REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 31 AUGUST 2023**

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

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1 To inform the Committee regarding progress made in relation to a Moray Daytime Unscheduled Care Service 10 week test of change (January – March 2023).

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee considers and notes:

i) the evaluation made in relation to the test of change; and

ii) that the findings will be considered in the winter planning for 2023/24 and incorporated in the General Practice (GP) Vision Project, looking at the GP Services in their entirety.

3. BACKGROUND

3.1 This test of change was in response to considerable pressure across the health and care system in Grampian and locally in Moray. This pressure is particularly felt within General Practice, with acknowledgment both nationally and locally that sustainability is under threat. The ageing population, along with complex co-morbidities is resulting in an increasing number of patients being physically unable to attend the surgery. The unpredictability of the demand for unscheduled home visits during the day is becoming increasingly disruptive on an already stretched workforce. Often practices require two General Practitioners as a minimum to be in the building until 6pm and in smaller practices this can mean a dependence on locums – another increasingly depleted resource. GPs often triage these later requests for home visits and manage them by telephone or by deferring the visit until the next day. In some cases this may result in the visit being passed onto the out of hour's service. Therefore, it was felt there was a need to find further initiatives that supports

Practices with this demand, and as such the within service was developed. Funding for this test of change was applied for and provided.

3.2. **Service model** - 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 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.

3.4 Exclusion criteria included:

- patients with illness related to pregnancy;
- psychiatric symptoms and other complex patients that may be more effectively handled by GPs.

The exclusion criteria was mirrored by a similar project previously held in Aberdeen City.

3.5 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.

3.6 The full evaluation report is attached in **Appendix 1**.

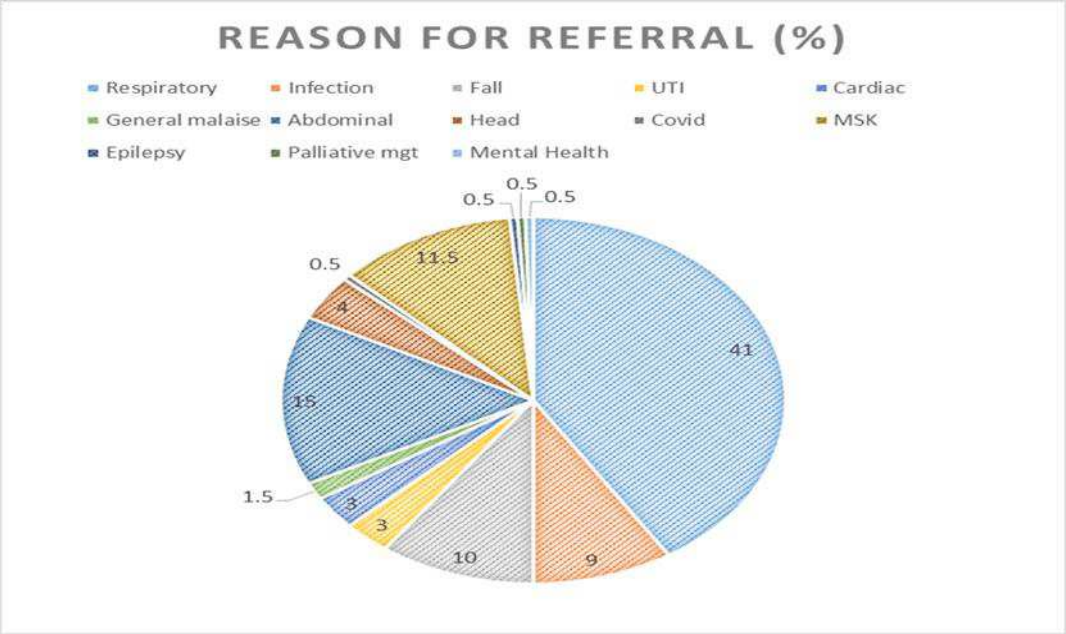
4. KEY MATTERS RELEVANT TO RECOMMENDATION

Visits overview

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

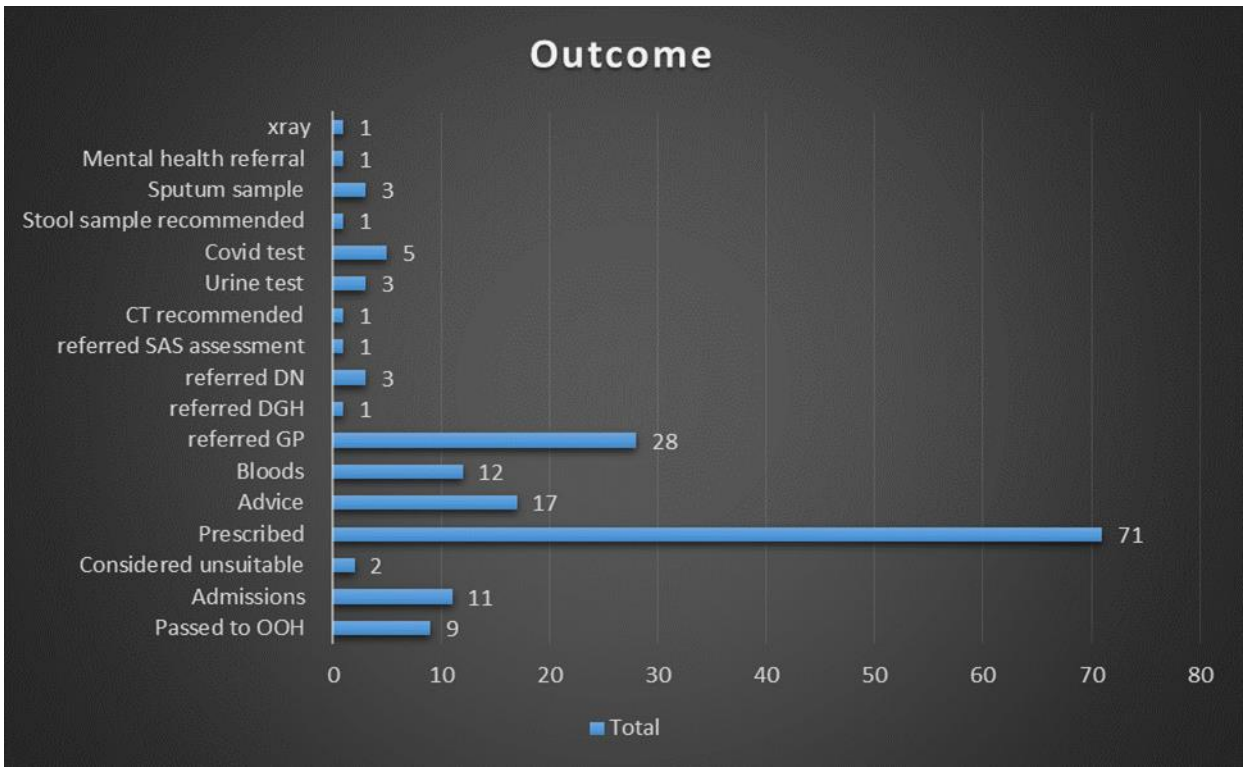
4.2 Average calls per week were 15, approximately three per day. From the referrals indicated, 57% had a chronic or long term condition exacerbating their symptoms.

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 of the project. Medication costs were also relatively low. There were six days in total that we could not run the service due to sickness and annual leave.

4.7 Average Costs per call:

- January £315
- February £436
- March £429

4.8 Costs were less than the anticipated overall expense. This is in part due to a reduced working day, staffing shortages and relying on less staff than planned and the lack of GP cover, particularly at the end of the test of change.

Initial Results:

4.9 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. 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 and full impact to be understood. 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.

4.10 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.

4.11 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.

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

4.13 The service was set up quickly with the use of volunteer existing GMED staff offering to cover the shifts. As the TOC 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.

5. FUTURE MODELLING

5.1 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.

6. 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

- Sean Coady, Head of Service, Health and Social Care Moray
- Dr Robert Lockhart, Primary Care Clinical Lead, Health and Social Care Moray
- Magda Polcik-Miniach, GMED Service Manager
- Dr Calum Leask Aberdeen City Evaluation Lead

- Moray GP practices
- Moray DUCS staff

7. CONCLUSION

7.1 The MIJB are asked to note the full evaluation report at Appendix 1 which contains recommendations and points for discussion.

Author of Report: Natalie Jeffery - Business Support Manager

Background Papers:

Ref: