Moray Daytime Unscheduled Care Service (DUCS)

Evaluation Report

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Key Points

- Given the short duration of this test of change, that was the consequence of being conceived through winter monies, coupled with staffing challenges in its delivery, all of the findings presented within must be interpreted with this context.

- It is feasible to develop and implement and unscheduled care service of this nature in a timely manner

- The value of an unscheduled care service was perceived variably across Practices, with some acknowledging the pressure this helped alleviate, whilst others did not feel this had much impact on their business.

- Pilot projects that are characterised by a short implementation time and reliant on a small cohort of staff to deliver the service may only result in a proportion of eligible Practices choosing to adapt their ways of working to fully test the approach.

- Such models may be more efficient for patients, but this comes at the expense of discontinuity of care.

- Future work would benefit from greater co-design of the service model with Practices to ensure the approach is congruent with their needs

- Adopting a multi-disciplinary approach to staffing such a model would help address staffing challenges and ensure the most effective use of resources

- Alternative delivery approaches could support greater relationship building between visiting teams and Practice teams, including adopting a hub and spoke model, or co-location.

Executive summary

Background

There is considerable pressure across the health and care system in Grampian. This pressure is particularly felt within General Practice. The unpredictability of the demand for unscheduled home visits during the day is becoming increasingly disruptive on an already stretched workforce. Therefore, it was felt there is a need to find further initiatives that supports Practices with this demand, and as such the within service was developed.

The purpose of this report is to evaluate the Moray Daytime Unscheduled Care Service (DUCS).

Method

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 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 Adastra to the peripatetic clinicians. 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.

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.

Results

Service delivery - There were a total of 131 visits between January 23rd 2023 to March 31st 2023. Respiratory symptoms were the most common reason for referral. Prescriptions were the most common outcome of visits.

Practice perspective - Practices provided an average satisfaction score for the service of 5.5/10. Positives reported included a more efficient service for patients; new clinicians providing a fresh perspective on patients; allowing practice staff to focus on other things; feeling supported knowing there was support available; and a straightforward referral process. Perceived negatives included workload not being reduced as anticipated; service unavailability due to staffing; reduced continuity of care with this model; perceptions that the model was inappropriate for the majority of (complex) home visits; and already managing their demand. Future recommendations included taking a multi-disciplinary team approach; ensuring better integration with existing Practice staff; and upskilling staff to deal with more complex conditions.

DUCS staff perspective – Staff who engaged in the evaluation had a mean satisfaction score of delivering the service as 6.3/10. Positives reported included a more efficient service for patients; feeling like they were making a difference; supporting professional development; and a simple approach to reduce pressure in primary care. Perceived negatives included a lack of continuity of care; service uptake leading to unused capacity; and challenges staffing the service. Future recommendations included implementing such models for longer; spending more time co-designing

services with Practices; refining the referral criteria for patient cohorts; developing a hybrid model to support both central and rural populations; and taking a multi-disciplinary approach.

Discussion and recommendations

Results indicate that it is feasible to implement such a model in Moray. However, changes would be required before recommending that this would be worthwhile to continue in its current guise. This is the case for several reasons, including: 1) the benefits of supporting Practices with this patient cohort was variable, a challenge that could be alleviated in the future through further co-design of such models with Practices; 2) staffing challenges and the short duration of the test meant Practices weren't willing to change how they worked, challenges that could be alleviated by adopted a more multi-disciplinary approach, and attempting to secure additional funding to run the pilot for a longer duration; 3) the delivery mode meant that relationships did not have the opportunity to develop between the DUCS team and Practices, a challenge that could be alleviated in the future by either adopting a longer test; a more systematic approach to relationship building between services; or an alternative delivery model that could see co-location or even integration of these services.

Background

There is considerable pressure across the health and care system in Grampian. This pressure is particularly felt within General Practice, with it being acknowledge both nationally and locally that its 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 is a need to find further initiatives that supports Practices with this demand, and as such the within service was developed.

The purpose of this report is to evaluate the Moray Daytime Unscheduled Care Service (DUCS).

Method

Moray context

Moray has a population of approximately 96,000. Some of this population is transient due to a large Armed Forces population. Elgin remains the largest town with over 25% of Moray's population centred there. Biggest employers are the NHS and Armed Forces.

GP recruitment is difficult as per the national picture. The population is growing older with majority of long term conditions being asthma, diabetes, some cancers. Problems in recruitment and retention overall are seeing the centralisation of some services. The three leading groups of causes of ill-health and early death in Moray are cancers, cardiovascular diseases and neurological disorders.[1] These groups of causes account for 50% of the total burden of health loss. The largest differences in burden - compared to Scotland - occur due to substance use disorders, digestive diseases and cancers.

Service model

The Moray Daytime Unscheduled Care Service (DUCS) was a test of change that comprised of an in-hours urgent care team, operating from a Monday-Friday, for a period of three months from January 23rd 2023 to March 31st 2023. Six posts were required to facilitate the test of change: 1 X GP, 2 X band 7 Advanced Nurse Practitioners, (ANP) 2 X Band 3 Drivers, 1x Band 3 admin dispatcher. Two 4x4 vehicles were available during the hours chosen: 1200-1800. Posts were employed by the Out Of Hours Primary Care service (GMED). These staff were already contracted bank GMED staff so impact on other services was deemed to be minimal. Rota participation was voluntary.

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 Adastra to the peripatetic clinicians. 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.

Reviews were made weekly with some shifts covered by a dispatcher, ANP and driver, depending on availability. This was considered sustainable in the long term. It was agreed the service's infancy that should the service be unable to run due to sickness or lack of staff availability, the service would be cancelled for that day.

The operational base chosen was a GMED out of hours base – The Oaks, in Elgin, which allowed for central Moray access. GMED staff were familiar with the layout and access of this building and the GMED vehicles were kept on site. Pharmacy/ medication was provided using additional GMED pharmacy boxes. Mileage and medication usage was recorded. Total Costings estimated for the 3 month period were £117,649.44. Communication was via the Business manager.

Data collection and analysis

Service descriptive data

Following each visit, the clinicians recorded a variety of data on Adastra. This included: symptoms; expected versus actual outcome; demographic information; clinical reason for referral. A separate

[1] ScotPHO
https://www.scotpho.org.uk/comparative-health/burden-of-disease/local-area-burden-of-disease/

spreadsheet was kept for manual completion and additional notes, allowing for agile decision-making on a weekly basis based upon what practices were using the service and for what reasons; locality bias; demographic information;, recognition of known recent delayed discharges or community crisis persons; as well as long term condition monitoring. Costs were monitored weekly.

General Practice experience of service

All Practices were invited to engage in a focus group to describe their experience of engaging with the DUCS service. Practices that were unable to accommodate this request were offered the opportunity to document their experiences in written format. Focus groups were semi-structured in nature, and explored the Practices perceptions of positives and potential improvements to the service, from the perspective of patients, staff and Practice working. Focus groups were held via Microsoft Teams for a maximum of one hour. Fieldnotes were taken during the discussions and then sense-checked with participants to ensure that the data captured was representative of their view. Data collected from all Practices were combined and analysed thematically, providing key themes and subthemes. Discussions were also audio recorded for the purposes of extracting quotes that exemplified the essence of each theme and subtheme. Participation was voluntary and anonymised.

DUCS Staff experience of delivering service

The same process was undertaken separately for the staff who delivered the DUCS service as described above.

Results

GP practice information

The characteristics of the Practices within Moray are visible below:

Table 1	Practice population	No GP	Male	Female
Ardach Health Centre	**8587**	8	4242	4345
Seafield & Cullen Medical Centre	**6906**	4	3395	3511
Linkwood Medical	**12207**	9	6004	6203
Fochabers Medical Practice	**4485**	2	2172	2313
Moray Coast Medical Practice	**10179**	10	4887	5292
The Maryhill Group Practice	**22250**	12	10871	11379
Varis Medical Practice	**8250**	8	3977	4273
Culbin Medical Practice	**8268**	8	4021	4247
Keith Medical Group	**7257**	5	3597	3660
Aberlour Health Centre	**3103**	1	1569	1534
Rinnes Medical Group	**3121**	6	1540	1581
Glenlivet Medical Practice	**558**	8	296	262

Patients in 15% most deprived areas	Quintile 1 - Most Deprived	Quintile 2	Quintile 3	Quintile 4	Quintile 5 - Least Deprived	Unassigned	Over a third of patients in Quintile 1?		
0%	0	1,342	5,368	2,164	0	1	×	32586	Ardach Health Centre
0%	0	563	3,764	2,243	0	3	×	32622	Seafield & Cullen Medical Centre
5%	995	2,490	2,677	4,633	1,241	17	×	32707	Linkwood Medical
0%	1	632	1,127	2,665	1	1	×	32750	Fochabers Medical Practice
0%	43	1,497	1,708	3,995	2,906	6	×	32764	Moray Coast Medical Practice
3%	1,090	3,803	4,574	8,886	3,667	36	×	32779	The Maryhill Group Practice
0%	249	1,130	3,318	2,430	987	14	×	32801	Varis Medical Practice
0%	275	1,157	3,370	2,415	1,006	16	×	32815	Culbin Medical Practice
0%	0	1,926	3,671	1,691	0	2	×	32904	Keith Medical Group
0%	2	15	450	2,828	8	5	×	33004	Aberlour Health Centre
0%	1	0	1,672	1,286	0	2	×	33057	Rinnes Medical Group
0%	0	1	501	74	1	1	×	33061	Glenlivet Medical Practice

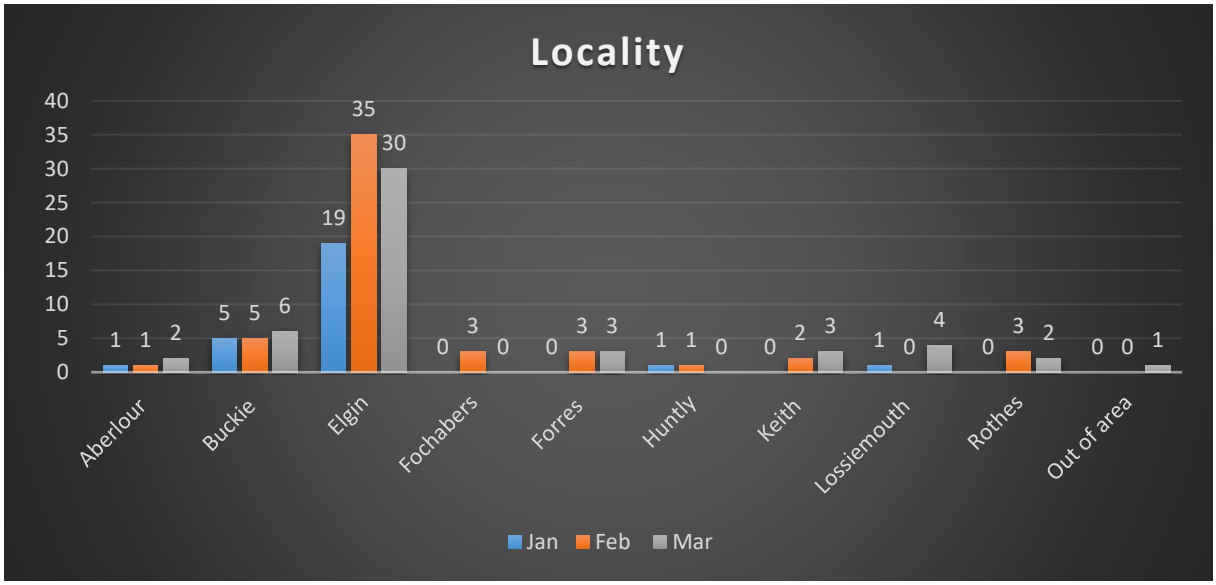
Name	Urban 1 - Large Urban Areas	Urban 2 - Other Urban Areas	Urban 3 - Accessible Small Towns	Urban 4 - Remote Small Towns	Urban 5 - Very Remote Small Towns	Urban 6 - Accessible Rural	Urban 7 - Remote Rural	Urban 8 - Very Remote Rural
Ardach Health Centre	0	0	0	6,189	0	1,141	1,544	0
Seafield & Cullen Medical Centre	0	0	0	2,945	0	704	2,921	0
Linkwood Medical	0	8,876	2	0	0	3,157	1	0
Fochabers Medical Practice	0	10	0	8	0	4,397	11	0
Moray Coast Medical Practice	2	788	5,722	0	0	3,636	1	0
The Maryhill Group Practice	0	13,941	891	0	0	7,127	61	0
Varis Medical Practice	0	4,655	2	0	0	3,457	0	0
Culbin Medical Practice	0	4,916	0	0	0	3,307	0	0
Keith Medical Group	0	0	0	4,561	0	803	1,924	0
Aberlour Health Centre	0	29	1	9	0	2,256	1,007	1
Rinnes Medical Group	0	1	0	2	0	331	2,591	34
Glenlivet Medical Practice	0	2	0	0	0	29	513	33

Visits overview

By Locality:

Town	%	Jan	Feb	Mar	Total
Aberlour	3	1	1	2	4
Buckie	12	5	5	6	16
Elgin	64	19	35	30	84
Fochabers	2	0	3	0	3
Forres	5	0	3	3	6
Huntly	1.5	1	1	0	2
Keith	4	0	2	3	5
Lossiemouth	4	1	0	4	5
Rothes	4	0	3	2	5
Out of area	0.5	0	0	1	1
Totals	100	27	53	51	131

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 did use the service.



