Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Cover Sheet

Subject:	Board of Directors update on Commissioning Intentions	**Date:** September 2017	
Prepared By:	Richard Mitchell – Chief Executive		
Approved By:	Richard Mitchell – Chief Executive		
Presented By:	Richard Mitchell – Chief Executive		
Purpose			
Report on the actions taken, to date, regarding proposals for service changes received from our commissioners		**Decision**	
		Approval	
		Assurance	**X**

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
X			**X**	**X**
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
			X	

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	If the intentions are not carefully transacted and managed, they may increase commissioner or provider deficit
Patient Impact	If the intentions are not carefully managed, they may reduce the quality of care or access standards that SFH is delivering
Staff Impact	If the intentions are not carefully managed, they may have an adverse impact on staff morale and engagement
Services	The logic to these proposal and intentions is well thought through and supports national policy
Reputational	

Committees/groups where this item has been presented before

- Board of Directors workshop

Executive Summary

The local health system through the formal workings of the Alliance Partnership and Sustainability and Transformational Partnership (STP) and less formal relationships involving relationships formed at a sub-board level has to transform the way we work. This includes:

- Improving the quality of care that all patients receive, especially on the emergency pathway
- Reducing the level of activity that Sherwood Forest Hospitals NHS Foundation Trust receives
- Providing more patient care closer to home

- Ensuring that patients receive seamless care irrespective of their needs and who is providing their care
- Reducing the system deficit – ie we are spending more money than is available.

Sherwood Forest Hospitals NHS Foundation Trust (SFH) received a formal letter from our commissioners on 31 March 2017 confirming they would be disinvesting in services provided by us from 1 October 2017. Over the last couple of months, the SFH executive team and senior leadership team have been working with commissioners to shape these decisions. Our medical director and chief nurse have signed off on quality impact assessments for all of the proposals. We support some of the proposals, we have concerns about some of them but believe these concerns can be overcome and some we do not support.

We need to continue to work closely and collaboratively with partners including our commissioners and Nottinghamshire Healthcare NHS Foundation Trust, to ensure we deliver safe patient care, closer to home at a cost that is affordable.

Board of Directors update on Commissioning Intentions

Introduction

It is essential that we work very closely and collaboratively with our partners, especially our commissioners, Nottinghamshire Healthcare NHS Foundation Trust and social care to transform health and social care for our patients. We are working in challenging times with national demand for health and social care growing faster than the money and staff available. Our local health system has a well formed Sustainability and Transformational Partnership (STP) which Sherwood Forest Hospitals NHS Foundation Trust (SFH) is a key part of and we also work closely with local partners through our Alliance Partnership. Our joint aims are to:

- Improve the quality of care that all patients receive, especially on the emergency pathway
- Reduce the level of activity that SFH receives
- Provide more patient care closer to home
- Ensure that patients receive seamless care irrespective of their needs and who is providing their care
- Reduce the system deficit – ie we are spending more money than is available.

Overall we want to keep on providing high quality of care by ensuring that only appropriate patients are cared for in an acute setting and where possible we safely and timely transfer the care of patients to a lower cost setting, which often will be closer to their home.

Commissioner led service changes

NHS Mansfield and Ashfield Clinical Commissioning Group and NHS Newark and Sherwood Clinical Commissioning Group who commission the majority of services that SFH provides, wrote to us on 31 March 2017 to confirm that they wished to disinvest in particular services by 1 October 2017. This is a recognised mechanism for disinvestment and it is supported by the national context of trying to alleviate pressure on acute trusts and providing care closer to home.

Over the last couple of months we have been working closely with commissioners to understand more about their plans, to make sure we are playing an active role in shaping the service changes and to make sure that we move through the period of service transition as smoothly as possible with no impact on quality of care and or staff morale and engagement.

The majority of the commissioners' intentions for service change are focussed on these four areas:

- Inpatient wards at Mansfield Community Hospital (Lyndhurst and Oakham)
- Inpatient wards at Newark Hospital (Sconce and Fernwood)
- Emergency Department at Kings Mill
- Urgent Care Centre at Newark Hospital.

New Care Models Pilot

We recognise there are medically fit patients in our beds who can be cared for elsewhere. Changes to and a reduction in inpatient beds and wards at Mansfield and Newark could be achieved by the safe and timely discharge of these patients. To support the exploration of this idea,

on Monday 4 September we began the trial of a new care models pilot which involved Call for Care, local integrated care teams and intensive home support services working together to support complex discharges. This methodology is similar to others in place in other health and social care systems. Whilst we (SFH executive team, senior leadership team and staff directly involved in patient care) are absolutely committed to positive and collaborative working with partners to make a success of these changes, concerns were raised early on in the trial.

