wardrobes and wiring for IM&T, security system etc. Group 1 equipment also includes items where there would be an unacceptable contractual risk if supplied by the trust. Mersey Care recognises that some items of equipment are best supplied by the P21+ provider. This is to offset risk arising from delivery delays (affecting the overall programme) and space planning.

4.7.3. Group 2 and 3 equipment will be purchased by the trust in line with existing procurement strategies. To ensure best value can be demonstrated the trust will utilise the benefits of trust negotiated contracts and national framework agreements.

4.7.4. Mersey care has developed an equipment schedule based on discussion with key stakeholders see Appendix 4.3:Equipment Schedule. Reviews were conducted of all existing departments to determine how much equipment could be transferred or re-used when the new facilities are commissioned. A proportion of existing equipment will transfer.

4.7.5. The equipment budget is therefore based on ensuring that appropriate equipment is procured, with maximisation of equipment transfer from existing inventories and any surplus assets (although it is assumed the latter will be minimal). This has generated an equipment budget of £1.5m (exclusive of VAT). The types of equipment covered by this budget are: furniture, I.T., gym, therapy equipment.
full transfer audit will be undertaken before the equipment procurement begins to ensure maximum re-use of existing equipment. The trust is yet to make a decision around the procurement route in terms of in-house by the trust’s Procurement Department or to sub-contract this task. Once this decision is taken by the trust a full procurement timetable will be published.

4.7.6. The equipment schedule was priced by the trust’s Procurement Department and this has generated a gross budget for equipment. Allowances have been prepared for Group 2 and lower-value Group 3 equipment, linked to the number and types of rooms. Special focus has been paid to high-value Group 3 equipment.

4.7.7. User input in the design process and equipment detailing was achieved by review with key stakeholders utilising the room data sheets and equipment lists. This has been supported by one to one meetings to provide further details. All decisions regarding equipment specification will include input from applicable users, considering issues such as infection control, manual handling and health and safety.

Facilities Management

4.7.8. Hard FM (maintenance) for the MSU will be provided via the trust’s existing hard FM contract with MITIE. The additional hard FM and lifecycle costs for the options have been included in the forecast costs.

4.7.9. Soft FM (cleaning etc.) services for the facilities affected by this project are currently undertaken and managed in-house, supported by a sub-contract for laundry services. Mersey Care provides such services across a number of sites and does so currently at Scott Clinic and at Whalley and Gisburn sites. The trust is content with the cost and quality of services and the current strategy is to continue with this in-house service provision.

4.7.10 The trust considers these services to be both satisfactory but may consider options around delivery in the future. In addition it is not considered practicable for these services to be split across different providers. The scope and delivery of the services will not materially change with the new development.

Information Technology (IT)

4.7.11 Mersey Care will follow internal procurement guidelines regarding purchase of IT equipment.

4.8 Design and Clinical Model of Care

4.8.1. In an increasingly competitive health sector our model of care and specialist expertise delivered in a state of the art facility will give us a competitive advantage. This will enhance the ability to articulate service users’ needs quickly and streamline treatment through and out of the secure care pathway which will be beneficial for service users and carers and be attractive to commissioners. The new MSU will be sufficiently flexible to enable it to respond to changing needs in
the model of care or service delivery ensuring we deliver exceptional care and treatment for offenders and high risk service users with severe mental illness, learning disability, neuro-developmental disorders and personality disorder.

Ward function

4.8.2. The model of care recognises the expansive range of mental and physical health and social needs of this group of service users. Specialist care and treatment will be delivered on dedicated wards from highly trained and qualified staff in response to service users’ holistic needs. There will be specialist wards for service users with diagnosis of learning disabilities and severe mental illness. It is likely that the clinical presentations of a small number of individual service users will reveal significant comorbidity with multiple diagnoses and functional difficulties such as severe mental illness, learning disabilities, personality disorder and substance misuse. The resultant complex and sometimes contradictory pattern of health and social care requirements for these service users means that admission to specific wards will be based on an individualised assessment of their needs, risk and vulnerability.

4.8.3. The wards will be configured in streams providing care and treatment from admission through to discharge. This pathway will reduce the number of times that service users need to change wards which can cause distress and hinder recovery. This also allows the service users to be streamed in areas with individuals at similar stages of their care, for example: new admissions requiring significant support to be on a different ward to those who are soon to be moved to a lower level of security or into the community.

Design principles

4.8.4. The trust has determined that the following key design principles will deliver a “distinctive and exceptional medium secure environment consistent with the national specification for medium secure units. This will facilitate the integration and prioritisation of safety, security and therapy. The building design is critical to enabling the planned model of care to be delivered.

4.8.5. The key design principles are to:

- provide privacy, dignity, safe visiting and access to outside space, i.e. basic human rights;
- support recovery by providing a comfortable and healing environment for service users, staff and visitors;
- support observation 24 hours a day to maintain safe and effective care;;
- minimise risk of escape, self harm or harm and injury to others or suicide;
- support service users and staff to have positive and productive relationships;
• provide adaptable and flexible environments that will be able to respond to changes in referral demand and different service user groups;

• value staff: provide environments that meet the needs of staff;

• deliver workforce efficiencies and cost improvements whilst improving quality.

4.8.6. Within Scott Clinic there is a lack of space which negatively impacts on day to day operational issues, therapeutic interventions and limits the opportunities for the involvement of families in service users’ care. An essential aspect of the design of the new unit will be to ensure that there is sufficient multi-functional space to offer the opportunity to improve therapeutic and social interactions. Other aspirations are for:

• good lines of sight throughout the building;
• selection of spaces for a variety of different uses;
• natural light;
• feeling of space and openness;
• ease of access to the outside from main communal areas;
• good ventilation, maximising natural ventilation;
• corridors with resting places of interest;
• developments in the use of technology and innovation to enhance service user care and recovery.

4.8.7. The development of high quality seclusion suites with access to outside space and fresh air will ensure that service users, whilst being subject to seclusion, will continue to have access to a positive therapeutic environment which is comparable to other service users within the ward environment. This will support enhanced de-escalation and reduce stress and tension on the wards and to our service users and staff.

4.8.8. The design of the wards will provide an enhanced operational environment which will allow clear lines of sight, ease of observation and increased resources and facilities for de-escalation and behavioural management.

4.8.9. A peer review of the design was conducted by Beatrice Fraenkel, Chairman and Design Champion of the trust, who has a wealth and breadth of experience and knowledge around ergonomics and architecture. The outcome of the review was very positive. The design of the unit has further been reviewed by the Design Champions Board, who unanimously supported the innovative design produced by IBI architects. This board is made up of both clinical and non-clinical staff from the trust along with representatives external to the trust who have lived experience, knowledge and an interest in the design of trust buildings to ensure these environments meet the clinical needs of service users and staff.
Environment

4.8.10 Following consultation with service users, a number of design principles have been identified. Service users have specifically requested:-

- personal private space to watch television or play on a games console with good positioning of the television;
- bedrooms to include an armchair and space to relax and recuperate;
- freedom to access open space at any given time. The therapeutic benefits of access to outdoor, green space are well chronicled and have been included in the design to improve care and recovery for service users.

4.8.11 The environment within a medium secure unit is a crucial element in delivering therapeutic services which have a positive outcome for service users and aid recovery. The key features to assist with achieving a therapeutic environment include:-

- a familiar, domestic, homely in style environment;
- safe and secure outside space;
- single rooms big enough for personal belongings, an armchair and writing space with en-suite facilities;
- multi-functional spaces to allow for the delivery of a range of different therapeutic interventions.

4.8.12 Following consultation with service users and staff, lengthy consideration has been given to identifying the key environmental benefits for both staff and service users that can be achieved from the successful completion of the project. In summary these include:-

- Increased access to therapeutic space;
- Single en-suite bedrooms;
- Increased access to outside space;
- Improved working and personal environment for staff;
- Improved, and an increase in the amount of, social environments for service users;
- Greater autonomy and independence for patients around the building.

4.8.13 Both the trust and Kier have a commitment to the Government Construction Strategy. Elements of the Strategy have been built into the P21+ contract along with Kier’s proposals. For example, Kier and IBI followed the principles set out in the Better Bedroom and the P21+ Repeatable Rooms initiatives. The proposed bedrooms are illustrated in the image below.
Figure 2: Illustration of bedroom

Please note the image is for illustrative purposes only. Every effort has been taken to minimise ligature points and the coat hook shown in the image will not be used within the building.

Accommodation
4.8.14 The new unit will contain a total of 123 beds configured within eight wards as follows:

- Four male mental illness wards;
- Two male learning disability wards;
- One female mental illness ward;
- One female learning disability ward.

4.8.15 Designed into the new unit will are the following areas:

- entrance area;
- therapy centre;
- sports facilities;
- relaxation areas/TV room;
- music room;
- family visiting;
- Tribunal suites;
- office accommodation;
- staff facilities;
• primary care facilities run by the trust’s team with visiting professionals (GP, chiropodist, dentist);
• facilities management areas.

4.8.16 A full schedule of accommodation for the new unit detailing the individual areas/rooms is provided within the Schedule of Accommodation contained within the Estates Annexe. A schedule of compliance with the standards within HBN documentation, including any derogations from Department of Health and other guidance, is attached within the Estates Annexe.

Management of the increase in service user numbers

4.8.17 The provision for 123 beds encompasses an increase in bed numbers for service users with a diagnosis of mental illness. NHS England recognises that approximately 20 service users are placed in out of area treatment places at any given time. Therefore a cohort of patients for whom their needs would be optimally met in a local MSU will remain in alternative placements until the new unit is opened. The trust and NHS England acknowledge the logistical challenges of operationalising the additional provision in a timely and responsive manner and have therefore agreed to implement a phased uptake of the additional beds.

4.8.18 Throughout the period of the build a detailed plan will be developed for the opening of the fourth mental illness male ward in a cost efficient and clinically effective manner, allowing for the recruitment of the staffing establishment. At an operational level the trust aim is to have this ward at capacity within nine months from opening. This will be done in two distinct phases. It is anticipated that the three male mental illness wards will operate at capacity in the initial stages. When a small number of additional appropriate referrals have been identified (2-3 within the first quarter) two service users from each ward will be transferred into the fourth male mental illness ward. This will allow the opening of the ward at 50% capacity. The ward design allows safe and effective care at this level. It is anticipated that at this point a more assertive programme of assessment and admission will ensure the optimum capacity is attained by the agreed target date.

Control of Infection

4.8.19 The design of the unit has been developed in collaboration with the trust’s Infection Prevention and Control and Estates and Facilities Teams, in line with HBN 00-09 Infection Control in the Built Environment and is further supported by trust policies and procedures. Throughout the design phase careful consideration has been given to:-

• all clinical areas;
• waste segregation;
• storage and disposal;
• laundry and linen;
• catering;
• sanitary provision including hand washing;
• ancillary areas;
• finishes;
• maintenance;
• engineering systems.

4.8.20 All equipment will comply with Department of Health or Medium Secure guidance where appropriate.

4.8.21 The design of the unit was created by IBI who are market leading architects in the mental health field. All the design elements have been reviewed in terms of best practice.

4.3.22 The trust Fire Officer has been involved in all stages of the design and approved the PF10 form relating to the Fire Strategy for the new unit.

4.9 Sustainability and Environmental Impact

4.9.1. The development will be subject to the general requirements of Part L2A, the Sefton Council Unitary Development Plan and to the NHS EnCO2de energy consumption requirement of 30-40 GJ/100m3. The building is designed to incorporate energy efficiency measures as far as is practicable. These will meet or exceed limiting values set in Part L2A of the Building Regulations, as required to achieve compliance. Upon completion of the building, an Energy Performance Certificate will be produced, which evaluates the asset rating of the building that is comparable with other buildings of similar use.

4.9.2. An Energy Report has been undertaken by WSP which outlined the performance of the development against Part L of the Building Regulations based on the current Building Services strategy to demonstrate how compliance will be achieved with the emphasis on maximising energy demand reduction for the building as well as reducing carbon emissions. A copy of the report can be found in the Estates Annexe.

4.9.3. The report also considered appropriate low and zero carbon technologies for the site.

4.9.4. The building will be designed to incorporate energy efficiency measures as far as practicable, for example:
• all occupied spaces will include 100% low energy lighting;
• the building will be served by a centralised heating system;
• cooling will be provided by local variable refrigerant flow (VRF) technology units;
• on-site and zero carbon technologies, Combined Heat and Power (CHP) will meet all of the targets without further systems to supplement the on-site energy generation;
• within the service user bedrooms, air will be extracted through the en-suite bathroom with make up air being provided by natural ventilation means via operable windows;
• in non-naturally ventilated areas, a combination of central and local extraction systems will be provided.

Building Research Establishment Environmental Assessment Method (BREEAM)

4.9.5. BREEAM outlines the standards, in line with best practice, in sustainable building design, construction and operation and is recognised as the most effective measure of the environmental performance of a building.

4.9.6. The trust has confirmed a target rating for the new unit as “very good”. This rating was selected following consideration of the various benchmarks. Given that the trust has plans to use industrial machines in the unit, this would negate against the trust being able to achieve a target rating of “excellent”. The decision to use industrial machines was taken from a value for money standpoint in terms of the longevity of the machines. The machines in question relate to both washing machines and tumble dryers. The Stage 3 BREEAM Report can be found in the Estates Annexe.

4.9.7. Further to discussions with external review bodies a review of the BREEAM pre-assessment schedule was undertaken by the trust. This confirmed that should the trust achieve certain credits a potential score in excess of the threshold for “Excellent” could be achieved.

4.9.8. Taking this information into account the trust has taken the decision to confirm a target rating of “excellent” for the new unit and a validation exercise is underway.

AEDET

4.9.7. The AEDET (Achieving Excellence – Design Evaluation Toolkit) is used to evaluate how the design meets the investment objectives.

4.9.10. A workshop, attended by both staff, service users and members of the design team, was held in November 2014 to review the previous design for the MSU. See information contained in table below.
4.9.11 Although the layout for the current proposed MSU is different to the design reviewed in November 2014, most aspects remain unchanged eg the functionality (room layouts), build quality and impact. In March 2017 Kier undertook a review of the previous AEDET and confirmed that the marking and the design principles are consistent with the previous review and it is likely that the score would be higher if reviewed again as a number of items such as Access & Maintenance was not scored previously owing to the level of design. The AEDET evaluation is contained within the Estates Annexe.

Travel plan

4.9.12 In September 2015 WSP – ParkersBrinkerhoff produced a travel plan in relation to the proposed re-location of services to the Maghull site. Following the subsequent change to the project in terms of the re-location of the MSU from the Whalley site the Travel Plan was reviewed and updated in September 2016. The revised Travel Plan is attached at Appendix 4.4: Travel Plan.

4.10 Personnel Implications

4.10.1 TUPE Regulations will not apply to this investment as no undertakings will transfer between employing entities as the Mersey Care acquisition of Calderstones has been completed prior to the conclusion of this investment.

4.10.2 Excess mileage will be payable in situations where there is a compulsory change of base, either permanent or temporary, resulting in extra daily travelling expenses, for a period of 4 years from the date of transfer.
4.10.3 Workforce implications due to the change in the clinical model of care have been detailed in the Management Case.

4.11 Planning Approvals

4.11.1 Mersey Care undertook initial discussions with the Local Authority’s Planning Department for the previous scheme, however no formal pre-application was raised. The discussion went through the general principles of the development and the initial layout plans (for the previous 120 bed scheme).

4.11.2 Discussions with Sefton Planning Department re-commenced for the new scheme and a full planning application was submitted on 1 October 2016. Planning permission was granted on 13 January 2017 following a decision by the National Planning Casework Unit not to call in the application to the Secretary of State. A copy of the planning approval notice is contained in Appendix 4.5: Planning Approval Notice

4.12 Accounting treatment

4.12.1 The assets underpinning delivery of the service will be on the Statement of Financial Position (SOFP) of the trust; those sold will be removed from the trust’s SOFP at the time of the sale.

4.12.2 The plan is for the Scott clinic site to be disposed of for residential development and early meetings with local planners brought no objections in principle on the understanding that the land remains in the green belt. This will be post opening of the new unit at Maghull and would subsequently be removed from the trust’s SOFP. Currently there are on-going discussions around the options for the Whalley site.
5.1 **Introduction**

5.1.1 The purpose of this section is to set out the forecast financial implications of the preferred way forward (as set out in the Economic Case) and the proposed solution and its procurement route (as set out in the Commercial Case). It describes the impact on the main financial statements – the Statement of Comprehensive Income (SOCI statement) and Statement of Financial Position (SOFP Sheet) – and forms a conclusion on the overall affordability of the preferred option.

5.1.2 The financial modelling demonstrates that the Preferred Option (123 bed new build at Maghull) as identified in the Economic Case is recurrently affordable subject to the achievement of the trust’s CIPs and income assumptions being maintained as per the trust’s Long Term Financial Model (LTFM). A healthy SOFP is maintained as well as delivery of a normalised surplus on SOCI throughout the construction and operational period.

5.1.3 Sensitivity analysis demonstrates that the trust is in a robust position to manage the impact on the affordability of the trust’s preferred option once identified mitigations have been implemented.

5.1.4 The projections have been prepared recognising compliance with NHS Improvement’s criteria for well performing, financially viable and sustainable service delivery.

5.1.5 The financial models and assumptions used in support of the long-term financial model (LTFM) derive much of their input from the activity and workforce planning models. The LTFM demonstrates that the preferred option is recurrently
affordable assuming achievement of overall trust CIP (cost improvement) requirement, and in line with NHS Improvements CIP planning assumptions.

5.2 Current Financial Position

5.2.1 Mersey Care has consistently delivered all statutory financial duties and the trust has established a position of financial strength and stability. This financial performance provides a sound platform to support clinical services in the delivery of perfect care and shows that financial governance and stewardship are high priorities for the trust.

5.2.2 High level projected financial performance data for Mersey Care is shown below, which reflects all currently Board approved developments and is consistent with the plan submission for 2017/18.

![Figure 5.2: Summary Mersey Care projected performance 2017/18 to 2020/21](image)

5.3 Capital Costs

5.3.1 The estimated capital costs of the project have been re-assessed by the trust’s capital cost consultants, using a PUBSEC index of Q2 2016 for approval purposes. PUBSEC refers to the tender price index of public sector building contracts in the public sector in Great Britain. It measures the movement of prices and publishes indices on a quarterly basis.

5.3.2 A design concept has been developed based on the 123 bed requirement which has identified a Gross Internal Floor Area (GIFA) of 11,010m2.

5.3.3 The costs reflect a start-on-site date of October 2017 with inflation from that point assessed on the basis of movements in the Price Adjustment Formula for Building and Specialist Engineering Works to PUBSEC index.

5.3.4 Practical Completion for the MSU is scheduled for a handover in December 2019.
5.3.5 Table 5.1 below summarises the key components of the capital cost forecast for the preferred options taken from the latest OB Form. The full OB forms are presented in the Estates Annex.

5.3.6 The capital costs in the table below have also been included for the trust as part of the Cheshire & Merseyside STP Planning submission in April 2017.

Table 5.1: Key Components of the Capital Cost Forecast

<table>
<thead>
<tr>
<th>Summary</th>
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<tbody>
<tr>
<td>1. Building and Service Costs</td>
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<td>3. Works Cost Total (1+2) at BIS PUBSEC 218</td>
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<td>4. Provisional Location Adjustment</td>
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<td>14. Forecast Outturn Business Case Total (excluding VAT)</td>
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<td>16. Forecast Outturn Business Case Total (including VAT)</td>
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</table>

5.4 Capital Funding

5.4.1 The funding for the project will be funded by a loan from the Independent Trust Financing Facility (ITFF). The application for this loan was submitted in May 2017 and approved in June 2017.

5.4.2 The breakdown of the funding is set out in Table 5.2.
Table 5.2: Key Components of the Capital Cost Forecast

<table>
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<tr>
<th>Capital Funding</th>
<th>£m</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Capital Cost</td>
<td>60.7</td>
<td>See table 5.1</td>
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</tbody>
</table>

Funding Sources

<table>
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<tr>
<th>Loan (ITFF)</th>
<th>60.7</th>
<th>Loan assumed to have a 25-year equal instalment repayment profile at an interest rate of 2.50%13</th>
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<tr>
<td>Total</td>
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<tr>
<td>Funding Shortfall</td>
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</table>

5.4.3 The trust made an application for £60.7m to the Independent Trust Financing Facility which was approved in June 2017. The capital cost has remained broadly consistent with that included within the Acquisition Full Business case submitted for the acquisition of Calderstones NHS Foundation Trust in 2016.

5.5 Approach to Affordability Modelling

5.5.1 The financial impacts of this project have been worked up whilst being mindful of the wider health economy and the fact that Mersey Care needs to work with commissioners to ensure an affordable health economy solution is developed.

5.5.2 The work undertaken to date has been discussed with NHS England Commissioners, including financial and planning teams and with Local CCGs also as part of the learning disability Transforming Care Programme.

5.5.3 The modelling of the financial impacts of the MSU Project has followed a structured process which is outlined below.

5.5.4 The starting point was the current Mersey Care NHS Foundation Trust base LFTM for 2017/18 (at Month 12, 2016/17). The MSU development impact and any other future capital investments included in this LTFM were extracted to provide a Do Nothing position.

5.5.5 A Do Minimum option has been created to reflect 123 beds which would include a new build for learning disability beds and refurbishment of the current Scott clinic.

5.5.6 A further model was developed with the Preferred Option implications being overlaid on the Do Nothing position. The preferred option as set out in the Economic Case is based on the building a single building with 123 beds to provide both mental illness and learning disability services.

5.5.7 The process has been developed to dovetail with the LTFM preparing a base model with the preferred option and further versions reflecting downside scenarios.

13 Interest rate (National Loan Fund rate) per www.dmo.gov.uk as at 3 July 2016 1.37%. A buffer of 1.13% is currently included in the modelling to ensure sufficient scope for movement until drawdown of the loan. Given the current uncertainty in the market this is considered prudent.
5.6  Cost Improvement Programme

5.6.1 Plans are in place to deliver £11.7m over the next two years across the organisation. Mersey Care has a proven track record in the achievement of recurrent CIP plans. The CIP plans have been agreed by multi-disciplinary teams and all budget holders within each division. The multi-disciplinary teams include directors, clinicians, other staff and service users/carers.

5.6.2 The plans are quality impact assessed (QIA) by the medical director and the executive director of nursing. They are presented to and discussed by the executive committee, the Quality Assurance Committee (QAC) and the Performance & Investment Committee (PIC). Mersey Care’s Board of Directors will reject plans considered to carry too great a risk to quality.

5.6.3 The CIP plans follow three key strategic initiatives; local services care strategy, secure campus and corporate services review. The strategic nature of these schemes will result in front loaded savings which in turn will allow for a reduced level of CIPs in the outer years.

5.6.4 The trust has successfully delivered £21.2m of CIP plans in the previous two financial years. £21.0m of these schemes were recurrently achieved, with £8.4m in 2015/16 and £12.6m in 2016/17.

5.7  Summary Modelling Impacts

5.7.1 The trust has undertaken significant additional work to identify the expected workforce implications of the new clinical model of care and how this will be delivered in the new building which will result in changes in the costs. The average annual revenue impact of the options is summarised in the table below.
5.7.2 As part of the acquisition of Calderstones NHS Foundation Trust, NHS England has agreed to fund the capital charges implications of the trust moving the learning disability services to a new site, this is noted as LD Premium in the table above.

5.7.3 The Do Minimum position assumes a new learning disability build and therefore additional funding of £1.6m is assumed, this reduces to £0.2m under the Preferred Option as the capital cost is less under this option. The Do Minimum option would operate with a deficit of £2.6m per annum.

5.7.4 In terms of the Preferred Option the trust has worked up a detailed workforce plan to deliver the provision of care for 123 beds in line with commissioning intentions received from NHS England. The Preferred Option would operate at breakeven.

5.7.5 The additional EBITDA achieved under the Preferred Option is expected to offset some of the additional capital charges as a result of the new 123 bed unit. However the capital charges and interest on loan are greater than the EBITDA in the early years.

5.7.6 In summary, the trust maintains a strong financial position retaining an overall Utilisation of Resources (UoR) score of 2 throughout the construction and first two years of operation.

5.7.7 A bridge below table 5.4 shows the movement between the Do Nothing Position and the Preferred option for the first full year of operation in 2021/22.

**Table 5.4: Bridge 2021/22**

5.7.8 The detailed impact on income, costs and capital charges on the trust's forecast financial statements are set out in the following sections:
5.8 Impact on SOCI

Model 1 - The Do Nothing

5.8.1 In order to have a clear audit trail of the modelled impact of the preferred option on the SOCI the trust has first removed the assumed costs relating to the MSU from the Base. This gives a Do Nothing position i.e. mental illness continues to be provided from Scott Clinic and learning disabilities from Whalley site.

5.8.2 The SOCI position for the Do Nothing is shown in the table below.

5.8.3 The do nothing position project costs shows those costs incurred ahead of business case approval at the organisation's own risk. These costs are £4.1m shown in non maintenance capital expenditure within the do nothing LTFM contained in appendix 5.2.

Table 5.5: SOCI – Do Nothing

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<td>227.8</td>
<td>249.8</td>
<td>247.9</td>
<td>253.1</td>
<td>258.4</td>
<td>263.8</td>
</tr>
<tr>
<td>Other income</td>
<td>7.5</td>
<td>20.3</td>
<td>18.0</td>
<td>16.6</td>
<td>19.3</td>
<td>19.6</td>
<td>20.0</td>
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<tr>
<td>Total Income</td>
<td>213.4</td>
<td>248.1</td>
<td>267.8</td>
<td>264.5</td>
<td>272.4</td>
<td>278.1</td>
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<td>(177.4)</td>
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<td>(198.3)</td>
<td>(190.3)</td>
<td>(202.8)</td>
<td>(207.3)</td>
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<tr>
<td>Non-pay</td>
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<td>(49.3)</td>
<td>(43.3)</td>
<td>(43.7)</td>
<td>(47.7)</td>
<td>(49.6)</td>
<td>(51.2)</td>
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<tr>
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<td>(226.7)</td>
<td>(247.0)</td>
<td>(242.0)</td>
<td>(247.2)</td>
<td>(252.4)</td>
<td>(258.5)</td>
</tr>
<tr>
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<td>20.8</td>
<td>22.6</td>
<td>25.4</td>
<td>25.7</td>
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<td>(6.6)</td>
<td>(23.2)</td>
<td>(22.9)</td>
</tr>
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<td>(28.7)</td>
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<td>(11.2)</td>
<td>18.8</td>
<td>2.4</td>
<td>2.4</td>
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<td>16.7</td>
<td>-13.8</td>
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<td>2.6</td>
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<tr>
<td>Normalised Net surplus/(deficit)</td>
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<td>5.5</td>
<td>5.2</td>
<td>5.4</td>
<td>5.0</td>
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<td>5.5</td>
<td>4.4</td>
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<td>4.7</td>
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<td>CIPs as % of cost base</td>
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<td>2.7%</td>
<td>2.5%</td>
<td>2.3%</td>
<td>1.8%</td>
<td>1.8%</td>
<td>1.8%</td>
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<tr>
<td>EBITDA %</td>
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<td>8.6%</td>
<td>7.8%</td>
<td>8.5%</td>
<td>9.3%</td>
<td>9.2%</td>
<td>8.9%</td>
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<tr>
<td>Net surplus %</td>
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<td>-4.3%</td>
<td>6.9%</td>
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<tr>
<td>Normalised net surplus %</td>
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<td>2.6%</td>
<td>1.9%</td>
<td>2.1%</td>
<td>1.8%</td>
<td>1.8%</td>
<td>1.8%</td>
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</tbody>
</table>

5.8.2 The key component parts of the Base Case: Do Nothing are summarised below.

5.8.3 The Do Nothing option would remove all capital expenditure associated with a new Medium Secure Unit. However, one of the core assumptions of this Business case, underpinned by the NHS England Consultation, alongside the trusts strategic intentions, is that Do Nothing is not a viable option i.e. the trust moves learning disability medium secure services from the Whalley site and the premises are improved for mental illness medium secure patients on the Scott Clinic site.
and therefore the true like for like comparator for the purposes of the Economic Appraisal (refer to Section 3) is the Do Minimum.

5.8.4 This involves the construction of a 46 bedded unit for the learning disabilities medium secure service that is to be relocated from Whalley, but includes no movement of the mental illness service which would be a refurbished and extended Scott clinic building.

Model 2 - The Preferred Option

5.8.5 As set out in section 5.5 the trust has modelled the Preferred Option. The best case and worst case scenarios have been considered as sensitivities in section 5.12.

5.8.6 The trust has modelled the impact of the additional income and cost associated with the Preferred option and is confident that based on the planning assumptions around activity growth which have been discussed with commissioners the trust can continue to deliver its financial strategy.

5.8.7 The Preferred Option has been built up from the Do nothing by adding in the costs of the capital expenditure, and its associated depreciation and impairments, and the costs of the loan required to fund that capital expenditure, along with associated interest. Workforce costs have been calculated by reference to the trust’s workforce model developed for the preferred option. Additional income is based on the average annual bed income for mental illness beds and as agreed with NHS England Commissioners for 118 of the 123 beds. The trust has included within its costings both the internal costs of the project team and the costs of advisers and technical support. These are included within the LTFM tables in the appendices.

5.8.8 The key assumptions that form the basis of the Preferred Option are listed below:

- Assumes a 123 bed facility, 107 operational beds upon opening, and the additional ward 16 beds opening 6 months later, expected to be full by 9 months;
- Total Capital expenditure of £60.7m;
- Construction start Q3 17/18, practical completion Q3 19/20;
- Associated loans & repayments - £60.7m. Interest calculated at 2.50%\(^{14}\).
- Scott Clinic sale proceeds of £2.65m & net book value of £1.5m in 19/20 This is as per the valuation received from VOA in March 2017.
- Increased revenue staffing and non-pay costs – part year in 19/20; and
- Double running costs of £0.4 in 19/20 relating to the opening of the unit, staff orientation and mobilisation of patients in the transition between the old and new buildings.

\(^{14}\) Interest rate (National Loan Fund rate) per www.dmo.gov.uk as at 3 July 2016 1.37%. A buffer to 2.5% is currently included in the modelling to ensure sufficient scope for movement until drawdown of the loan. Given the current uncertainty in the market this is considered prudent.
5.8.9 The table below shows the summary projections for the forecast period.

Table 5.6: SOCI – Preferred Option

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<thead>
<tr>
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<tbody>
<tr>
<td>Clinical income</td>
<td>218.4</td>
<td>239.0</td>
<td>236.7</td>
<td>241.9</td>
<td>249.3</td>
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<td>Other income</td>
<td>29.7</td>
<td>28.8</td>
<td>27.8</td>
<td>30.7</td>
<td>31.3</td>
<td>31.9</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>248.1</td>
<td>267.8</td>
<td>264.5</td>
<td>272.6</td>
<td>280.6</td>
<td>288.6</td>
</tr>
<tr>
<td>Pay</td>
<td>(177.4)</td>
<td>(203.7)</td>
<td>(198.3)</td>
<td>(199.3)</td>
<td>(203.0)</td>
<td>(208.9)</td>
</tr>
<tr>
<td>Non-pay</td>
<td>(49.3)</td>
<td>(43.2)</td>
<td>(42.9)</td>
<td>(46.6)</td>
<td>(49.5)</td>
<td>(51.8)</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>(226.7)</td>
<td>(246.9)</td>
<td>(241.9)</td>
<td>(245.9)</td>
<td>(252.4)</td>
<td>(260.8)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>21.4</td>
<td>20.9</td>
<td>23.4</td>
<td>26.7</td>
<td>28.2</td>
<td>27.3</td>
</tr>
<tr>
<td>Non-operating expenses</td>
<td>(50.0)</td>
<td>(24.3)</td>
<td>(34.6)</td>
<td>(22.8)</td>
<td>(25.7)</td>
<td>(25.4)</td>
</tr>
<tr>
<td><strong>Net surplus/(deficit)</strong></td>
<td>(28.7)</td>
<td>(3.4)</td>
<td>(11.2)</td>
<td>3.9</td>
<td>2.4</td>
<td>2.4</td>
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<tr>
<td>Normalised items</td>
<td>35.1</td>
<td>8.6</td>
<td>16.7</td>
<td>1.1</td>
<td>2.6</td>
<td>2.6</td>
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<tr>
<td>Normalised Net surplus/(deficit)</td>
<td>6.8</td>
<td>5.2</td>
<td>5.4</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
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</table>

5.8.10 The MSU investment is considered affordable from an SOCI perspective as the trust continues to make a recurrent surplus and the trust can afford to make the capital repayments. The LD Premium (income) assumed under the Preferred Option is as shown in Table 5.3, £0.2m.

5.8.11 The detailed SOCI flows for all of the options are shown in full in Appendix 5.1 to Appendix 5.4 LTFMs.

5.9 Impact on Statement of Financial Position

Model 1 - The Do Nothing Option

5.9.1 The Do Nothing option SOFP, shown in the table below, remove the original assumptions for the MSU to arrive at the Do nothing.

Table 5.7: SOFP – Do Nothing
5.9.2 The trust has modelled the impact of the additional asset and funding associated with the preferred option and is confident that the trust remains in a sound financial position.

5.9.3 The modelled SOFP for the Preferred Option is set out in the table below.

### Table 5.8: SOFP – Preferred Option

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</thead>
<tbody>
<tr>
<td>Property, Plant Equipment</td>
<td>233.9</td>
<td>191.8</td>
<td>196.5</td>
<td>226.8</td>
<td>244.1</td>
<td>241.6</td>
<td>238.9</td>
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<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
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<td>226.9</td>
<td>244.2</td>
<td>241.7</td>
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<td>7.8</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>Cash</td>
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<td>21.6</td>
<td>11.7</td>
<td>7.3</td>
<td>7.4</td>
<td>10.8</td>
<td>14.3</td>
</tr>
<tr>
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<td>8.2</td>
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<tr>
<td>Current assets, Total</td>
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<td>23.3</td>
<td>26.8</td>
<td>30.5</td>
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<td>(13.5)</td>
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<td>(75.9)</td>
<td>(74.3)</td>
<td>(72.7)</td>
<td>(71.0)</td>
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</table>
5.9.4 The detailed SOFP for all of the above options are shown in full in Appendix 5.1 to 5.4 LTFMs.

