Complete Care Community

Demonstrator sites project prospectus

July 2021

Arden&GEM
Health and social care systems support

healthworks

Welcome to the 'Complete Care Community' programme

The NHS Long Term Plan established clear objectives for health systems to deliver improvements in health inequalities that have been a persistent feature of the social landscape of England.

More recently, Covid-19 has also put a spotlight on how social, economic and environmental conditions are inextricably linked to the health and wellbeing of our population.

The ‘Complete Care Community’ programme will centre on working within Primary Care to identify the key health inequality challenges faced by local populations, in particular those associated with the wider determinants of health, that require collaborative working with local councils and other agencies.

There are 20 demonstrator sites taking part. Each creating a project that will put existing evidence into practice by testing new ideas and approaches, and sharing learning across the health, care and local services community. The shared approach aims to spread and transfer learning nationally.

Martin Charters
Senior Responsible Officer
NHS Arden & GEM

James Kingsland
Clinical Director
Healthworks

Meeting the holistic complex care needs of a locally registered population through a multi-disciplinary team-based approach in England

Reducing health inequalities has been at the forefront of most past governmental reforms of the welfare state. This precept still applies but progress has been variable. Previously reported successful programmes have been localised and rarely sustained or adopted.

Over the last decade, increasing life expectancy in England has stalled, something that has not happened since the end of the 19th century. If improvements in population health and well-being have similarly regressed, exacerbated by the covid-19 pandemic, then the signs for civil society are ominous

The Health and Social Care Act 2012 introduced the first legal duties concerning health inequalities. In addition, the Social Value Act 2012 requires public sector commissioners to consider economic, social and environmental wellbeing in procurement of services or contracts. The Care Act 2014 also set out various duties and obligations to 'prevent, reduce and delay' the need for long term care.

Individuals living in the most deprived communities experience both injurious health and the poorest health outcomes. The social determinants of health have a significantly greater impact on people's health than can be managed by the NHS alone. The principles of a welfare state recognises that the economic and social well-being of citizens requires a community structure facilitating access to education, work, shelter, security and social network.

The purpose of the Complete Care Community Programme (CCCP) is to design an approach through which NHS Primary Care Networks (PCNs) working in association with other community and local council services can help address some of the challenges facing their local populations, especially those associated with the wider determinants of health.

The delivery of integrated care through a multidisciplinary team working to provide comprehensive and personalised care to individuals, groups and populations is now a consistent ambition for health and care improvement. However, it has historically been difficult to demonstrate sustainable community-based models of comprehensive care with measurable impact.

The CCCP aims to practically find solutions and demonstrate approaches to reducing health inequalities.

This programme focuses initially on understanding the cross-sectoral relationships, behaviors and actions that underpin success (and failure) rather than the precise interventions developed. This should allow learning about effective practice to be disseminated to areas with differing local contexts. However, sharing information about the successful interventions themselves will be a helpful secondary objective.

The CCCP aims to demonstrate a process through which a number of PCNs can work towards a high-level goal of reducing health inequalities by delivering improved care to defined 'segments' of their local population in partnership with the local council and other public statutory and voluntary services. In so doing, this should also provide a framework through which demonstrator sites can share their learning and identify factors that enables sustainability and then transfer this knowledge to other sites in the country.

In summary the goals are to:

- Identify inter-sectoral methods of collaboration that impact on health inequalities
- Identify 'enablers' and 'barriers' to addressing health inequalities
- Collate case studies and thematic reviews that demonstrate how health inequalities may be reduced
- Establish a process by which the approach and learning in demonstrator sites could be adopted across England.

The worsening health inequalities divide, highlighted in the February 2020 *Health Inequity in England: The Marmot review 10 years on*, will be further adversely affected as part of an overall increasing inequalities disparity caused by the Covid-19 disaster. It will be important to recognise the contribution that selected sites in this demonstrator programme can make in this recovery period.

The CCCP aims not to just build back better, after this pandemic, but build back fairer.

J P Kingsland

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Demonstrator sites and their projects (x20)

Each Demonstrator Site has designed a bespoke project that they wish to trial in order to prevent or attempt to eradicate the health inequalities in their chosen population group.

Region	Demonstrator sites
North West – Cheshire & Merseyside	Aintree, South Wirral, Runcorn, Knutsford, Ellesmere Port
North West – Lancashire & South Cumbria	Blackpool Central West
London	Newham, Kingston & Richmond, South Kentish Town
South West - Bristol, North Somerset & South Gloucestershire	Pier Health Group PCN
South West - Somerset	North Sedgemoor, Bridgwater Bay
South West - Cornwall	Bosvena & Three Harbours, Falmouth & Penryn, Saint Austell, Truro, West Cornwall
South West - Dorset	South Coast Medical Group, The Vale Network, Weymouth & Portland Two Harbours Healthcare

Get in touch to access PMO support at: agcsu.transformation@nhs.net

Demonstrator sites

North West region

Cheshire and Merseyside
1. Aintree PCN
2. Ellesmere Port PCN
3. Knutsford PCN
4. Runcorn PCN
5. South Wirral PCN

Lancashire and South Cumbria
6. Blackpool and Central West PCN

South West region

Bristol, North Somerset and South Gloucestershire
10. Pier Health Group PCN

Cornwall
11. Bosvena and Three Harbours PCN
12. Falmouth and Penryn PCN
13. Saint Austell PCN
14. Truro PCN
15. West Cornwall ICA

Dorset
16. South Coast medical group PCN
17. The Vale Network PCN
18. Weymouth and Portland PCN

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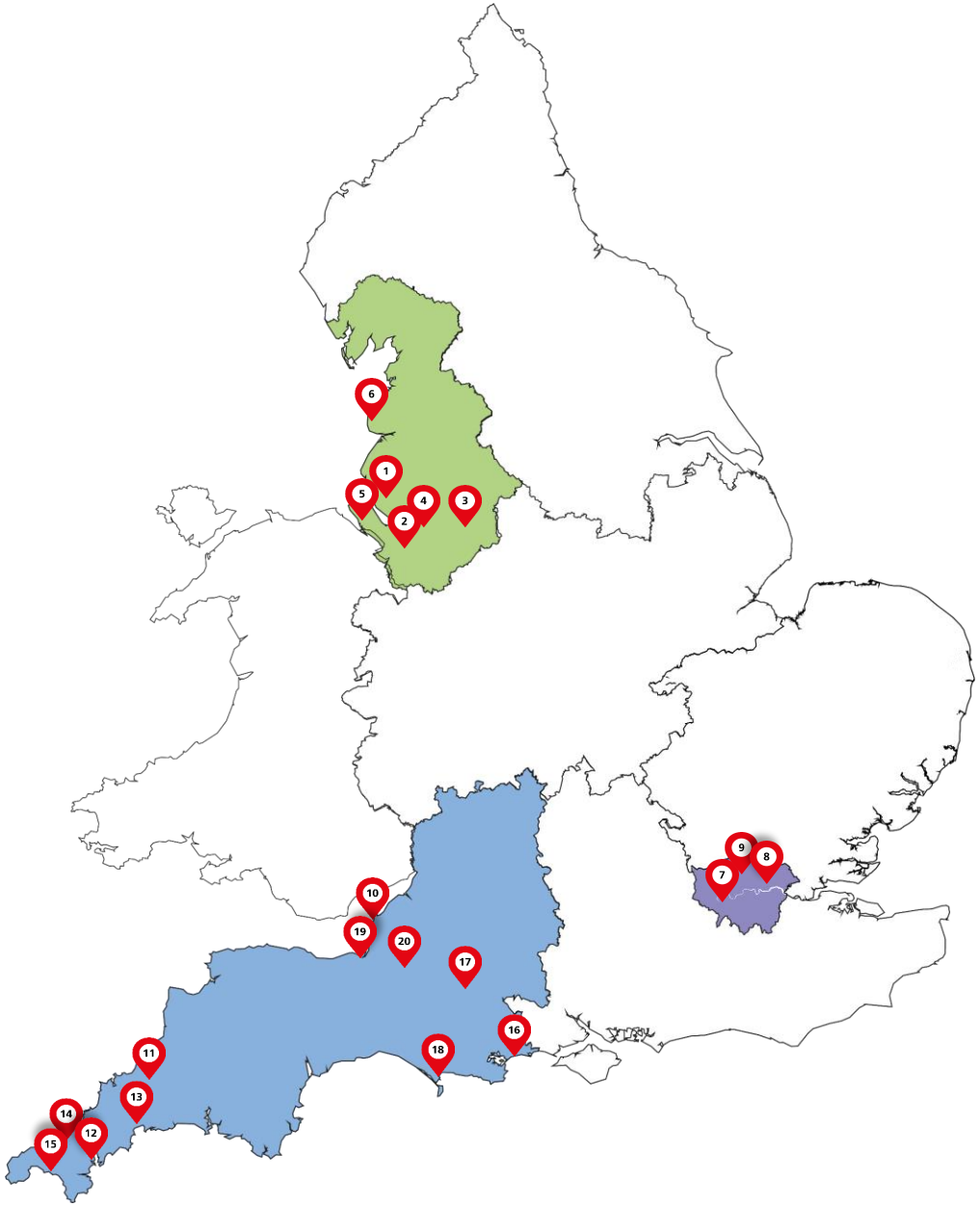

London region

7. Kingston and Richmond PCNs
8. Newham PCN
9. South Kentish Town PCN

Project list

Project Lead	Organisation / PCNs	Project
Dr Stewart Smith	St Austell PCN	Mental Health in young people
Dr Isabel Boyd	Falmouth & Penryn PCN	Mental Health 'Gap' population
Dr Emma Langstaff	Bosvena and Three Harbour PCN	Cardiovascular disease in people with learning disabilities
Dr Chris Tiley	Truro PCN	Early years health creation
Paul Abram	West Cornwall ICA	Personalisation approach for those with 5 co-morbidities
Dr Simone Yule	The Vale Network	Falls reduction
Dr Tanya Stead	Weymouth and Portland PCN - Two Harbours Healthcare	Children and families improved health and wellbeing
Dr Maggie Kirk	South Coast Medical Group	The HealthBus primary care for people experiencing homelessness
Dr Joey McHugh	North Sedgemoor PCN	A One Team approach to Learning Disabilities
Dr Cathryn Dillon	Bridgwater Bay PCN	Raised Patient activation and maintained wellness
Dr Martin Jones	Pier Health Group PCN	Mental health in young people and single mums
Dr Farzana Hussain	Newham Central 1 PCN	Knife crime
Dr Nicola Bignell	Kingston & Richmond PCNs	Long term health conditions
Dr Jonathan Levy	South Kentish Town PCN	Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities
Dr Thomas Wyatt	Healthier South Wirral PCN	Cardiovascular disease
Dr Mark Wigglesworth	Aintree PCN	Learning disabilities in young people
Dr Gary O'Hare	Runcorn PCN	Conduct disorder in children and young people
Dr Emily Morton	Ellesmere Port PCN	Childhood obesity
Dr Philip Coney	Knutsford PCN	A project aiming to connect all public facing services and start a social movement of care within the care community
Luan Stewart - PM	Central West PCN	Obesity

North West region:
Overview

Cheshire and Merseyside

Aintree PCN
Has 4 practices serving a population of 37,843. Aintree has a higher than national average percentage of people aged 45 and over. Based on data from the CSU, CCG, Liverpool City Council and Aintree Network data pack, there is also a higher than the national average amount of people living with a learning disability.

Ellesmere Port PCN
One Ellesmere Port was created in 2018 and has a network of 6 GP practices serving over 68,000 patients where 59.9% are aged 18-64. Cheshire West and Chester.gov report that 1 in 3 children are overweight by the time they leave primary school and obesity levels double between reception and year six.

Knutsford PCN
Knutsford has a population of 22,954 served by 3 GP practices. There is a diverse age range with over 53% of people aged between 18-64 years. Analysis of NHS estimates by the House of Commons Library shows 13.1% of adult GP patients across Cheshire East had a diagnosis of depression in 2019-20.

Runcorn PCN
Comprises 6 practices serving a population of 61,789 with almost 60% aged 18-64 years and 22.8% are aged 0-17 years.

Healthier South Wirral PCN
Comprises 6 practices serving a population of 49,015. The Constituency has an older profile than both England and Wirral overall. One in four of the population is aged 65 or over, compared to one in six in England overall. The British Heart Foundation reports that around 11,000 people in South Wirral are living with a heart circulatory disease.

Lancashire and South Cumbria

Central West PCN
Serves 33,000 patients across 4 GP practices, of those 80.6% are over the age of 18 and just under 10% of the PCN's registered population are clinically obese. The PCN also has the highest levels of deprivation within the CCG.

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Lancashire and South Cumbria
6. Blackpool and Central West PCN

North West region:
Cheshire and Merseyside - Aintree

Aintree PCN

To support and enable the local population to improve their physical health and mental wellbeing by building community social connectedness and focusing resource on those most in need. Focussing on Learning Disability and serious Mental Illness to improve the health of young people aged 15-35 with learning disabilities.

The team will work collaboratively with the following services; PCN practices, Mersey Care NHS Trust, Liverpool City Council, Liverpool CCG, Citizens Advice Liverpool, Health Trainers, Alder Hey Children's Hospital, Fazakerley Children's Centre, YPAS, Sefton & Knowsley Councils (cross border working), specialist schools & Care Homes, Housing Organisations, Police, Mencap and other voluntary organisations, those with lived experience & NIHR.

