Feedback from morning breakout session

Your strategy needs to recognise factors outside your control. What are the main external drivers for change?

<u>1. Policy</u>

Patient choice
- higher expectations
- more empathises on patient experience
- empowerment of patient/ service user
- driving higher standards of service

Providing care closer to home
- Darzi report, NHS Next Stage Review
- Community care, admission prevention and early discharge
- Presents both opportunities and challenges

Practiced Based Commissioning –contrive / destruct forces

World class commissioning

Payment by Results and unbundling of tariff

Staffing initiatives
- EWTD
- Professional bodies
- Consultant contracts
- Education and training

Politics
- General Election- change of national government
- Local Government Review

Successful clinical networks
- what is a network?
- should we network locally or regionally

Local govt. –social care merger

External scrutiny/ guidance/ initiatives
- External targets – 18 weeks
- Scrutiny and standards of service: NPSA; NICE
- NICE guidelines
- NSF
- HCC reviews
- National screening programmes

The unknown
- huge number of possible drivers over which the Trust has no control

2. Money

Money following the patient

- referral patterns
- competition from other providers
- quality versus quantity
- economise of scale

Payment by results

Tariffs

- nationally set to achieve a 3% efficiency gain per annum
- smart management of tariffs, make money were you can
- income generation from tariff; need to trade at surplus and then invest the surplus

Reference costs

Practice based commissioning

- PbC deals at less than tariff e.g. diagnostics

PFI hospitals

- 3 out of 5 Trust sites are PFI hospitals

Need for coherent replacement of technology

- investment planning

Flexibility in recruitment and rewards

- hard to recruit 'good staff'
- need to attract and retain

Market forces factors

Financing of the NHS

- DH pot of money not growing as quickly as in previous years
- Relative reduction in government spending of health
- Where else can money come from? Insurance companies, benefaction?

Interaction with social services

- Transport costs for accountability and interaction with social services

Service Line Management and accounting

3. Health demand and patient expectations

Marketing

- Advertising to patients, GPs and PCTs
- Good information to patients about services and treatment available (lack of information at present
- At present GP interface can be positive and negative
- Public often misinformed by the media
- Increased availability of information from the internet
- Patients need confidence in safety and quality of service – willing to travel for timely and quality service
- Need to showcase flag ship departments

Service delivery

- Choose and book versus accessibility of services
- How do we decide on service delivery?
- What is quality? Different perspectives of staff and patients and between different age groups.
- Outreach work – providing consultancy to support primary care → strategic aim

Specific local needs

- Demographic changes/ ageing population – shorter life expectancy
- Long term conditions
- Obesity
- Relatively deprived pockets of catchment area
- More data required on patients needs rather than demand

Patient expectations/ demand

- Patients expect all services locally
- Proximity of care to patients' homes
- Demand for therapy earlier
- Instant access –expectations of a service industry
- Expectations coloured by local and national political agenda and the media
- Patients expect car parking and TVs

Local geography

- Distant communities but competitors very nearby – individual PCTs run county hospitals
- Rural
- Access issues due to rurality and deprivation (low car ownership in some areas)

Car parking and transport

- Car parking of high importance to patients
- relatively low car ownership in some parts of catchment area, therefore poor access to hospital services

4. Clinical technology and clinical trends

More work being carried out in the community

- May be able to counter balance by swapping activity
- Commissioners looking at providing primary care centres- move technology to these centres. i.e. radiology could be provided then looked at with telemedicine.
- Care in the community; can we achieve vertical integration?
- Polyclinics

Secondary care

- Highly complex but low volume cases

Diagnostics

- Non invasive diagnostics → less work in invasive provider services
- Move to diagnostics screening on people who are well
- More diagnostics could lead to more work
- Early access to OP and diagnostics and prompt results.
- Patient self testing

More specialist care provided in tertiary centres

- lower workload in specialist DGH areas
- Move to local elective work in DGH can still lead to opportunity

Private healthcare

- Potential to moving to private healthcare due to expectations of patients – clean, good food, patients waiting lists, clinical outcomes, when convenient for them (out of hours, convenience of services) - as waiting times come down move more towards this.

Technology

- more day case short stay surgery (but this has been well exploited already so say not be huge)
- use space and technology to make sure stay at fore front
- Choose and book
- National IT programme – slow pace
- Sharing of technology tertiary to secondary care – shared packages of care i.e. major specialised work in tertiary cannot keep taking on; will need to move some general care back
- Technology – access to national standards and worldwide standards increase expectation e.g. breast surgery
- Clinical technology at home?

- Availability of scanning technology including revenue support versus requirement for appropriate clinical care.
- Expensive technology
- Due to costs need to concentrate technologies potentially on single site versus polyclinics; what and where; how can we influence?
- informed patients with expectations regarding technology
- Coherent replacement / investment planning
- Concentrate technology on sites for critical mass + cost

Children

- Paediatrics – reduction n seriously ill children – but those that are patients are more complex therefore need for fewer more specialised centres. Increase in number of referrals of not very ill children to secondary care.

Prevention and screening

- Initiation of prevention and screening by specialist services in DGH

Primary care

- if not on QOF not done by GP, if on QOF then will be done.

Higher levels of competition/ collaboration

- Comparators – Neighbouring Trusts
- Need for collaboration versus competition
- Competition from other Trusts
- Multiple providers; integration of care pathways
- Collaboration/ partnership versus competition
- Vertical integration with community services
- Boundaries between 2nd + 3rd and 1st + 2nd care sectors