REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2023**

SUBJECT: **MORAY DAYTIME UNSCHEDULED CARE SERVICES (MORAY DUCS)**

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. To inform the Board of progress made in relation to a Moray Daytime Unscheduled Care Service 10 week test of change, which took place during January 2023 – March 2023.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and note the findings of the test of change and the recommendations regarding a sustainable model solution, that will potentially meet the needs of patients requiring unscheduled medical treatment within daytime hours.

3. BACKGROUND

3.1 This test of change was in response to considerable pressure across the health and care system in Grampian. This pressure is particularly felt within General Practice, with acknowledgment both nationally and locally that sustainability is under threat. After a successful application for Winter Funding a steering group was set up to drive the test of change for 3 months to support Primary Care capacity and the front door of Dr Gray's Hospital.

Service model

3.2 The Moray Daytime Unscheduled Care Service (DUCS) was a test of change that comprised of an in-hours urgent care team (1 x GP and 2 x Advanced Nurse Practitioner (ANP)), operating from a Monday-Friday, for a period of three months. Posts were employed by the Out Of Hours Primary Care service (GMED). Referrals were professional to professional with Practices calling a dedicated number: the GP/ANP would then triage the call deciding on a one-, two-, or four-hour urgency in discussion with the requesting Practice clinician. The call would then be dispatched via the Ad Astra operating system to the peripatetic clinicians.

3.3 Inclusion criteria were: patient unable to attend the surgery; patient home-visit request was between 1300-1700 hours; patient's clinical condition was suitable to be managed by an advanced practitioner and the patient agreed to being seen by an advanced practitioner. Exclusion criteria included patients with illness related to pregnancy; psychiatric symptoms and other complex patients that may be more effectively handled by GPs.

3.4 Evaluation approach – Data collected included demography of patients; reason for referral and outcome of visits. Staff running the DUCS service and Practices who referred into the service were invited to engage in focus groups to share their experience of both delivering and receiving the service.

3.5 The full evaluation report is still awaiting ratification and thus subject to some amendment.

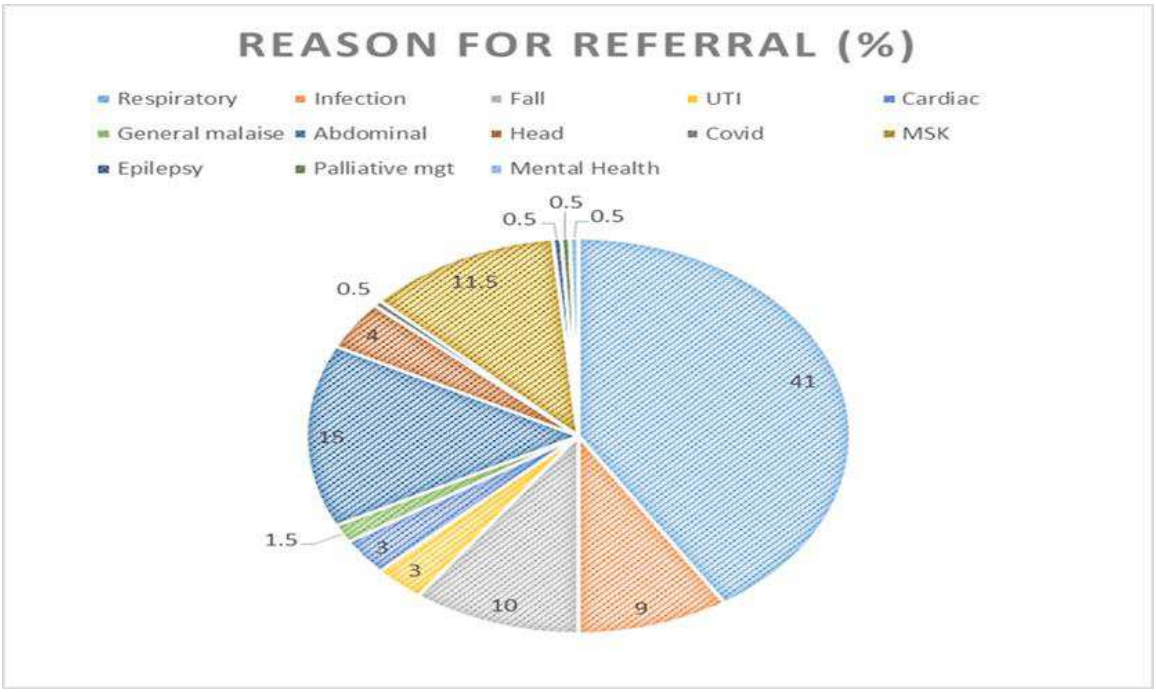
4 KEY MATTERS RELEVANT TO RECOMMENDATION

