Complete Care Community

Demonstrator sites project prospectus

July 2023

Arden&GEM
Health and social care systems support

healthworks

Introduction

The Complete Care Community (CCC) Programme commenced its third year of delivery in April 2023.

There has been a phased approach to incorporating demonstrator sites in the programme.

In the early months of 2021, the first 20 sites received some direct funding from three NHSE Regions to begin their design work and funding was also received to create a central Project Management Office (PMO). Six further sites from one of these NHSE Regions later joined what was then deemed phase 1 of the programme and which formally commenced in April 2021.

A second phase of sites then received funding through a regional competitive process and 20 further sites were admitted into the programme in April 2022.

We have selected 19 new 'Third Phase' demonstrator sites to join those 46 sites currently active from the first two phases in this national learning network.

The CCCP now incorporates a total of 65 sites working throughout England and covering an aggregate population of approximately 3 million people.

We are pleased to present our latest prospectus describing the impressive work of these CCCP demonstrator sites.

Several reports describing their collective work have already been produced and provide some actionable insights into reducing health inequalities in England.

These can be reviewed on the Complete Care Community webpage.

This evaluative approach of the CCCP will continue with our next report which is due in the autumn.

Chris Davies
Senior Responsible Officer
NHS Arden & GEM

James Kingsland
Clinical Director
Healthworks

Construct and Purpose of the CCCP

Complete Care Community

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 the risk of people getting ill, compromise their ability to prevent sickness and ultimately limit their chance to lead a long and healthy life.

In relation to the widening health inequalities gap in England and to explore the extent to which the NHS can maximise its contribution in addressing health inequalities. 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.

The CCCP is therefore also investigating ways to enable local projects to become sustainable by sharing and transferring their successful developments. In this way the CCCP aims to work like a sector rather than with individual and isolated quality improvement projects.

Despite the first legal duties concerning health inequalities being introduced through the Health and Social Care Act of 2012, increasing life expectancy in England has stalled over the last decade. This is something that has not happened since the end of the 19th century. If improvements in population health and well-being have similarly regressed and have been exacerbated by the Covid-19 pandemic, then the signs for civil society are ominous.

NHS Integrated Care Boards (ICBs) in England have a statutory duty to allocate resources to reduce health inequalities in the areas they serve. The CCCP now looks to these Boards to support and invest in this type of development.

If life expectancy follows the social gradient, then the more deprived an area, the shorter is the life expectancy. The gradient has become steeper and inequalities in health and care have increased in recent times.

There are also marked regional differences in life expectancy, particularly for people living in deprived areas. The gradient in ‘healthy life expectancy’ is steeper than that of overall life expectancy. It means that people in more deprived areas spend a greater amount of their shorter lives in ill health. Inequalities in poor health harm individuals, families and entire communities.

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Construct and Purpose of the CCCP

Complete Care Community

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In addition, the Social Value Act 2012 requires public sector commissioners to consider economic, social and environmental wellbeing in procurement of services or contracts. Indeed, the Care Act of 2014 also set out various duties and obligations to 'prevent, reduce and delay' the need for long term care. The CCCP has been designed to address these issues through the field work being carried out by our numerous demonstrator sites and help to find answers and new approaches to tackling health inequalities through systematic evaluation and research.

We recommend that ICBs focus their future commissioning intentions accordingly.

More specifically, the CCCP has adopted an approach that;

1. moves forward from merely describing the challenges, to enabling a better understanding and rationale for them and then developing strategies for change through new service development.
2. develops and uses multi-level designs and methodologies that facilitate a focus on the factors that impact on people's everyday lives and who are living with deprivation.
3. acknowledges the complexity, diversity, and reciprocity of the relationship between socioeconomic status and health.
4. provides an explanation of the increases in health inequalities from a local community causation perspective.
5. adopts a life-course approach and investigates the aetiology of socioeconomic health inequalities in defined population groups.
6. applies the science of spread and scaling to the findings from the CCCP demonstrator sites.

This is a multiyear task in a very challenging area of research. However, our programme is now well established and is starting to provide data and inform an approach which is demonstrating success in tackling inequalities in health.

Programme Facilitation & Mentorship

Each CCCP demonstrator site is supported by our facilitation and mentoring team from Healthworks and Arden and Gem CSU.

This team includes some of the most experienced and knowledgeable health and care professionals working in and alongside primary care in the NHS.

Our team can help you throughout the process of designing, developing, delivering and disseminating projects through effective strategic planning, accelerating the implementation process, minimising risk, evaluating and increasing the value of your work.

This team has been assembled to support the sustainability and transferability of your project work.

Prof. James Kingsland OBE
Complete Care Community Programme Clinical Lead. Director, Healthworks
Architect of the CCCP. Co-creator of the Primary Care Home, a reform programme for primary care provision which led to the development of Primary Care Networks nationally in England. GP and Clinical Professor, School of Medicine, UCLan.

David Collingbourne
Director, Healthworks
A strategy consultant with a solid commercial background and a proven track record of building successful organisations and the innovation and delivery of successful projects. Particular health interest is value-based approaches.

Dr Farzana Hussain
CCCP Mentor, Healthworks
A GP principal at The Project Surgery for 20 years. Immediate past PCN Clinical Director for Newham Central 1 and previous national roles as Co-Chair of the National Primary Care Network at NHS Confederation and NAPC board. In 2019 she was awarded GP of the Year.

Olivia Butterworth
CCCP Mentor, Healthworks
Former Head of Public Participation for NHS England ensuring the NHS works with citizens and communities to have a voice that influences the development, design and delivery of our health and care services.

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Facilitation & Mentorship - Healthworks

Becky Harrington
CCCP Mentor, Healthworks
Experienced and skilled at bringing together and supporting teams working across organisations to transform the health outcomes of local communities. Becky helps create the energy, connections and environment for positive change.

Dr Nicholas Hicks
CCCP Mentor, Healthworks
Former GP, Director of Public Health, PCT Chief Executive, has held senior positions developing and implementing policy in the NHS, local and national government. He has a strong interest in health inequalities, outcomes, value based and integrated care.

Dr Peter Smith OBE
CCCP Mentor, Healthworks
Change management can often feel daunting. Based on decades of experience, Peter can help with your case for change - which data to use, where to find it and how to focus your presentation and implementation to engage people and professionals.

Prof. Paul Batchelor
CCCP Mentor, Healthworks
Dentist and public health specialist. Has worked at supporting policy development in a variety of care arrangements. Experience of helping develop contractual arrangements that provide a framework for improving health and addressing inequalities.

Programme management – NHS Arden & GEM CSU

Complete Care Community

Chris Davies
Transformation Partner, Arden & GEM CSU
A programme manager with considerable experience working across a wide range of NHS services from clinical governance and operational management through to service transformation and strategy and planning.

Paul Fradgley
Head of Marketing, Arden & GEM CSU
An experienced marketing professional who has worked in both agency and client-based roles. Specialties: Marketing communications, product marketing, channel management, CRM, new product development, account management.

Catherine Hughes
Project Manager, Arden & GEM CSU
A skilled project manager having previously worked in acute, mental health and community trusts as a patient safety lead, healthcare standards lead and digital transformation as part of the NHS Global Digital Exemplar programme of work.

Justine Holt
Project Support Officer, Healthcare Solutions Transformation, Arden & GEM CSU
Supporting a wide range of health-related projects, including: Diabetes Services Review; measuring the impact of Covid; NHS Digital Personas. Skilled in Presentation delivery, Public Speaking, Project support to specified deadlines, Microsoft Office applications.

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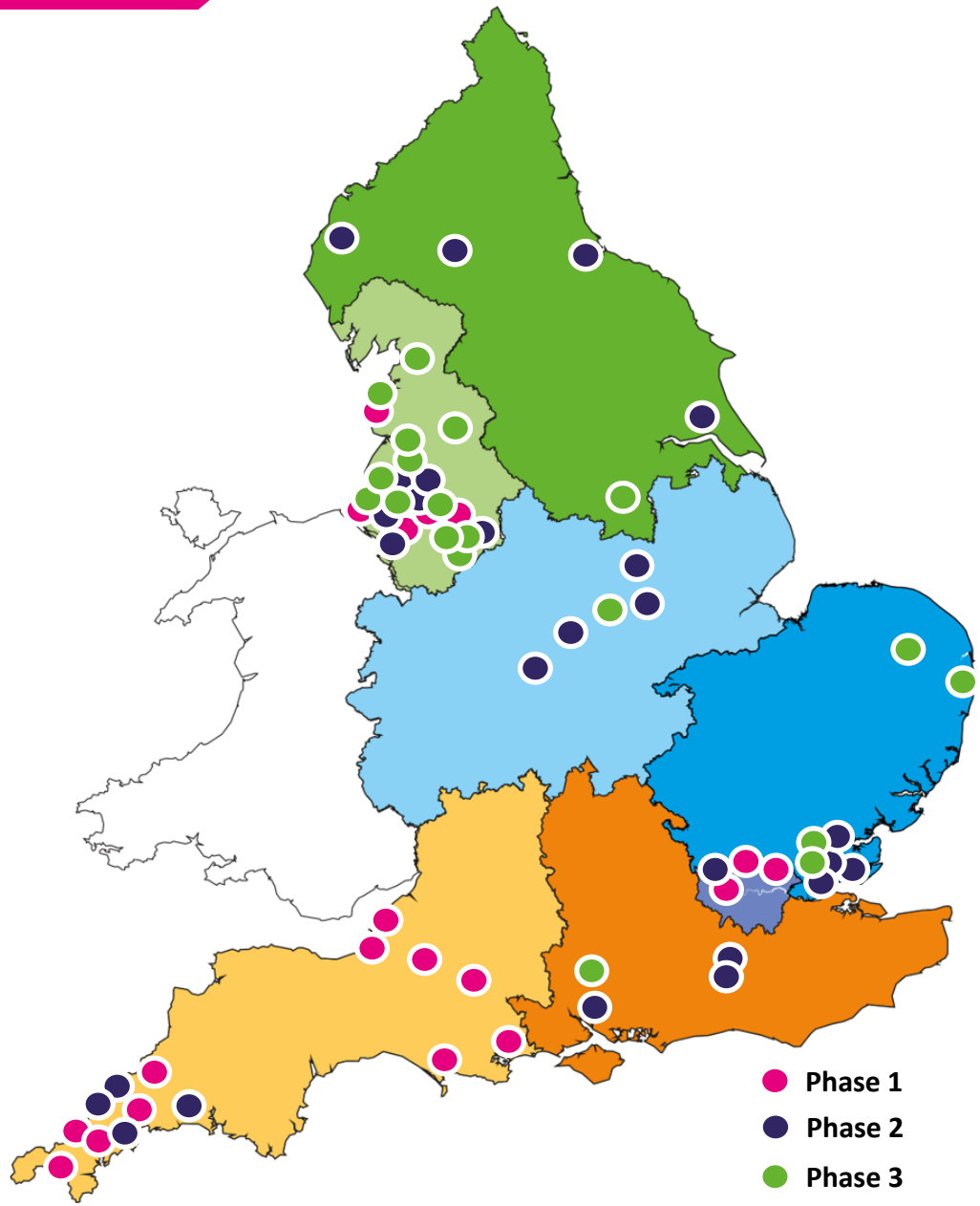
Demonstrator sites: phases 1, 2 and 3

Complete Care Community

Region	Phase 1	Phase 2	Phase 3	Total
North East, Yorkshire & Cumbria	0	4	1	5
North West	6	6	12	24
Midlands	0	4	1	5
East of England	0	4	4	8
South West	11	4	0	15
South East	0	3	1	4
London	3	1	0	4
				65



Demonstrator sites: phases 1, 2 and 3

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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	Cockermouth and Maryport PCN, Eden PCN, Haxby Group, Heeley Plus PCN, Stockton-on-Tees PCN
North West – Cheshire & Merseyside	Aintree PCN, Central Liverpool PCN, CHAW PCN, Chester South PCN, CHOC-NW, Chorley Central PCN, Ellesmere Port PCN, Healthier South Wirral PCN, Kirkby PCN, Knowsley Central and South PCN, Knutsford PCN, Macclesfield, Middlewood PCN, Moreton and Meols PCN, Picton PCN, Runcorn PCN, South Sefton PCN, Southport and Formby PCN, St Ann's Hospice
North West – Lancashire	Blackpool Central West PCN, Burnley East PCN, Fleetwood-NW, Lancaster, Leyland
Midlands	Caritas PCN, Derby City – PCCO PCN, East Staffs PCN, Mid-Nottinghamshire PBP, Nottinghamshire West/South Nottinghamshire PBP
East of England	Braintree PCN, Central Basildon PCN, Colchester Medical Practice PCN, Lowestoft PCN, Norwich PCN, Southend Victoria PCN, Stanford-le-Hope & ASOP PCN, West Basildon PCN
South West - Bristol, North Somerset & South Gloucestershire	Pier Health PCN (Weston-super-Mare)
South West - Somerset	Bridgwater Bay PCN, North Sedgemoor PCN
South West - Dorset	The HealthBus Trust, The Vale (BVP) Network PCN, Weymouth & Portland PCN - Two Harbours Healthcare
South West - Cornwall	Arbennek Healthcare, Bosvena & Three Harbours PCN, Coastal PCN, East Cornwall PCN, Falmouth & Penryn PCN, North Kerrier West PCN, Penwith PCN, St Austell PCN, Truro PCN
South East – Surrey, West Sussex, Hampshire	Alliance for Better Care – Crawley PCN, Alliance for Better Care, Healthy Horley – East Surrey PCNs, Dentaid (Winchester), Woolston and Townhill PCN
London	Kingston & Richmond PCNs, Newham Central 1 PCN, North West London ICB, South Kentish Town PCN

Project list – Phase 1

Complete Care Community

Project Lead	Organisation / PCNs	Project
Sharon Poll	**Aintree PCN**	Learning disabilities in young people
Kate Ballout	**Blackpool Central West PCN**	Obesity
Dr Emma Langstaff	**Bosvena and Three Harbour PCN**	Cardiovascular disease in people with learning disabilities
Dr Harry Smallwood	**Bridgwater Bay PCN**	Raised Patient activation and maintained wellness
Dr Emily Morton	**Ellesmere Port PCN**	Childhood obesity
Dr Mark Morris	**Falmouth & Penryn PCN**	Mental Health 'Gap' population
Dr Thomas Wyatt	**Healthier South Wirral PCN**	Cardiovascular disease
Sue Lear	**Kingston & Richmond PCNs**	Long term health conditions
Dr Phil Coney	**Knutsford PCN**	Connect all public facing services & start a social movement of care within the care community
Dr Saravanan Chellappan	**Newham Central 1 PCN**	Knife crime
Kyle Hepburn	**North Sedgemoor PCN**	A One Team approach to Learning Disabilities
Rachel Hall	**Penwith PCN**	Personalisation approach for those with 5 co-morbidities
Dr Martin Jones	**Pier Health Group PCN**	Mental health in young people and single mums
Dr Gary O'Hare	**Runcorn PCN**	Conduct disorder in children and young people
Dr Stewart Smith	**St Austell PCN**	Mental Health in young people
Dr Jonathan Levy	**South Kentish Town PCN**	Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities
Dr Maggie Kirk	**The HealthBus Trust, Bournemouth, Christchurch and Poole**	A charity that provides accessible and appropriate specialist healthcare to people experiencing homelessness.
Dr Simone Yule	**The Vale (BVP) Network PCN**	Falls reduction
Dr Chris Tiley	**Truro PCN**	Early years health creation
Rachel Stratton	**Weymouth and Portland PCN - Two Harbours Healthcare**	Children and families improved health and wellbeing

