# East Cornwall Health Hub

# SETTING THE SCENE

- ICS required to develop local plans for improving health and reducing inequalities
- GPs struggling under the growing quantity of appointments
- Life expectancy has stalled since 2010: health is linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources

# OUR POPULATION

**Oak Tree: 16772**

**Old Bridge: 9980**

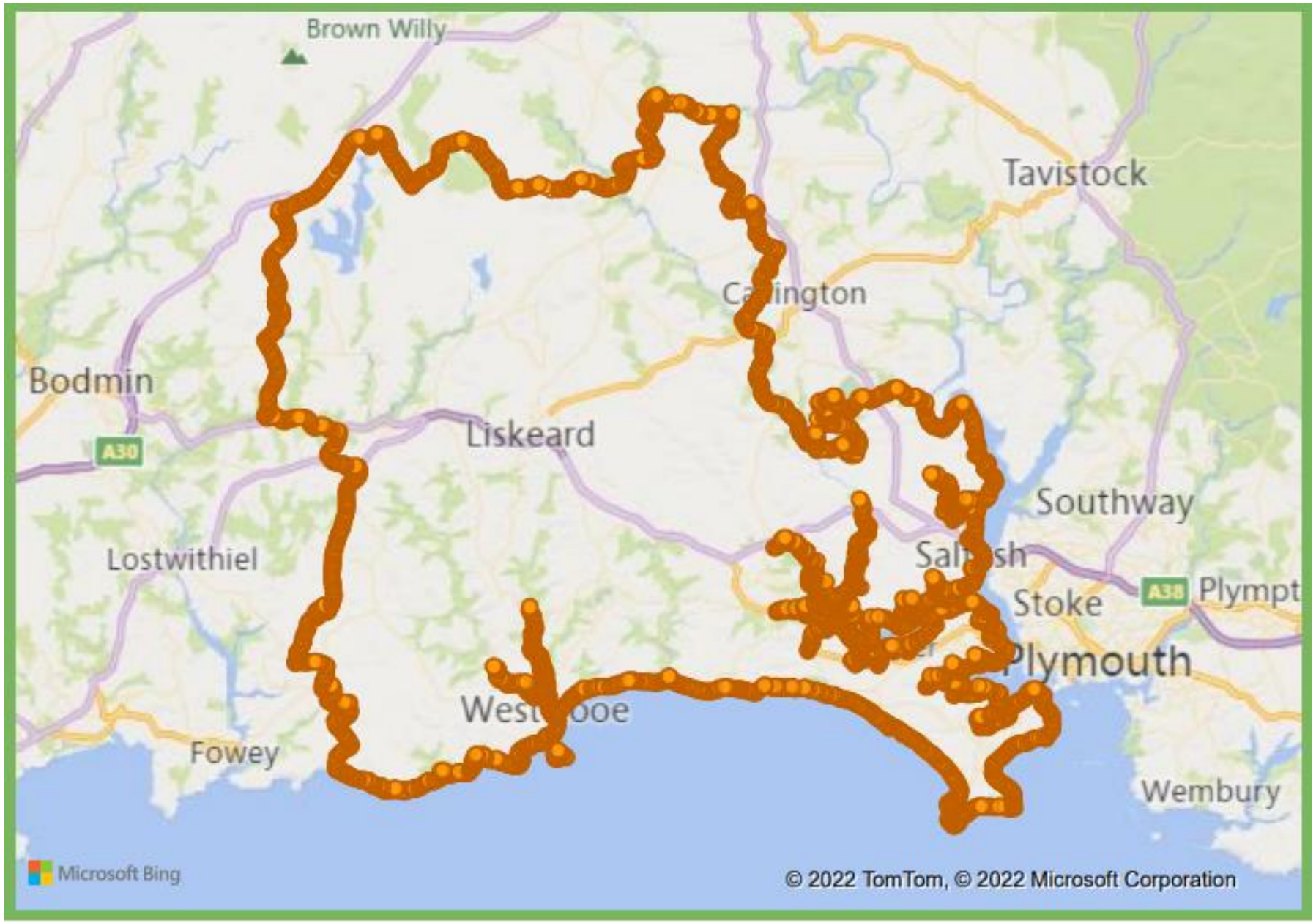
**Rosedean: 9700**

**Quay Lane: 4549**

**Saltash: 12413**

**Port View: 6768**

**Rame Grp: 11905**



# POPULATION NEED

- Around 35% of our population in ECPCN are living with one or more long term conditions
- Cancer and respiratory diseases are the main causes of death
- obesity, circulatory disease and diabetes the predominant long-term conditions
- Demand from people needing mental health service is high in this area
- rural area with a housing crisis, unemployment, and socioeconomic deprivation
- Services fall within the University Hospital Plymouth acute hospital in Derriford, approximately a thirty minute drive away for car users. 14% of households have no car. Public transport has been cut
- A small percentage of patients are using a large proportion of the GP appointments.
- Another group of patients are not engaging with health services at all but they have long-term conditions that require oversight and interventions.

# FREQUENT ATTENDERS

- *East Cornwall PCN has 13787 /72000 patients on frequent attender list. That makes up 19% of the practice patient population.*

- *The group of frequent attenders are not getting their needs met and so they keep coming back. Inadvertently, they take time away from patients quietly at home with long term conditions that might need assertive engagement.*

# FREQUENT ATTENDERS

**Coded diagnoses of our frequent attenders we see:**

- 10% have Asthma
- 10% have COPD
- 6% have or have had a mental health diagnosis
- 20% have Diabetes
- 14% are Smokers

**When we look at the general needs of our wider PCN population we see:**

- Cancer
- CVD
- Respiratory disease
- Asthma
- Diabetes
- Obesity
- Mental health diagnoses

# FINDING A VIABLE SOLUTION

# OUR VISION


Multi agency working
Improved access to care
Services provided in a local community setting
More specialist appointments available
Mental health services on site
HEALTH & WELLBEING HUB
Bringing together health, social care, voluntary and community services

# SERVICE

- IPS workers via Pentreath
- Mental Health Linkworkers
- Health for Homeless
- Music for Good
- Pharmacist with an interest in Mental Health available for a session a week to discuss medication changes that could improve a patient's wellbeing

# PROJECT SCOPE

**Condition led clinic days to focus on:**

- **COPD**
- **Hypertension**
- **Complex Emotional Difficulties**
- **Weight Management**
- **Smoking Cessation**
- **Diabetes**

# LOGISTICS

- Available to all adult patients within the PCN footprint
- Days and hours of operation will be a combination of day time core hours and, within time, some evening and weekend hours to support enhanced hours activity
- Single and simple access and referral route through from practice to the hub via Emis or SystmOne or email for outside agencies
- Patients will be identified via a one-to-one, personalised approach by Social Prescribers, mental health staff, care coordinators, GPs and other cross sector agencies

# EVIDENCE BASE

- Person-centred care
- Wrapped around the needs of local residents
- Focus on Health prevention
- Targeting Health Inequality
- Enhancing out of hospital care
- Supporting High Frequency Users benefitting all system partners including ED, 111, 999, and SWAST
- Providing increased capacity for NHS Health Checks
- Reducing the burden of appointments at GP practices
- Creating much needed extra capacity in our system


THANK YOU