Wirral Urgent Response Centre

Strategic Outline Case

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Version 3.0

Version Control

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1.0 EXECUTIVE SUMMARY

1.1 Introduction

This Strategic Outline Case (SOC) is in support of investment in a new Urgent Response Centre (URC) on the Wirral on behalf of Cheshire and Wirral Partnership NHS Foundation Trust (CWP) with the support of partner organisations. This project will enable the development of suitable and sustainable accommodation in order to deliver and support modern models of care in the most appropriate setting in terms of service users in mental health crisis.

The OBC is based on the Five Case Model, which is the format recommended as best practice by HM Treasury.

Whilst based on the five Case Model this SOC is currently not compliant with NHS England (NHSE) fundamental assessment criteria, once a funding stream has been identified and commercial strategy agreed this document can be updated accordingly.

1.2 Strategic Case

The Strategic Case articulates the case for change, setting it in both the national, regional and local context. It articulates how the development of an Urgent Response Centre in Wirral to co-locate several urgent care teams both within Cheshire and Wirral Partnership NHS foundation Trust and external partners will enhance the collaborative approach to deliver person centred care to people in mental health crisis. Also confirming that the proposal is fully aligned with Trust, partners, ICS, DHSC and Government policies and plans.

The development of the URC is central to the development of a first response approach to delivering an urgent care mental health response for people in Crisis who do not require Emergency Department attendance. Opportunities for a system wide response which is deployed from the First Response Service , Children and Young People, Urgent Support Teams and other partners will support effective triage and divert from ED into the community assets which will include Crisis Cafes and peoples' own homes. This will reduce footfall through local Emergency Departments as appropriate.

The URC will create a centralised point within Wirral footprint for all urgent mental health work requests and distribute the need and demand across existing services in a co-ordinated way, utilising all the different skills within the teams. Staff would work across community and Emergency Department as part of the urgent mental health response. This would reduce the peaks and troughs of individual service demand and level the overall response.

This function would also support North West Ambulance Service and Police forces, and therefore ensure people with mental health needs are not being conveyed to ED unless they required physical health interventions (e.g. those who have self-harmed).

The proposal would also support ED pressures and reduce the risk of vulnerable people with mental health needs being unnecessarily conveyed to ED with the ethos of the centre being home/community first.

In response to the drivers for change the following project objectives have been agreed:

Investment Objective 1	Location of the Wirral URC
Definition	• Bolstering existing service provision, both acute and community • Optimising co-location of resources • Parity of access • Supporting people in crisis in the best possible location

Investment Objective 2	To provide a therapeutic environment for service users in crisis.
Definition	• Ensuring care is delivered in a calm, therapeutic and secure space • Supporting the varying needs of service users e.g. autism and dementia friendly • Enabling delivery of high-quality care in appropriate accommodation • Improving service user experience

Investment Objective 3	Patient and staff experience
Definition	• Fit for purpose for both staff and service users • Enabling co-location for colleagues whilst ensuring separate access for service users • Considering access to the facility in conjunction with wider acute and community offering

Investment Objective 4	Demand and future proof
Definition	• Reducing pressure on existing emergency department • Reducing pressure on existing place of safety facilities • Enabling appropriate deflections away from the ED • Supporting improved mental health capacity in the Wirral and management of future demand

Investment Objective 5	Partnership working – enabling the model of care
Definition	• Ensuring the facility acts as a key enabler for the delivery of the model of care for mental health services in the Wirral • Ensuring parity of access for all • Enabling better partnership working between primary, secondary, third sector, social care and other key partners.

1.3 Economic Case

Based on the case for change and the agreed project objectives, the critical success factors (CSFs) for the project are shown in the figure following. The CSFs that have been developed for this scheme are in line with the CSFs suggested by the HM Treasury guidance.

The options considered in this case were considered against these CSFs.

CSF	Description
Strategic fit and business needs	How well the option: • meets the agreed spending objectives, related business needs and service requirements, • provides holistic fit and synergy with other strategies, programmes and projects
Potential value for money	How well the option: • 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. • Minimises associated risks.
Potential achievability	How well the option: • Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change, and • matches the level of available skills required for successful delivery.
Supplier capacity and capability	How well the option: • Matches the ability of the service providers to deliver the required level of services and business functionality, and • is likely to be attractive to the supply side.
Potential affordability	How well the option: • Meets the sourcing policy of the organisation and likely availability of funding, and • Matches other funding constraints.

A long list of options was identified using the Options Framework within the HM Treasury 'Green Book' (covering scope, solution, delivery, implementation and funding). The options framework provides a structured approach to identifying and filtering a broad range of options for delivering programmes of work or individual projects.

The outcome of the options generation and appraisal workshop was a shortlist of options as shown below.

Short-List Options
Option 0 - Business as Usual
Option 1 – Do Minimum (Extension or Refurbishment on Arrowe Park co-located with ED)
Option 2 (Option A) – New-Build on a CWP Community of Partner Site within the Wirral Geographical Footprint
Option 3 (Option B) – New-Build on Arrowe Park

The figure following summarises the planned benefits, categorised as cash-releasing, non-cash-releasing, societal and non-monetisable. The benefits shown following link with the benefits realisation plan, included in the Management Case.

Ref.	Benefit Name	Benefit Description
NCRB1	Reduction in ED Attendances	Reduction in ED attendances through delivery of the scheme and provision of alternative pathway for people in mental health crisis. If they do attend the ED this will only be instances when they have an acute problem that needs medical attention.
NCRB2	Reduction in incidents	Reduction in number of incidents reported in the Trust's incident recording system through improved throughput, increased capacity and treatment of patients in the most appropriate setting.
NCRB3	Reduction in incidents of physical aggression and/or harm	Reduction in incidents; patient on patient, patient on staff, self-harm and patient behaviour, incidents of damage to property.
NCRB4	Improvement against 4 hour quality standard	Improved Trust performance against the 4 Hour Quality Standard through management of service users in the most appropriate setting. Reduced attendance at ED and therefore reduced wait times.
NCRB5	Reduced wait times for people in Mental Health Crisis	Reduction in overall wait time for those in MH crisis.
NCRB6	Improved Staff Wellbeing	Reduction in staff sickness due to reduced pressure on ED staff due to disruptive patients presenting at the URC instead of ED. Reduction in sickness, absence, associated with the environment and burnout.
NCRB7	Reduced agency/bank spend	Reduced agency/bank spend – directly employed NHS staff will be more interested in working in new builds because they will have a therapeutic environment designed to give the patients the best care
NCRB8	Improved Staff Retention	Reduced costs associated with recruitment, and issues with retention
NCRB9	Out of Area Placements	Reduction in out of area placements through collective use of resources, alternative admissions pathways.
NCRB10	Delays in transfer of care	Reduced service user Length of Stay through reduced delays in transfer of care by managing patients in the most appropriate setting.
NCRB11	Wider benefit linked to the other sites in the model	Improved system performance in regard to management of mental health crisis with the project acting as an enabler to the wider model of care and supporting the URCs across the patch.
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system.

Key:
CRB – Cash Releasing Benefit
NCRB – Non- Cash Releasing Benefit
SB – Societal Benefit
UB – Unquantifiable Benefit

The figures following present the key economic appraisal outputs based on the assumptions and inputs described above, expressed as Benefit / Cost Ratios.

Option	0	1	2	3
Incremental Capital (Cost)	-	£8,643,915.87	£9,024,973.39	£9,024,973.39
Incremental Revenue Cost	-	-	£12,038,087.28	-
Incremental Opportunity Cost		£9,591,152.94	-	-
Incremental Risk	-	£292,740.00	£485,830.00	£482,080.00
Incremental Costs – Total	-	£18,257,808.81	£21,548,890.66	£9,507,053.39
Incremental Benefit NPV	-	£105,288,338.18	£88,867,443.58	£108,417,986.01

Net Present Social Value (NPSV)	-	**£86,760,529.37**	**£67,318,552.92**	**£98,910,932.62**
Benefit/Cost Ratio	-	5.68	4.12	11.40
Economic Ranking of Options	4th	2nd	3rd	1st

This economic analysis indicates that:

- All options have the potential to show a positive Benefit / Cost Ratio (BCR) compared to BAU; and
- **Option 3 is the preferred option**, with a BCR of 11.40.

On the basis of the BCR the Option 3 provides better value. This BCR is considerably higher than the 4:1 ratio which is typically seen in CIAM's. This can largely be attributed to the gaps in cost data, which means that the cost of option 3 is significantly lower than option's 1 and 2. We expect that this BCR will reduce when the CIAM is revisited at a later date, with fuller, more comprehensive cost data.

A summary of the capital costs of this option are shown following, with a planned outturn cost of £11,972,00.00 (rounded figures used).

Capital Cost Elements	Option 3
Departmental Works Costs	£2,928,010.00
On-Costs	£1,396,801.00
Location Adjustment	Inc
Fees	£948,424.00
Non-Works	£60,000.00
Equipment	£505,642.00
Planning Contingencies (20%)	£758,738.00
Optimism Bias (15%)	£1,327,765.00
Total Capital Cost excluding inflation	£11,187,958.00
Inflation (3% p.a.)	£784,243.00
Total Capital Cost	£11,972,200.00

1.4 Commercial Case

The preferred direction of travel is a new build facility on the Arrowe Park Hospital site adjacent to the Emergency Department. The accommodation requirements for the project reflect the capacity modelling undertaken and the need to deliver therapeutic, safe, high quality and fit for purpose facilities as emphasised in the investment objectives. The figure below summarises the estimated accommodation requirement for the project:

URC SoA Summary Sheet		
Departments		Departmental Gross (sqm)
Entrance Zone		168.7
Assessment Zone		174.7
Administration Zone		379.0
Support Zone		123.0
		845.4
Communication Space	*8%*	68
Plant	*8%*	68
Total Gross Area (sqm)		980.80

The development of the optimum estate's solution, based on the agreed model of care has had the consistent and integral input from clinical leaders and frontline clinical and non-clinical staff, with a detailed design brief being developed which includes the following functional content:

- **Entrance Zone**
    - Joint entrance for adults and children and young people
    - Joint waiting area with sections to accommodate adults, children and quite spaces
    - Interview/quiet room
    - Reception (ideally positioned centrally with clear visual of the whole area)
    - Visitor WCs
- **Assessment Zone**
    - Consult/assessment rooms
    - Interview room
    - Physical health treatment room
    - Section 136 suite with assessment room, quiet room / de-escalation room and dedicated entrance
    - Clinical Support - clean utility, dirty utility, store, disposal hold.
- **Administration Zone**
    - Open plan office and desks for various teams
    - General Hot Desks and touchdown space
    - Collaboration space
    - None face2face rooms, 121 meeting rooms, meeting rooms
- **Staff and Support Zone**
    - Staff room/kitchen
    - Staff change, showers, WC's
    - Cleaners room
    - IT/Server room

The designs for the development primarily follow the HBN guidance and currently assume no derogations. The Trust is targeting a BREEAM rating of 'Excellent' (based on BREEAM 2018).

At this stage in the business planning process for the Wirral URC a number of options have been considered for the methodology of delivering the preferred direction of travel which is on the Arrowe Park hospital Site owned by WUTH and the preferred delivery will be intrinsically linked to the funding strategy for the project.

There are currently two main options which have been considered:

- **Option 1** – CWP would enter into a long lease for a suitable freehold site on Arrowe Park Hospital for a peppercorn ground rent. CWP would then undertake the construction of the URC and ultimate ownership of the asset.
- **Option 2** – CWP would enter into a development agreement with WUTH who would agree to construct on CWP's behalf the URC on the Arrowe Park Hospital site in return for the capital to construct the new facility . CWP would then into a lease agreement with WUTH for a 25-30 year period for a peppercorn rent.

Both of these options for the preferred direction of travel will require further discussion between the two Trusts and will also be linked to the funding stream identified for the project.

The current staffing model will not change with the development of the URC, however the colocation of staff across multi organisations should generate increased efficiency and will support the model of care.

1.5 Financial Case

The capital requirement for the scheme is **£11,972,200** (including VAT at 20%). The summary OB Capital Cost forms and associated report for the scheme showing the costs and contingencies included in the capital cost calculations and showing the overall capital costs of the scheme is included as an appendices to the main body of the SOC.

Once the source of potential funds has been identified and the commercial strategy for the delivery of the URC has been confirmed this SOC will be updated with revenue costs for the preferred direction of travel.

In order to fund any additional schemes, CWP will need to lobby the ICB and NHSE for additional CDEL. Given the potential scale of the Wirral URC project, ideally this would need to be cash backed by securing additional Public Dividend Capital (PDC). Ordinarily, additional capital resources are not accompanied by revenue support for day-to-day costs. Working on that assumption, aside from ensuring that the accounting treatment is correct, any subsequent Financial Case would have to clearly demonstrate the full capital and revenue consequences of any scheme, the impact on CWP's balance sheet and income & expenditure statement, the overall affordability and fundability of the scheme and confirmation of support from the relevant stakeholders.

1.6 Management Case

A clear and robust governance structure has been agreed for the delivery of the Wirral URC project and will be implemented as part of the approval of this business case. The programme is overseen by the Urgent Response Centre Project Board, which is accountable to the CWP Executive. Reporting to the Project Board is the Wirral URC Delivery Group and relevant workstream groups as required.

The structure of the project will be developed to follow the principles set out in the NHS Capital Investment Manual and the HM Treasury Green Book, supported by PRINCE2 project management principles.

The Senior Responsible Owner (SRO) and Programme Sponsor is Suzanne Edwards Chief Operating Officer, CWP.

The table below summarises the key milestones for the successful planning and delivery for the Wirral URC. This shows that construction could potentially commences in January 2025 with a completion in 12 months and the facility operational by Early Spring 2026.

Programme Stage	Completion Date
SOC approval (internal)	April 2023
OBC approval (external)	December 2023
FBC approval (external)	October 2024
Start on site	January 2025
Construction completion	January 2026
Operational date	April 2026

The Trust's approach to risk management in accordance with its internal assurance framework is designed to ensure that the risks associated with the project are systemically identified, appraised and action plans developed for effective reduction, elimination and mitigation.

A planning contingency of £758,738 including VAT has been included within the OB capital cost forms and as such form part of the capital budget for the project. A sum of £1,327,765 including VAT has been included for optimism bias, which equates to 15%. At this time the Trust does not intend to undertake an external assurance review but will keep this decision under review.

CWP and its partners are committed to a process of meaningful stakeholder engagement and communication. It already has established formal and informal channels adapting its communications and engagement as far as possible to the methods and frequency preferred by stakeholders. The intention is to develop a Stakeholder Engagement and Communications Strategy which will be produced at the next stage of the business planning process and prior to commencement of the OBC process. It will set out the communication and engagement objectives and describes how the Trust will work together to communicate and engage by identifying target audiences, key messages, and appropriate channels. It will also describe the resources required to deliver the strategy and how the Trust will manage the communications and engagement risks.

A benefits realisation plan (BRP) will also be developed with the aim of providing an evidence base to support the intended health, quality and other identified benefits, where that evidence exists, and to quantify the benefits, wherever possible, to ensure that they can be measured and demonstrated over time.

1.7 Conclusion and Recommendations

This Strategic Outline Business Case document provides a case for investment in the development of a Wirral Urgent Response Centre. This SOC demonstrates:

- The strategic need for change in line with national, local and organisational drivers;
- The proposed delivery model and scope of the project;
- The preferred direction of travel to develop a URC on the Arrowe Park Hospital site;
- The capital consequences of the options set in the context that engagement with the ICB and NHSE will be required to consider funding routes; and
- Detailed plans for the governance and management of the implementation of the project in order to update the SOC and progress to the next stages business planning process.

The Strategic Outline Business Case is being presented to the Board in April 2023 with a request to:

- APPROVE the strategic fit within the context of CWP;
- APPROVE the identification of the preferred way forward;
- APPROVE engagement with the ICB and NHSE to consider potential funding routes;
- APPROVE engagement with WUTH to progress the commercial case;
- APPROVE the governance as noted in the management case and
- APPROVE undertaking further work to this Strategic Outline Business Case once a funding stream has been identified and subsequent progression to development of the Outline Business Case.

2.0 STRATEGIC CASE

2.1 Introduction

The Strategic Case articulates the case for change, setting it in both the national, regional and local context. It articulates how the development of an Urgent Response Centre (URC) in Wirral to co-locate several urgent care teams both within Cheshire and Wirral Partnership NHS foundation Trust (CWP) and external partners will enhance the collaborative approach to deliver person centred care to people in mental health crisis. Also confirming that the proposal is fully aligned with Trust, partners, ICS, DHSC and Government policies and plans.

This section of the Strategic Outline Case (SOC) also sets out the scope of the project, investment objectives plus the associated high-level benefits, risks, constraints and dependencies which have been identified at this stage.

The structure of this Chapter follows the guidance set out in the HM Treasury Green Book.

PART A: Strategic Context

2.2 National Context

The national policy context against which this project has been developed consists primarily of the NHS Long Term Plan and the DHSC Five Year Forward View for Mental Health. Figure 1 provides a summary of the broader national strategic direction.

Figure 1 - National Strategic Direction Alignment with SOC Proposals

Policy	Overview
NHS 'Long Term Plan' (2019)	The overriding aim of the NHS Long Term Plan (LTP) is to redesign patient care to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment. The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the overall NHS budget. It requires a more proactive and preventative approach to reduce the long term impact of people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services. Leaders across the system are tasked to take decisive steps to break down the barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer and improve outcomes.
Mental Health Taskforce 'The Five Year Forward View for Mental Health' (2016)	'The Five Year Forward View for Mental Health' (FYFVMH) sets out the national vision for health and social care services, it was the start of a ten-year journey for NHS mental health transformation. It acknowledges the chronic underinvestment in mental health across the NHS in recent years and requires efficiencies made through achieving better value for money to be re-invested to meet the significant unmet mental health needs of people to improve their experiences and outcomes. The recommendations include the need to treat people in the least restrictive setting, as close to home as possible and, in doing so, seek to address existing fragmented pathways in care.