Aims and Objectives

1. Increased uptake of physical health checks, immunisation, cancer screening and attendance for Chronic Disease Management reviews.
2. Use of quality prescribing indicators and Social Prescribing Link Worker.
3. Reduced admissions and use of emergency, urgent or crisis services.

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North West region:
Cheshire and Merseyside – Ellesmere Port

Ellesmere Port PCN

Childhood obesity

Aims and Objectives

Awaiting POAP

North West region

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North West region:
Cheshire and Merseyside – Knutsford, Runcorn

Knutsford PCN

A project aiming to join up community groups and start a social movement within the care community. To create a community spirit of togetherness and care and to improve health and wellbeing outcomes. The team will realise their goals by collaborative working with Community Volunteers services and Knutsford Town Council.

Aims and Objectives

To target areas of health inequality in Knutsford through the provision of exercise and social opportunities. Aimed at people who have a learning disability and social opportunities for the isolated and elderly, many of whom suffer from cognitive decline.

Runcorn PCN

Improving the health & life chances of young people with conduct disorder using a human learning systems approach. The service will align with the Health Engagement Service (HES) and the Wellbeing Link Workers that support children and young peoples needs in primary care in addition to schools and mental health services.

Aims and Objectives

1. Develop a system which works collectively as one, to fully understand the issues that make our population vulnerable.
2. Creating a collaborative approach with all partners to solve and mitigate these vulnerabilities.

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North West region:
Lancashire and South Cumbria – Central West

Central West PCN

To provide a Social Prescribing Service to identify root causes of obesity and encourage people to reconnect with their community, post Covid-19. The team will work with local social care and voluntary, community, faith and social enterprise sector partners (VCFSE), to develop a holistic support package. They will link up with existing health and social care commissioned weight management services to best support service users throughout the project.

Aims and Objectives

1. To work on the root cause of the issues causing obesity.
2. To naturally enhance and improve the quality of life of people which will improve the overall health of service users.
3. Ensure all service users are given the opportunity to access all appropriate services.

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London region:
Overview

Kingston and Richmond PCNs

There are 5 GP PCN's across Kingston and 6 in Richmond serving populations of Circa 200,00 each. Both boroughs are predominantly affluent areas masking some pockets of deprivation and inequality in access and health outcomes within the populations.

In Kingston 5.1% of the population have diabetes and there is an 8% prevalence gap in detection of people with hypertension and 13.8% of the population smoke. At age 65 68.3% have hypertension, 24% diabetes and 15.9% CVD.

In Richmond 1:10 people are living with 3 or more long term conditions. Richmond see's the highest rate for risk taking behaviour with an associated 4th worst average mental wellbeing score in London in 15 year olds.

Newham Central 1 PCN

48 GP practices serving 352,005 people.

Newham has a higher than national average proportion of 0-15 year olds and 16-64 year olds.

Newham.gov reported in 2019 that Stratford and New Town, and Canning Town North wards had the greatest number of reported knife crime incidents in the past year.

Children's exposure to violence – both as victims and suspects in acts of police-recorded violence in Newham rises between the age of 10 and 13-15 years.

South Kentish Town PCN

South Kentish Town PCN has the highest prevalence of severe mental illness in North Central London hence experienced with the nuances of supporting mental health in its deprived BAME community.

London region

7. Kingston and Richmond PCNs
8. Newham PCN
9. South Kentish Town PCN

London region:
Kingston and Richmond, Newham

Kingston and Richmond PCNs

A systemwide approach to the prevention of long-term conditions, addressing inequalities by finding and working with the underserved population within PCN's across the boroughs. The team will work collaboratively with community leaders, and voluntary care organisations to build community hubs around places of association to support healthy behaviours, self- management and improve access to services and improve outcomes in targeted populations.

Aims and objectives

1. Weight management.
2. Mental wellness.
3. Reduction of risky behaviour.
4. Supported self-management.

Newham Central 1 PCN

The reduction of knife crime in NE London by targeting 'at risk' young people to change norms and values towards violence at a young age. The team will collaborate with West Ham United football club and Youth Link Workers to reach out to young people at risk.

Aims and objectives

Improving the lives of young people, their families, and communities and therefore reducing the burden of cases going to secondary and tertiary care.

Increased awareness of VR amongst healthcare staff and identification of those at risk of violence by care professionals.

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London region:
South Kentish Town

South Kentish Town PCN

A project aimed at facilitating female Mental Health Empowerment in Camden's Bengali and Somali Communities.

Aims and objectives

1. Empower mental health resilience in Camden's Somali and Bengali residents, by their community for their community.
2. Using and enhancing the community's assets by engaging them in designing a self-sustaining model
   to reduce stigma, engender resilience and increase access to mental health support.
   In partnership with Hopscotch Women's Centre in Euston (a charity working at the intersection of
   gender and racial inequity) we have identified a gap in provision.

London region

7. Kingston and Richmond PCNs
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South West region:

Overview - Bristol, North Somerset and South Gloucs, Somerset, Dorset

Bristol, North Somerset and South Gloucestershire

Pier Health Group PCN
Weston, Worle and Villages (WWV) has around 104,000 patients served by nine GP Practices and five satellite surgeries. The CCG reports that Weston currently has an older demographic with pockets of significant deprivation and large health inequalities.

Somerset

Bridgwater Bay PCN
Comprises 10 surgeries with a population of over 80K patients.

North Sedgemoor PCN
North Sedgemoor is a 5 practice PCN serving 48,000 patients.
There is a high degree of deprivation and health complexity increased by the high number of people living in care homes.

Dorset

South Coast Medical Group PCN
Comprising of 4 GP practices and five sites serving a population of 35,000. The PCN has a high population of older people, multi-national local workforce, ethnic minority communities, a large population of students, social deprivation, homelessness and high turnover of transients (holiday makers).

The Vale Network PCN
Covers over 200 square miles of rural countryside and 2 market towns plus several isolated villages. The PCN reports that the population comprises over 5,550 people over the age of 70. This is 22% of the overall population, compared to the national average of 18%, with a large amount of these patients classed as frail. The PCN report that falls in the elderly are historically a particular area of concern, exacerbated by the Covid-19 pandemic.

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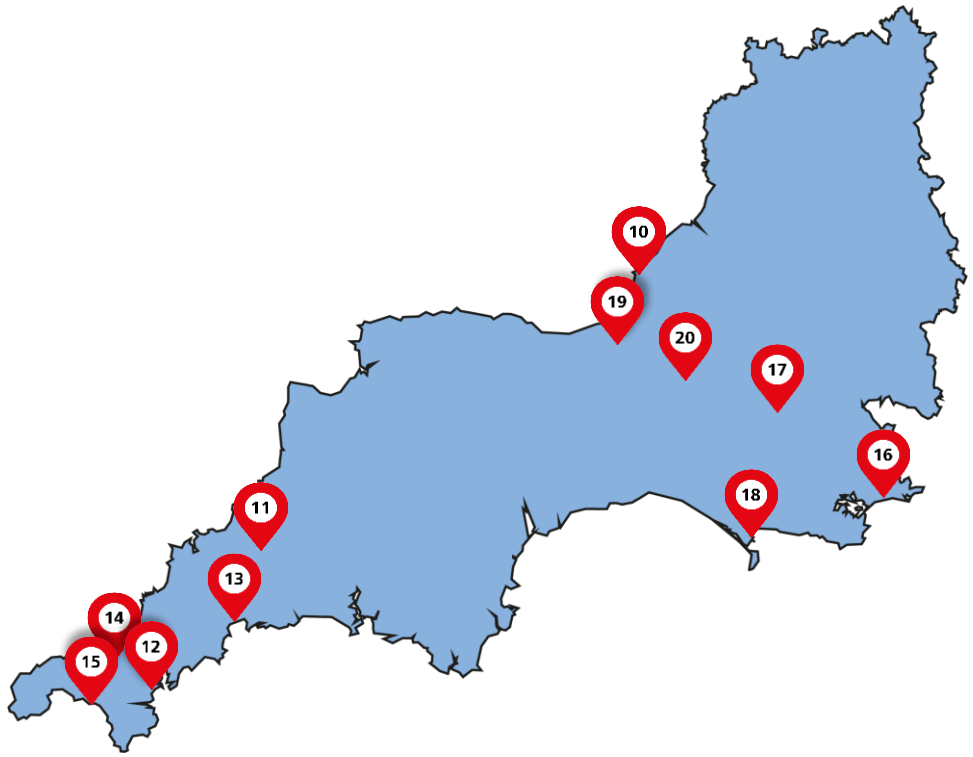

South West region:
Overview - Cornwall

Bosvena and Three Harbours PCN
Bosvena and Three harbours has 2 GP practices that serves a population of 42,595 patients. The area is rural with significant distances for patients to travel to the main acute hospitals.

Falmouth and Penryn PCN
Has a network population of 47,805 served by 4 GP Surgeries. 1 in 9 residents live in the top 20% of deprived neighbourhoods in England which are known to have the poorest health outcomes.

Saint Austell PCN
Has a registered population of 36,378 served by 2 GP practices. The PCN report that St Austell ranks among the top 10% of most deprived areas in the country inner cities.
Rural isolation outside of the city causes issues for young people due to a lack of public transport.

Truro PCN
2 GP practices serve a registered population of 35,786. The population served is 58.2% aged 18-64 and 96.1% white ethnic origin. The percentage of residents in Truro rating their health as 'very good' is less than the national average.

West Cornwall ICA
Area comprising of 4 PCNs, Penwith, Isles of Scilly and South Kerrier, North Kerrier West, North Kerrier East.

The combined registered population served is 167,574 across 18 GP practices. The PCN report that their population has a disproportionately higher number of people living with limiting long-term Illness compared to the rest of the country (23% of people compared with 18% nationally).

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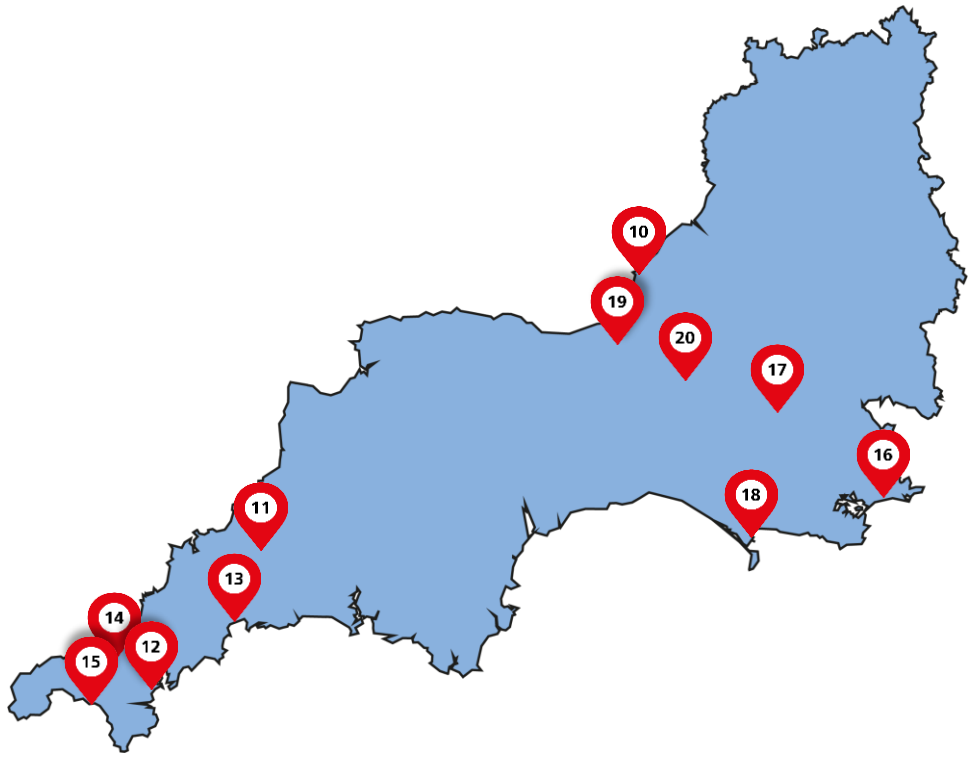

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South West region:

Bristol, North Somerset and South Gloucestershire – Weston-super-Mare

Pier Health Group PCN

Programme aimed at reaching out to young people/single mums with mental health issues, and other affecting issues such as homelessness, alcoholism and diabetes. Using a central building as a hub and centre for help, support will be offered to improve access to various services. The team will draw support from working with Pier Health Group Ltd, Pier Health, North Somerset LA Alliance Housing, For All Healthy living Centre, The Bournville One (Police, Education, Social Services, Health, Mental Health).

Aims and Objectives

Intervention and assistance to target & reach & engage with young people/single mums, through a social hub & social media. To explore the opportunities of utilising the services of people with lived experience. Dispelling the myth that these groups are hard to reach & acknowledging that historically, it has been the services that have been hard for this group to reach & access.

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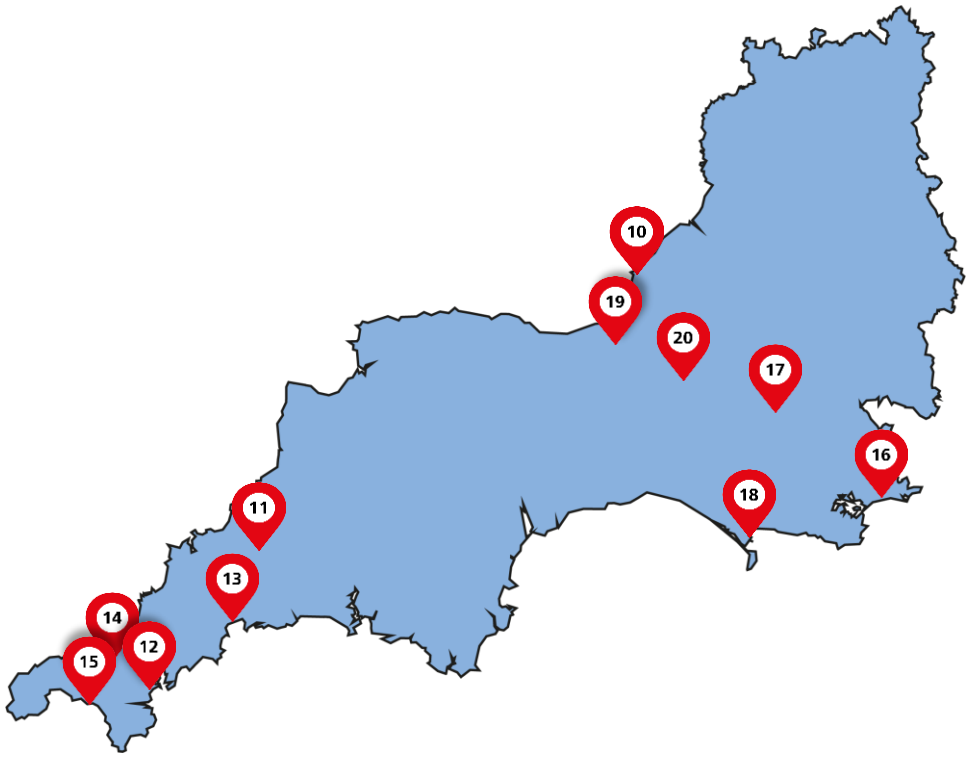

South West region:
Somerset – Bridgwater Bay

Bridgwater Bay PCN

To give the population of Bridgwater Bay the tools to move from area of high disease prevalence to one of raised patient activation and maintained wellness.
The team will work collaboratively with the public health team, health coaches and social prescribers to work with young families with high GP contacts and social need. These families will be identified by population health methodology to select those household that have the most to gain from gaining greater health confidence.

Aims and Objectives

1. To expand and evaluate a single proxy question for patient activation.
2. To focus on interventions to bring households up the activation scale by gaining health confidence and an internal loci of control.
3. The promotion of physical activity and lifestyle education will be key. This will be done through building a community based on activity. Recording patient activation will also be brought into GP consultations and child health reviews.
   Methods will include a variety of innovative communication tools, including nudge techniques and opportunistic motivational interviewing. Patient activation will be measured at incremental points of the project. We will look at longer term GP contact numbers in those who have been through the scheme compared to those who have not, but are demographically matched.

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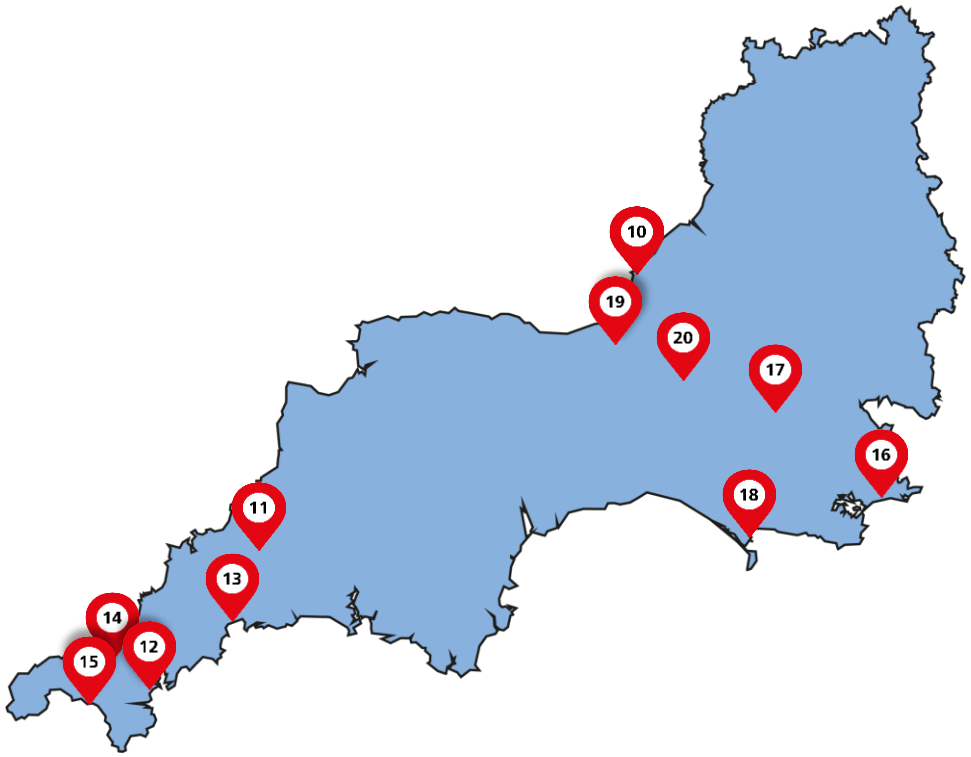

South West region:
Somerset – North Sedgemoor

North Sedgemoor PCN

To offer a seamless 'One Team' approach to the care of patients registered within the PCN with a learning disability; enabling patients and colleagues to achieve their full potential. The One Team is a Team of Teams - including and working with PCN Practices, Community Teams, Somerset Social Services, Somerset CCG, PCN Team members, Village Agents, LARCH, LD team at SFT, Collaboration Hub, North Somerset Social Services, LD Social Services in Somerset, Police, Voluntary Sector, people with lived experience and Digital Services and communications.

Aims and Objectives

1. Development of shared vision / aim aligned to wider Somerset health and care system strategy.
2. Utilising a 7 Step QI approach to the delivery of the programme. Extensive stakeholder mapping to understand whole situation, Linking in with all services to ensure a joined-up provision that is easy for all to navigate. Improved accessibility and accuracy of data resources.

South West region

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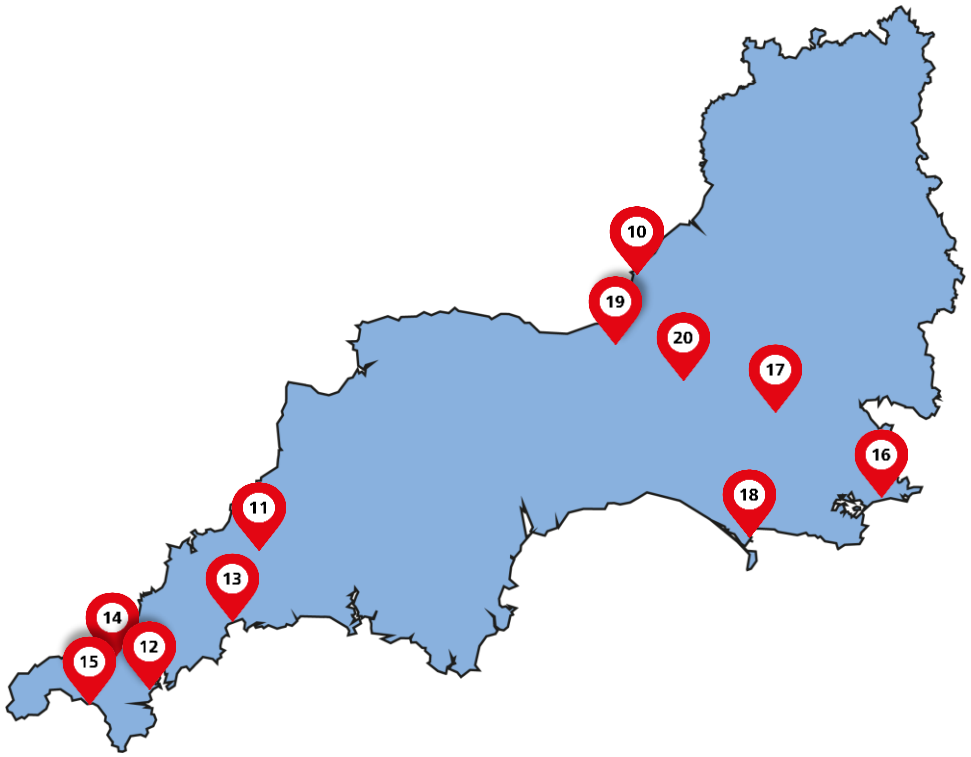

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South West region:
Cornwall – Bosvena and Three Harbours, Falmouth and Penryn

Bosvena and Three Harbours PCN

An integrative project aimed to prevent and explore the connection between cardiovascular disease and learning disabilities. The team will work collaboratively with Cornwall Council, a Health and Wellbeing Coach, a Social Prescriber, Community Health Champion, Lanivet Community Team, CHAMPS team Healthy Cornwall, a Primary Care Liaison Nurse LD, A LD consultant, Bowden Derra Park, Polyphant and Cromarty House, Bodmin.

Aims and Objectives

1. Understanding any link between Cardiovascular Disease and Learning Disabilities, taking any preventative measures possible. Sharing any learning with other PCNs.

Falmouth and Penryn PCN

A project focussed on providing a comprehensive mental health service in primary care. Aimed at a target population who are not unwell enough for secondary care, enabling them to receive support within the community.
The team aim to succeed by working with PCN practices, Kernow CCG, RCHT (acute trust), CPFT (provider of mental health and community services), PLUSS (social prescribing provider), HOPE lived experience, patient participation groups, Dracaena Centre, Falmouth & Exeter University Student Services, Healthwatch Cornwall, MIND, CPFT Research Team, Clinical Leads of early implementer sites, Sea Sanctuary, voluntary organisations, We Are With You, Cornwall Council, Housing Organisations, Falmouth School, Penryn College, Falmouth Family Centre and Faith Groups

Aims and Objectives

1. Prevent admissions and re-admissions to secondary care by empowering patients to manage their own mental health.

2. Provide joined up assistance by pooling resources and utilising Social Prescribers.

South West region

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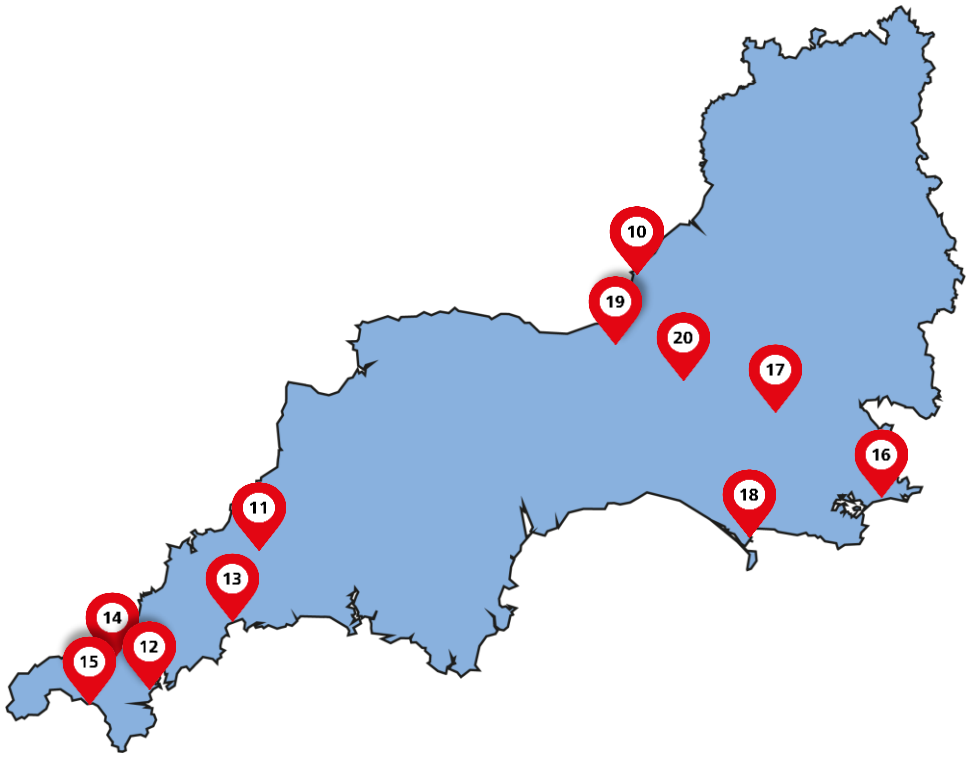


South West region:
Cornwall – St. Austell

St. Austell PCN

A codesigned project with Social Prescribers to improve the mental health of younger people. The team will work closely with local schools, colleges, voluntary sector organisations and community enterprises.

Aims and Objectives

1. Codesign the service with young people, taking individual and flexible approaches.
2. Provide access and opportunities for all children and young people and vulnerable groups including:
    i. Social Prescribing with a focus on outdoor opportunities.
    ii. Creative opportunities for art, dance and music participation and physical and social activities.
    iii. Encouraging peer support and peer mentoring and the establishment of a Youth Patient Participation Group.

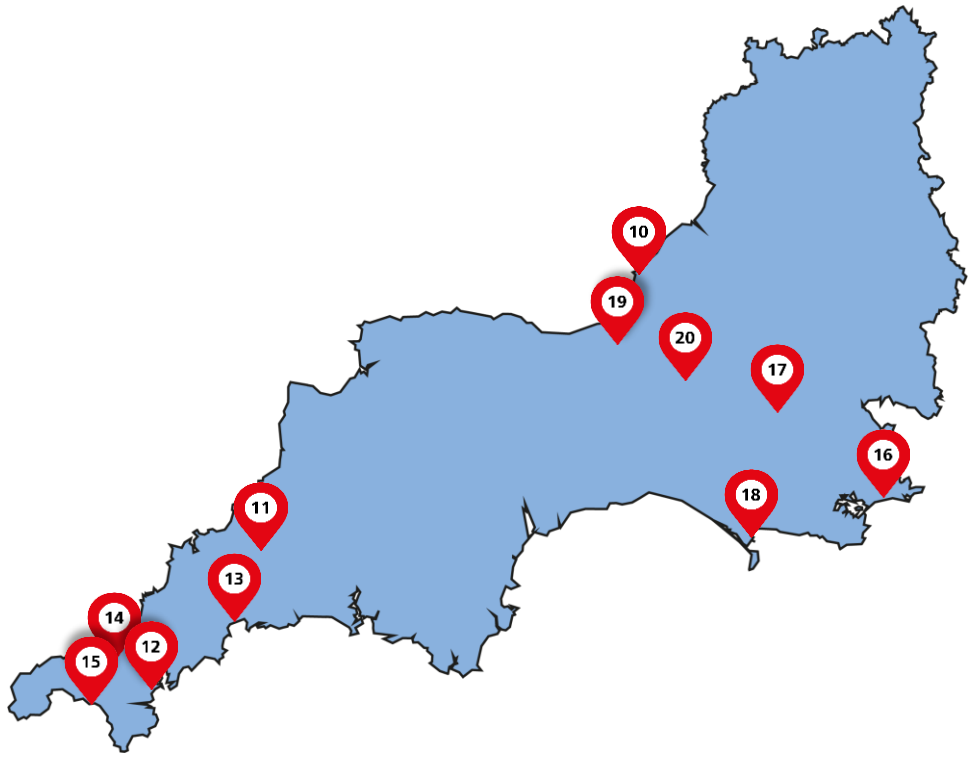
South West region

Bristol, North Somerset and South Gloucestershire
10. Pier Health Group PCN

Cornwall
11. Bosvena and Three Harbours PCN
12. Falmouth and Penryn PCN
13. Saint Austell PCN
14. Truro PCN
15. West Cornwall ICA

Dorset
16. South Coast medical group PCN
17. The Vale Network PCN
18. Weymouth and Portland PCN

Somerset
19. Bridgwater Bay PCN
20. North Sedgemoor PCN



South West region:
Cornwall – Truro, West Cornwall

Truro PCN

Exploring how local communities can be the support structure for people. Focusing on several different areas and harnessing local community assets for support. To support this a virtual group has been created. Membership includes:- GP, Police, City Council, Social Prescriber, Housing Association, local charity, and members of the public.

Aims and Objectives

1. Connect individuals and families to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.
2. Improving the link between primary healthcare and community organisations. Use of social prescribing, green gyms, community hubs in libraries and faith settings, healthy living centres, community-centred commissioning.

West Cornwall ICA

A personalised approach for people with 5 or more co-morbidities, such as respiratory conditions. Link this to social issues such as poor housing and deprivation and utilise Social Prescribing and community-based support.

Aims and Objectives

1. Promotion of shared decision making, personalised care and support planning.
2. Creating personal and integrated health budgets.
3. Use of Social prescribing and community-based support to aid self-management.

South West region

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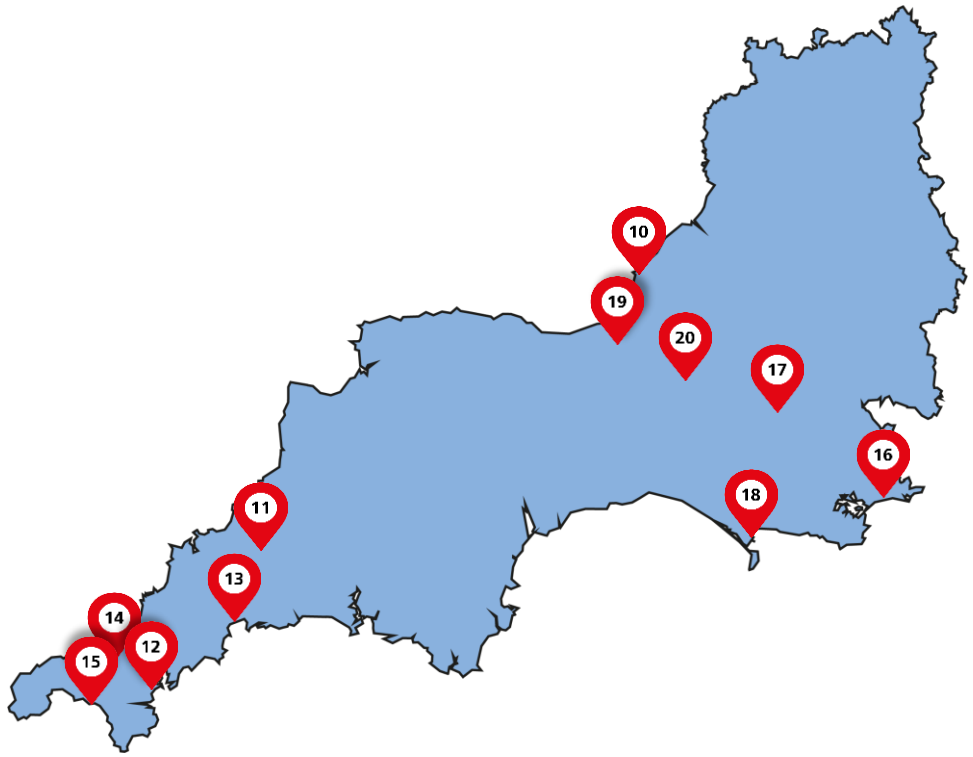

South West region:
Dorset – South Coast Medical Group, The Vale Network

South Coast Medical Group PCN

HEALTHBUS

The HealthBus primary care for people experiencing homelessness. Created to address unmet primary care health needs for people who are homeless. The team will work collaboratively with St Mungo's, BCP Housing teams, Street outreach and Mental Health Nurses and Voluntary services.

Aims and Objectives

1. Ensure that all homeless people within the PCN are registered with Primary Care and have access to all healthcare services.
2. Provide enhanced GP and nursing provision in addition to patient advocacy and support

The Vale Network PCN

A Public Health Management approach to falls reduction and confidence building in the isolated frail elderly population, that has been exacerbated through Covid-19, by the creation of a risk stratification falls tool. The team will work closely with the following services: Physiotherapist, Social Prescriber,
Occupational Therapist, Health Champions, Safe and Independent Living Worker from the Fire and Rescue Service, Live Well Dorset and Active Ageing Community groups, Pharmacist and Health Coach.

Aims and Objectives

1. Identify target population from patient's first fall records, ambulance call out or other means such as assisted bin collection or polypharmacy.
2. Prevention and reduction of falls in the elderly and thus reduction in secondary care admissions.
3. Reduction of social isolation through increased confidence and improved mobility.

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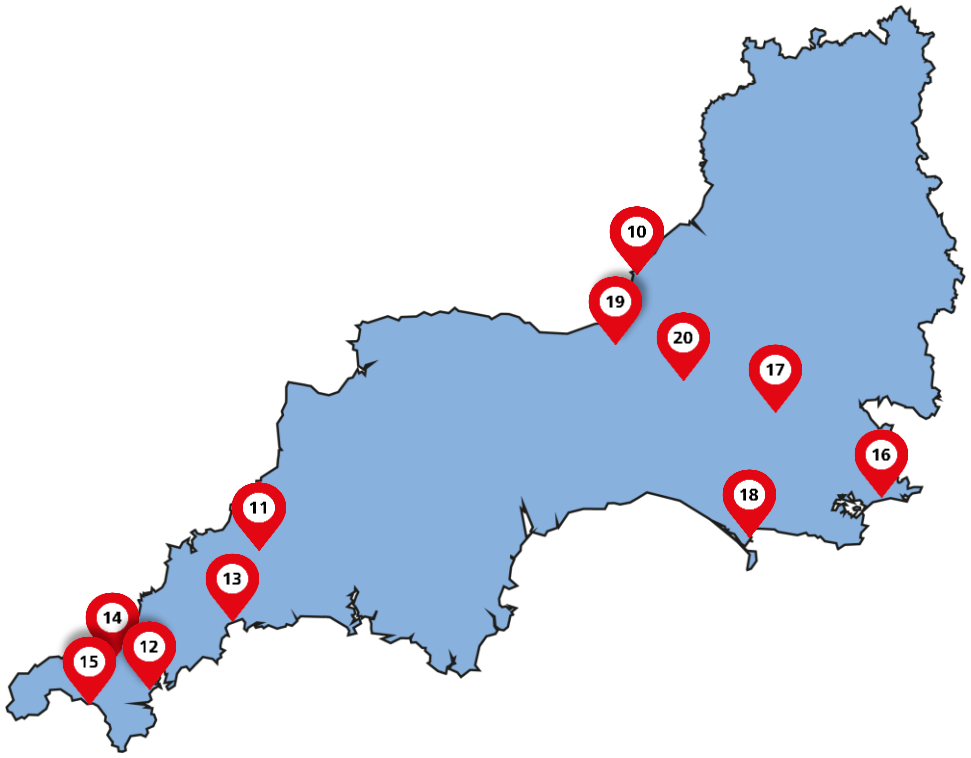

South West region:
Dorset - Weymouth & Portland Two Harbours Healthcare

Weymouth & Portland Two Harbours Healthcare PCN

Project to provide an umbrella service to support children and families to improve their health and wellbeing, removing the stigma of weight loss. The team will collaborate with Dieticians, Care Coordinators, the Family Partnership Zone, CAMHS and local children's charities and voluntary services

Aims and Objectives

Provide access support for children identified as being overweight or obese by providing a care coordinator led service. Working in conjunction with Public Health and Active Dorset, promoting local sports and activity opportunities for families and children.

Maximising partnerships to promote emotional wellbeing and support for mild anxiety and low mood symptoms.

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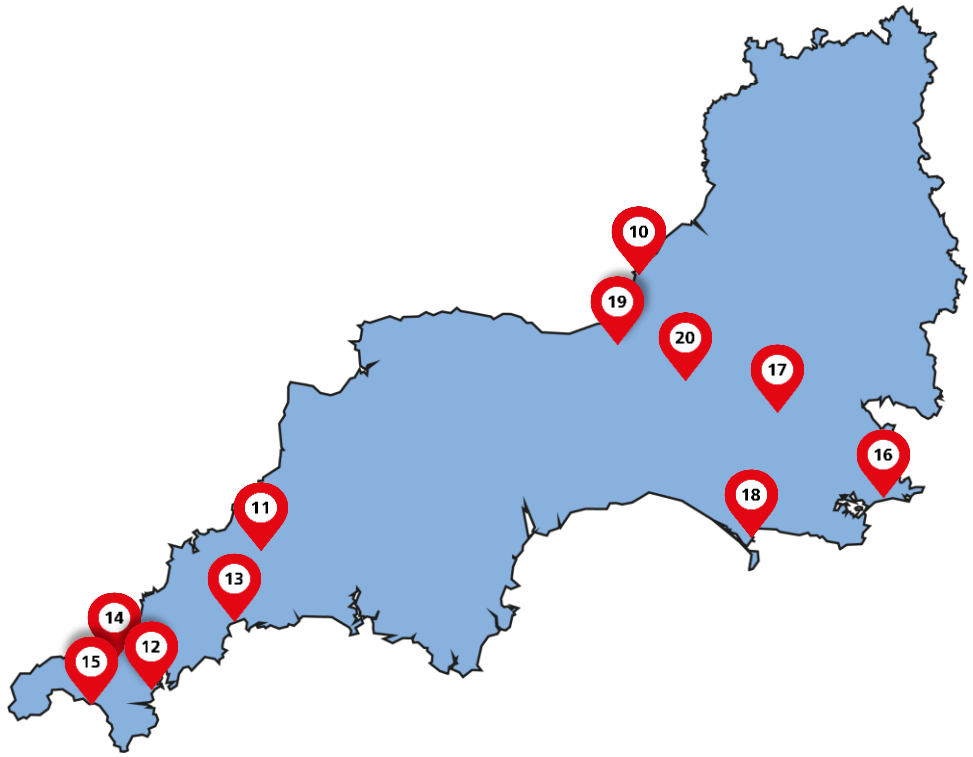

Welcome
Demonstrator sites
Projects
North West region
London region
South West region
Bibliography
Contact us

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If you require any further information about this programme of work please contact Arden & GEM PMO:

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www.ardengemcsu.nhs.uk

Arden&GEM
Health and social care systems support

healthworks