Royal Papworth Hospital
NHS Foundation Trust

2018/19 Activity Recovery Action Plan

Key for categorisation of Status	
On track / complete	**Green**
Behind schedule but mitigations in progress and being tracked	**Amber**
Deadline **delayed** / **not started**	**Red**
Date is **currently TBC** or 'on-going' therefore cannot measure status	**Grey**

All figures obtained from Activity Report Q1 2018/2019

Specialty	Ref	Action	Owner	Due	Status	Additional Comments	Activity Gain	Comp Date
Respiratory						RSSC Assumptions: 1. Current nursing vacancies to stay static or improve slowly. 2. Reduced CMT junior doctor availability from August 2018. 3. That we are already actively trying to recruit to mitigate the lack of junior doctor cover (lack of medical staff likely to be the main constraint to activity from August). 4. The activity plan is a stretch target +++, especially in the current climate of lack of staff. Our overriding priority must always be patient safety.		

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	RSSC IP 1.0	Switch some CPAP patients from day-case to inpatients.	JArcher / ISmith	TBC		(e.g. CPAP starters from Outreach clinics). This enables increased inpatient activity with the smallest possible impact on the (smaller) medical workforce. It will reduce day-case through CPAP, though this would mitigate a current shortage of CPAP nurse availability	Est. 3-6 in patients per week.	
	RSSC IP 2.0	Move StR grade doctors more available for ward duties. By removing those from Outpatients (I.e. ensure 1 always available every weekday afternoon).	MDavies	30/9/18		Benefit improved inpatient throughput, improved supervision of FY grade doctors (there will be no CMT doctors from August), likely improved training experience for StRs (current team feel they have endured excessive clinic experience (if we do not do this we will need to reduce activity from current levels to accommodate the loss of CMT grade presence) Downside = reduced outpatient capacity. Need to understand what this reduction would be. Starting the Manea medical clinic should mitigate some of this, but obviously reduces consultant availability at base	Est. 10-15 Inpatients per week	

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	RSSC IP 3.0	Improve the efficiency of patient admissions and discharges – (number of doctors is main current constraint)	MDavies	1/12/18		a. Pharmacist attendance to review all daily weekday admissions (taking drug charts from doctors) b. Procure new POC blood gas analyser for RSSC with direct feed into Lorenzo (saving significant time and reducing human error).		
	RSSC IP 4.0	Increase use of ward-based polysomnography via early procurement of new kit	DW/SJ/TQ	1/11/18		Current plans to bring some new kit to current location because of the delay could help increase PSG activity. By bring 4 pieces of the new 10 over 3 for the labs and use the 4th to convert to mobile unit we can utilise ward beds. We would need to plan this, ensure that we select appropriate patients. Also ensure that we don't end up with suboptimal tests (noise / light reduction). *Bringing new equipment to the hospital has been agreed. Order still not placed with Stowood. Procurement chased and escalated at Performance review. Once order placed 8 weeks lead in time.*	4 Inpatients per week	
	RSSC DC 1.0	Continue introduction of new ANPs to day-case sessions	AWhite	On-going		Already started. Added additional patients to consultant lists to ensure supervised introduction (both individuals highly experienced respiratory nurses, though 1 is new to RSSC).		

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	RSSC DC 2.0	Admin team to identify more patients suitable for day-case review (e.g. NIV reviews planned for inpatient assessment)	PButters	TBC		Already doing this. See suggestion for a more defined coordinator role below in RSSC DC 5.0		
	RSSC DC 3.0	New consultant appointed (previously covered by Locum) due to start in August: Locum Initial focus to see if we can open slots in day-case pending further discussion around job plans.	ISmith	30/8/18		We are planning new slots for August and will review further plans once the colleague starts.		
	RSSC DC 4.0	Bring forwards Clinical Fellow recruitment	DW/JW			Due in October – Plan to advertise early. *Now confirmed that deanery funding for LAT posts no supplied, does stay with us and can be used to recruit LAS.*		
	RSSC DC 5.0	Improve the speed of assessment: Main constraint to patient throughput from medical perspective = Lorenzo.	ISmith	TBC		a. Procure new POC blood gas analyser with direct feed into Lorenzo. As above RSSC IP 3.0 b. b. Consider employing a physician's assistant or a senior admin member in a coordinator role; documentation prep, comorbidity.		
	ILD DC 1.0	Increase New patient daycase attendance, in line with Brompton PVDU model. Currently see in OP but should be daycase.	DW/MT	17th Sept		From September Consultants are no longer seeing CUH pts at CUH. Capacity was provide on Day ward. Can see 2 pts every 2 weeks.	Est 4 day case per month.	