NHS England 'Mental Health Implementation Plan 2019/20 – 2023/24'	The 'NHS Mental Health Implementation Plan' summarises the FYFVMH and LTP ambitions to deliver against ICS-level plans to eliminate all inappropriate adult acute out of area placements by 2020-21 (FYFV) and to improve the therapeutic offer from inpatient mental health services through increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital by 2023/4 (in line with LTP ambition).
Royal College of Psychiatrists – Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983	The Multi-agency Mental Health Act Group have produced the following recommendation in regard to Section 136: The custody suite should be used in exceptional circumstances only. 1. A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed. 2. The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3h in all cases where there are not good clinical grounds to delay assessment. 3. The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act. 4. A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases. Commissioners should ensure that there is a multi-agency group meeting to develop, implement and quality assure the agreed policy. This group should review the monitoring data. It should also consider how the need for use of Section 136 might be reduced.
Mental Health Act 1983 - Section 136	Section 136 allows the police to take you to (or keep you at) a place of safety. They can do this without a warrant if: • you appear to have a mental disorder, AND • you are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, AND • you are "in need of immediate care or control" (meaning the police think it is necessary to keep you or others safe). Before using section 136 the police must consult a registered medical practitioner, a registered nurse, or an AMHP, occupational therapist or paramedic. The police can keep you at the place of safety for up to 24 hours, which can be extended for another 12 hours if it was not possible to assess you in that time. The time starts when you arrive at the place of safety, or whenever the police arrived if you are not taken somewhere else.
CQC Health and Social Care Act 2008: Regulation 15	The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located.
CQC: 'State of Care 2019/20'	This report is an annual assessment of health and social care in England. Key point of relevance to this case is the need to maintain a safe environment including managing the need to socially distance or isolate people
Cross-Government Suicide Prevention Workplan 2019	The Department of Health and Social Care (DHSC) announced the publication of its first cross-government suicide prevention workplan.

	This was created in response to the Suicide prevention inquiry led by the Health Select Committee, which called for a clearer implementation strategy for the overall Suicide Prevention Strategy for England (2012).
National Disability Strategy 2021	In July 2021, the Government published its strategy to improve the lives of disabled people in the UK. Part one of the strategy sets out the immediate actions needed to improve the everyday lives of disabled people. Part two covers longer-term changes that will put disabled people "at the heart of government policymaking and service delivery." Part three sets out the actions that will be taken by each Government department.
Major Conditions Strategy	In January 2023, the Government announced it will publish a Major Conditions Strategy that will include mental health. The Government has said a joined-up strategy will ensure that mental health conditions are considered alongside physical health conditions. The responses to the consultation for the 10-year strategy will be used to inform the Major Conditions Strategy and to develop a new Suicide Prevention Strategy.

The proposal set out in this SOC is in line with the ambitions of the NHS Long Term plan to develop crisis services including:

- The NHS will ensure that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21.
- In the next ten years there is commitment to ensuring the NHS will provide a single point of access and timely, universal mental health crisis care for everyone.
- The will also be increased alternative forms of provision for those in crisis.
- Ambulance staff will be trained and equipped to respond effectively to people in a crisis.
- Clinical decision units can also prevent admission.
- Trust to work hand in hand with the voluntary sector and local authorities on these alternatives and ensuring they meet the needs of patients, carers, and families.

The NHS Long Term Plan also makes a commitment that by 2023/4 all children and young people experiencing a mental health crisis will be able to access age-appropriate crisis care 24 hours a day, 7 days a week. This will include crisis assessment, brief response, and intensive home treatment.

2.3 Regional Context

Cheshire and Merseyside Healthcare Partnership

The Cheshire and Merseyside Healthcare Partnership Integrated Care Systems (ICS) is a collaboration of public NHS and council social care commissioners and providers across Cheshire and Merseyside working together with partners in the voluntary, community and independent sectors to manage the health and care needs of the population and provide high quality, sustainable care for the future. The Healthcare Partnership services a population of 2.7 million population across nine boroughs.

Both Cheshire and Merseyside have areas of substantial wealth and substantial deprivation contributing to significant health inequalities across the region. A third (33%) of the population of Cheshire and Merseyside reside in the poorest 20% of neighbourhoods in England, with 15% of children living in

absolute poverty households whilst 18% live in relative poverty. Six local authorities in Cheshire and Merseyside have alcohol-related mortality rates that are higher than the national average, and six also have above average drug-related mortality rates. In Wirral, more specifically, there are significant mental health inequalities with 16% of adults suffering from depression compared to an estimated 4.5% in the UK more widely. This impacts women more negatively, with 24% of women having experienced depression at some point in their life, compared to 13% of men. Additionally, the ageing population in Wirral poses a further challenge for the ICS. Figure 2 highlights the footprint of the ICS.

Figure 2 - ICS Footprint

Cheshire and Merseyside's shared vision is highlighted below[1]:

"Everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer".

The ICS have identified that this will be accomplished by working together, as equal partners, to tackle health inequalities and improve the lives of the poorest fastest.

Cheshire and Merseyside have been working towards this for some years and want to continue building on the work. This includes further strengthening the joint working throughout the Covid-19 pandemic, which made a significant difference to the lives of local people and their families.

Cheshire and Merseyside have four key strategic objectives.

- Improve population health and healthcare
- Tackle health inequality, improving outcomes and access to services
- Enhancing quality, productivity and value for money

[1] Healthwatch Cheshire west

- Helping the NHS to support broader social and economic development

The Health and Care Bill set out legislative changes required to change to enable health and care to work more closely together. In Cheshire and Merseyside, there has long been an ambition to improve the way services work together, but bureaucracy has often made this challenging. The reforms therefore support the ICS locally by removing some of the legal rules that can inhibit truly joined up care.

The Cheshire and Merseyside ICS governance structure includes:

- **Integrated Care Board (ICB)** - Integrated Care Board (ICB) has been established as a statutory organisations to lead integration within the NHS. The Cheshire and Merseyside ICB have a unitary board and minimum requirements for board membership will be set in legislation.
- **Integrated Care Partnership (ICP)** - The Integrated Care Partnership provides a forum for NHS leaders and local authorities (LAs) to come together, as equal partners, alongside important stakeholders from across Cheshire and Merseyside.
- **Place-Based Partnerships** - The Cheshire and Merseyside ICB has arranged for some of its functions to be delivered, and decisions about NHS funding to be made, in the region's 9 borough places – through Place-Based Partnerships. The ICB remains accountable for NHS resources deployed at borough place-level. The ICB has set out the role of designated Place-based leaders within its governance arrangements. Health and Wellbeing Boards (HWBs) will continue to develop the joint strategic needs assessment and joint health and wellbeing strategy, which both the ICP and ICB will give due regard.

There are ten principles that underpin how the Cheshire and Merseyside ICS will work with people and communities:

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feedback to people and inform communities about how their engagement has influenced activities and decisions.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

2.4 Cheshire and Wirral Partnership NHS Foundation Trust Organisational Overview

Overview

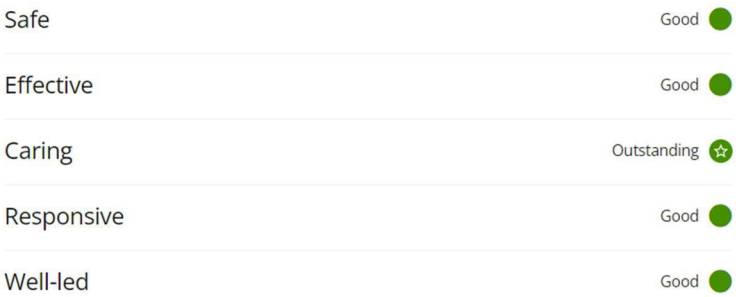
CWP provides a comprehensive mental healthcare service to residents of Cheshire and the Wirral and a range of specialist mental health services to communities in the Northwest and beyond. The Trust operates from 70 sites, serves a culturally and socially diverse population of over 1 million people and provides highly specialist services for 2 million. The Trust has an income of around £200m and a dedicated workforce of more than 4000 staff. It covers a range of local and regional services and partnerships covering inpatient, community and specialist mental healthcare.

The Trust provides a range of inpatient, community and specialist mental health services for service users. These services are split into four key areas:

- **Mental Health Core Services**
    - Forensic inpatient/secure wards
    - Child and adolescent mental health wards
    - Wards for older people with mental health problems
    - Acute wards for adults of working age and psychiatric intensive care units (PICU's)
    - Community-based mental health services for adults of working age
    - Wards for people with a learning disability or autism
    - Mental health crisis services and health-based places of safety
    - Specialist community mental health services for children and young people
    - Community-based mental health services for older people, people with a learning disability or autism
- **Mental Health non-core and specialist services**
    - Community eating disorder services
    - Inpatient eating disorder services
    - Community perinatal services
- **Acute – Community health core services**
    - Community health services – adults' community, children, young people and families and end of life care
- **Primary Care Services**
    - GP practices
    - Out of hours GP service

The most recent CQC assessment of the Trust (undertaken in 2020) rated it as 'Good overall, with it being regarded as outstanding in one category. (Figure 3).

Figure 3 - CQC Assessment



Vision and Strategic Direction

The Trust's Five-Year Strategy outlines how the Trust will provide the best care in the right way in the right place at the right time, with joined up care across health and social care.

The Trust's Strategic vision is to

"Work in partnership to improve health and well-being by providing high quality, person-centred care."

There are 8 strategic ambitions that directly relate to how the Trust will achieve its vision, as shown below. These strategic ambitions have driven the specific investment objectives that have been identified for the project (See section 2.10).

1. We will serve the people of Cheshire and Wirral (and beyond) through identifying need, reducing inequalities, and improving outcomes for all.
2. We will support the development of capability, resilience, and social value within communities.
3. We will serve the communities by working in partnership with others and providing care that influences advocates and support.
4. We will support the provision of integrated services that are outstanding, evidence based, and enable equitable access for all.
5. We will make the best use of the resources available to us and will allocate them according to need and best value outcomes.
6. We will use our influence, physical presence, and assets to reduce inequalities and improve the environment.
7. We will be person-centred and value-based and make CWP a place which enables people to be the best that they can be.
8. We will continuously improve, innovate and share our learning across communities.

Each objective has been defined through working with partners and people with lived experience in order to clearly set out what the Trust needs to achieve.

Figure 4 - Objectives

Objective	Requirement
Improving health, care and wellbeing	• Working within communities in partnership with the people who access our services, third sector and other health and care partners • Ensuring our service delivery emphasises health promotion and prevention • Contributing to the Cheshire and Merseyside No More Suicide partnership with the ambition of zero suicide
Working with communities	• Delivering person-centred services focused on care communities and dedicated to whole-person wellbeing. • Focusing on areas of local deprivation and working in partnership with communities to develop services to meet local needs. • Developing and providing access to education and training opportunities with and for stakeholders
Working in partnership	• Supporting the carers and families of those who access our services. • Being influential in Integrated Care Partnerships and working with Local Authorities and community partners to meet local needs. • By ensuring that all people who access CWP services are also supported by partners who support wider determinants of health
Delivering, Planning and commissioning services	• Commissioning services through other partners and leading in Provider Collaboratives • Ensuring delivery of services that are outstanding, evidence-based and enable equitable access and outcomes for all. • Ensuring provision of integrated physical and mental health services centred on care communities. • Ensuring that all care pathways focus on what matters most by being co-produced with those accessing or affected by services
Making best value	• Delivering high quality care that reduces unwarranted variation in outcomes and cost. • Supporting the provision of sustainable care within the limits of financial, social and environmental resources • Enhancing social value within our communities • Using benchmarking and continuous improvement to ensure our services provide value for money
Reducing inequalities	• Tackling social injustice • Being an Anchor Institution in our communities • Being good citizens with a social conscience. • Contributing to improving environmental sustainability • Collaborating with partners to address economic poverty and eliminate digital poverty within our population
Enabling our people	• Ensuring that everyone within CWP knows they belong and has the confidence to make their own unique contribution. • Providing opportunities to develop knowledge and skills and to fulfil our potential. • Creating a place of positive health and wellbeing and, through our policies and practices, treating colleagues equitably and fairly. • Being a community of people which is representative of the communities we serve.
Improving and innovating	• Building Quality Improvement Capability (capacity, competence and confidence) in our people, volunteers and peer support workers. • Conducting research and implementing research findings consistently and at scale to benefit the public and increase knowledge. • Using national and international evidence to develop learning and innovation • Supporting and encouraging innovation. • Developing our digital capability

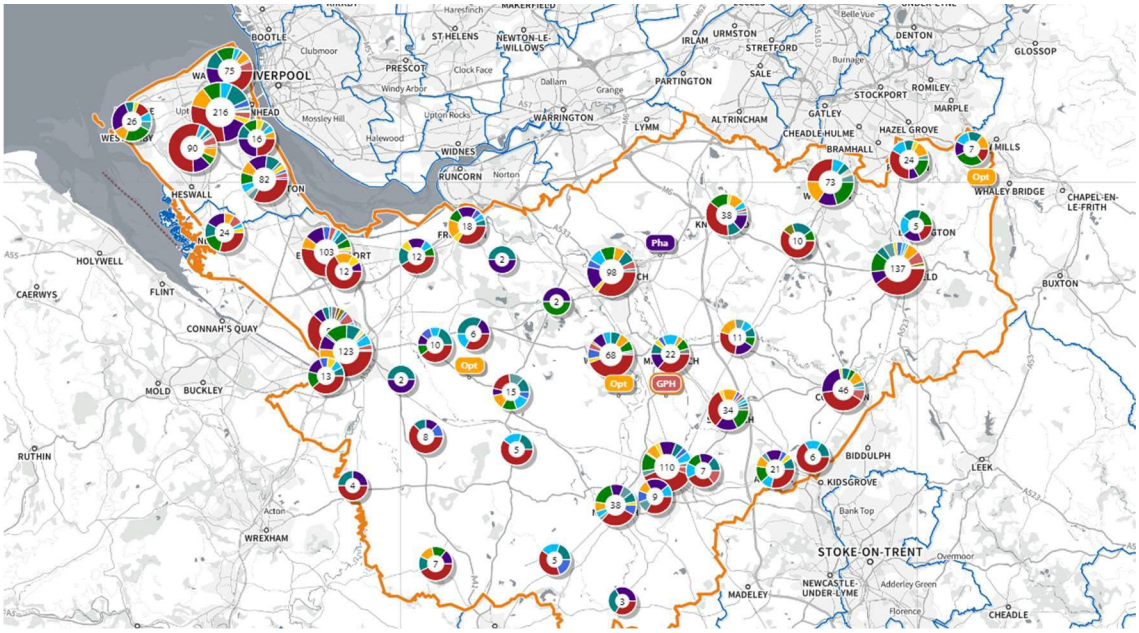
The Trust also commits to reducing inequalities and improving the overall wellbeing of the local people they serve. This means that, alongside their core business, they will play a significant role in making a strategic contribution to the local economy. As such, seek to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental wellbeing of the local population. As a result of this, The Trust will:

Figure 5 - The 6 C's

- Focus on tackling health inequalities, removing the barriers to enhancing wellbeing for all
- Maximise local investment, recognising the social, economic and environmental benefits of doing so
- Increase local employment and training opportunities for local people, especially from areas of High deprivation and unemployment
- Be recognised as a good employer, provide outstanding careers, ensuring our employees have a positive and fulfilling experience and empowering our staff to deliver outstanding services every day
- Champion equality, diversity and inclusion, recognising people from different backgrounds and experience make a valuable contribution to the way in which we work
- Be greener and sustainable, recognising the impact we have and could have on the environment

The map at Figure 6 shows the geographical location between the Trust and its ICS health partners.

Figure 6 - Geographical Location between Trust and ICS



This map includes a wide range of partner organisations including:

- Primary care
- Secondary care
- Care Homes
- Children's Centres
- Mental Health Facilities
- NHS Trusts
- NHS Property Services & LIFT
- Urgent & Emergency Services

CWP Clinical Strategic Direction

The Trust has an ambition to transform clinical services in order to provide the best care in the right way in the right place at the right time, with joined up care across health and social care. This ambition, as it aligns with the services detailed in this SOC, focuses on the 6C's:

- **Care**
    - To be more than just a support service. To work in partnership with clinicians, and to share the responsibility in delivering person-centred care.
- **Competence**
    - To ensure the department has the right combination of skills, training and knowledge to assure the board that the build environment is safe, fit for purpose and compliant to all standards.
- **Courage**
    - To establish a culture of learning from our mistakes and building on our successors.
- **Communication**
    - To acknowledge that talking, learning and listening to colleagues, patients and carers is the most effective way of improving our service.
- **Commitment**
    - To collaborate and work in partnership in order to achieve our goals.
- **Compassion**
    - To do our best to improve the lives and opportunities of our patients.

Estates Profile and Strategic Direction

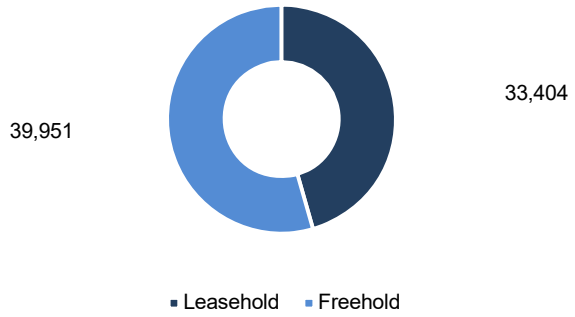
The Trust has a Board-approved Estates and Facilities Strategy 2022-2027. The priorities for estate investment and development have been based on the Trust's Clinical Services Strategy.

The priorities for 2022-2027 are:

1. The Quality of the Estate
2. Demand and Capacity
3. Rationalisation of the Estate
4. Adaptability and Flexibility of the Estate
5. Inpatients Transformation
6. Outpatients Transformation
7. Community Care
8. Digital Empowerment
9. Environmental Performance
10. Surplus Land and Estate for Disposal
11. Prioritised Capital Programme Planning
12. Workforce and Work Environment

The Trust currently deliver their services from a varied portfolio made up of freehold and leasehold assets, which are constantly evolving as services are delivered from different locations. The split between freehold and leasehold properties, in terms of their square meterage is shown below:

Figure 7 - Tenure



Green Plan

An integral part of the Estates Strategy is the planned reduction of carbon usage. The overall NHS commitment is to be Carbon Net Zero by 2040 with interim targets in 2030. The Trust's Green Plan vision is:

"We will work through our Green Plan to achieve a net zero NHS, reduce harm to the environment and to improve health outcomes and wellbeing for the people of Cheshire and the Wirral, now and for future generations. Drawing on our people, our values, and position as an anchor institution, we will incorporate sustainable development into everything we do. "

The Trust highlights their ambition to help the NHS become the first health service in the world with net zero greenhouse gas emissions. The focuses of the Green Plan are:

- Incorporating net zero actions, such as improving the energy efficiency of the built estate, decarbonising heating systems and strengthening sustainable procurement practices
- Developing a robust climate change adaptation plan
- Enhancing net zero awareness and skill bases across clinical and non-clinical areas of the Trust
- Strengthening our data collection processes to allow, refined target-setting, monitoring and action planning
- Developing green travel plans for staff, patients and visitors and purchasing/leasing ultra-low emissions or zero emission fleet vehicles

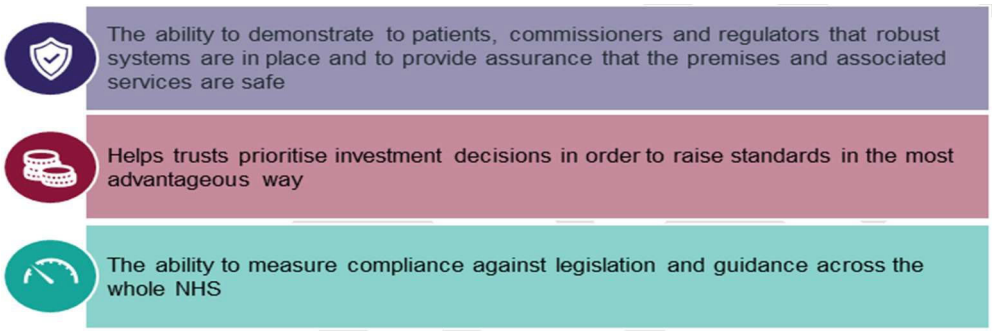
Operational Estates Performance – NHS Premises Assurance Model 2021

The Trust has undertaken a self-assessment of operational and strategic estate management and completed the NHS mandated Premises Assurance Model. This model supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of our estate and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality.

In 2013, the first NHS Premises Assurance Model (NHS PAM) was published. Since then, the model has been regularly updated by the Department of Health and Social Care and the NHS.
The latest version has been updated to reflect feedback from users and the working group, the NHS Constitution and changes in policy, strategy, technology and regulation. These updates ensure the model is as useful and effective as possible for Trusts.

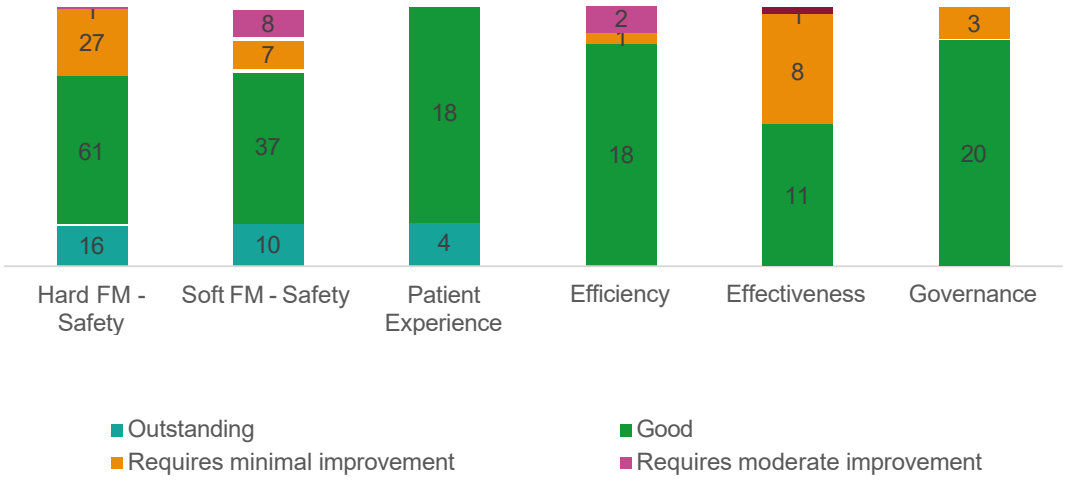
Functions and benefits of the model are included in Figure 8:

Figure 8 - Functions and Benefits



The results of the 2021 PAM assessment (Figure 9) report a high level of compliance with the expectations of NHS Estates and highlights areas where further improvements required.

Figure 9 - 2021 PAM Assessment



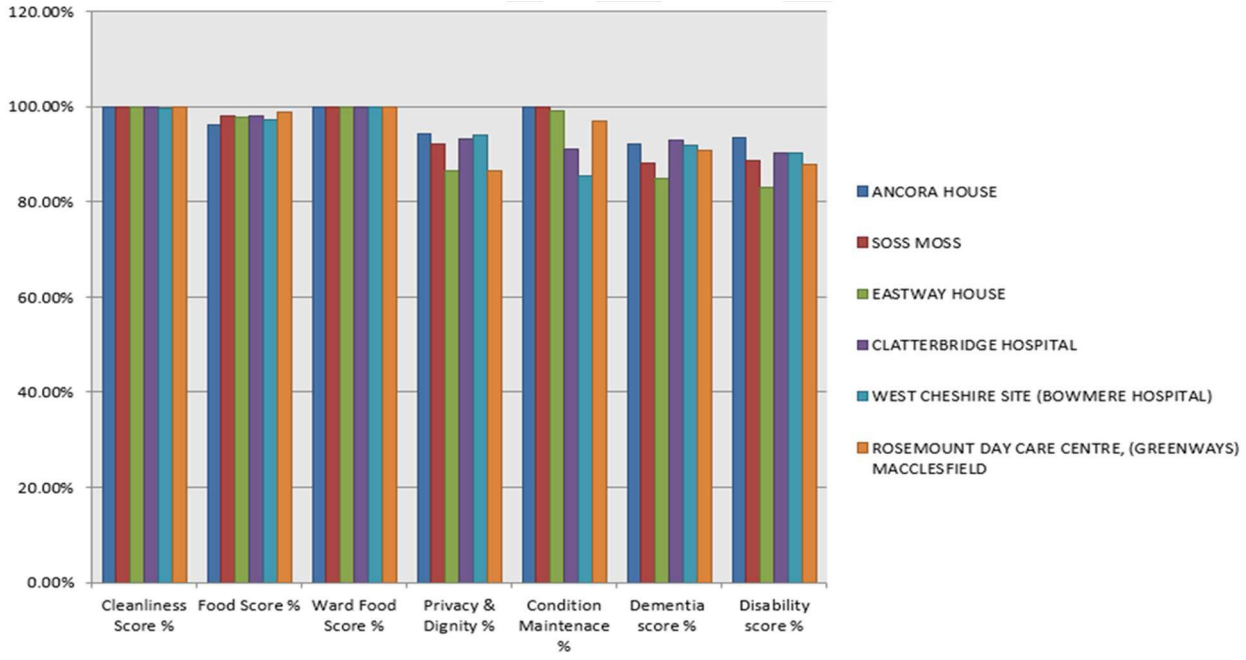
Patient Led Assessments of the Care Environment (PLACE)

Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but others are also encouraged and helped to participate in the programme.

The PLACE collection underwent a national review, which started in 2018 and concluded in summer 2019. The Trust estates team facilitated the 2019 PLACE inspection based on the new guidelines the results of which are illustrated in Figure 10. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The results of the PLACE inspection directly inform the Trust capital programme for targeted investment in patient environments. An example of this, as a result of the 2019 PLACE inspections, the board approved capital programme has included a cyclical programme of ward refurbishments.

Figure 10 - NHS Patient-Led Assessment of the Care Environment Collection, NHS Digital



Statutory Compliance

Estate compliance is co-ordinated, managed and reported by the Compliance Support Officer (CSO) for Infrastructure Services. Systems in place include a central dashboard for management of outsourced maintenance, a separate dashboard for in-house certificated maintenance, planned preventative maintenance software program licensed from Micad and water management software programme

licensed from Zetasafe. Systems were reviewed by MIAA during September to November 2020 and given a substantial level of assurance. The systems and reports introduced by the CSO enhanced those already in place and were critical in reaching this level of assurance.

As of 20 December 2021, overall compliance position was at 95% covering 1,908 assets over 36 compliance elements. This covers compliance disciplines outsourced to external service providers and services provided by the in-house trade team.

2.5 Key Partner Organisations Overview

Wirral University Teaching Hospital

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider Northwest area.

The Trust operates from two main sites:

- Arrowe Park Hospital, Upton – Delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides maternity, neonatal, gynaecology, children's inpatient, day case and outpatient units.
- Clatterbridge Hospital, Bebington – Delivers planned surgical services, dermatology services, breast care and specialist stroke and neuro rehabilitation services.

Outpatient services are provided from community locations including:

- St Catherine's Health Centre, Birkenhead – providing x-ray, community paediatric services, paediatric audiology and a range of outpatient clinics.
- Victoria Central Health Centre, Wallasey – providing x-ray, some outpatient services and antenatal clinic.
- GP practices, schools, and children's

centres. The Trust provides a full range of services

including:

- Accident & emergency services for adults and children
- Diverse range of acute and non-acute specialties
- Outpatient services
- Day surgery services
- Maternity including a midwifery led unit
- Diagnostic and clinical support services
- Specialist services including renal medicine, dermatology, orthopaedics (hip & knee revisions), ophthalmology (retinal), urology (cancer centre), stroke (hyper-acute unit), gynaecology (advanced laparoscopic endometriosis centre), neonatal level 3 unit and Ronald McDonald House a charity home providing accommodation for parents of sick children and premature babies.

WUTH is one of the largest hospitals in the North West and their vision, values, foundations and strategic objectives are highlighted below (Figure 11):

Figure 11 - WUTH Visions, Values, Foundations and Strategic Objectives

Wirral Metropolitan Borough Council

Wirral Metropolitan Borough Council, or simply Wirral Council, is the local authority of the Metropolitan Borough of Wirral in Merseyside, England. It is a metropolitan district council, one of five in Merseyside and one of 36 in the metropolitan counties of England and provides the majority of local government services in Wirral. It is a constituent council of Liverpool City Region Combined Authority.

The council delivers a wide range of services broken down into the following departments:

- Children, Families and Education including:
    - Early Help and Prevention
    - Education
    - Children and Families
    - Modernisation and Support
- Resources
    - Early Help and Prevention
    - Education
    - Children and Families
    - Modernisation and Support
- Neighbourhood Services
    - Highways

    - Transport
    - Parks, Environment and Climate Change
    - Libraries, Leisure and Customer Engagement
    - Neighbourhood Safety and Transport
- Regeneration and Place
    - Regeneration
    - Asset Management and Investment
    - Housing
    - Planning and Building Control
    - Special Projects
    - Culture and Visitor Economy

Local Plan Vision for 2037 is that Wirral offers a high quality of life to all and is an attractive place to live. It provides an active, productive, safe and healthy lifestyle in vibrant culturally rich communities across the Borough. It is an environmentally sustainable and prosperous Borough with a strong sense of place and identity, a place that people are proud to call home and want to invest in. Its success complements the attractiveness of, and makes a significant contribution to, the economic competitiveness and international standing of the Liverpool City Region.

2.6 Population and Demography (CWP Catchment)

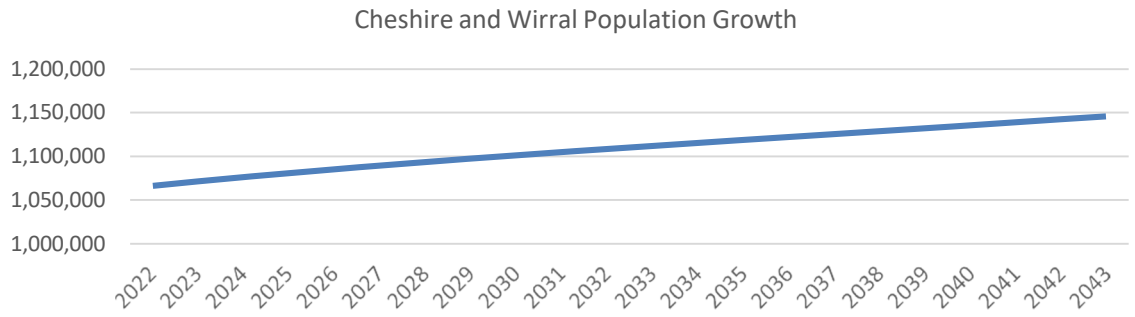
The catchment of CWP is ethnically diverse and characterised by economic inequality. As a result, there is a higher need for access to health services, including mental health. Figure 12 summarises key demographic statistics for the Trust's population.

Figure 12 - Trust Demographics

Category	Demographic Profile
Age	• Cheshire has an ageing population, with 23.9% of people being over 65 years old. • **The average age of the population in Wirral is 38.06 which is below the regional and national averages.**
Ethnicity	• 10.12% of those living in Cheshire identify with a non-white ethnic group. • **7.1% of those living in Wirral identify with a non-white ethnic group.**
Deprivation	• Wirral is one of the 20% most deprived boroughs in England, with a quarter of children living in low-income families.
Life expectancy	• The life expectancy for those living in Wirral is 81.6 years. • **The life expectancy for those living in Cheshire East is 80.3 years.**
Unemployment	• Over 9,000 people claim unemployment benefits in the Wirral. • **The unemployment rate in Cheshire West and Cheshire and Halton is 3.4% and 4.4% respectively. This is lower than the national average of 4.8%.**

ONS data (Figure 13) highlights that the population of Cheshire and Wirral is set to increase by 7.2 % from 2022 (1,066,265) – 2043 (1,145,609).

Figure 13 - Cheshire and Wirral Population Growth



ONS data (Figure 14) highlights that the population of Wirral is set to increase by 3.2 % from 2022 (325,816) – 2043 (336,348).

Figure 14: Wirral Population Growth 2022 - 2043

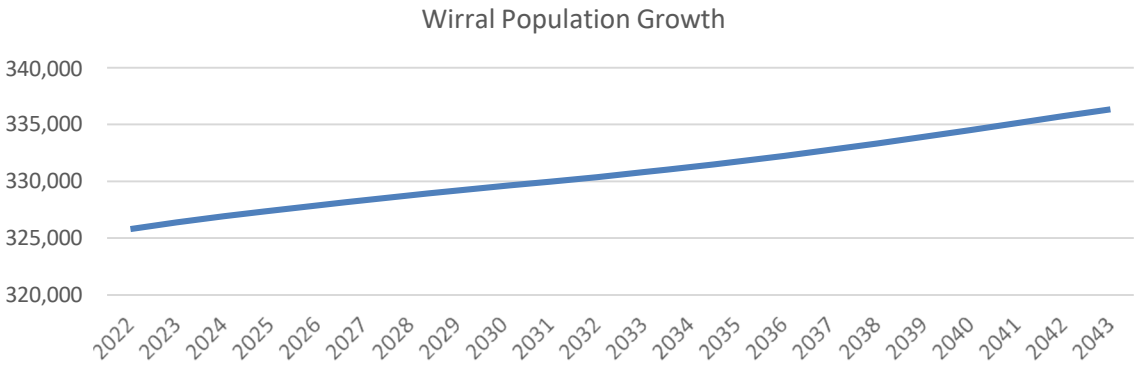


Figure 15 shows that the 0-19 population is set to decrease by 6.6%, as well as the 20-64 population which is set to decrease by 2.4%, however the 65+ is set to increase substantially by 23.5%.

Figure 15: Wirral Population Growth 2022 – 2043 by Age Group

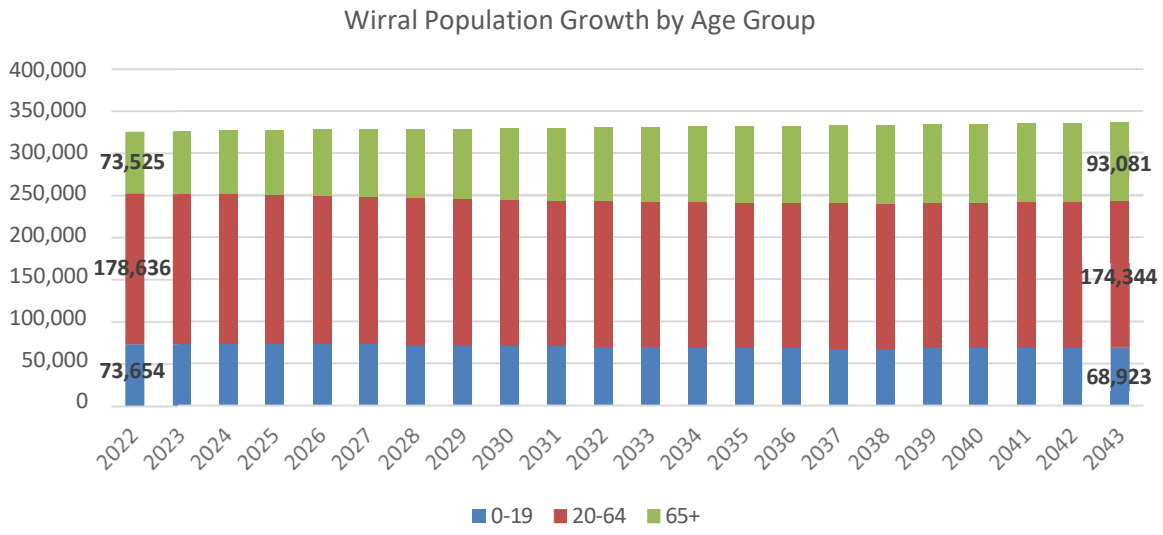


Figure 16 highlights the wider determinants of health for Cheshire and Wirral:

Figure 16: Wider Determinants of Health - PHE

Indicator	Period	England	Cheshire East	Cheshire West and Chester	Wirral
Life expectancy at birth (Female)New data	2018 - 20	83.1	83.8	83.4	81.6
Life expectancy at birth (Male)New data	2018 - 20	79.4	80.3	79.7	77.8
Inequality in life expectancy at birth (Female)	2018 - 20	7.9	7.2	7.8	11.5
Inequality in life expectancy at birth (Male)	2018 - 20	9.7	9.5	9.8	13.7
Mortality rate from causes considered preventable (2016 definition)	2016 - 18	180.8	164	179.6	214.7
Under 75 mortality rate from causes considered preventable	2021	183.2	142.5	174.2	218.4
Under 75 mortality rate from all cardiovascular diseases	2021	76	64.8	75.1	77
Under 75 mortality rate from cancer	2021	121.5	109.5	116.6	140
Under 75 mortality rate from liver disease	2021	21.2	20.5	24.7	25.5
Under 75 mortality rate from respiratory disease	2021	26.5	20.2	22.8	40.6
Health related quality of life for older people	2016/17	0.735	0.764	0.737	0.718

Part B: The Case for Change

2.7 Existing Arrangements

Current Wirral Crisis Response Services

CWP are in the process of developing an adult First Response Service that will bring together the different teams and functions that provide support to people experiencing a self-defined crisis. The following functions make-up the First Response Team (FRS):

- Home Treatment
- Liaison Psychiatry
- Street Triage
- 24/7 Crisis Line
- Criminal Justice Liaison
- CWP enhanced transport

The FRS is also working closely with Children Young People and Families (CYP&F), Learning Disability (LD) Neurodevelopment Disorder (NDD) and Acquired Brain Injury (ABI) teams and their urgent response services to provide an integrated approach to people in mental health crisis across all ages.

In addition, the following partners also work closely with the FRS:

- Northwest Ambulance Service (NWAS)
- Police
- Local Authority Emergency Duty Team
- Crisis Café Providers
- ISL (Organisation who provide tailored services at home and in the community to enable people to reach their potential and achieve their goals)
- Red Cross

These multiple providers and teams however are currently accommodated at multiple sites across the Wirral geographical footprint.

The primary focus for services users currently accessing crisis response services is the emergency department (ED) at Arrowe Park Hospital and the ED is also the current designated “place of Safety” under section 136 of the Mental Health Act 1983.

The current delivery model increases the risk of fragmented care pathways, limited system oversight and poorer experience of services for both those that access care and those that provide care and support.

The current service issues include:

- Poor experience of Emergency Departments for service users in mental health crisis, especially in section 136 suites.
- The quality of environments varied, with some not being fit for purpose.
- Cheshire and Wirral are a national outlier on section 136 provision.
- Increasing demand within acute care especially in emergency medicine.
- Service users do not think of “NHS 111 First” pathways for mental health.
- Unwarranted variation in acute care pathways and multiple hand offs and transitions across the pathway of care.
- Physical health and mental health not integrated within urgent care pathways.
- Multiple assessment from multiple providers.

Estate

As noted in the section above urgent care in mental health services are focused on the Arrowe Park Hospital site in terms of service users in crisis who attend the ED on the site. However, the teams which deliver these services are based on different sites including:

- Crisis Resolution Home Treatment Team – Springview, Clatterbridge Health Park
- Liaison Psychiatry Team and Street Triage – Arrowe Park Hospital.
- Local Authority Emergency Duty Team - Stein Centre, St Catherine's

Hospital Figure 17 shows the current site plan for Arrowe Park Hospital.

Figure 17 - Site Plan

The ED at Arrowe Park Hospital is currently undergoing extensive refurbishment as part of a £28.8m upgrade due to be completed in Spring 2023. This upgrade will provide better accommodation for patients who have parallel physical and mental health needs, with an area which has four consulting rooms where patients presenting with a mental health condition can be cared for. Each room will be fully anti-ligature and compliant for escape if required. Whilst the area does not have a true defined 136 suite, it will be a suitable environment for a patient to be detained under sections 135 / 136 of the Mental Health Act whilst also receiving care for physical health.

Specific areas for improvement across Wirral in terms of supporting people in metal health crisis include:

- Requirements for dedicated alternative place of safety on the Wirral with suitable accommodation for patients in mental health crisis who do not necessarily require physical health interventions.
- De-escalation/quiet room to be provided as part of a dedicated 136/place of safety suite.

- Delivery of crisis response services from a building that delivers a calming and therapeutic environment, providing a non-clinical experience.
- Facilities which enable teams and services to work together in a more integrated way.

2.8 Crisis and Urgent Care Transformation Programme

The Crisis and Urgent Care Transformation Programme highlights the following key objectives:

- To provide an open, accessible mental health crisis line for people in self-defined crisis. Demonstrating the Crisis Lines achievements, targets, demand, accessibility and outcomes from contacts and calls etc.
- To develop and implement Assessment Suites in each locality and demonstrate the impacts on contacts, ED and diversion including provision of 136 facilities where required.
- Demonstrate improved patient experience, including reduction in waiting times, alternatives to section 136 and access to alternative support within the community. Demonstrate a seamless all age approach for patients in self-defined crisis.
- Transform the response culture; reduce silos through an inclusive approach to engagement by developing the Trust wide First Response Service.
- Development of Integrated Urgent Care Centre's Trust wide.

2.9 Urgent Response Model of Care

Service Model

The purpose of crisis and urgent Care Transformation as set out in the NHS Long Term Plan is to support multidisciplinary working and enable a more effective response to patients, by providing fast and efficient care closer to home, improving patient care and experience, whilst reducing unnecessary ED attendances. The Trust are working on transforming service delivery, by bringing services together, with an aim to ensure that patients get the right care, in the right place, whenever it is needed.

As well as increasing capacity and improving models of traditional NHS crisis care services, implementation of these ambitions will include a central role for NHS-funded voluntary sector services in providing complementary and alternative models of crisis care. It is expected that NHS services will work alongside other system partners to deliver comprehensive and accessible local crisis care pathways.

The creation of integrated URC's across the Trust is an innovative and ambitious response to support those with emergency mental health needs that don't require acute medical intervention. The Trust is keen to provide a 'one stop shop' to be able to cater to emergency primary mental health crisis and minor health complaints.

The multi-agency model of care has the potential to deliver the following benefits:

- Benefits to service users:
  - Great experience of integrated, joined up care and support when experiencing a crisis.
  - Right place, right time, right person principle reducing transitions, hand-offs and multiple assessments.

- Benefits to people supporting and providing care and support:
    - Peer support, improved morale
    - Clear standards and operational guidelines
    - Better value from resources through a shared approach of skills, knowledge and assets

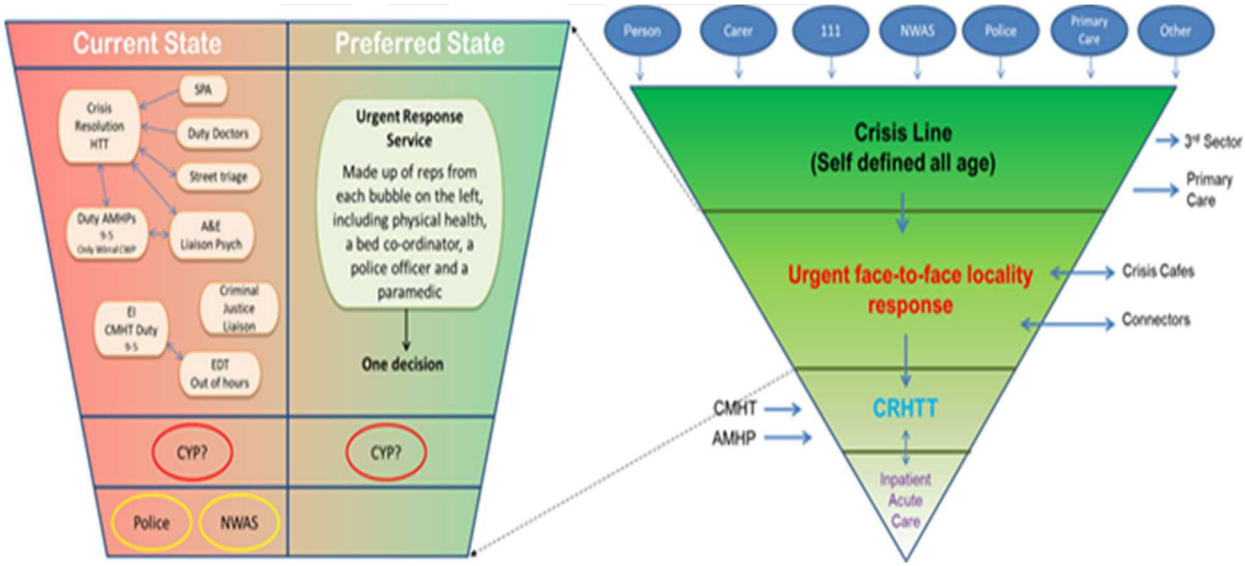
- Benefits to system:
    - Opportunity for greater collaboration
    - Escalation of strategic issues for resolution
    - Strategic problem solving
    - Better value from resources

The Trusts multi-agency model of care reduces waste, provides a better experience for all, is person centred and enables those accessing the integrated urgent care offer to define their own crisis, through a one front door approach, servicing all age and care groups.

The ambition is to provide a thorough therapeutic and holistic psychiatric evaluation, by a multi skilled mental health workforce, in a site that has been designed to offer the up most compassion and care.

The Trust have developed this model which highlights their current state and desired state for the pathway (Figure 18):

Figure 18 – The Trust's Urgent Care Model



This model shows that the Crisis Line can be accessed through numerous means, such as, individual, Carer, NHS 111, NWAS, Police, Primary Care and can be dealt with in several ways, including linking in with the 3rd Sector and Primary care provision.

The development of the URC is central to the development of a First response approach to delivering an urgent care mental health response for people of all ages in crisis who do not require ED attendance.

Opportunities for a system wide response which is deployed from the FRS, including CYP&F and urgent support teams along with other partners will support effective triage and divert from ED into the community assets which will include Crisis Cafes and peoples' own homes. This should reduce footfall through the Wirral ED as appropriate.

The URC will create a centralised point within the Wirral footprint for all urgent work requests and distribute the need and demand across existing services in a co-ordinated way, utilising all the different skills within the teams. Staff would work across community and ED as part of the urgent mental health response. This would reduce the peaks and troughs of individual service demand and level the overall response.

This function would also support NWAS and Police forces, and therefore ensure people with mental health needs are not being conveyed to ED unless they require more acute physical health interventions.

The next stage in the implementation of the model highlights the urgent face-to-face locality response, as noted previously this is currently disjointed, with multiple services trying to support the service users in an isolated matter. The preferred state highlights the desire to bring these services together with the need for improved collaboration, to ensure the needs of the patients are met in the right place at the right time. This will also allow for improved efficiencies and better-quality outcomes.

If a face-to-face assessment is required, and this cannot be completed within the individuals' home, crisis café or other community setting the URC will have available assessment rooms where people can be seen by the most appropriate practitioner in a suitable environment. The facilities will be provided to support all ages along an alternative place of safety for individuals who have been detained on section 136 of the mental health act. If more acute services are required, the service user may be referred to crisis resolution home treatment teams or inpatient acute care.

Environment to Deliver Service Model

The URC will have a multi-disciplinary team (MDT) approach. This will require close working across the different organisations which can only be achieved when there is a clear direction, focus and goal which every individual is working towards. The centre will be led by a team with many years' experiences and a special understanding for the diverse service user cohort. The staffing model also includes the ambition to provide minor physical health care within the centre.

The suggested services and teams based at or visiting the unit are highlighted below:

- Learning Disability
- Adults Mental Health Team
- Police
- Ambulance Service
- Local Authority– Emergency Duty Team
- CYP&F
- Neighbourhood Teams
- Home Treatment Teams

- Liaison Psychiatry
- Older Peoples Team
- Safeguarding Team
- Drug and Alcohol Team

2.10 Project Investment Objectives

The project investment objectives associated with this SOC are shown below. The measures associated with the project objectives have been used as the basis of the economic appraisal in the Economic Case, and the benefits realisation plan identified in the Management Case. The project investment objectives are based on the need for the Wirral URC to support the delivery of a joined up integrated model of care for service users in crisis, commissioning requirements and organisational objectives.

Figure 19 - Investment Objectives

Investment Objective 1	Location of the Wirral URC
Definition	• Bolstering existing service provision, both acute and community • Optimising co-location of resources • Parity of access • Supporting people in crisis in the best possible location

Investment Objective 2	To provide a therapeutic environment for service users in crisis.
Definition	• Ensuring care is delivered in a calm, therapeutic and secure space • Supporting the varying needs of service users e.g. autism and dementia friendly • Enabling delivery of high-quality care in appropriate accommodation • Improving service user experience

Investment Objective 3	Patient and staff experience
Definition	• Fit for purpose for both staff and service users • Enabling co-location for colleagues whilst ensuring separate access for service users • Considering access to the facility in conjunction with wider acute and community offering

Investment Objective 4	Demand and future proof
Definition	• Reducing pressure on existing emergency department • Reducing pressure on existing place of safety facilities • Enabling appropriate deflections away from the ED • Supporting improved mental health capacity in the Wirral and management of future demand

Investment Objective 5	Partnership working – enabling the model of care
Definition	• Ensuring the facility acts as a key enabler for the delivery of the model of care for mental health services in the Wirral • Ensuring parity of access for all • Enabling better partnership working between primary, secondary, third sector, social care and other key partners.

2.11 Business Needs

This section identifies the 'business gap' in relation to overall existing arrangements i.e. the difference between 'where we want to be' (as suggested by the proposed model of care and the investment objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, difficulties and inadequacies associated with the status quo. The table below (Figure 20) outlines the existing arrangements and describes the problems with these existing arrangements in order to identify business need.

Figure 20 - Business Needs

Investment Objective 1	Location
Existing Arrangements	Urgent care in mental health services are focused on the Arrowe Park Hospital site in terms of service users in crisis who attend the ED on the site or in the community, however the teams which deliver these services are based on different sites across the Wirral Geography.
Business Need	Development of a centralised URC where teams can be collocated in order to: • Bolster and improve existing service provision, both acute and community. • Colocation of physical and mental health services on one site. • Optimising co-location of resources and the associated improvements in patient outcomes. • Parity of access. • Supporting people in crisis in the best possible location.

Investment Objective 2	Therapeutic Environment
Existing Arrangements	Currently services are delivered in a variety of locations including the ED at Arrowe Park, although the facility is undergoing significant investment and will have some assessment rooms it will not have a dedicated 136 area and still be part of a more clinical feeling acute hospital department.
Business Need	A new URC will provide dedicated accommodation for people in mental health crisis but who do not need the acute physical support of an ED department, a specifically designed facility will: • Ensure care is delivered in a calm, therapeutic and secure space. • The facility can **be non-clinical and non-institutional**. • Support the varying needs of service users e.g., autism and dementia friendly. • Enabling delivery of high-quality care in appropriate accommodation. • Improving service user experience.

Investment Objective 3	Patient and staff experience
Existing Arrangements	Currently services are delivered in a variety of locations including the ED at Arrowe Park, although the facility is undergoing significant investment and have some assessment rooms it will not have a dedicated 136 area and be part of a more clinical feeling acute hospital department.. The teams which deliver these services are based on different sites across the Wirral Geography and this leads to a number of issues as noted previously in the SOC.
Business Need	A URC which will provide dedicated therapeutic accommodation for people in mental health crisis but who do not need the acute physical support of an ED department, whilst still being collocated with the ED on Arrowe Park Hospital, should patients' acuity in terms of physical health deteriorate. Also enable co-location for colleagues and provide dedicated staff welfare facilities.

Investment Objective 4	Demand and Future Proofing
Existing Arrangements	The lack of dedicated alternative facilities for people in mental health crisis along with dedicated place of safety/136 provision adds to the pressure on the ED at Arrowe Park. Also, the dispersed nature of the various teams does not promote integrated or coordinated pathways for people in mental health crisis.
Business Need	Development of a dedicated URC collocated with the ED at Arrowe Park Hospital which can support with: • Reducing pressure on existing emergency department • Reducing pressure on existing place of safety facility within the ED. • Enabling appropriate deflections away from the ED and support care in the right place at the right time for patients. • Supporting improved mental health capacity in the Wirral and management of future demand. Supporting integrated and coordinated care by all partners for people in crisis.

Investment Objective 5	Partnership Working - Enabling the Model of Care
Existing Arrangements	The teams which deliver mental health crisis response services are based on different sites across the Wirral Geography, which can lead to disjointed working, multiple assessments and handoffs for people in crisis.
Business Need	A dedicated URC with space for all the associated teams and partners to come together in an MDT approach which will: • Ensure the facility acts as a key enabler for the delivery of the model of care for mental health services in the Wirral. • Ensure parity of access for all. • Enable better partnership working between primary, secondary, third sector, social care and other key partners.

2.12 Potential Scope

The potential scope for the project has been developed based on the investment objectives and business needs identified in the previous section. The scope has been assessed against a continuum of need ranging from minimum to maximum (Figure 21).

Figure 21 - Potential Scope

	Minimum	Intermediate 1	Intermediate 2	Intermediate 3	Maximum
Potential Scope	Improved UR assessments co-ordinated by the crisis line to support ED but teams not collocated	Urgent Response assessments all undertaken in people's homes or the community, with teams collocated but	Provision of co-ordinated UR assessments to support ED with teams collocated in a URC but with	Provision of co-ordinated UR assessments, with teams co-located and new 136 provision within a URC - BUT not collocated with	Provision of additional suitable assessment space to support ED with teams collocated and new 136

	Minimum	Intermediate 1	Intermediate 2	Intermediate 3	Maximum
	and no new 136 provision	with no new 136 provision	no new 136 provision	ED but with a service user transport service in place.	provision within a URC collocated with ED on Arrowe Park

This business case will take forward the maximum scope which is to provide fit for assessment space to support ED with teams collocated and alternative 136 provision.

2.13 Benefits Planning

Based on the investment objectives and the agreed scope of works, benefits have been identified as categorised as follows:

- CRB – cash-releasing benefits (e.g., avoided costs)
- Non CRB – non-cash-releasing benefits (e.g. staff time saved)
- SB – societal benefits (e.g., achievement of targets)
- UB – unmonetisable benefits (e.g., improvement in staff morale)

Figure 22 shows the main categorised benefits.

Figure 22 - Benefit Log

	Benefit	Description
NCRB	**Reduction in ED Attendances**	Reduction in ED attendances through delivery of the scheme and provision of alternative pathway for people in mental health crisis.
NCRB	**Reduction in incidents**	Reduction in the number of incidents reported in the Trust's incident recording system through improved throughput, increased capacity and treatment of patients in the most appropriate setting
NCRB	**Reduction in incidents of physical aggression and/or harm**	Reduction in incidents against different categorisation to B2 above. Reduction in incidents; Patient on Patient, Patient on Staff, self-harm and patient behaviour, incidents of damage to property,
NCRB	**Improvement against 4-hour quality standard - Patient Flow**	Improved Trust performance against the 4 Hour Quality Standard through management of service users in the most appropriate setting. Reduced attendance at ED and therefore reduced wait times
NCRB	**Reduced Wait times for people in Mental Health Crisis**	As per B4 with specific reference to people attending in mental health crisis. Reduction in overall wait time through being seen at the URC.
UB	**Improved patient/staff experience**	Improved patient/staff experience measured through performance against surveys etc.

NCRB	**Improves staff wellbeing**	Reduction in staff sickness. Reduced pressure on ED staff. Taking away disruptive patients. Reduction in sickness absence associated with the environment, and burnout.
NCRB	**Reduced Agency/Bank Spend**	"Reduced agency/bank spend through improved environment, retention etc.
NCRB	**Improved staff retention**	"Reduced costs associated with recruitment, and issues with retention
NCRB	**Out of Area Placements**	Reduction in Out of Area Placements through collective use of resources, alternative admissions pathways etc Further work is needed to understand the full scope of this benefit to understand where the cost sits, how the scheme might reduce the initial need for OOA, what level of potential repatriation can be achieved (if any) and what costs are currently being born by stakeholders in relation to OOA that the project may alleviate.
NCRB	**Delays in transfer of care**	Reduced service user Length of Stay through reduced delays in transfer of care by managing patients in the most appropriate setting
NCRB	**Wider benefit linked to the other sites in the model.**	"Improved system performance in regard to management of mental health crisis with the project acting as an enabler to the wider model of care and supporting other URCs across the patch.
SB	**Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year (QALY) score**	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system

2.14 Strategic Project Risks

The indicative strategic risks associated with the planned investment, plus the management actions to assist in their mitigation, are shown at Figure 23.

Figure 23 - Risk Log

Risk Heading (there is a risk of)	Description and Consequence	Management Action
Project Management		
Insufficient resources in CWP/System to properly manage the project, contractors and design team caused by limited resource	Potential delay to programme caused by lack of resources	• Ensure adequate internal resource with the required skill set and experience to manage a capital project of this nature. • Allow for funding in the capital costs for internal or external project support.
Approvals		
Failure or delay to obtain relevant approvals (Business Case, planning approvals etc.)	Delay or termination of the programme.	• Early engagement with ICS and NHSE to discuss potential funding routes. • Early engagement with the local planning authority. • Ensure adequate internal resource

Risk Heading (there is a risk of)	Description and Consequence	Management Action
		with the required skill set and experience to manage a capital project of this nature.
Financial		
Potential cost overrun	Cost overrun meaning that the project becomes unaffordable	• Ongoing cost planning with cost advisor • Appropriate calculation of optimism bias and planning contingency
Failure to achieve capital funding for the project.		Ongoing liaison with ICS and NHSE
External		
External policy changes (e.g., Government removes funding on offer.)	No alternative funding source identified. Programme delays or termination.	Ongoing liaison with ICS and NHSE

2.15 Project Constraints, Dependencies and Interdependencies

As with all planned capital investments the programme is subject to potential constraints which have been identified and reviewed throughout the development of the proposals. The constraints and dependencies of the proposed development are laid out in Figure 24.

Figure 24 - Constraints and Dependencies

Element	How this is being managed	Constraint	Dependency	Assumption
Capital funding availability	• Early engagement with NHSE • Early engagement with the ICS.	✓		
Timescales and expectations around business case approvals	• Early engagement with ICS and NHSE	✓		
Site constraints	• Engagement with WUTH and CWP. • Engagement of healthcare planner to appraise future accommodation requirements		✓	
The project is reliant on planning permission in order to progress the scheme.	• Early discussions to take place with local authority planners.	✓		
Revenue costs to demonstrate financial viability to progress the project.	• Engagement with Trust finance team			✓
Success of the project is dependent on the budget being adequate to support the design and build of the new development and the project being delivered within the agreed cost envelope.	• Establish of workstream groups which report to the Programme Board			✓
The project is reliant on the capacity to deliver a capital scheme and will need to manage clinical, management, estates and facilities and corporate support services availability.	• Identification of resource capacity requirements for OBC and FBC		✓	

Element	How this is being managed	Constraint	Dependency	Assumption
The project will require the support of key stakeholders, including partners and the ICS.	• Ongoing liaison with ICS. • Ongoing engagement with partners.	✓		
The project will align to the Trust Strategy and four strategic priorities.	• Development of robust business cases aligning the scheme with national, regional and local priorities			✓

2.16 Equality Impact Assessment

Promoting equality and addressing health inequalities are at the heart of Trust values. Throughout these early stages of the project, the Trust has given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Furthermore, the Trust will give regard to the need to reduce inequalities between patients with access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

An Equality Impact Assessment (EIA) will be undertaken at the next stage of the business planning process to ensure that are no needs or barriers which could affect people with protected characteristics, and the likely impact of the scheme is considered low. The EIA will then be reviewed monthly and reported to the Project Board. It is an iterative process and will be fully considered during the design phase to ensure any health inequalities and the 9 protected characteristics are fully considered.

3.0 ECONOMIC CASE

3.1 Critical Success Factors

Based on the case for change and the agreed project objectives as outlined in the Strategic Case, the critical success factors (CSFs) for the project are shown at Figure 25. The options considered in this case have been considered against these CSFs.

Figure 25 - Critical Success Factors

CSF	Description
Strategic fit and business needs	How well the option: • meets the agreed spending objectives, related business needs and service requirements, • provides holistic fit and synergy with other strategies, programmes and projects
Potential value for money	How well the option: • Maximisers 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. • Minimise associated risks.
Potential achievability	How well the option: • Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change, and • matches the level of available skills required for successful delivery.
Supplier capacity and capability	How well the option: • Matches the ability of the service providers to deliver the required level of services and business functionality, and • is likely to be attractive to the supply side.
Potential affordability	How well the option: • Meets the sourcing policy of the organisation and likely availability of funding, and • Matches other funding constraints.

3.2 Options Development Framework

An options development session took place with key management, estates and clinical stakeholders at the Trust and partners. The session focused on development of the long-List of scheme options. The session was carried out in line with HM Treasury guidance in developing the long list of potential options for the SOC in line with the key dimensions of the HM Treasury Options Framework, as outlined at Figure 26.

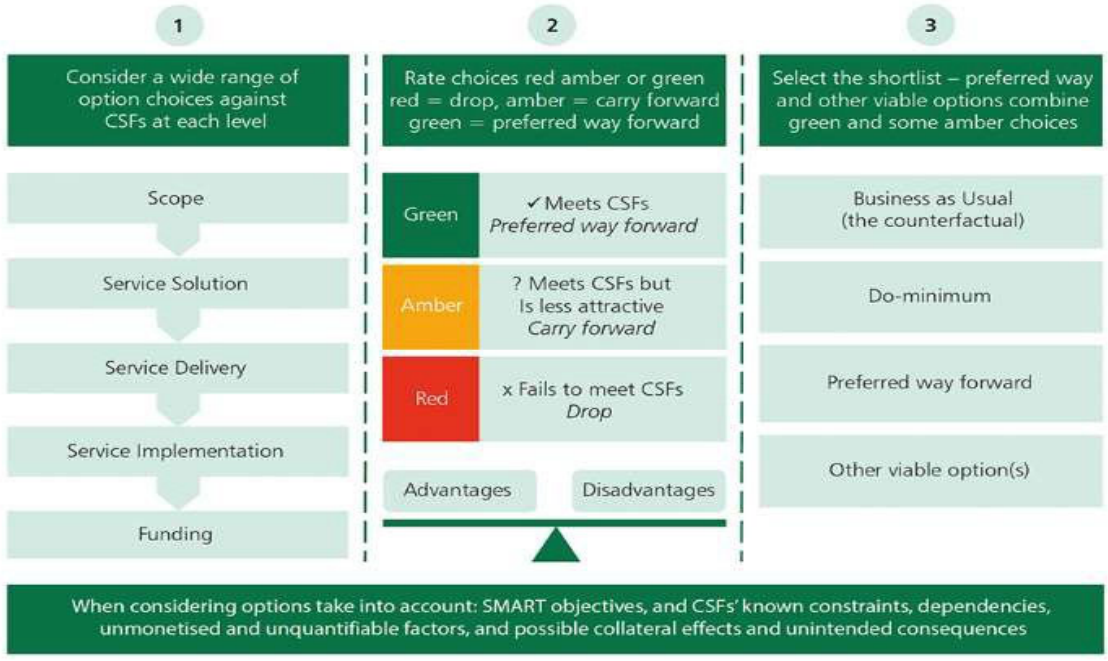
Figure 26 - HM Treasury Key dimensions of the Options Development Framework

Key Dimensions	Brief Description
Scoping Options	The "**what**", in terms of the potential coverage of the project. Potential scopes are driven by business needs, service requirements and the scale of organisational change required to improve service capabilities. Examples include coverage in terms of business functions, levels of service, geography, population, user base and other parts of the business.
Service Solution	The "**how**" in terms of delivering the "preferred" scope for the project. Potential service solutions are driven by available technologies, recognised best practice and what the marketplace can deliver. These solutions provide the potential "**products"** (inputs and outputs) and as such the enabling work streams and key activities required.

Service Delivery	The "**who**" in terms of delivering the "preferred" scope and service solution for the project. Potential options for service delivery are driven by available resources, competencies and capabilities - both internal and external to the organisation. Examples include in-house provision, outsourcing, alliances and strategic partners.
Implementation	The "**when**" in terms of delivering the "preferred" scope, solution and service delivery arrangements for the project. Potential implementation options are driven by deadlines, milestones, dependencies (between outputs), economies of scale, benefit realisation and risk management. The optimal option provides the critical path for delivery of the agreed products and activities and the basis for the project plan. Options for implementation include piloting, modular delivery, big bang and phasing (tranches).
Funding	The "**funding**" required for delivering the "preferred" scope, solution, service delivery and implementation path for the project. Potential funding options are driven by the availability and opportunity cost of public funding, value for money and the characteristics of the project. Potential funding options include the public or private capital, the generation of alternative revenue streams, operating and financial leases, and mixed market arrangements.

Use of the options framework-filter is considered best practice for consideration of a longlist of possible options. The method disaggregates the design of viable options into its basic components, breaking down the choices to be made into a sequence of logical steps. When constructing the longlist, a predetermined or complete final option should be avoided. Instead, the method supports the building of a number of alternative viable options by considering the logical sequence of option choices. This is an iterative process and in the initial pass through the framework minima, maxima and a provisional preferred way forward are identified. Variations around the preferred way forward, which at this stage is not a preferred option, are considered in the light of the choices made at the preceding levels of choice. Option choices that do not at least meet the "Do Minimum" requirement of meeting the core objectives must therefore be rejected at this stage. Figure 27 below shows the process in diagram form.

Figure 27 - HM Treasury Options Framework



Longlist consideration begins with the choice of service scope. The maximum and minimum potential scope should be identified. The minimum must, by definition be, the scope required to just meet the business needs, so it therefore meets the strategic objectives. The maximum may or may not be viable. Between these two extremes, examination in a workshop setting will generate valuable insights into viable possibilities. Several alternative option choices for scope between the maximum and minimum should be examined to test the effect on viability through considering the CSFs. Each choice should either be rejected or carried forward as possible.

The next choice concerns the service solution choice which is about how the required changes will be realised. On this first iteration of the framework filter this choice is made assuming that the preferred scope identified above is used. This approach continues until all option choices have been considered (see below - scope, solution, delivery, implementation, funding).

The focus of the options development session was the development of the service scope element, and was successful in generating four options, in addition to Business as Usual and Do Minimum benchmarking options. The options developed are outlined in Figure 28. The long list of options is detailed against the five options dimensions in Figure 29.

Figure 28 - Options Scope

Option	Scope
BAU	Fragmented service delivery model coordinated by the crisis line remotely.
Do Minimum	Improved UR assessments co-ordinated by the crisis line to support ED but teams not collocated and no new 136 provision
Option 1.0	Urgent Response assessments all undertaken in people's homes or the community, with teams collocated but with no new 136 provision
Option 2.0	Provision of co-ordinated urgent response assessments to support ED with teams collocated in a URC but with no new 136 provision
Option 3.0	Provision of co-ordinated urgent response assessments, with teams co-located and new 136 provision within a URC - BUT not collocated with ED but with a service user transport service in place.
Option 4.0	Provision of additional suitable assessment space to support ED with teams collocated and new 136 provision within a URC collocated with ED on Arrowe Park.

3.3 Options Appraisal Analysis

The options appraisal framework is set out in Appendix A.

Figure 29 sets out the Options Appraisal Analysis in accordance with the HM Treasury described process, designed to id
Carried Forward elements.

Figure 29 - Options Development Framework

Key Dimensions	BAU	Do Minimum	Option 1	Option 2	Option
1. Scope	Fragmented service delivery model coordinated by the crisis line remotely.	Improved UR assessments co-ordinated by the crisis line to support ED but teams not collocated and no new 136 provision	Urgent Response assessments all undertaken in people's homes or the community, with teams collocated but with no new 136 provision	Provision of co-ordinated UR assessments to support ED with teams collocated in a URC but with no new 136 provision	Provisi ordina assess teams new 13 within not col but wit transp place.
	Carry Forward	Discount	Discount	Discount	Carry F
2. Service Solution	Do nothing	Extension or refurbishment on Arrowe Park collocated with ED.	New build or refurbishment on a CWP site within the Wirral geographical footprint.	New build on the WUTH site at Clatterbridge.	New b Arrowe site co ED in a 52appr
	Carry Forward	Carry Forward	Carry Forward	Carry Forward	Preferr
3. Service Delivery	No Delivery	Traditional tender	Design and Build / P23 Framework		
	Carry Forward	Carry Forward	Preferred		

4. Service Implementation	No implementation required	Phased Approach	Single phase "big bang"			
	N/A	Carry Forward	Preferred			
5. Funding	None Required	ICS capital / potential capital slippage	HM Treasury Capital			
	N/A	Carry Forward	Preferred			

3.4 Identification of Short List Options

The preferred way forward, and those options which have been carried forward, are shown at Figure 30.

Figure 30 - Short List Options

	Business As Usual	Option 1 Do Minimum	Option 2	Option 3 Preferred Way Forward
Service Scope	Fragmented service delivery model coordinated by the crisis line remotely.	Provision of additional suitable assessment space to support ED with teams collocated and new 136 provision within a URC collocated with ED on Arrowe Park.	Provision of co-ordinated UR assessments, with teams co-located and new 136 provision within a URC – **BUT** not collocated with ED but with a service user transport service in place.	Provision of additional suitable assessment space to support ED with teams collocated and new 136 provision within a URC collocated with ED on Arrowe Park.
Service Solution	Do nothing	Extension or refurbishment on Arrowe Park collocated with ED.	New build on a CWP community or partner site within the Wirral geographical footprint.	New build on the Arrowe Park site collocated with ED in a campus approach.
Service Delivery	Not required	D&B/P23 Framework	D&B/P23 Framework	D&B/P23 Framework
Implementation	Not required	Phased Approach	Phased Approach	Single phase "big bang"
Funding	Not required	HM Treasury / ICS capital / potential capital slippage.	ICS / HM Treasury Capital	ICS / HM Treasury Capital

3.5 Economic Assessment Summary

Process

The economic appraisal of the short-listed options follows HM Treasury Green Book guidance and is underpinned by the Comprehensive Investment Appraisal (CIA) model. Key assumptions are:

- Covers an appraisal period of 60 years and uses a discount rate of 3.5%;
- Costs, benefits and risks are expressed in real prices at 2020/21 levels;
- VAT, planning contingency and transfer payments are excluded from cash flows.

CIA model inputs are described in the sections that follow.

An electronic version of the CIA model is available at Appendix B, and the CIAM support information is available at Appendix C.

Capital Costs

The capital costs have been developed by the Trust's advisors and are summarised at Figure 31 (may not fully calculate due to rounding) (full OB capital cost forms are at Appendix E). Figure 31 provides a summary of the cost breakdown, at the required PUBSEC reporting index of 300, but total costs at outturn prices (assessed at mid-contract PUBSEC index levels) and includes a percentage increase for inflation.

Figure 31 - Capital Cost of Schemes including VAT

Capital Cost Elements	Do Minimum	Option 2	Option 3
Departmental Works Costs	£2,509,942.00	£2,928,010.00	£2,928,010.00
On-Costs	£1,657,949.00	£1,396,801.00	£1,396,801.00
Location Adjustment	Inc	Inc	Inc
Fees	£914,011.00	£948,424.00	£948,424.00
Non-Works	£60,000.00	£60,000.00	£60,000.00
Equipment	£433,445.00	£505,642.00	£505,642.00
Planning Contingencies (20%)	£731,209.00	£758,738.00	£758,738.00
Optimism Bias (15%)	£1,271,512.00	£1,327,765.00	£1,327,765.00
Total Capital Cost excluding inflation	£10,722,263.00	£11,187,958.00	£11,187,958.00
Inflation (3% p.a.)	£751,423.00	£784,243.00	£784,243.00
Total Capital Cost	£11,473,686.00	£11,972,200.00	£11,972,200.00

Key assumptions are:

- For the development options, Departmental Works Costs are based on the Healthcare Premises Cost Guides (HPCGs) applied to the areas derived from the 1:200 drawings prepared by the Architect;
- On-costs are based on the site layout drawings and any known conditions such as site levels, plant/services age and capacity, and other constraints;
- Non-works costs are included;
- Equipment costs are included;
- Optimism Bias has been assessed in line with HM Treasury requirements. Optimism bias calculations for each option are included in Appendix E;
- Planning contingencies are included in the OB forms and the Financial Case but are excluded from the Economic Appraisal in the CIAM. This means that the capital costs in the CIAM are exclusive of VAT and Planning Contingencies.

Lifecycle Costs

Lifecycle costs for building and engineering works have been assessed and are based on standard NHS replacement profiles, those being:

- All structural components - 60 years
- General fabric - 50 years
- Mechanical and electrical services – 25 years
- Internal finishes – 10 years

At this stage, assumptions regarding life cycling were made and a baseline figure from a comparable mental health scheme was applied. Life cycling should be revisited at a later stage.

Opportunity Costs

Opportunity costs are assumed to be zero under all the short-listed options except the BAU and Option 1 position.

Assessment Financial Benefits

The proposed development of the Wirral URC is expected to deliver a wide range of benefits. Figure 32 summarises the planned benefits, categorised as cash-releasing, non-cash-releasing, societal and non-monetisable. Also see Section 6.7 for the benefits realisation plan.

Figure 32 - Benefits Plan

Ref.	Benefit Name	Benefit Description
NCRB1	Reduction in ED Attendances	Reduction in ED attendances through delivery of the scheme and provision of alternative pathway for people in mental health crisis. If they do attend the ED this will only be instances when they have an acute problem that needs medical attention.
NCRB2	Reduction in incidents	Reduction in number of incidents reported in the Trust's incident recording system through improved throughput, increased capacity and treatment of patients in the most appropriate setting.
NCRB3	Reduction in incidents of physical aggression and/or harm	Reduction in incidents; patient on patient, patient on staff, self-harm and patient behaviour, incidents of damage to property.
NCRB4	Improvement against 4-hour quality standard	Improved Trust performance against the 4 Hour Quality Standard through management of service users in the most appropriate setting. Reduced attendance at ED and therefore reduced wait times.
NCRB5	Reduced wait times for people in Mental Health Crisis	Reduction in overall wait time for those in MH crisis.
NCRB6	Improved Staff Wellbeing	Reduction in staff sickness due to reduced pressure on ED staff due to disruptive patients presenting at the URC instead of ED. Reduction in sickness, absence, associated with the environment and burnout.
NCRB7	Reduced agency/bank spend	Reduced agency/bank spend – directly employed NHS staff will be more interested in working in new builds because they will have a therapeutic environment designed to give the patients the best care
NCRB8	Improved Staff Retention	Reduced costs associated with recruitment, and issues with retention
NCRB9	Out of Area Placements	Reduction in out of area placements through collective use of resources, alternative admissions pathways.