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<tr>
<td></td>
<td>£m</td>
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<td>Payables</td>
<td>(13.3)</td>
<td>(13.2)</td>
<td>(13.2)</td>
<td>(13.5)</td>
<td>(13.7)</td>
<td>(13.9)</td>
</tr>
<tr>
<td>Other current liabilities</td>
<td>(6.8)</td>
<td>(6.8)</td>
<td>(7.0)</td>
<td>(7.1)</td>
<td>(7.2)</td>
<td>(7.2)</td>
</tr>
<tr>
<td><strong>Current liabilities, Total</strong></td>
<td><strong>(20.1)</strong></td>
<td><strong>(21.9)</strong></td>
<td><strong>(22.6)</strong></td>
<td><strong>(23.0)</strong></td>
<td><strong>(23.3)</strong></td>
<td><strong>(23.5)</strong></td>
</tr>
<tr>
<td>Net current assets / (liabilities)</td>
<td>17.1</td>
<td>5.0</td>
<td>(2.0)</td>
<td>(2.2)</td>
<td>0.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Borrowings</td>
<td>0.0</td>
<td>(9.2)</td>
<td>(43.1)</td>
<td>(53.5)</td>
<td>(51.1)</td>
<td>(48.6)</td>
</tr>
<tr>
<td>Other non-current liabilities</td>
<td>(52.4)</td>
<td>(50.8)</td>
<td>(75.9)</td>
<td>(74.3)</td>
<td>(72.7)</td>
<td>(71.0)</td>
</tr>
<tr>
<td><strong>Non-current liabilities, Total</strong></td>
<td><strong>(52.4)</strong></td>
<td><strong>(60.0)</strong></td>
<td><strong>(119.0)</strong></td>
<td><strong>(127.8)</strong></td>
<td><strong>(123.7)</strong></td>
<td><strong>(119.7)</strong></td>
</tr>
</tbody>
</table>

| Total assets employed | **156.6** | **153.2** | **153.8** | **157.7** | **160.2** | **162.6** |

| Total taxpayers equity | **156.6** | **153.2** | **153.8** | **157.7** | **160.2** | **162.6** |
5.10 Impact on Cash Flow

Model 1 - The Do Nothing Option

5.10.1 The Do Nothing option SOCF, shown in the table below, remove the original assumptions for the MSU to arrive at the Do nothing.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Non cash flows in operating surplus</td>
<td>17.5</td>
<td>21.4</td>
<td>20.8</td>
<td>22.6</td>
<td>25.4</td>
<td>25.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Movement in working capital</td>
<td>(1.4)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Movement in non-current provisions</td>
<td>(5.8)</td>
<td>(0.4)</td>
<td>(0.2)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Cash generated from operations</td>
<td>13.6</td>
<td>22.0</td>
<td>20.2</td>
<td>22.2</td>
<td>25.5</td>
<td>25.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Investing activities</td>
<td>(12.2)</td>
<td>(12.3)</td>
<td>(21.7)</td>
<td>(17.2)</td>
<td>(13.6)</td>
<td>(10.2)</td>
<td>(9.7)</td>
</tr>
<tr>
<td>Financing activities</td>
<td>(11.4)</td>
<td>(2.4)</td>
<td>(8.4)</td>
<td>(9.3)</td>
<td>(11.8)</td>
<td>(12.2)</td>
<td>(12.1)</td>
</tr>
<tr>
<td>Net cash flow</td>
<td>(10.6)</td>
<td>7.3</td>
<td>(9.9)</td>
<td>(4.3)</td>
<td>0.1</td>
<td>3.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Opening cash balance</td>
<td>24.3</td>
<td>14.3</td>
<td>21.6</td>
<td>11.7</td>
<td>7.3</td>
<td>7.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Closing cash balance</td>
<td>14.3</td>
<td>21.6</td>
<td>11.7</td>
<td>7.3</td>
<td>7.4</td>
<td>10.8</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Model 2 - The Preferred Option

5.10.2 The trust has modelled the impact of the additional asset and funding associated with the preferred option and is confident that the trust remains in a sound financial position.

5.10.3 The modelled SOCF for the Preferred Option is set out in the table below

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Non cash flows in operating surplus</td>
<td>17.5</td>
<td>21.4</td>
<td>20.8</td>
<td>22.6</td>
<td>25.4</td>
<td>25.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Movement in working capital</td>
<td>(1.4)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Movement in non-current provisions</td>
<td>(5.8)</td>
<td>(0.4)</td>
<td>(0.2)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Cash generated from operations</td>
<td>13.6</td>
<td>22.0</td>
<td>20.2</td>
<td>22.2</td>
<td>25.5</td>
<td>25.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Investing activities</td>
<td>(12.2)</td>
<td>(12.3)</td>
<td>(21.7)</td>
<td>(17.2)</td>
<td>(13.6)</td>
<td>(10.2)</td>
<td>(9.7)</td>
</tr>
<tr>
<td>Financing activities</td>
<td>(11.4)</td>
<td>(2.4)</td>
<td>(8.4)</td>
<td>(9.3)</td>
<td>(11.8)</td>
<td>(12.2)</td>
<td>(12.1)</td>
</tr>
<tr>
<td>Net cash flow</td>
<td>(10.6)</td>
<td>7.3</td>
<td>(9.9)</td>
<td>(4.3)</td>
<td>0.1</td>
<td>3.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Opening cash balance</td>
<td>24.3</td>
<td>14.3</td>
<td>21.6</td>
<td>11.7</td>
<td>7.3</td>
<td>7.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Closing cash balance</td>
<td>14.3</td>
<td>21.6</td>
<td>11.7</td>
<td>7.3</td>
<td>7.4</td>
<td>10.8</td>
<td>14.3</td>
</tr>
</tbody>
</table>

5.10.4 The impact on the working cash balances and liquidity days are also taken into account within the Use of Resources score as set out below in section 5.11.

5.10.5 The Statements of Cash Flows for all of the options are shown in full in Appendix 5.1 to Appendix 5.4 LTFMs.

5.11 Use of Resources (UoR)

Model 2 – Do Nothing

5.11.1 The forecast risk rating after extracting the MSU development from the Base figures is set out in the table below.
5.11.2 The forecast risk rating after including the revised MSU development impacts is set out in the table below.

**Table 5.10: Use of Resources – Preferred Option**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Sustainability</td>
<td>0.2</td>
<td>Capital servicing capacity</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>liquidity (days)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td>0.2</td>
<td>I&amp;E margin</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Financial controls</td>
<td>0.2</td>
<td>Distance from financial CT</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>Agency spend</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Weighted Score</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Overall Rating</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

5.11.3 The underlying scores are higher than for the Do Nothing model for liquidity and capital servicing capacity scores due to increased capital expenditure. However the Use of Resources score of 2 indicates the trust remains in a strong financial position through the construction and then the operation of the new MSU development.

### 5.12 Sensitivities, Downsides and Mitigations

#### Approach

5.12.1 Sections 5.6 to 5.11 provide assurance that the preferred option is affordable to the trust.

5.12.2 In addition the key risks to the project beyond bed numbers have been considered and sensitivities undertaken to assess the impact of these risks materialising when compared against the base case assumptions in section 5.12.2.
5.12.3 A combined downside scenario has been developed to assess the overall potential risk to the trust.

5.12.4 The trust has identified a number of mitigations available to offset the impact of the sensitivities. Consideration has been given only to areas which the trust can directly influence and are not dependent on external factors. The mitigations have been applied to the downside scenario to demonstrate the resilience of the trust against the potential risks of the project.

Risks
5.12.5 The key risks identified for sensitivity analysis are included in the trust’s Project risk register and are being actively monitored and mitigated as far as possible.

5.12.6 The risks considered are set out in the table below.

Table 5.11: Risks and Sensitivities

<table>
<thead>
<tr>
<th>Number</th>
<th>Risk</th>
<th>Sensitivity</th>
<th>Likelihood</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Capital costs higher than planned</td>
<td>Capital costs 10% higher than planned</td>
<td>1:200 plans have been signed off and a GMP will be agreed shortly and therefore the risk of increased capital costs is considered low.</td>
<td>An increase in the capital cost by 10% would increase the cost of capital (revenue) by £0.3m per annum.</td>
</tr>
<tr>
<td>2</td>
<td>Interest rates higher than planned</td>
<td>Borrowing required from Private sector as opposed to ITFF. Assumption of current rate of around 4%</td>
<td>Availability of public sector borrowing is severely restricted. The trust continues to discuss with NHS ENGLAND, NHS IMPROVEMENT and the ITFF. Where no public sector borrowing is available the trust would need to consider alternative sources. The risk of this is currently assessed as low as the ITFF has approved the loan in June 2017 however it will need to access the loan as soon as possible to get the best interest rates.</td>
<td>Each 0.25% increase in interest rate increases costs by around £0.1m per annum. The movement to 4% from the currently modelled 2.5% would impact by around £0.3m per annum. The trust has included a buffer of 1% and therefore rates would need to rise above 2.5% before they changed the affordability of the project.</td>
</tr>
</tbody>
</table>

5.12.7 The total risk to the trust if all of these materialised is an estimated increased cost of between £0.3m and £0.6m per annum.
Downside

5.12.8 A downside LTFM has been run by the trust that considers the impact of these risks and models the impact to the trust's financial statements.

Mitigations

5.12.9 The trust has modelled a prudent position in its base case by modelling for example a buffer on the interest rate of over 1% (assuming public sector borrowing is available) and assuming income would only be received matched to the costs of the new ward becoming open.

<table>
<thead>
<tr>
<th>Number</th>
<th>Mitigation</th>
<th>Sensitivity</th>
<th>Likelihood</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attainment of VAT certificate</td>
<td>If the trust is able to recover the VAT on the new build this will reduces the requirement for loan funding by around £8m.</td>
<td>The trust is confident in the achievement of the relevant VAT certificate based on previous cases (Pennine Care) and is awaiting feedback from HMRC.</td>
<td>The reduction in the loan would result in a saving of around £0.4m per annum.</td>
</tr>
<tr>
<td>2</td>
<td>Workforce efficiencies</td>
<td>The model of care has been set out in this FBC with a fully costed workforce plan. However, further efficiencies in workforce are expected to be realised.</td>
<td>Initial assessments that new ways of integrating particularly non-ward based teams of staff and working across a new site could realise financial efficiency. The trust is confident its proposed model of care will provide a sound basis from which further efficiencies can be achieved.</td>
<td>Initial discussions have suggested that financial savings of up to 5% per annum, or up to £0.8m may be realised.</td>
</tr>
<tr>
<td>4</td>
<td>Spot Purchase beds differentially priced</td>
<td>Current modelling assumes block contracts remain at same price per bed as currently for the 96 block commissioned beds... A pricing strategy will need to be developed in relation to this unit as while current MI beds are £0.185m per...</td>
<td>It is likely that commissioners currently paying £0.218m per patient per year will continue and should the spot purchase placements be admitted from the same commissioner this will result in higher income.</td>
<td>The additional income for 6 LD spot purchase beds per year at 95% occupancy would be £0.2m</td>
</tr>
</tbody>
</table>
5.12.10 The total benefit to the trust if all of these materialised is estimated at between £0.2m and £1.4m per annum and would therefore offset the risk adjusted sensitivities identified in section 5.11.3.

**Mitigated Downside**

5.12.11 A mitigated downside LTFM has been run by the trust that considers the impact of these risks and mitigations and the impact to the trust’s financial statements.

**Conclusion**

5.12.12 The trust is confident that it has identified sufficient mitigations to offset the potential financial risks to the project.

**5.13 Conclusion**

5.13.1 This Financial Case shows how:

- the preferred option is affordable and the trust is able to maintain its underlying surplus throughout the 5 year period modelled;

- the preferred option requires £0.4m non-recurrent support for double running in 2019/20;

- EBITDA % remains positive and strong throughout the planning process and modelling period;

- Use of Resource rating remains at no greater than 2 throughout the modelling period; and

- The trust is confident that it has developed sufficient mitigations to successfully manage potential downside scenarios.
6. Management Case

6.1 Introduction
6.1.1 This section of the FBC explains the governance and management arrangements for delivering the project. It provides details of the actions that will be required to ensure the successful delivery of the project in accordance with best practice.

6.1.2 The project structure has been designed to ensure compliance with guidance set out in the:

- P21+ (P21+) Guide;
- NHS Estates Capital Investment Manual;
- Treasury Green Book.

6.1.3 It is supported by the project management disciplines of PRINCE2, which will be tailored to suit the needs of this project.

6.1.4 The design of the unit has been reviewed by the Design Champions Board who unanimously supported the innovative design produced by IBI architects. This board is comprised of both clinical and non-clinical staff from the trust along with a range of external representatives who have experience, knowledge and an interest in the design of trust buildings to ensure these environments meet the clinical needs of service users and staff. Many of these external stakeholders have lived experience of mental health services and this has been invaluable in informing the way we have thought about design and layout of this building to aid recovery and wellbeing for service users.