Visits overview

4.1. Aberlour, Fochabers and Glenlivet Practices did not refer into the service. Elgin referred the largest proportion of calls and is representative of their larger practice populations. The west therefore had a higher percentage of overall calls, although Buckie did use the service.

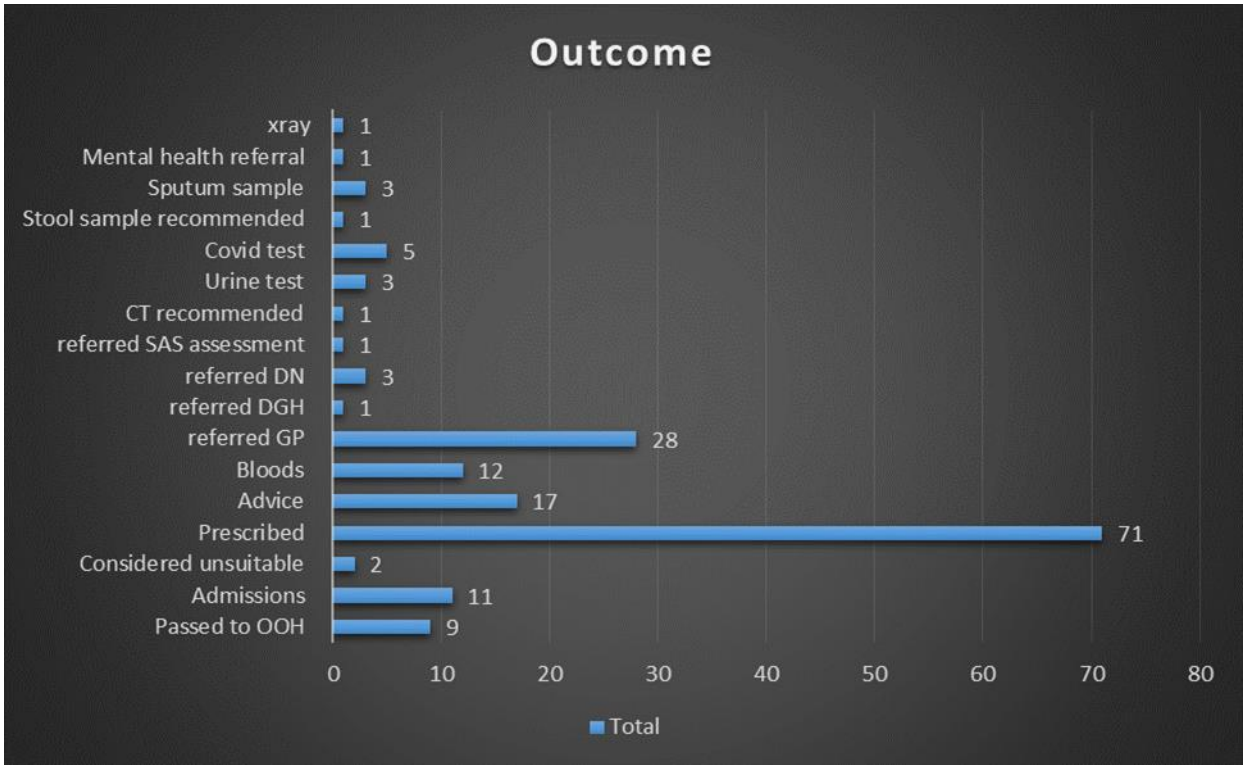
4.2. Average calls per week were 15, approximately three per day. From the referrals indicated, 57% had a chronic or long term condition exacerbating their symptoms.

4.3. The most common reason for referral was respiratory symptoms, then abdominal: this was mirrored by Out of Hours activity during the period. Post-Falls complications were the third most common factor.



4.4. Outcome was measured in both clinical activity and also an expected as well as actual outcome was recorded.

4.5. Outcome was predominantly prescription based: this was expected. There was evidence of admission avoidance.



4.6. Costs were kept minimal by using ANP rather than GP as GP capacity became limited as time went on and shifts were shorter than expected as was the duration. Medication costs were also relatively low. There were six days in total that the service could not run due to sickness and annual leave.

5. INITIAL RESULTS

5.1 The feedback from the practices was generally positive however there was an overall message from practices that a minor illness service would be more appropriate and that the project needed to be run over a much longer period of time, with a much more sustainable workforce to enable the full service to be evaluated. The duration length did not allow for the embedding of the service, and so impact on GP workload was minimal, however it was acknowledged that the Practices felt the treatment received by their patients was helpful and appropriate.

5.2 It was thought that the service would be better integrated within the practices rather than stand alone and would benefit from a multi-disciplinary team approach.

5.3 The data presented allowed for identification of complex patients that were known in a hospital, community and out of hours environment: there is potential for early identification allowing for early or crisis intervention.

5.4 Face to face appointments were preferred by some, particularly parents of sick children who were willing to travel.

5.5 The service was set up quickly with the use of volunteer existing GMED staff offering to cover the shifts. As the test of change progressed, the staffing became more difficult, exacerbated by annual leave (end of leave year), long term sickness and phased retirement. GP cover became particularly difficult.

6. FUTURE MODELLING

6.1 Future models would need to incorporate:

i) A sustainable workforce – dedicated sustainable staff of a multi-disciplinary nature to ensure early intervention was applied where appropriate.

ii) A Pan Grampian model would be preferable with face to face hubs established, particularly for minor illness. This would allow for centralisation of dispatch and data collation facility and reduce overall staffing costs.

iii) The model would need to be Nurse led rather than GP led- this would be economically sustainable.

iv) Robust systems communication would need to be in place to allow NHS 24/Acute/Primary care and Out of Hours information to be collated: this would allow for identification of vulnerable or failing patients allowing for early identification and prevention facilitation at the earliest opportunity.

7. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

The policy and approach set out in this report is consistent with the ambitions of the MIJB Strategic Plan in providing care at home or close to home. This locality approach is also consistent with the ambitions of the Moray Council Corporate Plan and the Moray Community Planning Partnership LOIP. The NHSG Unscheduled Care Strategy – *right care, right place, right time.*

(b) Policy and Legal

A number of policy and legal implications require to be considered, particularly regarding clinical pathways and data sharing.

(c) Financial implications

Financial implications relating to building, systems, resourcing and staffing costs.

(d) Risk Implications and Mitigation
Risks and mitigating factors are outlined within the report

(e) Staffing Implications
There are implications on staffing provision and on staff terms and conditions.

(f) Property

Implications relating to the Practice surgery premises across Grampian as well as face to face hub facility needed during the day.

(g) Equalities/Socio Economic Impact
Pan Grampian needs analysis would need to be carried out prior to establishment of service to ensure hubs were centralised and rural areas were considered**.**

(h) Climate Change and Biodiversity Impacts
Potential increase in carbon emissions due to peripatetic nature of service.

(i) Directions
None arising directly from this report.

(j) Consultations

- Head of Service, Health and Social Care Moray
- Primary Care Clinical Lead, Health and Social Care Moray
- GMED service manager
- Aberdeen City Evaluation Lead
- Moray GP practices
- Moray DUCS staff
- Democratic Services Manager, Moray Council

8. CONCLUSION

8.1 The MIJB are asked to note the full evaluation report is due at the end of June 2023 and contains recommendations and points for discussion.

Author of Report: Natalie Jeffery - Business Support Manager

Background Papers:

Ref: