Trust Board Paper H

Meeting title:	Trust Board					
Date of the meeting:	11 July 2024					
Title:	Productivity; Defining & Measuring Productivity at University Hospitals of Leicester NHS Trust					
Report presented by:	Siobhan Favier (Deputy COO)					
Report written by:	Siobhan Favier (Deputy COO)					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	TLT 25th June OPC 26th June FIC 28th June					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Financial risk Elective care risk- backlog

Impact assessment
Patients and workforce - This plan highlights the plans developed to reduce backlogs and long waiting lists, at the same time as identifying significant efficiency savings and delivering more activity within existing resources while maintaining high quality patient care. Equality, Diversity & Inclusion – The focus areas within the improvement plan will support improving health equity, delivering the right care at the right time and in the right place. The impact will be better access to elective care through plans that support a population-based approach. This year there will be a drive to improve communication between our patients and partners, wrapping additional support around those that need it most. Finance – The report highlights work being undertaken to improve productivity and achieve better value for money. Reputation/legal – The 2024/25 NHS operational planning guidance positioned improving the productivity of the NHS as one of its core priorities, this report describes the approach being taken within UHL.

Acronyms used:

- RTT – Referral to Treatment
- HVLC - High Volume, Low Complexity Surgery
- GIRFT – Get It Right First Time
- BADS - British Association of Day Surgery
- CIP- Cost Improvement Plan
- DNA- Did not attend
- SOP- Standard Operating Procedure
- GIRFT- Getting it Right First Time
- CpWAU- Cost per Weighted Activity Unit
- UHN- University Hospitals of Northamptonshire
- IS- Independent Sector

Purpose of the Report

The purpose of this paper is to seek agreement on the way UHL will define productivity and the approach to measuring and improving productivity within planned care.

Recommendation

The Trust Board is asked to note the contents for information and discussion.

Summary

This report concentrates on potential productivity improvements in the operational management of elective patient pathways.

Report explains:

- Clarity on the definition of productivity to be used.
- Recommendation on the metrics used to measure productivity.
- Current performance
- Approach to improving productivity in elective care over the next 12 months.
- Next steps

Main report detail

Background / definitions

Productivity is defined as the "effectiveness of productive effort" and should be measured in terms of the rate of output per unit of input. Across sectors and organisations approaches can differ depending on the data that is recorded and reported.

There is often confusion about the term 'productivity' and what it really means, with efficiency and productivity often used interchangeably despite meaning very different things. In the simplest terms, an increase in productivity is when a business makes more of a product (in the case of the NHS, it would be more "care"- doing more operations, for example) using the resources they have available. Efficiency, however, relates to the quality of the work being done – so producing the same, but at a lower cost to the NHS or with less waste. (Kings Fund 2019).

For the purposes of defining productivity for UHL, we propose that "Productivity" will encompass both above definitions, as the number of factors involved in the delivery of NHS patient care and the recording of this activity means that is difficult to disaggregate measures into the two separate elements.

With this in mind, our 'output' should be considered as the volume and quality of patient care delivered and the 'input' the cost of resources consumed in the delivery of patient care.

Productivity at UHL: 'an improvement in the ratio of resource to patient treatment (represented in volume and/or outcomes'). This might present in treating more patients (or the same number with better outcomes) with the same or less resource or treating the same number of patients with less resource.

Considerations when using the above definition:

- Careful consideration will need to be given to schemes where there is a judgment on clinical outcomes. For example, robotic surgery could be considered as providing better outcomes for patients but may be more costly (immediately) in resource terms. However, the definition will provide a framework to couch these discussions and should help with the modelling of expected benefit.
- This definition is to be used for patient services and does not reflect wider productivity within the organisation such as productivity of corporate teams.

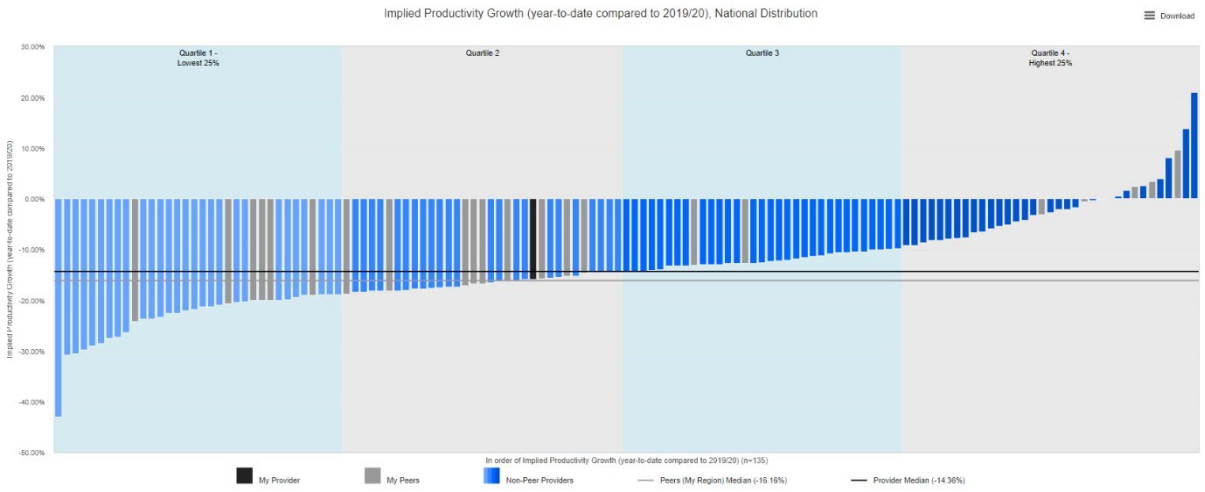
Measurement of productivity

NHS England productivity measures

Implied productivity growth is a new measure released this month by NHSE to support Trusts to understand their own performance around productivity. A national productivity dashboard is currently in development and yet to be released.

