Final Business Case (January 20)

Proposed Development of Jubilee House, Medina Road, Portsmouth

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1. Background

Jubilee House (JH) is a 25 bed unit managed by Solent NHS Trust, in Cosham, Portsmouth. JH has suffered a range of problems over the last decade that have significantly affected its capability to offer the type of care required for the current need. This is the result of a number of underlying factors that reflects its design and that it is not suitable for either its proposed function or proposed patient group, and is more in keeping with the provision of end of life care that now represents only a small proportion of admissions[1].

However, a more important and now urgent issue is its capability to serve current and future demand from referring units including Queen Alexandra Hospital and GP practices, safely, effectively and throughout the year (including at times of high system level demand). This reflects that the nature of referrals for community beds is changing to a higher acuity and complexity unsuited to the JH environment. To achieve this, the unit needs to be redesigned for managing more complex and unwell patients (e.g. medium acuity) including more advanced rehabilitation.

Furthermore, JH needs to accommodate the requirements of a new model of workforce providing the enhanced skills and extended working day required to manage such patients. This includes a new medical/practitioner workforce model for Solent developed for both inpatient (JH and Spinnaker wards) and crisis/reablement and rehabilitation (PRRT).

2. The new model of care and single-site working

The new medical / advanced practitioner model of care has been introduced to uplift the capability of JH to care and treat patients admitted with medium acuity and rehabilitation needs. This has involved a change from limited and generally junior or GP led and delivered service to full time advanced nurse practitioner delivered care supported by dedicated geriatricians and/or trained GP geriatricians. This model additionally involves the same level of cover for our other inpatient unit (Spinnaker) and crisis response and rehabilitation and reablement (PRRT).

The new service model has involved the recruitment of a team of practitioners funded by a reduction in the contracted medical service. The requirements for this service are dependent on same site working to allow:

a) team working between practitioners who have a different skill sets
b) a single medical on site team to provide support for practitioners

For PRRT, same site location will allow patient management to move to more effective real time support of the teams from weekly MDTs and for deteriorating patients. The centralisation of the inpatient and crisis response services allows:

[1] The redirection of low acuity patients (including end of life care and for Continuing health care assessment) that was traditionally accommodated by JH (and to an extent Spinnaker beds) is now principally directed home or to care homes. This has also allowed a reduction in bed numbers at JH from 25 to, it is proposed, 10-13 with associated workforce redeployment across ASP.

a. The reduction in medical support from two to one team
b. Changes to real time practitioner led responsive care.
c. An enhanced level of day to day care required for medium acuity management.

The proposed changes within both PRRT and the inpatients wards allows a reduction in cost to fund the new service model to better meet the needs of our community.

3. Current options for the service based at Jubilee House, Cosham

3.1 Remain at JH.

This is a minimal cost option in the short term, however retention of the Jubilee building will necessitate significant reactive repairs and backlog maintenance works in addition to upgrades to meet the changing patient acuity and need in the medium to longer term. An estimation of these costs is likely to be around £2m over a 3-5 year period and will not deliver a the optimum setting due to physical constraints. There are no rehabilitation facilities and it will be more difficult to manage medium acuity patients. There will be a need to continue with two separate medical teams which is not cost effective.

This option does not allow the disposal or repurposing of the Jubilee site, possibly to support the Hampshire system and improve patient flow from Queen Alexandra Hospital. will be unchanged and there will be a failure of real time support for crisis response. It does not support the utilisation of the estate at St Marys, or the STP ambition to rationalise health estate.

JH has reduced to 12 beds, partly reflecting the investment in senior clinicians (as practitioners) and the development of a community end of life team supporting people to die in their own homes if this is their preference. This has allowed closure of 13 beds with associated cost savings.

3.2 Amalgamation of services on single unit on St Mary's campus

This is a medium cost option. It will require capital investments for rebuilding of a new ward at St Mary's Hospital but this could be offset against the sale or onward use of Jubilee House by the Hampshire system. If the Hampshire system does not require the JH facility, this would allow Solent to consider disposal options.

Centralisation of services on the St Mary's site will allow the implementation of the full medical/practitioner model. This will include:

a. The reduction in medical support to a single team (with associated cost savings).
b. Cost neutral support for recruited practitioners
c. Real time support for PRRT/crisis response allowing higher acuity patients.
d. Reduction in medical support needed for routine care in PRRT and replacing current high cost and limited medical team MDT support.

e. The facilitation of rehabilitation and acceptance of medium acuity patients for JH patients (now on JH ward on St Mary's campus) and the conversion of Spinnaker to a medium acuity/rehabilitation unit.
f. Acceptance of medium acuity patients discharged from Queen Alexandra Hospital.

