East Lancashire Hospitals NHS
NHS Trust

FIT FOR THE FUTURE

ELHT Clinical Strategy 2016/17 - 2020/21

Safe | Personal | Effective

PREFACE

The NHS, and East Lancashire Hospitals NHS Trust, face a significant challenge to maintain high quality, sustainable, services in a difficult financial climate. The health needs of our local population are significant and rising, and we have a duty to make sure the outcomes of healthcare interventions both in and out of hospital are as good as they can possibly be. We are on a "burning platform" and doing the same over and over again is not an option for us. It is necessary for us to be bold in our thinking and our actions. Our Clinical Strategy reflects a committed approach to addressing the needs of the population of Pennine Lancashire. We propose to address the changes through integration: with other providers of health and care services, across primary, secondary and tertiary care, and with partners in our locality and across all of Lancashire. Our services and our expertise shall have "no walls" as we seek to provide and influence the health care offered to the population. We recognise that the clinical strategy is a live document and will be subject to many changes and iterations as we respond to stakeholder comments and views. We welcome this debate and challenge and look forward to developing and over arching strategy for Pennine Lancashire with the specific aim of improving the health outcomes of our communities .

Professor Eileen Fairhurst, Chairman of East Lancashire Hospitals NHS Trust

I am grateful to all the clinicians of the Trust who took part in shaping this strategy, in contributing their ideas and expertise through a series of workshops, clinical discussions and through their senior leadership roles. This strategy represents the voice of clinical opinion in East Lancashire Hospital NHS Trust. It represents our commitment to change, our commitment to improvements, and our recognition of opportunity and challenge. The Trust is in a stronger place than ever before, with the best clinical outcomes in its history. This strategy allows us to build upon our foundation of expertise and credibility. We will make tackling local health needs a priority, focusing on the conditions such as frailty, chronic respiratory disease, and cancer which affect our local population. We will move care and expertise into communities, and expand our delivery of care over seven days.

Kevin McGee, Chief Executive of East Lancashire Hospitals NHS Trust

EXECUTIVE SUMMARY

Towards Better Health, Better Care

Over the next five years East Lancashire Hospitals NHS Trust (ELHT) will see closer integration with providers of health and care across Pennine Lancashire through the Pennine Lancashire Transformation programmes, and across all Lancashire as part of Healthier Lancashire. We will seek greater roles in the prevention of illness, encouraging self-care, in primary care, and in regional specialist work. We will describe ourselves as a Healthcare Trust, rather than a Hospitals Trust

Across Pennine Lancashire, we will integrate more closely with providers in the primary, community, voluntary and third sectors. We will undertake co-design with commissioners, creating an 'accountable care system' in Pennine Lancashire. This programme will sit under the Healthier Lancashire overall strategic commissioning and planning framework. Clinicians of the Trust will increasingly work with their professional colleagues from other providers to form Lancashire-based sustainable networks which determine the standards of care, the governance, and the delivery of care pathways.

Our transformation themes will drive us towards a clinically and financially sustainable integrated organisation. These themes are:

- Agreeing new system-governance principles with Healthier Lancashire and Pennine Lancashire Partners, agreeing key outcomes for the system
- Increasing primary and community care involvement: new models of care
- Increasing standardisation
- Improving efficiency in elective care
- Changing non-elective pathways
- Reviewing and networking specialist services.

We will achieve greater efficiencies, reducing length of stay for key medical conditions including COPD, reducing theatre times for elective and emergency surgery through increased productivity measures, and reducing our overall bed-base by the equivalent of at least two wards by new pathways of care and integrated community care services.

We will continue to improve care in our Trust and community, increasing access to all relevant services across all seven days of the week, reducing avoidable mortality and improving patient experience.

INTRODUCTION

Principles, Drivers, National and Local Context, and Transformational Themes

Principles of Our Strategy

2. East Lancashire Hospital NHS Trust has the following strategic aims:

- To be a **Safe, Personal, Effective** provider of generalist hospital, community and primary care services, by working in partnership with others
- To be integrated in the health and care economy across Pennine Lancashire as part of a **Sustainability and Transformation Plan**
- To be a **networked provider** of key specialist services in conjunction with other Trusts across all of Lancashire (including stroke services, maxillofacial services, vascular services, radiology services and cancer services)
- To be a **regional centre** of excellence for specific services (for example certain urology and hepatobiliary surgery and neonatology).

3. Our new strategy will be required to drive and deliver:

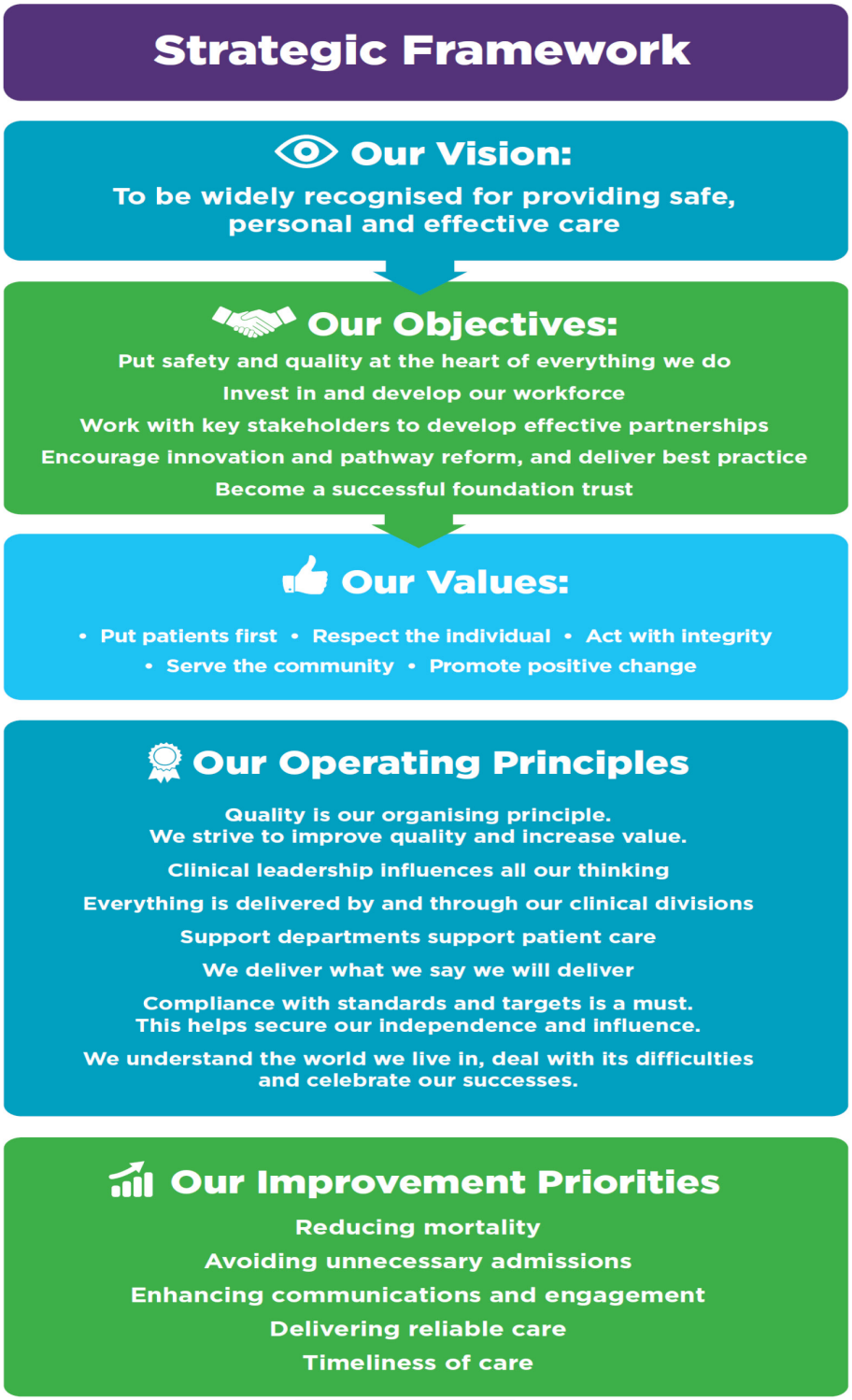
- Safe, Personal and Effective Care
- Sustainable services which demonstrate affordability
- Standardised and consolidated services which demonstrate efficiency
- Clinical leadership and professional networking, both within and between organisations.

4. Our strategic and transformational themes in 2016/17 – 2020/21 will be:

- Agreeing new system-governance principles with Healthier Lancashire and Pennine Lancashire partners
- Increasing primary care involvement and agreeing new models of care
- Increasing standardisation
- Improving efficiency in elective care
- Changing non-elective pathways
- Reviewing and networking specialist services.

5. The Strategic Framework which outlines our Vision, Objectives, Values, Operating Principles and Priorities (see diagram 1) remain at our core.

Diagram 1: ELHT Strategic Framework

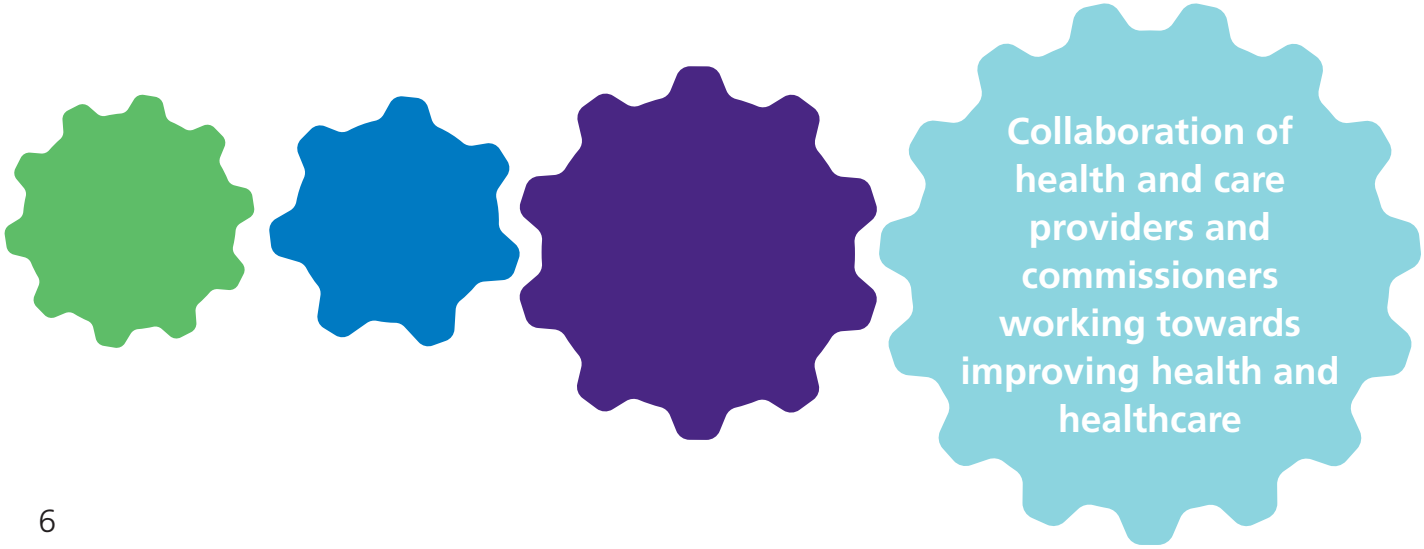


6. Whilst a divisional and directorate structure in the Trust will remain for the short to medium term, there will be an increasing tendency to deliver care through functional teams which bring together the multidisciplinary clinical and managerial expertise.

7. Our ethos reflects commitments already agreed with local partners, as follows:

- We will deliver services around the needs of patients and their carers
- We will continuously improve the care given to patients and their carers
- We will implement transformational change, maximising innovation and use of technology to deliver care in a standardised and efficient way
- Co-production will be the hallmark of care redesign: commissioners and providers will develop a shared approach and focus of continuous quality improvement
- We will strive for more third sector involvement in the delivery of care
- We will develop the workforce, and facilitate learning and education of staff, patients and carers at every opportunity
- We will all recognise our role in prevention of ill-health; we will work in partnership and will share responsibility for health and outcomes with partners and the public
- We will continuously strive to improve our commitment to research.