Sex of patient visits by month

	Jan	Feb	Mar
Female	13	32	36
Male	14	21	15
Totals	27	53	51

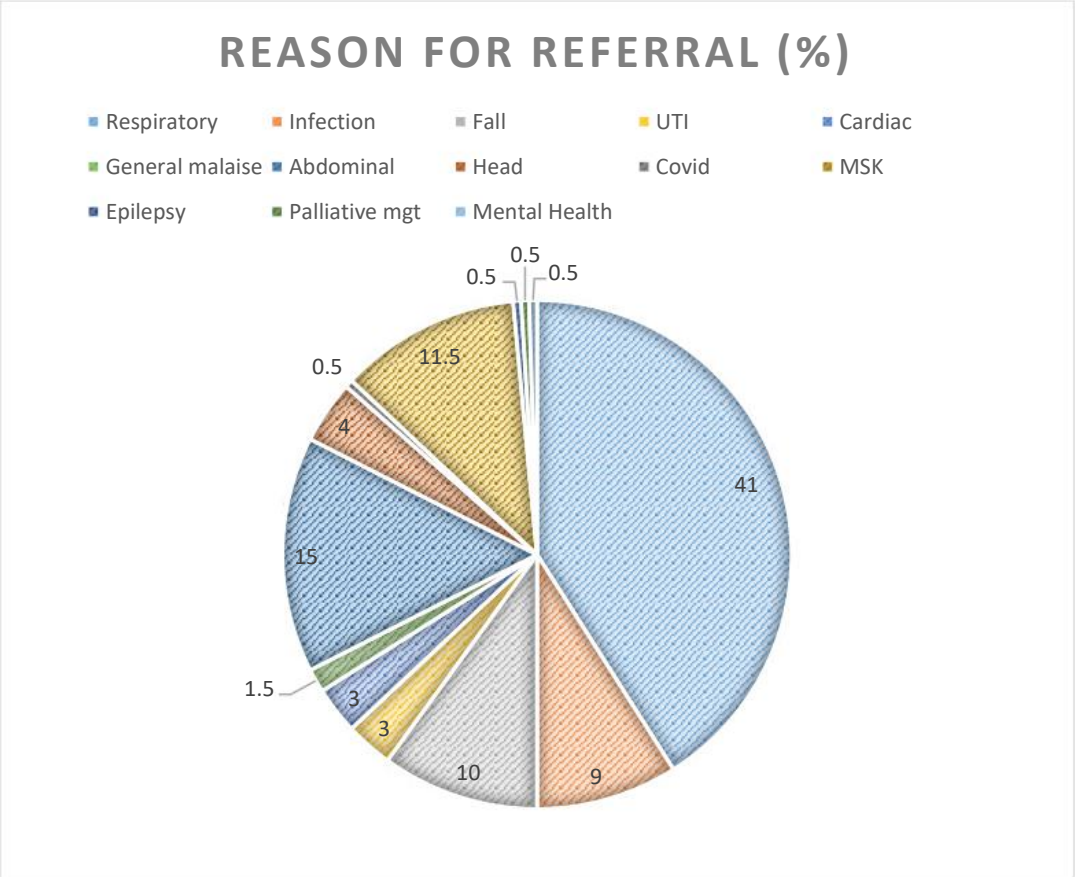
NB: This reflects a female to male ratio of 62:38 which is generally reflective of practice population demographics.

Average costs per call £	**Jan**	**Feb**	**Mar**	**Overall average**
	315	436	429	393.3333

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.

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.

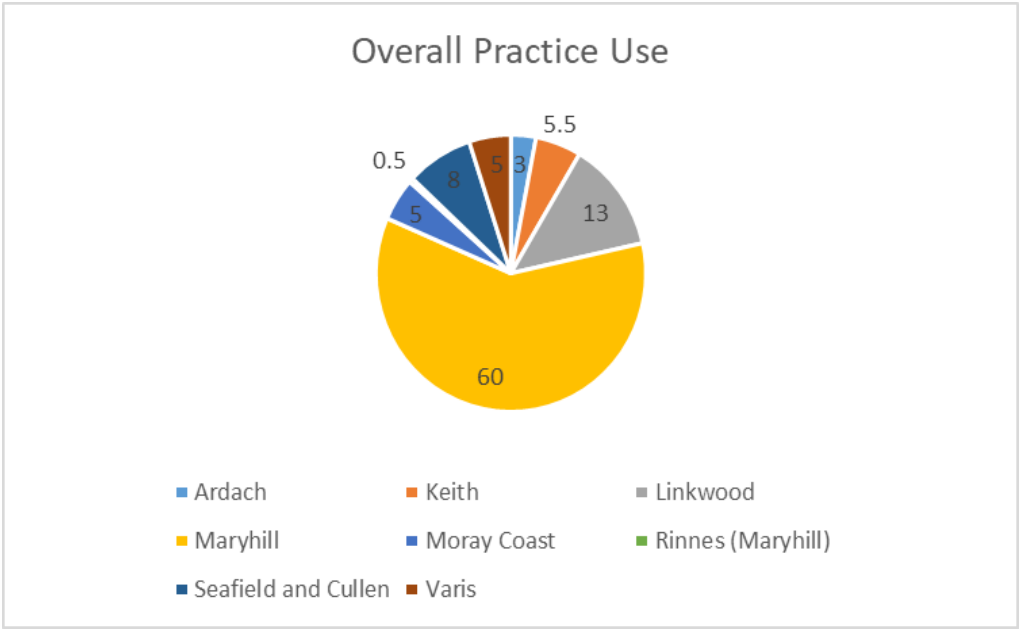
Symptom	**Jan**	**Feb**	**Mar**
Respiratory	12	24	17
Infection	3	5	4
Fall	2	4	7
UTI	1	1	2
Cardiac	0	2	2
General malaise	0	0	2
Abdominal	4	7	8
Head	0	2	3
Covid	0	0	1
MSK	4	8	3
Epilepsy	0	0	1
Palliative mgt	1	0	0
Mental Health	0	0	1
Totals	27	53	51



GP practice usage of service

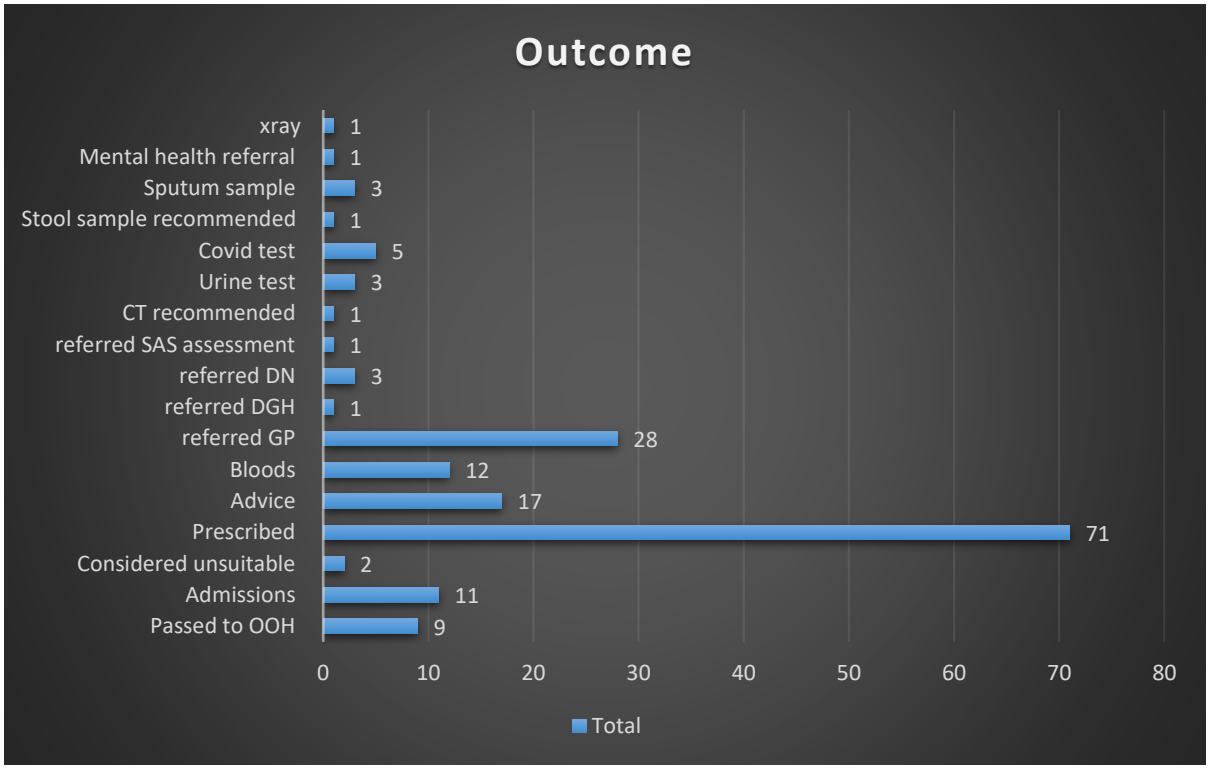
Figure 1. Overview of visits per month by practice. NB: As analysis is of the first six months of implementation, only data up until 31st March is presented.

Practices	Jan	Feb	Mar	Totals
Ardach	2	0	2	4
Keith	1	3	3	7
Linkwood	5	10	2	17
Maryhill	16	33	30	79
Moray Coast	0	0	6	6
Rinnes (Maryhill)	0	1	0	1
Seafield and Cullen	3	3	5	11
Varis	0	3	3	6
Totals	27	53	51	131



Outcome of visits

Outcome	Total	%
Passed to OOH	9	5
Admissions	11	7.3
Considered unsuitable	2	0.7
Prescribed	71	42
Advice	17	10
Bloods	12	7
referred GP	28	16
referred DGH	1	0.5
referred DN	3	2
referred SAS assessment	1	0.5
CT recommended	1	0.5
Urine test	3	2
Covid test	5	3
Stool sample recommended	1	0.5
Sputum sample	3	2
Mental health referral	1	0.5
xray	1	0.5



Costings

Expected:

	DailyCover		Weekly Cover	Weekly Cost (incl on cost)	4 weeks test of change cost
ANP	0800-1600	7.5	37.5	£ 1,089.67	£ 4,358.68
	1000-1800	7.5	37.5	£ 1,089.67	£ 4,358.68
GP	0800-1800	10	50	£ 5,388.00	£ 21,552.00
Logistics					
Car Lease - 41% of lease	*calculated for 2 cars			£ 89.45	£ 357.79
Fuel	*£10 per day /underestimate			£ 50.00	£ 200.00
B2 Driver	0800-1600	7.5	37.5	£ 540.85	£ 2,163.38
B2 Driver	1000-1800	7.5	37.5	£ 540.85	£ 2,163.38
B3 Admin	0800-1800	10	50	£ 790.67	£ 3,162.67
Adastra					
Licence				£ 100.29	£ 401.17
Toughbook				£ 124.68	£ 498.73
Sundries	*normally calculated on what was used basis				
Medication	*normally calculated on what was used basis				
			Totals	£ 9,804.12	£ 39,216.48

Actual Costs

	Shift	Hours per day	Hours per week	Daily	Weekly	Actual 44 days	Costs
ANP	1200-1800	6	30	174.03	870.15	8353.44	8353.44
	1300-1900	6	30	174.03	870.15	7831.35	7831.35
GP	1200-1800	6	30	646.56	3232.8	16164	16164
Logistics							
Car Lease 41%	for 2 cars			17.89	89.45		769.27
Fuel	£10 per day under estimate			10	50		
Mileage						1386 miles = 320.34	320.84
						Average cost of diesel 0.19 per mile	
b2 driver	1200-1800		30	86.54	432.6	3721.22	3721.22
b2 driver	1300-1900		30	86.54	432.6	3721.22	3721.22
b3 admin	1200-1700	5	15		237.2		1186
Ad Astra							
Licence					100.29		1002.9
Toughbook					124.68		1246.7
Sundries						35.71	35.71
Medication						75.47	75.47
							44428.12

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. 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. Actual cost per call was therefore £339.15.

GP experience

The characteristics of Practices that chose to engage with this evaluation are visible below:

Table x

Practice number	Respondents	Mode of response	Satisfaction score (of Practice)	Recommend? (Y/N)
1	GP x4 Practice Manager x1 Advanced Paramedic x1 Advanced Nurse Practitioner x1	Focus group	5.5	Y=3/7 N=4.7
2	GP x1	Focus group	7	Y
3	GP x1	Focus group	6.5	Y (on the right day for the right patient)
4	Practice Manager x1	Written feedback	3	N/A
5	Practice Manager x1	Written feedback	N/A	N/A

Project Benefits

Patients

Efficiency - It was felt that the service was more efficient for patients, particularly when practice staff may be busy whereas DUCs was a dedicated service that could see the patient straight away:

"Patients were phoning up and they were getting assessed pretty promptly and the clinical plans seemed sensible."