In delivering this option, a number of Mental Health teams are displaced and alternative accommodation will need to be sourced as part of the estates plan. In doing this, there are 'knock on' benefits that include the significant reduction in overall footprint used by the service through the reduction in support areas such as under-used waiting and reception space. This scheme fully supports STP and Trust Estate Strategies, increases the percentage clinical space at SMH, and furthers the development of the site as a Healthcare Campus. In addition it will support the strategic direction of Adult Services Portsmouth, supporting the medium acuity model and in achieving longer term workforce efficiencies.

3.3 Move to a new site outside of the St Mary's campus (e.g. Kite unit)

Creating two standalone inpatient units (at St Marys (Spinnaker) and Kite unit/St James Hospital (JH)) as comparably compliant permanent facilities would be a significantly higher cost option.

This option again could also be offset against the sale of JH. However, the absence of single site working will similarly lead to inefficiencies of the new medical model and therefore will require 2 medical teams. In addition there will be an absence of day to day support of practitioners that will limit case mix to low acuity patients with inability to admit medium acuity. This will limit the capability to support Queen Alexandra admissions and step up from the community. The recruitment of practitioners already undertaken represents a substantial uplift in current workforce costs (see below) but will be required in view of the need to provide more senior support in these potentially isolated units

There will also be an inability to provide the expected support for crisis response/PRRT as the level of senior medical support at St Mary's Hospital will be restricted to current levels, restricting the opportunity to uplift the acuity. In addition, the lack of diagnostics on the St James site reduces the ability of Solent to move toward a medium acuity service in the future.

4. Options appraisal:

Cost/Benefit/Risk/Finance	**OPTION 1** **Remain at Jubilee House**	**OPTION 2** **Single Unit Services at SMHC**	**OPTION 3** **Permanent relocation to Kite Unit**
COST: *Description:*	**£2m** Update and repair of estate	**£3.8m** Full SMHC programme	**£3.9m** Extension and refurbishment
BENEFIT: **Re: ££ -** *Description:*	**£0.525m** £0.4m from Redeployment of surplus staffing from JH only £0.125m facilities provisions based on reduced patient numbers	**£1.225m** £0.8m from redeployment of surplus staffing across JH and Spinnaker £0.05m from reduced medical input for one single team across inpatient floors + 3PAs within PRRT. Offset by £0.25m cost of Consultant Practitioners. £0.375m from moving to SMHC	**£0.46m** £0.4m Redeployment of surplus staffing from JH only. £0.125m in facilities provisions based on reduced patient numbers (as in Option 1), reduced to £0.06m because of addition expense of being on SJH site.
Re: Provision of care: *Description:*	Negative impact on proposed medical model (see below)	Operation from one site will allow for implementation of medical model as planned - 1 team across the inpatient footprint and PRRT, with two Consultant Practitioners.	Negative impact on proposed medical model (see below)
Re: Income potential: *Description:*	**£0.2m** from using empty half of JH estate	Possible disposal of Jubilee	Possible disposal of Jubilee

5. Recommended Option

Option 2 is recommended as the optimal option to deliver the medical/practitioner model or care and for medium acuity patients in the community. Option 2 in the longer term will also be less expensive, eliminating the significant backlog liability within Jubilee House, and addressing maintenance obligations within refurbished areas of SMH. In addition option 2 is the only one that delivers savings against the 4 year plan signed up to by Solent and Portsmouth CCG. This option will also allow the introduction of the proposed medical model leading to significant recurring financial, staff and patient benefit.

6. Patient Engagement

Solent NHS Trust commenced the engagement strategy led by our Associate Director of Patient Experience in early January 2020. Meetings have taken place with stakeholder groups, a questionnaire has been developed. The project group have sessions planned with community groups in the coming weeks. Feedback from the community groups and the stakeholders will be used to shape the future service on the St Marys site.

7. Estates Plan

The realisation of the estates plan is dependent on the completion of four individual projects and associated service relocations:

i. **First Floor Block E (DSU) refurbishment**
Refurbish the first floor of Block E (formerly DSU) to create a new home for the OPMH team who have recently relocated from St James to a temporary home on the first floor of Block A. Prior to this refurbishment, the existing services operating out of the first floor of Block E will be relocated.

ii. **Third Floor Block A – AMH Out Patients**
Remodel elements of the third floor, Block A, to create a new home for the Adult Mental Health Out Patients, who currently operate from the first floor of Block A.

iii. **First Floor Block A – AMH Community Team**
Remodel elements of the first floor, Block A, to allow the Adult Mental Health Community Team to relocate from the third floor of Block A. This releases space on the third floor for the new inpatient beds from Jubilee.

iv. **Third Floor Block A – Jubilee Beds**
Remodel the vacated areas for the third floor, Block A, to create the new inpatient bed spaces. These works will be highly dependent on detailed phasing for their execution, as there is limited decant space for the existing Spinnaker beds.

This is a complex project and therefore difficult to accurately predict a completion date for all the phases. Moving patients over the winter period is unadvisable so realistically completion is likely to be Spring / Summer 2021.

8. Draft Plans

These are draft drawing and therefore subject to change.

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