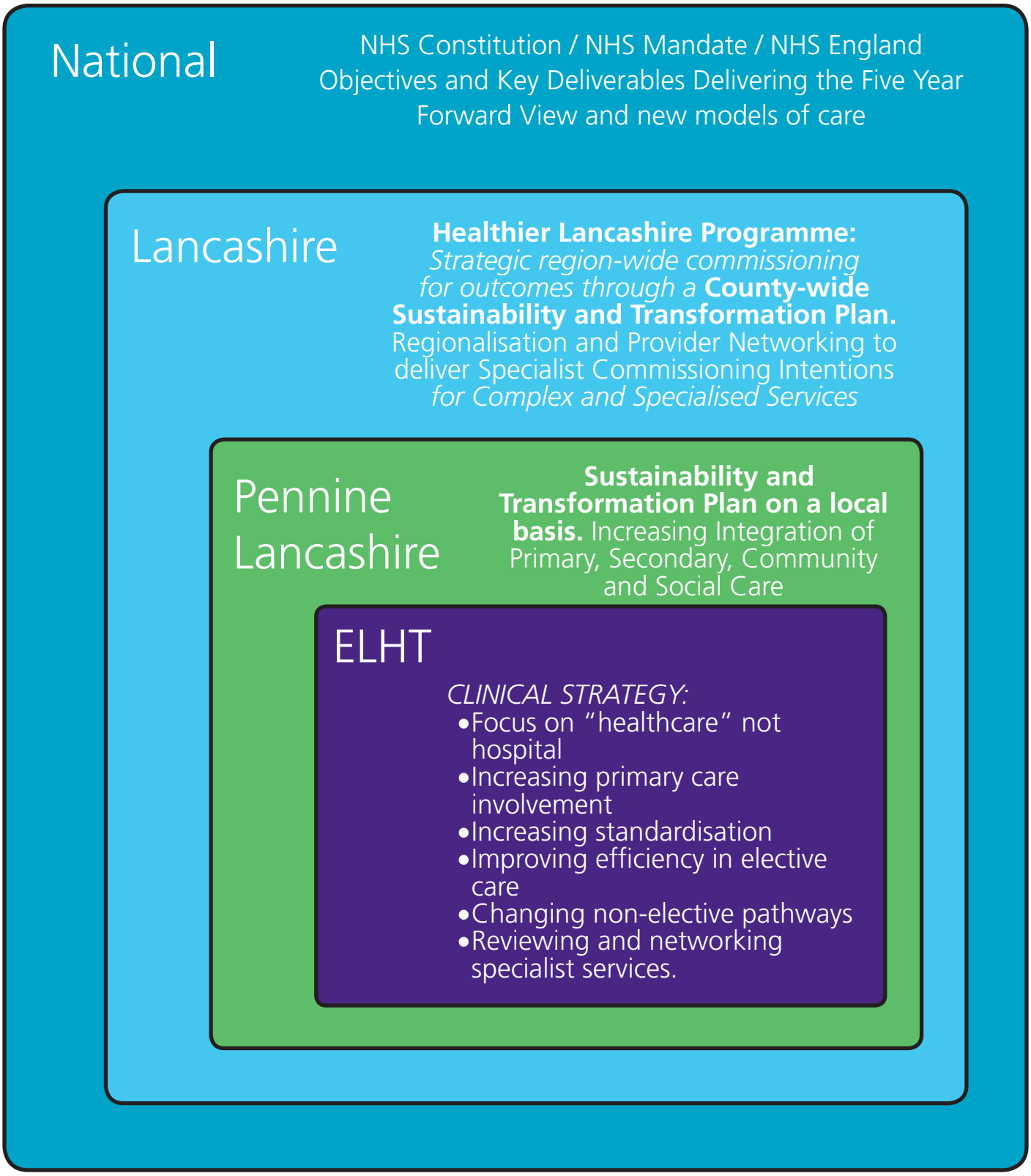
8. The Trust sees itself increasingly as a partner in a collaboration of health and care providers and commissioners working towards improving health and healthcare across a population base. With renewed focus on prevention, long term conditions management and cross-sector working, the Trust influences both demand, quality and outcome. The Trust will reflect this by developing its name and brand, indicating a shift towards a wider **healthcare** perspective.



The National, Regional and Local Context

9. Our strategy is seen in the context of national "must-dos", with regional collaboration and networking in response to wider system planning, but with local planning footprints in order to respond to local needs. Diagram 2 depicts how the national, regional and local planning influences the context for our strategy.

Diagram 2: The Context of ELHT strategy



10. Provision of ELHT services will be focussed conceptually across three footprints:

- The boundaries of our estate and our centres in East Lancashire as we seek *quality and efficiency*
- All Pennine Lancashire, as we seek *integration, locality modelling, unified standards and improved access*
- All of Lancashire through networked arrangements as we seek *sustainability of and access to specialist services.*

11. We will also work in professionally-coordinated network arrangements (or where indicated franchising arrangements) with regional tertiary centres for highly specialised services. Therefore whilst we network with Lancashire hospital provider partners for many aspects of specialist services, we will network with hospital provider partner organisations in Greater Manchester and Merseyside for others, such as specialist or tertiary children's services. The national context is set each year as the Government sets the "Mandate" for the NHS, and NHS England creates the overall operating framework and system objectives for the delivery of the Government's Mandate.

12. The Government's 2016/17 Mandate to the NHS contains the following key objectives:

- Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities
- To help create the safest, highest quality health and care service
- To balance the NHS budget and improve efficiency and productivity
- To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives
- To maintain and improve performance against core standards
- To improve out-of-hospital care
- To support research, innovation and growth.

13. NHS England has accepted the Mandate and has incorporated the requirements into the Planning Guidance "*Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*" published on 22 December 2015. This guidance is published in the context of the recent pending review announcements, and is explicitly positioned to set out how the sector is expected to deliver the Five Year Forward View by 2020, 'restore and maintain financial balance' and 'deliver core access and quality standards for patients.'

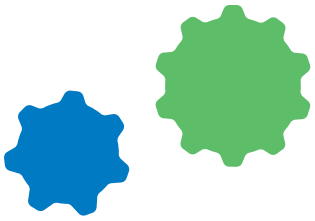
14. This guidance is jointly prepared by NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), and Public Health England (PHE).

15. Planning guidance directs each locality to create a Sustainability and Transformation Plan (STP). Taken together, all transformation footprints should form a complete national map. Under an overarching Healthier Lancashire STP, our local STP footprint will be Pennine Lancashire. The STP is the umbrella plan, holding underneath it a specific delivery plans and individual organisational plans. Pennine Lancashire is chosen because it builds upon natural communities, existing working relationships, patient flows and takes account of the scale which is needed to deliver the services, transformation and public health programmes required. Change in footprint may occur with time.

16. Our Clinical Strategy is influenced by the following nine "must dos" for NHS organisations and locality 'systems' as articulated in the planning guidance for 2016/17:

- Develop an agreed Sustainability and Transformation Plan
- Return the system to aggregate financial balance
- Develop and implement a local plan to address the sustainability and quality of general practice including workforce and workload issues
- Getting back on track with access standards for A&E and ambulance waits (so that 95% patients wait no more than four hours in A&E and that ambulances respond to 75% of Category A calls within eight minutes)
- Improvement and maintenance of NHS Constitution standards for referral to treatment (so that more than 92% patients on non-emergency pathways wait no more than 18 weeks from referral to treatment), including offering patient choice
- Deliver constitutional standards on cancer care, including the 62 day cancer waiting standard and the constitutional two week and 31 day cancer standards, making progress in earlier diagnosis and improving one year survival rates
- Achieve and maintain the two new mental health access standards (more than 50% people experiencing a first episode of psychosis will commence treatment with a NICE approved package within two weeks of referral; 75% referrals to IAPT will be treated within six weeks and 95% within 18 weeks). Continue to meet dementia diagnosis targets
- Deliver actions in local plans to transform care for people with learning disabilities including enhanced community provision, reducing inpatient capacity and rolling out care and treatment reviews
- Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. (In addition providers are required to participate in the annual publication of avoidable mortality rates).

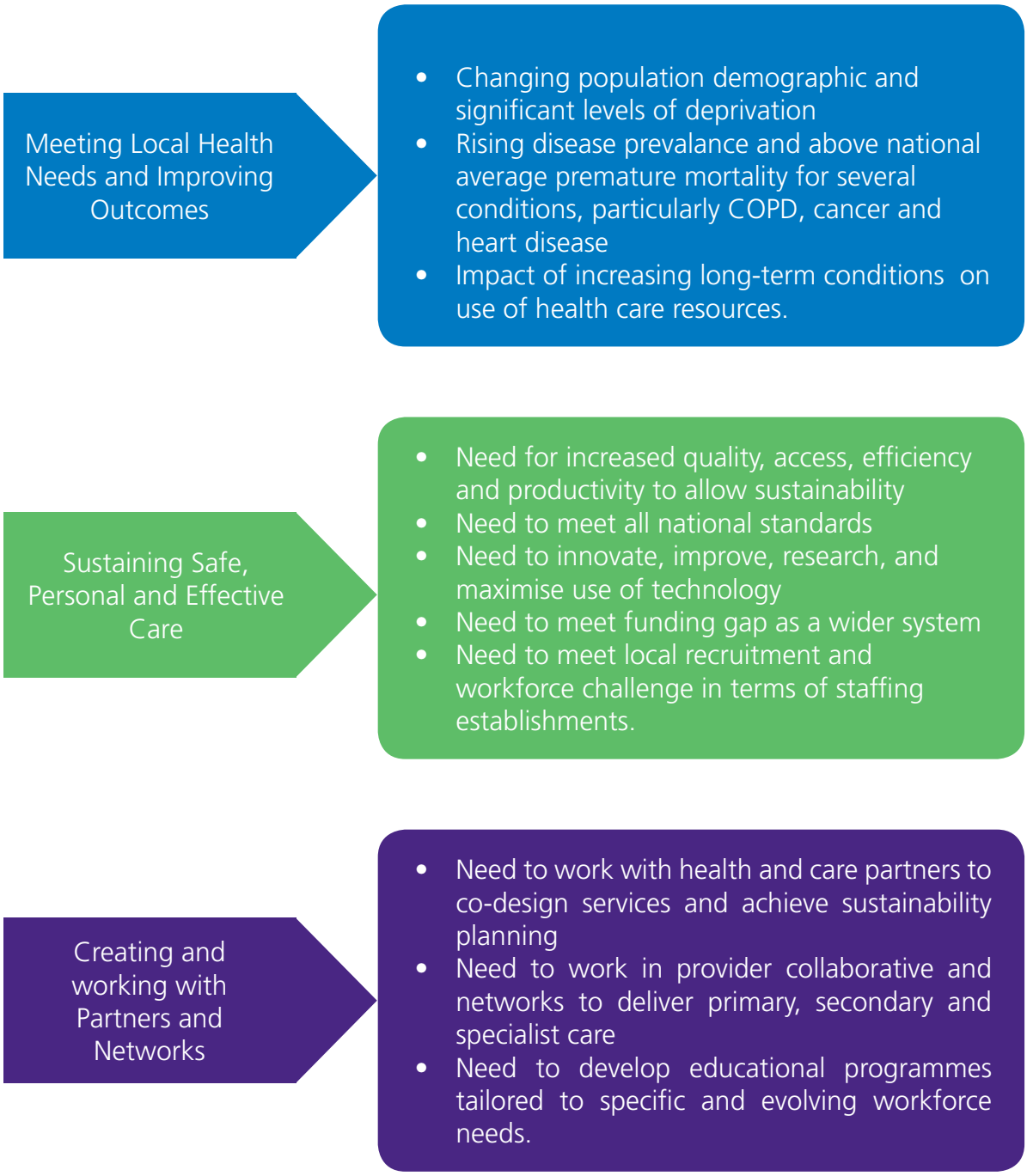
17. Our response to the must-dos will be addressed through delivery of the strategy and is summarised in Appendix 1.



Local Drivers for Change

18. Much of the 2014-2016 Clinical Strategy remains relevant and is incorporated into ongoing workstreams. Local challenges as well as national priorities now give rise to the opportunity to refresh our clinical strategy for 2016-2020. The nature of pressures acting as 'drivers for change' in the development of this Clinical Strategy are summarised in diagram 3.

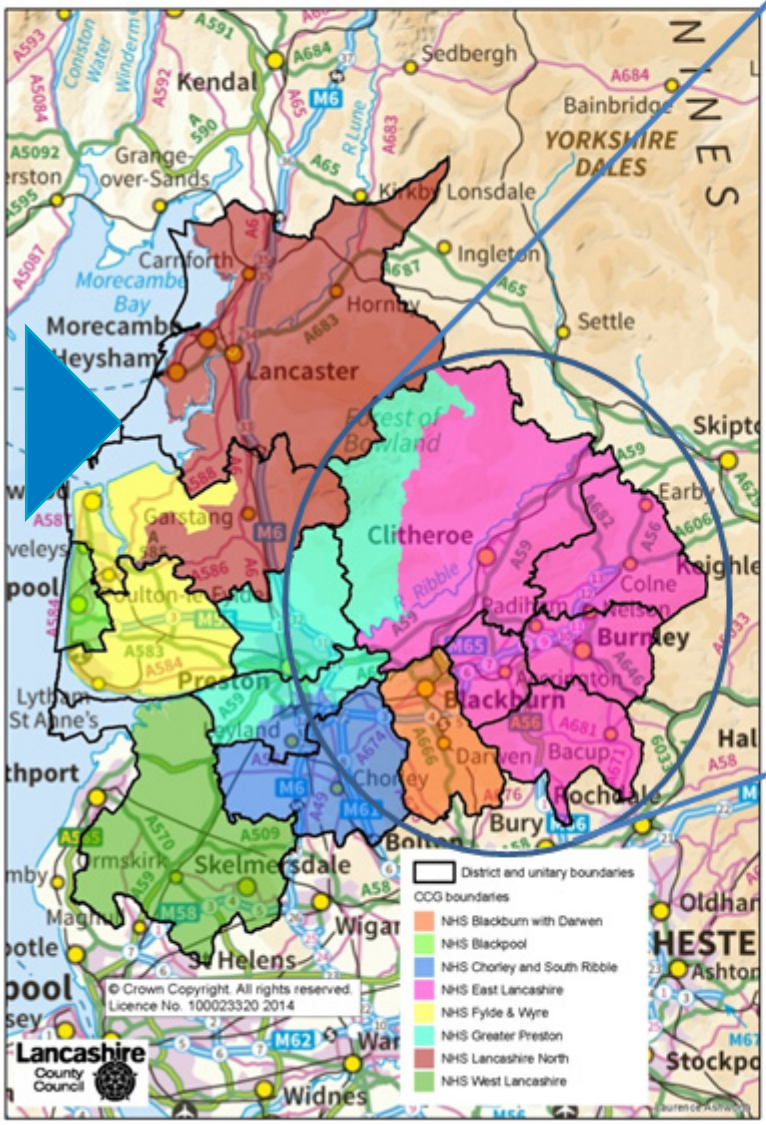
Diagram 3: Drivers for Change



Public Health Context

19. Pennine Lancashire comprises the six local authorities of Blackburn with Darwen, Rossendale, Burnley, Pendle, Ribble Valley and Hyndburn (see diagram 4). With a population of more half a million, Pennine Lancashire has a diverse population, with over 25% of Blackburn with Darwen residents and 10% of East Lancashire residents being of South Asian heritage. Blackburn with Darwen has one of the youngest populations in England, with half its school-age children coming from BME communities. The Pennine Lancashire population is estimated to grow by 1.9% overall by 2020 with a 4.5% increase in those aged under 16 years, and a 7.7% increase in over 65s.