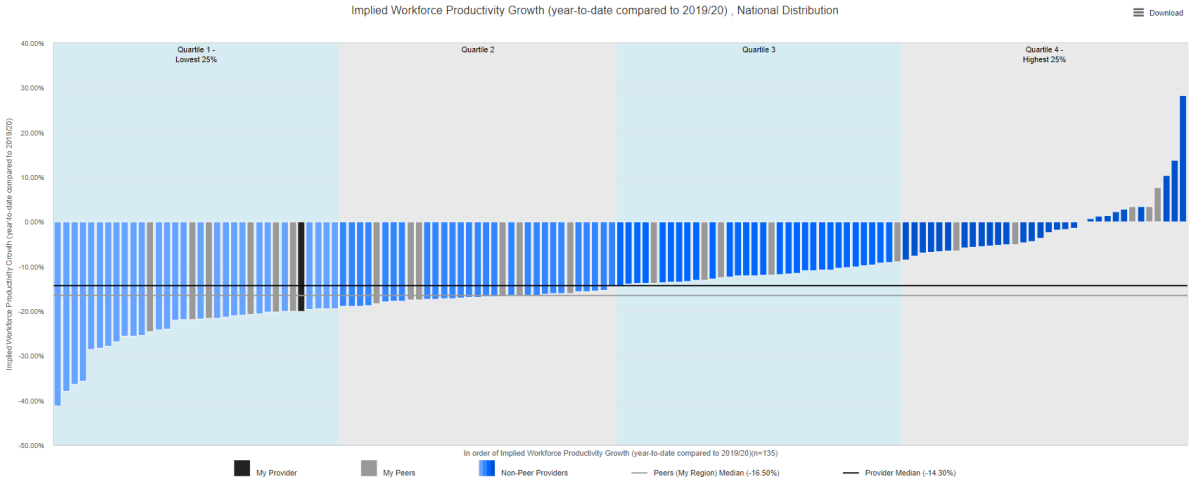
- The first metric (see figure 1 below) looks at the Cost-weighted Activity Growth compared to the Total Cost Growth.
- This looks at the total productivity drag covering pay and non-pay.
- According to this measure UHL is within quartile 2, showing that we are performing slightly worse than the national position but are in line with the peer median (national average is -14.36%, peer average is -16.16% and UHL performance is -15.84%).

Figure 1; Implied productivity growth



- The second metric (see figure 2) introduced is Cost-weighted Activity Growth compared to the Pay Cost Growth. This looks at the total productivity drag covering only pay.
- UHL is within quartile 1, showing poor performance compared to national and peer values (national average -14.30%, peer average -16.50% and UHL performance is -20%).

Figure 2; Implied workforce productivity growth



Limitations of this approach is that the 'cost weighted activity growth' calculated by NHSE only weighs activity based on the point of delivery that the activity is recorded against. It does not consider the complexity or case mix of activity within points of delivery.

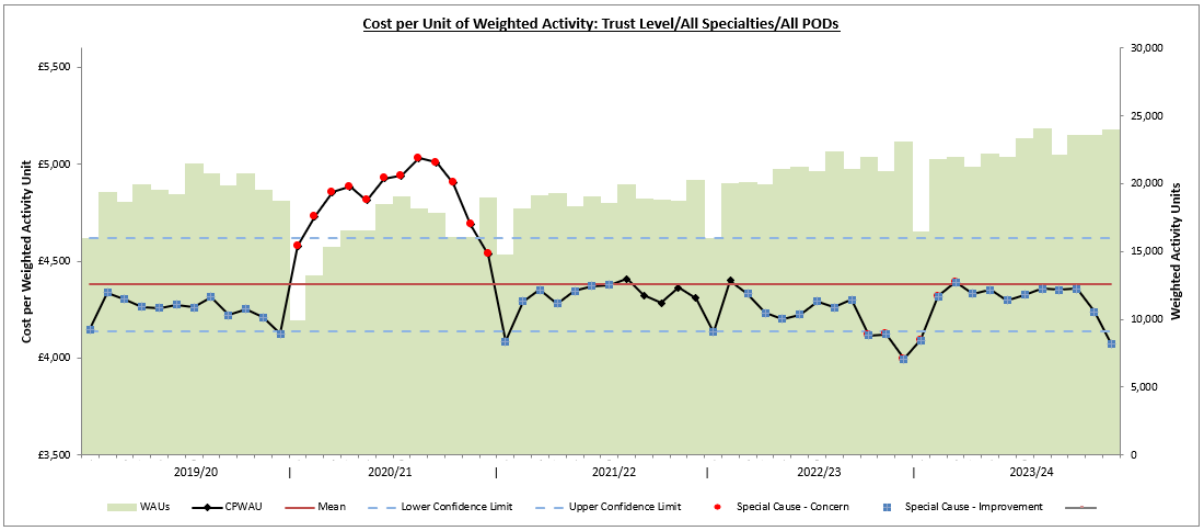
Current Productivity Measures at UHL

There are several indicators of productivity reported at UHL. These provide insight into the outputs generated by the organisation (and its services) and will to some extent measure this against inputs. An example of this is the ‘Average Cases per List’(ACPL) in theatres which measures the average number of operations (outputs) per theatre list (inputs). These can be known as operational productivity measures.

One issue with these measures is that whilst a high-level representation of the input may be considered, the cost or complexity of the resources is not always reflected.

The current internal Cost per Weighted Unit of Activity (CpWAU) measure (see figure 3 below) goes some way to addressing the above shortfall. The measure tracks the inflation adjusted cost of delivering services over our units of output over time, to give one view of productivity trends. In this instance, activity is value weighted based on tariff prices to determine the number of weighted activity units (equivalent to an average episode of elective care).

Figure 3; Cost per Unit of Weighted Activity



There are, however, also limitations with this approach – whilst it is based on detailed Patient Level & Costing Information System (PLICS) data, it is not always possible to break down into the specific drivers of productivity in the patient pathway due to the number of elements involved in the provision of care. It is also subject to the quality of costing and clinical coding data.

Recommendation: proposed alignment of measures

Due to the limitations in both approaches, the Productivity and Efficiency Steering Group propose that a combination of operational productivity measures and the PLICS derived CpWAU are reviewed to assess a services performance in terms of productivity.

It should also be noted that none of the existing measures reflect the quality of output produced, which can be considered as another component of the output side of the productivity equation. This is something that requires further consideration in the future, but due to the capture of data, is a complex issue.

The below operational productivity measures for the purposes of this paper centres on elective care. The reason for this is that elective care accounts for around 18% of providers' total annual expenditure, rising to over 30% if outpatient spend is included (National schedule of reference costs, NHS Trusts and Foundation Trusts, Department of Health). Daycase and Elective Inpatient activity accounted for almost 19% of total spend in UHL for 23/24, when including outpatient care spend (first, follow-up and procedure appointments) it is 37% (PLICS data for 23/24). Therefore, there is a large opportunity to reduce costs.

Secondly, day case and elective inpatient activity is paid variably by ICB/Specialised commissioners in 24/25 at the full national tariff rate, with no limits in the contract on over (or under) performance against the contract plan. Commissioners in turn receive additional funding from NHSE to support additional elective activity.

Operational productivity measures:

The operational productivity metrics can be split into 4 core 'lead' measures, which will show if we are likely to achieve the goal of improved productivity, with subsequent lag measures

telling us if we have achieved, tracking the success of the programme. Further work is required to develop an integrated report of these measures.

Lead measures:

- **Average Case Per List (ACPL):** Increased throughput in theatres, number of procedures per hour per surgeon and theatre team
- **Capped Theatre Utilisation (target 85%):** Touch time within session vs planned. Session time is the total touch time within the start and end time of the planned session, in proportion to planned theatre session/list duration. The aim is to show effective in session utilisation of theatres (use of theatre time).
- **Performance against operational plan:** Activity above what is contained within the operational plan (taking account of any additional costs to deliver) would be able to be allocated as CIP attributed to productivity. *NB: where we have business cases approved as part of the business case process that fund themselves through additional income generation, the activity is not included in the operational plan and therefore, will not be able to count as CIP as it the additional income will need to be used to fund the business case expenditure.*
- **Outpatient first appointments and appointments with an outpatient procedure as a % of all outpatient appointments (target 46%):** measure included within the 24/25 operational planning guidance. The aim is to increase the proportion of all outpatient attendances that are for first appointments or follow-ups attracting a procedure tariff, thereby reducing the number of contact points within the patient pathway before a decision is made on treatment or discharge.

Lag measures:

Theatres/inpatient operational metrics:

- **Improving daycase figures and reducing length of stay:** These practices include optimising analgesia, hydration and postoperative mobilisation as well as preoperative patient education and involving family members in a patient's recovery. The reason for this being suggested as a lag measure is due to the tariff change in daycase i.e. no longer higher than the same procedure done as an inpatient and a reduction in length of stay would not (in most cases) reduce the fixed cost of the ward staff. The productivity benefit would be seen in being able to treat more patients through existing resource i.e., bed stock.
- **Reduce late starts (target 4.9%):** Contributes to efficient running of theatre lists allowing an increase in throughput.
- **Reduce cancellations on the day (target 5%):** Contributes to efficient running of theatre lists allowing an increase in throughput.

Outpatient operational metrics:

- **DNA (Did not attend/did not bring) rate:** Contributes to efficient clinic utilisation, seeing more patients within the same resource. *NB: assumes allowances have not been made to the clinic in terms of over-booking to accommodate predicted DNA rate.*
- **Patient Initiated Follow up (PIFU):** Aim is to reduce the number of follow-ups required and convert capacity into new appointments.
- **Clinic utilisation:** Increase in volume of activity within the same resource.

- **Patients discharged at first outpatient appointment (%):** reduced number of contact points within the patient pathway before a decision is made on treatment or discharge.

Diagnostic operational metrics:

- **Endoscopy ACPL:** Increased throughput based on the number of "points" per list aligned to Joint Advisory Group (JAG) standards
- **Endoscopy clinic utilisation:** Increase in volume of activity within the same resource.
- **Endoscopy in-session utilisation:** Increase in volume of activity within the same resource.
- **Imaging Machine utilisation:** Increase in volume of activity within the same resource.
- **Number of straight to test pathways:** reduced number of contact points within the patient pathway before a decision is made on treatment or discharge.
- **DNA rate:** Contributes to efficient utilisation, seeing more patients within same resource.

Current Performance

Significant progress has been made in the productivity of elective care throughout 23/24 (see appendix 1, 23/24 Key Achievements). The programme for 24/25 aims to improve the below metrics further, improving productivity across elective care. See appendix 3 for the actions being taken.

Looking at table 1 and table 3 below, it does show positive improvement overall in productivity at this point in the year. However, building on this and the pace at which the improvement needs to continue to achieve the productivity CIP will be challenging.

Table 1 Lead measures current performance 24/25

Lead Measures	Target/Plan	May 24	YTD 24/25	Note/Comment
ACPL	1.89	1.57	1.57	*Source: Qlik Theatre Productivity 2.0, Operation Type Elective*
Capped Theatre Utilisation	85%	76.8%	76.1%	*Source: UHL IPR May 2024*
Performance against operational plan - Daycase	19,651 YTD	10,500	20,739	*Source: UHL Informatics*
Performance against operational plan - Inpatient	3,195 YTD	1,956	3,735	*Source: UHL Informatics*
Outpatient first appointments and appointments with an outpatient procedure as a	46%	43.4%	43.2%	*Source: UHL Informatics*

% of all outpatient appointments				

Table 2 Lag measures current performance 24/25

Lag Measures	Target/Plan	May 24	YTD 24/25	Note/Comment
Improving BADS daycase rates	85% for BADS	76.1%	76%	*Source: Qlik Theatre Productivity 2.0, Operation Type Elective, Actual Management type Daycase as a % of total*
Length of stay for HVLC specialities	Upper quartile nationally and in line with GIRFT best practice targets	-	-	Speciality specific targets
Reduce Late starts (%)	>15 mins 0%	39.5%	40.5%	*Source: Qlik Theatre Productivity 2.0, Operation Type Elective*
Cancellations on the day (%)	<5%	9.90%	9.98%	*Source: Qlik Theatre Productivity 2.0, Operation Type Elective*
DNA Rate	<5%	6.5%	6.4%	DNA rate performance has improved significantly since January 24 with an average of 6.2%, compared to 2023 average of 7.4%.
PIFU	5.0% National 6.5% Local Stretch	4.2%	4.2%	PIFU performance has been improving since September 23. We achieved the locally set 3.5% target last year. 24/25 targets have been set for each specialty and where specialties are already achieving above national/stretch benchmark a further stretch target has been set.
Clinic Utilisation	95%	93%	93.3%	Clinic utilisation has been averaging below target at 93% since April 22 and is not significantly improving. Although data is not accurate due to the way different specialities adapt their templates. Standardised outpatient clinic templates are due to be implemented across UHL from October 2024.
Discharged at first outpatient appointment (%)	~	34.5%	35.3%	*Source: Qlik Outpatient Performance*

Table 3 CpWAU by CMG

CMG	Target (2019/20 Av)	Current Mth Performance	Rolling 6 Month Av.	Rolling 12 Month Av.
Alliance & Elective Care	4,448	3,624	3,915	3,958
C.H.U.G.G.S	3,991	3,615	3,911	3,957
Clinical Support and Imaging	4,778	3,408	4,499	4,674
Emergency & Specialist Medcine	4,396	5,061	5,187	5,067
I.T.A.P.S	3,490	2,855	2,858	3,271
Musculo & Specialist Surgery	5,202	4,884	5,046	5,033
Renal, Respiratory, Cardiac & Vascular	4,010	3,584	4,012	4,006
Womens & Childrens	3,890	3,193	3,681	3,803
Grand Total	**4,217**	**3,904**	**4,260**	**4,276**

CIP attached to productivity:

The cost saving attached to productivity for 24/25 is £20 million (additional income net of costs). This accounts for an increase of 10% in Trust income.

Overperformance for all variable lines at month 2 was £5.7m and assuming an average variable cost rate of 20%, the contribution would be £4.5m. See table 4 below.

This assumes no additional premium spend to what is already included in the expenditure plan for M2 YTD and does not address the impact coding improvements may have made (although activity has increased, indicating mainly a volume contribution).

A standard operating procedure (SOP) has been written to clarify (see appendix 2):

- The identification of additional income each month
- Process of reporting
- Inclusion of productivity within CMG CIP Trackers each month

The SOP was agreed at Improvement and Financial Sustainability Programme board (IFSP) on 18/6/24.

Table 4 2024/25 early cut- variable activity

2024/25 Early Cut - Variable Activity Only

		Year to Date (M2)					
Activity Type	PbR Actual Management	Plan (Activity)	Actual/Forecast (Activity)	Variance (Activity)	Plan (£)	Actual/Forecast (£)	Variance (£)
IP	Day Case	18,527	19,257	730	12,773,246	13,566,041	792,795
	Inpatient	2,958	3,472	514	13,965,949	16,332,920	2,366,971
IP Total		**21,484**	**22,729**	**1,245**	**26,739,194**	**29,898,961**	**3,159,766**
OP	New Outpatients	35,383	37,564	2,181	7,549,531	8,005,001	455,470
	New Outpatients (NFTF)	3,911	3,556	(355)	807,492	746,209	(61,282)
	Outpatient Procedures	27,519	31,190	3,671	4,616,527	5,147,507	530,980
OP Total		**66,813**	**72,310**	**5,497**	**12,973,549**	**13,898,718**	**925,168**
DA	Direct Access (Cardiac)	914	741	(173)	157,774	124,470	(33,303)
	Direct Access (Diagnostics)	34,271	34,771	500	1,853,792	2,104,961	251,169
	Direct Access (Respiratory)	-	-	-	-	-	-
DA Total		**35,185**	**35,512**	**327**	**2,011,566**	**2,229,431**	**217,865**
DI	Diagnostic Imaging	26,622	30,804	4,182	3,392,810	4,187,871	795,061
DI Total		**26,622**	**30,804**	**4,182**	**3,392,810**	**4,187,871**	**795,061**
Other	Cardiac Investigations	-	472	472	-	65,961	65,961
	Respiratory Physiology	-	-	-	-	-	-
Other Total		**-**	**472**	**472**	**-**	**65,961**	**65,961**
UB	Unbundled Inpatient HRGs	3,901	5,328	1,427	1,284,629	1,740,381	455,752
	Unbundled Outpatient HRGs	542	966	424	83,072	144,000	60,927
UB Total		**4,442**	**6,294**	**1,852**	**1,367,701**	**1,884,380**	**516,679**
Grand Total		**154,546**	**168,121**	**13,575**	**46,484,820**	**52,165,321**	**5,680,500**

Approach to improving productivity in elective care over the next 12 months.

24/25 Operational Improvement plan

A planned care operational plan was produced for 24/25 and forms year 2 of the 3-year elective care strategy (aligned to the LLR Five Year Joint Forward Plan). The focus of the plan is a continuation of delivering improvements in our waiting times with plans built around five key pillars; improving Productivity and efficiency, making our Processes as efficient as possible (getting the fundamentals right), Transforming Outpatients, building strong Partnerships and sustainable Capacity that meets the future needs of the population.

The focus areas will support improving health equity, delivering the right care at the right time and in the right place. The impact will be better access to elective care through plans that support a population-based approach. This year there will be a drive to improve communication between our patients and partners, wrapping additional support around those that need it most. Recruiting and retaining workforce and delivering new capacity will be a critical success factor, for example, the full opening of EMPCC, Hinckley CDC and the Endoscopy unit at the LGH in the latter months of 24/25.

The main theme throughout the entire plan is on improving productivity. See appendix 3 for high level plans. The monetary benefit of this work is to be tracked through the Productivity and Efficiency bimonthly group with representatives from finance, income team, transformation and operations (see appendix 4: for the operational productivity governance structure).

The below are the potential value for money opportunities within the improvement plan, see appendix 3, which illustrates the actions being taken to deliver the below.

Opportunities:

Day case procedures:
Main sources of efficiency include: lower number of outpatient appointments pre surgery; reduced costs per procedure due to increased number of cases per theatre list; lower overhead costs per procedure due to extended hours. Increased theatre throughput- due to lower number of on-the-day cancellations due to lack of bed availability *(caution here, as the same number of beds on the first day needed- depends on outlying from medicine into surgical beds etc.)*

Inpatient procedures:
Main sources of efficiency include: decreased volume of outpatient appointments per procedure; increased theatre throughput; lower staff costs per procedure in theatre; reduction in postoperative length of stay; reduced number of readmissions; repatriation of activity from the IS (starting with cataracts, moving to Orthopaedics and Hernias).

Outpatients:
Main sources of efficiency include: reduced number of contact points within the patient pathway before a decision is made on treatment or discharge; better capture of work undertaken in clinic; increase in clinic throughput.

Diagnostics:
Main sources of efficiency include: increased throughput; standards for time of reporting.

Partnership working:
We continue to work closely with the GIRFT programme and the localised improvement plans are built and informed by GIRFTs best practice recommendations. The top 17 HVLC specialities have regular meetings with other Trusts within the GIRFT cohort and the Deputy Medical Director for Planned Care and Deputy Chief Operating Officer report progress and discuss issues as part of GIRFT senior cohort meetings monthly.

Collaborating to tackle shared challenges working with UHN. There is a monthly meeting with senior operational colleagues from the three Trusts and ICB leads across Leicestershire and Northamptonshire to discuss productivity and any areas of shared learning or pathway opportunities that could be explored across the patch. An example of this is the system led work on repatriating cataracts from the IS back into the NHS.

Productivity reviews:

Deep dive reviews into specialities as part of a rolling 12-month programme is proposed to run alongside the improvement plan. The deep dive will look at productivity, cost and income i.e., how productivity is realised in practice. For example, consideration will be given to what are fixed or semi-variable costs such as, we cannot reduce the cost of one staff member by 10%; staff costs can often only be reduced by 100% of a full time equivalent (FTE) at a time. This will also pick up consumable costs and variation within the speciality and per procedure.

Specialities will be prioritised for review based on:

a) The level of net deficit and
b) The cost per weighted activity unit movement since 2019/20

Table 5 illustrates the specialities, based on the above criteria, that will be prioritised first.

Table 5 Specialities prioritised first for review

Elective PODS (EL/DC)

		Activity	Income	Net Surplus / Deficit	CpWAU (to 1920 Opp)
110	TRAUMA & ORTHOPAEDICS	3,682	£15,048,185.	-£8,994,566.	£4,435,325.
320	CARDIOLOGY	3,057	£12,794,165.	-£7,702,561.	£4,802,163.
100	GENERAL SURGERY	3,360	£11,584,179.	-£5,738,896.	£1,111,889.
172	CARDIAC SURGERY	526	£8,887,443.	-£3,671,611.	£1,094,463.

All POD's

		Activity	Income	Net Surplus / Deficit	CpWAU (to 1920 Opp)
300	GENERAL MEDICINE	66,082	£67,218,132.	-£27,997,494.	£10,969,280.
340	RESPIRATORY MEDICINE	67,345	£46,610,526.	-£17,476,482.	£5,017,047.
430	GERIATRIC MEDICINE	21,339	£29,528,387.	-£15,887,781.	£8,334,583.

Following the review there will be a series of recommended actions that will be discussed and agreed with the speciality in question to improve productivity within set timelines for recovery.

Challenges and risks

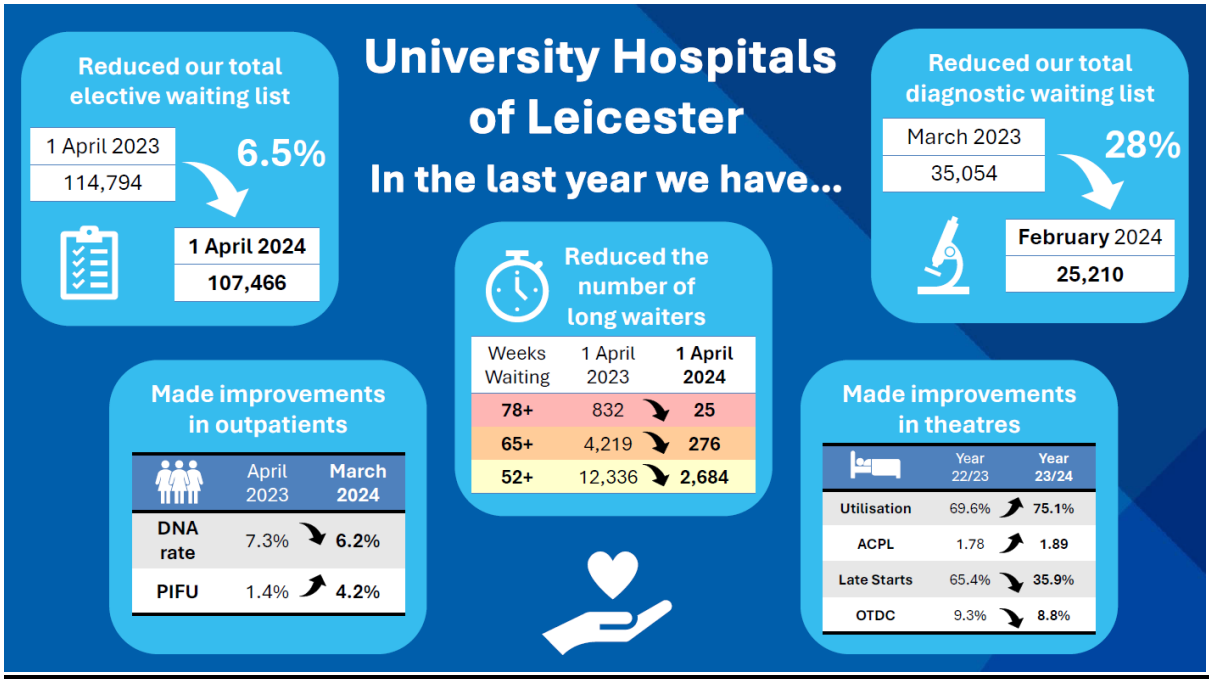
- Nervecentre rollout- any short-term reduction in activity due to implementation is not factored into the operational plan.
- Continued industrial action.
- Capital for equipment- with an increase of cases per list more equipment will likely need to be purchased for some procedures.
- Age of theatre estate leading to potential periods of unavailability, limiting capacity.
- Estate limitations e.g., in being able to co-locate services, amalgamate teams etc. This is also linked to the larger organisational wide reconfiguration plan.
- Impact of emergency demand if unmitigated by UEC actions.
- Workforce availability.
- Attracting and retaining suitable workforce noting the full opening of EMPCC, Hinckley CDC and the Endoscopy unit at the LGH are in in the latter months of 24/25.
- Large non-RTT overdue follow-up waiting list, activity does not attract income.
- Non-funded activity e.g., e-triage, virtual follow-up.

