Breakout Session 2 – Clinical Summit 26th February

What needs to change given your current performance and relationships with your competitors, and partner care providers?

1. What are you good at and can build on?

Hitting targets
Hitting targets generally
Trauma targets
Colposcopy service meets all national standards, maternity service charter mark and CNST level 2

Financial management
Reference costs comparable to other multi site trusts

Patient engagement and satisfaction
Good engagement with service users
Satisfied patients
Patient environment good on some sites
Patient and customer focused
Good understanding of local issues
Patient involvement within service planning
2nd in the country for patient satisfaction, first in North East
Patients seen on time, listened to, half hour consultation

Service delivery
High level of consultant input into care of child
Low complication rates
Angioplastery flagship for trust
Sharing services/ working together across services: maternity, dermatology, colo-rectal surgery, breast, day surgery, endoscopy, cancer services, plastics
Well integrated service between sites - some services e.g. maternity
Innovation
Good at recognising weaknesses in service delivery and job that needs to be done
Team work
Obs and gynae; passionate about services
Well established joint governance across sites
Improved relationships developed already e.g. radiology, diagnostics, etc

Relationships with partner care providers
Good working relationships with social services / PCT / Education / CAMHS
Community services already part of childrens services
Links and relationships with other trusts services
Responding to initiatives: -care bundles
Team work
Innovation service delivery e.g gynae, out-reach, MLU, termination service, midwifery service in childrens centres
Public health foundation – teenage pregnancy education, smoking cessation, breast feeding promotion, etc. Sexual health, pre-conceptional

Staffing and training

Range of specialist expertise – links with regional network
Nursing staff – good recruitment / retention within paeds and speciality like neonates which are hard to recruit to
Provide teaching and education opportunities
Staff flexibility
Hard working, flexible, work well under pressure
Across trust educational framework for junior doctors

Research and Development
Very good research in general
Internationally research in stroke. 1st established acute stroke service

Modesty(!)

What are the external opportunities to increase your offer and local market position?

Providing services more locally
e.g. Easington – provide community services and general paediatric OPD locally
Provide nursing staff for "care packages" for children at home.
Opportunities for surgery closer to home
Community clinics Middlesbrough and Sedgefield
Vertical integration

Collaboration with care partners
Building relationships with other providers
Get consultants to meet GPs
Collaboration or competition?
Open evening / GP bulletin
Relationship with emergent community trust
Work with Assura / PBC leads

New ways of working/ work areas
Treatment centres
Innovation and expansion into new areas of work
Elective/ emergency service split. 'Treatment service'
Innovation – weekend clinics, etc. → patient choice
Clinical opportunities – develop new work
State of art pain services
Day surgery and short day surgery

Promotion of Trust and its services
Promoting clinical services – centres of excellence
Build Trust identity
Traditional views of DMH hospital (with new consultant team) needs to be changed
Open evening / GP bulletin
External relations management with stakeholders / public

Providing transport
Transport for patients - if we want to use all sites need to improve transport links
Transport PTS service – park and ride for staff

Competition
Weakness of some competitors

What do you need to improve and how?

Brand and marketing
Use of communications. e.g. Intranet
Marketing including to patients
Our marketing – we don't sell ourselves
Need to use the size/brand "CDDFT" more
Our reputation Trust and orthopaedics e.g. DMH
Image / positive image
Market critical care services: "let everyone know what they do"
Market our services better to customers – sell our selves. DIALOGUE WITH GP

Hitting targets and external standards
Standards quality
Continue to work towards compliance with all NSF standard including surgeons / anaesthetists
Meeting highest national standards in all areas irrespective of site

Service delivery
Develop MDT approach in all specialties
Day surgery –short of national targets
- efficiency
- workstream separation
- customer friendliness, etc.

Provision of high dependency unit for paediatrics
RNC in emergency department / mixed OPD
Improved bed management
Children's pharmacist
Relationships between departments – partners, not service, consultancy not supermarket
Develop the idea of sub-specialism + "flagship" services, e.g. arthoplasty services
Centralise parts of the service such as revisions/rehab
Improve length of stay
Rehab/SBH/BAGH to be used for rehab
Hospital at home for IV antibiotics
Develop option for delivering healthcare across the local community, e.g. outreach, intermediate care
2 sites for acute medicine, 1 site for elective diagnostic care
Clear strategy on day surgery - just one site?
Formalise arrangement across all 3 sites for emergency care
Discharge planning at earlier opportunity
Alternative to admission – support in community
- access to other services and different types of care

Develop MDT approach in all specialties

Market threats
Identify loss of business to other trust and act upon it
Target specific GPs who are not sending us market share
Do we compete/set up community/step down services??

Partnership working with other healthcare providers
Relationships –better understanding / dialogue with GPs
Communication – become a proper part of the joined up process (not of healthcare) but of making people better
We need dialogue to establish networks and partnerships

Could develop minor surgery in primary care (provide healthcare services)
Can we work more with universities?
Greater influencing relationships with key players in PCT i.e. commission arm
Mechanisms for trust and primary care clinician dialogue, working together and action
Change the ineffective process/pathway if bidding/application to change / introduce new services

Patient experience
Marketing including to patients

Joined up working across sites
Improvement in networks (and professional behaviour) across and between sites
Performance management –Reflect context e.g. intra-site travel
Cross-site working
Communication between sites
Quality control: -same standard of care delivered trust-wide
Development of networking across sites within specialties to lead to single services across 3 sites – mutual trust
Improved methods of communication and information sharing to professionals and patient – standardisation across trust- MDT author. x intranet, internet, etc.

Finance
Consider impact of tariff on packages of care
Investment /Leadership – show me the money – make it flow → let PbR work its magic
Improve cost reference e.g. private consultations undercut us
Develop local tariffs for packages of care – dialogue

Information/ resource management
Need big improvement in information flows
- planning
- aligning resources wk. by wk.
- retrospective evaluation of use of resources

Capacity planning looking at forward opportunities
Better clinical decisions need more clinical information
Better data information and its technology – being absolutely sure that we are making the right decisions
Information flows – especially theatres / capacity planning
Not good at financial and human resource management

Clinicians to have improved working knowledge of finance and business – S. L. M.!

Staffing
Staff morale
Leadership (clinical)
Rewarding good practice
Mentoring and self development, facilitation of professional development - to increase high quality staff – leading to retention and improved knowledge management
Improvement in professional behaviour

Where are you vulnerable?

Loss of Trust activity to competitors
Predatory trusts around
Not good at presenting ourselves
If GPs not aware of services may lose referrals
North Tees (Hotel-type builds)
Developments in independent sector (woodlands / one life)
Cheaper competitors
Surrounded by predatory trusts
In-county competition also inter county
Services where we have historically collaborated
If we move to 1 or 2 sites for certain services, we will lose patients to other providers

Loss of Trust activity to new care settings
Tertiary networks
Tertiary centres on each side / Networks

Working across different sites
Risk of fracture –Geography, location
Fracture North / South BAGH/DMH: geography and location
Lack of trust wide services – site culture → clinical teams
Problems offering excellent services on multiple sites - difficulty maintaining equality of services

Service delivery
Interdependence –Stand of fall together
Single-handed specialties

- Too acute focused (wider healthcare agenda)

- Cross-directorate dependences

Providing acute paediatric services across 3 sites (sustainability)

Provision of support to emergency departments (depending on their review)
Multiplicity of systems delivered across a variety of sites
3 sites in patients / 5 sites out patients
Too acute focused – need to x from delivery healthcare services

Political interference
High profile local MPS

Finance
Finance – CAP
Degrees of flexibility PFI
- Overhead costs of multiple sited

Finance – scale of CRP – efficiency (- number of sites)

Staffing
- Recruitment and retention
- Recruitment of middle-grade staff

Junior docs and recruitment of consultants

Internal, e.g. delays

Recruitment issues → External e.g. rotas, site issues which restrict competition

Access

- Transport – patients
- Low car ownership in some areas of Trust

Lack of transport to bring patients in to trust

Leadership

- Board management barriers / inhibition to innovation

Board management – inhibition of innovation –feeling is this will improve now
Delays in translating decisions to action and implementation

Partnerships

- Relationship with commissioners (esp. clinician to clinician)

External relationships

Clinical vulnerability
24/7 support on 3 sites

Information
Lack of information and intelligence
Availability of information
Collection of data
(?) e.g. worforce, competitors
Access to

Recruitment issues → Internal, e.g. delays
→ External e.g. rotas, site issues which restrict competition

Requirement for critical care services unknown

- lack of information

Technology
Lack of telemedicine for radiology and dermatology

Facilities
Darlington infrastructure