Diagram 4: Lancashire CCG configuration and Pennine Lancashire Local Authorities



20. Pennine Lancashire has some of the most deprived areas of England, with Blackburn with Darwen, Burnley, Pendle and Hyndburn all ranking highly on the latest (2015) Index of Multiple Deprivation. All Pennine Lancashire boroughs except for Ribble Valley have a substantial proportion of their neighbourhoods among the most deprived 20% in England. In terms of health deprivation, more than a third of Pennine Lancashire neighbourhoods are among the worst 10% in England. Levels of child poverty vary markedly over Pennine Lancashire, with Burnley and Blackburn with Darwen both having more than 22% of children in poverty, while Ribble Valley has only 5.7% (the lowest equal proportion in England).

21. Pennine Lancashire experiences high levels of health inequalities and there is a big gap in terms of health outcomes. Pennine Lancashire has some of the worst health outcomes in the country, with life expectancies in Burnley, Hyndburn and Blackburn with Darwen all ranking in the bottom 20 out of more than 300 local authorities. The rates of heart failure, asthma, depression and severe mental illness are all higher than national averages and the long term drivers of inequalities in non-communicable diseases, such as obesity, alcohol and tobacco, persist and are strongly associated with the high levels of deprivation.

22. According to the latest NHS Atlas of Variation, both Pennine Lancashire CCGs are in the worst 20% in the country for:

- Mortality from cancer in people aged under 75 - *so we will work with CCGs to improve cancer pathways*
- Rate of epilepsy emergency admissions in people aged 18+ *so we will work with CCGs to improve diagnostic and urgent care pathways*
- Percentage of people with epilepsy aged 18+ who were seizure-free for last 12 months - *so we will work with primary care to improve local management*
- Rate of COPD admissions - *so we will improve community respiratory care services, urgent care pathways and reduce COPD length of stay in hospital*
- Rate of asthma emergency admissions in people aged 19+ *so we will improve community respiratory care services and urgent care pathways*
- Percentage of people in National Diabetes Audit who met treatment targets - *so we will work with CCGs and GP federations to establish better models of care*
- Coronary heart disease mortality in people under 75 - *so we will improve access to cardiology services*
- Quality of stroke care - *so we will commit to improving stroke care, achieving improved national audit standards*
- Hospital admissions for dental caries age 0-4 - *so we will offer expertise to local dental programmes*
- Child emergency admissions for asthma - *so we will redesign access to paediatric services*
- Child admissions for mental health problems - *so we will redesign access to paediatric services*
- Emergency admissions for ambulatory care sensitive conditions - *so we will develop better ambulatory care services and facilities in the Trust*

23. Five out of the six Pennine Lancashire districts (i.e. all except Ribble Valley) are in the worst category for:

- Percentage of people aged over 16 years who are physically inactive - *so we will work with Pennine Lancashire Partners to improve the focus on healthy lifestyle, as well as becoming a "healthy hospital" to promote improved lifestyle choices*
- Hospital admissions for alcohol-related causes - *so we will improve our care of alcohol related disease.*

Case for Change as a system

24. The health, disease management and care needs of our population are outstripping the resources available. It has been estimated that if we do not change the way we deliver care in Pennine Lancashire, the resource gap will grow and become £250m over the next 5 years. The Pennine Lancashire care partners will need to work together to secure high-quality and financially sustainable prevention, information and care services driven through improved productivity and efficiency in targeted ways.

25. The scale of the affordability challenge will require options that involve a package of estate rationalisation, reduced unit labour costs, the reconfiguration or closure of some services, and improvements in the delivery of long term conditions, frail elderly and mental health services. In order for the challenge across health and social care to be met, a pool of transformation schemes are required meet the affordability gap that will need to be identified in collaboration with our local communities.

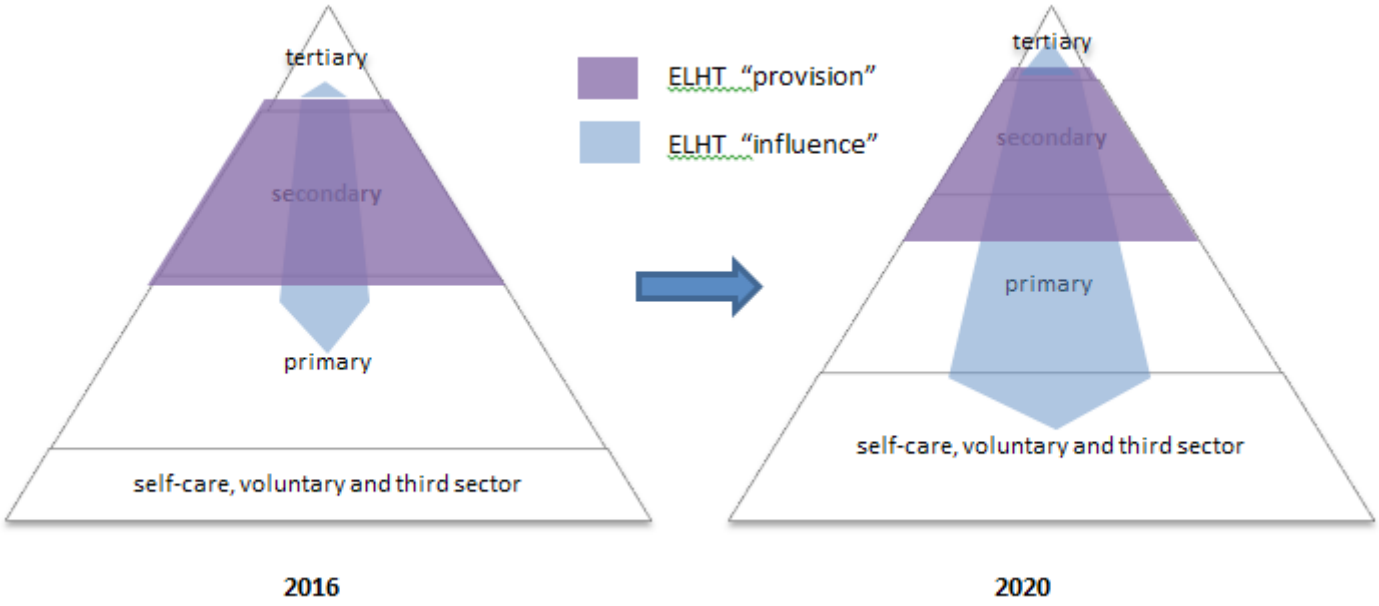
Transformational Themes

26. In order to tackle health needs, improve outcomes, deliver efficiency, and make safe, personal and effective care sustainable, our strategic and transformational themes in 2016-20 will be:

- Agreeing new system-governance principles with Healthier Lancashire and Pennine Lancashire Partners and agreeing key outcomes for the system
- Increasing primary and community care involvement: new models of care
- Increasing standardisation
- Improving efficiency in elective care
- Changing non-elective pathways
- Reviewing and networking specialist services

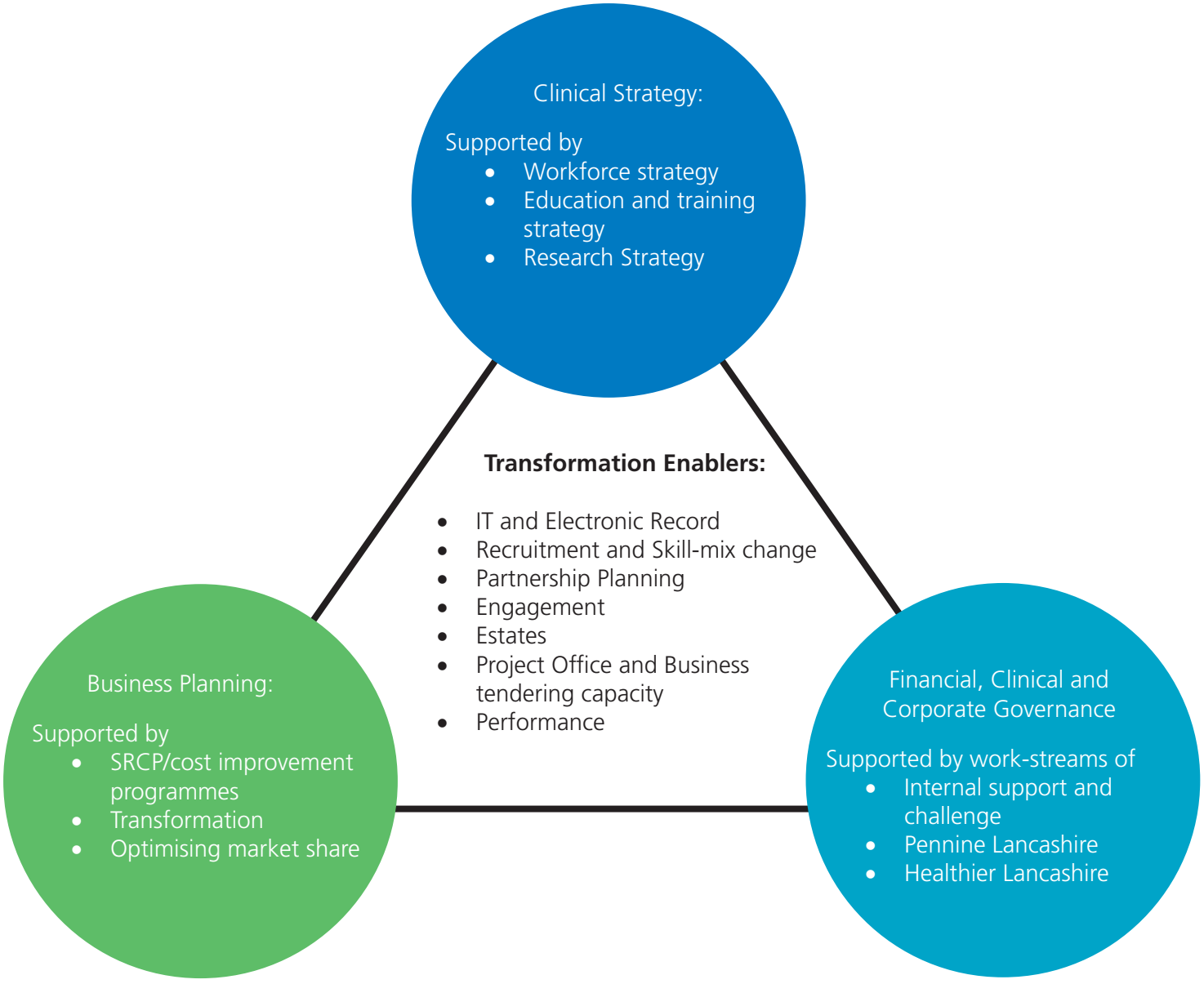
27. The Trust will work with partners to enhance self-care. We will increasingly influence delivery of care in tertiary, secondary, primary, third sector and self-care sectors, by system leadership, transformation and provision. This requires partnership and collaboration with health and care providers and commissioners across the population base. With renewed focus on prevention, long term conditions management and cross-sector working, the Trust influences both demand, quality and outcome across more than just the secondary care sector, as shown in diagram 5:

Diagram 5:
Schematic of current and increasing sectors of provision and system influence



Relationship to ELHT Business Planning, Financial Planning, and strategies for Workforce, and Education, and Research

28. Within ELHT as an organisation, our Clinical Strategy develops in line with our evolving business planning processes and the astute financial modelling of all proposals and transformation programmes. The governance and priorities for these will increasingly be shaped by the influence of Pennine Lancashire (via the Sustainability and Transformation Plan) and Healthier Lancashire Programmes.



Using today's estimates, the community of Pennine Lancashire will have £962m available to it in 2016-17 to buy and provide healthcare services, rising to £1069m by 2010-21. This is the equivalent of £1300 per resident per year. This money buys services from a range of providers – from GPs, to pharmacists, to Trusts like ELHT and Lancashire Care NHS Foundation Trust. It is estimated that if we do not change, the cost of providing care will outstrip resources available by £250m in 2020-21.

PART ONE

Agreeing new system-governance principles with Healthier Lancashire and Pennine Lancashire Partners

29. The Trust will conform to Healthier Lancashire governance and strategic intentions in a way that optimises the benefits for our patients and public. Under the umbrella of Healthier Lancashire, the Trust will have a renewed focus on the delivery of key outcomes and the delivery of services through networked arrangements. The Trust will actively contribute clinical and managerial leadership through Healthier Lancashire.

30. Networked arrangements will include:

- Professionally-generated networking for continuing professional development and multidisciplinary team meetings for case management such as cancer MDT meetings
- Professional "pool" arrangements with shared workforce for in-hours or out-of-hours services
- A hub and spoke service, whereby one Trust in Lancashire provides the overriding governance, leadership and contractual infrastructure, with other Trusts providing work as part of that system on their own sites
- Non-clinical administrative and 'back-office' function collaboration and pooling to provide economies of scale, robust governance and standardisation
- A Shared digital roadmap supporting better decision-making.

31. Across Pennine Lancashire the goal will be to create a unified system with integration of health and social care. The term **"Accountable Care System"** may be used to describe such integration. Breaking down the barriers between commissioner and provider, and unifying both health and social care provider systems will bring advantages and should be developed at a pace that regulatory, contractual and financial stability will allow.

32. The Trust - and therefore the whole health economy - can only become sustainable through systematised approaches at scale, which reduce the demand on expensive acute care. As it develops, the Pennine Lancashire Transformation Group will be an overarching alliance of all commissioners and relevant providers in the locality. It will oversee the planning, governance and outcomes of health and care systems, for both scheduled (elective) and unscheduled (unplanned and non-elective) care.

33. The Pennine Lancashire system is led by health and care commissioners. Providers are held to account through contractual mechanisms for planned and elective care programmes.

34. The forum for commissioner and provider organisations to mutually oversee and agree planning for unscheduled care, cancer services, and provider contributions to escalation/emergency planning is the Pennine Lancashire System Resilience Group (SRG) at which all relevant agencies will be represented.

35. Aside from this, there is currently no one single organisation who has the responsibility for improving healthcare to the community of Pennine Lancashire, Therefore, the existing governance architecture will not drive the necessary changes, or hold the system to account, and a new model of Pennine Lancashire governance is required.

36. The healthcare economy system will plan together to optimise opportunities and challenges including:

- 111 procurement and service specification
- Addressing social isolation
- Addressing opportunities and challenges for funding and delivering seven-day services
- Defining the role of intermediate care
- Ensuring the continuous improvement in quality and performance of the health economy
- Overseeing wider workforce planning
- Standardising discharge planning and arrangements for those patients no longer in need of acute-hospital care across the two CCG footprints.

37. Whilst health and social care integration remains the goal for achievement by 2020, during 2016 the Trust will promote closer working and where necessary integration of healthcare commissioners and providers in order to create the Sustainability and Transformation Plan for Pennine Lancashire.

38. Working within a Sustainability and Transformation Plan, the Trust will encourage the closer integration and unified management and commissioning intentions of the Clinical Commissioning Groups of East Lancashire and Blackburn with Darwen. This closer integration will enhance capacity for the Trust and the CCGs to co-produce service developments, to reduce wastage in transactional system costs, and to align incentives for better patient care.

39. The Trust will seek to achieve the benefits of a single system of community care across Pennine Lancashire. The Trust will seek to become the provider of community services across Pennine Lancashire in order to:

- Standardise care
- Create a stable workforce with a move to generic therapists, closely aligned to Local Authority workforce
- Enhance multidisciplinary networking
- Reduce transactional costs
- Reduce duplication and system wastage currently seen in the efforts of clinical and ward based staff administering two systems of community care in Pennine Lancashire.

40. The Trust will seek closer integration with partner providers of primary care as detailed in Part Two. This Integration between healthcare providers across primary and secondary sectors is in order to:

- To agree and standardise pathways, and create new access to care
- Upskill primary care to manage long term conditions closer to home
- Create flexible workforce with emphasis on generic workers.

41. The Trust will create strategic partnership, professional collaboration, and functional patient pathways in liaison with Manchester-based tertiary providers for selected specialist services. This includes Christie Hospital for certain cancers, Royal Manchester Children's Hospital for certain paediatric conditions, and providers in Manchester for specific vascular and cardiac conditions.

42. As an "Accountable Care System" across Pennine Lancashire we will agree key strategic objectives, based on measurable outcomes, with our partners. This will include: reducing premature mortality, addressing inequalities in health, improving cancer detection at an earlier stage, improving cancer survival, improved access to universal healthcare services, sustainability and affordability, and continuous quality improvement in quality.

What does this mean for 2016-17

- We will put resources into the Healthier Lancashire programme, creating system wide governance
- We will develop provider collaboration across Lancashire
- We will work towards an Accountable Care System in Pennine Lancashire, supporting programmes of work which reduce avoidable admissions, avoidable mortality and improving access to healthcare.

PART TWO

Increasing primary and community care involvement: new models of care

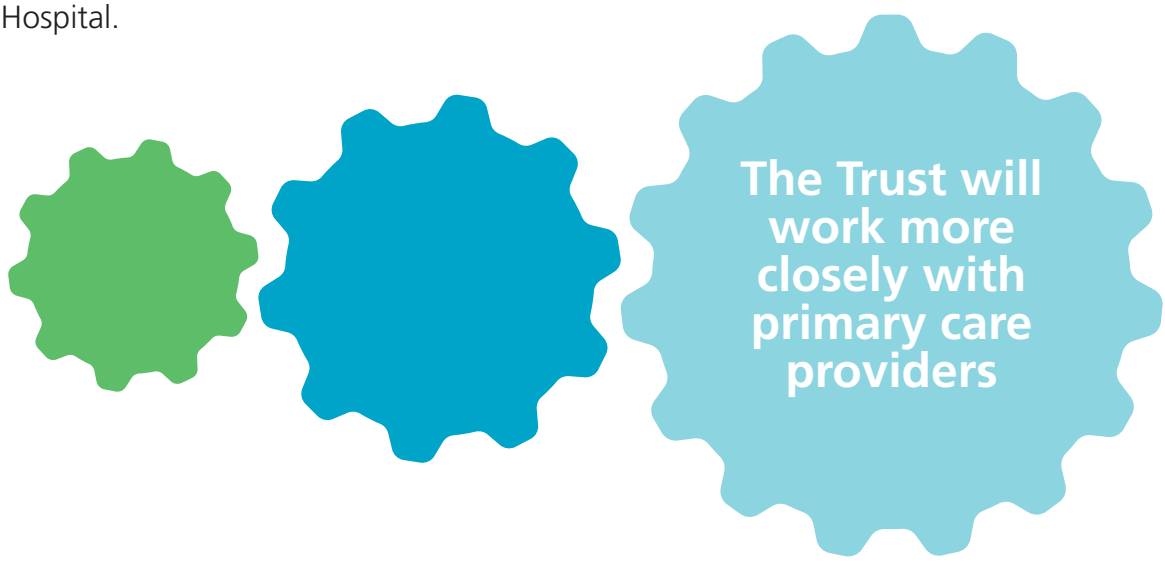
43. The Trust will develop better relationships with primary care providers, including GP federations, and will forge better links and direct communications to other providers. There is a recognised role for expertise of the secondary care sector to be used in primary care. This role includes both service delivery and contributing to education and facilitating the enhanced delivery of additional services by a primary care workforce. This includes a role in "in-hours" and "out-of-hours" care provision.

44. General Practice has historically provided an effective delivery model but faces challenges to workforce recruitment and retention. The "practice partnership" model is not attractive to all newly qualified GPs. The Trust will develop a salaried primary care workforce in conjunction with local GP providers, working in urgent care / primary care centres.

45. The Trust will employ such workforce in urgent care centre in order to provide rapid diagnostic and holistic assessment of the variety of primary care based conditions regularly seen in such centres. The skill base will enhance the specialist services already available in the Urgent Care and Emergency Departments.

46. The Trust will submit tenders for primary care provision under Alternative Provider Medical Services contracting arrangements when beneficial to population and organisation. The Trust will also explore the willingness of Pennine Lancashire primary care providers to create partnerships with the Trust as contract holders for General Medical Services and Personal Medical Services practices.

47. Working more closely with primary care providers the Trust will seek to break down boundaries between primary care secondary care, integrating the delivery of care between primary and secondary care providers. We will propose a "health campus" model for primary, community and urgent care in the locations of Accrington and Pendle. A similar community centre model will be explored for Clitheroe Community Hospital.



48. We propose to work with local GP providers in a joint venture, redeveloping these hospital sites and ensuring integrated on-site provision of primary, community and step-up as well as step-down care.

49. The Trust will create an enhanced primary care centre through use of facilities at the urgent care centre Burnley General Hospital, ensuring the integration of the children's unit and urgent care facilities can be used to create a 24/7 primary care facility.

50. Working in conjunction with GP practices and federations, the Trust will aim to create a more multidisciplinary primary care workforce, recognising the difficulty in recruitment of general practitioners. In localities, the Trust will seek to provide community geriatricians, community paediatricians, community gynaecologists, community orthopaedic and musculoskeletal specialists and community diabetologist specialist input.

51. If successful in tendering for GP practices, and in creating "health campuses" in Pendle and Accrington, the Trust will explore developing open-access and self-referral routes for patients to the community specialist care outlined above. There will be opportunities for increased use of Skype or similar consultations models with Trust specialists.

52. The Trust will explore options for developing a consolidated children's service on the Trust site which provides the "core" service, with community children's centres and identifying new community locations combining GP care, paediatrician care and integrated specialist nursing and therapy teams.

53. The Trust will continue to develop the frailty pathway, delivered by enhanced multidisciplinary neighbourhood teams, with "reach in" into homes, care homes, and into the Trust.

54. The Trust will develop new clinical management models, both in community hospitals and acute Trust sites. With appropriate clinical and information governance, we will encourage formal in-reach of GPs into hospital wards to facilitate handover to primary care and to get patients back to or closer to their home.

55. The Trust clinicians will work with primary care in establishing joint Clinical Education events, and developing tailored interventions to help high users of secondary care, as well as creating learning and feedback in relation to GP referrals.

56. The Trust will seek full primary care provider and commissioner involvement in enhancing care planning and treatment escalation plans for complex care patients and those who prefer their care at home rather than in hospital.

57. The Trust will work with GP federations for enhanced and more appropriate use of community hospital beds (in-hours and out-of-hours) as "step-up" and intermediary facilities, expanding services in community settings such as blood transfusions, and short therapeutic admissions.

58. The Trust will seek to maximise the use of treatment rooms as a means of preventing admission, performing for example transfusion and venesection in community.

59. The Trust will explore opportunities for greater involvement of self-care, family care, the third sector, community independent contractors and the private sector where it is beneficial to do so.

60. The Trust will work with partners in order to create the wrapping of a comprehensive system of care around care home residents. This will involve closer working with GP federations, GP practices and other providers, further development of integrated neighbourhood teams, and increased advanced care planning in the community. It is an expectation that the sustainability planning of Pennine Lancashire will confirm the commitment to care planning, treatment escalation planning, involving 'Do Not Attempt Resuscitation' and end-of-life care arrangements for all vulnerable patients in order to ensure better care in line with patient wishes.

61. Medicine for elderly should move towards a community based specialty, working in the acute sector but also in nursing and residential homes, working alongside GPs.

62. The Trust will continue to work closely with Lancashire Local Pharmaceutical Committee, the Local Professional Network (Pharmacy) and the 154 community pharmacies in Pennine Lancashire to maximise the benefits of the Refer-to-Pharmacy hospital to community pharmacy electronic referral system.

What does this mean for 2016-17

- We will engage with GP federations
- We will work towards new models of care for diabetes
- We will develop our approach to defining, assessing and managing frailty
- We will reduce the length of in-patient stay for patients with frailty
- We will shape the use of community step up and step down facilities.

PART THREE

Increasing Standardisation

63. At the heart of ELHT is a strong and efficient District General Hospital (DGH) service. Defining and upholding the characteristics of such a DGH are important. We will sustain the strong brand of "Safe, Personal, Effective" which enshrines how we work here.

64. Standardisation of care is the repeated and reliable delivery of safe, personal and effective care. It is characterised by adherence to agreed pathways and processes of care, and when best practice is systematised, can reduce hospitalisation, length of stay, risk to patients, litigation, costs to the NHS, and it is facilitated by audit and research. The Trust will assure itself of the delivery of standardised care to patients.

65. It is expected that all clinicians have systematised performance metrics and feedback on their own and their team's performance within two years. Striving to be in the national upper quartile will be our aim.

66. As described in our annual Quality Accounts we will partake in all relevant national audits (see Appendix 2) and in addition we will partake in selected Advancing Quality local North West audits, where these can deliver measures of reliability that national audit programmes or local and national CQUINs cannot. Trust performance in these will be monitored through Clinical Effectiveness Committee.

67. Through increasing standardisation we will achieve:

- More day case procedures
- Widespread adoption of care bundles
- Enhanced recovery programme inclusion of all relevant surgical patients
- Reduced investigations
- Reduced variability between clinicians
- Admitting only "acutely" ill patients in an "Acute" hospital; and we will seek agreement with primary care commissioners and providers as to the expectations of services provided in our Emergency Department
- Care remaining evidence based and effective and in line with national (NICE) guidance.

68. The Trust will expect professionalism to be the driver for continued improvement in the delivery of optimum care.

69. In addition, through the work streams of Pennine Lancashire Transformation, we will support standardised care delivery across the wider footprint of our health economy, intervening through co-design, education feedback, and medicines optimisation.

What does this mean for 2016-17

- We will standardise packages of care and develop enhanced auditing of managing acute kidney injury and sepsis
- We will develop individualised performance metrics for individual doctors, teams, and directorates
- We will reduce inappropriate use of CT and MRI
- We will refine our process for identifying the named Consultant in Charge
- We will develop our plans for an electronic patients record
- We will improve our discharge letter templates
- We will standardise process in Theatres, including ordering of equipment and prosthetic usage.

PART FOUR

Improving Efficiency in Elective Care

70. In line with guidance from Monitor (now functioning under NHS Improvement), we will adopt five principles to improve efficiency in elective care procedures:

- Stratifying patients by risk and creating low-complexity pathways for lower-risk patients
- Extending clinical roles to enable staff of junior or lower grade to undertake routine tasks in theatre or outpatients which are within their competencies
- Increasing throughput in theatres by explicitly measuring, communicating and managing the number of procedures per theatre session
- Implementing enhanced and rapid recovery practices to reduce length of stay
- Providing virtual follow-up for uncomplicated patients.

71. We will explore the benefits of the following in order to increase efficiency and productivity:

- Piloting three session days in theatres and in out-patients
- Removing divisional silos – developing care teams and ward based teams.
- Reducing investigations requested unnecessarily
- Implementing care pathways and bundles increased to standardise care
- Pre-operative work shifting to skilled non-medical staff, in community
- Managing some patients post-operatively in their own home by nursing staff
- Piloting day-after-surgery telephone follow-up for those discharged on the day
- Moving to seven-day home and community based chemotherapy delivery if it is cost effective to do so
- Transferring of activity to day case or to outpatient or primary care centre setting where appropriate, for example with hysteroscopy, cystoscopy and endometrial ablation
- Piloting outpatient physiotherapy delivered other than at the hospital, for example in local facilities, gyms, GPs, health centres
- Enhancing self-referral for specialties such as dermatology and cancer services
- Developing open access for breast clinic patients, rectal bleeds and others
- Introducing pharmacy staff working in pre-operative assessment clinics to ensure effective medicines reconciliation and optimisation.

72. We will explore different use of outpatient facilities and services, including:

- Increasing telephone and/or Skype review appointments
- Introducing GP-led review clinics
- Centralising of Outpatient Nursing staff
- Developing different models of care for follow-up of cancer survivors e.g. breast, colorectal, urology creating open-access follow up
- Chemotherapy – more home and community based delivery, evening and weekend provision
- Reducing consultant follow-ups – increase specialist nursing roles and more therapist-led clinics
- Transferring activity to outpatient setting where appropriate e.g. hysteroscopy, temination of pregnancy, cystoscopy and endometrial ablation
- Operating as Prime Contractor where appropriate when multiple providers link on a care model.

What does this mean for 2016-17

- We will develop new models of dermatology services
- We will develop new models of diabetes care
- We will pilot rescheduling of trauma lists in orthopaedic theatres
- We will move more elective surgery to Burnley General Hospital
- We will continue to plans for Phase 8 development to improve the services to ophthalmology and maxillofacial patients at Burnley General Hospital.
- We will increase access to the Enhanced Recovery Programme after surgery
- We will pilot delivery of an Eating Disorder Service

PART FIVE

Changing Non-Elective Pathways

73. The aim of our strategy is to get the right treatment in the right setting for every patient, to reduce unnecessary admissions, optimise patient flow and ensure patients are discharged to the right environment.

74. The Trust - and therefore the whole health economy - can only become sustainable through systematised approaches at scale, which reduce the demand on expensive acute care. The forum for much of the partnership working for non-elective care will be the Pennine Lancashire System Resilience Group (SRG) which we view as taking the overall system overview to non-elective healthcare planning and population unplanned care management.

75. Therefore, organisational form and integration of providers is relevant to how whole system change is delivered. Earlier sections have referred to these key aspects.

76. The healthcare economy system will have to plan together to optimise opportunities and challenges including:

- 111 procurement and service specification
- Addressing social isolation
- Addressing the funding and delivery of seven-day services: choosing priorites
- Defining the role and investment in intermediate care
- Ensuring the quality and performance of the health economy and providers outside the hospital
- Overseeing wider workforce planning
- Standardising discharge planning and arrangements for those patients no longer in need of acute-hospital care across the entire Pennine Lancashire footprint, with no difference between CCGs.

77. Clinical teams in the Trust have identified a number of initiatives which will be modelled and explored as part of the development of our clinical strategy, and these are described in the following paragraphs.

78. With regard to Emergency Department and Urgent Care centres, the Trust will explore the following:

- Increasing senior decision-makers at the "front door"
- Increasing the Intensive Home Support Service in-reach both in the Emergency Department (ED) and on the Acute Medical Unit (AMU)
- Changing the workforce with increased employment of general practitioners and MSK/ Orthopaedic skills in ED and UCC, with reduced reliance on ED Consultants and locums. Physiotherapy non-medical prescriber working in ED on MSK injuries and simple wound management
- Increased access to Cardiology wards and direct ED Consultant-led admission to the Critical Care Unit (CCU).

79. With regard to Ambulatory Care Services the Trust will explore the following:

- Extending the role of Ambulatory Care Unit and Acute Assessment Units and "hot clinics" developing an ambulatory cardiac unit
- Enhancing the Urology Assessment Unit and
- Developing Ambulatory Nurse-led units for Gynaecology conditions.

80. With regard to in-patient acute admissions the Trust will aim for the following:

- Utilising a radiologist opinion on AMU to advise on imaging decisions
- Undertaking only the urgent procedures whilst the patient is an inpatient, and arranging those which can be safely performed as an outpatient to be done so accordingly, where appropriate completing assessments in patient's home.
- Increasing the role of pharmacists and technicians to confirm drug histories on all non-elective patients admitted to ELHT within the patient's first day of admission; and confirm histories for elective patients at pre-op, and to facilitate discharge arrangements
- Piloting the feasibility and impact of Consultant presence on-site 24/7
- Piloting Consultants freed up as 'consultant of the week' to concentrate on the emergency take, providing direct support to the Emergency Department/UCC
- As part of the move towards seven day urgent care full diagnostic and team care support the Trust will aim for "today's scans being done today".
- The Trust will aim for a 10% reduction in laboratory investigations by education and prioritisation of use of the laboratory
- The Trust will reduce HCAI year on year and will reduce incidence of Clostridium *difficile* infections through improved hand hygiene and antibiotic stewardship
- Development of designated inpatient beds/ward for acute oncology
- A reduction in length of stay in hospital of one day for key conditions, including COPD. The delivery of this length of stay reduction will initially focus on acute respiratory conditions and cerebrovascular conditions
- The Trust will prioritise development of nurse-led and criteria-led discharge.

81. With regard to Acute Stroke services the Trust is committed to an improved stroke pathway with improved stroke nurse leadership, earlier scanning, optimising thrombolysis, and optimising therapist input to patients care. The Trust aims to reach "B" rating in the Sentinel Stroke National Audit Programme by the end of 2017. This will involve a re-designation of the Stroke Unit and all stroke patients being looked after on one site.

82. With regard to discharge processes the Trust will aim for the following:

- Standardising discharge arrangements across both our CCG footprints: the Trust considers it essential to systematic progress that existing variation in the discharge arrangements between the CCGs is removed
- Introducing dedicated ward pharmacy teams which will include the presence of pharmacists on ward rounds. They will facilitate the Safely HERE Safely HOME principles of using a ward round checklist to ensure the safe care and effective planning for discharge, including the pharmacy team generating the medicines related elements of the electronic discharge letter so that, wherever possible, the following days discharges are completed in advance
- Extending the SAFER initiative for the proactive management of controlled discharge of patients, with the deployment of operational enablers or "progress chasers" within the wards
- Use community pharmacies for TTOs (take home medication after discharge).

83. With regard to Paediatric services the Trust will

- Undertake feasibility and financial modelling for day-case paediatric and Neonatology services to be located alongside General Paediatrics
- Review the staffing of the Neonatal Intensive Care Unit particularly with regard to trainee doctors
- Incorporate some of the services currently provided in the existing Burnley Childrens Unit (CMIU) in any model of Primary Care Centre in Burnley General Hospital whilst retaining some specialist aspects of this service by relocation to be alongside general paediatrics at the Blackburn site.

84. With regard to maternity services:

- Midwifery staffing ratios and skill mixing will be reviewed
- The sustainability of all birth centres will be reviewed and a feasibility proposal will be considered for the closure of Rossendale Birth Centre.

86. With regard to Trauma, the Trust will aim to reduce trauma theatre time by 10% by increasing efficient flow and productivity through the pathway. The Trust will implement recommendations from the British Orthopaedic Association Review of the Fracture Neck of Femur Pathway.

What does this mean for 2016-17

- We will create expanded roles for ward based pharmacists and develop the roles of "ward flow coordinators"
- We will increase complex case management support
- We will develop new models of ambulatory care with enhanced provision
- We will refine our Acute Medical Unit function
- We will increase our SSNAP audit rating for Stroke care to a grade "C" as a minimum
- We will improve the pathway of care for patients with fractured neck of femur and increase the proportion of patients operated within 36 hours
- We will start first case of orthopaedic trauma lists at 0900hrs and pilot two trauma lists each morning
- We will seek GP federation support in new models of community step-up .

PART SIX

Reviewing and Networking Specialist Services

87. The Trust is recognised as a centre of excellence for certain key clinical services and takes referrals into the service from a wide geography across the North West. These include vascular services, cardiology services, uro-gynaecology services, neonatology, hepatobiliary surgical and medical procedural interventions, oral and maxillo-facial services, head and neck cancer services and urogenital dermatology.

88. It is recognised that these services attract high calibre clinicians to work in the Trust. However it is also clear that some specialist services can only be provided sustainably by the Trust with collaboration and professional networking across a wider Lancashire footprint in order to gain a critical mass of population base, commissioner support, and to maintain 24/7 rotas and clinician expertise. The balance of access, commissioner intention, workforce availability and outcome measure will determine sustainability. As a result we will have to accept that some specialist services will not be provided by ELHT on its own.

89. Our Clinicians recognise that there is considerable scope to collaborate on a wider footprint and there is generally consensus that it makes sense to do this where appropriate over the Lancashire footprint. We envisage being in a network across Lancashire but remaining a skilled centre for provision for key services as follows:

High dependency care for children –

- Becoming a tier 2 provider
- Developing paediatric oncology
- Becoming a second regional centre for haemoglobinopathy
- Paediatric TB services
- Site specific cancer services
- Vascular services (including Interventional radiology)
- Cardiology services
- Uro-gynaecology services
- Neonatology
- Hepatobiliary surgical and medical procedural interventions,
- Oral and maxillo-facial services
- Head and neck cancer services
- Cardiology Implantable cardiac devices and primary interventions
- Considering all hip revisions to be done in one centre
- Robotic assisted surgery (urology, hepatobiliary, colorectal surgery)

90. There are instances where collaborating in networks and referral mapping with centres beyond Lancashire - for example in Manchester, Greater Manchester, Mersey region or Yorkshire hospitals - is appropriate. This will include some aspects of specialist children services and some cancer services.

91. Collaboration will be underpinned by strong data in terms of quality, performance, finance, and governance. Arrangements for joint provider boards will need defining. We will explore opportunities to create workforce teams at a Lancashire level with standardised job descriptions, a pool of training opportunities, pooled rotas, harmonised pay and terms, 'no poaching' agreements, centralised agency work, a centralised bank, and shared on-call rotas.

92. Some services across Lancashire may develop partially autonomous governance and be offered back to the Trust. A model for "Lancashire Urological Cancer Surgery Services" is an example which may be explored.

93. Discussions will be undertaken across the North West for there to be a single centre for all hip revisions.

94. The Trust will seek to be commissioned to provide implantable cardio-defibrillator devices.

95. The Trust will work as part of a Lancashire network of vascular services, whilst retaining status as an arterial centre.

What does this mean for 2016-17

- We will add an additional vascular surgeon to our rota and remodel our provision of acute vascular and interventional radiology services
- We will work with tertiary centre providers for their services to be provided at East Lancashire
- We will work collaboratively across Lancashire towards a NICE compliant surgical site for urological cancers
- We will develop urogenital dermatology services as a leader across Lancashire
- We will lead the formation of the operational delivery network for Hepatitis C.

PART SEVEN

Enabling Programmes and Supportive Strategies - Seven Day Services

96. We will enhance seven day services, in line with national priorities, as follows:

National Priority Objective		ELHT Strategic Planning
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.	Subject to funding the acute medical and surgical admission processes will support daily or twice daily consultant review of acute and new medical and surgical admissions. ELHT will explore feasibility of resident consultants over extended hours and ultimately 24/7 in key specialties.
5	Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients	Subject to appropriate funding clarification, ELHT will achieve this by 2017-18. We will include a focus on paediatric investigations to allow weekend ultrasound scheduling, and 7 day reporting of MRI's for all patient groups.
6	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols	Subject to appropriate funding clarification, ELHT will achieve this by 2017-18.
8	All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Subject to appropriate funding clarification, ELHT will achieve this by 2020.

Research and Innovation

97. We will rigorously and systematically adopt those innovations which are proven to be resource efficient and help to improve outcomes.

98. ELHT will play a continued significant role in the Greater Manchester Academic Health Science Network (AHSN) and North West Coast AHSN, and through our clinicians will influence the work of both Strategic Clinical and Operational Delivery Networks. Through our Research Strategy we will actively develop a research conscious workforce by supporting staff to be research aware, engaged and for some to develop research skills. This approach is designed to achieve a culture in which staff of all disciplines examine critically all aspects of healthcare, develop and test appropriate research questions, and apply research-based knowledge in clinical practice.

99. Specifically we will:

- Host and support high quality research which has the potential to improve patient care in the short, medium or long term
- Encourage and support application for internal and external research grants to fund "home grown" major research projects
- Support research that relates to the Trust's objectives around clinical effectiveness and service improvement
- Develop collaborative and consultative partnerships with patients, carers and the public to prioritise research to meet the clinical needs and improve quality of life for patients and improve the health of the population
- Develop collaborative and consultative partnerships with regional and national higher education institutions, and other NHS Trusts to identify and prioritise research
- Identify and prioritise areas of exceptional research activity within the Trust to further develop and support individual and departmental/ divisional strategies
- Ensure recognition for local researchers in collaborative research
- Continue to direct research training support at a number of individuals from a range of disciplines who would be expected to become proficient in research methods.

Education

100. We will look at education provision across the health economy and work towards more multi-disciplinary (MDT) professionally led senates and related MDT groups.

101. We will involve GPs to an increasing extent in our education and service redesign programmes.

102. We will continue to develop how we provide medical education, working closely with Health Education England, Manchester Medical School, University of Central Lancashire Medical School (UCLan) and Lancaster Medical School. This is particularly focussing on the clinical education and supervision provided to cohorts of medical students, and postgraduate trainees (including GP trainees), but also ensuring the provision of medical education is a core activity extended to doctors in non-training "clinical fellow" posts.

Leadership Development

103. The implementation of strategy is predicated on our service redesign being clinically-led. In this it is recognised that the role of Clinical Directors is seen as key leadership role. A clear and transparent clinical decision making process is required. The Trust will offer leadership capacity to Pennine Lancashire and Healthier Lancashire Programmes. The Trust will continue to develop leadership skills in senior clinical staff. We will review the scope and agenda of our Consultant Leadership Development Programme.

Workforce

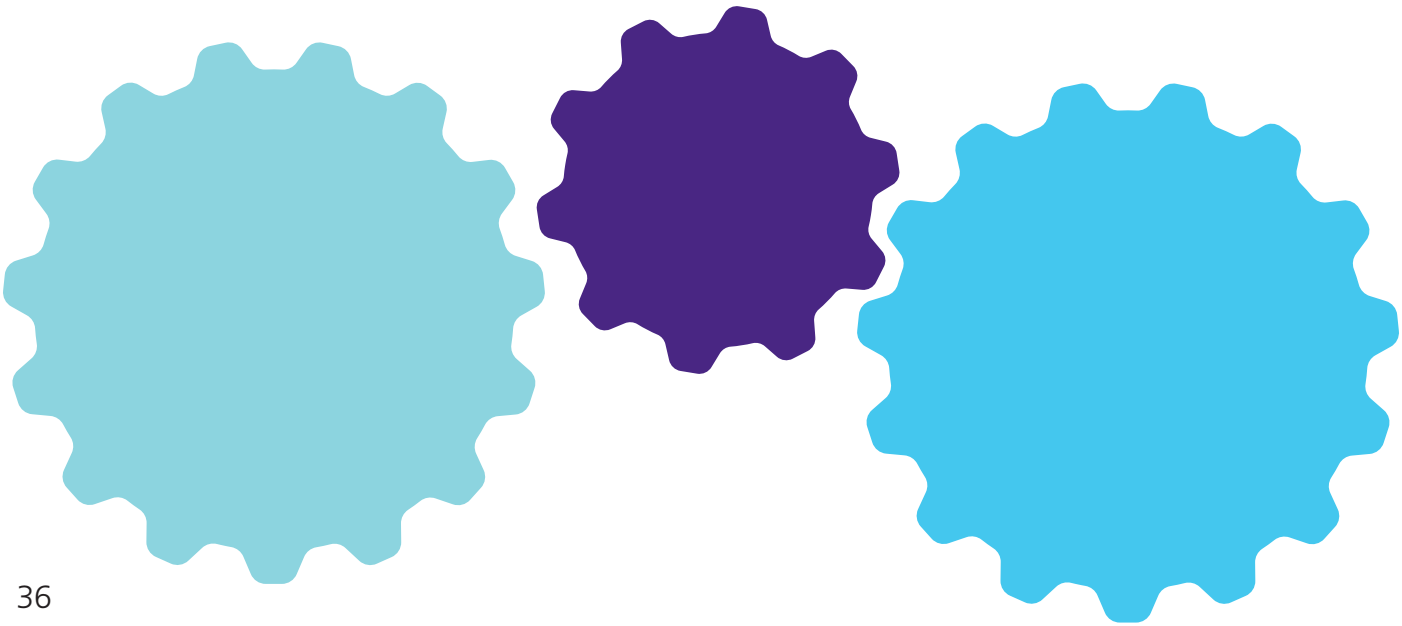
104. We will work towards the following:

- New clinical roles e.g. ward based pharmacists, ward flow coordinators, physicians assistants and extended scope practitioners
- Clinical teams "owning" their administrative support and audit capacity – as part of the team
- Teams becoming cross-divisional based on patient need, not professional silos
- Teams being led by the professional with the best leadership skills, not always the most senior consultant
- Expert patients providing education and support
- Voluntary sector forming an integral and increasing part of care teams
- Video conferencing for team meetings to prevent travel
- Reduced dependency on locums
- Training the wider workforce in a more standardised fashion, collaborating with Trusts across Lancashire
- Creating new roles and training ourselves or with local education partners such as UCLan and other Universities
- Strengthening our culture and the sense of "This is how we work here" – taking formal action against inappropriate behaviours
- Workforce planning and development across a bigger footprint for e.g. in specialities where it is difficult to recruit, with joint CPD, joint training, creation of opportunities for workforce teams or bank at a Lancashire level – using the same job descriptions, a pool of training opportunities, pooled rotas, harmonised pay and terms, 'no poaching' agreements, centralised agency work, centralised bank, shared on-call rotas
- Working with schools to encourage volunteers and offering increased work experience
- Involving non-medical prescribing pharmacists in the management of long-term conditions eg COPD, asthma, rheumatology, diabetes, heart failure.

Information Technology / Informatics and Clinical Records

105. We will continue to progress the following:

- 24/7 IT support
- Telemedicine, to provide advice to GPs to prevent referral or attendance and on line appointments
- Single care e-record
- Integrated PACS (Picture Archiving and Communication System) and RIS (Radiology Information System) across Lancashire
- View and addition to GP/Community/tertiary care record and vice versa
- Medication changes in hospital auto-populated on local GP systems or pharmacists given access to populate changes
- Clinical decision support on the local web for "right care", agreed pathways across the continuum, regularly updated, reducing over use of healthcare
- Patient access to "apps" for guidance
- Immediate data and feedback for "right care"
- Electronic alerts including for deteriorating patients
- Patients "commenting on" their own records
- E-based patient contacts – Skype, email, etc
- Development of our website at specialty level – more links to patient information, evidence etc
- Greater use of robot technology in medication systems, in pharmacy and in clinical areas.
- On-line self-booking by patients for outpatient appointments
- Enhanced switchboard functionality to improve patient communication/recorded telephone conversations to improve handling complaints etc.
- Utilising and developing Refer-to-Pharmacy e-referral solutions, expanding to offer for example Refer-to-District Nurse or Refer-to-Social Services.



Communications and Engagement

106. We will explore how to:

- Aim for all communication being electronic - no letters or faxes being used routinely
- Clarify the point of contact for each patient when needed – using only one if possible
- Make every contact count in delivering the public health agenda
- Contribute more on prevention in schools and businesses
- Use health apps to guide the patient
- Use Phone first – advice lines professionals and patients - to senior clinicians
- Develop more emphasis on patient self-care and management, seeing patients as experts
- Offer more opportunities for patients to self-refer – informed, activated patient rather than patients being on long-term follow-up schedules
- Create Self-management tools such as videos
- Create and facilitate communities of health which patients can be part of to educate and learn from each other
- Gain support from local business.

Estates

107. We will review Estate efficiencies and consider increased home working to reduce estate needs.

108. We will influence local partnership working into modelling the sustainability and efficiencies of delivering care closer to home.

109. We will explore the feasibility and effectiveness of "3 session days" for some services.

Mental Health

110. We recognise the important liaison role with mental health services and it is our aim to remove boundaries between mental health and physical healthcare.

111. We will explore the feasibility of a mental health assessment unit at the Royal Blackburn Hospital site, if necessary with mental health staff employed by the Trust to work in the Emergency Department.

112. We will aim for provision of more adolescent mental health services in the community, including piloting the development of an Eating Disorder Service.

113. We will aim to reduce the gap between East Lancashire Children and Adolescent Service (ELCAS) and adult mental health services, with increased psychology support where needed.

PART EIGHT

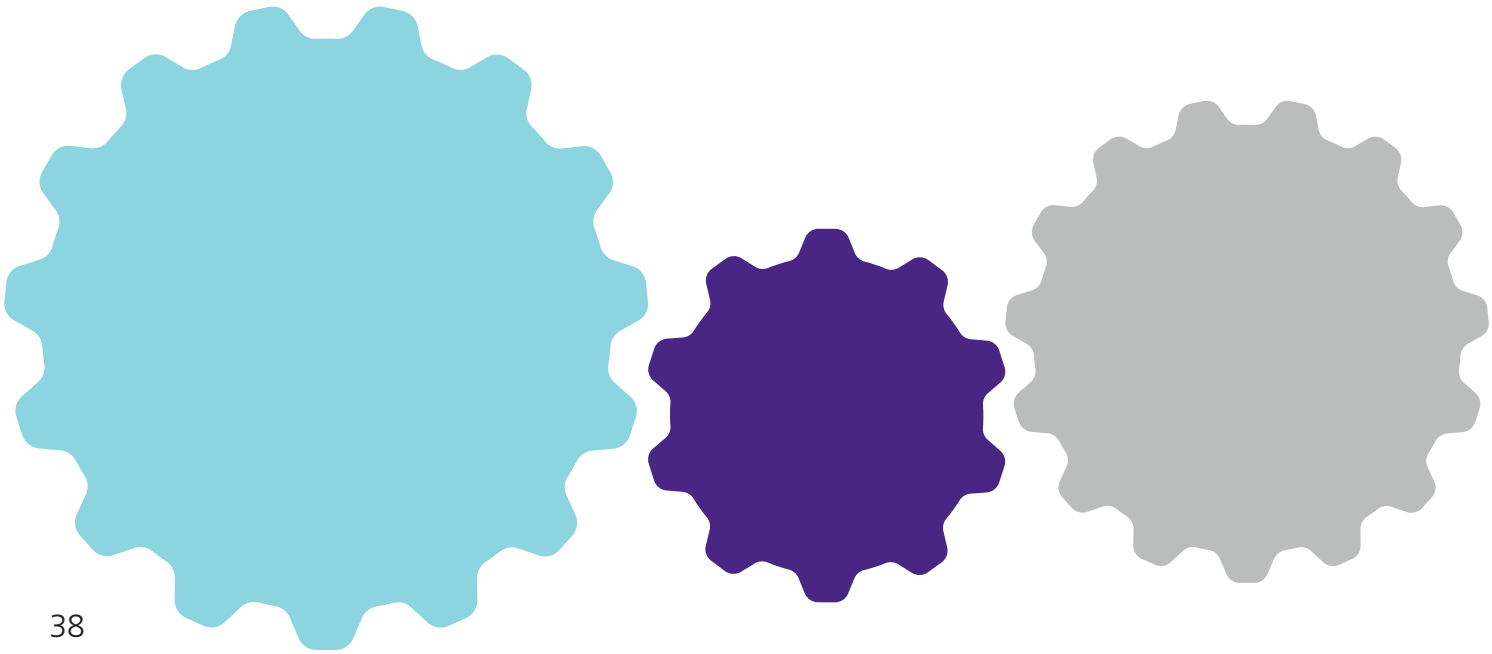
Business and Financial Modelling

114. The net gain for the workstreams in this strategy will allow specific savings to be realised. The Divisions will be aligning their business plans to the Clinical Strategy Priority and will in summation achieve:

- Average Length of Stay decreases by one day
- Reduction in beds by equivalent of two wards
- Decreased trauma theatre time by up to 20%
- Decrease Community management costs with increased integration
- 100% priority scans being done on the day with no patients waiting as an in-patient simply for a scan
- Decrease laboratory tests by 10%
- Decrease use of locum, agency and bank staff by 20% compared to 2015/16, and adherence to national capping of payment rates for locums.

115. Appendix 3 shows an example financial modelling of some key elements of the clinical strategy.

116. The 2015 estimate of ELHT market share for individual specialties is shown in Appendix 4. The Trust will aim to increase its market share in all possible specialties but the net financial impact has not yet been calculated in terms of income and delivery costs. Appendix 4 lists a fuller account of present day-case and elective in patient market share.



APPENDIX 1: Summary of approach of East Lancashire Hospitals NHS Trust strategic intentions with regard to national "must-do's"

	National Planning Guidance "must-do"	ELHT proposals
1	Develop an agreed Sustainability and Transformation Plan (STP)	ELHT will make senior leadership available to the Pennine Lancashire Transformation Programme and System Resilience Group, and will ensure subsequent delivery of agreed STP milestones in 2016/17. We will ensure our Operational Planning forms an integral part of the Pennine Lancashire STP. The 2016/17 Operational Plan will be regarded as 'year one of the five year STP' and contribute to the transformation agenda. The operational plan will demonstrate how quality and safety will be maintained and improved for patients and how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan.
2	Return the system to aggregate financial balance	We will engage with Lord Carter's productivity work programme, comply with agency spending rules, tackle unwarranted variation in demand and care. The operational plan will demonstrate how we reconcile finance with activity (and where a deficit exists, how to return to balance). We will aim to achieve the following indicators of change • Average Length of Stay decreases by 1 day • Reduction in beds by equivalent of 2 wards • Decreased trauma theatre time by at least 20% • Decrease Community management costs – increased integration • 100% priority scans done on the day by end of 2016/17 • Decrease laboratory tests by 10% by end of 2016/17 • Decrease use of agency and bank staff by 20% by end of 2016/17 • Increase in patients discharge on predicted day and before noon • Income generation – developing new services

3	Developing and implementing a local plan to address the sustainability and quality of general practice including workforce and workload issues	Where we invest in and work with Primary Care we will offer new salaried employment models, and we will seek to tender for GP provision. We will work with Out Of Hours providers to optimise access, care planning and effectiveness. We will continue to improve and transform community services, including Intensive Home Support, Integrated Discharge Services and COPD services in the community to reduce admissions. We will include this workstream as part of our improvement of seven day services. We will pilot models of Care home patients undergoing review by Medicine for the Elderly Consultants We will seek the Increased use of Community Hospitals as nurse-led / step-up
4	Getting back on track with access standards for A&E	We will achieve the standard that 95% patients wait no more than four hours in A&E
5	Improvement and maintenance of NHS Constitution standards for referral to treatment	We will ensure more than 92% patients on non-emergency pathways wait no more than 18 weeks from referral to treatment
6	Deliver Constitutional standards on cancer care,	We will achieve the 62 day cancer waiting standard and the constitutional two week and 31 day cancer standards, making progress in earlier diagnosis and improving one year survival rates
7	Improving mental health access standards	We will continue to meet dementia screening diagnosis targets in the Trust to ensure prompt recognition and treatment
8	Deliver actions in local plans to transform care for people with learning disabilities	We will work with partner organisations to enhance community provision of services

9	Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures.	We are not in special measures, however we will implement necessary plans to improve quality. We will maintain a clearer focus on mortality reviews and identify avoidable mortality. We will participate in the annual publication of avoidable mortality rates by Trust. We will continue to enhance our delivery of services across seven days, as required for the reduction in excess deaths at weekends. The delivery of seven day services in the Trust will reflect the national ambition that by March 2017, 25% of the population will have access to acute hospital services that comply with four priority clinical standards (Standards 2,5,6 and 8) every day. We will commence a programme to better align service requirements at departmental level with workforce and consultant job planning at individual level. Supporting professional activities (SPAs) will be awarded to offer time for auditing, assessing and appraising the reliability of care offered by clinicians and clinical teams. This empowers clinicians to invest in teaching, training, education, continuing professional development, appraisal, research, clinical management, clinical governance, and service development - in particular investing time in audit for both national and local audits of services offered by the Trust. It is expected that all individuals, directorates and divisions will have metrics for performance measures which are monitored though the Trust's Clinical Effectiveness Committee and governance processes.

APPENDIX 2

NHS England Quality Accounts List 2016/17 The table below lists the National Clinical Audits and Clinical Outcome Review programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2016/17.

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)
2	Adult Asthma	British Thoracic Society
3	Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)
4	Asthma (paediatric and adult) care in emergency departments	Royal College of Emergency Medicine
5	Bowel Cancer (NBOCAP)	Royal College of Surgeons
6	Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)
7	Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)
8	Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
9	Chronic Kidney Disease in primary care	Informatica Systems Ltd
10	Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)
11	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)
12	Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health
13	Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre (HSCIC)
14	Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons
15	Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians
16	Head and Neck Cancer Audit	Saving Faces - The Facial Surgery Research Foundation
17	Inflammatory Bowel Disease (IBD) programme	British Society of Gastroenterology /Royal College of Physicians
18	Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol
19	Major Trauma Audit	Trauma Audit & Research Network
20	Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)
21	Medical & Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

22	Mental Health Clinical Outcome Review	National Confidential Inquiry into Suicide and Homicide (NCISH) - University of Manchester
23	National Audit of Dementia	Royal College of Psychiatrists
24	National Audit of Pulmonary Hypertension	Health & Social Care Information Centre (HSCIC)
25	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)
26	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Royal College of Physicians
27	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	NHS Blood and Transplant
28	National Diabetes Audit - Adults	Health & Social Care Information Centre (HSCIC)
29	National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists
30	National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research
31	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership
32	National Lung Cancer Audit (NLCA)	Royal College of Physicians
33	National Neurosurgery Audit Programme	Society of British Neurological Surgeons
34	National Ophthalmology Audit	Royal College of Ophthalmologists
35	National Prostate Cancer Audit	Royal College of Surgeons
36	National Vascular Registry	Royal College of Surgeons of England
37	Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health
38	Nephrectomy audit	British Association of Urological Surgeons
39	Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons
40	Paediatric Intensive Care (PICANet)	University of Leeds
41	Paediatric Pneumonia	British Thoracic Society
42	Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons
43	Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists
44	Radical Prostatectomy Audit	British Association of Urological Surgeons
45	Renal Replacement Therapy (Renal Registry)	UK Renal Registry
46	Rheumatoid and Early Inflammatory Arthritis	Northgate
47	Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians
48	Severe Sepsis and Septic Shock – care in emergency departments	Royal College of Emergency Medicine

49	Specialist rehabilitation for patients with complex needs	London North West Healthcare NHS Trust
50	Stress Urinary Incontinence Audit	British Association of Urological Surgeons
51	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust

APPENDIX 3 - Example Financial Impact Modelling

Alignment to Clinical Strategy	Strategic Objective	Operational Tactic	Expected Financial Saving £000s	Associated Measures
Standardisation/Improving Efficiency in elective care/Changing Non-Elective Pathways	Reduce the number of in-patient beds	**Trust Bed Reduction Opportunity**		
		Re-commissioning of 2 wards	2,200	Total Bed Numbers by Division
		ICG Bed Reduction Opportunity	1,200	Length of stay (wards, AMU and IHS)
		SAS Bed Reduction Opportunity	2,100	Daycase rates
		Family Care Bed Reduction Opportunity	1,200	Emergency re-admissions within 30 days
				Proportion of delayed discharges attributable to the NHS
				Weekend discharges
				Length stay Assesment units
				Average LOS elective and daycase
				Ward transfers per patient
				Average LOS non-elective
				Non-medical discharges
				Pre-procedure beddays
Improving Efficiency in Elective Care	More efficent theatre utilisation	Increased theatre utilisation	970	Theatre Utilisation
				Increased number of cases on each list
				Activity moved from theatre to procedure rooms
				Reduced turnaround time between cases
				Reduced Theatre cancellations within 2 days by hospital
				Reduced theatre cancellations on the day
	More efficient use of Outpatient capacity	Outpatient clinic utilisation	500	DNA rate
		Footprint utilisation/reduced accommodation		Clinic utilisation rates
		Reduced DNA rate		Late starts/early finishes
		Improved new to review ratio		New to review ratio
Standardisation/Improving Efficiency in Elective Care	Maximise Income	Best Practice Tariff Adherence	500	Best Practice Tariff Performance
		Market Optimisation	750	Achievement of income plans
		Service reviews	500	Measure - lost income e.g. DNAs
		Overseas and private patient income	200	Market share %
				Demand/Capacity data
Standardisation	Reducing Variation in Practice	Reduction in prescribing spend	2,000	Readmission rates
		Diagnostics - reduce internal demand	500	Activity data - diagnostics
		Standardisation of equipment		
		Reducing hospital attendances		
		Reducing likelihood of admission/re-admission		
		Reducing time to diagnosis/test to enable swifter turnaround		
		Asset management improvement	200	
Increasing primary and community care involvement/Changing Non-Elective Pathways	Improved Community Productivity	Community Carter Challenge (ICG)	2,000	Productivity improvements
		Family care/midwives productivity		
		DCS community therapies productivity		
		SAS Community model development		
All Themes	Workforce	Specialist Nurse Reduction/Redeployment to consultants	1,500	Staff in Post
		Reduction in premium staff costs	3,000	Trust turnover rate
		Reduction in management costs	1,900	Increase use of bank staff
		Reduction in administration costs	3,200	Agency usage
		Skill mix and grade mix review	1,000	Areas with agency but no active recruitment
		Reduction in sicness absence	500	Trust level total sickness rate
		Standardise terms and conditions	150	Total Trust vacancy rate
		Outsource process functions	300	Temporary costs as % total paybill
		Increase use of voluntary sector	200	Effective E-roster usage
				Use of overtime
All Themes	Non-Pay Efficiencies	Procurement Efficiency/Savings	2,500	Spend % of non-pay
		Increase in-house capability	175	Non-pay spend reduction
		Standardise stationary/admin usage/costs	100	
		Transport Strategy - Shuttle bus	500	
		Transport Strategy - Car Parking	200	
		Salary Sacrifice schemes	100	
			30,145	

APPENDIX 4 - East Lancashire CCG Elective Inpatient Activity (Sep-14-Aug-15)

Specialty and Provider	% Market Share	Potential to increase local Market Share (i.e. currently less than 90%)?	Potential to increase referral footprint from surrounding areas?
General Surgery	100.0%		Yes
East Lancashire Hospitals NHS Trust	79.2%	Yes	
Airedale NHS Foundation Trust	6.7%		
Bmi Healthcare	5.8%		
Lancashire Teaching Hospitals NHS Foundation Trust	3.5%		
Urology	100.0%		
East Lancashire Hospitals NHS Trust	79.3%	Yes	Yes
Airedale NHS Foundation Trust	6.5%		
Pennine Acute Hospitals NHS Trust	5.4%		
Central Manchester University Hospitals NHS Foundation Trust	2.4%		
Breast Surgery	100.0%		
East Lancashire Hospitals NHS Trust	86.2%	Yes	
Airedale NHS Foundation Trust	9.4%		
University Hospital of South Manchester NHS Foundation Trust	4.4%		
Vascular Surgery	100.0%		Yes
East Lancashire Hospitals NHS Trust	93.0%	No	
Bradford Teaching Hospitals NHS Foundation Trust	3.7%		
Pennine Acute Hospitals NHS Trust	3.3%		
Trauma & Orthopaedics	100.0%		
East Lancashire Hospitals NHS Trust	54.5%	Yes	
Bmi Healthcare	21.7%		
Wrightington, Wigan and Leigh NHS Foundation Trust	7.5%		
Pennine Acute Hospitals NHS Trust	3.6%		
Airedale NHS Foundation Trust	3.5%		
Spire Healthcare	3.2%		
Lancashire Teaching Hospitals NHS Foundation Trust	2.0%		
ENT	100.0%		
East Lancashire Hospitals NHS Trust	72.7%	Yes	
Bmi Healthcare	14.0%		
Bradford Teaching Hospitals NHS Foundation Trust	5.8%		
Pennine Acute Hospitals NHS Trust	4.2%		
Ophthalmology	100.0%		
East Lancashire Hospitals NHS Trust	67.8%	Yes	
Central Manchester University Hospitals NHS Foundation Trust	28.0%		

Barts Health NHS Trust	4.2%		
Maxillo-Facial Surgery	100.0%		Yes
East Lancashire Hospitals NHS Trust	100.0%	No	
Pain Management	100.0%		
East Lancashire Hospitals NHS Trust	57.9%	Yes	
Leeds Teaching Hospitals NHS Trust	42.1%		
General Medicine	100.0%		
East Lancashire Hospitals NHS Trust	98.7%	No	
Gastroenterology	100.0%		Yes
East Lancashire Hospitals NHS Trust	85.6%	Yes	
Pennine Acute Hospitals NHS Trust	8.6%		
Central Manchester University Hospitals NHS Foundation Trust	3.8%		
Cardiology	100.0%		Yes
East Lancashire Hospitals NHS Trust	51.4%	Yes	
Blackpool Teaching Hospitals NHS Foundation Trust	16.6%		
Central Manchester University Hospitals NHS Foundation Trust	10.0%		
University Hospital Of South Manchester NHS Foundation Trust	9.5%		
Leeds Teaching Hospitals NHS Trust	8.2%		
Respiratory Medicine	100.0%		Yes
East Lancashire Hospitals NHS Trust	41.9%	Yes	
University Hospital Of South Manchester NHS Foundation Trust	34.6%		
Airedale NHS Foundation Trust	11.8%		
Lancashire Teaching Hospitals NHS Foundation Trust	7.4%		
Sheffield Teaching Hospitals NHS Foundation Trust	4.4%		
Paediatrics	100.0%		
East Lancashire Hospitals NHS Trust	94.9%	No	
Alder Hey Children's NHS Foundation Trust	5.1%		
Gynaecology	100.0%		Yes
East Lancashire Hospitals NHS Trust	81.0%	Yes	
BMI Healthcare	8.2%		
Airedale NHS Foundation Trust	4.1%		
Pennine Acute Hospitals NHS Trust	3.0%		

East Lancashire CCG Daycase Activity: ELHT % Market Share

Specialty and Provider	% Market Share	Potential to increase local Market Share (i.e. currently less than 90%)?	Potential to increase referral footprint from surrounding areas?
General Surgery	100.0%		
East Lancashire Hospitals NHS Trust	79.1%	Yes	
Bmi Healthcare	11.5%		
Airedale NHS Foundation Trust	6.3%		
Lancashire Teaching Hospitals NHS Foundation Trust	1.3%		
Urology	100.0%		
East Lancashire Hospitals NHS Trust	67.9%	Yes	
Airedale NHS Foundation Trust	15.6%		
Bmi Healthcare	9.0%		
Pennine Acute Hospitals NHS Trust	2.8%		
Lancashire Teaching Hospitals NHS Foundation Trust	1.8%		
Breast Surgery	100.0%		
East Lancashire Hospitals NHS Trust	96.1%	No	
Airedale NHS Foundation Trust	3.9%		
Vascular Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	96.4%	No	
Pennine Acute Hospitals NHS Trust	1.8%		
Trauma & Orthopaedics	100.0%		
East Lancashire Hospitals NHS Trust	64.9%	Yes	
BMI Healthcare	20.7%		
Wrightington, Wigan and Leigh NHS Foundation Trust	3.7%		
Airedale NHS Foundation Trust	3.1%		
Pennine Acute Hospitals NHS Trust	3.1%		
Lancashire Teaching Hospitals NHS Foundation Trust	2.7%		
ENT	100.0%		
East Lancashire Hospitals NHS Trust	81.0%	Yes	
BMI Healthcare	12.0%		
Pennine Acute Hospitals NHS Trust	2.2%		
Ophthalmology	100.0%		
East Lancashire Hospitals NHS Trust	76.0%	Yes	
BMI Healthcare	7.6%		
Airedale NHS Foundation Trust	3.8%		
Pennine Acute Hospitals NHS Trust	3.0%		
Central Manchester University Hospitals NHS Foundation Trust	2.8%		
Spamedica	2.5%		

Maxillo-Facial Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	99.7%	No	
Lancashire Teaching Hospitals NHS Foundation Trust	0.3%		
Pain Management	100.0%		
East Lancashire Hospitals NHS Trust	57.5%	Yes	
Pennine Acute Hospitals NHS Trust	24.8%		
BMI Healthcare	7.2%		
Lancashire Teaching Hospitals NHS Foundation Trust	5.7%		
Ramsay Healthcare Uk Operations Limited	2.1%		
General Medicine	100.0%		
East Lancashire Hospitals NHS Trust	74.6%	Yes	
Airedale NHS Foundation Trust	11.6%		
Pennine Acute Hospitals NHS Trust	10.1%		
Lancashire Teaching Hospitals NHS Foundation Trust	3.8%		
Gastroenterology	100.0%		yes
East Lancashire Hospitals NHS Trust	83.3%	Yes	
Airedale NHS Foundation Trust	4.6%		
Pennine Acute Hospitals NHS Trust	3.4%		
Salford Royal NHS Foundation Trust	2.6%		
Clinical Haematology	100.0%		
East Lancashire Hospitals NHS Trust	22.9%	Yes	
Airedale NHS Foundation Trust	31.4%		
Blackpool Teaching Hospitals NHS Foundation Trust	17.1%		
Central Manchester University Hospitals NHS Foundation Trust	13.1%		
Pennine Acute Hospitals NHS Trust	8.4%		
The Christie NHS Foundation Trust	4.9%		
Cardiology	100.0%		yes
East Lancashire Hospitals NHS Trust	72.2%	Yes	
Airedale NHS Foundation Trust	10.8%		
Pennine Acute Hospitals NHS Trust	7.5%		
University Hospital Of South Manchester NHS Foundation Trust	4.2%		
Blackpool Teaching Hospitals NHS Foundation Trust	2.3%		
Respiratory Medicine	100.0%		yes
East Lancashire Hospitals NHS Trust	63.7%	Yes	
Lancashire Teaching Hospitals NHS Foundation Trust	19.9%		
Sheffield Teaching Hospitals NHS Foundation Trust	9.5%		
Airedale NHS Foundation Trust	3.6%		
University Hospital Of South Manchester NHS Foundation Trust	2.0%		
Rheumatology	100.0%		
East Lancashire Hospitals NHS Trust	84.7%	Yes	
Pennine Acute Hospitals NHS Trust	7.8%		
Airedale NHS Foundation Trust	4.0%		

Paediatrics	100.0%		
East Lancashire Hospitals NHS Trust	95.8%	No	
Airedale NHS Foundation Trust	2.4%		
Gynaecology	100.0%		
East Lancashire Hospitals NHS Trust	76.3%	Yes	
Central Manchester University Hospitals NHS Foundation Trust	8.3%		
BMI Healthcare	6.6%		
Airedale NHS Foundation Trust	6.2%		
Dermatology			yes

Blackburn with Darwen Elective Inpatient Activity (Sep-14-Aug-15) ELHT % market share

Specialty and Provider	% Market Share	Potential to increase local Market Share (i.e. currently less than 90%)?	Potential to increase referral footprint from surrounding areas?
General Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	88.4%	Yes	
BMI Healthcare	6.8%		
Lancashire Teaching Hospitals NHS Foundation Trust	4.8%		
Urology	100.0%		yes
East Lancashire Hospitals NHS Trust	94.6%	No	
BMI Healthcare	3.9%		
Breast Surgery	100.0%		
East Lancashire Hospitals NHS Trust	100.0%	No	
Vascular Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	100.0%	No	
Trauma & Orthopaedics	100.0%		
East Lancashire Hospitals NHS Trust	57.7%	Yes	
BMI Healthcare	22.4%		
Wrightington, Wigan and Leigh NHS Foundation Trust	5.9%		
Lancashire Teaching Hospitals NHS Foundation Trust	5.0%		
Spire Healthcare	4.3%		
Ramsay Healthcare Uk Operations Limited	2.3%		
ENT	100.0%		
East Lancashire Hospitals NHS Trust	71.7%	Yes	
BMI Healthcare	25.7%		
Lancashire Teaching Hospitals NHS Foundation Trust	2.5%		
Ophthalmology	100.0%		
East Lancashire Hospitals NHS Trust	66.7%	Yes	
Central Manchester University Hospitals NHS Foundation Trust	24.2%		
Royal Liverpool and Broadgreen University Hospitals NHS Trust	9.1%		
Maxillo-Facial Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	100.0%	No	
General Medicine	100.0%		
East Lancashire Hospitals NHS Trust	100.0%	No	
Gastroenterology	100.0%		yes
East Lancashire Hospitals NHS Trust	94.2%	No	
Central Manchester University Hospitals NHS Foundation Trust	5.8%		

Clinical Haematology	100.0%		
East Lancashire Hospitals NHS Trust	66.3%	Yes	
Blackpool Teaching Hospitals NHS Foundation Trust	24.4%		
The Christie NHS Foundation Trust	9.3%		
Cardiology	100.0%		yes
East Lancashire Hospitals NHS Trust	61.1%	Yes	
Blackpool Teaching Hospitals NHS Foundation Trust	22.9%		
University Hospital Of South Manchester NHS Foundation Trust	12.1%		
Central Manchester University Hospitals NHS Foundation Trust	3.8%		
Respiratory Medicine	100.0%		yes
East Lancashire Hospitals NHS Trust	56.1%	Yes	
University Hospital Of South Manchester NHS Foundation Trust	43.9%		
Paediatrics	100.0%		
East Lancashire Hospitals NHS Trust	100.0%	No	
Gynaecology	100.0%		yes
East Lancashire Hospitals NHS Trust	84.4%	Yes	
BMI Healthcare	8.6%		
Lancashire Teaching Hospitals NHS Foundation Trust	5.7%		

Blackburn with Darwen Daycase Activity (Sep-14-Aug-15) ELHT % market share

Specialty and Provider	% Market Share	Potential to increase local Market Share (i.e. currently less than 90%)?	Potential to increase referral footprint from surrounding areas?
General Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	75.4%	Yes	
BMI Healthcare	19.6%		
Ramsay Healthcare Uk Operations Limited	2.3%		
Lancashire Teaching Hospitals NHS Foundation Trust	2.2%		
Urology	100.0%		yes
East Lancashire Hospitals NHS Trust	76.5%	Yes	
BMI Healthcare	16.2%		
Lancashire Teaching Hospitals NHS Foundation Trust	5.8%		
Breast Surgery	100.0%		
East Lancashire Hospitals NHS Trust	100.0%	No	
Vascular Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	97.0%	No	
Lancashire Teaching Hospitals NHS Foundation Trust	3.0%		
Trauma & Orthopaedics	100.0%		
East Lancashire Hospitals NHS Trust	61.0%	Yes	
BMI Healthcare	23.1%		
Lancashire Teaching Hospitals NHS Foundation Trust	8.9%		
Wrightington, Wigan and Leigh NHS Foundation Trust	3.5%		
Ramsay Healthcare Uk Operations Limited	2.0%		
Salford Royal NHS Foundation Trust	0.6%		
ENT	100.0%		
East Lancashire Hospitals NHS Trust	81.9%	Yes	
BMI Healthcare	13.3%		
Lancashire Teaching Hospitals NHS Foundation Trust	4.8%		
Ophthalmology	100.0%		
East Lancashire Hospitals NHS Trust	73.6%	Yes	
BMI Healthcare	6.8%		
Lancashire Teaching Hospitals NHS Foundation Trust	6.4%		
Spamedica	6.0%		
Central Manchester University Hospitals NHS Foundation Trust	3.5%		
Maxillo-Facial Surgery	100.0%		yes
East Lancashire Hospitals NHS Trust	99.0%	No	

Pain Management	100.0%		
East Lancashire Hospitals NHS Trust	66.4%	Yes	
Lancashire Teaching Hospitals NHS Foundation Trust	19.8%		
BMI Healthcare	6.7%		
Salford Royal NHS Foundation Trust	3.5%		
General Medicine	100.0%		
East Lancashire Hospitals NHS Trust	79.6%	Yes	
Lancashire Teaching Hospitals NHS Foundation Trust	16.0%		
Central Manchester University Hospitals NHS Foundation Trust	4.4%		
Gastroenterology	100.0%		yes
East Lancashire Hospitals NHS Trust	90.1%	No	
Lancashire Teaching Hospitals NHS Foundation Trust	2.9%		
Salford Royal NHS Foundation Trust	2.4%		
BMI Healthcare	2.0%		
Clinical Haematology	100.0%		
East Lancashire Hospitals NHS Trust	53.4%	Yes	
Blackpool Teaching Hospitals NHS Foundation Trust	23.8%		
Central Manchester University Hospitals NHS Foundation Trust	13.5%		
The Christie NHS Foundation Trust	5.4%		
Pennine Acute Hospitals NHS Trust	3.9%		
Cardiology	100.0%		yes
East Lancashire Hospitals NHS Trust	92.0%	No	
Blackpool Teaching Hospitals NHS Foundation Trust	3.3%		
University Hospital Of South Manchester NHS Foundation Trust	2.8%		
Respiratory Medicine	100.0%		yes
East Lancashire Hospitals NHS Trust	60.8%	Yes	
Lancashire Teaching Hospitals NHS Foundation Trust	29.8%		
Sheffield Teaching Hospitals NHS Foundation Trust	6.8%		
University Hospital Of South Manchester NHS Foundation Trust	2.7%		
Rheumatology	100.0%		
East Lancashire Hospitals NHS Trust	98.2%	No	
Paediatrics	100.0%		
East Lancashire Hospitals NHS Trust	98.3%	No	
Gynaecology	100.0%		
East Lancashire Hospitals NHS Trust	77.0%	Yes	
Central Manchester University Hospitals NHS Foundation Trust	11.3%		
BMI Healthcare	7.1%		
Lancashire Teaching Hospitals NHS Foundation Trust	4.1%		
Dermatology			yes