Project list – Phase 2

Complete Care Community

Project Lead	Organisation / PCNs	Project
Lena Abdu	**Alliance for Better Care - Crawley PCNs**	Increased Primary Care Accessibility for Black & Asian Men age 35-60 - inc prostate cancer
Lena Abdu	**Alliance for Better Care - Healthy Horley – East Surrey PCNs**	Addressing Mental Health inequalities in Asylum Seekers
Dr Rawlins Murthy	**Arbennek Healthcare**	Social Prescribing Service for children and families inc MH Practitioner and Wellbeing Coach
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.
Dr Sue Truman	**Central Basildon PCN**	Dance on Prescription - Arts based intervention for multiple conditions
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
Peter Yates	**Coastal PCN**	Severe Mental Illness
Julia Laws	**Cockermouth and Maryport PCN**	Mental Health in 11–30-Year-olds in most Deprived Area of PCN
Dr Susan Pickford	**Colchester Medical Practice PCN**	Anxiety/Phobia in highly deprived areas -(Cohort of 74 people aged between 13-18)
Paula Varndell-Dawes	**East Cornwall PCN**	Mental Health utilising Mental Health Connectors
Sarah Laing	**East Staffs PCN**	Diabetes Prevention/Management utilising the Joy App
Rachel Preston	**Eden PCN**	Exploring the causal link between pre-diabetes, diabetes, cardiovascular sequelae and rural isolation
Dr Joseph Witney	**Haxby Group**	Children's Mental Health
Dr Hassan Argomandkhah	**Kirkby PCN**	Perinatal Social Prescribing response to the mental health needs of parents/carers
Dr Victoria Hoyle	**Knowsley Central and South PCN**	Obesity and Mental Health
Lorraine Palmer	**Mid Nottinghamshire PBP**	To Promote healthy and happy communities in the more deprived areas of Mid Notts
Dawn Jonathan	**North Kerrier West PCN**	Social Prescribing Model for Deprived Families who Frequently Access Services
Dr Wingmay Kong	**North West London ICB**	Diabetes MDFT Footcare: Minor and Major Amputations and unscheduled Admissions against ethnicity
Colette Foulds	**Nottinghamshire West/South Nottinghamshire**	Achieving 'community togetherness' using a population health management approach
Rachel Stead	**South Sefton PCN**	Families with low level safeguarding needs to prevent escalation

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Project list – Phase 2 ...continued

Project Lead	Organisation / PCNs	Project
Dr Kristina Rusakoviene	**Southend Victoria PCN**	Increased Primary Care Accessibility for BAME Communities
Deborah Adedoye	**Stanford-le-Hope & ASOP PCNs**	Adopting PHM to Combat Obesity with Personalised Care
Dr Fiona Smith	**Stockton-on-Tees PCN**	School Hub One Stop Shop Service
Dr Karen Malone	**Woolston and Townhill PCN**	Non-alcoholic and alcoholic Fatty Liver Disease in the most deprived areas

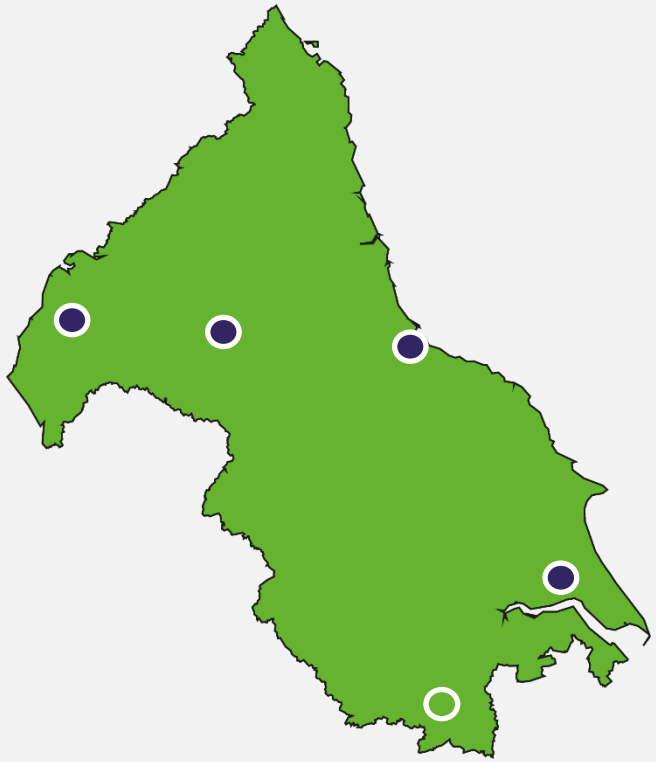
Project list – Phase 3

Complete Care Community

Project Lead	Organisation / PCNs	Project
Dr Yasara Naheed	**Burnley East**	Patients aged 75+, living alone with other identified social vulnerabilities including deprivation, fuel or food poverty and digital exclusion.
Lindsey Hunt	**Braintree PCN**	Further development of the Mental Health Hub.
Jon Barnsley	**CHOC - NW**	Adult Weight Management
Dr Shashi Khandavalli	**Chorley Central PCN**	Addressing suicide and self harm.
Edward Clark	**Derby City – PCCO PCN**	Addressing Health Inequalities for Slovak Patients.
Natalie Bradley	**Dentaid (Winchester)**	Focus on dental care for those living without shelter.
Mark Spencer	**Fleetwood PCN**	PCN Tackling health inequalities of CYP emotional health and wellbeing
Dr Ollie Hart	**Heeley Plus PCN**	Creating better health for marginalized community groups
Sarah Baines & Richard Walsh	**Lancaster**	Suicide preventing in a younger age group.
Debby Wilson	**Leyland**	Proactive management of the aging well cohort with mild to moderate frailty.
Dr Lucie Barker	**Lowestoft PCN**	Provide improved clinical reviews and screening for a defined patient cohort.
Amy Rowlands	**Macclesfield**	Young people's mental health
Dr David Ward	**Middlewood PCN**	Care Home Support
Fiona Harle and Jenny Harris	**Moreton and Meols PCN**	Tackling inequalities in cardiovascular disease.
Alice Vickers and Tracy Williams	**Norwich PCN**	Prevention and Creation of Health and Wellbeing
Samuel Thorley	**Picton PCN**	Perinatal Mental Health
Dr Mark Wigglesworth	**Southport and Formby PCN**	Complex Lives – fewer snakes, more ladders
Heidi McIntyre	**St Ann's Hospice (Greater Manchester)**	Evaluation of the service provided by St Ann's Hospice to people living without shelter and advanced ill health.
Dr Sue Truman	**West Basildon PCN**	Dance on Prescription - Arts based intervention for multiple conditions

Complete Care Community

North East, Yorkshire and Cumbria region



Phase 2	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heeley Plus PCN

Complete Care Community

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.

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	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heely Plus PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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.

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.

Phase 2	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heely Plus PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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%.

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	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heely Plus PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

Heeley Plus PCN

Heeley Plus PCN incorporates 7 general practices in Sheffield covering a population of c42,000 and works closely with Heeley Community Trust who host their social prescribing service.

The focus for this CCCP incorporated project is to explore the extent to which people in marginalised community groups can and are able to participate in creating better health at 3 levels; 1. Individual 2. In a collective local community group, and 3. within the wider system helping to design the provision of services focussed at reducing health inequalities.

The initial attention will be on seldom heard groups within areas of highest social deprivation and living with type 2 diabetes, mental health issues and suffering with menopausal symptoms.

With a real-time, proactive approach to evaluation, we hope to then spread the outcomes of this work to other demographics and disease areas.

Phase 2	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heely Plus PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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 Northeast 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 Northeast.

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:

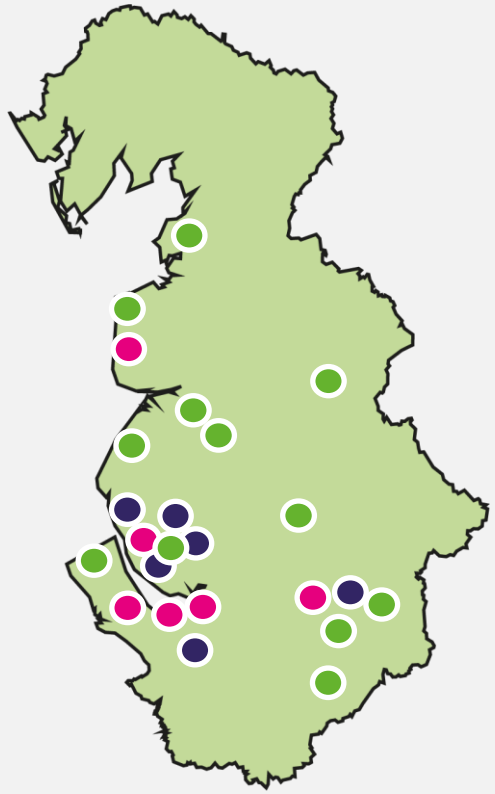
- To offer positive group therapy support, accessible to a central area, reducing inequalities of access.
- Provide a safe place for people to share feelings and gain knowledge from others experiencing similar difficulties.
- Exposure to new behaviours, thoughts, and beliefs to improve outlooks towards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

Phase 2	Phase 3
• Cockermouth and Maryport PCN • Eden PCN (North Cumbria) • Haxby Group • Stockton-on-Tees PCN	• Heely Plus PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

North West region



Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

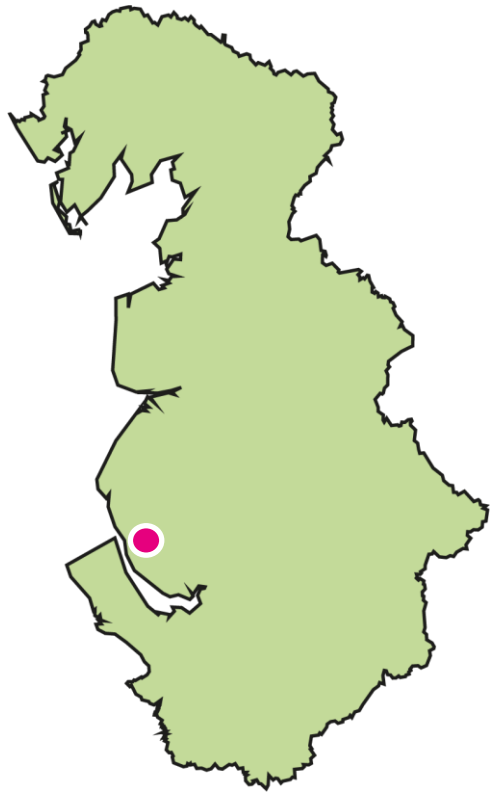
Cheshire, Merseyside and Greater Manchester – Aintree PCN

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Central Liverpool PCN

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 120,000 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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

Complete Care Community

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

North West region:

Cheshire, Merseyside and Greater Manchester - Chester South PCN

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann’s Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – CHOC (Congleton & Holmes Chapel) PCN

CHOC PCN

Congleton and Holmes Chapel (CHOC) care community has a population of approximately 45,500 patients over 4 GP practices, with 76% of the population under the age of 65 years.

Deprivation varies greatly across the care community, with some pockets of Congleton having a much higher deprivation scores in comparison to other areas and the regional average. Holmes Chapel is mostly an area of low deprivation.

The care community want to support the population to have a healthy lifestyle in relation to weight management. The focus will be on the adult population, as other partners are working on tackling childhood obesity in the area. It is hoped by targeting the adult population, many of whom will be parents, this will indirectly help to improve children's health.

Aims and Objectives:

- Reducing the number of people in CHOC with a BMI over 30.
- Meet the needs and goals of the individuals enrolled in the program.
- Engaging the community in health activities.
- Targeting activities in the most appropriate areas.
- Improving collaboration between multiple services (voluntary and statuary).

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Chorley Central PCN

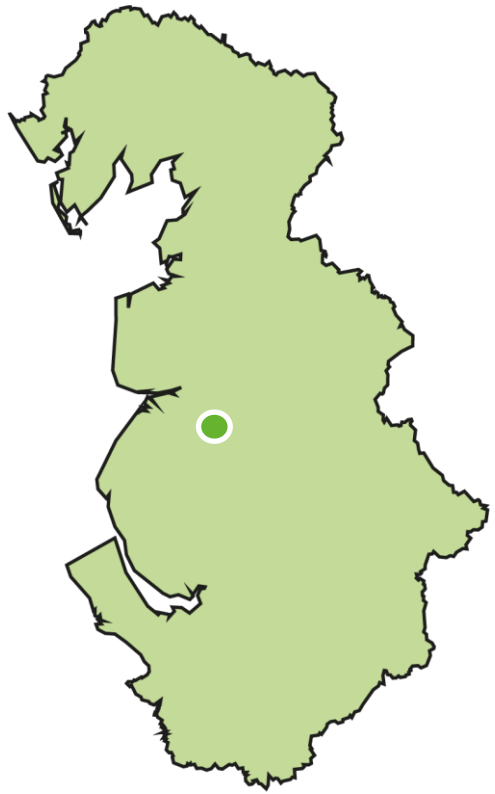
Chorley Central PCN

Chorley Central PCN includes 6 practices with a combined list size of around 55,000.

Chorley PCN has a higher than average rate of suicide. The practices have close links with Chorley Council and are exploring with them ways to identify and address the causes of this higher suicide rate and the impact of health inequalities upon it.

Aims and Objectives:

- Obtain detailed local data.
- Map and engage with stakeholders.
- Develop a codesigned response.
- Formulate interventions.



Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

Complete Care Community

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.

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

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

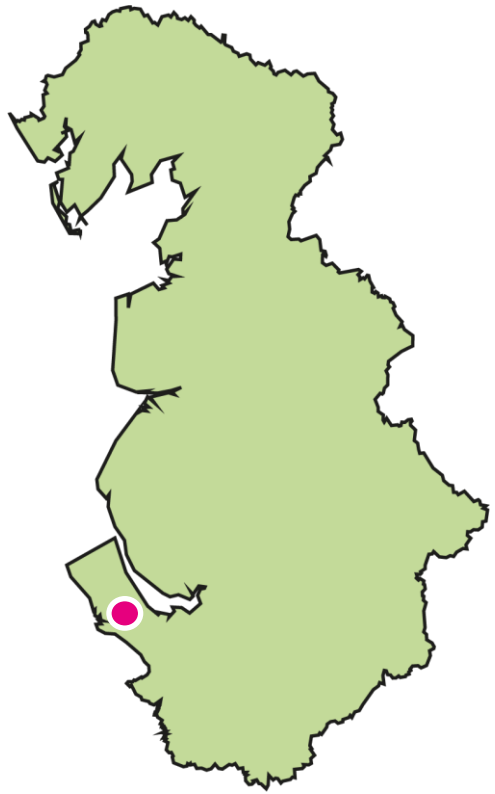
North West region:

Cheshire, Merseyside and Greater Manchester – Healthier South Wirral PCN

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Kirkby PCN

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.

At Kirkby PCN we believe in the importance of initiating a journey of care and support for expectant and new mums and dads in our community. Our aim is to further develop our custom-made **Perinatal Social Prescribing response to the Mental Health needs of parents/carers** already disadvantaged because of health inequalities and social deprivation in the area, which has been exacerbated by Covid pandemic and economic crisis. Knowsley is an area of high deprivation and low education attainment which results in high incidences of poor mental health.

