Moray Redesign of Urgent Care Action Plan

APPENDIX 1

Executive Lead: Simon Boker-Ingram SROs: Sean Coady a	nd Alasdair Pattison Programme Lead: Tori Higgins	Clinical Lead: Robert Lockhart Report Date: 27/04/23 Overall Status: On T	rack			
Objectives	Key Deliverables & Status					
 To develop and implement a Moray Redesign of Urgent Care Action plan. Decrease pressure points in the system by controlling, coordinating and collaborating 	Deliverable	Progress Update	RAG			
	Mapping Services Across Moray	Mapping Session 24/03/23. Planning meeting tomorrow for follow up session in June				
Agreed Scope Unscheduled activity across the Moray system	Ambulatory Emergency Care	Ambulatory Emergency Care launched on 09/01/23. DGH Strategy update and DGH footprint update (Future strategy of DGH – stabilising transfer and SAS boundaries) Flash report and poster to be shared.				
KPIs/Improvement Trajectory Measures Reduction in ambulance stacking Reduction in 12 hour waits from ED	Launch of Daytime Urgent Care Service (DUCS)	Launched 30/01/23 - Collected data on reason for request to visit and outcome of visit. Update on clinical discussions between hospital team and GP required. PMcLean to update on linking this with Primary Care Escalation Score. Evaluation date due 2nd week of May.				
Reduction in attendance in ED Reduction in G-OPES level for Moray and DGH Reduction in Delayed Discharge and Delayed Transfer of Care Reduced Length of Stay Patient satisfaction levels Staff satisfaction levels Staff absences/capacity Elective Care Activity	Documented description of FNC function and service model with agreed shared vision and plan to progress to this	Update: all decision makers to be in the same location. GMED NHS 24 co location. Discussions remain underway regarding FNC model and next steps – UUC Programme Board reviewing priorities from March 2023.				
	Optimising Patient Flow	Sharing of work form this group (Planned Date of Discharge, Criteria Led Discharge, Simulation Training, Discharge Tab, Patient Navigators and Whole System Flow Hub) workshop being planned for 23/05/23 – liaise with Susan Flannery (ask LB to facilitate Moray end). Pilot for discharge tab launched end of May but maybe June.				
Occupancy Levels Snap Audit of Bloods Number of ACPs in place CALUM AND DUNCAN TO PROGRESS DISCUSSIONS	Primary Care Access to Secondary Care Data	Progressing with IG and HI – Ben working on report format. IG confirmed position and agreed to proceed with Maryhill in first instance. Some already underway such as Boxi report on upcoming discharges – CY and AB Paperwork being finalised for submission.				
Key Risks/Issues & Mitigations (expanded in Project Charter) Key Risks Mitigations	Report with recommendations on improved system of communication between primary care and DGH	Community teams meeting – locality plans and activity already ongoing, PCIP.				
Staff capacity due to ongoing service pressures Shortened meeting with focussed discussions on key progress and challenges	Report on number of patients who would benefit from ACP with plan in place to support development where there are gaps	^m Overlaps with the LES. Work progressing with a TEPS/ReSPECT/ACP mapping session on 17/04/23 for a collective work streams discussion by Realistic Medicine Team. AG to come to meeting 11/05 to discuss output from this .				
Action plan focus too much on single part of system Bespoke engagement with community colleagues	Reduction in turn around time for blood test results to support patients to remain at home where appropriate	JM to give update				
Industrial Action Will develop through cells and be communicated. Key Progress	municated. Only a small portion of patients with ENT and Vascular conditions can receive assessment and treatment at DGH before transfer to Raigmore (ENT) and ARI (Vascular). Currently SAS convey patients to DGH ED prior to onward Define transfer to Raigmore (ENT) and ARI (Vascular). Currently SAS convey patients to DGH ED prior to onward					
 Action Plan drafted and agreed by stakeholder group Great engagement from community providers for USC MDT discussion linked challenge to actions already underway and well progressed 		suggested.				
 Action plan to be endorsed by Moray Portfolio SLT Comms plan 	Next Steps					

- > Action plan to be endorsed by Moray Portfolio SLT
- Comms plan

• Sharing of up to date LIVE AP

Evaluation progression

- Movement of actions from the system ٠ pressures plan to USC plan
- Stock take and summary paper of this to be written for planning beyond March 2023

Moray USC Programme – Theory of Change

AIM	PRIMARY DRIVERS	ACTIONS (activities)	KEY OUPUT (acting as proxy)	KEY METRIC (acting as proxy)	IMPACT (Complex KPIs)		
Develop and deliver a sustainable unscheduled care model in Moray	<u>Proposal A</u> We have awareness of system pathways and pressure points	A1 – Mapping services A2 – Review GOPES A3 – MDT comms to support hospital flow A4 – Reset DGH medical footprint / SOP	 → Systems map of services → MDT established 	% Practices completing G-OPES level %age patients admitted to appropriate ward within 24hrs	INDICATIVE ALIGNED IMPACT -Staff satisfaction (A2; B5) -Staff capacity (A2; B5) -Reduced delayed discharges (A3; A4; C1) -Reduced length of stay (A3; A4; C1) -Reduced A&E attendances (B2; C1; C2) -Reduced hospital admissions (C1; C3; C4) -Increased elective activity (C2) -Reduction in ambulance stacking (E2) -Reduction in 12 hour waits from ED (E2)		
	<u>Proposal B</u> Flow can be effectively navigated throughout the system	B1 – GMED redirection test of changeB2 – FNC enhanced understandingB3 – Reduce DDsB4 – Improved commsB5 – DUCS	→ SOP of pathways → TBC	Reduced delayed discharge			
	Proposal C Increase triage prior to admission	C1 – Redesign H@H C2 – Review and strengthen ACP C3 – Use MDT at front door C4 – rapid access to blood testing / results		Proportion of patients assessed at home ACPs Uptake Number of redirections from ED & AMAU % samples returned within 24 hours			
	Proposal D The Moray system connects daily regarding patient placement Proposal E Clinical activity is directed away from DGH when appropriate	D1 – Review comms systems E1 – Mvmt of MI activity from DGH E2 – Alt location for SAS	→ TBC	No. DATIX related to ambulance stacking			
	from DGH when appropriate			NO. DATIX related to ambulance statking			
CONFOUNDING MACRO E.g. Increased demand for health and care services							
VARIA	VARIABLES MESO E.g. Care Homes already at capacity						
jeopardise progress) MICRO E.g. Staffing shortages							