Patient Management - Due to an increased demand within primary care, the new service may help to manage patient demand and expectations:

"May be brought into focus for the patients, that everything's not normal at the moment you've always got a new service being developed to gives them an idea that maybe there are issues with general practice."

Some individuals reported they were happy with the clinical practice the service provided. They also noted that the new service provided a fresh perspective in terms of patient management especially with long-standing cases:

"Patients who we've been in a lot to see and we'll take a bit of a break somebody else can put some fresh eyes on it."

Staff

Efficiency - Practice staff who would have previously conducted the home visits could use their time to focus on other priorities within the practice. It was also discussed how seeing those with minor illnesses away from the Practice may prevent an unnecessary full GP consult:

"It was a double win because for the time that, those staff weren't out doing these visits, they tended to stay in the practice, helping with the other ongoing work… it had more of an impact than the numbers would suggest."

Staff Support - The staff mentioned that they felt supported, knowing there was another resource in DUCS, which they could use, particularly on days with increased workload. Some staff also expressed that they felt there was a good supportive relationship between the teams:

"If you have slightly less resources or you're under a huge workload. There's a benefit in knowing that there is another resource available to you."

Practice Working

Support- Staff felt having an extra resource particularly later in the day, when they may be less staff and prior to the 'Out of Hours' team starting was beneficial to practice working:

"The benefits for the practice I found was later on in the day and there was limited staff in the building and somebody needed a house call…that was helpful."

Efficiency- Individuals commented that the process for referring a patient to the DUCS team was quick and straightforward:

"I think it was all positive experiences. The referral process was very easy."

Appropriateness- Practice staff felt that this service was helpful for those with minor illnesses as rather than cases who are already known to the practice. In some cases the staff felt it was advantageous for those within minor illnesses to be assessed away from the practice as to free up practice consult time:

"Ideally suited to stand alone encounters; pneumonia, pyelonephritis, acute abdomen, etc"
[*provided via written feedback]*

Project Drawbacks

Patients

Efficiency- Some staff reported that the service added an unnecessary tier to the patient pathway which may contribute to longer assessment/treatment times:

"Another tier of management... for no real reason. It's not in the patient's best interest"

Continuity of Care- The feedback gathered highlighted that practice staff felt it was more beneficial for them to continue seeing patients as they recognise the importance of longer-term support:

"The patient still needs an actual management plan rather than this will see them through till the morning."

Patient Education- Some thought that the new service was an additional change for patients to deal which could lead to confusion about the service:

"Drawback to patients are being another change. They were phoning up and thinking well, phoned the practice but someone came and saw me. They don't understand the complexity."

Staff

Staff Time- Some of the Staff who fed back about the service felt GP workloads were not reduced as hoped. The staff felt it was more appropriate to refer simple cases which was felt to be a small proportion of their home visits:

"The overall aim was to reduce GP workload while it didn't because the people that they were going to see were simple, straightforward things... so it didn't reduce workloads."

Patient Management- Due to the DUCS team not being in-house, it made the logistics of communicating challenging on occasion, and this was from both staff and patient perspective. It was also noted that this set up can make it difficult to highlight who is responsible for follow up that may be required for patients seen:

"The DUCS team would then go and see them and there is in that gap where you didn't really know what happened. That presented a few real problems, so the patients didn't have any real point of contact either."

Availability- Practices reported that on occasions, the DUCS service was unavailable due to staffing issues resulting in the support not being there:

"The frustrating thing was thinking that you were referring a patient and then actually, they had no cover that day."

Practice

Efficiency- Some practices thought a more direct booking system would be beneficial as the current referral process was not efficient costing staff and patient's time. It was also felt that some practices felt disadvantaged about the service availability due to the geographical location:

"The administrative burden could be easier - a mechanism for us to book straight into appointments, usually triaged by admin/clinical at practice end, this has been like a second triage - too many steps for patients & referring clinicians"

Patient Management- It was felt that if patient records were accessible to the DUCS team, this could help create a safer, more streamlined patient pathway:

"The DUCs service, like GP OOH does not have access to electronic records – this is unsafe and does not provide continuity of care" [provided via written feedback]

Availability- Practices expressed there was instances where the service was unavailable and because of that didn't change their working ways. Other practices reported that they didn't want to keep referring and take up all the service capacity:

"Emails coming and saying that there is no DUCS service today... it wouldn't be reliable enough for us to go changing our service model."

Appropriateness- Staff commented that the service was not always appropriate for all patient cohorts. Some felt more comfortable seeing those with long term more complex conditions themselves, as practice staff will already know the patient's history and be able to put a more structured management plan in place compared to the DUCS team:

"I guess it felt like it was quite a narrow, slightly limited remit and those requiring a home visit in primary care is usually quite complex...ideally if it's someone who's complex with multimorbidity, then actually the usual GP is more appropriate"

Some practices felt the service was not as beneficial to them as others due to existing resource/ teams that able them to carry out home visits effectively:

"We cope well with the home visits as it is, there is the demand for home visits which is usually appropriate"

Future Recommendations

Delivery Model- The most commonly described improvement that could be made moving forward was adopting more of a multi-disciplinary approach, bringing in a variety of different staff with a broad range of expertise would ensure that limited resources were used in the most effective way:

"It would be amazing if there was a resource where you maybe had geriatrician … social worker, maybe another tier of physio who when you've got these patients who are on the brink of going into hospital … almost a hospital outreach into the community".

Some individuals thought by using the budget to integrate the resource within the practice would make the service more streamlined in-terms of staffing and communication:

"Overall I think that strengthening the general practice team is the best way forward, I think that we have lots of different services on the periphery becoming involved...but at the end of the day, it feeds back to the practice and the buck stops with us."

Facilitators- It was discussed, going forward, that stronger communication links would help integrate the service into practices. Communication, in-terms of the patient pathway and agreement of roles and responsibilities between the service and the practice:

"A conversation before the visit... if there are any problems, I'll phone when you're down there, you can get that visit done... save a big amount of time, but the doctor needs to be involved in that process."

It was discussed the need for the service within Moray as some practices already have an established unscheduled care team within the practice. It was suggested that an earlier GP OOH start time may help relieve the pressure within practices:

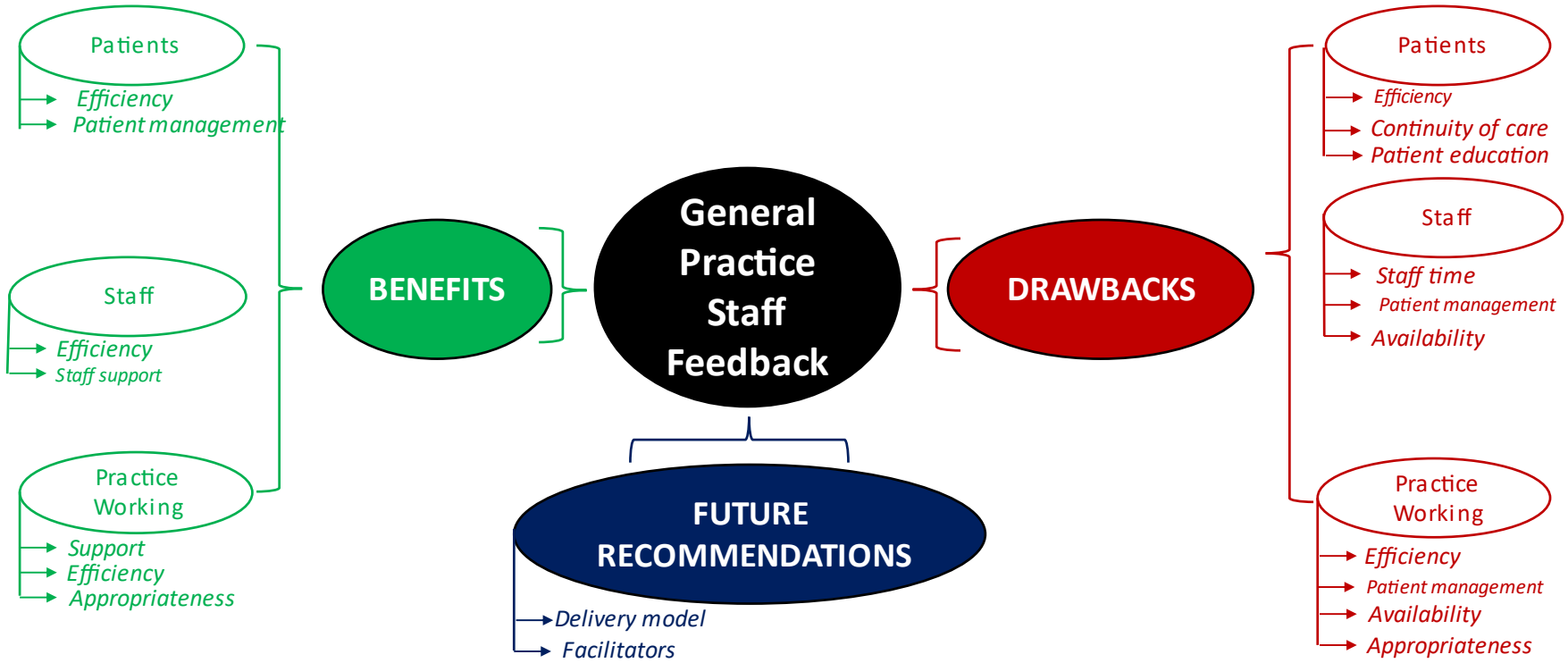
"We come from large practices where they've got a well-established unscheduled care team, much the same as other practices in Moray."

One of the practices mentioned that it would be advantageous to upskill already existing staff and increase efforts to recruit GPs and ANPs to Moray practices. Having more higher skilled staff would help maintain a home visiting service which may help with continuity of care:

[Improved skill set in DN and Community Nursing team would also be helpful. Both of the above options offer continuity which DUCs would not.] Provided via written feedback

From the practices, some felt that because the service was short term, the impact was not as significant as it may be if a longer-term plan was put in place:

"I guess we knew it was a short-term project so it wasn't like we made any changes"


General Practice Staff Feedback
BENEFITS
Patients
Efficiency
Patient management
Staff
Efficiency
Staff support
Practice Working
Support
Efficiency
Appropriateness
DRAWBACKS
Patients
Efficiency
Continuity of care
Patient education
Staff
Staff time
Patient management
Availability
Practice Working
Efficiency
Patient management
Availability
Appropriateness
FUTURE RECOMMENDATIONS
Delivery model
Facilitators

DUCS Staff experience

Two ANP's and one GP attended the session. They had a combined 53 years experience in their roles. Their average satisfaction score of delivering the DUCS service was 6.3/10.

Project benefits

Patients

Appropriateness - It was felt that during the initial phases of the service being live, the right cohort of individuals were being cared for:

"I think [in the beginning] … the patients we seen were very appropriate"

Patient satisfaction - The staff commented that they regularly received recognition from users of the service and their significant others:

"Huge positive feedback from them … and to the point that a few of them actually said, can we phone you directly next time?!"

Efficiency - It was also mentioned that there could be occasions whereby patients who required a home visit would be seen in a more timely manner by the DUCS team when compared to the other challenges General Practice staff would have to deal with at the same time:

"I think it was just probably more efficient because we [DUCS Team] had more time. You know, the visits came in, we were straight out we there's maybe, you know, in the practice there's maybe a delay of a few hours while they see all the centres they've to see or the triage"

Staff

Staff satisfaction – Respondents acknowledged that the initial experience of delivering the service was a positive one, particularly in instances where they felt they could really make a difference to patients:

"To start, but there was a lot of kind of excitement … there was that kind of sick patients who needed admitted and ones that took quite a bit of time, which was good for us because then you really felt that you were helping and you got good feedback from the practice the next day about … how you'd handled it … and the family had given thanks … So that was kind of nice and that kind of inspired you."

Professional development – It was felt that this type of service model would be one valuable strategy to support the advancement of staff by giving them more experience in a different type of service delivery:

"We've always thought for years and years and years that we could do more to either make a progression that allows you to really build the widest possible range of skills and confidence."

Flexibility – It was also thought that the concept might be attractive, particularly to individuals who wish for a balance between working through the day and then into the evenings, allowing them to better manage personal commitments:

"I thought one aspect of this might be that ANP is working in daytime practice, who had previously worked in GMED [out of hours service]. I think, ooh, this is a model I could get involved with. So if I could do some shifts during the day and then do some out of hours work, that might be a really nice."

Practice working

Positive feedback – The staff mentioned the value of communication with Practices that they visited patients on behalf of, particularly when they were satisfied with the care that had been provided:

"You really felt that you were helping and you got good feedback from the practice the next day about how you'd handled it"

Reduced demand – It was felt that the service itself was a simple way to try and decrease the pressures that were being felt in General Practice:

"We were providing a solution to was that the Practices were overwhelmed with demand and the worst of the demand came from unscheduled care and the worst of the unscheduled care demand came from having to go and do home visits when your team was depleted or you just couldn't do it … all you need to do is lift the phone and talk to me or [DUCS Staff] and we're going to do the home visit"

Rapid implementation – Individuals also reflected on how fast they were able to establish the service from the initial conception of the model, suggesting that similar approaches could be adopted in the future to support Practices in a timely manner:

"I guess in a practical sense, what we showed is you can do it very easily. You can pop it up and all the practicalities work and you can do it"

Project drawbacks

Patients

Referral appropriateness – Whilst it was felt that the patients that were visited during the initial phases were largely appropriate, there was a perception that this situation deteriorated over time:

"What we thought we were going to see and we ended up going to see some ended up seeing pretty sick people and admitting them directly to hospital … and then the mental health ones that we weren't to deal with"

Care discontinuity – One of the unintended consequences of such a model was that it would result in different clinicians visiting patients, perhaps more so than if the staff from the Practice were doing so:

"You can do part of the part of what the practice does, but you don't do the continuity of care"

Staff

Unused capacity – Respondents noted that whilst General Practice colleagues were struggling with demand on their services, this appeared to not translate into DUCS being fully utilised, and queries were raised as to why this was the case:

"It became clear quite early on that something a bit weird going on here. So why? Why if that was the storyline [Practices struggling], why do the practices not just jump on it? You'd think … that we would have been overwhelmed … we could have been absolutely swamped … the opposite occurred"

Perceived bias – One reason hypothesised for this unused capacity was a sense that Practices felt there was bias in how the service was being delivered. Respondents provided an example of where a more rural Practice patient could not be visited given the time of day and how this was perceived by the Practice staff:

"She [Practice Staff member] asked me if [patient visit] it had been local would we have gone, which I had said 'yeah, because of the time factor we could'. So she then said, 'well, that just shows me that

there's prejudice against my practice' … And I said 'there's nothing to do here with prejudice against any practice, it's purely … a time factor and [we] wouldn't have the capacity."

Working patterns – The shifts that were offered to staff were thought not to be the most appropriate to maximise uptake of staffing of the service:

"It would be worth doing a bit of digging and asking around a shift patterns that might have actually made that happen [better uptake], because I know if you only you were saying we could have started earlier in the day and from childcare point of view and these kind of factors which we didn't have a chance in such a short test of change to work that out. But I just wondered if that was why?"

Staffing – As a potential consequence to the working patterns that were offered, there were challenges throughout the test of change, whereby the service did not operate on some days and on others, patient visits had to be rejected due to reduced capacity:

"I'm sorry that we couldn't do the call because of the staffing at the time of the call."

Practice working

Service uptake – The DUCS staff felt that the service could have been utilised more by Practices, with suspicion that there could be numerous reasons as to why this was the case. One rationale hypothesised was, should such a model be successful, a question as to where this would leave the roles of particular staff within Practice:

"I wondered if part of that is that they [Practice Nurse Practitioners] were worried. What would happen to their jobs? if they're [DUCS] doing our visits and our minor illness appointments, then what are we [Practice Nurse Practitioners] gonna be doing?"

Perceived usage – Examples were also provided of potential confusion between staff in Practices about how much the DUCS was being utilised, which was felt could have added to complications:

"Their practice manager was told by the Advanced Nurse practitioner that they were booking the patients in, but they didn't … the practice manager thought that they had … used up 15 slots of face to face, but in actual fact they used three with one did not attend."

Future recommendations

Time

Given the short duration of the test of change, it was hypothesised that many of the challenges described here may have settled should it have run for longer:

"The West visits in Aberdeen [a similar test of change] going on for a long time now … I wonder whether that had gone through the similar kind of difficulties and then settled into appropriate referrals over time … and whether we just didn't really go long enough."

Engagement

It was felt that moving forward, future services could be further enhanced by being co-designed with Practices and linking in closer with them on a regular basis to ensure it fits their needs:

"I think going forward … we would need to concentrate possibly more for continuity [of care] and more interaction with the Practices, so there's a bit more joined up working between this service and the GP practices."

It was also recognised however that the patients' perspective was also important to integrate:

"We cannot just look at what we want and what the GP's want. There's a patient at the end of this that we're all trying to provide a service for. Therefore, I think their views and opinions count as well."

Delivery model

Patient cohort – It was recognised that further work would be required for future models to make sure the referral criteria was the most appropriate to make the biggest impact:

"We got messages, quite strong messages from certain GPs: 'Well, that's not that's not what we need. What we need is a minor illness service.'"

Work rotation – It was also felt that future models should provide greater flexibility in the hours that staff can work to help maximise the availability:

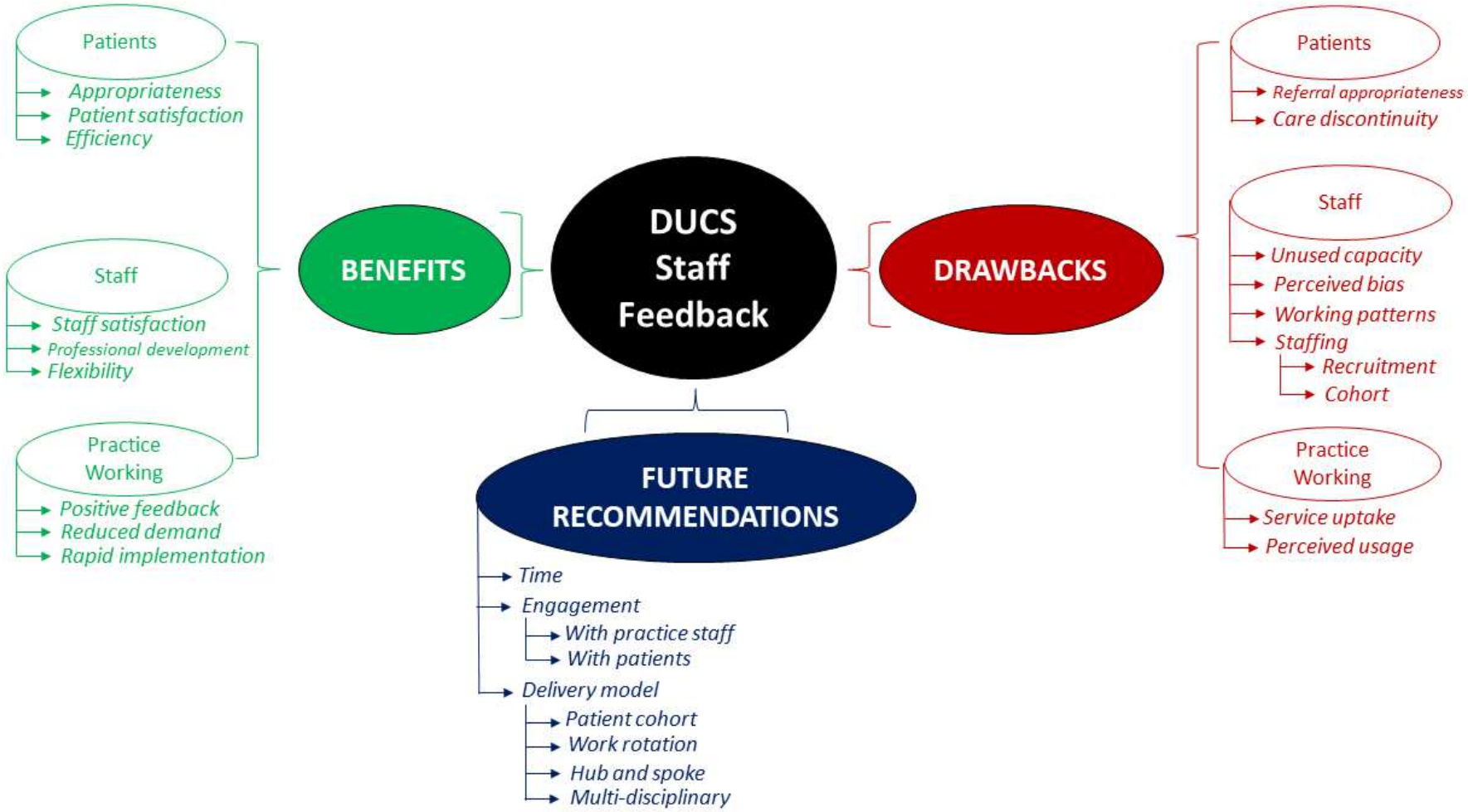
"It would be worth doing a bit of digging and asking around a shift patterns that might have actually made that happen, because I know if you only were saying we could have started earlier in the day and from childcare point of view and these kind of factors which we didn't have a chance in such a short test of change to work that out. But I just wondered if that was why [there were challenges getting staff to run the service]?"

Hub and spoke – Respondents were unanimous that in attempting to meet the needs of both urban and rural populations, a form of hub and spoke model would be a more effective strategy:

"You might have one hub in Aberdeen, and one in Moray and one in the Shire where you could bring together staff from practices and from people who wanted to do it as an extra, from and recruit staff in and you would run a minor illness kind of service. And you'd also have a home visiting hub based on the DUCS kind of model."

Multi-disciplinary – It was mentioned that the staff who run the service could be expanded upon to try and make the most effective use of resources. It was also acknowledged that having a GP deliver the service did make it more expensive than if only ANPs were used, but also that this additional cost was not necessary:

"Doesn't need to have the GP component in it at all … I think and it would make it far more cost effective service as well [if GPs did not deliver the service"


DUCS Staff Feedback
BENEFITS
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Efficiency
Staff
Staff satisfaction
Professional development
Flexibility
Practice Working
Positive feedback
Reduced demand
Rapid implementation
DRAWBACKS
Patients
Referral appropriateness
Care discontinuity
Staff
Unused capacity
Perceived bias
Working patterns
Staffing
Recruitment
Cohort
Practice Working
Service uptake
Perceived usage
FUTURE RECOMMENDATIONS
Time
Engagement
With practice staff
With patients
Delivery model
Patient cohort
Work rotation
Hub and spoke
Multi-disciplinary

Discussion and recommendations

The purpose of this report is to evaluate the Daytime Unscheduled Care Service in Moray, whereby General Practices could have home visits for patients undertaken by the DUCS team on their behalf. This was thought to be an initiative that could be useful to support Practices by reducing their demand, particularly given the rurality of the area and subsequent travel time to patients' homes, and has shown promise in other areas of Grampian previously, such as the West Visiting Service in Aberdeen City.

The results indicate that it is feasible to implement an unscheduled care home visiting service in Moray. The model was able to be established and implemented at a quick pace, with individuals generally satisfied that the process for referring into the service, in addition to delivering the service, was straightforward. However, changes would be required before recommending that this would be worthwhile to continue in its current guise. This is the case for several reasons, including:

Patient cohort - the benefits of supporting Practices with this patient cohort appeared to be variable. Some commented that this was helpful to how they worked beyond a simple count of the number of visits undertaken, whilst other practices felt that it was only appropriate to refer in a small proportion of their home visits, thus feeling it did not have a big impact on their workload. There was a general perception that this service was deemed inappropriate for patients with complex needs, with some Practices commenting that this cohort accounted for the majority of their unscheduled visiting demand. These challenges could be alleviated in the future through co-design of such models with the Practices prior to implementation, however within this pilot, it was not possible to do so given the short timescales between funding allocation and requirement to spend the funding.

Staffing challenges – There were several instances whereby the service was unable to run given challenges getting staff to volunteer on the rota, and on occasions having to reject referrals to more rural practices when staffing was reduced. This meant that some Practices were unwilling to change how they worked as it was not deemed viable, a point reinforced given the short duration of the test of change. Both DUCS staff and Practice staff thought that adopted more of a multi-disciplinary approach could be one strategy to not just address these issues, but also ensure that the limited compliment of staff within the moray system were used in the most effective and efficient way.

Delivery mode – Having the DUCS team based remotely, coupled with the short duration of the pilot, meant that relationships did not have the opportunity to develop between the DUCS team and Practices. Further, the concept of bias was raised from both these staff groups, with an acknowledgement that the centralised model of this meant that there could be occasions whereby, due to the time of day requests came in, central Practices could be favoured over more rural Practices. These challenges could be alleviated through exploring alternative models of delivery that could provide a greater opportunity for closer working between the teams, including a hub and spoke model (whereby the DUCS team could be based within Practices), or the team could be diffused within Practices as a further integrative step. This co-location would not be a mandatory requirement, however in such circumstances a more systematic and deliberate approach to relationship building over time would be warranted.

Limitations - There are some limitations that require acknowledgement. Most importantly, this test of change ran for a short duration of three months. This means that all of the findings within may not necessarily be representative should the evaluation had taken place at a later stage once the service was allowed to be more embedded into the moray health and care system, however funding constraints meant this was not possible. Second, resource and time constraints did not allow for

feedback to be gathered directly from patients, however both the data from the DUCS staff and Practice staff indicated that this was an efficient model of care and that the care provided was acceptable.

Acknowledgements

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