6.2 Project Governance Arrangements

6.2.1 The Medium Secure Unit Project is governed by a monthly Project Board whose remit is to provide oversight and direction and to review and assure the project’s progress. Minutes are taken of the meetings and are shared with the trust’s Operational Management Board. The Project Board may escalate information to the trust’s Executive Committee, Performance Investment & Finance Committee and ultimately to the Board of Directors.

6.2.2 The project governance arrangements for the MSU project are shown in figure 6.1 below:
6.2.3 The re-provision of a new medium secure unit on the Maghull site forms part of the programme for the transformation in Specialist Learning Disabilities. The aim of the programme is to satisfy the requirements of “Building the Right Support” in that:

“All hospital beds on the current Whalley site will therefore be subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Whalley site will close”.

6.2.4 The Programme consists of four objectives:

- Implementation of a new model of care for MSU
- Implementation of a new model of care for LSU

Figure 6.1 Governance Arrangements

Interdependencies
• Implementation of a new community model of care

• Close beds by improving the flow of service users through the secure system, preventing admission and supporting timely discharge from forensic service users from forensic pathways for people with learning disabilities.

6.2.5. The development of a new MSU on the Maghull site is not dependent on the remaining projects; however it does contribute to the overall programme aim.

Project Governance Arrangements

6.2.6 The Project Board is multi-disciplinary and consists of senior representatives from trust governance, clinical services, estates, finance, and HR teams. The operation of the Project Board is supported and supplemented by a number of commissioned specialist advisers. This has helped to ensure that the aims and objectives of the project are clearly set out, robustly governed and fully delivered in order that we ultimately deliver the highest quality facility possible to support recovery and discharge.

6.2.7 Mersey Care has participated in the development of design standards for Medium Secure Services which are adopted as Department of Health policy. The trust is also a member of the Royal College of Psychiatrist’s Forensic Quality Network which provides the opportunity to share expertise across the medium secure services through visits to other MSUs and the annual cycle of self and peer reviews.

6.2.8 The Project Team structure has been developed to ensure high levels of engagement with both clinical and corporate operational staff. The structure utilises a range of staff and managers who maintain operational duties whilst contributing to the project. This structure provides some assurance that the design, model of care, workforce and operational aspects of the unit are consistent with clinical practice and the needs of the services. This team is charged with clear and articulated responsibilities for delivering on specific areas of the projects (identified in figure 6.1 above).

6.2.9 A regular flow of information between team members and the project manager is ensured via the use of standardised checkpoint reports submitted each month prior to the Project Team meeting. These checkpoint reports then inform the Project Manager’s Highlight Report that is presented to the Project Board.

6.2.10 Immediate project governance is facilitated through weekly update calls held between the trust and its external advisors, allowing a rapid identification of issues and implementation of actions and resolutions:

• The Project Manager ensures weekly teleconferences are held with the Design & Build Lead, focusing on the progress of the design of the building.
• A strategic call between the Senior Responsible Office (SRO), Project Directors, Strategic Project Managers and external consultants which focuses on key strategic issues such as liaison with commissioners, Department of Health etc.

6.3 Project Roles and Responsibilities

Project Board

Membership

6.3.1. The Project Board comprises the members described in the table below.

Table 6.1: Project Board Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elaine Darbyshire</td>
<td>Executive Director of Communication and Corporate Governance (SRO)</td>
</tr>
<tr>
<td>Alison Jordan</td>
<td>Director of Estates (Project Director - Estates) (Senior Supplier)</td>
</tr>
<tr>
<td>Joanna Worswick</td>
<td>Strategic Transformational Programme Director (Project Director - Operational) (Senior Supplier)</td>
</tr>
<tr>
<td>Jo Minogue-Sharp</td>
<td>Head of Strategic Estates</td>
</tr>
<tr>
<td>Frank McGuire</td>
<td>Clinical Lead</td>
</tr>
<tr>
<td>Ian Lythgoe</td>
<td>Associate Director of Finance</td>
</tr>
<tr>
<td>Gayle Wells</td>
<td>Strategic Business Accountant</td>
</tr>
<tr>
<td>Des Johnson</td>
<td>Chief Operation Officer, Secure Division (Senior User)</td>
</tr>
<tr>
<td>Dr Melanie Higgins</td>
<td>Associate Medical Director (Senior User)</td>
</tr>
<tr>
<td>Andrew Simpson</td>
<td>Specialist Commissioner, NHS England</td>
</tr>
<tr>
<td>Gary Baines</td>
<td>Assistant Director, Mersey Internal Audit Agency (Assurance)</td>
</tr>
<tr>
<td>Andrew Meadows</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Lynn Lowe</td>
<td>Head of Human Resources</td>
</tr>
<tr>
<td>Lee Taylor</td>
<td>Chief Operating Officer, Specialist Learning Disabilities Division (Senior User)</td>
</tr>
<tr>
<td>Mandi Gregory</td>
<td>Chair of Staff Side (Staff Side Representative)</td>
</tr>
<tr>
<td>Paul Taylor</td>
<td>Service User &amp; Carer Representative</td>
</tr>
<tr>
<td>Joanne Cunningham</td>
<td>Communications Officer</td>
</tr>
<tr>
<td>Claire Ravenscroft</td>
<td>Business Development Manager</td>
</tr>
<tr>
<td>Jack Street</td>
<td>Associate Director, Turner Townsend (Senior Supplier)</td>
</tr>
<tr>
<td>Kelly Eaves</td>
<td>Partner, Deloitte (Senior Supplier)</td>
</tr>
</tbody>
</table>
Authority

6.3.2. The Project Board has the authority to direct the project within the remit agreed by the Board of Directors and the Performance, Investment & Finance Committee in relation to:

- Management of the budget;
- Setting of tolerances within the project;
- Decision making when there is a deviation from agreed tolerances forecast;
- Resolving issues raised by the Project Team;
- Management of risks.

6.3.3. Issues which are considered to be outside the authority of the Project Board are escalated to the Performance, Investment & Finance Committee. If resolution is not agreed the issue is escalated to the Board of Directors who has ultimate authority for the project. The Performance, Investment and Finance Committee will also consider proposals from the Project Board and recommend these to the Board of Directors.

Duties

6.3.4. The Project Board has delegated authority for the development of business cases up to the level of Board of Directors, NHS Improvement and Department of Health approval.

6.3.5. Responsibility for ensuring that adequate project controls and processes exist and for monitoring progress against key milestones is a further role for the Project Board.

6.3.6. A key responsibility is to oversee project performance and the effectiveness of the Project Team.

6.3.7. The Project Board has developed and implemented a comprehensive communication strategy ensuring the engagement of a wide range of internal and external stakeholders. An open and transparent process of communication ensures all stakeholders are provided with appropriate information and have the opportunity to contribute and express their views.

6.3.8. In addition the Project Board interfaces with strategic/operational groups which influence aspects of the project.

Reporting

6.3.9. The Project Board reports at each key stage by way of a project highlight report to the:

- Board of Directors;
- Performance Investment & Finance Committee;
- Executive Committee
6.3.10 Monthly highlight reports are produced and submitted to the:

- Operational Management Board;
- Secure Operations & Performance Committee;
- Strategic Implementation Group (Specialist Learning Disabilities Division);
- Project Management Office.

**Project Team Membership**

6.3.11 The key Project Team members and their associated roles are identified in the structure below:

---

**Figure 6.2 Project Team Members**

6.3.12 Consistency of approach to ensure all elements of both mental illness and learning disability requirements for the project are captured has been achieved by
ensuring there is adequate representation from both mental illness services (Scott Clinic) and learning disability services (Whalley and Gisburn) within the individual work streams.

Authority

6.3.13 The Project Team has the authority to deliver the project within the constraints set by the Project Board.

Duties

6.3.14 The main duties of the Project Team are:

- Create and manage work packages to ensure successful delivery of the intended objectives and outcomes of the project;

- Produce business cases that provide all key information and which demonstrates the project is affordable, deliverable and sustainable;

- Ensure procedures are developed to allow the building to be utilised to its full potential and assist with service delivery;

- Develop new ways of working to operationalise and deliver the new model of care supporting recovery at the earliest appropriate point in the care pathway;

- Identify the staffing requirements to deliver efficient and effective care for service users experiencing both mental illness and learning disabilities;

- Identify staff training needs to ensure high quality care is provided to service users experiencing both mental illness and learning disabilities;

- Ensure the identified benefits are realised, owned by the trust and managed appropriately to assure delivery;

- Identify the financial boundaries, both capital and revenue, undertake financial modelling exercises and monitor expenditure to ensure the project remains viable and affordable;
• Ensure the trust’s Estates Framework is used as the key enabler in the delivery of the Secure Division and the Specialist LD Services’ vision and strategy;

• Identify and manage risks and issues and to escalate such to the project board as required;

• Ensure that vacated premises are decommissioned as per agreed decommissioning programme;

• Produce and implement a clear communication strategy and plan incorporating all stakeholders to ensure that all feel engaged and involved in service and facility development;

• Ensure that the project remains within agreed timescales, tolerances and budget via robust monitoring

• Interface with other projects to ensure a consistency of approach across the trust. The primary interfaces for the medium secure unit project include the re-provision of learning disability secure services from the Whalley and Gisburn sites (contraction of services and re-provision of Low Secure LD services), the Secure Care Pathway Strategy inclusive of both mental illness and learning disability secure services and the re-location of the Step Down Unit.

6.3.15 The Medium Secure Unit Project has an experienced Project Board and Project Team and has strengthened arrangements in preparation for the delivery of the FBC and construction phase. The Board of Directors is confident that, with this structure, the MSU project will be appropriately resourced to support the future phases as set out in the project plan. The Project Board will continuously review the resource requirements to ensure a timely delivery of the new unit.

6.3.16 The Model of Care Work Stream is responsible for implementing the new model of care. This work stream works in collaboration with the Workforce and Operational Work Streams along with the trust’s Secure Care Pathway Group.

6.3.17 Ensuring that a highly skilled and effective workforce is in place is the responsibility of the Workforce Work Stream. A detailed workforce plan including associated costing has been developed and is aligned to the new model of care. This work stream is jointly chaired by an HR Business Partner and the Head of Nursing and Patient Experience.
6.3.18 The operational aspects of the new unit is the responsibility of the Operational Work Stream which is chaired by the Senior Nurse. This work stream has responsibility for reviewing existing operational policies and procedures and identifying where amendments or new policies or procedures are required. Further responsibilities of the work stream include identifying new innovative ways of working along with working in collaboration with the Transition Work Stream to ensure all staff are aware of the policies and procedures for the new unit along with orientation of the building.

6.3.19 The Service Users’ Forum is an existing group with both secure mental illness and learning disabilities services and meets on a monthly basis. The forums provide an opportunity for service users to discuss issues with trust managers and clinicians. These forums will provide a key avenue for communicating progress with the project. The Project Manager and Clinical Lead also attend Ward Community Meetings to provide updates on the project and obtain feedback along with the production of a monthly newsletter/poster which provides information on key aspects of the project.

**Reporting**

6.3.20 The Project Team reports directly to the Project Manager via the use of monthly checkpoint reports which measure progress against specified work stream targets. This information is collated by the project manager and incorporated into a monthly highlight report which is presented to the monthly Project Board Meetings.

**Resourcing**

6.3.21 The resourcing and structure for the project is agreed by the Performance, Investment & Finance Committee and reviewed on an annual basis. There is an allocated budget to support this resource which is monitored on a monthly basis by the Project Manager. The structure ensures that resources (both internal and external to the trust) are sufficient to deliver the project. The Performance, Investment & Finance Committee is satisfied that the structure demonstrates that the project is adequately resourced for future phases of the project as set out in the project plan. It should be noted that each of the work streams consist of both ward based clinical and non-clinical staff from both the Scott Clinic and Whalley and Gisburn sites. Staff are released from their day to day duties to participate in the work streams. The work streams meet on a monthly basis. Work streams that are currently active include Design & Build, Model of Care, Workforce, I.T., Innovation, Business Development, Communication, Project Assurance and Finance. The current resource to support the project is shown in **Appendix 6.1: Project Resourcing**
6.4 Project Management Methodology

6.4.1. The project is governed within a Prince2 project methodology with a central log of risks, issues, work packages and work streams, with benefit identification, profiling and tracking throughout the life of the project.

