NHS
Royal Devon and Exeter
NHS Foundation Trust

Castle Place Practice
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Primary Care

- 90% patient contact in NHS is with Primary Care
- General Practice Changing and Challenged
  - Pressure of rising demand, aging population, complexity of health
  - Decline in number of GPs, and part-time working patterns of GPs
- Current Primary Care Access
  - Varies per area, difficulty of appointments with own GP or any GP
  - Being addressed locally as it arises in different ways
- Continuity of Care Vs Urgent Episodical Cases
  - Own GP continuity still regarded as most effective for LTC patients
  - Any GP or other healthcare practitioner roles are developing depending on patients' presenting issue
  - Improving access 8-8 by end of 2018 across Devon adds to challenges

One Practice Perspective-part of Tiverton population

- **Castle Place Practice – access to GPs**
  - Currently excellent, but not experienced everywhere in Devon
  - Not complacent, can't stand still and do nothing
  - Potentially fragile, given traditional reliance on currently reducing workforce
- **Key to Future – Collaborative working across a place**
  - Work with patients, health, social, community, voluntary, place local services
  - Collaborate to set and manage expectations, prioritise need, design solutions together
- **Castle Place Practice- approached RD&E**
  - RD&E are the acute, community and social care* provider in Eastern Devon
  - January 2018 Castle Place Practice joined this collaboration-start of the journey
- **Castle Place Practice –approached Tiverton Health and Well-being Forum**
  - Raise awareness, better engage, navigate, signpost and expand to social prescribing
  - Tiverton Community Conversation (27.03.2018) –bring together active Tiverton organisations
  - What do we do well; what are the gaps/needs; work more collaboratively to ensure we are an active, smartly resourced and connected community
- **Technology**
  - Pivotal to future service provision
  - Pro-active prevention work

Winter 2017/2018

- SPOA (Single Point of Access)/ MTU – Service is good
  - SPOA –Resources for community care are improving but naturally a finite resource
- Discharge/blockage
  - GP involvement is post discharge – We aim to work differently in future
- Liaison nurses /GP dynamically linked to complex care team
  - Currently multi-agency and patient own GP focused
  - Aim for integrated and more urgent response by same day service. Prior to this point – be more proactive and use community connections to identify and support vulnerable patients earlier - link to Tiverton Community Conversation
- This winter?
  - Difficult flu year in some areas
  - Generally positive
  - CASE STUDY
  - Shortage of district nurses at points put some pressure on the system

NOTE – Advise to seek official views of LMC, CCG & RDE

CASE STUDY– 90 year old

- History of occasional falls osteoporosis, hypertension
- Lives alone and uses stick, family in same town
- Social housing 2nd floor flat, no lift
- No care package
- Following a Fall
- Rapid Response Try to Keep Home
- Admission for medical needs only
- Discharge facilitated by Rapid Response
- Interventions in place to prevent further falls.

UC- Urgent Care
RR – Rapid Response via Single Point of Access (SPOA)
PM – Paramedic
GP – Doctor
CT – CT Scan
COTE – Care of the Elderly Consultant
Psych – Elderly Pschiatry
CPP – Castle Place Assessment Team
Matron – Community Matron
SS – Social Services facilitated care package

PRE-ADMISSION	HOSPITAL	POST-DISCHARGE
28/01 UC	05/02 to 23/02	23/02 CPP
30/01 Family	CT Head/Pelvis	27/02 Matron
31/01 RR	COTE	01/03-03/03 Fam
03/02 PM	Psych	07/03 SS
05/02 GP		

Benefits of This System

- Patient happier in own home
- Less time in hospital to decondition – better prognosis
- Less confusion when at home and less risk of infections
- Specialist time focused on patients with medical need
- Assessments in home are more realistic
- Less costly – can help more people
- Good multidisciplinary working
- Funding must flow appropriately