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	ILD DC 2.0	Shared ILD consultant with CUH 9PA post. 5.2 PA from CUH 2.8 already available from our consultants. 1.0 shortfall and business case being written.	DW/MT	17th Sept		1.0 Additional PA being sort will fund shared post to see 3 new RPH Daycase pts alternate weeks. *Draft Business case written and finance working on cost and income numbers. Target date for completion 17th September*	Est 4-6 day case per month.	
	LD DC 1.0	Look to increase the number of Home IV day case patienst that attend.	KH/DB/PB	1st Oct		Need to understand the capacity to uplift with current staffing levels, as suggested that will need on hold nursing posts to be utilised to uplift this activity until re located. As they will then be needed to support the new ambulatory. Should be taken forward as a CTP or STP initiative. Following revised gateway 2 meeting on Friday 10th August, support was given by group including JR and EM for including the 2.5 home IV nurse uplift forward to support this. However this has not been approved through finance.	TBC	

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Cardiology						Cardiology assumptions: • Requires an additional 8 patients booked and discharged per week to attain the year end projection of activity • There were 14 more than projected daycases performed per week (on average) in Q1 • Q1 delivered an inflated numbers of outpatients being delivered in anticipation of the clinics being reduced over the holiday period in Q2. • Efficiencies in booking processes can improve utilisation of available capacity.		

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	CEI IP/DC 1.0	Initial review of demand (from PTL) and capacity (lab base) shows there were possibilities in Q1 to achieve a greater net number of patients booked. Review of the Booking team and booking processes will allow for greater efficiency and utilisation of capacity	CSH	30/9/18	Open		An additional 8 patients per week.	
		1st attendance for procedure is by letter invitation and confirmation with reasonable notice as per the national and local guidelines. New booking method enacted. Short notice appointments to continue to be negotiated.			Closed			
		The IP number is being offset by the cases being converted into daycase (e.g. EP 178% above plan).			Closed			
		Cryo has been placed into lab 6 to expand the patients that can be safely delivered in a mobile cath lab – this will likely further contribute to the day case numbers.			Closed			
		No further action required to adjust the activity numbers in terms of inpatient to daycase switch.			Closed			

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	COP 1.0	With the pressure of RTT there is anticipated increase in clinics until a stable PTL is achieved. This will be across Q2 and Q3, as the demand for new patients is met in Q2 and the demand for follow up patients is met in Q3.	CSH	30/9/18	Open		TBC once baseline understood.	
		Virtual clinics have triaged those patients who did not require an attendance.			Closed			
		Additional intervention clinics have answered the backlog of new patients and reduced the waiting time of first appointment to 2-3 weeks – in line with the timed pathway for intervention.			Closed			
		CRM capacity is currently being evaluated to deliver additional clinics. Virtual clinics are not appropriate.	CSH / CS	30/9/18	Open			

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Surgery						Surgery Assumptions: • Critical care open to 33 beds Monday to Friday. • CRU ring fence in place (9beds) • ECMO cases held to < 3 at a time. • Transplant activity constrained to 1 case at a time during daytime hours. • No further IHU increase		
	SIP 1.0	Reduce lost theatre time due to theatre being put on hold at the start of the day.	MM	30/8/18		The default should be to start all of the lists on time.		
	SIP 2.0	Review of theatre scheduling.	CB	30/9/18		Potential to reduce cancellations due to heroic booking. This will also reduce the burden of 28 day re-books. Robust compliance to leave policy Minimum of 70% of capacity must be booked 6weeks in advance. This will allow rebooking of cancellation within 28days Encourage more generic referrals Clear distinction between capacity allocated for private patients and NHS patients		
	SIP 3.0	Maintain ring fence beds on CRU to maximize opportunity to deliver pump activity.	JB	1/8/18		Complete		
	SIP 4.0	Reinstate Sunday lists.	CB	30/9/18		Shortage of anaesthetic cover has resulted in these lists stopping over the summer.	2 cases per week.	

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Radiology						The biggest area of activity growth in radiology falls primarily to cardiac imaging. Both MRI and CT have seen a sustained year on year demand in this area. Capacity has been released to meet these increasing demands through additional lists and bought-in MRI services. Demand is unlikely to subside and continuation of the additional capacity schemes will be supported through appropriate business cases.		