Next steps

- Work is underway to develop a roll out plan for deep dives into specialities productivity, cost and income. The first review will start in July, the outcome will be reported through the financial and sustainability committee (see appendix 4, for governance framework).
- Development of a productivity dashboard/integrated report.
- Agreement of where Bain maybe able to provide support.

- Method for monitoring additional income: where we have business cases approved as part of the business case process that fund themselves through additional income generation, the activity is not included in the activity plan and therefore will not be able to count as CIP as the income will need to be used to fund the business case expenditure.
- Further consideration of quality metrics to measure the quality of the outcome. Metrics could include indicators such as, how we monitor complications post-surgery, average length of stay per consultant, per procedure, friends and family, number of complaints etc.

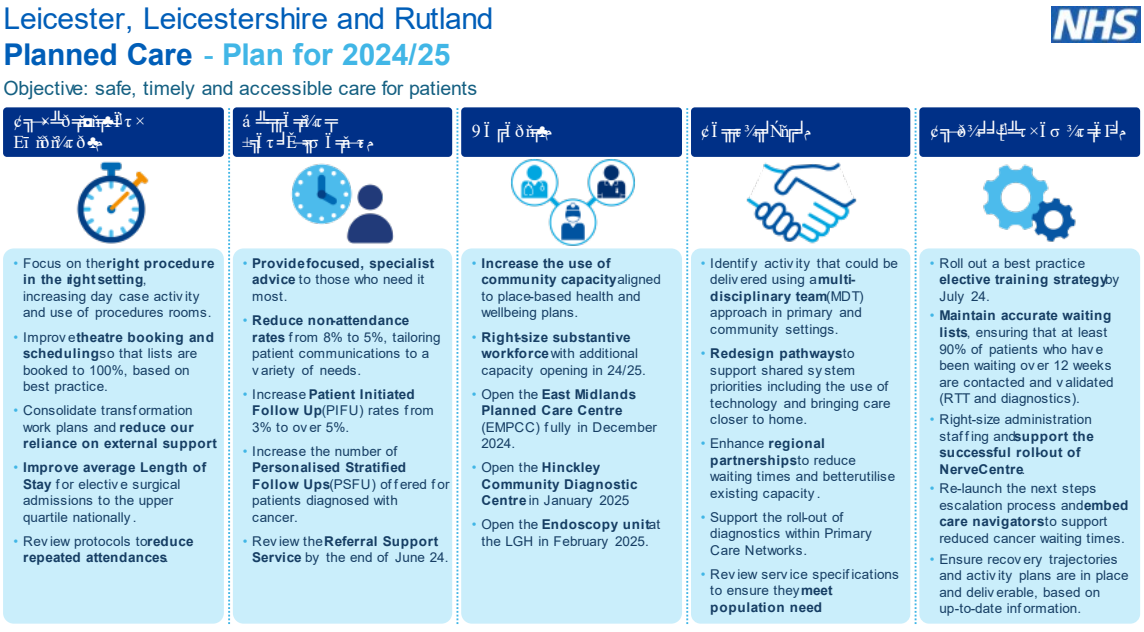
Appendix 1: 23/24 Key Achievements



Appendix 2: Productivity Income SOP

Internal document – available upon request.

Appendix 3: Operational Plan 24/25 for planned care



Leicester, Leicestershire and Rutland **Elective** - Plan for 2024/25

Objective: safe, timely and accessible care for patients

Elective Care Strategy 2023 - 2026

Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
• Stabilise waiting list • Deliver zero 104+ • Reduce 78+ week waits	• Channel long term conditions and diagnostics out to the community • Longer term agreements with IS • Deliver zero 65+	• EMPCC fully operational • Net importer of activity into capacity • Upper Quartile Productivity • Digital Leader

Ec Ei

- Achieve **85% theatre touch time utilisation**
- Improve **theatre booking and scheduling** so that lists are booked to 100%, based on best practice.
- Ensure that procedures take place in the **most appropriate setting**.
- Deliver **throughput at the standard** for High Volume Low Complexity cases.
- Improve **day case rates to 85%** for British Association of Day Surgery (BADS) procedures.
- **Improve average Length of Stay** for elective surgical admissions to the upper quartile nationally

Ec Ei

- Provide **focused, specialist advice** to those who need it most.
- Improve **non-attendance** rates from 8% to 5%.
- Increase **Patient Initiated Follow Up** (PIFU) rates to 5%.
- **Standardise** clinic templates.
- Standardise **reminder messaging for outpatient appointments** including moving to a single provider of text messaging.
- Review the **Referral Support Service** by the end of June 24 and Implement the eycare Electronic Referral Service

Ec Ei

- **Increase the use of community capacity** aligned to place-based health and wellbeing plans.
- Open the **East Midlands Planned Care Centre** (EMPCC) fully in **Winter 2024**
- Open the **Hinckley Community Diagnostic Centre** in January 2025.
- Open the **dedicated Endoscopy unit** at the LGH in Spring 2025.

Ec Ei

- Ensure **patient choice of** accredited providers is maintained
- Enhance and **improve Independent Sector contracts**.
- Develop an '**Intermediate Tier Offer**' that will bring primary care and secondary care together for pathways where a multi-disciplinary approach is most effective.
- **Work collaboratively** with Northamptonshire to support best practice, ensuring the best use of shared capacity and **drive improvements in productivity**

Ec Ei

- Roll out a best practice **elective training strategy** by July 24.
- **Maintain accurate waiting lists**, ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (RTT and diagnostics).
- Create an '**excellence in administration**' programme.
- Support the successful **roll-out of NerveCentre** improving and streamlining administration processes.

Leicester, Leicestershire and Rutland **Diagnostics** - Plan for 2024/25

Objective: safe, timely and accessible care for patients

Diagnostics Strategy 2023 - 2026

Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
• 85% of patients <6 weeks • Staffed Endoscopy modular on site • Deliver 82,000 CDC tests from LGH	• 95% of patients <6 weeks March 2025 • Hinckley CDC operational and deliver (PYE) 22,000 tests • No 13+ weeks patients	• Meet 99% patients > 6 weeks • A reduction in temporary machines • Workforce strategy implemented

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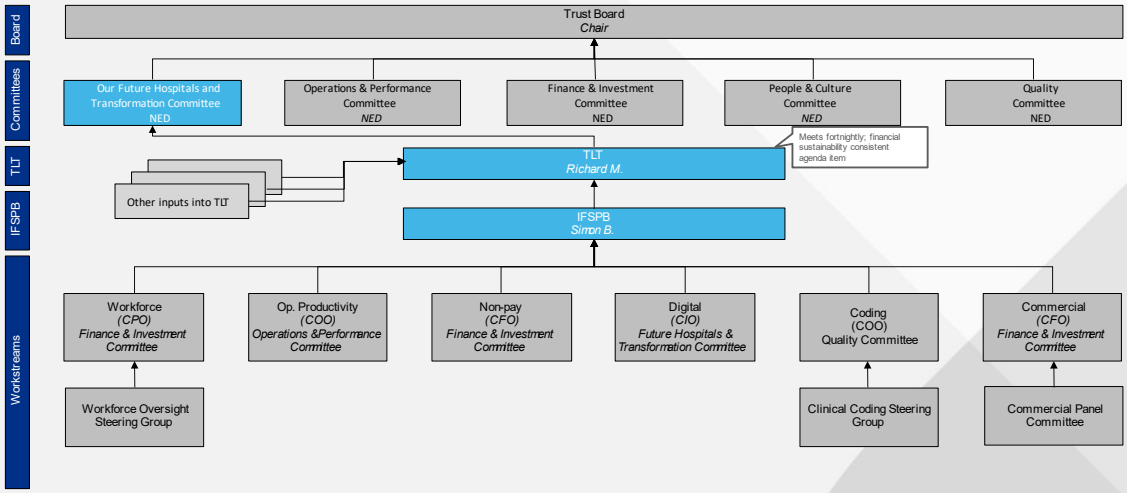
Appendix 4: Operational Productivity Governance Structure

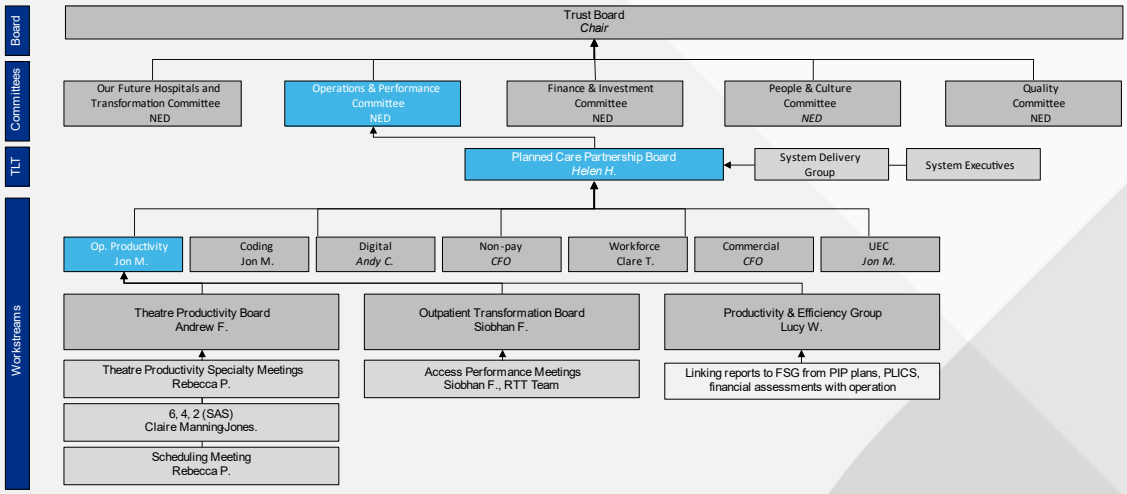
Improvement & Financial Sustainability



Note: TLT – Trust Leadership Team; ISFPB Improvement & Financial Sustainability Programme Board; The Trust Board and Committee both a public and private agendas

University Hospitals Leicester

Operational Productivity Governance



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