6.5 Project Plan

6.5.1. The project plan below highlights the key milestones and associated dates identified to deliver the new unit.

Table 6.2: Project Plan

<table>
<thead>
<tr>
<th>Milestone Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of planning permission</td>
<td>13 January 2017</td>
</tr>
<tr>
<td>Submission of FBC to NHS England / NHS Improvement / Department of Health/ HM Treasury</td>
<td>13 April 2017</td>
</tr>
<tr>
<td>Approval of FBC by Performance, Investment &amp; Finance Committee</td>
<td>21 April 2017</td>
</tr>
<tr>
<td>Approval of FBC by Board of Directors</td>
<td>26 April 2017</td>
</tr>
<tr>
<td>Confirmation of FBC approval by Board of Directors to NHS Improvement and NHS England</td>
<td>2 May 2017</td>
</tr>
<tr>
<td>Site preparation works</td>
<td>December 2016 – May 2017</td>
</tr>
<tr>
<td>Approval of FBC by NHS England / NHS Improvement / Department of Health/ HM Treasury</td>
<td>November 2017</td>
</tr>
<tr>
<td>Approval of GMP and Execution of Stage 4 Contract by Performance &amp; Investment Committee and Board of Directors</td>
<td>December 2017</td>
</tr>
<tr>
<td>Start on site</td>
<td>January 2018</td>
</tr>
<tr>
<td>Construction completion</td>
<td>March 2020</td>
</tr>
<tr>
<td>Trust commissioning phase</td>
<td>April –May 2020</td>
</tr>
<tr>
<td>MSU operational</td>
<td>June 2020</td>
</tr>
</tbody>
</table>

6.5.2. The dates shown in the above table relating to construction, trust commissioning and occupation are indicative dates and are subject to change dependent on the external approval timescales.

6.5.3. A detailed project plan has been developed and included at Appendix 6.2: Project Plan
6.6 Use of Specialist Advisors

6.6.1. The project will be delivered as a P21+ National Framework Agreement and as such the trust is following an agreed approach for project management and standard contract documentation.

6.6.2 Specialist advisers have been used in accordance with the Treasury Guidance: Use of Specialist Advisers. These advisers are shown in the table below.

Table 6.3: Specialist Advisers

<table>
<thead>
<tr>
<th>Role</th>
<th>Company</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSCP (P21+)</td>
<td>Kier</td>
<td>Construction</td>
</tr>
<tr>
<td>Direct appointment</td>
<td>Rider Hunt</td>
<td>P21+ framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost adviser</td>
</tr>
<tr>
<td>Business case development</td>
<td>Deloitte</td>
<td>Production of business cases</td>
</tr>
<tr>
<td>Design</td>
<td>IBI Group</td>
<td>Lead architect</td>
</tr>
<tr>
<td>PSCM</td>
<td>WSP UK Ltd/Parsons Brinckerhoff</td>
<td>Civil Engineers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Structural Engineers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acoustic Consultants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fire Engineers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BREEAM Assessor</td>
</tr>
<tr>
<td>PSCM</td>
<td>Strategic Healthcare Planning LLP</td>
<td>Healthcare planner</td>
</tr>
<tr>
<td>PSCM</td>
<td>Edge Property Solutions</td>
<td>Cost adviser</td>
</tr>
<tr>
<td>PSCM</td>
<td>BCA Landscape</td>
<td>Landscaping architect</td>
</tr>
<tr>
<td>Planning</td>
<td>IBI Group</td>
<td>Planning application</td>
</tr>
<tr>
<td>PSCM</td>
<td>Spring &amp; Co</td>
<td>Principal Design</td>
</tr>
<tr>
<td>Direct appointment</td>
<td>Kathryn Berry</td>
<td>NHS Improvement and NHS England Approval route</td>
</tr>
<tr>
<td>Direct appointment</td>
<td>Turner &amp; Townsend</td>
<td>Senior Project Management</td>
</tr>
<tr>
<td>Direct appointment</td>
<td>MIAA</td>
<td>Audit</td>
</tr>
<tr>
<td>Direct appointment</td>
<td>Hempsons</td>
<td>Trust legal advisers</td>
</tr>
</tbody>
</table>
6.7 Arrangements for Change and Contract Management

Contract Management

6.7.1. The construction works are being procured under the P21+ framework agreement. Such an agreement provides a detailed and structured set of guidelines for the management of contracts. Procurement guidance is being followed for the procurement process, with the support of professional advisors and appropriate NHS leads. Throughout the project, the responsibility for coordination of the management requirements of the PSCP will belong to the Project Director – Estates.

6.7.2. P21+ uses the NEC3 Option C: Target Contract with Activity Schedule. The NEC3 contract sets out the foundations for effective and efficient management of a scheme to deliver it on time, within cost and to the quality specified or better.

6.7.3. Mersey Care uses the guidelines and adopts the P21+ NEC3 Option C Contract Administration pro-formas in accordance with the provisions of the P21+ NEC3 contract template, together with the Works Information Template that incorporates procedures that are to be used.

6.7.4 The trust has appointed a P21+ Technical Project Manager and Cost Advisor (Rider Hunt) whose duties are based on the templates for these roles included in the guidance; the roles and responsibilities are outlined in section 6.6, above.

Change Management

6.7.5. Change management associated with this scheme is managed through the Project Board. The day to day change management is reported within the Project Team meetings and any resultant changes will require approval by the Project Board. Notification of any changes to the project will be via the provision of exception reports. An impact analysis of the proposed change, undertaken by the Project Board, measures the impact of implementing the change in terms of time, quality and cost prior to any change being approved by the Project Board.

6.7.6. The results of the impact analysis show whether a proposed change is 'within tolerance' or whether it will impact on key milestones. If within agreed tolerances the Project Board has the ability to authorise the change. If it is outside ‘tolerance’ levels, the Project Board seeks authorisation from the Performance, Investment & Finance Committee and ultimately the Board of Directors.

6.7.7. The Model of Care, Workforce, Operational and Transition Work Streams will form a key element of the change management process, ensuring preparations for transition and the operationalisation of the new unit. Change management processes will be utilised throughout the transition period. A high level transition plan has been developed. Throughout the life of the project the transition plan will be updated to include training programmes as necessary.
6.8 Service User Transition

6.8.1. A Transition Work Stream has been formed comprising of representatives from all departments including clinical, administration, facilities, security, risk, procurement, finance, Information Technology and estates. A high level Service User Transition Plan has been produced setting out the activities needed, timescales and responsibilities, attached at Appendix 6.3: Transitional Plan. A more detailed plan will be produced closer to the date when construction will be completed. Specific attention will be given to:-

- Service users;
- Staff;
- Carers;
- Other stakeholders;
- Equipment;
- Transport;
- Communication;
- Resources;
- Estates;
- Facilities;
- Maintenance;
- Service Level Agreements;
- Utilities;
- Budget;
- Issues;
- Risks;
- Post Evaluation.

6.8.2. The Transition Work Stream works in collaboration with the Operational, Model of Care and the Workforce Work Streams along with the Building Commissioning Work Stream (when created) to ensure that all elements affecting change management and transition are captured within the transition plan including pre and post occupation periods especially in the first weeks following occupation. Following occupation, a post occupation review will be conducted and findings reported back to the Project Board.

6.9 Workforce Planning

Strategic Direction and Vision for Secure Services

6.9.1. The investment of a new medium secure unit on the Maghull site for both mental illness and learning disability services is a significant part of Mersey Care’s strategy to continue to deliver the best possible care for the people we serve. Transforming the secure care pathway will provide the opportunity for a fluid and responsive care pathway across the spectrum of secure mental health and learning disabilities within existing commissioning frameworks. This exciting development will allow us to radically overhaul the way in which the diversity and
complexity of secure mental health care is delivered through innovations and utilising our philosophy of constantly striving to provide ‘perfect care’.

6.9.2. A Specialist Learning Disabilities Division has been created which operates alongside the current Secure and Local Divisions. This Division is headed up by a Chief Operating Officer, who has responsibility for the integration agenda. At some point in the future the trust has a desire to integrate both the Specialist Learning Disabilities Division and the Secure Division.

6.9.3. The co-location of medium secure services onto the Maghull site is one of Secure Division’s strategic priorities and forms a fundamental part of the Division’s transformation plan. The proposed clinical model has been developed with clinical and operational leads from both the Secure and Specialist Learning Disability Divisions in line with best practice and national policy and seeks to address future clinical and workforce challenges.

6.9.4. Through innovative thinking, experienced management and investment, the trust will transform the existing secure care pathway across, high, medium and low secure services. This will create a cohesive and seamless pathway providing access to the appropriate level of secure care for all service users and supporting recovery and discharge in a timely and managed way.

6.9.5. This is a unique opportunity which will be centred around a world leading model of service located on a site which accommodates both high and medium secure services.

Workforce Planning to Support Divisional and Trust Vision

6.9.6. To support the change in the clinical model requires an equivalent change in the workforce model, both for clinical and corporate staff. The intention of the workforce plan is to ensure that the trust has the right number and quality of staff in the right place at the right time, aligned with the long term financial model, in order to ensure the delivery of quality and safe care.

6.8.7. Workforce planning cannot be done in isolation and can only be developed alongside the model of care. The workforce plan has been created to capture the workforce requirements to support the delivery of medium secure services within the new unit. In order to create a truly responsive, effective operational workforce plan, we must take into account not just headcount needs, but the future and existing skills and capabilities required to deliver our services and model of care and have a thorough understanding of the associated costs and performance of our workforce. To do this successfully we need to take a longer term approach, forecast where risks are likely to emerge and put plans in place to address these before they arise.

6.9.8. Following the acquisition of Calderstones, the services at Whalley and Gisburn were subject to a TUPE transfer to the enlarged organisation. This was equivalent to an 868 WTE increase in staff. Mersey Care has experienced a number of workforce challenges including recruitment and retention issues in line with other mental health services, high sickness absence and vacancy rates again in line with other mental health trusts. The trust intends to implement a number of initiatives to alleviate these pressures, including: creating a more fluid and flexible
workforce, integration of pathways; sharing staff across the pathway and between settings of care and implementing clear structures for career progression, learning and development.

6.9.9 These initiatives will provide a number of benefits including:

- Better able to attract clinical staff to fill any recruitment and skills gaps;
- Increased scale and flexibility to manage workforce pressures;
- Access to broader range of employment, learning and development opportunities thus making Mersey Care a more attractive place to come and work;
- Retention of highly skilled and experienced staff within NHS learning disabilities services;
- Access to a broader range of employment and training opportunities
- Increased scale and opportunities to develop clinical expertise - training and opportunities for medical and nursing students, clinical psychologists, occupational therapists and other professionals will be improved by providing access to a more diverse client group;
- The opportunity to develop the right skills for the future. There will be opportunities to work with the educational institutions to develop academic programmes, following an analysis of skill and role redesign, which will help to improve staff career prospects and employability;
- Greater opportunities to share learning and best practice between teams and services and to “take the good from both organisations to become outstanding”;
- Development of new career pathways and roles within the enlarged organisation;
- Greater opportunities for high quality research and development;
- Greater assurance for employment and increased opportunities for diversification.

6.9.10 There are a number of workforce benefits associated with a co-location of services onto the Maghull site along with the development of an individualised model of care for mental illness and learning disabilities. There will be a fundamental shift in the way that the trust’s workforce is organised, trained and functions. The future workforce model has been designed around the service user’s functional needs, rather than their diagnosis, and will be fluid across the clinical pathways and levels of service provision.

6.9.11 Economies of scale achieved through moving to larger wards and aligned with safe staffing levels will deliver service efficiencies whilst also improving outcomes for service users. The current Scott clinic, Whalley and Gisburn provision for MSU are on smaller wards that those proposed within this business case. These small ward sizes result in inefficiencies in nursing staff numbers. The new model of care and increased patient numbers per wards allows for considerable scope for an economy of scale given that the nursing establishments will not be increased for
the currently commissioned and new service user numbers. Alongside greater access for therapeutic and social activity in the model of care supported by the build which will reduce time spent on the ward in future. Improvements to the quality of service and pathways for service users will be achieved as a result of more cross site working, improved relationships, improved focus on physical health, reduced restraint and suicide prevention, improved access to treatment, improved pathway management, services closer to home, better environment, reducing risk and improving service user experience.

6.9.12 The challenges ahead in having a workforce that can effectively and efficiently provide perfect care for offenders and high risk service users with severe mental illness, learning disability, neuro-developmental disorders and personality disorder are recognised. The plan acknowledges expansion and integration as an opportunity to make increased efficiencies in delivering services and supports the achievement of CIPs. Plans are in place to ensure that we have the right staff in the right place at the right time, aligned with the long term financial model and our model of care for medium secure services.

6.9.13 The Workforce plan is included in **Appendix 6.4: Workforce Plan**.

### 6.10 Arrangements for Benefits Realisation

#### Overview

6.10.1 Benefits management and realisation is a core element of any project and is supported by change management processes. It provides a systematic approach to identifying, monitoring, optimising, reviewing and communicating benefits both during and beyond the end of the project. Benefits realisation needs careful management and close measurement, forming an integral part of the implementation process and then adopted into business as usual.

6.10.2 To facilitate the identification of benefits for the project, key stakeholders from both clinical and non-clinical fields were invited to participate in a benefits realisation workshop. Key to achieving the benefits is establishing benefit owners. Each benefit was linked to a specific work stream lead tasked with delivering the benefit. Realisation of the benefits is linked to the change management process and the work stream leads will be supported by a business change manager to ensure benefits are monitored and delivered. It is ultimately the responsibility of the Senior Responsible Officer (SRO) to drive the benefits agenda throughout the life of the project.

6.10.3 The benefits which could be realised as a result of the proposed investment are identified in the attached Benefits Realisation Plan, see **Appendix 6.5a: Benefits Realisation Plan**. The plan highlights the benefits from a qualitative, non-cash releasing and cash releasing perspective and is used to quantify the benefits along with both a baseline and future comparator and the timescale within which the benefit will be realised.

6.10.4 Following the identification of the benefits a core group of staff, including both clinicians and non-clinicians, were invited to an option appraisal meeting to assess
the relevant importance of the benefit criteria against the different options for the project and agree a ranking and weighting of the benefits. The outcome of this exercise supported the options appraisal exercise detailed in the Economic Case with the preferred option being Option 7 one building on the Maghull site. Further detail on the option appraisal exercise can be found at Appendix 6.5b: Benefits Option Appraisal.

6.10.5 Communicating the achievement of benefits is an important element of benefits realisation. The trust’s Communication Department has a pivotal role in ensuring that the success of achieving the benefits is notified to all key stakeholders.

6.10.6 Mersey Care envisages that the benefits from the investment will form part of “normal business”. The NHS has in place systems to measure a wide range of performance indicators. It is recognised that the benefits realisation plan will need to be translated into a set of specific and measurable performance indicators linked directly to both the outputs and outcomes. By regular monitoring and reporting on the of the new performance indicators to both the trust and Commissioners, the realisation of the project’s benefits can be demonstrated. The monitoring process would indicate any benefit failing to be realised and allow the project to plan interventions to address any potential issues.

Main areas of Benefit

6.10.7 The benefits to be delivered by the MSU Project are categorised into five different benefit criterion:

- Seamless Secure Care Pathway
- Improved Outcomes
- Improved Environment
- Effective and Efficient Workforce
- Service Growth and Differentiation

6.10.8 A summary of the key benefits include:

- Provision of a fit for purpose medium secure unit providing improved service user environments, designed and realised with a therapeutic focus capable of delivering individualised care and managed length of stay;
- To maximise service user experience making best use of both technological and operational innovations and enabling greater autonomy within the building with a resultant reduction in the requirement for service users to be escorted;
- Increased workforce efficiency as a result of increased bed numbers per ward;
- Broadening the range of secure services to integrate learning disabilities services in line with national commissioning intentions;
- Greater flexibility to respond to changing fluctuations in market demand and changes in commissioner needs which will ensure service users can be treated closer to home, in line with the national commissioning agenda;
• Improved allocation of personal facilities including en-suite bedrooms and secured access to therapeutic tools in service users’ bedrooms;
• Increased opportunity for social interaction;
• Greater access to physical health care including dentistry, weight management and self care opportunities;
• Reduced geographical isolation to facilitate the sharing of expertise across disciplines;
• Increased health and wellbeing opportunities with the development of a social space within the medium secure unit in order to accelerate recovery and support a life beyond care;
• Increased opportunity for professional development to meet the needs of the service user group;
• Improved working and common/social environments for staff which will facilitate overall staff well-being.

6.11 Arrangements for Risk Management

6.11.1 The trust has robust risk management systems in place. Every employee within Mersey Care has a responsibility for risk management. They have a duty to act in a safe and effective manner, which will reduce or eliminate harm to themselves, other employees, service users, visitors and the organisation itself.

6.11.2 During the operationalisation phase of the new unit the dedicated commissioning team will monitor operational safety, security and risks in line with the trust’s Risk Management Policy and Strategy, see attached Appendix 6.6a: Risk Management Plan.

Risk Management

6.11.3 Risk management is recognised as an integral part of good management practice. It is a learning process consisting of steps which, when undertaken in sequence, enable continual improvements in decision-making.

6.11.4 Risks to which service users, staff, visitors and the organisation may be exposed are constantly changing and/or being identified. The trust therefore has a system of internal control that will allow known and potential risks and hazards to be dealt with on a continuous basis. The trust has a comprehensive, organisational wide risk register that records financial, clinical and organisational risk. The risk register also:

• uses a common currency to evaluate initial risk rating for all identified risks;
• allows the initial risk ratings to be altered to reflect the results of implementation of risk treatment plans.

6.11.5 These processes enable the trust to identify and prioritise risks that may threaten the achievement of its strategic objectives, service user care, or safety of all staff,
service users and visitors and develop and review action plans for the management of risk.

6.11.6 This systematic approach to risk management will be based on the model outlined above. This model, used in conjunction with the risk assessment tools and the risk assessment matrix will enable all services to systematically identify and review their risks.

6.11.7 Mersey Care utilises an online risk register system, Covalent. Each risk is assigned an “owner” who is notified via an alert when a review of the risk is required. The use of Covalent provides the trust with a level of assurance that risk are being effectively managed.

**Project Risks**

6.11.8 Risk management arrangements for the project are consistent with the overall risk management methodology of the trust.

6.11.9 The Joint Project Directors have overall responsibility for ensuring effective project risk management. A project risk register is maintained and forms part of the overall corporate risk register. All risks have individual detailed risk mitigation action plans and any risks scoring 15 or above are escalated to the trust Risk Committee who report within the Board Assurance Framework. The project risk register is discussed in detail at both the Project Team and Project Board monthly meetings providing a level of assurance that risks are regularly monitored, reviewed and remain viable.

**Key Project Risks and Mitigations**

6.11.10 The project has a risk register which is linked to the wider trust risk register. A copy of the current risk register can be found at Appendix: 6.6b: Risk Register.

6.11.11 High level risks with mitigations include:

**Table 6. 4 – High Level Risks**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>If capital and revenue costs for the medium secure unit are deemed to be too expensive it will adversely impact on the trust’s ability to gain the necessary approvals to proceed with the project.</td>
<td>Detailed costing for both capital and revenue completed. Discussions occurred with NHS England regarding transition monies for Whalley. Financial modelling undertaken in FBC Continued review of capital and workforce costs as more accurate data becomes available. Schedule of Accommodation reviewed to allow for alternative design options to assist in realising affordability Guaranteed Maximum Price review of both</td>
</tr>
<tr>
<td>Risk</td>
<td>Mitigations</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Delay in the approval process may extend the lifecycle of the project. | Key personnel identified and made aware of the Project  
Project Plan developed and regularly monitored highlighting critical paths  
Remedial action enforced if issues arise affecting timescales.  
On-going dialogue between the trust and approval bodies  
Planning permission granted on 13 January 2017. |
| Failure to retain the contract to provide both mental illness and learning disability medium secure beds which would mean an alternative use of the facility would be required or sold to the winning organisation and could mean the loss of the high secure service license | Approved provider status  
Quarterly contract meetings with specialist commissioners have not identified any proposed changes to current contracts  
Regular meetings with specialist commissioners regarding progress with the project  
Creating a purposely designed facility  
Agreed a new model of care  
Attendance at pre-procurement sessions with NHS England. |
| Project unable to be financed and additional monies required to fund the project not secured due to borrowing constraints | Early application of loan fund.  
Loan funding included in LTFM, IBP and Monitor detailed plan  
Engaged with Monitor on loan requirements.  
Funding strategy agreed with Board of Directors and Monitor within FBC.  
Modelling work undertaken  
Cost of borrowing reflected in FBC  
Adherence to recently released capital guidance |
| Failure of project to be delivered within the budget of the GMP cost envelope | Use of P21+ contract which negates the adverse impact of overspends on building works.  
Agreement with stakeholders on costs for all individual stages of the project  
Risk transfer to contractor  
Costs constantly reviewed  
Robust costing exercises completed for both capital and revenue costs.  
GMP and FBC incorporated within a new LFTM |
| Difficulties in the recruitment and retention of qualified nursing staff | Recruitment & Retention Strategy in place  
Workforce Plan in place  
Unqualified clinical staff approved to undertake nurse training |
### Risk Mitigations

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apprenticeship scheme operational</td>
<td></td>
</tr>
<tr>
<td>Fast Track Master Class for Mental Illness and Learning Disability nurse training commenced</td>
<td></td>
</tr>
<tr>
<td>Good relationships with higher education facilities and universities</td>
<td></td>
</tr>
</tbody>
</table>

#### 6.12 Arrangements for Post Project Evaluation (PPE)

6.12.1 The PPE will be in line with and satisfy the requirements of the Department of Health’s **Good Practice Guide: Learning Lessons from Post Project Evaluation** (Department of Health 2007) and will incorporate a detailed review of all targeted specific outcomes from the project (a detailed Benefits Realisation Plan is provided in this business case). The outline arrangements for project evaluation review (PER) and post implementation review (PIR) are summarised below.

6.12.2 The trust has included costs for carrying out their PPE in the overall cost plan. Mersey Care is committed to ensuring that a thorough and robust post project evaluation is undertaken at key stages in the process (see Table 6.5 below) to ensure that positive lessons are learnt. The evaluation will be led by the Project Directors and will include:

- Plan the scope of the PPE exercise;
- Monitor progress and evaluate the project outputs;
- Evaluate project and benefits realisation;

6.12.3 The table below shows the dates upon which the trust intends to undertake the key stages of the post project evaluation.

#### Table 6.5: Timetable for the Post-Project Evaluation

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Evaluate design and construction including associated benefits</td>
<td>December 2020</td>
</tr>
<tr>
<td>2</td>
<td>Service user flows and clinical care</td>
<td>June 2021</td>
</tr>
<tr>
<td>3</td>
<td>Benefits delivery first review</td>
<td>June 2021</td>
</tr>
<tr>
<td>4</td>
<td>Benefits delivery final review</td>
<td>December 2021</td>
</tr>
</tbody>
</table>

#### Project Evaluation Reviews (PERs)

6.12.4 The project will be reviewed six months after commissioning to evaluate the design and construction process, and then 12 months after opening to evaluate the changes to service user flows and clinical care along with a first review of the benefits followed by a final review of benefit six months thereafter. The results of these reviews will be scrutinised by the Quality Assurance Committee and the Performance, Investment and Finance Committee. Following on from the review lessons learned workshops will be held and the outcome of the workshops disseminated throughout the trust.
Post Implementation Review (PIR)

6.12.5 These reviews ascertain whether the anticipated benefits have been delivered and are timed to take place immediately after the new facilities open and then two years later to consider the benefits planned.

6.13 Gateway Review Arrangements

6.13.1 Department of Health formal Gateway reviews are no longer mandatory: however, Mersey Care recognises the benefit received from an independent review and as such the trust has engaged with Mersey Internal Audit Agency (MIAA) to provide assurance on the project arrangements throughout the process.

6.13.2 The agreed objectives and scope of MIAA’s work is to provide an independent view of how the project is progressing, see Appendix 6.7: MIAA Terms of Reference. The Terms of Reference include whether the project remains viable in terms of costs and benefits are continually assessed, user requirements identified and met, and that the overall project is delivering a suitable solution for all key stakeholders. An assessment of the on-going application of robust project methodology and governance will be a theme throughout each key stage of the project.

6.13.3 The scope of the review has been developed alongside the project plan to assess critical points at which formal project assurance is required, but will incorporate assessment at each end stage of the project as highlighted below:

<table>
<thead>
<tr>
<th>Assessment Stage</th>
<th>Assessment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Design Phase</td>
<td>December 2017</td>
</tr>
<tr>
<td>End of construction phase</td>
<td>March 2020</td>
</tr>
<tr>
<td>End of Commissioning</td>
<td>May 2020</td>
</tr>
<tr>
<td>End of Transition Move</td>
<td>June 2020</td>
</tr>
<tr>
<td>End of Post Project Evaluation</td>
<td>December 2021</td>
</tr>
<tr>
<td>Project Closure</td>
<td>June 2022</td>
</tr>
</tbody>
</table>

6.13.4 The Project Team consists of both staff employed directly by the trust as well as third party suppliers working to the same reporting standards at Project Team meetings. As independent contractors it is acknowledged that the third party suppliers may conduct their business processes within their own distinct operating frameworks to achieve operational outputs. The trust’s project manager and senior project manager (provided by Turner & Townsend) work closely with Kier (main contractor) and Rider Hunt (construction consultants) who are the notable third
party suppliers to quality check and ensure consistency of outcomes from both main suppliers.

6.14 Contingency Plans and Business Continuity

6.14.1 Contingency plans have been included in the Risk Management arrangements.

6.14.2 Mersey Care has been clear that it will be detrimental to service users and staff to continue to provide treatment in the existing Scott Clinic premises. This building is not fit for purpose, continues to deteriorate and fails to meet accepted standards. The re-provision of this medium secure unit is required as soon as possible.

6.14.3 The trust is currently in the process of producing a Business Continuity Plan along with undertaking a Business Impact Analysis Assessment. Unfortunately neither document is available for appending to this FBC as they are still in development and at the time of submission of this business case are not yet completed. However, the Scott Clinic has a well developed Business Continuity Plan. This document, dated 2015, is in the process of being reviewed, however the principles remain the same. See Appendix 6.8: Business Continuity Plan. This document provides assurance that the Medium Secure Service is able to provide an acceptable level of service in the event of any disruption.

6.14.4 To ensure continuity of business during the transition phase to the new unit plans are in place and have been costed within the financial modelling for the dual running of the two existing units and the new unit. All non-urgent admissions to the existing units will cease prior to the transition to the new unit to reduce any disruption to patient care.

6.15 NHS Premises Assurance Model

6.15.1 Currently Mersey Care does not have an NHS Premises Assurance Model, however, the trust is working to develop this document.

6.16 Equality Impact Assessment

6.16.1 Mersey Care has an Equality and Human Rights process in place to ensure that an internal assurance process exists and aims to eliminate discrimination, establish equality of opportunity and foster good relations between groups. The trust has included a human rights element in this process to actively consider how it engages with people’s human rights in recognition as a public body that we have a duty not to contravene the Act but also to actively protect people’s human rights.
6.16.2 The trust utilises the Equality Analysis Six Steps method when undertaking an equality impact assessment – see table below.

![Equality Analysis Six Steps Diagram]

Figure 6.6: Equality Analysis Six Steps

6.16.3 Mersey Care has plans to undertake the first stage of the equality impact assessment on the design and build element of the process in the near future see Appendix 6.9: Equality Impact Assessment.

6.17 Communication and Consultation

Communication Strategy

6.17.1 Communication is a standing agenda item for both the Project Board and Project Team meetings and provides an opportunity for detailed discussions on communication issues. The strategy assists with informing, educating and influencing a wide range of stakeholders to provide an understanding of the
project and how it will act as an enabler to provide high quality service user care whilst maintaining safety.

6.17.2 The main communication objectives include:

- Make the case for the change to support the project;
- Promote understanding and obtain support from all stakeholders;
- Inform and gain support from staff through effective employee engagement using internal communication channels and opportunities for involvement;
- Promote service improvements delivered through the project, focusing on quality, productivity and efficiency based on evidence;
- Deliver integrated messages with partners to communicate changes in services;
- Through public consultation gaining understanding and support;
- Keep service users, family and carers engaged throughout the process and obtain their involvement in the future developments.

6.17.3 The main themes articulated within the strategy are:

- Improving quality of care – improve service user experience and better outcomes;
- Innovating – new ways of delivering services, sharing and using best practice;
- Enhanced accommodation - having first class facilities that are fit for purpose and meet the specification.
- A number of key communications principles shall apply consistently across the Project including:
  - Consistency of overarching messages across the trust and all partner agencies;
  - The use of values-based messages in all internal communications;
  - Internal and external communications should align with the NHS – messages focused on quality, standards, re-design;
Open and honest, on-going conversations with service users, carers, staff and the general public about issues and choices, in order to build trust and a reputation for integrity;

Ensuring all communications are clear, easily understood, timely and up to date;

Use of the full range of communication channels and engagement tools to ensure messages effectively reach all stakeholders.

6.17.4 A copy of the communication strategy can be found at Appendix: 6.10a: Communication & Media Strategy.

Communication with key stakeholders internal within Mersey Care

6.17.5 The Project Board and Project Team acknowledge the importance of ensuring accurate, up-to-date information is cascaded to all key stakeholders within the trust and also the need to provide an arena to enable both staff and service users to discuss the project. To facilitate this key members of the Project Team attend numerous forums across the trust:

- Departmental Meetings;
- Ward community meetings, which are attended by both service users and staff, on a regular basis;
- Senior Management Meetings including, Operations & Performance Committee, Transformation Group.

6.17.6 Members from the Project Board attend various trust committees to provide updates on progress reports including:-

- Executive Committee;
- Performance, Investment & Finance Committee;
- Board of Directors.

6.17.7 Other forms of communication media platforms are utilised to convey messages around the project including blogs, monthly update posters, website, roadshows etc.

Communication with Key Stakeholders External to the Trust

6.17.8 An extensive consultation programme was undertaken with both statutory and non-statutory bodies during the public consultation programme. Further consultation with the general public was undertaken to support the planning permission application. Updated information is provided to the local councillors and parish councillors and other community groups within the local area. Regular
meetings are held with specialist commissioners to provide updated information on the progress with the project.

6.17.9 Interaction with a number of external bodies also provides an opportunity to check assurance and quality both on a regular and ad hoc basis.

6.17.10 NHS England Specialist Commissioning Team for Secure Services has representation on the Project Board and also receives regular updates from the trust, ensuring that the programme is designed in line with the commissioning intentions of NHS England. This vital communication contributes to maintaining a strong relationship with commissioners to assure the transformation will deliver a service suited to needs of the service user population.

6.17.11 The Health and Wellbeing Boards for both Liverpool and Sefton, along with Sefton and St Helens Oversight & Scrutiny Committees, are updated on a regular basis. A meeting has been held with the MP for Sefton Central, who was very supportive of the project and the plans for further engagement with the local community. Mersey Care is keen to foster close working relationships with the local community and has made open dialogue with local schools to provide mental health awareness sessions along with opportunities for apprenticeships both during the construction phase of the unit and thereafter within the unit. The trust has also sought the support of Sefton at Work to assist with developing employment opportunities for those more disadvantaged residents of the local area.

6.17.12 Upon successful completion of this business case and funding approval, the detailed communications plan will address the next stages of engagement. The Emergency Services, Citizen’s Advice, Ministry of Justice and Advocacy Service will all be notified directly or information will be published in arenas that can be easily accessed and will provide opportunity to engage with the programme.

6.17.13 A communications implementation plan has been developed and is contained in Appendix 6.10b: trust’s Stakeholder Engagement Action Plan.

Consultation

Scott Clinic

6.17.14 Between January and March 2015, Mersey Care undertook a public consultation exercise. It was deemed necessary to instigate a joint Overview and Scrutiny Committee (OSC) review including members of Sefton and St Helens Councils as both authorities viewed the relocation of Scott Clinic to Ashworth site as a substantial variation. The Joint OSC received evidence from a range of stakeholders over the course of three meetings and focused on key lines of enquiry around:

- The case for change and the rationale behind the proposals;
- Service user perspectives;
- Front line staff perspective;
- Transport routes in and out of the Ashworth site and project management plans;
- Additional traffic issues;
- Staffing Issues, including possible redeployment of staff not able to move;
- The Consultation report;
- Concerns held by a local Maghull Ward Councillor and a representative of Maghull Town Council.

6.17.15 Having received and considered the presented evidence the Joint OSC agreed that the public consultation process had been robust and unanimously supported the proposal for the future provision of medium secure services on the Maghull site.

6.17.16 Meetings have continued with both Sefton and St Helens OSCs to keep them appraised of progress with the project. Both OSCs remain supportive of the project.

Whalley

6.17.17 Based on the ‘homes not hospitals’ principle of *Building the right support*, institutionalised medium and low secure care should not be delivered on the Mersey Care Whalley site, (formerly Calderstones Partnership NHS Foundation Trust).

6.17.18 In 2012, a wide range of organisations including the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS), NHS Confederation and the Royal Colleges signed up to the Winterbourne View Concordat which committed the signatory organisations to “the development of personalised, local, high-quality services” and “the closure of large-scale inpatient services”.

6.17.19 The public consultation ran over a 12-week period from 1 December 2016. The consultation considered all views received from a broad range of service users, families and carers, and other stakeholders. There have been a variety of methods of consultation to ensure engagement that meets the needs of people with a learning disability, ASD or both, ensuring their voices are heard. 16 events were held by independent advocates who held targeted discussions with 181 service users and their families, regarding the consultation statements. In addition, we received 22 letters/emailed documents and summaries from the feedback events with a total of 450 participants, which included staff events, attendance at stakeholder meetings and expert groups. There was also the opportunity to give feedback online with 619 responses, however, it should be noted that only 2% of online responses were identified as service users.

6.17.20 The consultation closed on 23 February 2017 and the responses have now been independently analysed. Responses were analysed into different categories as follows:

- Current service users, families and carers;
- Other people with a learning disability or ASD and their families and carers;
• Expert groups, such as the Learning Disability Professional Senate, Royal College of Nursing Learning Disability Committee, Mencap and the Challenging Behaviour Foundation (CBF);

• Other organisations, such as overview and scrutiny committees, local authorities and NHS organisations;

• Staff and union groups;

• Whalley residents

6.17.21 The outcome of the public consultation process concluded that NHS England would not commission learning disabilities secure inpatient services at the Whalley site in the future.

6.18 Arrangement for Publication

6.18.1 The Freedom of Information Act 2000 (FOI) came into force in January 2005. This Act gives anyone, regardless of age, nationality or location the right to require information from public authorities including the government, local authorities, school, police and the NHS.

6.18.2 To comply with the FOI the approved FBC and all submitted documentation will be made available. Arrangements are in place to make the FBC available to the public within 3 months of its approval by the Department of Health.

6.18.3 However, where publication of any aspect of the FBC would prejudice the legitimate security of the hospital or be commercially sensitive, those aspects of the FBC will be removed from the publicly published document.