Ref.	Benefit Name	Benefit Description
NCRB10	Delays in transfer of care	Reduced service user Length of Stay through reduced delays in transfer of care by managing patients in the most appropriate setting.
NCRB11	Wider benefit linked to the other sites in the model	Improved system performance in regard to management of mental health crisis with the project acting as an enabler to the wider model of care and supporting the URCs across the patch.
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system.

Key:
CRB – Cash Releasing Benefit
NCRB – Non- Cash Releasing Benefit
SB – Societal Benefit
UB – Unquantifiable Benefit

Summary Impact of Benefits

Figure 33 summarises the financial impact of the benefits for each option over the same 60-year period as the costs (see the CIAM at Appendix B).

Figure 33 - Summary Impact of Benefits

Summary (Discounted) - £000	Business as Usual	Do-Minimum	Option 2	Option 3
Cash releasing benefits	£0.00	£0.00	£0.00	£0.00
Non-cash releasing benefits	£0.00	£102,339,635.33	£85,942,668.92	£102,786,022.59
Societal benefits	£0.00	£0.00	£0.00	£0.00
Total benefits	£0.00	£102,339,635.33	£85,942,668.92	£102,786,022.59
Rank	**4th**	**2nd**	**3rd**	**1st**

Risks

An analysis of risk has been undertaken including design, construction, performance, operating, revenue and technology and other costs. At this stage, a number of assumptions had to be made based on a comparable MH scheme. This can be revisited at a later date.

3.6 Economic Appraisal

Figure 34 presents a summary of the key outputs of the economic appraisal based on the assumptions and inputs described above, expressed as Net Present Values (NPV) (see Appendix B).

This economic analysis indicates that:

- All options have the potential to show a positive Benefit / Cost Ratio (BCR) compared to BAU and;
- Option 3 is the preferred direction of travel, with a BCR of 11.40.

On the basis of the BCR the Option 3 provides better value. This BCR for all options is higher than the 4:1 ratio we usually expect in CIAM's. This can be attributed to the significant gaps in cost data, which skew the findings slightly towards benefits. We expect the BCR's to reduce when the CIAM is revisited at a later date with more comprehensive cost data. This is evidenced in figure 34.

The outputs of the CIA model are included at Appendix B.

Figure 34 - Economic Appraisal of Options

Option	0	1	2	3
Incremental Capital (Cost)	-	£8,643,915.87	£9,024,973.39	£9,024,973.39
Incremental Revenue Cost	-	-	£12,038,087.28	-
Incremental Opportunity Cost		£9,591,152.94	-	-
Incremental Risk	-	£292,740.00	£485,830.00	£482,080.00
Incremental Costs – Total	-	£18,257,808.81	£21,548,890.66	£9,507,053.39
Incremental Benefit NPV	-	£105,288,338.18	£88,867,443.58	£108,417,986.01
Net Present Social Value (NPSV)	-	**£86,760,529.37**	**£67,318,552.92**	**£98,910,932.62**
Benefit/Cost Ratio	-	5.68	4.12	11.40
Economic Ranking of Options	4th	2nd	3rd	1st

3.7 Economic Sensitivity Testing

Economic sensitivity testing will be undertaken at a later date when the data is more complete.

3.8 Preferred Option

The outputs of the qualitative and economic appraisals confirms that **Option 3** which provides suitable clinical assessment space to support ED collocated with the teams and new 136 provision on the Arrowe Park site is the preferred direction of travel at this stage.

3.9 Chapter Appendices

Appendix Number	Appendix Title
A	Options Appraisal Framework
B	CIAM
C	CIAM Support Information
D	Capital Cost Report
E	OB Forms

4.0 COMMERCIAL CASE

4.1 Clinical Quality

Since the inception of the projects to deliver URC's across the CWP geographical footprint, improvements in clinical quality have been a key driving factor supporting the delivery of the development of a first response approach to delivering an urgent care mental health response for people in Crisis who do not require ED attendance.

The development of the optimum estate's solution, based on the agreed model of care has had the consistent and integral input from organisation and clinical leaders along with frontline clinical and non-clinical staff. This will continue throughout the further development of this SOC and the subsequent OBC and FBC and will increasingly incorporate feedback and input from service users and groups.

Clinical quality aspects have informed and been integral to the project through the following means:

- **Processes:**
    - Appointment of a healthcare planner to lead on the development of the high-level design brief from the model of care and high level capacity planning.
    - A schedule of accommodation has been developed based on the agreed model of care.
    - Various workshops including an operational workshop which included mental health and emergency medicine clinicians.
    - Alignment with key estates guidance e.g. HBNs and HTMs.
- **Design:**
    - Clear evidence and future plans for sustained stakeholder involvement in design development.
    - Outline designs based on established service user need, as defined in the design brief.
- **Suitability for purpose:**
    - Supporting delivery of the identified service user and service efficiency benefits.
    - Proposed facility which will support with the integration of various teams who deliver the urgent response model of care.
    - Affordability of the estate's solution.

4.2 Future Capacity Modelling

Overview

The capacity modelling exercise provides the Trust with an insight into a high-level perspective into the potential activity that could be delivered by the service and suggests the way in which the services and departments could be configured for optimum performance and efficiency of the Urgent Response Centre.

Methodology

The following parameters were used to calculate possible patient contacts per Consult / Assessment, Interview / Counselling rooms and Physical Treatment Rooms for mental health urgent response services based on the number of potential rooms available.

The following parameters were used to calculate possible patient contacts per room:

- 45-minute appointments
- 60-minute appointments
- 120-minute appointments

The modelling assumes the centre will run 24 hours, 7 days a week for 52 weeks per year based on 85% and 90% utilisation allowance. See Appendix F for workings.

Assessment Zone

The following outputs in Figure 35 highlight the number of sessions that could be accommodated per day:

Figure 35 – Capacity Modelling Outputs

Assessment Zone	Minutes			
At 24 hours per day 1 consult/exam room delivers (minutes)	1440	45	60	120
Room / Space	Quantity of rooms	Number of Sessions		
Contact/Clinical Space				
Consult assessment	2.0	64	48	24
Interview rooms	1.0	32	24	12
Treatment Rooms	1.0	32	24	12
Total number of sessions		128	96	48
Total number of sessions at 85%		109	82	41
Total number of sessions at 90%		115	86	43

4.3 Scope of Project

Functional Content

The preferred direction of travel is a new build facility on the Arrowe Park Hospital site which would comprise of the following functional content:

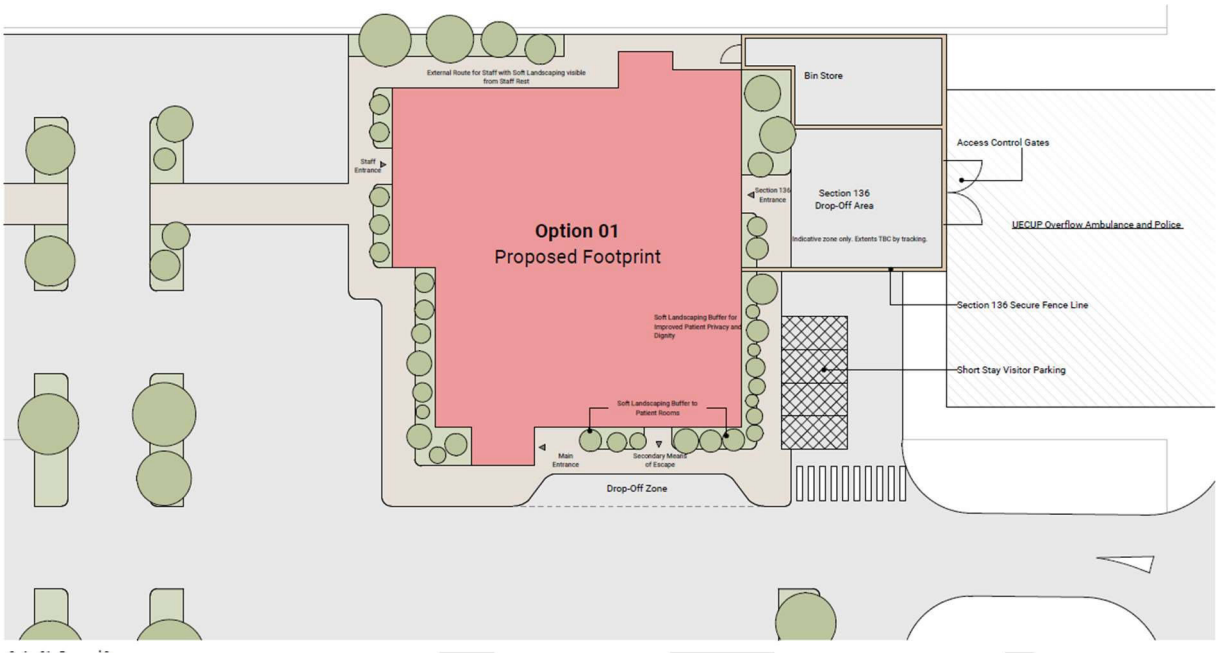
- **Entrance Zone**
    - Joint entrance for adults and children and young people
    - Joint waiting area with sections to accommodate adults, children and quite spaces
    - Interview/quiet room
    - Reception (ideally positioned centrally with clear visual of the whole area)
    - Visitor WCs
- **Assessment Zone**
    - Consult/assessment rooms
    - Interview room
    - Physical health treatment room
    - Section 136 suite with assessment room, quiet room / de-escalation room and dedicated entrance
    - Clinical Support - clean utility, dirty utility, store, disposal hold.
- **Administration Zone**
    - Open plan office and desks for various teams
    - General Hot Desks and touchdown space
    - Collaboration space
    - None face2face rooms, 121 meeting rooms, meeting rooms
- **Staff and Support Zone**
    - Staff room/kitchen
    - Staff change, showers, WC's
    - Cleaners room
    - IT/Server room

4.4 Scheme Description – Preferred Site

Site Description

The proposed site (Figure 36) is adjacent to the existing emergency department on the Arrowe Park Hospital site. The proposals indicate that the site will be developed as a single-phase project. The financial cost estimates and project timescales are based on this assumption. (Appendix G provides a feasibility report prepared by DAY Architecture which details the various options on Arrowe Park Hospital site).

Figure 36: Proposed Site



Accommodation Requirements

The accommodation requirements for the project reflect the capacity modelling work outlined at Section 4.2 and the need to deliver therapeutic, safe, high quality and fit for purpose facilities as emphasised in the investment objectives. Figure 37 summarises the estimated accommodation requirement for the project (Appendix H provides detailed accommodation schedule).

Figure 37 - Accommodation Requirements

URC SoA Summary Sheet		
Departments		Departmental Gross (sqm)
Entrance Zone		168.7
Assessment Zone		174.7
Administration Zone		379.0
Support Zone		123.0
		845.4
Communication Space	*8%*	68
Plant	*8%*	68
Total Gross Area (sqm)		980.80

Design, Design Principles, and Design Standards

The designs standards that have been used as the baseline for the development of the plans are shown at Figure 38.

Figure 38 - Design Standards

HBN / HTM Reference	Title
HBN 00-01	General Design Guidance for Healthcare Buildings
HBN 03-01	Adults Acute Mental Health Units
HBN 11-01	Primary and Community Care for Healthcare Buildings
HTM 00	Policies and Principles of Healthcare Engineering

At this stage no derogations from HBN / HTM guidance are anticipated. However, should this be necessary as the design develops, this will be documented and appraised using the new NHSE guidance, with an aim of assessing the derogations reported, the reasons behind these and the risk and mitigation that the Trust's advisors (in-house and external) consider appropriate to ensure user safety.

Day Architecture has developed a series of site plans and indicative layout drawing, based on the agreed model of care, schedule of accommodation and capacity requirements as set out in the Strategic Case. The plan for the URC at Arrowe Park is included at Figure 38 (Appendix G provides further detail).

Figure 39 - Drawings Ground Floor

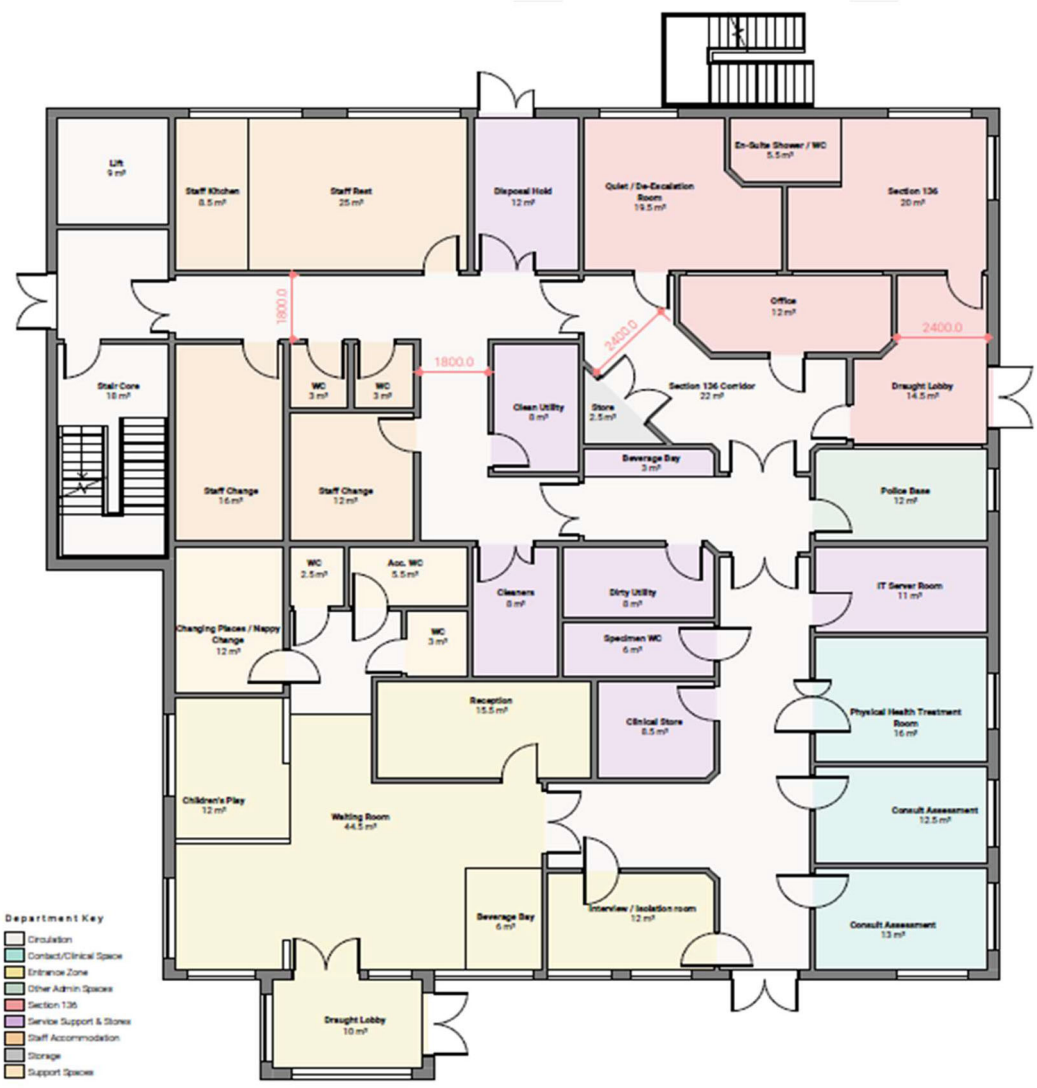


Figure 40 - Drawings First Floor

Layout Acceptance

The Feasibility Report and plans for the scheme have been developed in conjunction with key stakeholders involved in the project with the aim of establishing:

- Footprint works on site available
- Indicative overall area for the project. Key because capital costs and Estates and Facilities revenue costs have been established from this value
- Shows all stakeholders including the Trust, Clinicians, Staff, Service Users, etc. and other members of the Project Team the development direction of the project
- Formulates the strategic approach to the premises development including a site plan

The layouts will be further developed and sign off against relationships of rooms, size, location, shape, etc at OBC stage. This will be achieved through detailed design workshops with the appointed Architects and Engineers, key Clinicians, Trust advisors (Risk Management, Infection Control, Fire Safety, Security, etc).

Design Quality

The Trust is keen to ensure that the "Design Quality" and "Quality Agenda" is addressed to inform the design and ultimately demonstrate how:

- Design solutions will reflect service user, visitor and staff needs in terms of "sense of place and space".
- Design solutions will be sensitive to the physical, emotional and well-being needs of service users, visitors and staff.
- Design solutions will include and respond to the requirements of the "human senses" and the opportunities that art and the performing arts can offer.
- Design solutions will take on board environmental needs and be sensitive to the characteristics of the local and immediate surrounding area.

As the design is developed it will need to reflect some of the key areas from the design quality wheel shown in Figure 40 below:

Figure 41 - Design Quality Wheel

For the URC this will be centred around the key areas shown in Figure 41 below:

Figure 41 - URC Design Quality

Design Quality		
Responding to 5 senses	Smells, Aromas, Touch, Hear	This has the potential to positively stimulate the services user's feelings, memories and experience.
	Daylight, views and lighting	• **Daylight** – The optimisation of natural light within a space has the ability to provide health benefits. • **Views** – Views to outdoor spaces have shown to be therapeutic, reduce stress and boost productivity. • **Lighting** – Has the potential to improve visual condition and comfort for patients and staff.
	Sense of space and awareness	Individuals are aware of their body in relation to other objects and people, so it is key to ensure service users and staff feel comfortable in the centre.
Built Environment	Maintainability	Maintainability is key to the building system design, ensuring the comfort, accuracy, security, and economy of maintenance tasks within that system.
	Acoustic control	Good acoustic control is key to ensure good sound quality and privacy.
	Built use and form	Built use and form is key to ensure the environment is fit for purpose and supports the needs of the service.
	Safety	The design should be driven by safety considerations for all, site to be secure with good visibility and anti-ligature considerations within the publicly accessible areas of the building. Staff safety features such as panic call and CCTV to be discreet (considerations of how modern technology could assist in this).
Patient Environment	Privacy and Dignity	Privacy and dignity are person centred values which ensure there, views, choices and decisions are respected.
	Right spaces	It is key to offer the right space for the right care that is accessible to service users in the right place.
	Patient Choice and control	This offers the service user control of their health and a choice in how they would like to receive services.
	Patient and staff security	This provides the support in which care, and treatment can safely be provided by staff for service users and is a fundamental baseline requirement.
	Wayfinding and movement	This is a purposeful, intended, and self-regulated movement that guides and individual from one space to another and is key when navigating new space.
Creating Value	Adaptability, flexibility and growth	This is a key form of a systems growth and success in a space where needs and expectations are constantly changing.
	Effective value; released value	The creation of effective and released value can only be co-created by the health provider and service user and will be unique in every case.

4.5 Sustainable Development

CWP has a Board-approved **Sustainable Development – Environmental Strategy (2021 - 2024)** in which the Trust commits to the principles of Sustainable Development and will progressively integrate these principles into its daily activities. It is the Trust's vision to set the national standard for leadership in healthcare, staff wellbeing, engagement and community. To achieve this, it is important to not only look at the services the Trust offer and how they can improve but also the three pillars of sustainability, covering environmental, economic and social performance.

The Trust already incorporates sustainability in many aspects of its activities. However, recognise that more can be done. The huge challenge presented by COVID-19 is also an opportunity to rethink the way care is delivered. Realising the potential for sustainable development will help the Trust meet the objectives of its Clinical Strategy. The financial benefits accruing from increasingly sustainable activities will also allow the Trust to invest further in its clinical services.

CWP ensure that going forwards all capital developments comply with BREEAM 'Excellent' or above, ensures that the Trusts plans will focus on the reduction of building emissions from all sources.

The Trusts Capital Project ambitions are:

- Building energy efficiency standards for new builds and refurbishments, such as BREEAM 'Excellent' and the Zero Carbon Hospital Standard and on-site renewables
- Construction supplier alignment to net zero commitments, such as onsite contractor measures on waste reduction, low emission construction plant etc.
- Low carbon substitutions and product innovation, such as lower embodied carbon construction materials

4.6 Modern Methods of Construction

The Trust is committed to maximising the application of Modern Methods of Construction on its project and to complying with Government policy in this respect. At the next stage of the business planning process the Design Team will consider the use of modular build / off-site construction methods as part of the alternative construction methodologies, as a means to deliver time and cost savings as well as whole life cost benefits and in use costs.

4.7 Procurement and Contract Strategy

Delivery Methodology

At this stage in the business planning process for the Wirral URC a number of options have been considered for the methodology of delivering the preferred direction of travel which is on the Arrowe Park hospital Site owned by WUTH and the preferred delivery will be intrinsically linked to the funding strategy for the project.

There are currently two main options which have been considered:

- **Option 1** – CWP would enter into a long lease for a suitable freehold site on Arrowe Park Hospital for a peppercorn ground rent. CWP would then undertake the construction of the URC and ultimate ownership of the asset.

- **Option 2** – CWP would enter into a development agreement with WUTH who would agree to construct on CWP's behalf the URC on the Arrowe Park Hospital site in return for the capital to construct the new facility. CWP would then into a lease agreement with WUTH for a 25–30-year period for a peppercorn rent.

Both of these options for the preferred direction of travel will require further discussion between the two Trusts and will also be linked to the funding stream identified for the project.

Construction

Once the preferred delivery methodology is confirmed then consideration will need to be given to the construction procurement method, these could potentially include:

- Traditional Tender
- Design and Build/ ProCure 23 Framework.

The traditional method tends to be used where the client has knowledge and experience of delivering such projects. A Design & Build/ProCure 23 Framework is considered to be for clients who may not have the experience, capacity and capability to manage the project. A Design and Build procurement approach assumes that the contractor is experienced in delivering the construction and can use this experience to improve the project delivery.

The Procurement Route will be aligned to the Contract Strategy with the appropriate forms of contract. The type of contract will be agreed with the design team and appropriate amendments to the standard form will be made to consider; contract terms, insurances, payment processes, retention, defects liability periods, treatment of latent defects, etc if required.

Advisors

CWP propose to utilise the NHS Shared Business Services (SBS) 'Construction Consultancy Services' procurement framework agreement, which provides Estates, Facilities and Capital teams a compliant route to market for the provision of Consultancy Services from a wide-range of specialisms, utilising both Small & Medium Enterprises (SMEs) and national providers, to deliver either a single service or provide a 'one-stop shop' for a range of services. Through this route providers will be asked to commit to developing projects utilising Building Information Modelling (BIM) Level 2 across the range of Consultancy Services, dovetailing with the Government's Soft Landings (GSL) agenda to help deliver added value and meet the Government's target of BIM being used in all public sector construction contracts.

The Trust anticipates procuring a range of specialist advisors to support the development of the OBC, including:

- Architect;
- MEP Engineer;
- Structural & Civil Engineer;

- Principal Designer;
- Landscape Designer;
- BREEAM Assessor
- Sustainability Advisor;
- Fire Engineer;
- Healthcare Planner;
- Cost Advisor;
- Project/Programme Manager(s); and
- Business Case Author.

4.8 Town Planning

Once a preferred funding route has been identified and as the business planning process progresses the Trust supported by the design team will engage with the Local Authority town planners.

4.9 Legal Implications

Other than the procurement process of contractor and advisors as described at Section 4.4, there are no legal implications in relation to this scheme.

4.10 Workforce Planning

Staffing Implications of New Unit

There are no workforce implications in relation to this proposal other than the relocation of staff bases which will remain in the Wirral geographical footprint so will not impact on excess travel.

TUPE and Consultation

There are no TUPE or formal consultation processes required. In accordance with Trust workforce principles and guidance the Trust will consult with staff regarding the planned change. A Stakeholder Communications and Engagement Strategy will be developed following the sourcing of capital and the update of this SOC.

4.11 Equipment Strategy

An Equipment Strategy will be developed as part of the OBC and FBC development to understand the levels of new equipment required for the facility and a capital figure has been allowed for in the OB Forms and is included in the overall capital envelope.

4.12 Risk Allocation Matrix

Figure 42 includes the indicative risk allocation matrix identifying key risk categories and their allocation to the Trust or the contractor / supplier, or if it is a shared risk. This risk category apportionment will be reviewed as part of the risk management process and will be reflected in the risk register.

Figure 42 - Risk Allocation Matrix

Risk Category	Trust Risk	Contractor Risk	Shared Risk
Design	✓		
Brief	✓		
Financial	✓		
Logistics		✓	
M&E			✓
Management			✓
Operational	✓		
Planning	✓		
Programme			✓
Quality		✓	

4.13 Chapter Appendices

Appendix Number	Appendix Title
F	Capacity Modelling
G	Architectural Feasibility Report
H	Schedule of Accommodation
I	Design Brief

5.0 FINANCIAL CASE

5.1 Financial Overview

The Department of Health and Social Care (DHSC) capital budget (referred to as the capital departmental expenditure limit - CDEL), covers all capital spending by the DHSC and the NHS. Both the DHSC and the NHS are legally obliged not to spend above this limit. A major part of CDEL is allocated to NHS Trusts and NHS foundation Trusts (i.e. NHSTs) in each existing Integrated Care System (ICS), via a system-wide envelope. The ICB (Integrated Care Board) and its constituent NHSTs, have a joint responsibility to prepare a plan setting out their planned capital resources in line with that allocation.

Each Trust is allocated an individual allocation (i.e., control total) for each financial year. Indicative control totals for 2023/24 and 2024/25 have been provided to CWP, which includes a recognition of two major projects due to be completed in 2024/25. There is no capacity within either of these existing control totals for either year to absorb any additional other material capital schemes.

In order to fund any additional schemes, CWP will need to lobby the ICB and NHSE for additional CDEL. Given the potential scale of the Wirral URC project, ideally this would need to be cash backed by securing additional Public Dividend Capital (PDC). Ordinarily, additional capital resources are not accompanied by revenue support for day-to-day costs. Working on that assumption, aside from ensuring that the accounting treatment is correct, any subsequent Financial Case would have to clearly demonstrate the full capital and revenue consequences of any scheme, the impact on CWP's balance sheet and income & expenditure statement, the overall affordability and fundability of the scheme and confirmation of support from the relevant stakeholders.

5.2 Capital Requirements

The capital requirement for the preferred direction of travel scheme is **£11,972,200 (including VAT at 20%)**. The summary OB Capital Cost forms and associated report for the scheme showing the costs and contingencies included in the capital cost calculations and showing the overall capital costs of the scheme is included in Appendix D. The potential funding sources to meet this capital requirement are discussed below in section 5.3.

The makeup of the capital cost is as per Figure 43 with planning contingency included at 10% and optimism bias calculations are at 15%.

Figure 43 - Capital Costs

Cost Summary	Cost £	VAT (20%) £	Cost (incl VAT) £
Construction costs Total (OB2 and OB3)	6,332,823	1,264,565	7,587,388
Fees (15%)	948,424	-	-
Non-Works costs (OB4)	50,000	10,000	60,000
Equipment costs	421,368	84,274	505,642
Planning risk contingency	632,282	26,456	758,738

Sub total	**8,374,897**	**1,485,295**	**9,860,192**
Optimism Bias	1,106471	221,294	1,327,765
Inflation adjustment (Assumed start on site January 2025 and completion January 2026)	664,676	119,567	784,243
Forecast outturn capital cost	**10,146,044**	**1,826,156**	**11,972,200**

The profile of indicative capital spend is shown at Figure 44.

Figure 44 - Capital Cashflow

	2024/25	2025/26	2026/27	Total
Spend Profile	£1,000,000	£10,466,558	£505,642	**£11,972,200**

5.3 Sources and Application of Funds

The total capital value of the preferred option is £11,972,200 allowing for VAT at 20%. It is assumed that CWP will need to lobby the ICB and NHSE for additional CDEL and this would need to be cash backed by securing additional PDC.

5.4 Procurement Costs

Procurement costs associated with both the construction and equipping elements of the scheme are included in the overall fees structure and shown at OB4 of the capital cost forms (Appendix E).

5.5 VAT Treatment

No VAT recovery has been assumed at this stage with the exception of professional fees. This assumption will be tested further at OBC stage.

5.6 Revenue Costs

Once the source of potential funds has been identified and the commercial strategy for the delivery of the URC has been confirmed this SOC will be updated with revenue costs for the preferred direction of travel.

5.7 Financial Risks

Some indicative financial risks have been identified and are summarised in Figure 45, together with mitigating actions.

Figure 45 – Risks and Mitigating Actions

Financial Risks	Mitigating Actions
Failure to translate design could lead to facilities not being fit for purpose	Detailed design drawings to be developed in conjunction with CWP and WUTH clinical/management/estates colleagues to minimise the risk to design and will be completed at OBC stage. Multiple engagement sessions planned to mitigate the risk further.
Continuing development of design could lead to facilities not being fit for purpose	Sign-off of by clinical/management staff of key spaces, SoA, 1:50 and detailed drawings to be agreed at key milestones to mitigate risk. Multiple engagement sessions planned with key stakeholders.

Failure to build to brief could cause delays, additional cost and design not supported by users.	Full Trust and partners involvement in design and early consideration of procurement process.
Incorrect cost estimates leading to increase in capital costs	Project Team and estates work stream group (once set up under the project governance) to ensure designs are cost led to ensure budgets are achieved. Rigorous cost planning required throughout the healthcare planning/design planning period. Work in regard to capital costs and affordability will be managed through the estates work stream group with clear accountability to the Project Board. Capital costing work is started early in the process in order to identify any potential issues.
Legislative / regulatory change e.g. Brexit impact, Covid impact, market suitability	Early market testing and quantity surveyor to give regular updates on current market demand, pricing and any potential legislative change.

5.8 Chapter Appendices

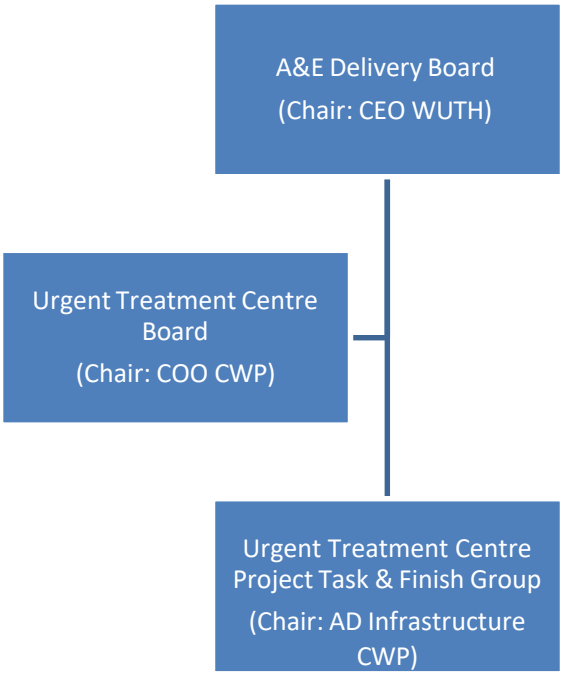
Appendix Number	Appendix Title
D	Capital Cost Report
E	OB Forms

6.0 MANAGEMENT CASE

6.1 Project Governance Structure

A clear and robust governance structure has been agreed for the delivery of the Wirral URC project and will be implemented once the SOC and key principles have been agreed. The programme is overseen by the Urgent Response Project Board, which is accountable to the CWP Executive. Reporting to the Project Board is the Task and Finish Working Group and relevant workstream groups. Figure 46 shows the governance structure of the Project.

Figure 46: Project Governance Structure



Wirral Urgent Response Project Board

The Project Board has decision-making and programme assurance responsibility and is accountable to the CWP Executive and is subject to regular scrutiny and review through reporting. It is responsible for the successful delivery of the Urgent Response Centre's across the Cheshire and Wirral geographical footprint. The other urgent response center's within East and West Cheshire are outside of the scope of this SOC. The Project Board will be informed of ongoing strategic guidance from the CWP Executive. The Project Board represents the higher-level interests of the Trust, users and suppliers within the project and has overall responsibility for strategic planning, service quality and the operational and financial performance of the programme. It is therefore responsible for the investment of financial and human resources.

The Project Board's responsibilities are to:

1. To review, approve and monitor the project brief, Project Initiation Document and Business Case
2. To review and approve project health checks at each stage of the project
3. To review and approve any major deviation from agreed plans via Exception Reports and or Business Change Requests
4. To ensure that necessary resources are committed to the project.
5. To arbitrate on any conflicts within the project
6. To review and monitor risks and issues that are escalated for attention ensuring risks are effectively mitigated and the planned actions are having the desired effect
7. To negotiate a solution to any problems between the project and external bodies
8. To judge whether constraints of time, budget and resources are reasonable

The Project Board is chaired by Suzanne Edwards, Director of Operations/Deputy Chief Executive for CWP. The full membership of the Project Board is shown at Figure 47.

Figure 47: Project Board Membership

Name	Role / Department	Organisation
Suzanne Edwards (SRO)	Director of Operations/Deputy Chief Executive	CWP
Emma Danton	Programme Manager	WCHT
Mark Buchanan	Consultant	WUTH
Paul Mason	Director of Capital Planning	WUTH
Stephen Bailey	Deputy Chief Operating Officer	WUTH
Craig Hayden		NWAS
Darren Birks	Head of Mental Health Commissioning	C&M ICB
Justin Pidcock	Associate Director of Infrastructure	CWP
Sean Boyle	Lead Mental Health Practitioner	CWP
Hayley Sherwen	Mental Health Liaison Officer	Merseyside Police

Wirral URC Task and Finish Group

The Wirral URC Task and Finish Group is responsible for the successful delivery of the Wirral URC project and reports directly to the Project Board. The Task and Finish Group is chaired by Justin Pidcock and its responsibilities are to:

- Ensure the scheme delivery to meet all critical delivery objectives including time, cost and quality
- Manage the Procurement Structure and Contract Strategies
- Agree the Project Plans and key critical path milestone dates and ensure the project stays within the agreed delivery timeline
- Agree key activity sign-off and delivery
- Ensure capital costs remain within the agreed parameters in this SOC
- Oversee the risk register and issues log and escalate where advised.

Membership of the Task and Finish Group is detailed at Figure 48.

Figure 48: Task and Finish Group Membership

Name	Role	Organsation
Dave Appleton	Head of Clinical Services	CWP
Kathryn McDermott	Head of Capital Planning and Portfolio	CWP
Justin Pidcock	Associate Director of Infrastructure (Group chair)	CWP
Sean Boyle	Lead Mental Health Practitioner	CWP
Mark Buchanan	ED Consultant	WUTH
Louise Fitzpatrick	Operational Lead for the Integrated Front Door and Emergency Duty Team (EDT)	Wirral Council
Paul Mason	Director of Capital Planning	WUTH
Jacqui Hale	Project Manager	WCHT
Jonathan Turner	Director (Business Case Writing Support and Health Planning)	AA Projects

Workstream Groups

As the business planning process develops towards Outline Business Case (OBC) a variety of delivery groups will be set up including The Delivery Group is responsible for implementing the work stream group packages:

- Built Environment Group – focus on design and build of the project including ensuring project build adherence to current standards (fire regulations and security requirements), ordering equipment, signing off plans and delivery of model plans that support the delivery of the building.

- Clinical Reference Group – tasked with reviewing current clinical model to ensure that it is fit for purpose for the new building. Review operational policies to ensure fidelity to the model.
- Stakeholder Group – ensure that those affected by the changes are communicated with (internally within the Trust, External partners, local community).
- Financial Group – oversee the project spend, confirm capital and revenue implications, and provide due diligence and financial assurance.
- Expert By Experience Group – establish consistent patient and carer representation at meetings. Ensure there is an engagement plan for the wider patient and carer group affected by the project. Identify appropriate engagement with the built environment group and the Clinical Reference group.
- Staff Group - establish consistent staff representation at meetings. Ensure there is an engagement plan for the wider staff group affected by the project. Identify appropriate engagement with the built environment group and the Clinical Reference group.

6.2 Project Management Methodology and Arrangements

Robust project management arrangements are in place to drive programme and project delivery.

The structure of the programme has been developed to follow the principles set out in the NHS Capital Investment Manual and the HM Treasury Green Book, supported by PRINCE2 project management principles.

All project management and consultancy services, and project management methodology are as set out in the NHS Shared Business Services framework - Construction Consultancy Services upon which all delivery services have been secured.

6.3 Project Team Roles & Responsibilities

Key Project Roles

The **Senior Responsible Owner (SRO)** and Programme Sponsor is Suzanne Edwards, Director of Operations/Deputy Chief Executive, CWP.

The project SRO is accountable for the success of the programme ensuring that the outcomes meet declared objectives and deliver benefits. The SRO will ensure that the programme maintains business focus in a changing healthcare context and that risks are managed effectively. The key roles and responsibilities of the SRO are to:

- Provide input into the development of the Project Brief, business case and Project Initiation Document (P.I.D)
- Secure funding from the appropriate Trust committee for the project

- Present the business case/Project Brief at meetings to committees and boards as appropriate
- Ensure that there is a coherent project team structure and logical set of plans
- Authorise expenditure and proposed tolerances
- Ensure that risks and issues are validated
- Approve the Project Plans and Reports
- Take responsibility for use of resources and authorise corrective action where necessary
- Liaise with the PMO Lead to assure the overall direction and integrity of the project
- Liaise with the finance lead to ensure costs and savings are captured and monitored accordingly
- Ensure that the benefits have been realised by holding a review and forward the results of the review to the Project Board
- To actively participate and input in the formal project closure process, as directed by the PMO lead

6.4 Use of External Advisors

External Project Roles

Delivery of the preferred direction of travel will require the appointment of direct external appointments to support the internal Project Team. The key appointments include the external Project Manager, Cost Advisor, Architect, Health Planner, and other Construction / Engineering disciplines.

Current appointments are as shown at Figure 49.

Figure 49 - SOC External Advisors

Name	Project Role
AA Projects	Business Case Consultant Healthcare Planner Cost Manager
Day Architecture	Architect

Costs of Project Implementation

The costs associated with fees and contractor fees are included in the OB forms.

The total fees are calculated at £948,424.00 or 15% and include the following:

- Contractor management

- Architectural, interior design, healthcare planning, M&E, structural design fees
- BREEAM Consultant fees
- Business case author fees
- Project management fees
- Cost management fees
- CDM Co-ordinator fees
- Survey fees
- Internal fees

6.5 Project Delivery Programme Milestones

Figure 50 summarises the key milestones for the successful planning and delivery for the Wirral URC project. This shows a potential operational date subject to funding of August 2026.

Figure 50 - Summary Key Milestones

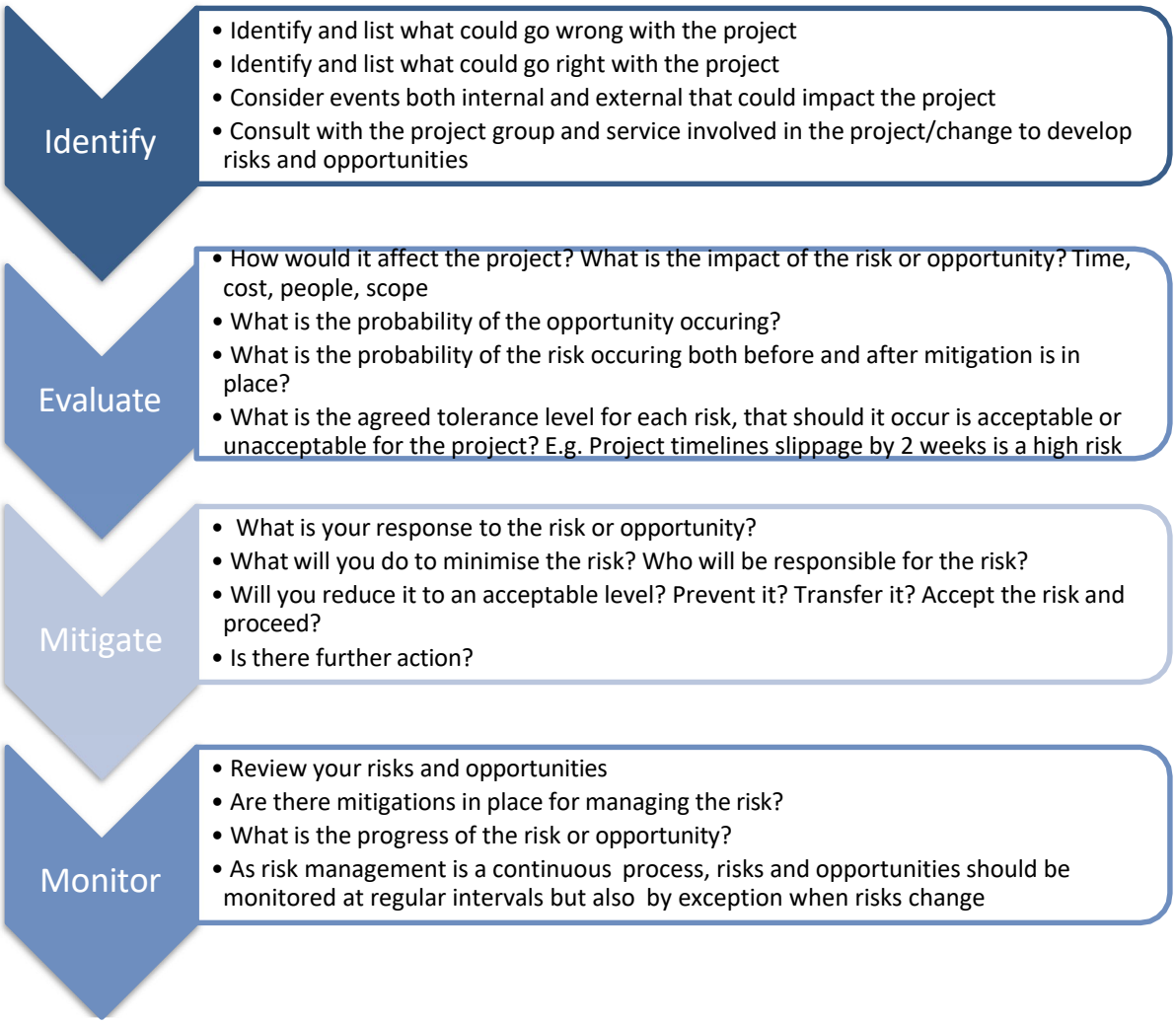
Programme Stage	Completion Date
SOC approval (internal)	April 2023
OBC approval (external)	December 2023
FBC approval (external)	October 2024
Start on site	January 2025
Construction completion	January 2026
Operational date	April 2026

6.6 Risk Management Strategy

Risk management for the project will enable the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to minimise, monitor, and control the probability and/or impact of negative effects or to maximize the realization of opportunities. For risk management to be effective risks need to be identified, assessed, and controlled and the process needs to be visible, repeatable, and consistent. It is the role and responsibility of the project board to ensure that risks and issues are highlighted and raised through to the project lead and Senior Responsible Owner. The process for identifying and managing a risk or opportunity is illustrated at Figure 51.

Once the full project governance structure is implemented following identification of a clear funding route, a project specific risk register will be developed and then managed by the project board.

Figure 51- Risk Identification Process



6.7 Benefits Realisation Planning

Benefits Planning

Benefits planning and realisation will be developed in accordance with NHSE requirements.

The Benefits Realisation Strategy will provide an evidence base to support the intended health, quality, financial and other identified benefits, where that evidence exists, and to quantify the benefits, wherever possible, to ensure that they can be measured and demonstrated over time. The Benefits Realisation Plan (BRP) will include detailed benefits. The BRP will detail:

- Key deliverables required to secure the benefit
- Performance measure
- Baseline and Baseline date
- Target outcome
- Data source

- Officer responsible for ensuring benefits are realised
- Benefits measurement timescale
- Risks to benefit delivery
- Benefit dependency

The communication and use of this strategy will help ensure that there is a shared understanding across the project team, workstreams and stakeholders of the process of benefits management and realisation in relation to:

- The approach to benefits planning, which includes how benefits are identified, defined, measured, recorded and prioritised
- The functions, roles and responsibilities of those involved in benefits planning and benefit realisation
- When and how reviews and assessments concerned with measuring benefit realisation will be carried out, and who is to be involved
- Measurement methods and steps that will be used to monitor and assess the realisation of benefits
- The tool(s), system(s) and source(s) of information that may be used to enable benefit measurement
- The use and definition of any benefits management terminology that is specific to the Project.

The realisation of benefits will in most cases continue beyond project closure and into benefits realisation. The management activities for outstanding/incomplete benefits will transfer from the PMO to the Benefit Owner and be accountable to the Director or appropriate manager of the service area where the benefit will be delivered.

The benefit owner will remain with the benefit and be responsible for the continual reporting of benefit performance information for the purpose of monthly Business Plan Return reports and service area quarterly planning and performance reviews.

A summary of the high level benefits that have currently be identified as a consequence of this development project are set out in Figure 52, note these are the benefits which have been utilised within the draft CIAM within the economic case, which can be found at Appendix B.

Figure 52 - Benefits Summary

Ref.	Benefit Name	Benefit Description	Calculation of benefit
NCRB 1	Reduction in ED Attendances	Reduction in ED attendances through delivery of the scheme and provision of alternative pathway for people in mental health crisis. If they do attend the ED this will only be instances when they have an acute problem that needs medical attention.	See draft CIAM for assumptions.
NCRB 2	Reduction in incidents	Reduction in number of incidents reported in the Trust's incident recording system through improved throughput, increased capacity and treatment of patients in the most appropriate setting.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
NCRB 3	Reduction in incidents of physical aggression and/or harm	Reduction in incidents; patient on patient, patient on staff, self-harm and patient behaviour, incidents of damage to property.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
NCRB 4	Improvement against 4 hour quality standard	Improved Trust performance against the 4 Hour Quality Standard through management of service users in the most appropriate setting. Reduced attendance at ED and therefore reduced wait times.	See draft CIAM for assumptions.
NCRB 5	Reduced wait times for people in Mental Health Crisis	Reduction in overall wait time for those in MH crisis.	See draft CIAM for assumptions.
NCRB 6	Improved Staff Wellbeing	Reduction in staff sickness due to reduced pressure on ED staff due to disruptive patients presenting at the URC instead of ED. Reduction in sickness, absence, associated with the environment and burnout.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
NCRB 7	Reduced agency/bank spend	Reduced agency/bank spend – directly employed NHS staff will be more interested in working in new builds because they will have a therapeutic environment designed to give the patients the best care	See draft CIAM for assumptions.
NCRB 8	Improved Staff Retention	Reduced costs associated with recruitment, and issues with retention	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
NCRB 9	Out of Area Placements	Reduction in out of area placements through collective use of resources, alternative admissions pathways.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
NCRB 10	Delays in transfer of care	Reduced service user Length of Stay through reduced delays in transfer of care by managing patients in the most appropriate setting.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.

Ref.	Benefit Name	Benefit Description	Calculation of benefit
NCRB 11	Wider benefit linked to the other sites in the model	Improved system performance in regard to management of mental health crisis with the project acting as an enabler to the wider model of care and supporting the URCs across the patch.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system.	At this stage, there is not enough data to sufficiently calculate this benefit. However, this can be revisited at a later date.

6.8 Stakeholder Engagement and Communications Strategy

A Stakeholder Engagement and Communications Strategy will be produced at the next stage of the business planning process and prior to commencement of the OBC process. It will set out the communication and engagement objectives and describes how the Trust will work together to communicate and engage by identifying target audiences, key messages, and appropriate channels. It will also describe the resources required to deliver the strategy and how the Trust will manage the communications and engagement risks.

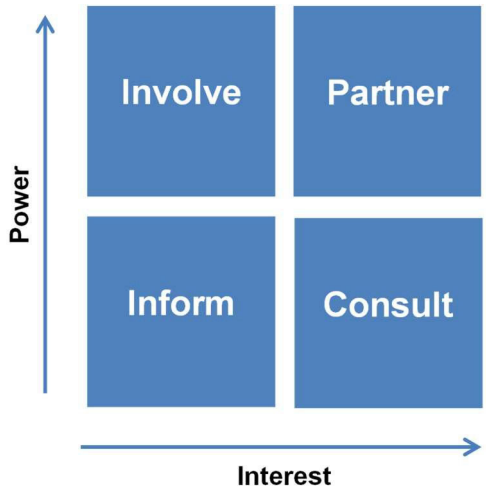
Communications and Engagement Objectives

It is anticipated the Trust's communications and engagement objectives are:

- To provide a realistic timeline and reassurance of the Trust's commitment to this development.
- To inform all Trust staff about key developments and benefits.
- To ensure that all stakeholders are appropriately and regularly involved, engaged and informed about the work we are doing, the case for change and the benefits that will be realised through the development of Wirral URC. This will work on the principle of 'no surprises'.
- To work with patient engagement team and Trust management to build meaningful and two-way communication and engagement with service users, carers to ensure that they have a genuine opportunity to influence the planning, development, design, production and evaluation of services.
- To ensure that equality, diversity, and inclusion is considered and promoted in all communications and engagement activities.
- To ensure that the public, particularly residents and communities, are informed and engaged about the development and have opportunities to provide feedback.

Stakeholder mapping will allow the Trust to determine the appropriate messages, timing, channels and resources to communicate and engage with each audience, broadly segmented as shown at Figure 53.

Figure 53 - Stakeholder Influence Mapping



- Partner – high power, interested: requires individually tailored communications. It is important that their involvement is encouraged throughout the programme as a good relationship with them is essential to the successful recognition and positioning of the programme.
- Involve – high power, less interested: It will be beneficial to provide this group with general information on a regular basis as it is possible that the interest of stakeholders within the group could grow as the programme progresses.
- Consult – low power, interested: whilst not considered high power, without involvement from this group the successful delivery of the project is at risk. It is therefore important that this group feel their opinions, concerns and ideas are heard and understood.
- Inform – low power, less interested: Whilst not essential to the success of the programme, this group will be extremely valuable in enabling access to a wide range of further stakeholders. They should therefore be kept informed, and use of existing mass communications channels is often the best method to update this group on key developments.

6.9 Business Continuity Planning

The Trust recognises the need to adequately plan to ensure business continuity during the development and delivery processes for the new facility. A business continuity plan will be developed during OBC and FBC stages.

6.10 Post Completion Review / Project Evaluation Planning

The Trust is committed to the full evaluation of capital schemes and projects through a formal evaluation methodology in line with the requirements of NHSE's Post Project Evaluation (PPE) guidance.

The Programme Team intend to complete an NHSE-format PPE report c. 12 months of scheme completion. The evaluation will also encompass the evaluation of the scheme whilst in construction.

The objective is to prepare a report which assesses how well and effectively the scheme was managed during the initial operation of the new facility.

In line with the guidance the programme will be evaluated against the investment objectives set out in this SOC and the processes involved in the programme delivery. In summary:

- Lessons will be captured throughout a project lifecycle and published and declared at project completion (to inform subsequent projects on a rolling basis);
- Formal evaluation of alignment with business case and user expectations will be completed within twelve months of project completion;
- An annual declaration of cumulative activity and evaluations will be declared to the Programme Board; and
- A final consolidated PPE will be produced and published at Programme Closure.

The aim of the PPE is to:

- Improve the design, organisation, implementation, and strategic management of other projects.
- Ascertain whether the project has been running smoothly so that corrective action can be taken if necessary.
- Promote organisational learning to improve current and future performance.
- Avoid repeating costly mistakes.
- Improve decision-making and resource allocation (e.g., by adopting more effective project management arrangements).
- Improve accountability by demonstrating to internal and external parties that resources have been used efficiently and effectively.
- Demonstrate acceptable outcomes and/or management action, thus making it easier to obtain extra resources to develop healthcare services.

In addition, a Post Completion Report will be completed, using NHSE format, within 6 months of practical completion of the new facility. The process will be over seen by the Project Management Team.

The lessons learnt will be of benefit to:

- The Trust – in using this knowledge for future projects including capital schemes.
- Other key local stakeholders – to inform their approaches to future major projects.

6.11 Chapter Appendices

Appendix Number	Appendix Title
A	CIAM

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

This Business Case document provides a case for investment in the development of a Wirral Urgent Response Centre. The SOC demonstrates:

- The strategic need for change in line with national, local and organisational drivers;
- The proposed delivery model and scope of the project;
- The preferred direction of travel to develop a URC on the Arrowe Park Hospital site;
- The capital consequences of the options set in the context that engagement with the ICB and NHSE will be required to consider funding routes; and
- Detailed plans for the governance and management of the implementation of the project in order to update the SOC and progress to the next stages business planning process.

7.2 Recommendations

The Strategic Outline Business Case is being presented to the Board in April 2023 with a request to:

- APPROVE the strategic fit within the context of CWP;
- APPROVE the identification of the preferred way forward;
- APPROVE engagement with the ICB and NHSE to consider potential funding routes;
- APPROVE engagement with WUTH to progress the commercial case;
- APPROVE the governance as noted in the management case and
- APPROVE undertaking further work to this Strategic Outline Business Case once a funding stream has been identified and subsequent progression to development of the Outline Business Case.

8.0 GLOSSARY OF TERMS

Acronym	Full Title
BAU	Business as usual
BCR	Benefit Cost Ratio
BRP	Benefits Realisation Plan
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CIAM	Comprehensive Investment Appraisal Model
CQC	Care Quality Commission
CRB	Cash Releasing Benefit
CSF	Critical Success Factor
CWP	Cheshire and Wirral Partnership NHS Foundation Trust
DHSC	Department of Health and Social Care
DQIfH2	Design Quality Indicator for Health 2
EIA	Equality Impact Assessment
FBC	Full Business Case
FM	Facilities Management
FT	Foundation Trust
FY	Financial Year
HBN	Health Building Notes
HTM	Health Technical Memorandum
HWB	Health and Wellbeing Board
ICS	Integrated Care System
LOS	Length of Stay
LTP	Long Term Plan
MMC	Modern Methods of Construction
NCRB	Non Cash Releasing Benefit
NHS	National Health Service
NHSE	National Health Service England
NPV	Net Present Value
NZC	Net Zero Carbon
OBC	Outline Business Case
ONS	Office for National Statistics
PD	Programme Director
PMO	Programme Management Office
PPE	Post Project Evaluation
QIPP	Quality, innovation, productivity and prevention
SOC	Strategic Outline Case
SRO	Senior Responsible Owner
SWOT	Strengths, Weaknesses, Opportunities, Threats

Acronym	Full Title
URC	Urgent Response Centre
VFM	Value for Money
WUTH	Wirral University Teaching Hospital NHS Foundation Trust