

The logo consists of a large, light orange heart shape at the top. Below the heart are two stylized human figures, one on the left and one on the right, both in a light blue color. They are facing each other with their arms raised, holding hands. The background is white.

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

An illustration featuring three white, stylized human figures standing in a circle. They are positioned in front of a large, light-orange, heart-shaped background. At the bottom of the image, two blue hands are shown cupping the figures from below. The overall composition is symmetrical and centered.

FINDING A VIABLE SOLUTION

OUR VISION

Multi agency
working

Improved
access to care

HEALTH & WELLBEING HUB

Mental health
services on
site

Bringing together health,
social care, voluntary and
community services

Services
provided in a
local
community
setting

More
specialist
appointments
available





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

The background features a large, stylized illustration of two figures, possibly representing a family or a community, holding hands. The figures are depicted in a light blue color, with their heads and upper bodies visible. They are positioned behind a large, light orange oval shape that frames the central text and list.

- 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

A stylized illustration featuring two blue hands at the bottom, palms up, holding a group of white human figures. Behind the figures is a large, solid orange heart shape. The text "THANK YOU" is centered over the white figures in a bold, teal, sans-serif font.

THANK YOU