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

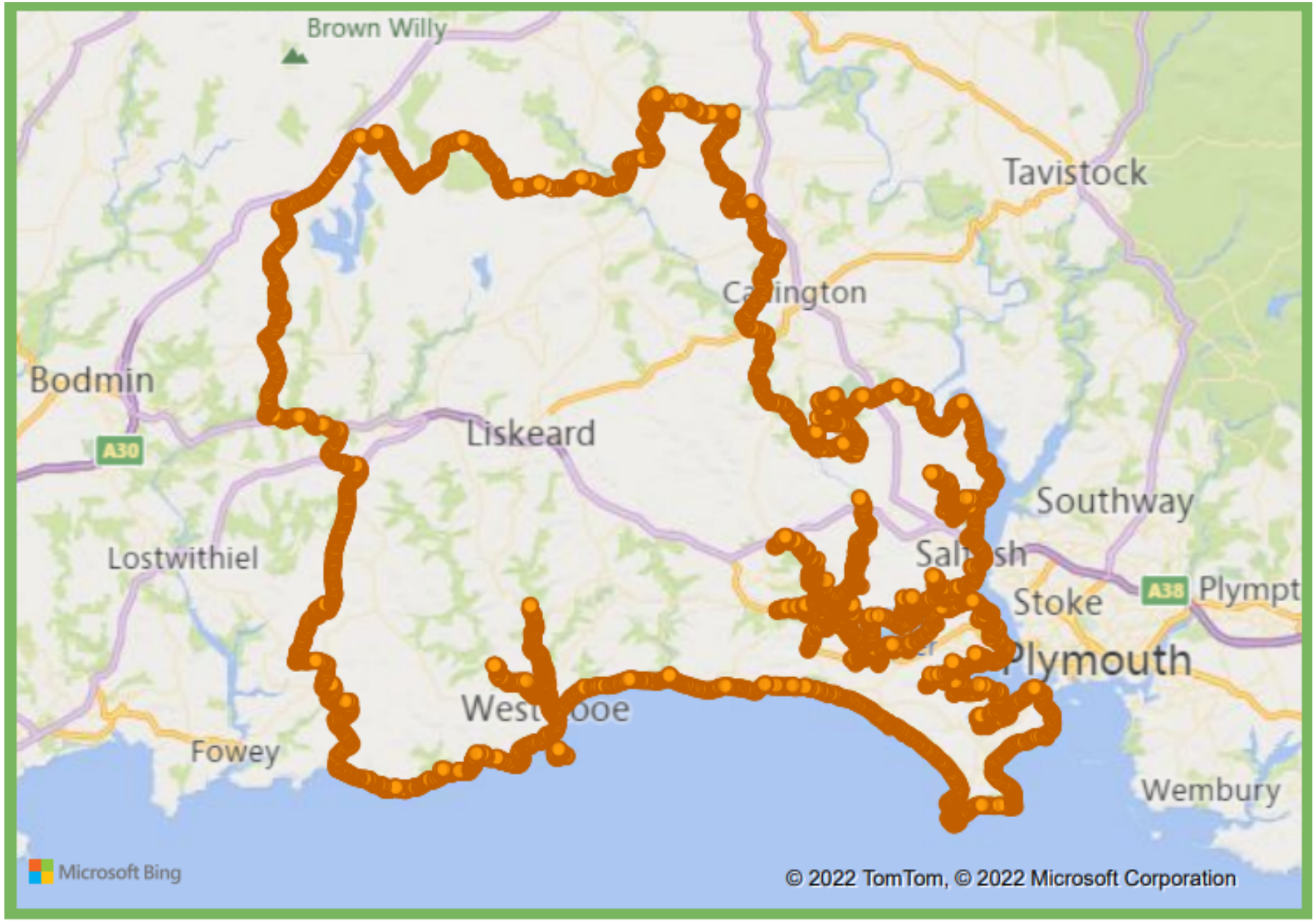
Rosedean: 9700

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

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