At the five staff briefings wc 11 September 2017, the CEO drop in session at Mansfield Community Hospital on Thursday 14 September and a meeting with Newark staff on Friday 15 September, we focussed on how staff, actually involved in the pilot, felt it was progressing. On Thursday evening 14 September/ Friday 15 September morning I took the decision to pause the pilot scheme using Call for Care as the single point of access for facilitating complex discharges, and revert to the previous arrangement and we communicated it to relevant staff groups internally and Alliance partners.

The main reason is that managing flow was particularly challenging wc 11 September, and this led to a dip in compliance with the four hour ED standard, with the predominant reason being waits for beds at Kings Mill. We cannot make a direct causal link between the operation of the pilot and these challenges, but it has marked a significant change in practice and only a very small number of patients have gone “home first”, so on the balance of risk, reverting to the old system and assessing whether flow and performance recover seems the sensible course. Since we reverted back to the old system, flow and four hour performance improved.

We have also had a good deal of feedback from staff, expressing some concern about both the way in which the pilot is operating and the impact it may be having. Once again, it is difficult to distinguish between issues relating to the external component of the trial and those relating to our internal systems and processes, but we have to take the concerns seriously and seek to address them both through internal conversations and interactions with Nottinghamshire Healthcare NHS Foundation Trust and other partners.

It is the hope and expectation of all parties that we will re-establish the pilot in an adapted form in the near future, but we cannot yet be definitive about when that will happen.

The winter planning for 2017-18 confirms that we need all of our wards at Newark, Mansfield Community Hospital and King’s Mill Hospital open to help support us providing a winter of high quality of care to our patients, and this is what we propose to do.

Emergency care

Commissioners have proposed a series of service changes that we feel would weaken our ability to provide high quality and timely care to emergency patients at King’s Mill Hospital. Our medical director and chief nurse have completed quality impact assessments about these changes and we have shared these with commissioners. Whilst the services should, probably, be funded via national tariff, our contract with commissioners and control total, agreed with NHSI, both take into account these services being fully funded this year. If these services are not funded for the rest of 2017-18 we either need to withdraw them, which will impact on quality and access standards, or fund them which may weaken our ability to deliver on our agreed control total. Conversations with commissioners about these two options continue. Commissioners have also proposed a change to the Urgent Care Centre at Newark Hospital which would move to a service which is led more by

GPs. Whilst we support this change, we do have concerns about the timelines and conversations with commissioners continue. There are no firm proposals agreed at the moment.

Neuro rehabilitation services on Chatsworth Ward

We have confirmed an intention to withdraw from providing the current neuro-rehabilitation services on Chatsworth Ward at Mansfield Community Hospital. This is due to a number of factors related to clinical sustainability and is not a financially driven decision. We have had difficulties in recruiting the specialist medical staff needed to secure the future of the service and reach the standards required to deliver a comprehensive neuro-rehabilitation service, and this has combined with a reducing need for the services within a hospital setting. Our thinking in the area has also been influenced by Mansfield and Ashfield Clinical Commissioning Group seeking to provide the service with closer links to community services and in the most clinically and cost effective way.

We do not provide Level one care and we have confirmed we will withdraw Level two care but we are now liaising closely with the CCG which has confirmed there will continue to be services to care for Level 3 care neuro patients potentially at a different location or using a different care model. Discussions are taking place to define what the future needs might be and how they can be met.

I feel that staff, patients and their families have been listened to, and their views will continue to be taken into account. One listening event with approximately 40 people was held in August and the CCG and Trust are committed to holding more events and will ensure public and patient views are taken into account before any decisions are made. The next one is due to take place on October 4. Both the Trust and the CCG are committed to making sure there is a continuity of service, so no changes will take place until these conversations are completed and new services are put in place. This means patients currently having treatment on Chatsworth do not need to worry about their care changing, in the short term. We are also clear that there will not be redundancies for staff on Chatsworth Ward.

Conclusion

We have to play, and are playing a key role in shaping decisions about service changes across Nottinghamshire. We recognise we need to actively support the move to reducing unnecessary acute admissions and the safe, timely transfer of patients to another, non-acute setting. However we cannot support decisions which may impact on our quality of care, access standards or agreed financial position.