Complete Care Community

Demonstrator sites project prospectus

July 2022

Arden&GEM
Health and social care systems support

healthworks

Welcome to the 'Complete Care Community' Programme

We are pleased to present this updated brochure describing the work of the Complete Care Community (CCC) Programme.
Now into its second year there are currently 46 active sites participating in this learning network and this brochure provides an overview of their collective work.
Our first report and early evaluation of the programme has recently been published and can be reviewed at https://healthworks.uk/report
As the programme advances and continues to develop we aim to provide some actionable insights into a collective approach to reducing health inequalities in England.

Chris Davies
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

The CCC has been created to tackle health inequalities through local demonstrator sites, known as *Complete Care Communities*, and explore how today's NHS can contribute to a reduction in health inequalities throughout England. These demonstrator sites aim to establish the evidence and causation of disparities in the health of local population groups and then design new ways of providing care based on their findings. The approach is not only to test new ideas and approaches and put them into practice, but also to share learning widely across healthcare and local community services.

Demonstrator sites are constructed from NHS Primary Care Networks (PCNs), working in association with other community and local council services, designed to address some of the most complex challenges facing their local populations, especially those associated with the wider determinants of health.

'There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in'

(Desmond Tutu)

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.

Our hypothesis is that past uncoordinated, disparate, and siloed approaches to tackling health inequalities has resulted in poor adoption and spread of local successful project work, which then becomes unsustainable in isolation.

Therefore, the design of the overall programme and its demonstrator sites is of primary importance in these early stages of the CCC development.

'Every system is perfectly designed to get the results it gets

(W. Edwards Deming)

Health inequalities go against the principles of social justice because they are avoidable and arise from the unequal distribution of social, environmental and economic conditions within societies. They do not occur randomly or by chance. They are socially determined by circumstances, largely beyond an individual's control.

Such factors disadvantage people and increase their risk of getting ill, compromise their ability to prevent sickness and ultimately limit their chances of a long and healthy life.

'The greatest of evils and the worst of crimes is poverty'
(George Bernard Shaw)

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. Demonstrator sites recognise that the economic and social wellbeing of citizens requires integrated community services that can facilitate access to education, work, shelter, security and social network.

Launched in April 2021, The CCC is now an established national programme which supports PCNs to identify and narrow health inequalities in their local area and encourages local networks to adopt a systematic approach to addressing the wider determinants of health inequalities, including using data to inform action.

This results in the CCC acting like a sector, not a series of independent quality improvement projects. The programme delivers a collaborative cross-sector approach to tackling local health inequalities, the lessons from which can then be shared nationally.

Initially 26 demonstrator sites across three English regions were identified, each involving one or more PCNs, but the programme has now expanded to incorporate 46 sites across all seven NHSE regions.

The Programme receives funding from the National Healthcare Inequalities Improvement Programme at NHS England and supports Core20PLUS5, the national NHS England approach to reducing healthcare inequalities.

Historically, many pilot or demonstrator programmes have focused on particular interventions designed to deliver improved outcomes. However, it has often proved difficult to generalise actionable learning given the widely different contexts, and local objectives of heterogeneous pilots. Therefore, this programme has a focus on understanding the cross-sectoral relationships, behaviours and actions that underpin success, and failure, rather than systematically measuring the precise interventions developed.

In this way it is hoped this facilitates learning about how effective practice can be disseminated to areas with differing local contexts. Sharing information about the successful interventions themselves, however, may be a helpful secondary objective.

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The consistent design approach and methodology adopted by demonstrator sites also facilitates the long-term systemised evaluation which is now being undertaken.

The fieldwork being undertaken by the CCC demonstrator sites has developed into a real-world study, and a first report has now been published in July 2022 as the start of what will be an ongoing evaluation of the programme.

A core component in demonstrator site design is to clearly define the group of people to be served and who are characterised by the debility that this population segment endures in relation to deprivation.

An important part of the evaluation of the CCC is how an overall integrated partnership approach, particularly between PCNs, the local council and other community services approach, can be enhanced.

It has also been recognised in the construct of the programme that there are perpetual constraints on local resources and workload pressures in delivering current contractual requirements. It was therefore expected that relatively small groups of people would develop the demonstrator sites and their projects in the early stages

Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has'

(Margaret Mead)

The above quote has become increasingly pertinent to the evolving approach of this programme. There may also be opportunities to study how local health and care services could be aligned to operate within a defined 'place'. Indeed, a strengthened description of 'place-based care' may be achieved through building the right coalition between statutory and non-statutory services within the boundaries of a local authority.

In summary the overarching goals of the CCC 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

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The Department of Health and Social Care has also been supportive in developing a Policy Research Programme to be funded through the National Institute for Health and Care Research.

This high-quality research aims to deliver relevant, timely and accessible evidence to inform national policy decisions in relation to health inequalities. The ambition is to incorporate more formal research into the CCC construct and our approach in early 2023.

All our team in the project management office of the CCC look forward to continuing our work and supporting the national demonstrator sites

Professor James Kingsland OBE
National Clinical Programme Lead
Clinical Director **Healthworks**

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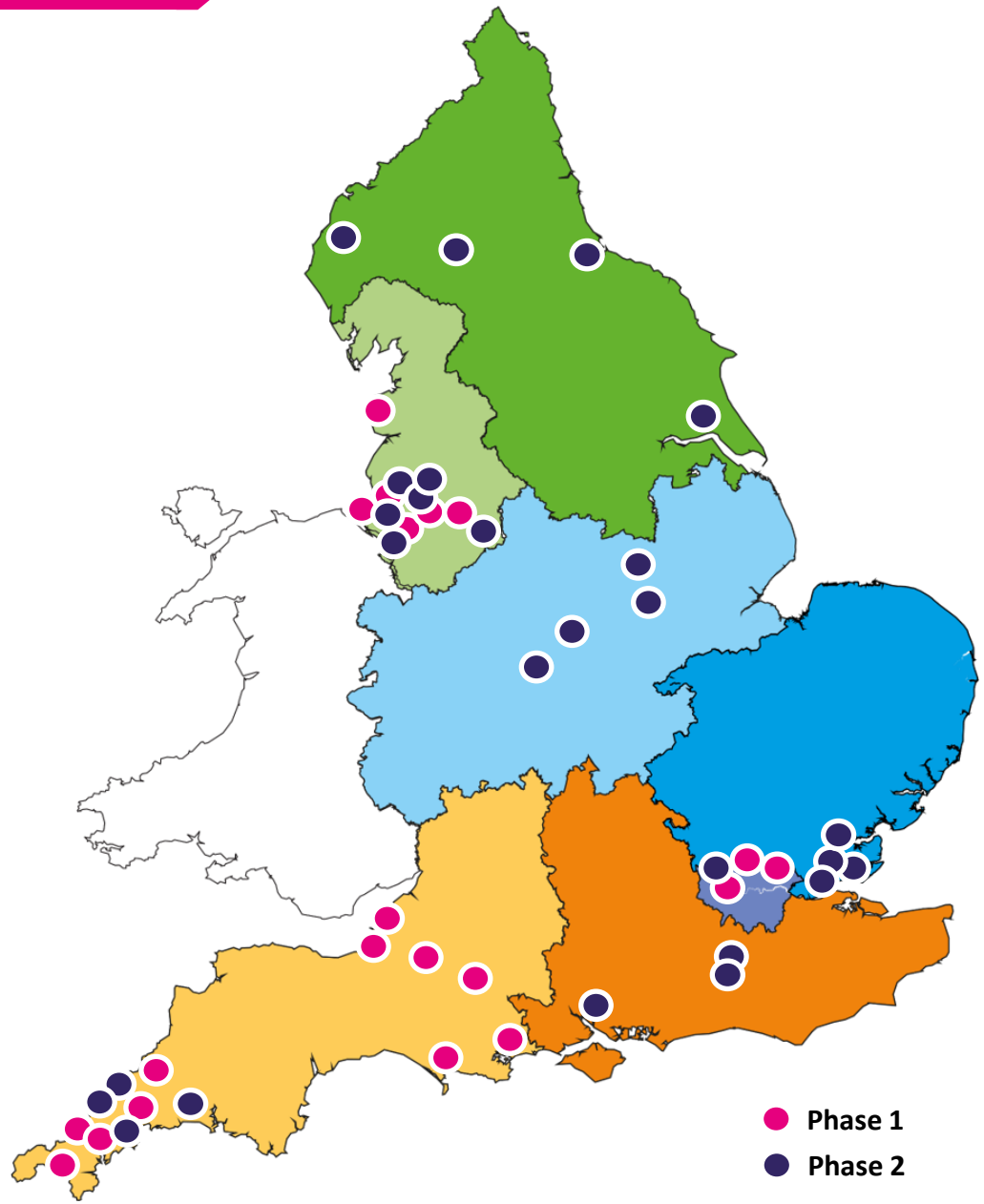
Demonstrator sites: phases 1 and 2

Region	Phase 1	Phase 2	Total
North East, Yorkshire & Cumbria	0	4	4
North West	6	6	12
Midlands	0	4	4
East of England	0	4	4
South West	11	4	15
South East	0	3	3
London	3	1	4
			46



National Demonstrator Sites

Complete Care Community

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 East Yorkshire and Cumbria (Phase 2)	Stockton-on-Tees, Cockermouth and Maryport, Eden, Haxby Group
North West – Cheshire & Merseyside	Aintree, South Wirral, Runcorn, Knutsford, Ellesmere Port, Central Liverpool, Kirkby, CHAW, South Sefton, Knowsley Central and South, Chester South
North West – Lancashire	Central West (Blackpool)
Midlands (Phase 2)	East Staffs, Mid-Nottinghamshire, Caritas, Nottingham West
East of England (Phase 2)	Southend Victoria, Central Basildon, Colchester Medical Practice, Stanford-le-Hope
South West - Bristol, North Somerset & South Gloucestershire	Pier Health - Weston-super-Mare
South West - Somerset	North Sedgemoor, Bridgwater Bay
South West - Cornwall	Bosvena & Three Harbours, Falmouth & Penryn, Saint Austell, Truro, West Cornwall, North Kerrier West (Phase 2), Arbennek Healthcare (Phase 2), Coastal (Phase 2), East Cornwall (Phase 2)
South West - Dorset	South Coast Medical Group, The Vale (BVP) Network, Weymouth & Portland Two Harbours Healthcare
South East – Surrey, West Sussex, Hampshire (Phase 2)	Alliance for Better Care – Crawley, Alliance for Better Care – Healthy Horley, Woolston and Townhill
London	Newham, Kingston & Richmond, South Kentish Town, NW London (Phase 2)

Project list – Phase 1

Complete Care Community

Project Lead	Organisation / PCNs	Project
Dr Stewart Smith	**St Austell PCN**	Mental Health in young people
Dr Mark Morris	**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 (BVP) Network PCN**	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 PCN**	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
Sue Lear	**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
Sharon Poll	**Aintree PCN**	Learning disabilities in young people
Dr Emily Morton	**Ellesmere Port PCN**	Childhood obesity
Dr Patrick Kearns	**Knutsford PCN**	Connect all public facing services & start a social movement of care within the care community
Dr Gary O'Hare	**Runcorn PCN**	Conduct disorder in children and young people
Daisy Jackson	**Central West PCN**	Obesity

Project list – Phase 2

Complete Care Community

Project Lead	Organisation / PCNs	Project
Rachel Stead	**South Sefton PCN**	Families with low level safeguarding needs to prevent escalation
Dr Cait Taylor	**Central Liverpool PCN**	Racial Inequality
Dr Farhat Ahmad	**CHAW PCN**	Social Isolation and Mental Health in Children
Julia Bailey	**Chester South PCN**	Depression
Dr Mike Merriman	**Kirkby PCN**	Young Mother's Perinatal Health
Dr Victoria Hoyle	**Knowsley Central and South PCN**	Obesity and Mental Health
Wendy George	**North Kerrier West PCN**	Social Prescribing Model for Deprived Families who Frequently Access Services
Dr Rawlins Murthy	**Arbennek Healthcare**	Social Prescribing Service for children and families inc MH Practitioner and Wellbeing Coach
Karen Grayson	**Coastal PCN**	Severe Mental Illness
Paula Varndell-Dawes	**East Cornwall PCN**	Mental Health utilising Mental Health Connectors
Dr Wingmay Kong	**North West London ICB**	Diabetes MDFT Footcare: Minor and Major Amputations and unscheduled Admissions against ethnicity
Sarah Laing	**East Staffs PCN**	Diabetes Prevention/Management uitilising the Joy App
Laura Pugh	**Caritas PCN**	Social Prescribing and Chaplaincy Service for frequent attenders with poor proactive care (inverse care law) Utilising local land to set up gardening and walking club.
Diane Carter	**Mid Nottinghamshire PBP**	To Promote healthy and happy communities in the more deprived areas of Mid Notts
Fiona Callaghan	**South Nottinghamshire PBP**	Achieving ‘community togetherness’ using a population health management approach
Dr Kristina Rusakoviene	**Southend Victoria PCN**	Increased Primary Care Accessibility for BAME Communities
Dr Sue Truman	**Central Basildon PCN**	Dance on Prescription - Arts based intervention for multiple conditions
Dr Susan Pickford	**Colchester Medical Practice PCN**	Anxiety/Phobia in highly deprived areas -(Cohort of 74 people aged between 13-18)
Deborah Adedoye	**Stanford-le-Hope & ASOP PCNs**	Adopting PHM to Combat Obesity with Personalised Care
Dr Yusuf Soni	**Stockton-on-Tees PCN**	School Hub One Stop Shop Service

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Project list – Phase 2 continued…

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Anna Sives	**Eden PCN**	Exploring the causal link between pre-diabetes, diabetes, cardiovascular sequelae and rural isolation
Ann-Marie Steel	**Cockermouth and Maryport PCN**	Mental Health in 11–30-Year-olds in most Deprived Area of PCN
Eva Bangova	**Alliance for Better Care - Healthy Horley – East Surrey PCNs**	Addressing Mental Health inequalities in Asylum Seekers
Jeredyne Stanley	**Alliance for Better Care - Crawley PCNs**	Increased Primary Care Accessibility for Black & Asian Men age 35-60 - inc prostate cancer
Dr Karen Malone	**Woolston and Townhill PCN**	Non-alcoholic and alcoholic Fatty Liver Disease in the most deprived areas
Dr Joseph Witney	**Haxby Group**	Children's Mental Health

Overview:
North East, Yorkshire and Cumbria region

Cockermouth and Maryport PCN

PCN comprises of 2 Surgeries – Castlegate and Derwent surgery and Maryport Health Services with a total of 32,000 registered patients.

Maryport has a much higher incidence of deprivation with some wards in the town being in the top 2.5% nationally. Both surgeries have areas that demonstrate varying degrees of health inequalities. PCN patients' life expectancy is 10.8 years lower for men and 8.3 years lower for women, nationally in the most deprived areas.

Eden PCN (North Cumbria)

Eden Primary Care Network has ten member practices with a population of approximately 54,000 patients. Practices span across a rural landscape with the area having the lowest population density of any local authority in England, meaning access to community services is challenging in many areas. The district has an older age profile than nationally, 27.1% over 65 compared with 18.5% due to rise to 37% by 2035. It has been identified that 10% of patients are at risk of diabetes in Eden.

Haxby Group

PCN with 5 Practices based in West Hull serving 33,800 patients in a diverse and socioeconomically deprived urban area in West Hull. According to the IMD 2019 Hull ranks highly as one of the most deprived cities in England. York has 1 LSOA (Lower Layer Super Output Area) in the top 10% quintile and York has 6 LSOAs falling in the most deprived 20%.

Stockton on Tees PCN

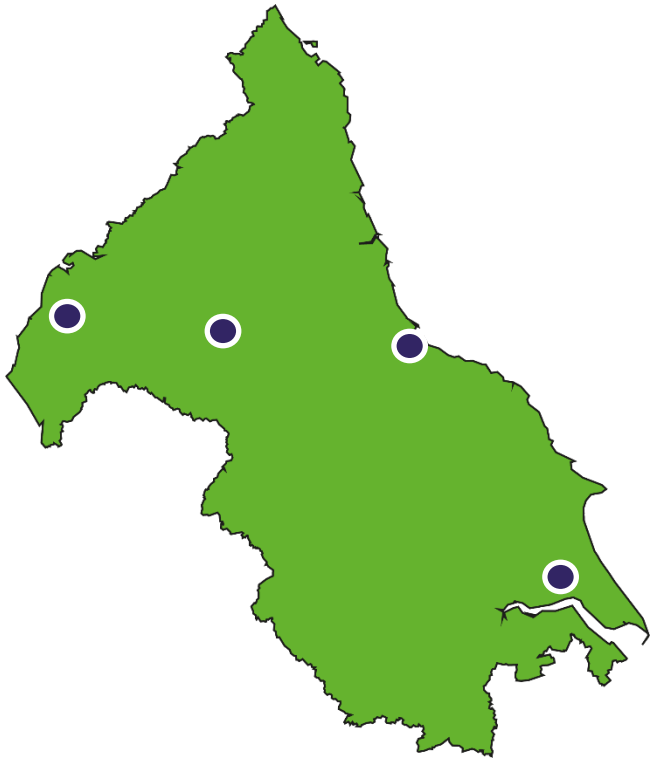
Large PCN comprising of 23 practices serving 204,084. Affluent areas sit alongside areas of deprivation, 9 wards are in the 10% most deprived in the country and there's an average male life expectancy gap of 21 years between the most and least deprived areas.

Mental health problems are more commonly found in areas of deprivation and the North East has a relatively high proportion of deprived areas.

Over the Stockton on Tees area about 21% (7,600) of children live in low-income families. Children living in low-income households are nearly 3 times as likely to experience mental health problems than their peers. Nationally 20.1% of under 16s are defined as being in low-income families compared with 24.9% in the North East.

Phase 2

- Cockermouth and Maryport PCN
- Eden PCN (North Cumbria)
- Haxby Group
- Stockton-on-Tees PCN



North East, Yorkshire and Cumbria region:

Cockermouth and Maryport PCN

Cockermouth and Maryport PCN

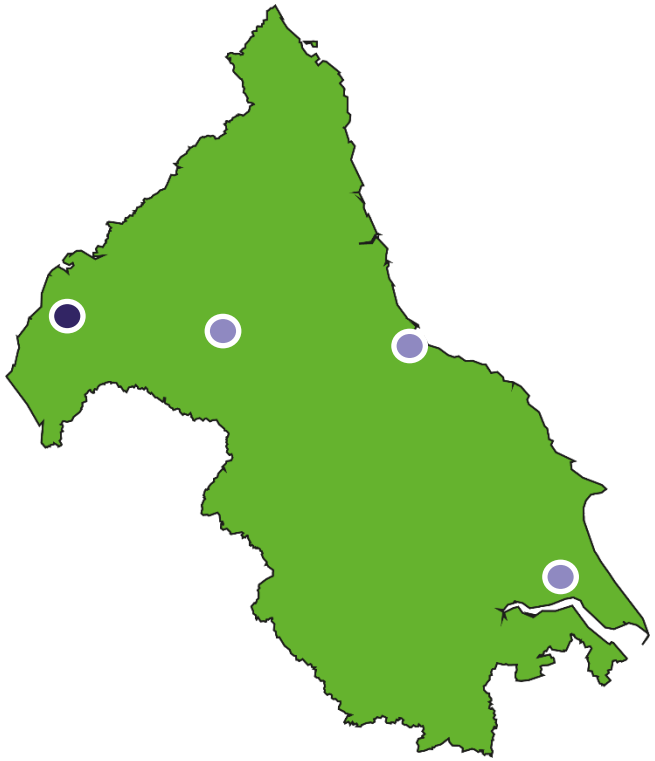
Project aim is to support and enable the community of 11-30 year olds to improve their mental health and wellbeing using a network approach with schools, colleges and community to understand the health inequalities and drivers leading to their poor mental health and well-being.

Aims and objectives:

- Building the networks of third sector and community support groups whilst educating families and young people, building resilience and skills within the communities using a comprehensive personalised care model
- Working collaboratively with a ‘complete community care’ team which could involve a dedicated telephone line referring to either social prescriber or mental health nurse for assessment, building a personalised care plan using ONS 4 measure and wellbeing outcome star. The care plan could involve coaching style support, decider skills training to encourage life skills and resilience building.

Phase 2

- Cockermouth and Maryport PCN
- Eden PCN (North Cumbria)
- Haxby Group
- Stockton-on-Tees PCN



Eden PCN (North Cumbria)

The PCN has chosen to focus on diabetes and explore any links between susceptibility to the condition and rurality. Linking in with the local council, community services and voluntary services to provide a framework to share learning and identify factors that enable sustainability and then transfer this knowledge throughout the PCN.

Aims and objectives:

- Understanding any links between patients at risk of Diabetes and Rurality
- Reduce variation of service across practice areas
- To identify patients at time of diagnosis and refer onto pathway outside of traditional general practice
- To focus on interventions to motivate and empower patients in gaining health confidence and self-management
- The service will be run in the community, predominantly by non-clinicians, to embed the understanding that prediabetes is reversible through lifestyle choices for most people and is not yet a medical problem
- To identify underlying concerns preventing healthier lifestyle though utilisation of health and wellbeing link workers
- To promote participation in the National Diabetes Prevention Programme and NHS weight loss programmes when appropriate
- Promotion of physical activity and lifestyle education through utilisation of health coaches
- Co-design and build communities based on activity
- Work with Stakeholders to develop an Eden wide strategy to tackle rising numbers of pre-diabetes.

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- Cockermouth and Maryport PCN
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North East, Yorkshire and Cumbria region:

Haxby Group

Haxby Group

Propose to assess the specific mental health needs of children within the PCN aged below 5, and to investigate whether linking up community services - including family hubs, GPs and mental health services - is to the betterment of pre-school mental health and subsequent outcomes in the area. Project focuses on the Marmot principle of giving every child the best start in life.

The PCN has witnessed differential disadvantage for families and children living in poverty over the last 10 years. This has been exacerbated by the Covid-19 pandemic with early evidence for worsening mental health, increased exposure to adverse childhood events, and subsequent cost to society.

Aims and objectives:

- Conduct a mental health needs assessment, including qualitative and quantitative data; to assess the current need and apparent data gaps
- Target subsequent research to data black spots, and intervention to areas of greatest need
- Use family hubs as the provisional physical base of intervention, multidisciplinary working as the vehicle, and place-based preventative care as the ethos of intervention
- Stay agile to local need, by adapting the approach throughout, as informed by evolving evidence and priorities
- If successful in our earlier aims, to assess whether the service could form the basis of a new multidisciplinary infant mental health service in the area.

Phase 2

- Cockermouth and Maryport PCN
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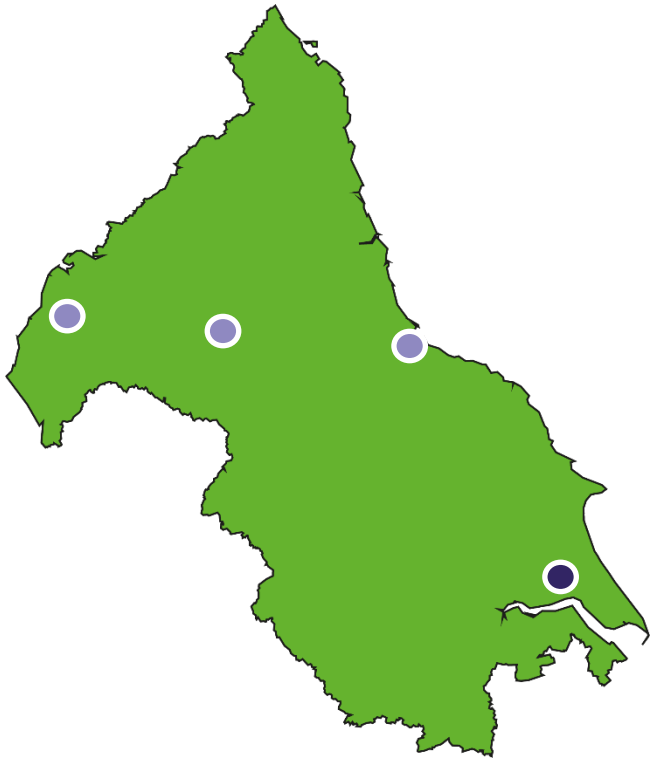

North East, Yorkshire and Cumbria region:

Stockton-on-Tees

Stockton-on-Tees PCN

A project to increase the capacity of the already successful School Hub within the award-winning Footsteps CYP One Stop Shop service to cover areas of highest deprivation within the PCN. The focus of this service is to provide accessible mental health support to CYP in these areas by obtaining PCN data and overlaying with IMD statistics.

Aims and Objectives:

- To offer positive group therapy support, accessible to a central area, reducing inequalities of access
- Provide a safe place for people to share feelings and gain knowledge from others experiencing similar difficulties
- Exposure to new behaviours, thoughts, and beliefs to improve outlooks towards education establishment to increase attendance in school
- Provide an early intervention to avoid escalation of mental health.

Phase 2

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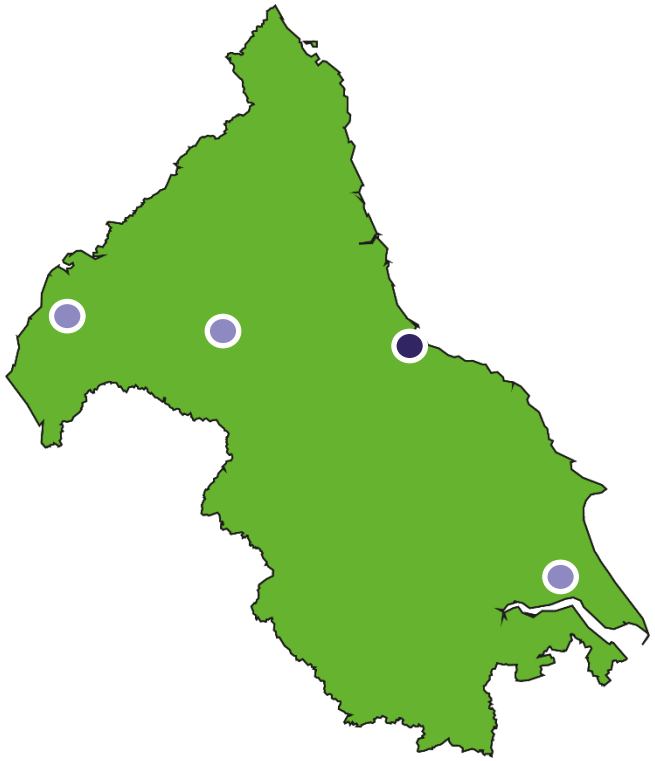


North West region:

Overview – Cheshire and Merseyside – Aintree, Central Liverpool, CHAW

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.

Central Liverpool PCN

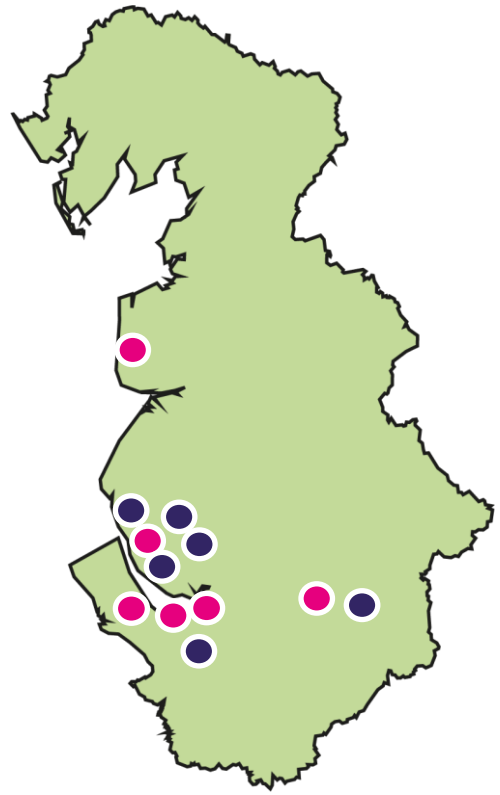
A PCN comprising of 9 Practices. According to the IMD 2019, Central Liverpool has 23.5% of its population living in income deprived households of which 29% of these house children and the 4th deprived area, nationally.

Central Liverpool Primary Care Network (CLPCN) has 110,000 patients and is the most ethnically diverse PCN in Liverpool. It is estimated that over 35% of the population are not White British/Irish. 11.9% are 'Asian/Asian British' ethnicity and 5.9% are Black/African/Caribbean/Black British ethnicity, however ethnicity recording is poor. Around 17.3% of the population's main language is not English, the highest in Liverpool. Around 820 people are registered as asylum seekers or refugees.

Chelford, Handforth, Alderley Edge and Wilmslow PCN (CHAW)

Comprises of 6 Practices serving a registered population of 47,477.

The PCN is predominantly affluent, Cheshire East having an IMD score of 9-10 (1 being the most deprived and 10 being the least deprived), however there is significant variation within the patch reflecting the areas with social housing and rural poverty where residents experience worse health outcomes compared to their wealthier counterparts.



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North West region:

Overview - Cheshire and Merseyside – Chester South, Ellesmere Port, Healthier South Wirral

Cheshire and Merseyside

Chester South PCN

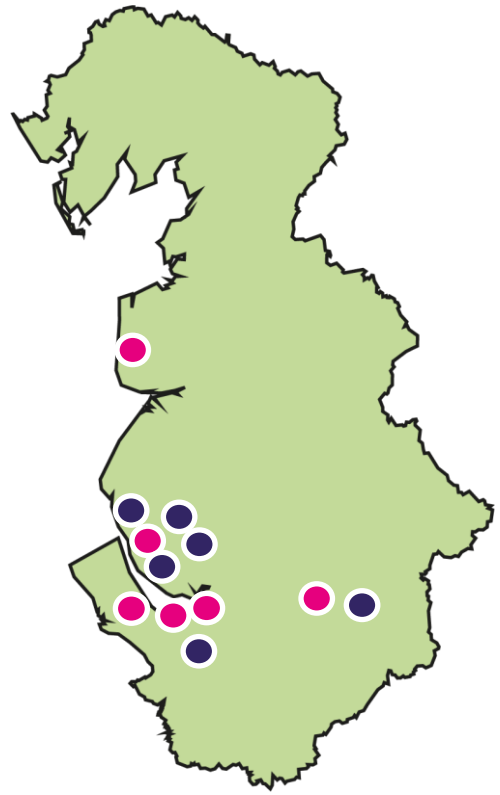
Chester South Primary Care Network has a population of over 34,000 patients across 4 GP practices. Over fifteen percent of the registered population have been diagnosed with depression, with some of the worst affected practices in more deprived areas having a patient population that nearly has 20% of the population diagnosed with depression. Patients diagnosed with certain long-term conditions were found to have an even higher rate of depression.

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.

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.



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North West region:

Overview – Cheshire and Merseyside – Kirkby, Knowsley, Knutsford

Cheshire and Merseyside

Kirkby PCN

Kirkby PCN comprises of 6 practices and provides primary care services to 52,000 patients which in total represents around one third of the Knowsley population

Knowsley Central and South PCN

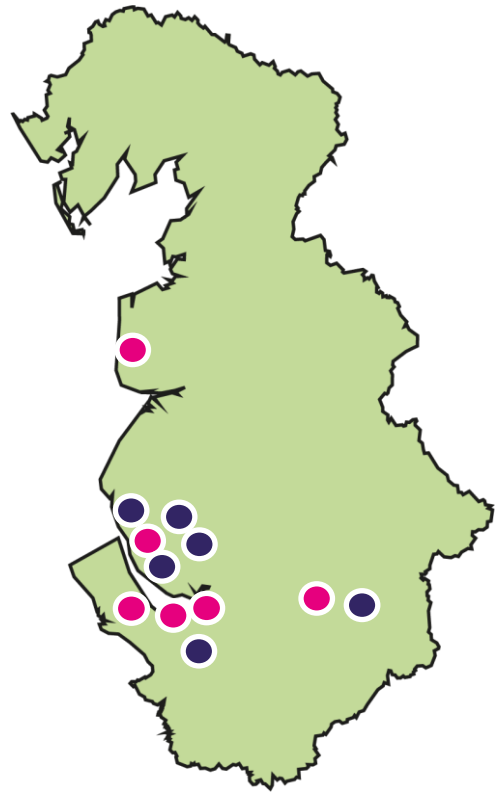
Comprises 9 practices serving a population of 61,789 with almost 60% aged 18-64 years and 22.8% are aged 0-17 years. Knowsley falls within the 20% of most deprived areas in England. Health life expectancy is lower than the national average. Knowsley is one of the areas in England with the highest rates of prescribing for obesity medications and has a higher than average rate of obesity among Year 6 children.

Knutsford PCN

Knutsford has a population of 22,954 served by 1 GP practice.

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.



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North West region:

Overview - Cheshire and Merseyside – South Sefton, Runcorn

Cheshire and Merseyside

South Sefton PCN

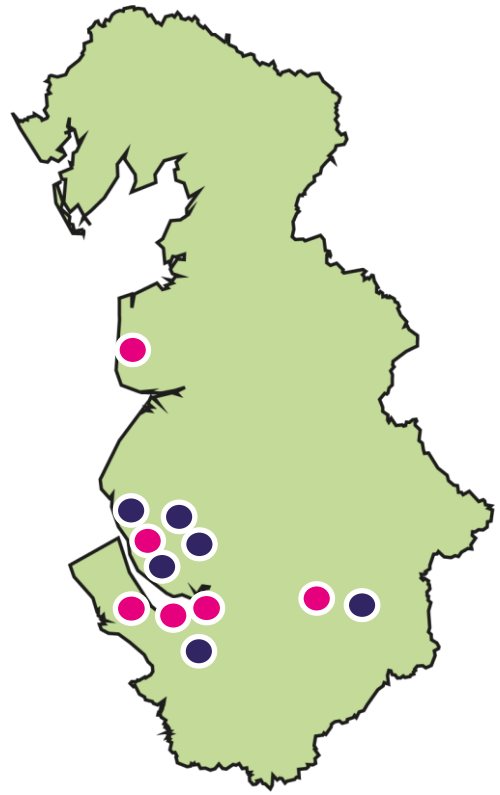
South Sefton PCN's are made up of two (2) Primary Care Networks: Bootle, Crosby & Maghull PCN and Seaforth & Litherland PCN. The network of seven practices serves around 34,000 patients.

Bootle is a deprived area with a young population with the highest level of Universal Credit claimants and widely recognised as one of the most deprived in the UK. The government's Indices of Deprivation state that Bootle, is among the worst 0.5% in the UK with high levels of unemployment, anti-social behaviour and crime, poor health, educational achievement and housing.

Crosby and Maghull, however is more affluent with an older population.

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.



Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

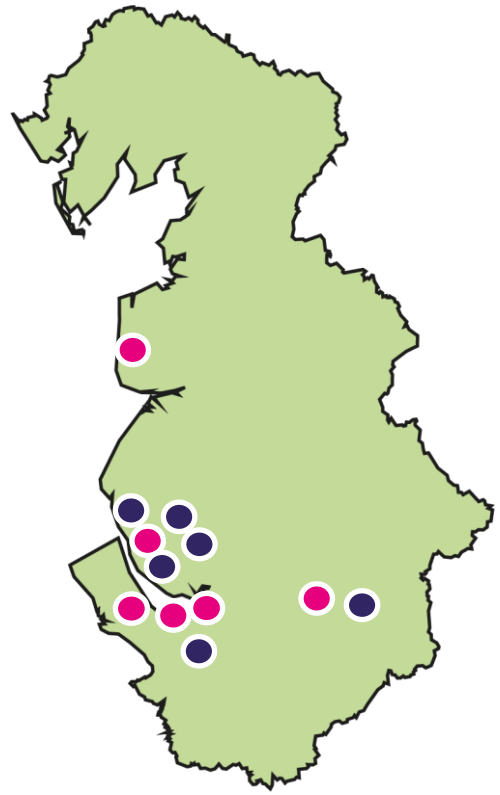
North West region:

Overview – Lancashire and South Cumbria – Central West PCN (Blackpool)

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.



Phase 1	Phase 2
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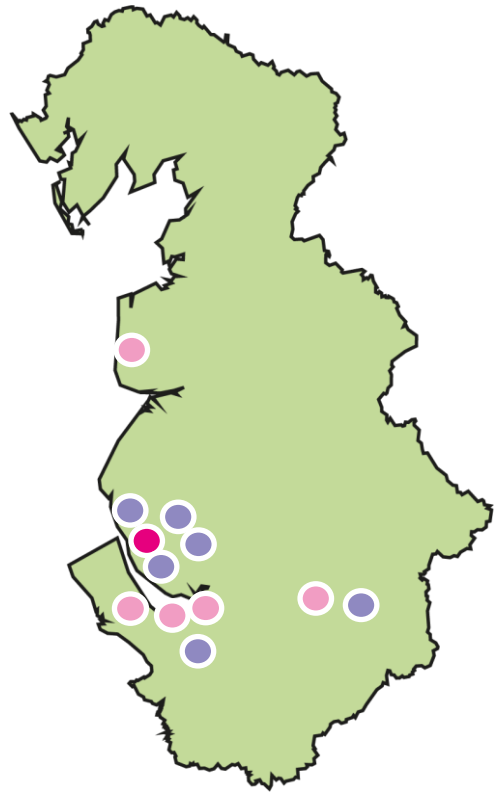
North West region:

Cheshire and Merseyside – Aintree PCN

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. Focusing on the 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:

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

Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

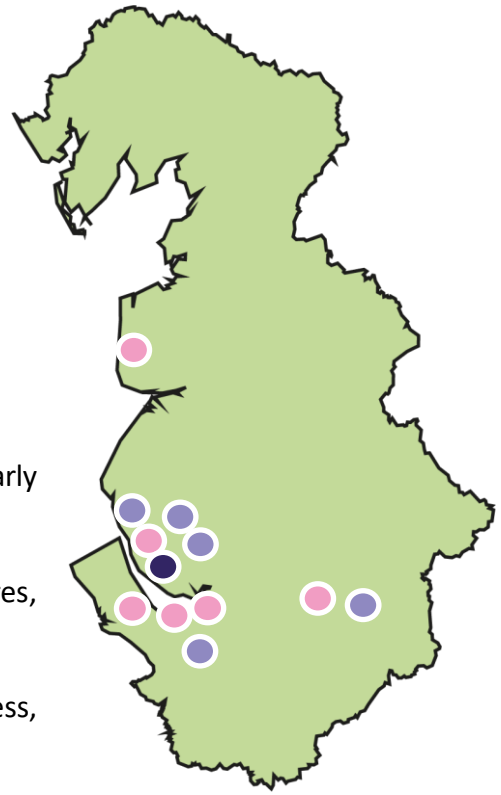
North West region:

Cheshire and Merseyside – Central Liverpool PCN

Central Liverpool PCN

Central Liverpool PCN has prioritised tackling racial inequality as a key work stream in response to the disproportionate impact of COVID-19 on ethnic minority staff and patients. This was a focus through which the PCN could start to look at the issues that impact the wider health inequalities of their population and aim to improve population health in partnership with local communities.

Central Liverpool PCN's longer term plan to reduce health inequalities centralises around connecting and collaborating with the Local Authority, third sector organisations and secondary care services. Our focus will be led by data collated from the CCG, Public Health England, and the Central Liverpool Network Intelligence Pack. We utilise learning directed from public bodied national reports such as the King's Fund Organisation. This work will also contribute to the 'One Liverpool' Strategy.



Aims and objectives:

- Working alongside community groups, and other sector organisations with the primary offer of co-located registration and early intervention health check opportunities
- Metrics and analytical support tools to be developed by Central Liverpool PCN will include patient and carer activation scores, subjective wellness scores and measures of accessibility to services.
- Data collection from engagement and community work will note any significant impact in relation to registration process, health/lifestyle assessments, screening, immunisation, and overall attendance of appointments.
- Quality Improvement tools such as driver diagrams and The Change Model will be used to compliment work being carried out, which will in turn be regularly reviewed via a Gantt chart and on-going internal leadership check ins.

Phase 1		Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN	**Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

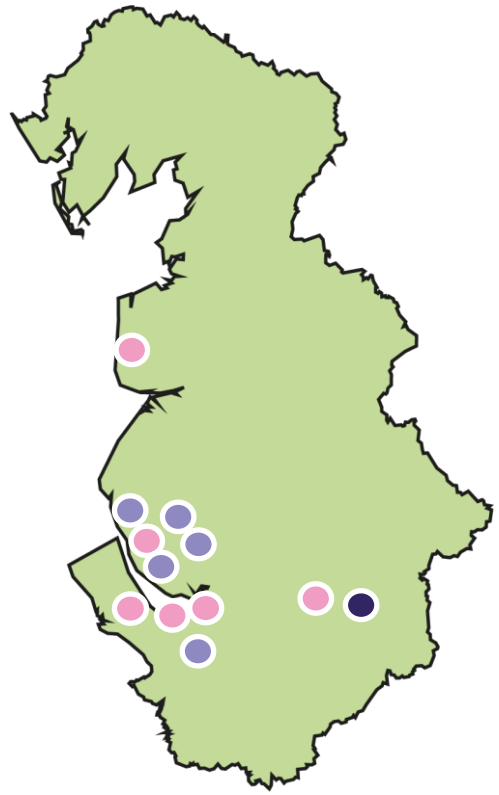
North West region:

Cheshire and Merseyside - Chelford, Handforth, Alderley Edge and Wilmslow PCN (CHAW)

Chelford, Handforth, Alderley Edge and Wilmslow PCN (CHAW)

The PCN have chosen to focus on the Mental Health of CYP due to rise in cases resulting from the Covid pandemic and some services closing temporarily as they were overwhelmed by the demand

Working with 3rd Sector organisations, asset mapping, working with the schools to provide early intervention, developing a pilot Young person's mental health worker role with the local CAHMs provider and considering specific young people's mental health social prescriber to address the specific local issues.



Aims and objectives:

- To provide a local model to reduce the waiting time burden using well motivated and appropriately trained volunteers to facilitate and self-direct support groups for young people including digital models and use of community assets, ensures sustainability of community mental health support to our local community
- Working collaboratively to identify and understand the extent of the problem
- Working collaboratively for solutions & ideas to develop easy access to all available support in way that will optimise basic well-being
- To try and influence local policy around support for YP experiencing mental health issues.

Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

Cheshire and Merseyside - Chester South PCN

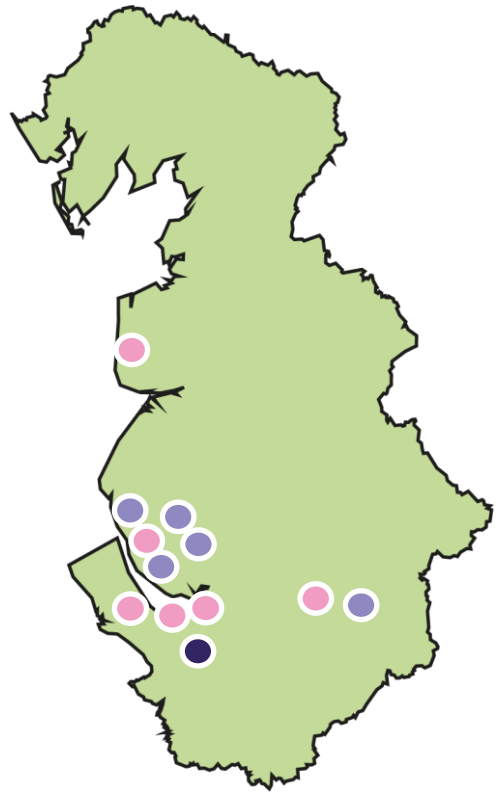
Chester South PCN

To set up a service to aid those who suffer with depression and one or more other long-term comorbidities who live in more deprived areas.

Chester South PCN are looking to create support pathways to be available for patient use such as signposting to appropriate community services and third sector organisations, opportunities for one-to-one counselling and peer support services aiming to improve patient activation and capacity for self-care. Tackling upstream mental health issues as well as helping Patients deal with long-term conditions.

Aims and objectives:

- The aim is to provide the Community with a proactive offer of support to build knowledge, skills and confidence through supported self-care and community-centred approaches
- The creation of patient support pathways that support 'safe space' culture and long-term aim of the service being sustained and managed in the Community.



Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

Cheshire and Merseyside – Ellesmere Port PCN

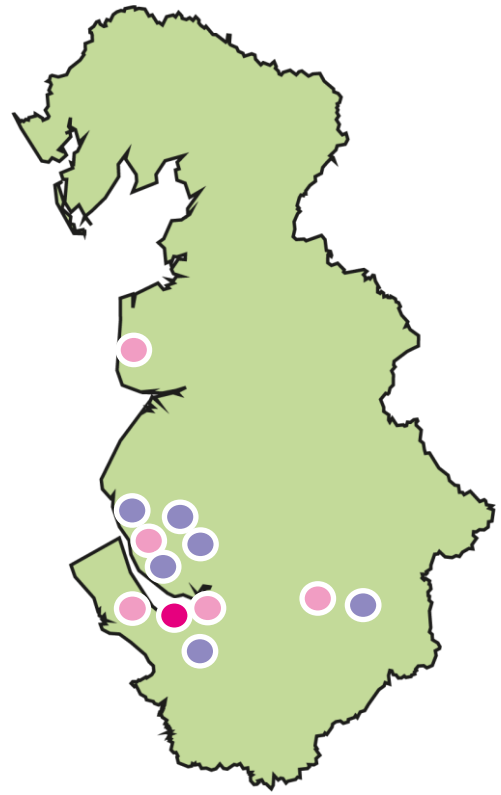
Ellesmere Port PCN

The key priority is to tackle childhood obesity through a project that will bring together public services, residents, third sector organisations and businesses in Ellesmere Port, to shape the local health and care services and improve the lives of the people that live within the town.

The PCNs will work collaboratively with 3rd sector organisations, police, social care, schools and local residents.

Aims and objectives:

- Promotion of Live Well Cheshire West website and logo in the community
- Integrated working with schools and school nurses to identify children at reception and year 6 who are obese
- Cross-reference with obesity register for adults to identify if parents / households are obese too
- Offer consultations with a dedicated family health and wellbeing coach to parents / guardians of children who have been identified as obese and to parents / guardians on the practice obesity register
- Take a personalised care approach to create family behaviour change, aiming to understand the barrier to change - family, educational, financial, mental well-being - and develop personalised weight loss plan
- Work in connection with children's social prescribing link worker to access third sector organisation that can support any other needs identified through consultation process
- Focus on building high self-esteem and children's sense of self-worth as well as traditional diet and exercise approaches.



Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

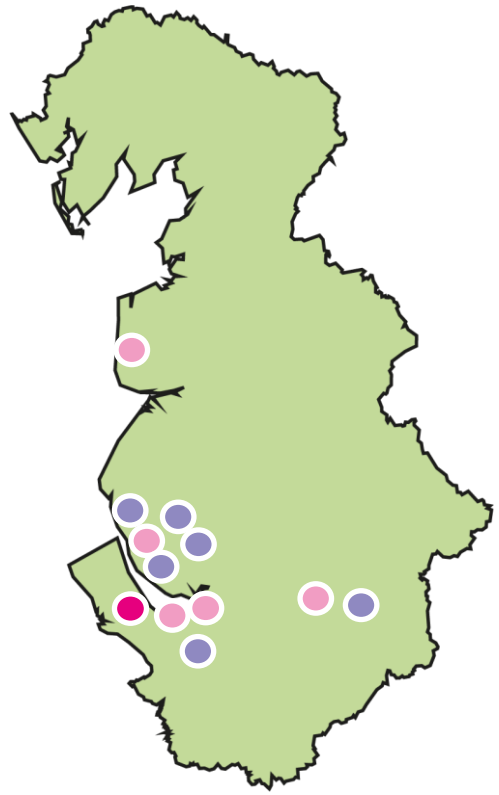
Cheshire and Merseyside – Healthier South Wirral PCN

Healthier South Wirral PCN

Utilise an Asset-Based-Community-Development approach within an adaptive network space that can accommodate both professionals and citizens so together they can understand and respond to Cardiovascular Disease (CVD) Health inequalities within South Wirral.

Aims and objectives:

- Work with both professionals and citizens to build a community of practice that can re-function and utilise evidence-based resources, so they are understood in the context of local experience, assets and environments
- Use an asset-based-community-development approach to implement evidenced based interventions in a way that means they are embraced, utilised, evolved and sustained by the people and communities that exist within Healthier South Wirral.



Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • Healthier South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

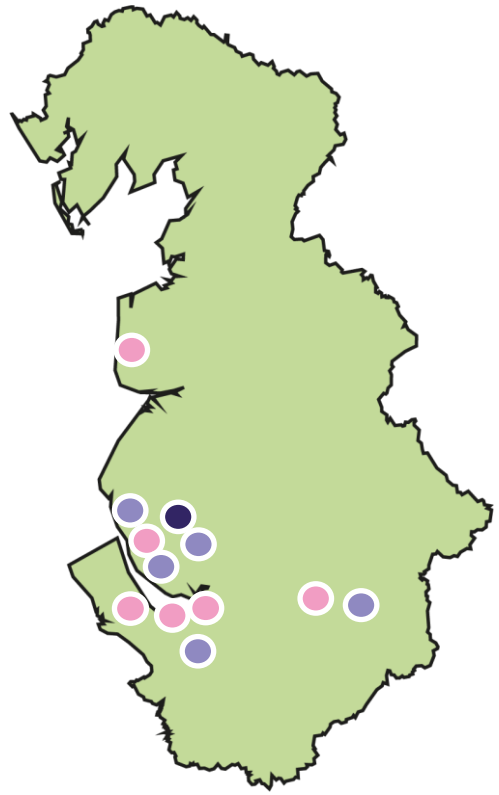
Cheshire and Merseyside – Kirkby PCN

Kirkby PCN

Kirkby PCN have chosen to focus on Mothers Perinatal Health linking mothers in with a Social Prescriber from early pregnancy to promote health, mental health, aspirations and job opportunities. Knowsley is an area of high deprivation and low educational attainment which results in high incidences of poor mental health.

Aims and objectives:

- Appoint a Social Prescriber with Perinatal expertise
- To create individual relationships with vulnerable single mums to start a journey to address the inequality
- Focussing on prevention, early intervention and confidence building
- Aim to encourage Women into the workplace and nurture a sense of purpose
- Working with Liverpool John Moores University for evaluation.



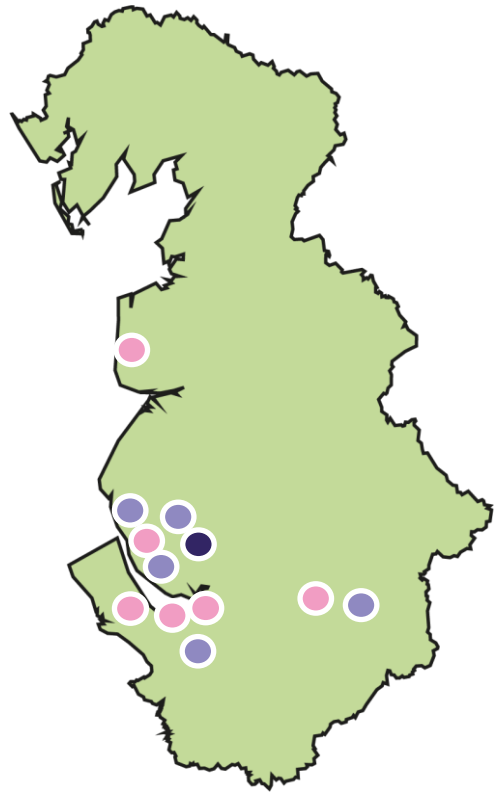
Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

Cheshire and Merseyside – Knowsley Central and South PCN

Knowsley Central and South PCN

Knowsley Central and South PCN have chosen to focus on the link between obesity and poor mental health in its areas with the highest levels of deprivation.



Aims and objectives:

- Aim to tackle obesity based on the 5 pillars of health: physical activity, nutrition, mental health and wellbeing, sleep and substance misuse
- The PCN will work with the Local Authority and other wider community stakeholders to offer a selection of in person or online sessions which are self-directed, expert-led and can be undertaken via a group model. Encourage participation in existing schemes but also bring new and innovative schemes to the area
- The programme will be designed so that it is accessible to all members of the community, in particular addressing challenges that vulnerable groups may have to accessing these services thus further reducing health inequalities.

Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

North West region:

Cheshire and Merseyside – Knutsford PCN, Runcorn PCN

Knutsford PCN

This social movement will provide opportunities for social interaction through exercise to improve health outcomes. The PCN will work closely with local partners to achieve this, including third sector organisations and Local Authority.

Aims and objectives:

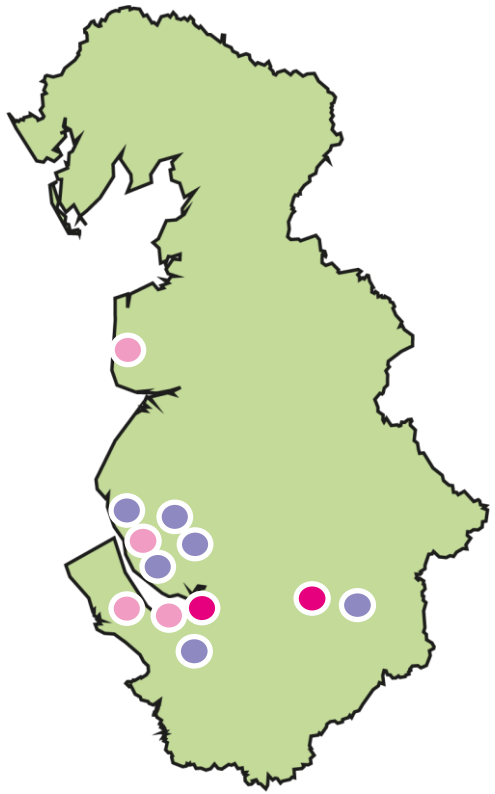
- To target areas of health inequality in Knutsford through the provision of exercise and social opportunities
- Work with people who have a learning disability and provide social opportunities for the isolated and elderly, many of whom suffer from cognitive decline.

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 people's needs in primary care in addition to schools and mental health services.

Aims and objectives:

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



Phase 1	Phase 2
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North West region:

Cheshire and Merseyside – South Sefton PCN

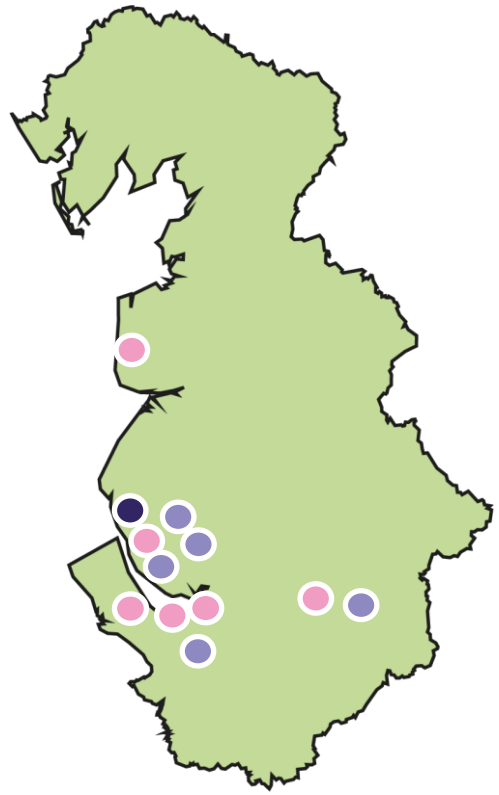
South Sefton PCN

Plan to create a complete care communities programme, initially focussing on families of concern to general practices in Bootle. Families will be of sufficient concern to be identified on safeguarding registers in practice, but without current statutory involvement, and have not been escalated to either children in need or child protection plans.

South Sefton PCN recognise the long-term health and wellbeing benefits that can be achieved by caring for a single family or household unit holistically. There is strong evidence that a joined-up approach between primary care, local authority and VCF colleagues can reduce incidences of adverse childhood experience.

Aims and objectives:

- Work with local authority and local voluntary, community & faith organisations (VCF) colleagues to create a no wrong door approach to identifying families that would benefit from referral to the family hub for trauma-informed group therapy
- Produce (or refresh) an asset map to identify services across primary care, secondary care, local authority and VCF sectors that offer care to families in need of additional support; and create a simple process that keeps the information up to date
- Develop social prescribing experts that focus on whole family health and wellbeing, creating a personalised care approach.



Phase 1	Phase 2
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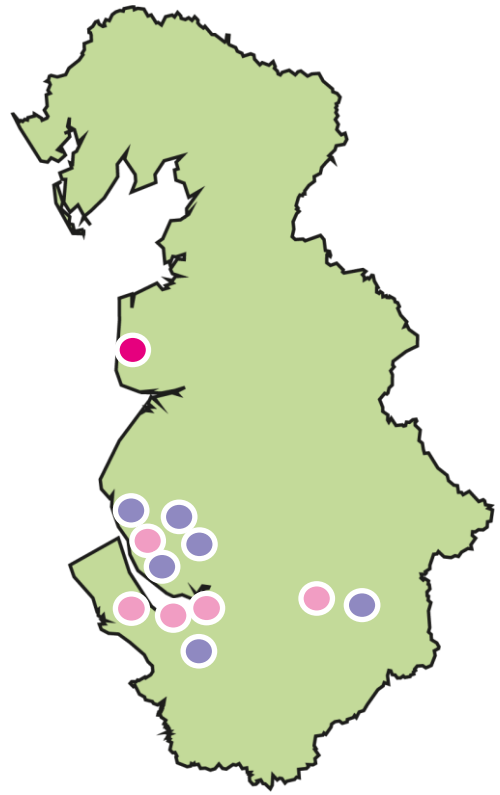
North West region:

Lancashire and South Cumbria – Central West PCN (Blackpool)

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:

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

Phase 1	Phase 2
Cheshire and Merseyside • Aintree PCN • Ellesmere Port PCN • Knutsford PCN • Runcorn PCN • South Wirral PCN **Lancashire and South Cumbria** • Central West PCN (Blackpool)	**Cheshire and Merseyside** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN

Midlands region:

Overview – Caritas

Caritas PCN

Cape Hill Medical Centre (list size approximately 12,000), is in an area of ethnic diversity and high deprivation, with pockets of harrowing poverty. The practice manages the Homeless service for Birmingham & Solihull (run separately) and are involved in the South West Birmingham care delivery for asylum seekers and Afghani resettlement patients in local hotels.

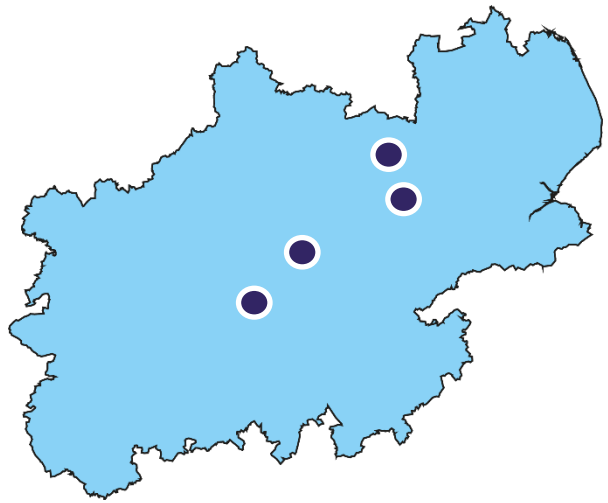
Caritas PCN is made up of Cape Hill Medical Centre and 2 other practices and although close together their populations have differing social needs. The inequalities are typical of these populations, with people unable to access health care due to other priorities taking precedent- or alternatively- ineffectively accessing health care- sometimes taking appointments once or twice a week - and still not getting the help they need through traditional delivery of care.

The service has critical problems with access, with difficulty providing the number of appointments that patients request (x2 the national average) - leaving less health literate patients at a disadvantage for getting the help they need.

The PCN has difficulty hitting targets such as reduction of modifiable cardiovascular disease risk factors (CVD being the highest killer) in high risk populations due to ethnicity and poverty-(smoking, blood pressure, cholesterol, obesity), attendance for annual health care reviews for long term conditions, cancer screening and immunisations.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



Midlands region:

Overview – East Staffordshire, Mid Nottinghamshire, Nottingham West

East Staffordshire PCN

East Staffordshire PCN has 18 GP practices with complex demographics and a population of 147,000. There are areas of significant ethnic diversity and deprivation, with of the largest practices residing in the 3rd most deprived deciles nationally, with others in the least deprived according to Public Health Data 2020.

As part of the PCN DES GP practices were asked to agree a priority area focusing on inequalities, all 18 practices agreed on Diabetes, both from a treatment and prevention perspective. The PCN will stop using traditional medical models of care, changing the focus from treating the disease to empowering the whole person.

Mid Nottinghamshire PBP

Place Based Partnership consists of 23 partner organisations and includes six PCNs bringing together health and social care services across Mansfield, Ashfield, Newark and Sherwood.

To promote healthy and happy communities in one of our more deprived areas by identifying purposeful and sustained approaches to tackle health inequalities through co-production with these communities.

The indirect outcome of this approach should provide increased access to preventative and screening services for these communities resulting in changes in health outcomes.

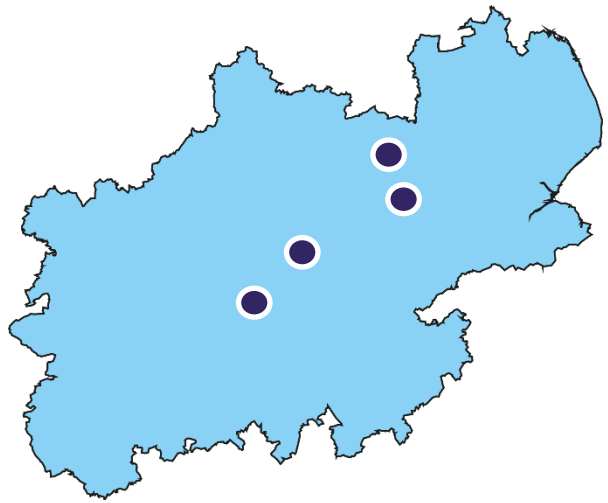
Nottingham West PCN

The Nottingham West PCN lies within the South Nottinghamshire Place Based Partnership (PBP) and has boundaries that are co-terminus with the borough of Broxtowe.

It comprises three neighbourhoods, Eastwood, Stapleford and Beeston and has a total of over 107,000 registered patients who are served by 12 GP practices.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



Midlands region:

Caritas PCN

Caritas PCN

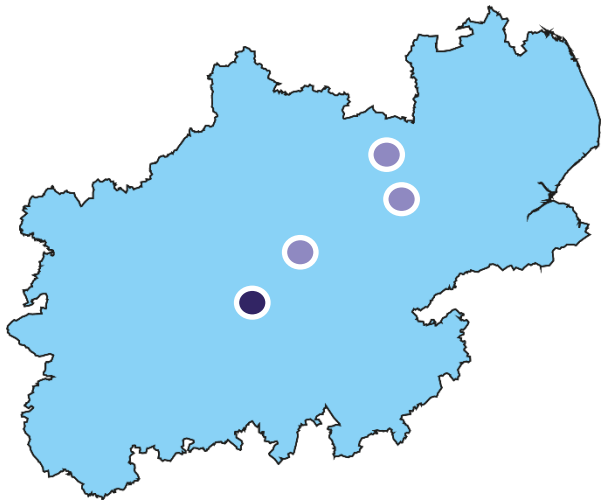
A project to test the hypothesis that four Social Prescribing and Chaplaincy strategies at Cape Hill Medical Centre (Primary care setting) within Caritas PCN, proactively offered to frequent attenders (needs not met) and to patients with a history of poor uptake for proactive care (inverse care law), as recognised by complex computer programming of social isolation factors against attendance rates (previous in house pilot), with an aim to tackle health inequalities (recognising Maslow's hierarchy of needs) will improve patient outcomes (social, physical and psychological well-being), reduce health inequalities and improve patient access.

Aims and objectives:

- Patients getting the help they need for their most pressing health needs, be it social or medical, from the most appropriate team member
- An improvement in patient's social, psychological and physical wellbeing
- An improvement in access for all patients
- An improvement in uptake of preventative health care as a targeted method of reducing health inequalities and reaching communities who have greatest difficulty with accessing care
- A more cohesive working relationship between the patients and the health centre.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



Midlands region:

East Staffs PCN

East Staffs PCN

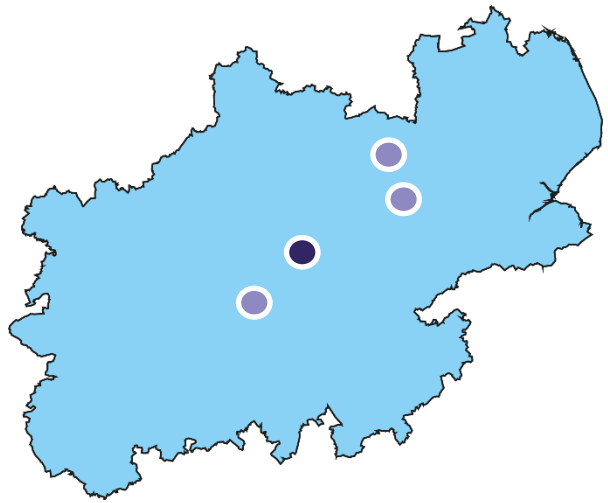
The PCN have chosen to focus on Diabetes, both from a treatment and prevention perspective. To STOP using traditional medical models of care, changing the focus from treating the disease to empowering the whole person.

Aims and objectives:

- Innovate and bring together a strong community network to work in true partnership
- Gain Compassionate Communities Charter Status
- Better communications and engagement across East Staffordshire especially in their hard-to-reach areas, this will result in a levelling up of services and providing equity of care and resource
- Engage with Community groups, Use the 'Compassionate community' Ethos, include Volunteers especially people living with diabetes young and old, Faith leaders, Schools, Local councils etc
- Implement “The Joy App” as a unified digital ecosystem platform
- Engage a Community Clinical Lead.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



Midlands region:

Mid Nottinghamshire PBP

Mid Nottinghamshire PBP

Mid Notts Place Base Partnership (PBP) proposes a model to enable work with communities of greatest need. Working with a commitment to tackle health inequalities in a sustainable way to achieve better population health and better quality of care.

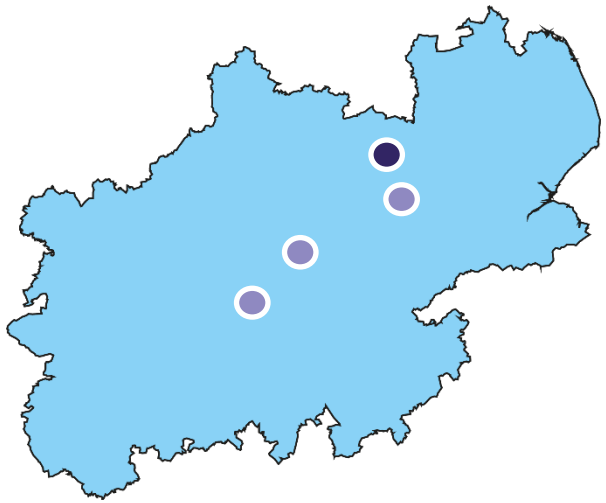
Building on the commitments and ambitions set out in the NHS Long Term Plan (2019), Breaking Down Barriers to Better Health and Care (2019) and Designing ICSs in England (2019), Mid Notts already has a strong and effective PBP, with all partners and is committed to improve the health and wellbeing of their communities.

Aims and objectives:

- To promote healthy and happy communities in the more deprived areas of Mid Notts by joining up the community groups and partners supporting the areas to create a community spirit that they are “in this together,” ensuring the population within those communities voices are heard, identifying purposeful and sustained approaches to tackle health inequalities through co-production with these communities
- Working with the residents to understand their priorities but also barriers to health and Wellbeing
- Enhance current work and relationships the partners already have with these communities
- Support through the creation of Patient's own lifestyle charter to create options and solutions to address the needs they identify.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



Midlands region:

Nottingham West PCN

Nottingham West PCN

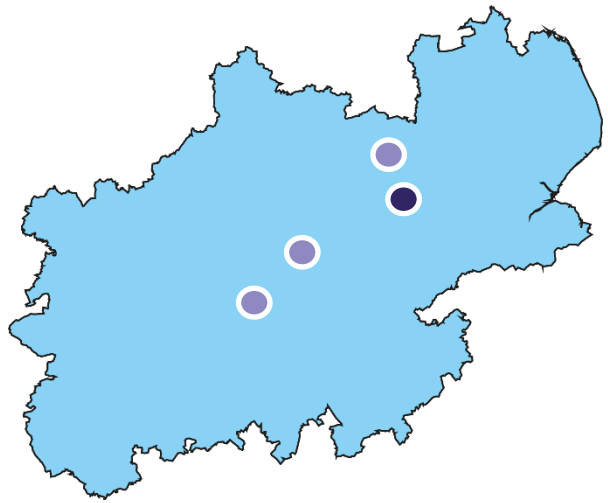
Eastwood, despite its problems, has a very strong identity and a very strong Community and Voluntary Sector. With the support of the PCN and Broxtowe Borough Council, a group of local volunteers have formed a citizen-led Community Interest Organisation and identified Durban House as a venue for a community hub. The purpose of the Hub is to provide a multi-functional environment that provides a central space for local service users and services to come together to start to achieve their goals.

Aims and objectives:

- Local citizens will lead and engage with the local community in the design and co-production of the potential service offer(s) in Durban House. They will also use a Population Health Management approach to identify and develop a service offer that:
    - helps to proactively identify those people who may benefit from the services at the community hub
    - uses care coordination and social prescribing services to seek to engage and motivate the local population
    - brings together all appropriate partners and community members, groups and services to co-design and co-produce a resource fit for people of Eastwood
    - utilises a ‘no wrong door’ approach to ensure that a holistic and person-centred approach for all who engage with the services offered
    - tackles health inequalities through a focus on the wider determinants of health (considers economic, social, and environmental factors associated with wellbeing) building on the collaborative work of place-based partners.

Phase 2

- Caritas PCN
- East Staffordshire PCN
- Mid Nottinghamshire PBP
- Nottingham West PCN



East of England region:

Overview - Central Basildon, Colchester Medical Group, Southend Victoria, Stanford-le-Hope

Central Basildon PCN

Within the Central Basildon PCN, a collaboration of eight GP practices serving approximately 49,000 patients from the central Basildon area, the Murree Medical Centre has been highlighted as CORE20Plus5 in the East of England to the 20% of the most deprived practices nationally.

Colchester Medical Group PCN

Colchester Medical Group PCN comprises four fully-merged surgeries serving 38,500 patients. The PCN covers the majority of Colchester and includes the wards with the highest deprivation indicators. The patient demographic is nearly identical to the national picture.

Southend Victoria PCN

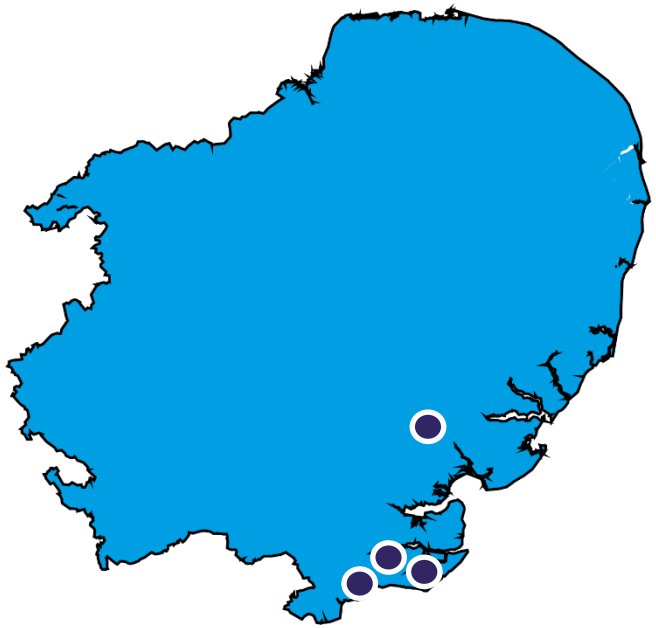
A collaboration of eight GP practices serving approximately 60,000 patients from the Southend Central and Westcliff-on-Sea areas.

Stanford-le-Hope PCN

PCN comprising of six GP practices serving approximately 33,000 patients, from the Stanford-le-Hope and Corringham areas.

Phase 2

- Central Basildon PCN
- Colchester Medical Group PCN
- Southend Victoria PCN
- Stanford-le-Hope and ASOP PCNs



East of England region:

Central Basildon PCN

Central Basildon PCN

Following on from a highly successful first tranche, providing activity and wellbeing sessions for Care Homes and in the local community, Mid and South Essex, Central Basildon PCN and partners, Basildon Council and Essex County Council, via Active Essex, as a system collaborative are continuing with a second phase as well as several new projects.

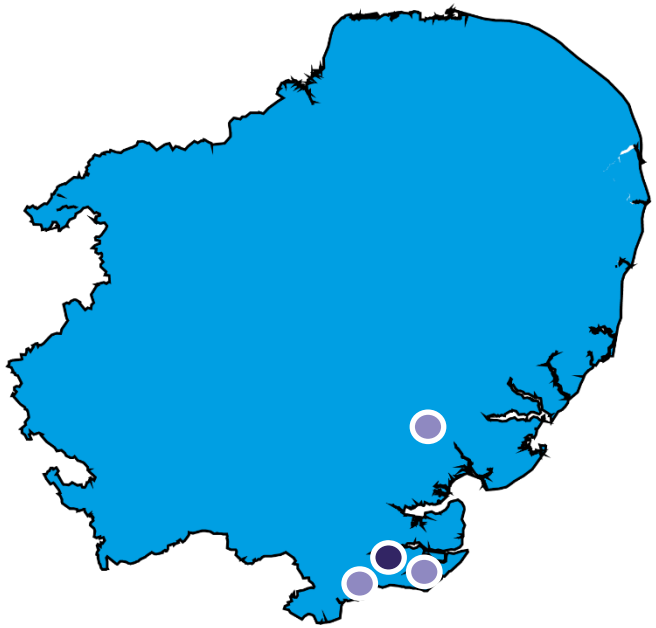
The project will deploy Latin dance styles as an intervention to improve psychomotor skills to benefit children still undiagnosed with ASD or ADHD. There is an opportunity to provide classes in schools and potentially special needs schools in the Basildon area to help this segment of the local community.

Aims and objectives:

- Work with local schools to provide for 12 to 15 children per class, with dance tutors in a 45-minute Latin dance session after school for primary school-age children for three months
- Explicitly targeting undiagnosed ADHD and ASD children and may also be designed to include parents to support parents and children together
- Incorporate a clinical and academic evaluation at the end of the proof-of-concept stage, it is hoped that further tranches will be commissioned once benefits are established.

Phase 2

- Central Basildon PCN
- Colchester Medical Group PCN
- Southend Victoria PCN
- Stanford-le-Hope and ASOP PCNs



East of England region:

Colchester Medical Group PCN

Colchester Medical Group PCN

Population health data demonstrated high levels of mental illness in children and young people (CYP) in the most deprived wards within the PCN. The project focuses on offering an early intervention to CYP living in these areas who are starting to experience poor mental health. There is huge gap in mental health provision for CYP living in Colchester. The demand for the PCN CYP counsellor and the level of need was much higher than anticipated. High volumes of patients had been self-harming and many with a history of multiple presentations at the local ED.

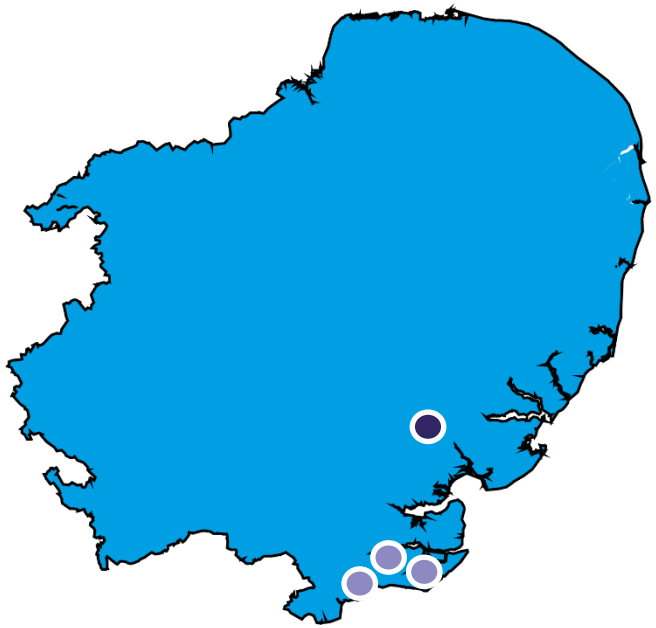
The PCN plan to identify CYP living in the areas with highest deprivation indicators with early signs of low mood or anxiety. Made links with schools, the local Neighbourhoods team and the leads for Children's Services, working with them to reach those most at risk of going on to develop mental illness. The PCN will initially offer six sessions of talking therapy carried out by the CYP counsellor based at the PCN.

Aims and objectives:

- Identify CYP at risk of health disadvantage with early signs of poor mental health
- Work towards improving mental health, well-being, and resilience
- Reduce referrals to the local CAMHS service and presentations at ED with self-harm
- Use the Young Persons CORE questionnaire before and after completion of the therapy sessions to measure the impact of the intervention.

Phase 2

- Central Basildon PCN
- Colchester Medical Group PCN
- Southend Victoria PCN
- Stanford-le-Hope and ASOP PCNs



East of England region:

Southend Victoria PCN

Southend Victoria PCN

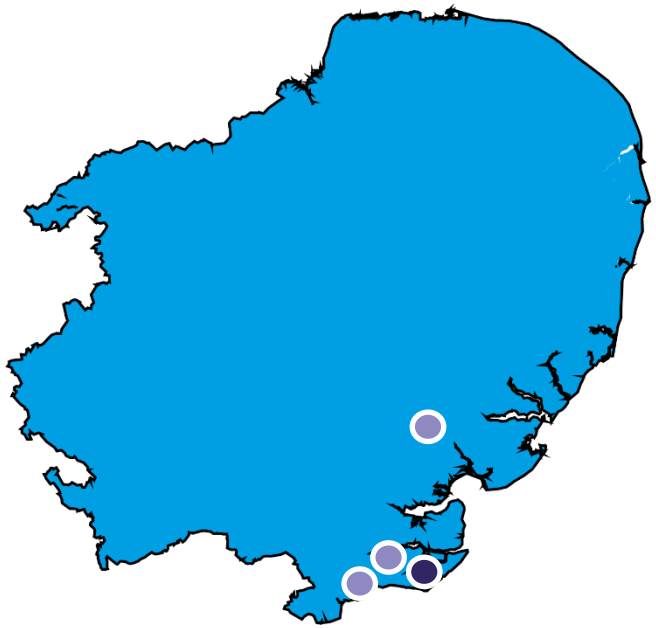
A project aiming to address at least 10% most deprived or most affected by health inequalities population. That is around 6000 patients from ~60000 Southend Victoria PCN patient list. The initial focus of the project will be on Patients from BAME communities to ensure that their attendance and non-attendance is physically checked, and they are reconnected. Taking into account aspects such as language, communication and cultural aspects that may reduce engagement with health services. Ensuring staff are trained to high safeguarding standards.

Aims and objectives:

- Ensure continuity of care for 75% of women from Black, Asian and minority ethnic communities
- To check all women who had baby delivery from BAME group in the last 3 years to ascertain whether there were any health issues after and if they were addressed appropriately, bloods, BP and weight check
- NHS CVD disease screening programme proactive check in both men and women from BAME population
- Proactive smear test invitations and for women in ethnic minority population.

Phase 2

- Central Basildon PCN
- Colchester Medical Group PCN
- Southend Victoria PCN
- Stanford-le-Hope and ASOP PCNs



East of England region:

Stanford-le-Hope (SLH) & Aveley, South Ockendon and Purfleet (ASOP) PCNs

Stanford-le-Hope (SLH) & Aveley, South Ockendon and Purfleet (ASOP) PCNs

Population health management findings of the two PCNs record circa 13,357 adults currently living with obesity and 97% of those have not received a weight management service (WM). Obesity is a chronic relapsing condition that requires a behavioural change in the long term. Traditional 12 week WM services had ~40% non completion rate. Additionally, ASOP PCN has areas of significant social deprivation which compound this access and result in health inequalities. Obesity and health inequalities place extra demand on health and social care services.

Thurrock & Brentwood Mind Charity Positive Pathways service has been commissioned in Thurrock since 2018. This features in a National Children's Bureau Report (2022) demonstrating the impact of adopting a personalised care model in reducing health inequalities in young people.

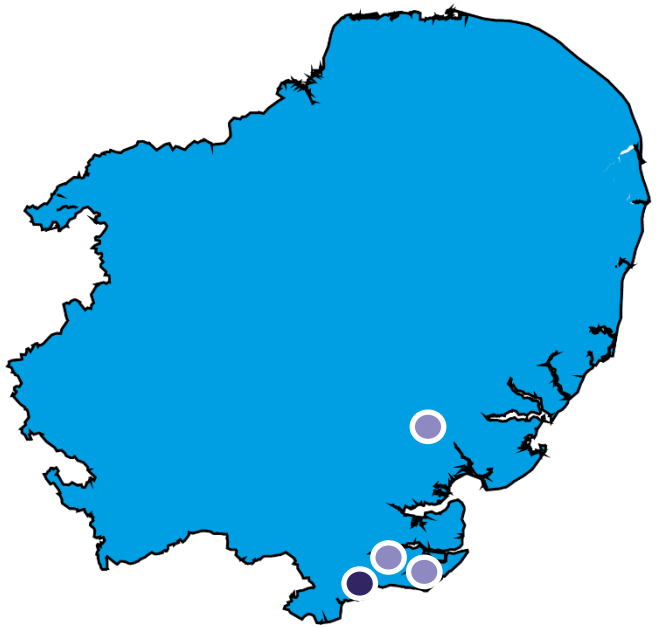
SLH and ASOP PCNs with cross sector organisations and people are working together to mobilise a personalised care model for people living with obesity.

Aims and objectives:

- Analysis revealed that the Obesity Register requires improvements therefore findings currently may be under-representing the real challenge. This project will improve data quality and prevalence recording of obesity and beyond
- To identify patient cohorts by designing a clinical risk stratification methodology. This co-produced Population Health Management case finding tool will include clinical and wider determinants of health risk factors
- Improve the likelihood of adherence to treatment and maintaining healthier lifestyles through a coaching approach
- Reduce the likelihood and prevalence of end organ damage as a result of living with obesity
- Implementing a multi-skilled, organisational team approach co-ordinated at primary care network level that adopts the universal, targeted and specialist components of the operating model of Personalised Care.

Phase 2

- Central Basildon PCN
- Colchester Medical Group PCN
- Southend Victoria PCN
- Stanford-le-Hope and ASOP PCNs



South West region:

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

Bristol, North Somerset and South Gloucestershire

Pier Health - Weston-Super-Mare 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 9 Practices 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).

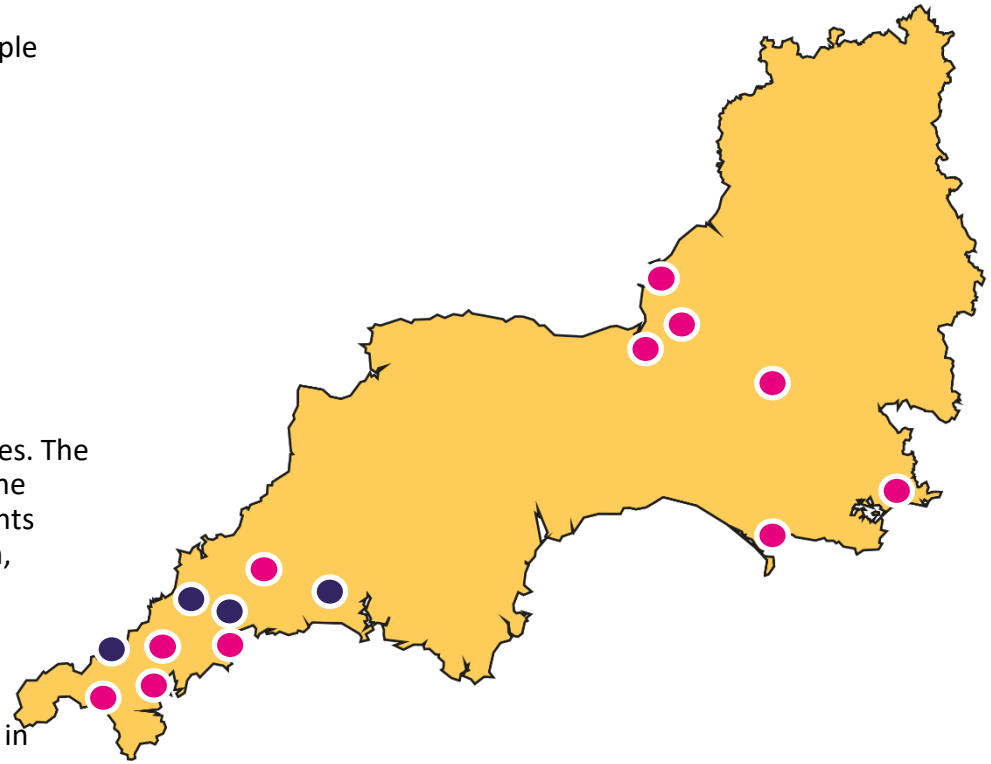
The Vale (BVP) Network PCN

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.

Weymouth and Portland

Six practices, serving our community of around 76,000 people. Seven neighbourhoods in Dorset fall into the top 20% nationally for income deprivation (up from five in 2010) - seven of these are in the former borough of Weymouth and Portland.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Bristol, North Somerset and South Gloucestershire – Pier Health - Weston-Super-Mare PCN

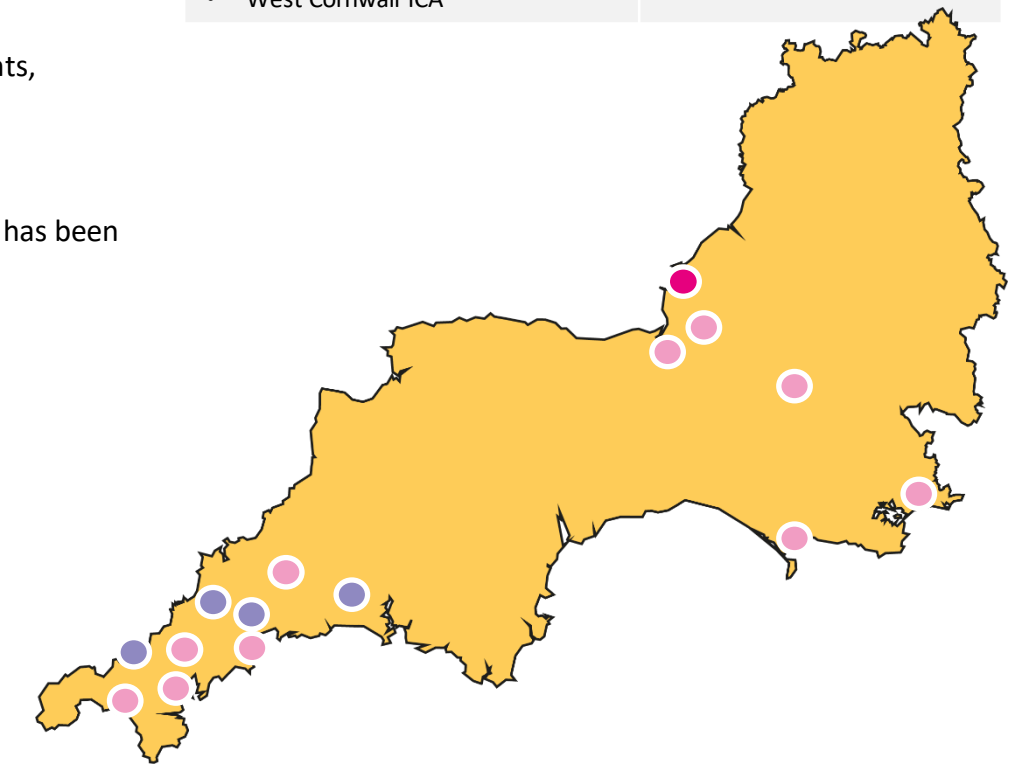
Pier Health - Weston-Super-Mare PCN

Programme aimed at reaching out to young families/single parents 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 Multi-disciplinary network (Police, Education, Social Services, Health, Mental Health).

Aims and objectives:

- Intervention and assistance to target and reach and engage with young families/single parents, 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 and acknowledging that historically, it has been the services that have been hard for this group to reach and access.

Phase 1	Phase 2
• Pier Health - Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Somerset – Bridgwater Bay PCN

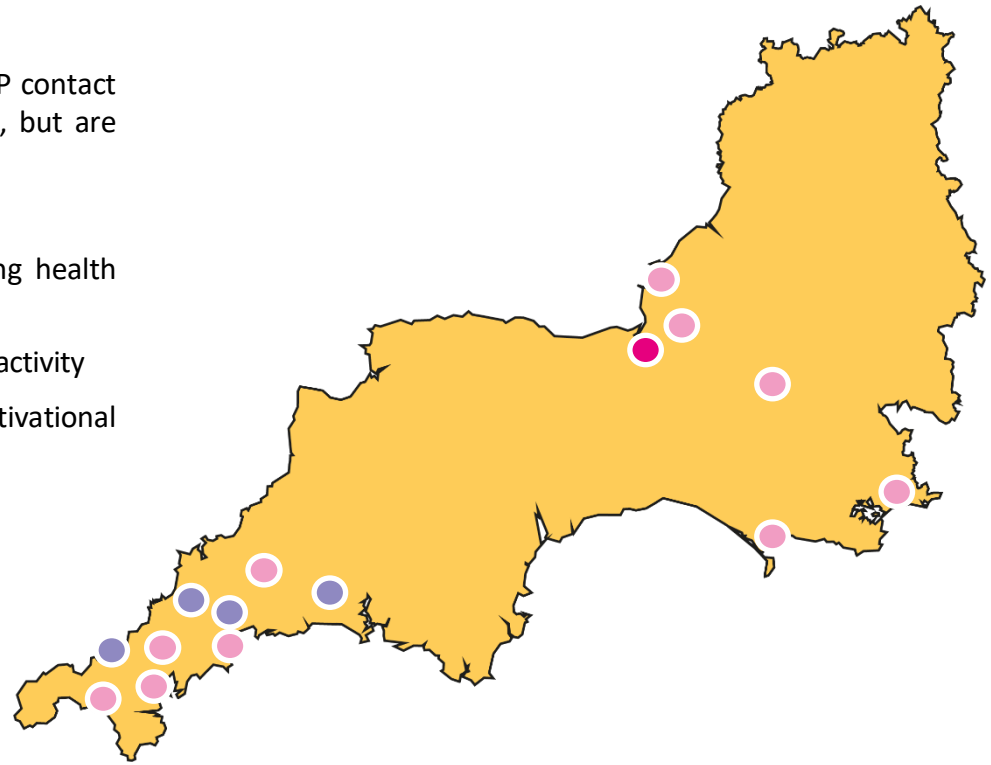
Bridgwater Bay PCN

To give the population of Bridgwater Bay the tools to begin to move from area of high disease prevalence to one of raised patient activation and maintained wellness. The team of dedicated health coaches will work with young mothers to assess their needs using the DIALOG tool. Then assess unmet need by forming collaborations with social prescribers, allied health professionals, social sectors and voluntary sector organisations. These families will be identified by both population health methodology and invitation through existing social group settings and family health professionals. This will select those households that will benefit most from gaining greater health confidence.

Aims and objectives:

- Patient activation, measured at incremental points of the project. Looking at longer term GP contact numbers in those who have been through the scheme compared to those who have not, but are demographically matched
- To expand and evaluate a single proxy question for patient activation
- To learn about the interventions that bring participants up the activation scale by gaining health confidence and increasing wellness
- To promote physical activity and lifestyle education, through building a community based on activity
- To test communication tools, including nudge techniques and opportunistic motivational interviewing.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Somerset – North Sedgemoor PCN

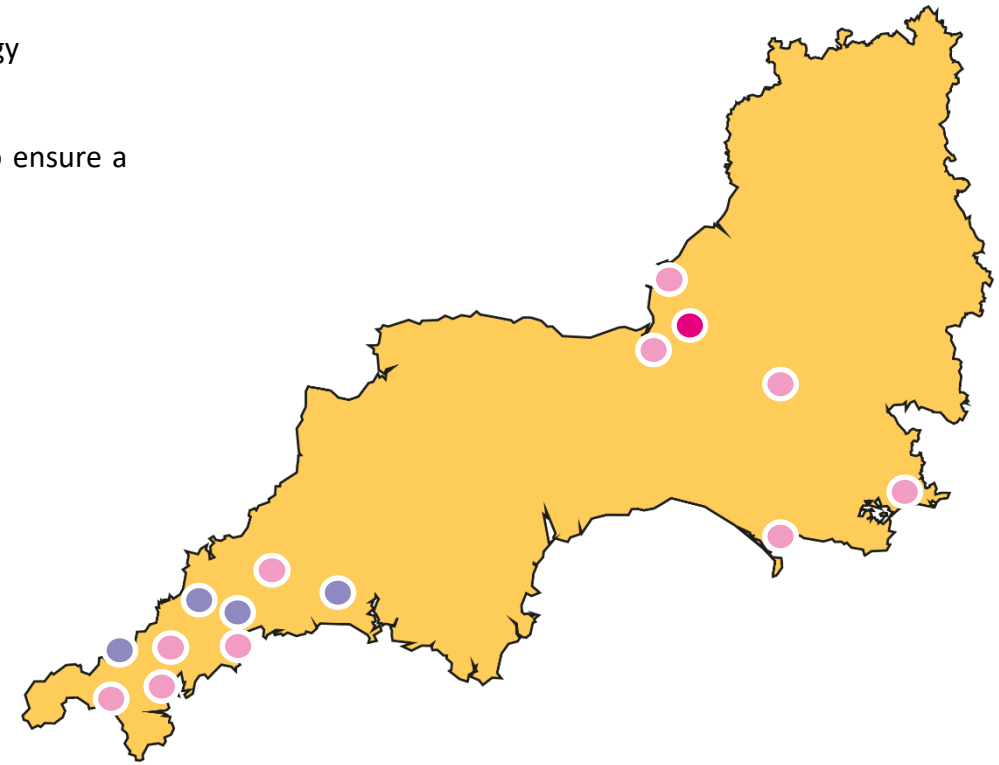
North Sedgemoor PCN

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:

- Development of shared vision / aim aligned to wider Somerset health and care system strategy
- 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.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Dorset – South Coast Medical Group PCN

South Coast Medical Group PCN

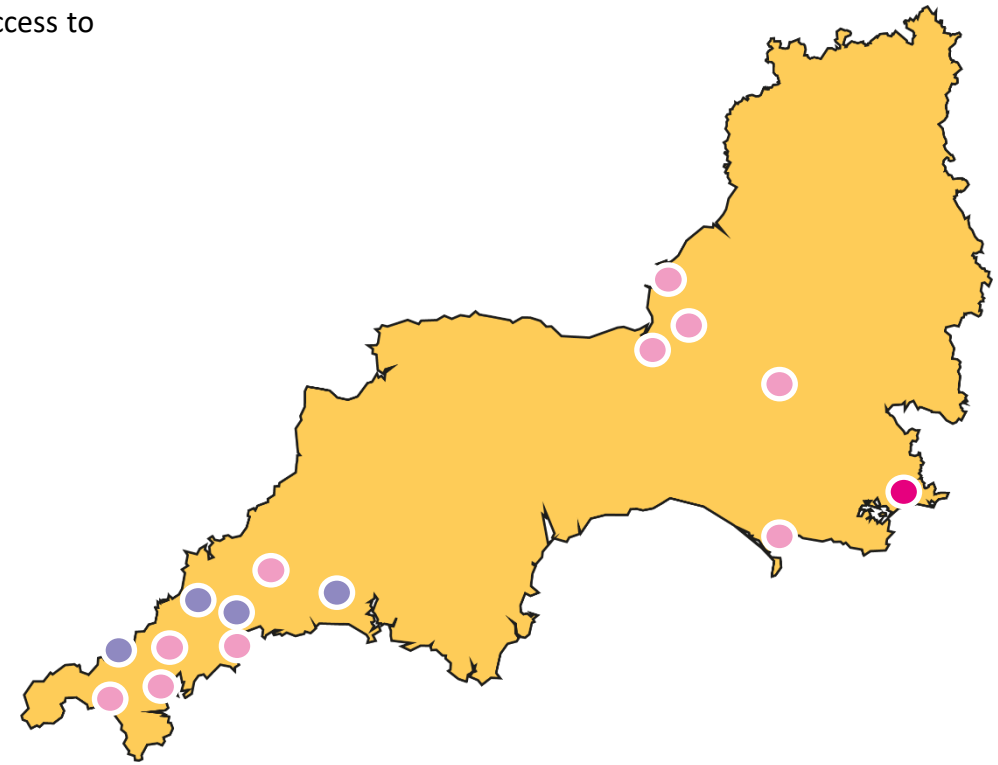
HEALTHBUS

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:

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

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Dorset – The Vale (BVP) Network PCN

The Vale (BVP) Network PCN

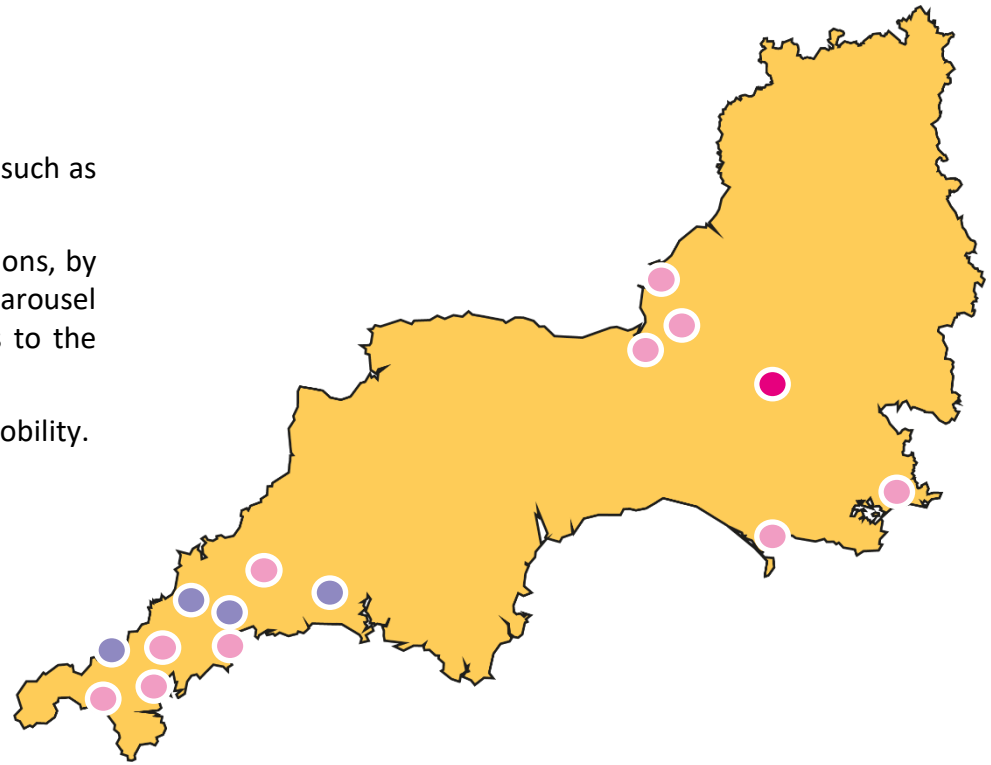
A Population Health approach to reducing falls risk and improve confidence in our frail population identified at being at risk of social isolation exacerbated by Covid 19.

The PCN has identified an at risk population group, by the use of a risk stratification falls algorithm within the Dorset analytics tool.
Interventions were designed to support risk groups through partnership working and an MDT approach which includes, a 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:

- Identify target population from patient's first fall records, ambulance call out or other means such as assisted bin collection or polypharmacy and flags for social isolation
- Prevention and reduction of falls in the elderly and thus reduction in secondary care admissions, by targeted interventions, including health champion activity buddies offering 1:1 support, a carousel clinic MDT in a non-medical setting including support from various VCSE's, and workshops to the wider low risk population
- Reduction of social isolation through increased confidence, social interaction and improved mobility.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Dorset - Weymouth & Portland Two Harbours Healthcare PCN

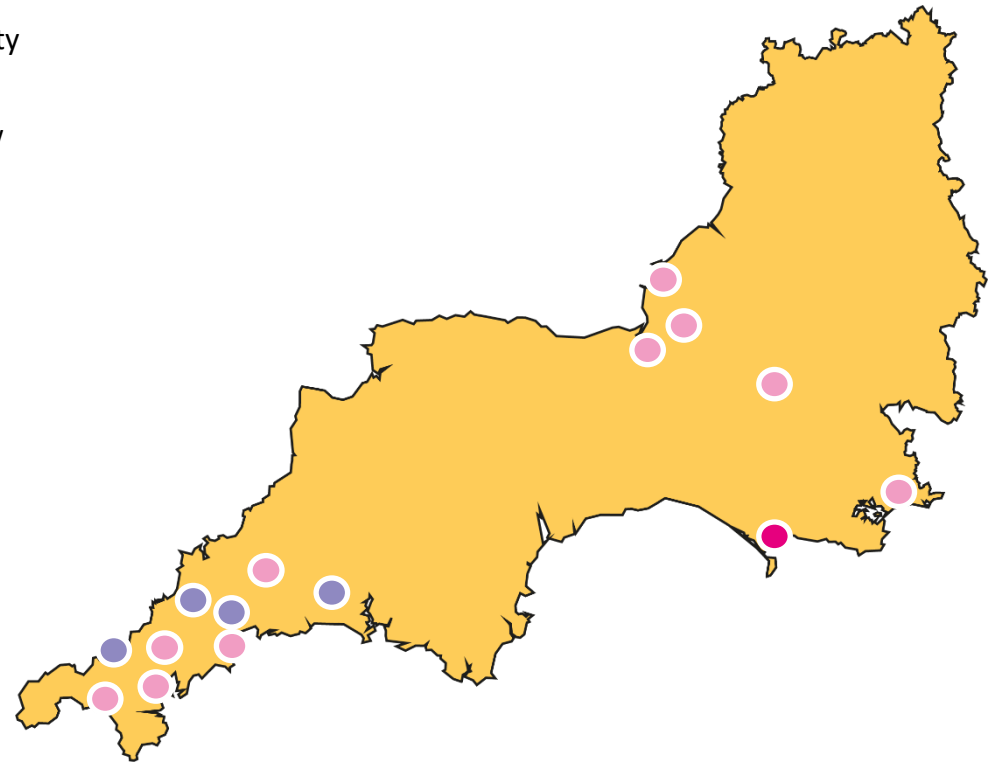
Weymouth & Portland Two Harbours Healthcare PCN

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.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Overview – Cornwall – Arbennek Healthcare, Bosvena and Three Harbours, Coastal, East Cornwall, Falmouth and Penryn

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Arbennek Healthcare PCN

Arbennek Healthcare PCN consists of the following four practices: Brannel Surgery, Clays Practice, Probus Surgery and The Roseland Surgeries. The PCN has a population of 30414 patients covering a wide area of central Cornwall. The LSOA (lower layer super output areas) for Brannel and Clays shows high levels of deprivation.

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.

Coastal PCN

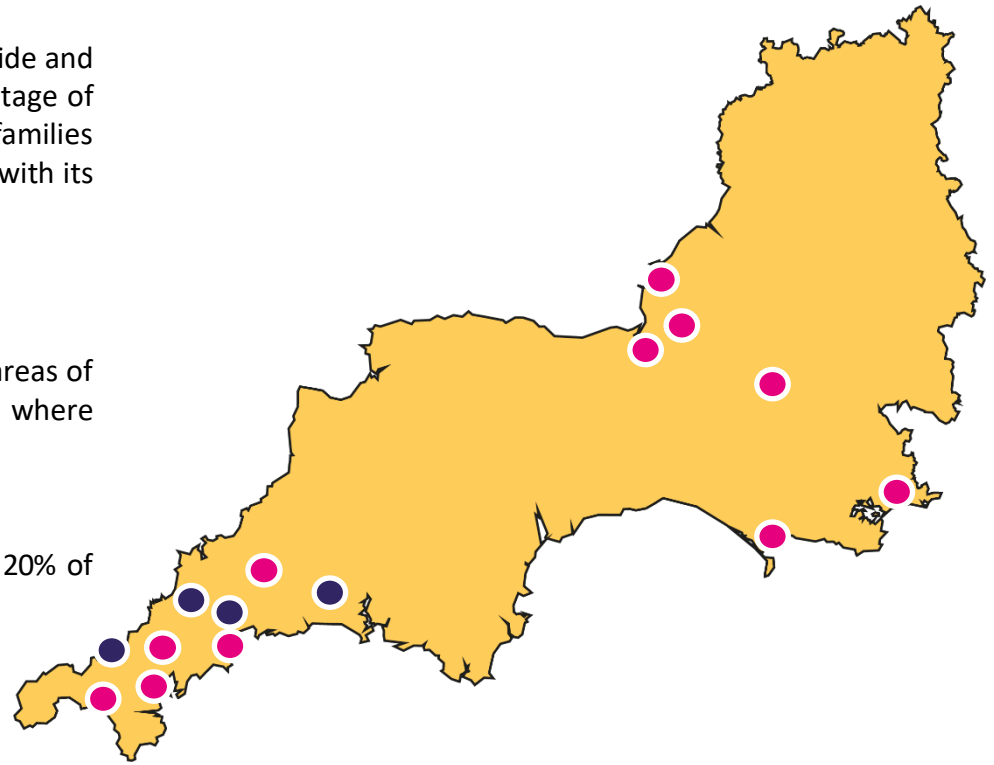
The Coastal PCN serves a population of 29,209 from 4 surgeries. It is spread over a reasonably wide and mostly rural area with a wide mix of patients – one of the PCN surgeries has the highest percentage of patients over 70 in Cornwall but with no elder care homes, another has a high number of young families and is a recognised holiday resort. It has both affluent and small pockets of deprived areas and, with its rurality, a high number of farmers and farm workers.

East Cornwall PCN

PCN comprises of 7 GP practices, with over 71,000 patients.
Life expectancy is 6.3 years lower for men and 5.2 years lower for women in the most deprived areas of Cornwall than in the least deprived areas. Liskeard is an area of the PCN with high deprivation, where homelessness and mental health issues are a significant factor for general practice.

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.



South West region:

Overview – Cornwall – North Kerrier West, St Austell, Truro and West Cornwall

North Kerrier West PCN

Comprises two practices serving just under 40,000 patients. The PCN has a mixed population in terms of age but has the highest index of multiple deprivation score within the County.

St Austell PCN

St Austell Health Care PCN has a registered population of 36,378 including 3 city centre surgeries, one in the coastal village of Mevagissey and one at Foxhole on the edge of China Clay country. Parts of St Austell rank among the 10% of the most deprived areas of the country. Young People in the PCN also experience the challenges of rural isolation and limited transport.

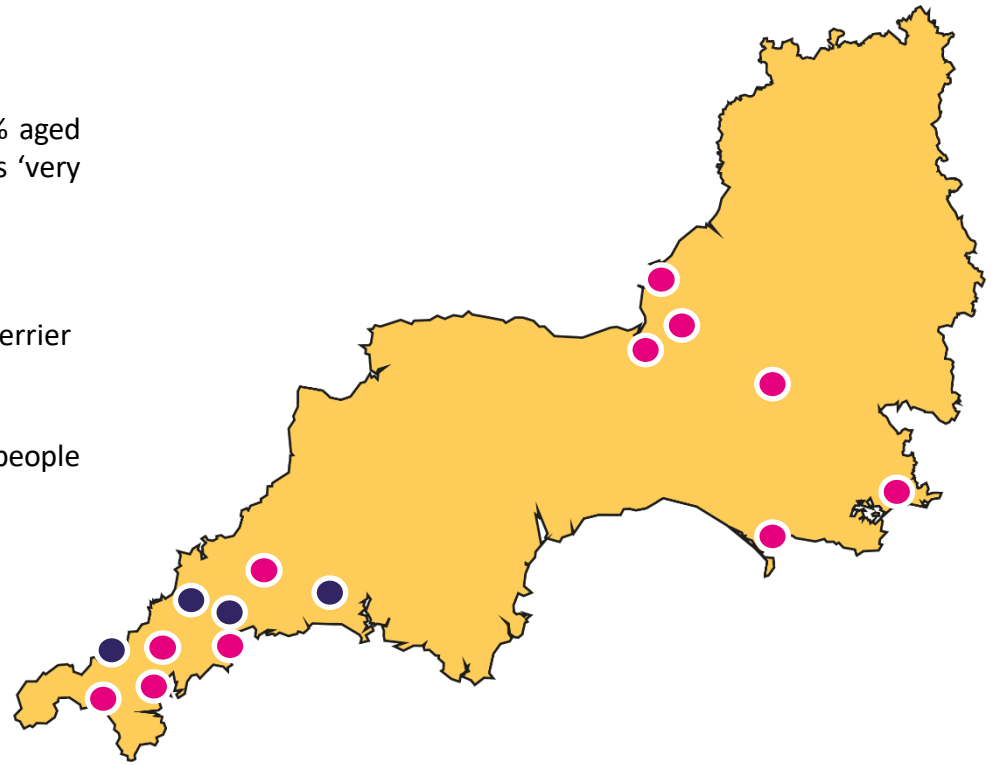
Truro PCN

Two GP practices serve a registered population of 35,786. The population demographic 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).

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – Arbennek Healthcare PCN

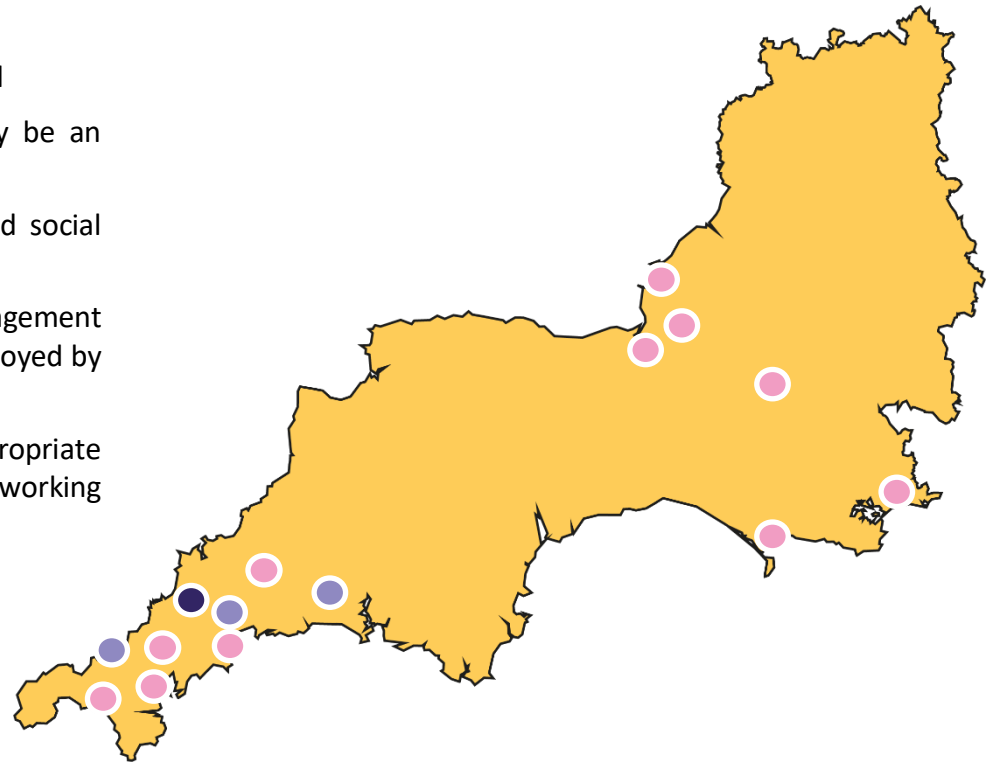
Arbennek Healthcare PCN

Project focussed around men aged between 18 and 30 with high lifestyle risk factors, who would not ordinarily engage with primary care, with a view of providing holistic, preventative care. As part of the population health management programme a focus has been put on men's health for those with high risk factors including mental health issues, high alcohol intake score, smoking and obesity. It has also been found that it is an area of low qualifications and employment. These factors have links to adverse childhood experiences for those in the household.

Aims and objectives:

- A two-prong approach will be taken by supporting both adults and children within the household
- Social prescribers will play a key role in identifying existing support groups and there may be an opportunity for the PCN to create new services based on gaps identified
- All four practices to review their safeguarding lists and to link in with the local schools and social services
- Support will be given to adults of the household through the population health management programme, social prescribers, mental health practitioner and health and wellbeing coach employed by the PCN
- Existing clubs and groups in place for children will be reviewed and children referred in as appropriate and gaps in service can then be considered and solutions discussed. The PCN will continue working collaboratively with Healthy Cornwall and other organisations
- Case Studies of successful interventions will be reviewed for learning outcomes.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – Bosvena and Three Harbours PCN

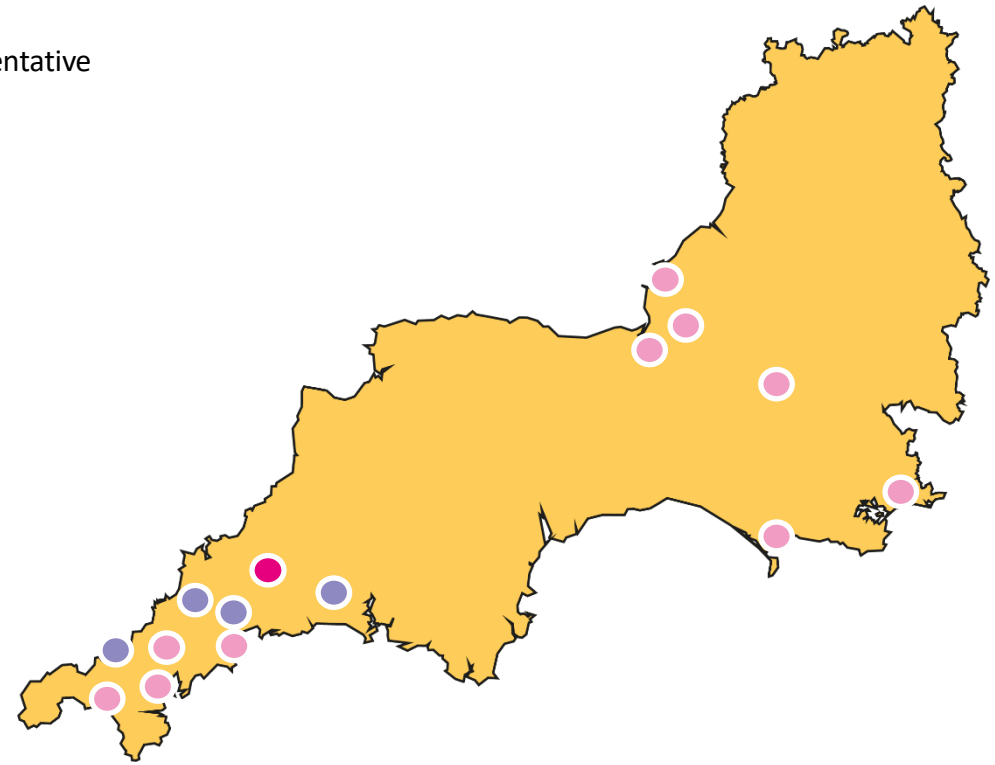
Bosvena and Three Harbours PCN

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:

- Understand any link between Cardiovascular Disease and Learning Disabilities, taking any preventative measures possible
- Share any learning with other PCNs.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – Coastal PCN

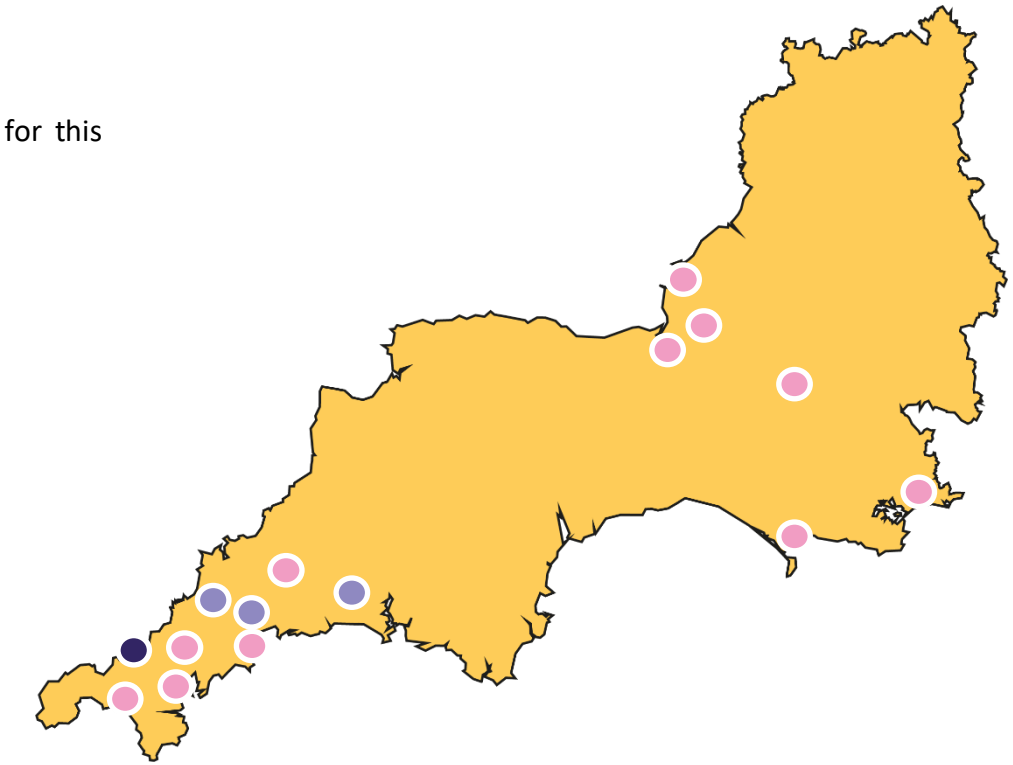
Coastal PCN

Project is to work with patients who are registered as having Severe Mental Illness (SMI). SMI patients tend to have a shorter life expectancy, other complex health issues and often have difficulties in accessing primary care. Mental health provision in Cornwall is patchy and MH patients with SMI are often only seen when they are in crisis. All patients on the register are invited for an annual review but not all take this up or engage fully if they do. The project is aimed at working with this group of patients.

Aims and objectives:

- Using coaching conversations to find barriers to engaging
- To provide confidence in patient disclosure and to provide ongoing contact and support for this group of patients to fill the gaps in provision of MH services.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – East Cornwall PCN

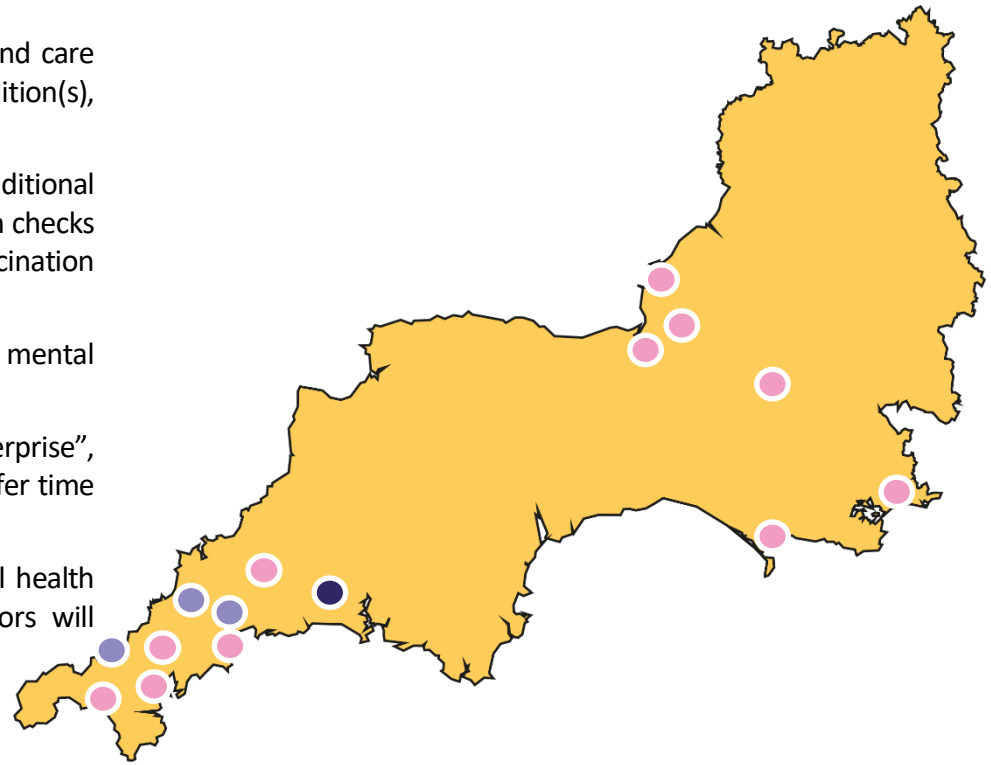
East Cornwall PCN

Project is to create a time bank, where support and befriending is available for patients suffering severe and enduring mental ill health. This will enable the community to come together and allow people to feel valued as well as creating a social space for people to utilise.

Aims and objectives:

- To support people to engage in community activities, reducing loneliness and isolation and improving their health and wellbeing
- To work with volunteer community and time banking UK, in partnership with our MHP, SPLW and care coordinator team, to develop a novel way of connecting people with a MH and long term condition(s), such as CVD and COPD, from communities across the East of Cornwall
- Place a MHP and Care Coordinator within a community hub/located with a timebank to offer additional resource and drop-in opportunities for patients using the timebank with the offer of physical health checks as part of the package of care. We aim to work with local volunteers from the COVID Vaccination programme
- SPLW and care coordinators to signpost and offer advice, with a focus on those suffering from mental health conditions
- Aim to join to join this programme with local community groups, such as "community enterprise", to create a social space, retail outlet, craft centre, enabling local groups to come together and offer time and skills to those most in need
- Single point of access will use the time bank to support at risk patients post discharge. Mental health practitioners will work with community organisations to refer to the bank. Care coordinators will have an alternative route of referral for vulnerable adults.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – Falmouth and Penryn PCN

Falmouth and Penryn PCN

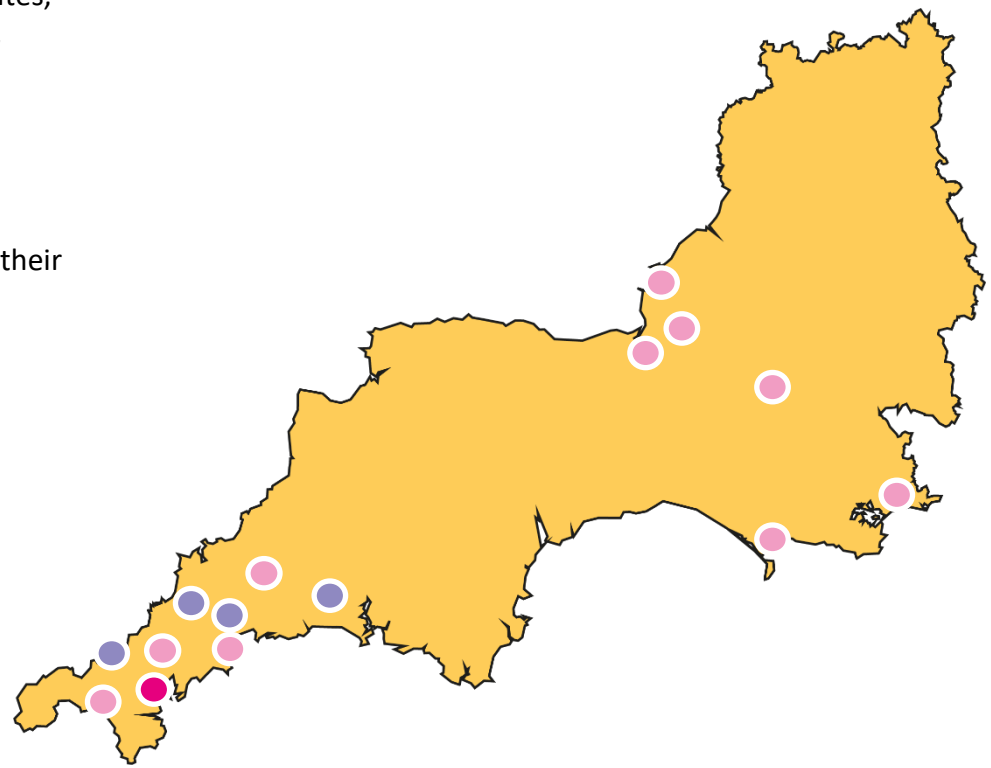
A project focused on providing a comprehensive mental health service in primary care. Aimed at a target population who are not unwell enough for secondary care, enabling them to receive support within the community.

The PCN will work 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:

- Prevent admissions and re-admissions to secondary care by empowering patients to manage their own mental health
- Provide joined up assistance by pooling resources and utilising Social Prescribers.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – North Kerrier West PCN

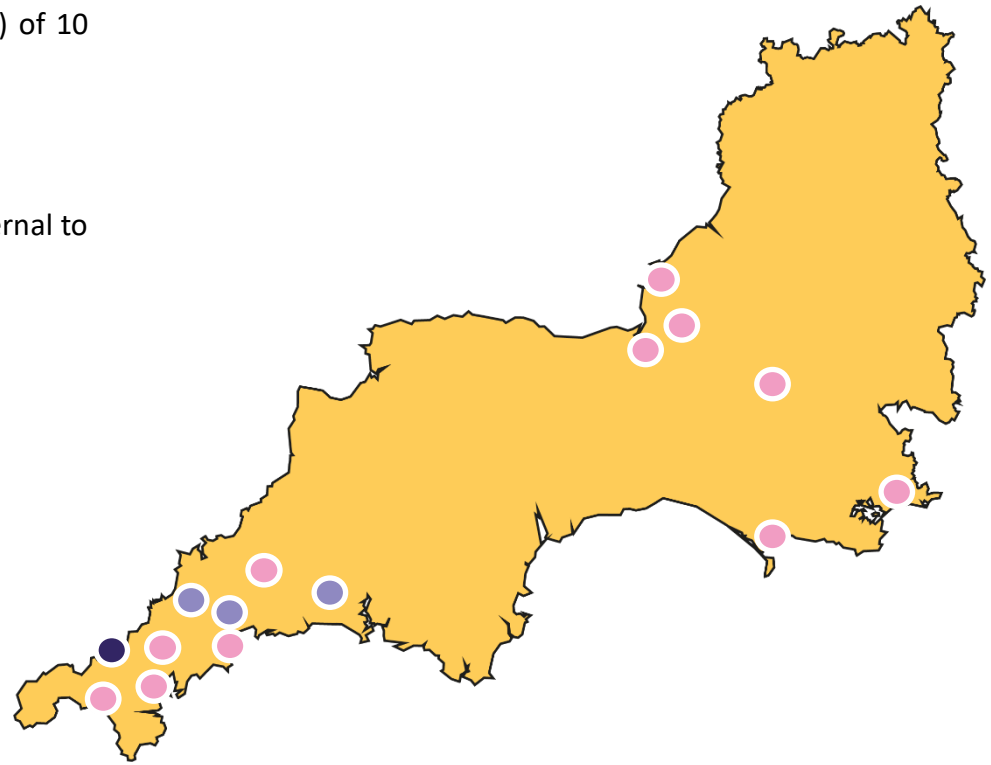
North Kerrier West PCN

Project to identify support requirements for the unmet need within a family unit through high intensity user data, cross referenced between ED attendance and at practice level. The support will be delivered through a family based social prescribing model (through Cornwall Neighbourhoods for Change) delivered outside of the practice at a locally developing social support hub over period of 12 months. The families will be supported with personalised and family-based interventions.

Aims and objectives:

- To support and sustain the improvement of health and wellbeing (physical, social & mental) of 10 families identified as being high intensity users but also of low socio-economic status
- Take a personalised, holistic approach to high intensity users
- Utilise the social prescribing model to provide a community-based support network
- Promote independence and self-management through connecting with multiple agencies external to the practice
- Identify and report on gaps in support/ opportunities.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale Network (BVP) PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – St. Austell PCN

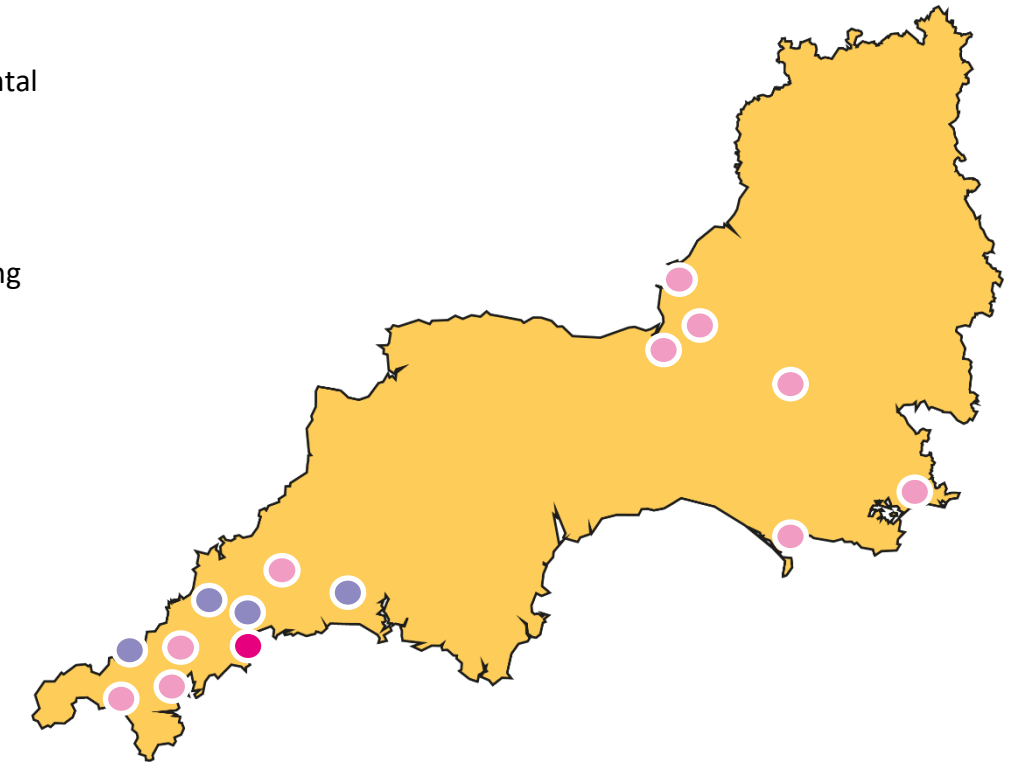
St. Austell PCN

A new Children and Young People (CYP) Social Prescribing project linking St Austell Health Care with community resources to improve mental health and well-being.

Aims and objectives:

- A new offer to CYP responding to increased demand for mental health support
- Improving links with the PCN, schools, local college, local authority and voluntary sector
- Offering support for CYP who are on waiting lists for specialist CAMHS and Neurodevelopmental assessments
- Using PCN blue and green environments to support better mental health
- Early intervention to prevent the escalation of mental health difficulties in childhood becoming enduring adult mental and physical health problems.

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South West region:

Cornwall – Truro PCN

Truro PCN

Truro PCN recruited third sector CIC CHAOS (Community Helping All of Society) to work in partnership on this project with Public Health. Utilising everyone's strengths – CHAOS community reach from working in the community directly with groups and existing trusting relationships.

Aims and objectives:

- The project undertook a qualitative research approach underpinned by thematic analysis. Delivered through groups and 1:1 with a mixed front facing and virtual model – to adapt to the COVID climate
- A systems mapping approach and methodology was used to represent a holistic understanding of the social systems components and their interactions
- The map provides insight into areas of potential leverage within the system that can be targeted to lead to positive achievable systems change
- Areas of leverage have been reported back to the stakeholders of the project, and CHAOS are now looking forward to moving forwards with our relationship with PH and Truro PCN to implement these recommendations into the System.

Phase 1	Phase 2
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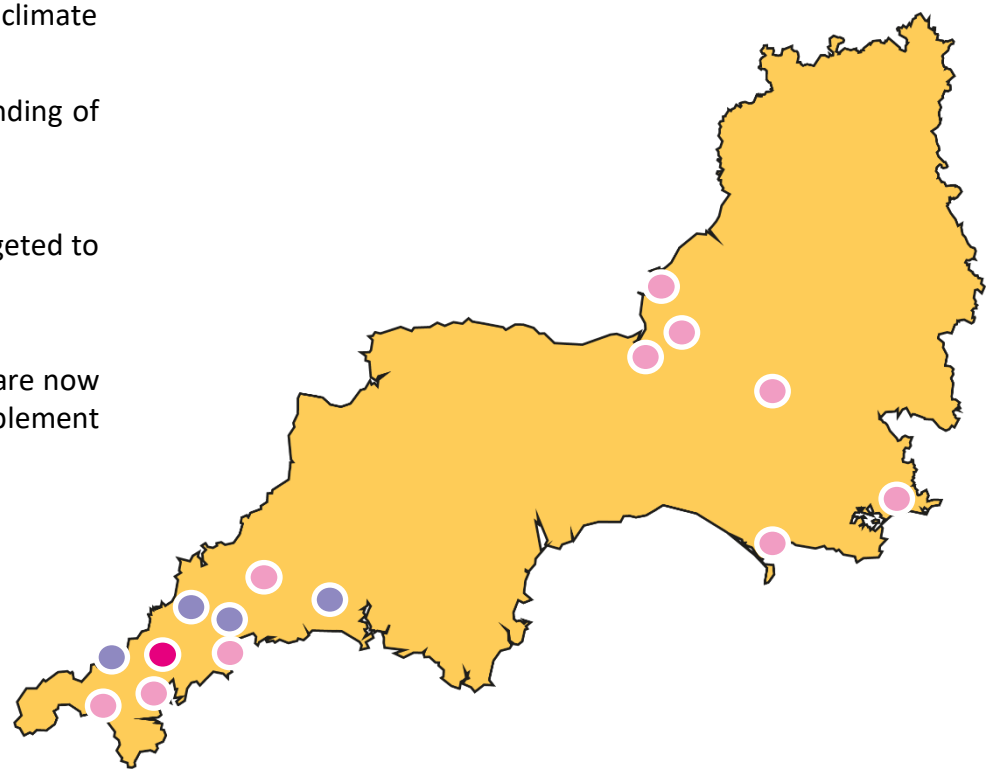


South West region:

Cornwall – West Cornwall ICA

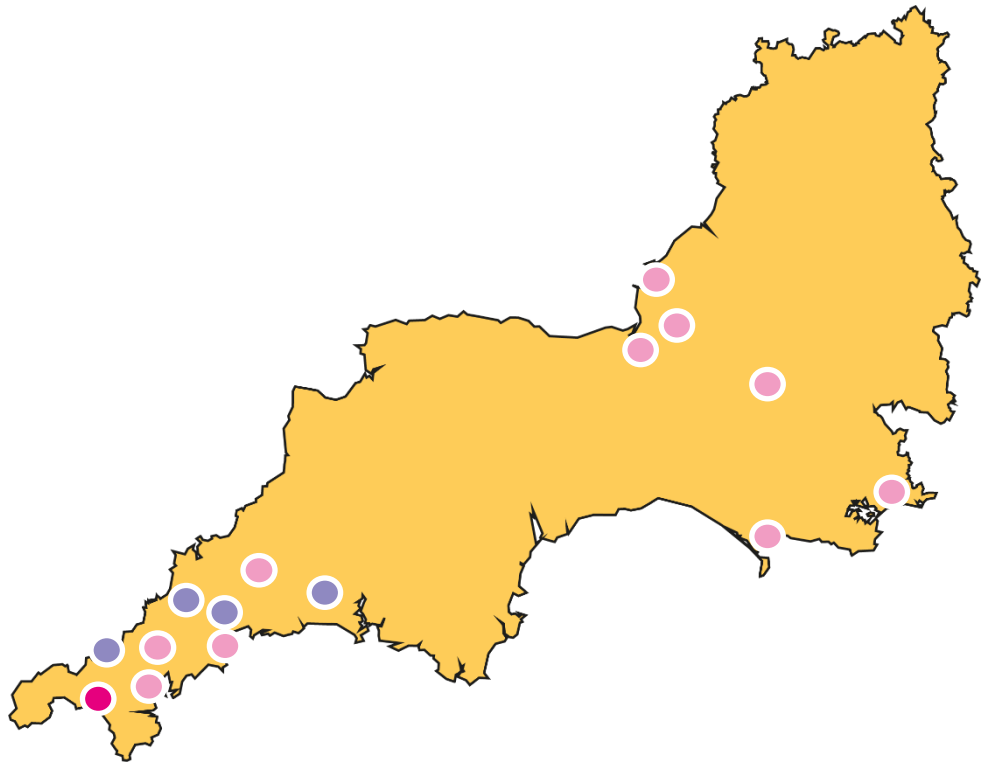
West Cornwall ICA

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

Aims and objectives:

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

Phase 1	Phase 2
• Weston-Super-Mare PCN • Bridgwater Bay PCN • North Sedgemoor PCN • South Coast Medical Group PCN • The Vale (BVP) Network PCN • Weymouth and Portland PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • Saint Austell PCN • Truro PCN • West Cornwall ICA	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN



South East region:

Overview – Alliance for Better Care Crawley, Alliance for Better Care Healthy Horley

Alliance for Better Care is made up of 47 member practices across 12 Primary Care Networks in East Surrey, Crawley, Horsham and Mid Sussex. Many of the boroughs are predominantly affluent areas, however there are some areas of significant deprivation within this population and evidence of inequality in both access to healthcare and health outcomes.

Phase 2

- Alliance for Better Care - Healthy Horley - East Surrey PCNs
- Alliance for Better Care - Crawley PCNs
- Woolston & Townhill PCN

Alliance for Better Care - Healthy Horley - East Surrey PCNs

12 GP practices across three PCNs serving 110,000 People.

There are over 1,900 refugees placed around East Surrey and Crawley, with more people arriving on a daily basis. This has created a long waiting list for permanent or private accommodation and the length of stay at local hotels is impacting the mental health and wellbeing of the individuals.

People seeking safety in the UK are often deeply traumatised. The Refugee Council estimates that refugees and asylum seekers are five times more likely to experience mental health issues compared to the average UK population.

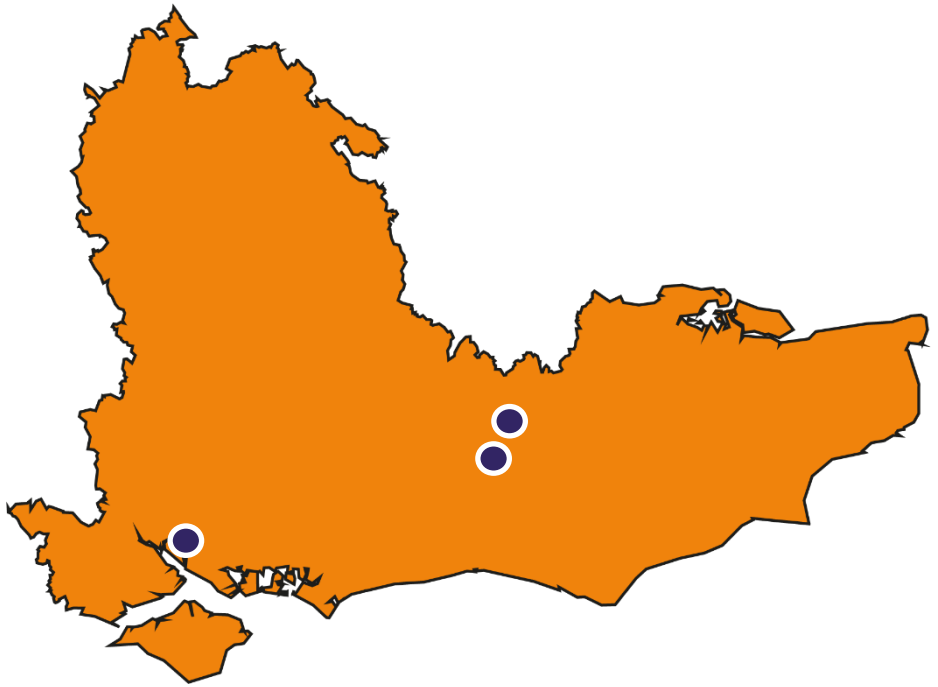
The Deprivation Indicators for this group are: Income Deprivation Domain, Employment Deprivation, Health, Education, Skills and Training domain, Barriers to housing and the living environment.

Alliance for Better Care - Crawley PCNs

12 GP practices across three PCNs serving 120,000 people

Crawley has the highest chance of a child being born into a low-income family in West Sussex - with a deprivation score 2.3 times higher than the least deprived district in the county. Poor health outcomes can be linked to lifestyle related health; obesity, physical activity, alcohol admissions, smoking prevalence and sexual health.

Crawley's largest increase in ethnic group size has been black or black British: other black from 82 to 840 (924.4 per cent).



South East region:
Overview – Woolston & Townhill

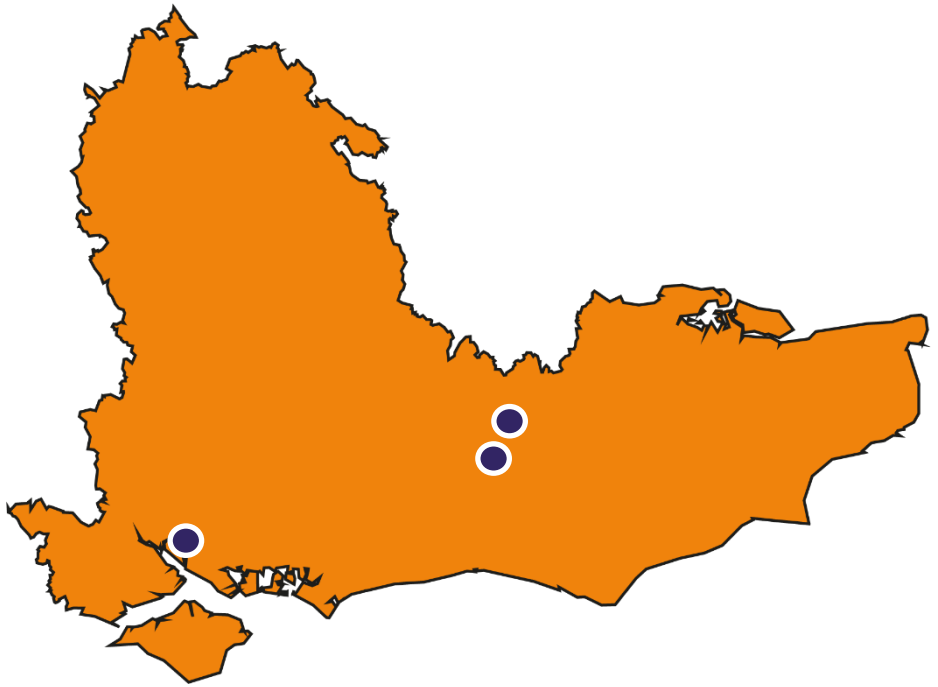
Woolston & Townhill PCN

PCN comprises of 4 practices in Hampshire and the Isle of Wight serving 35, 633 registered Patients.

In the latest Index of Multiple Deprivation (IMD) this area was ranked 708 out of 32,844 in England, where 1 was the most deprived and 32,844 the least.

Phase 2

- Alliance for Better Care – Healthy Horley - East Surrey PCNs
- Alliance for Better Care - Crawley PCNs
- Woolston & Townhill PCN



South East region:
East Surrey – Alliance for Better Care Healthy Horley – East Surrey PCNs

Alliance for Better Care - Healthy Horley – East Surrey PCNs

With the increased number of arrivals of refugees and asylum seekers to hotels in East Surrey and Crawley, the PCN have launched a programme aimed at addressing the mental health needs of those staying in local temporary settings.

Some hotels have expressed their concern about individuals' mental health, as service users find it hard to cope in their new surroundings.

The aim is to therefore support the hotel guests and work with local partners to deliver activities that will assist with integration, social inclusion and cultural awareness - all of which can reduce or prevent mental health issues.

Aims and objectives:

- Mental Health and Wellbeing Assessment
- Reduction and prevention of risky behaviour
- Supported self-management
- Integration to mainstream society.

Phase 2

- Alliance for Better Care – Healthy Horley - East Surrey PCNs
- Alliance for Better Care - Crawley PCNs
- Woolston & Townhill PCN

South East region:
East Surrey - Alliance for Better Care Crawley

Alliance for Better Care - Crawley PCNs

In the UK, about 1 in 8 men will get prostate cancer in their lifetime. Black men are twice as likely to get prostate cancer than other men. The most common age for men to be diagnosed with prostate cancer is between 65 and 69 years. If you are a Black man, your risk may increase once you're over 45.

Additional data identified during the Covid19 pandemic of 2020 has re-emphasised the wider health inequalities for the most vulnerable residents as well as those from Black, Asian and Minority Ethnic heritage.

The PCN-wide community engagement programme aims to bring attention to health inequalities in Crawley and raise awareness of the dangers of undiagnosed prostate cancer.

Aims and objectives:

- Raise awareness for more men to consider that their health is important
- Inform targeted population of the health checks that are available
- Get more people to register at GPs
- To offer simple health checks to the men who turn up at a mobile site
- To raise awareness of the dangers of undiagnosed prostate cancer.

Phase 2

- Alliance for Better Care – Healthy Horley - East Surrey PCNs
- Alliance for Better Care - Crawley PCNs
- Woolston & Townhill PCN

South East region:
Hampshire - Woolston & Townhill PCN

Woolston & Townhill PCN

According to the British Liver Trust, liver disease is on the rise and is now the 3rd leading cause of premature mortality in the UK, with a staggering increase by 400% since 1970 90 % of these deaths are caused by alcohol, obesity and viral hepatitis, and as such, are entirely preventable. When considering the effects of health inequalities and deprivation, the highest rates of hospital admission for non-alcoholic fatty liver disease were seen amongst those living in the most deprived neighbourhoods.

PCN alcohol related hospital admissions are significantly better than the city average, obesity prevalence is significantly worse. It is currently anticipated over the next decade, NAFLD (non-alcoholic liver disease) is expected to become the leading cause of end stage liver disease and transplantation.

With liver disease disproportionately affecting the most deprived of the population this will be the focus of the PCN. Given that NAFLD is an increasing problem, the initial focus will be on individuals with a confirmed diagnosis of NAFLD, whilst also being aware that a proportion of these individuals may have BAFLD (both alcohol and fatty liver disease).

Aims and objectives:

- Improving health of those with NAFLD (Non-alcoholic Fatty liver disease). (When considering the effects of health inequalities and deprivation, the highest rates of hospital admission for non-alcoholic fatty liver disease were seen amongst those living in the most deprived neighbourhoods).

Phase 2

- Alliance for Better Care – Healthy Horley - East Surrey PCNs
- Alliance for Better Care - Crawley PCNs
- Woolston & Townhill PCN

London region:

Overview – Kingston and Richmond, Newham, North West London, South Kentish Town

Kingston and Richmond PCNs

There are 5 GP PCN's across Kingston and 6 in Richmond serving populations of Circa 200,000 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

7 GP practices serving a population of approximately 68,000 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.

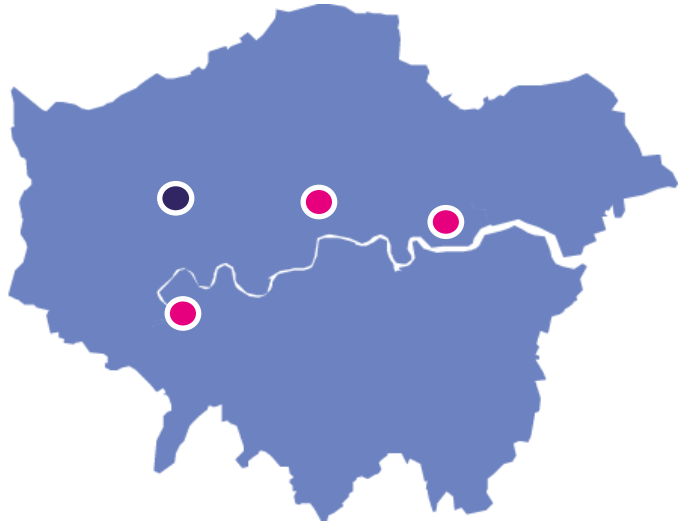
North West London ICB

North London is home to 95 of England's most affluent zones - and to 85 of the most deprived, according to government figures. The NW postcode area, also known as the London NW postcode area, is a group of 13 postcode districts covering around 13,895 live postcodes within part of northwest London with pockets of deprivation levels of 20% - 30%.

South Kentish Town PCN

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

Phase 1	Phase 2
• Kingston and Richmond PCNs • Newham Central 1 PCN • South Kentish Town PCN	• North West London ICB



London region:

Kingston and Richmond PCNs

Kingston and Richmond PCNs

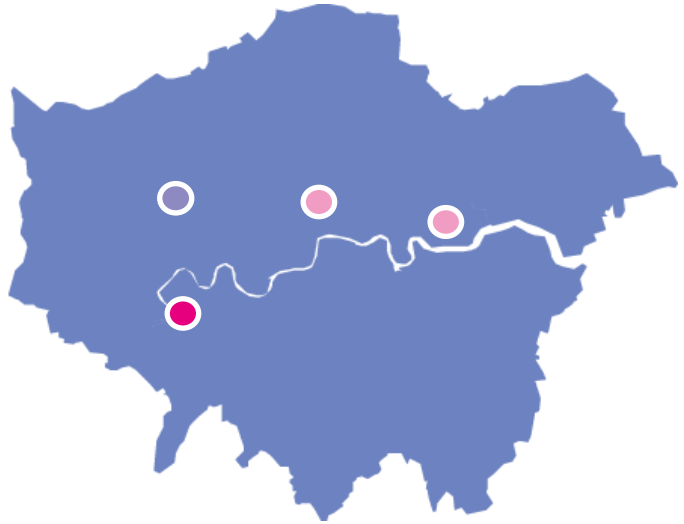
A systemwide approach to the prevention of long-term conditions, addressing inequalities by finding and working with the underserved population within PCN's across the boroughs. The team will work collaboratively with community leaders, and voluntary care organisations to build community hubs around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

Aims and objectives:

Providing targeted support for underserved communities, streamlining access to services to address:

- Mental wellness
- Prevention / identification of LTCs (hypertension, diabetes, weight management)
- Supported self-management
- Reduction of risky behaviour.

Phase 1	Phase 2
• Kingston and Richmond PCNs • Newham Central 1 PCN • South Kentish Town PCN	• North West London ICB



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London region:

Newham Central One PCN

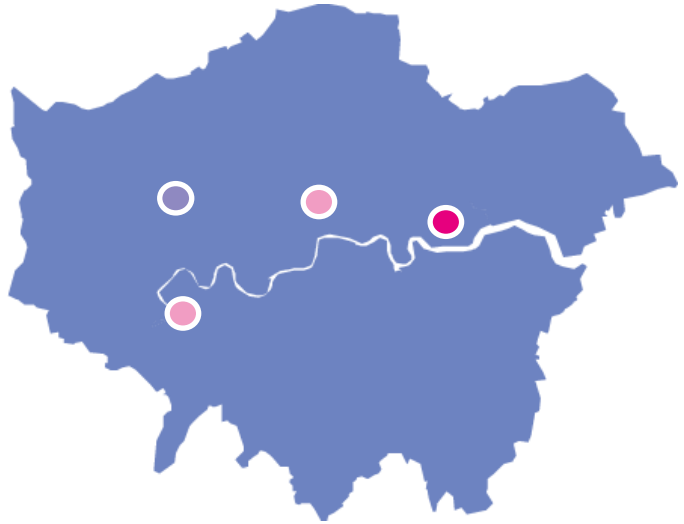
Newham Central One PCN

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 the voluntary sector and recruit a Young Persons Link Worker 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 violence reduction amongst healthcare staff and identification of those at risk of violence by healthcare professionals.

Phase 1	Phase 2
• Kingston and Richmond PCNs • Newham Central 1 PCN • South Kentish Town PCN	• North West London ICB



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London region:

North West London ICB

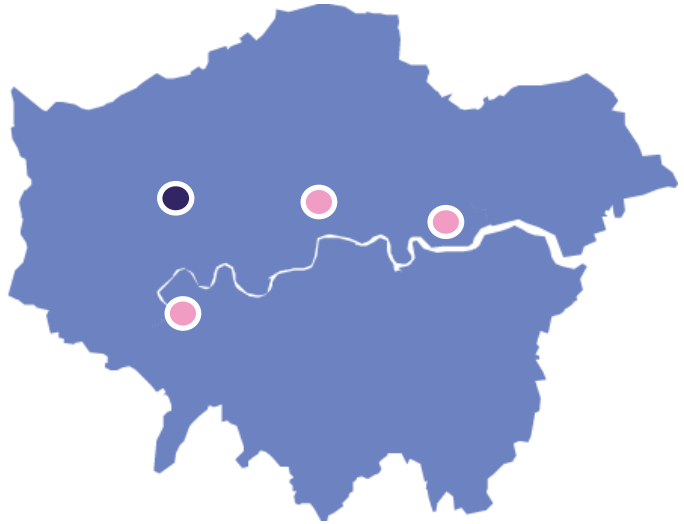
North West London ICB

Project to explore issues relating to accessibility and uptake of diabetic footcare services within hard-to-reach populations.
The Project seeks to address Health Inequalities by working towards better foot care outcomes.

Aims and objectives:

- Define the gaps and Co-design work with the right/identified population cohorts facing the inequality
- Identify key barriers and facilitators for engagement with footcare in hard to reach BAME populations
- Gain an understanding about how to adapt existing care pathways and utilise Community Foot Protection Champions for initial awareness sessions and signposting to places such as the Know Diabetes Services website.
- Gain an understanding of the experiences and perceived challenges of podiatrists in dealing with footcare within diabetic populations
- To liaise with the PCN allied health leads (Podiatrists and other AHPs) to reach the intended communities and share learning going forward.

Phase 1	Phase 2
• Kingston and Richmond PCNs • Newham Central 1 PCN • South Kentish Town PCN	• North West London ICB



London region:

South Kentish Town PCN

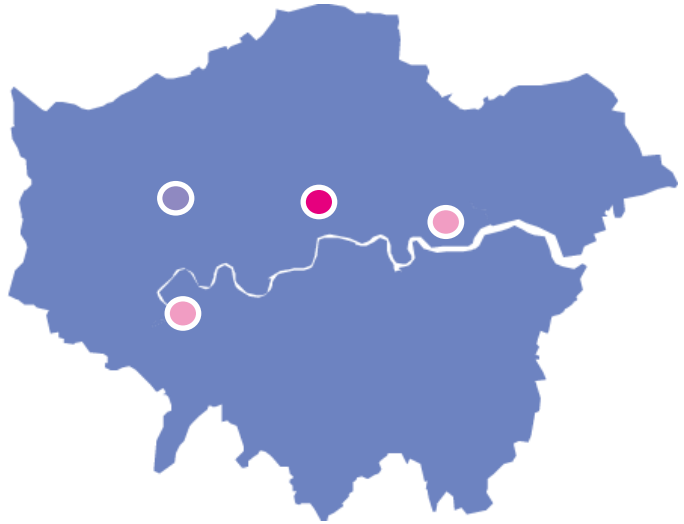
South Kentish Town PCN

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

Aims and objectives:

- Empower mental health resilience in Camden's Somali and Bengali residents, by their community for their community
- 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
- Work in partnership with Hopscotch Women's Centre in Euston (a charity working at the intersection of gender and racial inequity) to identify the gap in provision of care and work to address it.

Phase 1	Phase 2
• Kingston and Richmond PCNs • Newham Central 1 PCN • South Kentish Town PCN	• North West London ICB



Bibliography

- About us | South Coast Medical Group
- Around one in eight adults in Cheshire East depressed | Knutsford Guardian
- Bridgwater (Somerset, South West England, United Kingdom) - Population Statistics, Charts,
- Central West (blackpooljsna.org.uk)
- Ellesmere Port (Cheshire West and Chester, North West England, United Kingdom) - Population
- Excess weight in primary school children - Inside Cheshire http://inside.cheshirewestandchester.gov.uk
- Falmouth Penryn CNA profile (cornwall.gov.uk)
- Improving health and wellbeing in Kingston - South West London CCG (swlondonccg.nhs.uk)
- Kingston - Primary Care Networks - South West London CCG (swlondonccg.nhs.uk)
- Knutsford (Cheshire East, North West England, United Kingdom) - Population Statistics, Charts, Map, Location, Weather and Web Information (citypopulation.de)
- Map, Location, Weather and Web Information (citypopulation.de)
- Microsoft Word - Evidence briefing - Youth Safety in Newham for signoff 191216-final.docx
- Newham Info – Population
- NHS Kernow CCG - North Cornwall Primary Care Network - NHS Kernow CCG
- NHS-Richmond-Health-Care-Plan.pdf (richmondccg.nhs.uk)
- Our localities | NHS Bristol, North Somerset and South Gloucestershire CCG (bnssgccg.nhs.uk)
- Primary care networks - NHS Kernow CCG - NHS Kernow CCG
- Primary Care Networks - NHS Richmond Clinical Commissioning Group (richmondccg.nhs.uk)
- Runcorn (Halton, North West England, United Kingdom) - Population Statistics, Charts, Map, Location,
- Sedgemoor (District, United Kingdom) - Population Statistics, Charts, Map and Location (citypopulation.de)
- Socio-economic statistics for Aintree, Sefton (ilivehere.co.uk)
- Statistics, Charts, Map, Location, Weather and Web Information (citypopulation.de)
- Truro (Cornwall, South West England, United Kingdom) - Population Statistics, Charts, Map, Location,
- Weather and Web Information (citypopulation.de)
- Weather and Web Information (citypopulation.de)
- wirral-south-constituency-overview-june-2017.pdf (wirralintelligenceservice.org)
- wirral-south-bhf-statistics.pdf

Bibliography

- one-liverpool-plan-2.pdf (liverpoolccg.nhs.uk)
- The English Indices of Deprivation 2019 (publishing.service.gov.uk)
- Central Liverpool Primary Care Network | Working together towards healthier, happier lives. (clpcn.co.uk)
- Indices of Multiple Deprivation in York - data.gov.uk

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