Key to the delivery of our vision is the deployment of a place-based approach which recognises that strong relationships between the NHS, local government, communities and wider stakeholders is key.

Aims and Objectives:

- Develop a referral pathway which will help us reach those parent/carers with unmet needs.
- To create individual relationships with parent/carers with unmet needs to begin a journey to address their needs.
- Focussing on prevention, early intervention and confidence building.
- Aim to encourage new parent/carers back into the workplace and nurture a sense of purpose.
- Continue our collaborative work by building and maintaining strong relationships between the NHS, local government, communities and wider stakeholders.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – 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.

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Knutsford PCN

Complete Care Community

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.

The Care Community have focused on creating a connected community through Knutsford Together which offers one to one support and signposting by Local Connectors for local residents and the Monday Hub who run a weekly social club for those struggling with social isolation.

The Care Community have installed Parkletics outdoor gym equipment within a deprived area of Knutsford and will run classes with three cohorts of people initially to improve mild medical conditions, improve general wellbeing and to move more. The PCN also intend to build a traffic free, safe wellbeing loop at Tatton Park to support social resident becoming more active, to improve their health and wellbeing.

Aims and Objectives:

- To create a self-sufficient social support / signposting group run for the people by the people of Knutsford.
- To install a 'Parkletics' park exercise equipment within a community who would benefit from access to supported exercise programmes. The aim when in place will be to analyse BMI, blood pressure, HBA1c and lipids of patients before and after the programme to see if they improve their cardiovascular risk status. There will also be a programme linked to mental wellbeing and social isolation and these patients will complete the *Warwick-Edinburgh Mental Wellbeing Scales (WEMWS).*
- To create a round circuit outside exercise loop within the town to enable local residents to use a safe environment for walking, running or cycling and professionals to refer patients who would benefit from increased exercise opportunities.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester - Macclesfield PCN

Macclesfield PCN

Macclesfield PCN comprises 6 practices in East Cheshire that serve a population of just over 60,000 people. It works with and through Vernova Healthcare a Community Interest Company owned by 17 local GP practices.

The Macclesfield care community are working in partnership with the Macclesfield PCN to deliver projects which address Local population health inequalities.

The Macclesfield PCN comprises of 6 practices in East Cheshire that serve a population of just over 60,000 people. The network works through Vernova Healthcare, a Community Interest Company owned by 17 local GP practices.

For the CCCP programme, the suggested project of a Youth Champion will address inequalities in the mental health of young people aged 12- 19 years. Conscious of the impact that the Covid pandemic has had on the mental health of young people and the NHS's ability to meet the increased demand- the focus of this CCCP project is understanding and addressing the needs of those on the waiting list and for specialised child and adolescent mental health services assessment and care. Initially facilitating conversations with Space4Autism, CAHMS, Community connectors and social prescribers to gain an initial focus on Autism and ADHD.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

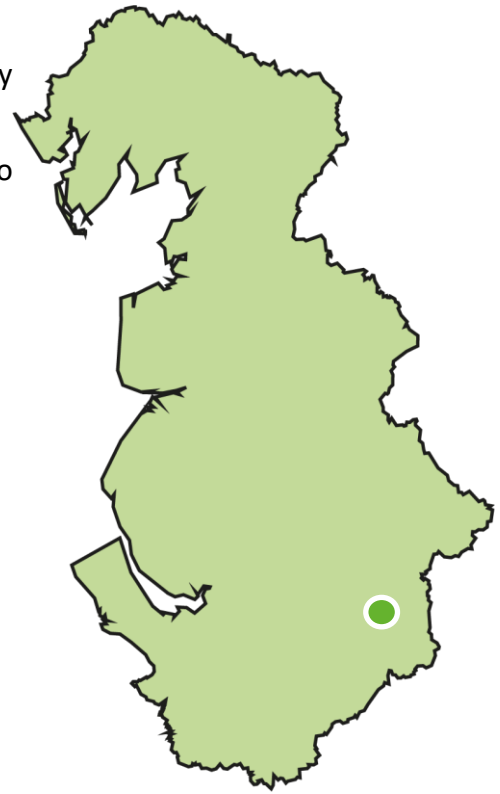
Cheshire, Merseyside and Greater Manchester – Middlewood PCN

Middlewood PCN

Bollington, Disley and Poynton Care Community is one of 5 Care Communities within Cheshire East. We have a population of approximately 32,750 patients and are coterminous with the Primary Care Network.

The average age of our population is higher than average, with more care home residents. We want to deliver a collaborative approach to tackling local inequalities for care home patients particularly around dementia and end of life.

We have noticed that there is a significance difference in the number of our care home residents being admitted between our 14 homes within our PCN. We have different organisations providing services to our patients but despite this there appears to be a lack of coordination resulting in an inequality in the chances of being admitted depending on which home people reside in.



Aims and Objectives:

- To analyse data to try to understand the reasons for this variation.
- To create a new role liaising between the homes trying to promote good practice and reducing variation.
- To help create an enhanced working relationship across the different organisations supporting Care Home Residents to mirror other pathways across our Care Community.
- To reduce duplication of response and increase efficiency across our Care Community.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Moreton and Meols PCN

Moreton and Meols PCN

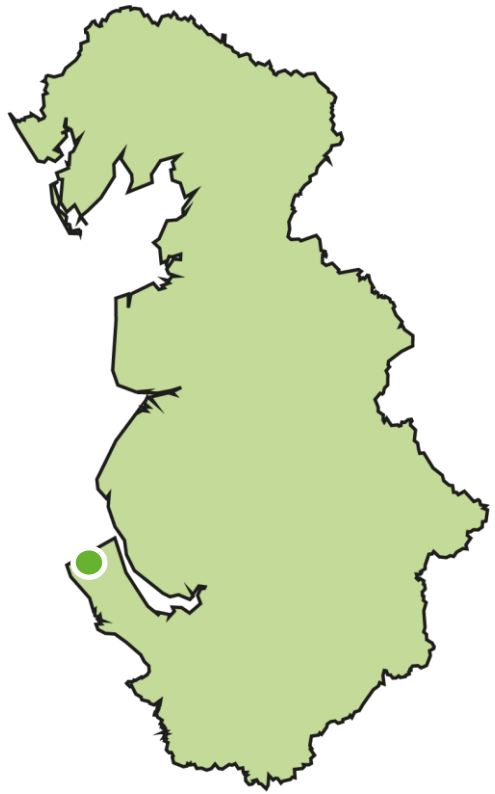
Moreton and Meols PCN in the Wirral is anchored in four general practices covering a combined population of c.30000 patients.

The PCN plan to continue to work with wider community services, the third sector and acute trust to improve outcomes for people living in deprivation and suffering from cardiovascular disease.

The PCN have established that the levels of CHD, STIA and hypertension are disproportionately higher than both local and national levels.

We aim to identify both those at high risk of developing CVD and those suffering inequity and poorer outcomes with existing CVD in relation to indices of deprivation. This should provide the PCN with a deeper understanding of how the wider determinants of health impact on patients with or at risk of CVD and how a new approach to team based care can better tackle this problem.

Although starting with this specific focus on CVD, we aim to develop an approach that can then be translated into other areas of inequalities.



Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester - Picton PCN

Picton PCN

Picton Primary Care Network consists of 6 GP practices in central Liverpool covering 45,000 patients. Picton is one of the most deprived areas in Liverpool, and therefore the UK, and is very ethnically diverse with multiple practices having 40% of their patients whose first language isn't English.

Picton Primary Care Network consists of 6 GP practices in central Liverpool covering 45,000 patients. Picton is one of the most deprived areas in Liverpool, and therefore the UK, and is very ethnically diverse with multiple practices having 40% of their patients whose first language isn't English.

We have the highest prevalence of patients on the serious mental illness (SMI) register of any Network in Liverpool and have therefore built practice and network teams to provide wrap around wellbeing support for our patients.

Aims and Objectives:

Our project is focusing on Perinatal support and through a community approach we aim to collaborate with our population and build effective pathways to fit their needs.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Runcorn PCN

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – South Sefton PCN

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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – Southport and Formby PCN

Southport and Formby PCN

Southport and Formby Primary Care Network (PCN) includes 17 practices covering a population of 125,000. It covers a coastal population of mixed demographic but with significant areas of deprivation in areas of Central Southport. St Marks Medical Centre has a population of 16,257 and includes areas in the highest quintile of multiple deprivation but surrounded by areas of affluence.

Our intended focus on inequality is the most marginalised population segment that experiences many of these risk factors requiring disproportionate support but still suffer poor outcomes - those living with **Complex Lives**.

Aims and Objectives:

- Identify and engage with people with complex lives.
- Co-production with patients / clients and supporting organisations with an aim to provide meaningful, practical and co-ordinated care for those experiencing homelessness and broader complex lives cohort.
- Begin to Identify measurable outcomes e.g. admission rates, emergency presentations
- Disseminate a model as learning progresses.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Cheshire, Merseyside and Greater Manchester – St Ann's Hospice

St Ann's Hospice – Greater Manchester

St Ann's Hospice operates from 2 sites in Greater Manchester and Cheshire and work to reach people living without shelter earlier on in their illness and improve the quality of care for those with advanced ill health.

People experiencing homelessness suffer from poor health disproportionately. They experience many barriers to health care, often dying 30 years younger than people who are housed. These deaths are often unplanned, with care being crisis-led and access to palliative care is very unusual.

St Ann's Hospice operates from 2 sites in Greater Manchester and Cheshire and work to reach people living without shelter earlier on in their illness and improve the quality of care for those with advanced ill health.

This is a well-established service which support clients, keyworkers and health and social care staff when someone's health is getting worse.

The CCCP will support the ongoing evaluation of the service and its effectiveness and impact on this group of people and help to establish how this type of service can be scaled.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

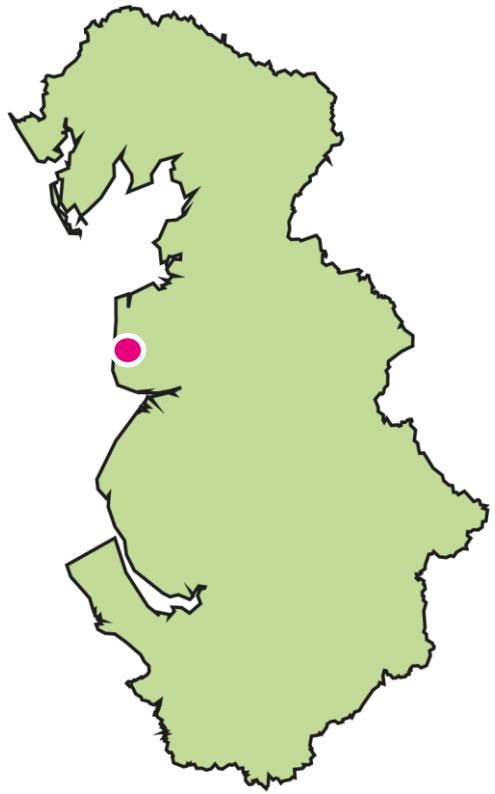
North West region:

Lancashire and South Cumbria – Blackpool Central West PCN

Blackpool Central West PCN

Serves 33,000 patients across 3 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.

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	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Lancashire and South Cumbria – Burnley East PCN

Complete Care Community

Burnley East PCN

Burnley East PCN comprises of 6 practices providing core GMS medical services to a population of over 53,000. Burnley is a large town spanning 111 km² it has 15 wards, and the number of people per km² is twice the England and Wales average. Burnley has the 10th Worst Life expectancy of all local authorities in England with people dying 6 years earlier than those who live the longest. According to the 2019 index of multiple deprivation, Burnley was ranked as the 11th most deprived area out of 317 districts and unitary authorities in England. This was based on the rank of average rank. The results also show that 23 (38.3%) of the lower super output areas in the authority were ranked in the 10% most deprived in the country. *(Burnley Borough Council).*

The programme aims to build on the understanding of the population to establish why some over 75s living at home fare better than others and then to develop interventions to identify the most vulnerable, helping them to achieve better health and wellbeing. Existing programmes have already been able to address the needs of the local population. The intention is to adapt and extend them to meet the needs of the over 75s unable to leave home.

Aims and Objectives:

- Understand and address the issues of why some over 75s living at home fare better than others.
- Develop interventions to identify the most vulnerable and help them achieve better health and wellbeing.
- Of the 4410 over 75's, to focus on 130 unable to leave their home.
- Offer welfare call and Physical health check.
- Establish needs including digital inclusion.
- Address identified needs.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Lancashire & South Cumbria - Fleetwood PCN

Fleetwood PCN

Fleetwood is a significantly socio-economic deprived town with repeated cycles of poor health outcomes heavily linked and evidenced to adverse early childhood experiences. Fleetwood PCN population profile data identifies the biggest adult disease prevalence as depression (22.59% PCN prevalence), second hypertension (17.74% PCN prevalence) and third obesity (13.06% PCN prevalence). These have common overlapping causes and symptoms which could be addressed and improved with a new CYP early intervention strategy including promotion, education, partnership working, recommissioning priorities, improving accessibility to healthy lifestyle choices (such as diet, increased activity, exercise, regular health checks, social prescribing etc) and increasing access to physical and mental health support locally. The early intervention strategy outcomes would help to prevent the diseases developing into a more serious fixed state in adulthood, secondary health conditions and intergenerational cycles of poor health and inequalities across the town.

Aims and Objectives:

Respond to the data on poor health, mental health, crime and education outcomes and develop an innovative early intervention and preventative approach to tackling poor health outcomes. Engaging with the younger population to gain a true understanding of why this is happening, what are the barriers and gaps in the community and what is required to help improve the future outcomes. A health inequalities lead to focus on the start well population of children and young people age 0-19, developing, implementing and promoting early intervention strategies with a secondary focus on how the PCN acknowledges and responds to the link between poor health outcomes and adverse child experiences to create positive change.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Lancashire and South Cumbria – Lancaster PCN

Lancaster PCN

Lancaster PCN is compromised of two practices with a total list size of 83,000 patients.

Lancaster District has one of the highest rates of Suicide across Lancashire with a suicide prevalence which does not fit the national profile of ages 30-50. Lancaster has a higher rate of Young People suicides. The District does not have a suicide prevent strategy.

Depression is the most prevalent recorded long-term condition in Lancaster. The District is currently averaging 14 deaths from suicide per annum (2021 and 2022) with 78% known to have mental health problems.

Aims and Objectives:

- Establish a multi-agency Community Safety Partnership (CSP) sub-group focusing solely on Suicide Prevention. Include health, education, local authority and mental health services.
- Complete a local suicide audit.
- Develop a local suicide prevention strategy/action plan based on local data/intelligence and national strategies including the younger age group, to be delivered across the district.

Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann's Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

North West region:

Lancashire and South Cumbria – Leyland PCN

Leyland PCN

Leyland Primary Care Network is comprised of 6 practices with a total list size of 42,500 patients.

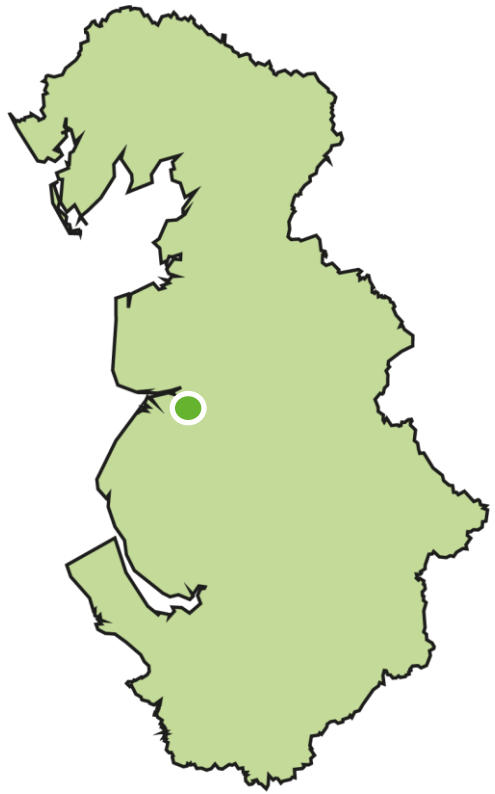
We will proactively identify, assess and manage our “ageing well cohort” with mild to moderate frailty to promote improved personalised care and optimal outcomes for individuals.

The population:

>65yrs, Mild and moderate frailty, BMI> 25, at least one anxiety coding, living alone or with one other person

Aims and Objectives:

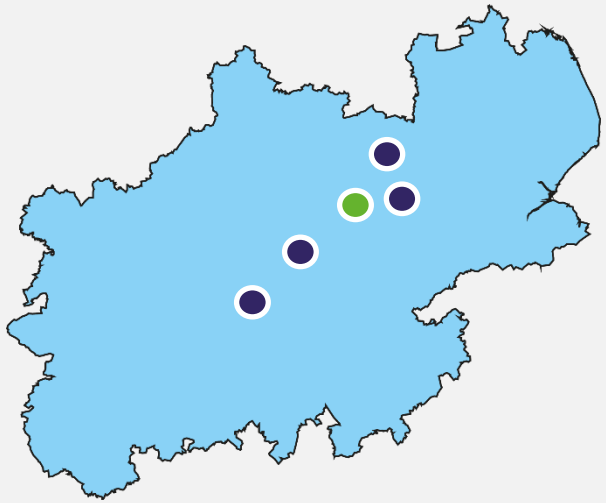
- Establish an accurate list of individuals in the Ageing Well Cohort.
- Deliver agreed Ageing Well Intervention: Targeted calls – initial and follow up @ 1 week, 1 and 1,3,6,9 and 12 months thereafter.
- Work within a multiagency integrated team, to review needs and access services and to help manage their own health and wellbeing.
- operate a single point of access via care coordinators working with the Population Health Management Team, SPLW and HWBC to triage referrals.
- Take referrals from the PCN’s GPs, practice nurses, physician associates, ANP, HCA, practice pharmacists, first contact practitioners, receptionists and other staff working in practice.
- Refer to other professionals within the PCN and to appropriate agencies.



Phase 1	Phase 2	Phase 3	
Cheshire, Merseyside and Gtr Manchester • Aintree PCN • Ellesmere Port PCN • Healthier South Wirral PCN • Knutsford PCN • Runcorn PCN **Lancashire and South Cumbria** • Blackpool Central West PCN	**Cheshire, Merseyside and Gtr Manchester** • Central Liverpool PCN • CHAW PCN • Chester South PCN • Kirkby PCN • Knowsley Central and South PCN • South Sefton PCN	**Cheshire, Merseyside and Gtr Manchester** • CHOC • Chorley Central PCN • Macclesfield PCN • Middlewood PCN • Moreton and Meols PCN • Picton PCN • Southport and Formby PCN • St Ann’s Hospice	**Lancashire and South Cumbria** • Burnley East PCN • Fleetwood • Lancaster PCN • Leyland PCN

Complete Care Community

Midlands region



Phase 2	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West/South Nottinghamshire PBP	• Derby City – PCCO PCN

Midlands region:

Caritas PCN

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.

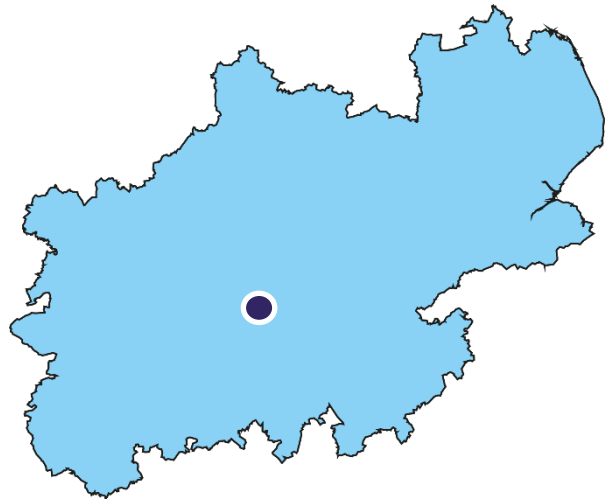
The service has critical problems with access, with difficulty providing the number of appointments that patients request (x2 the national average) - leaving less health literate patients at a disadvantage for getting the help they need.

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.

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	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West and South Nottinghamshire	• Derby City – PCCO PCN

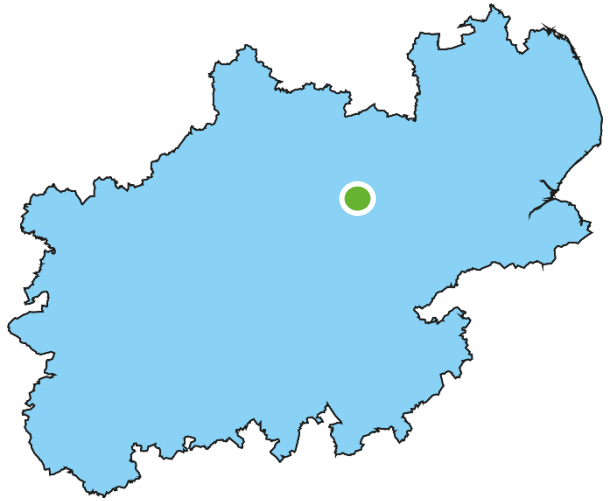
Derby City – Primary Care Community Options (PCCO) PCN

PCCO PCN in Derbyshire serves a population c.46,500 patients through a single practice partnership covering 2 sites.

This project aims to tackle the health inequalities faced by Slovak patients residing in Derby City.

The project will identify and address the factors that contribute to these health disparities, including access to healthcare services, language barriers, cultural differences, and socio-economic factors. The project will also strive to empower the Slovak community to become active participants in improving their own health outcomes, strengthening patient engagement within primary care in Derby.

The planned approach to address the identified health inequalities will include recommendations for enhancing access to healthcare services and reducing language and cultural barriers. Training and education materials for healthcare providers will be developed to improve the quality of care provided to Slovak patients and enhanced community engagement is planned to empower the Slovak community to become active participants in their own healthcare.



Phase 2	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West and South Nottinghamshire	• Derby City – PCCO PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

East Staffs PCN

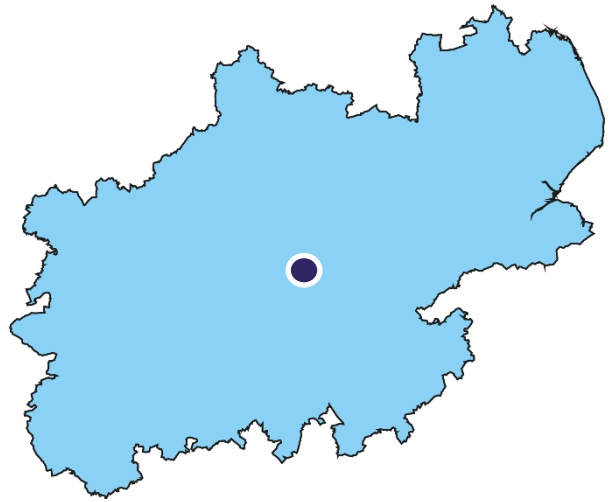
East Staffordshire PCN has 18 GP practices with complex demographics and a population of 147,000. There are areas of significant ethnic diversity and deprivation, with of the largest practices residing in the 3rd most deprived deciles nationally, with others in the least deprived according to Public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

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	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West and South Nottinghamshire	• Derby City – PCCO PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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.

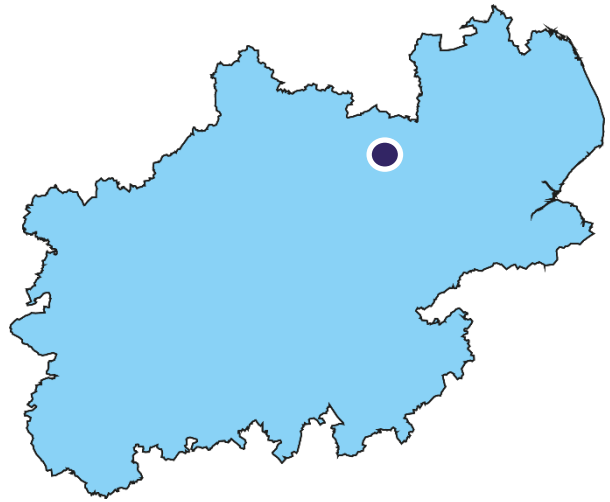
The indirect outcome of this approach should provide increased access to preventative and screening services for these communities resulting in changes in health outcomes.

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	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West and South Nottinghamshire	• Derby City – PCCO PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

Nottinghamshire West and South Nottinghamshire

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.

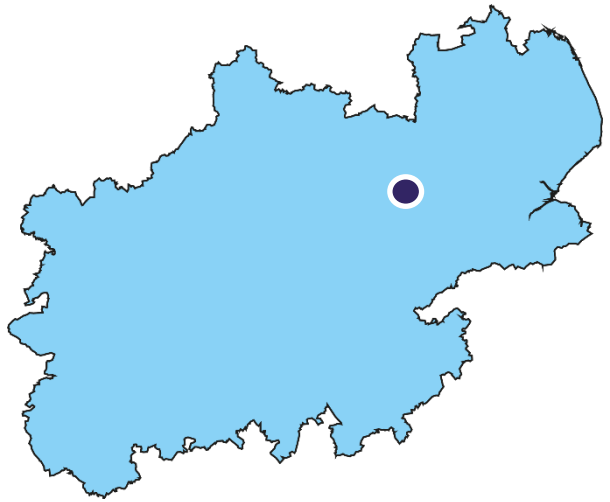
It comprises three neighbourhoods, Eastwood, Stapleford and Beeston and has a total of over 107,000 registered patients who are served by 12 GP practices.

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.

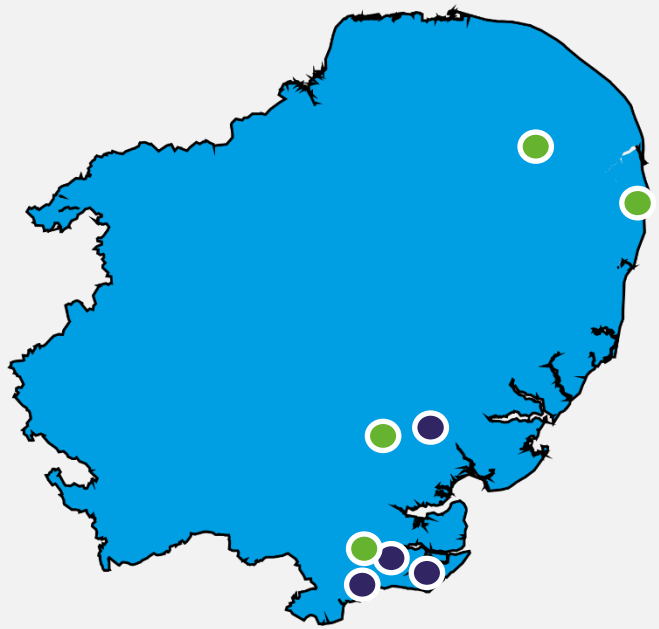


Phase 2	Phase 3
• Caritas PCN • East Staffordshire PCN • Mid Nottinghamshire PBP • Nottinghamshire West and South Nottinghamshire	• Derby City – PCCO PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

East of England region



Phase 2	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Complete Care Community

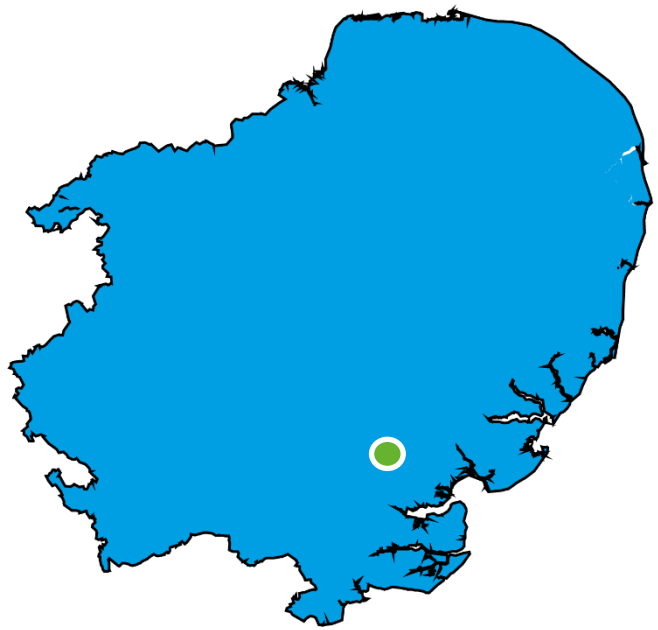
Braintree PCN

In 2018, the total population of the Braintree District was an estimated 151,561 people making it the fourth largest local authority area in Essex in terms of population. The rate of suicide amongst men in Braintree (17.61 per 100,000) was 19.9% higher than the England average (14.69) but was also higher than the rate across Essex as a whole (16.90).

The plan is to augment an existing 'Mental health Hub' to develop a comprehensive mental health service.

Aims and Objectives:

- Facilitates multi-disciplinary sharing of information and referral of patients between services.
- Places a MHP, Social Prescriber and Care Coordinator within the mental health hub to offer additional resource and drop-in opportunities for patients using the hub with the offer of health checks as part of the package of care.
- SPLW and Care Coordinator to signpost and offer advice with a focus on those suffering from mental health conditions.
- Identifying CYP at risk of health disadvantage with early signs of poor mental health.



Phase 2	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

Central Basildon PCN

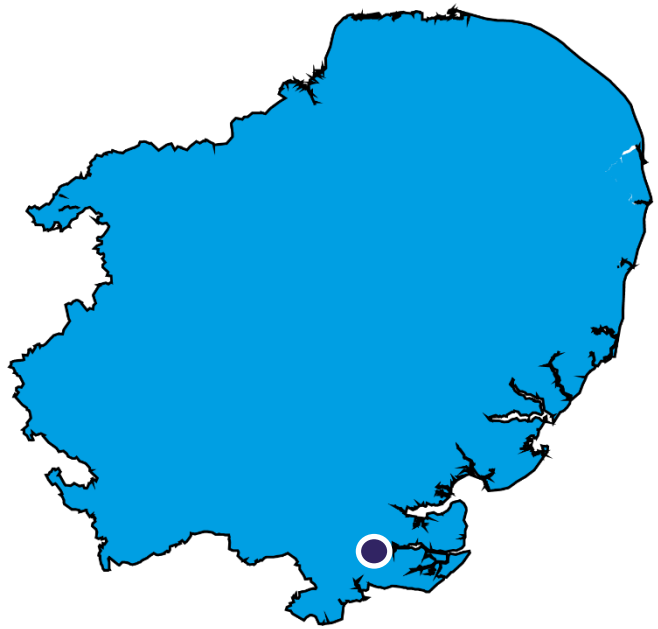
Within the Central Basildon PCN, a collaboration of eight GP practices serving approximately 49,000 patients from the central Basildon area, the Murree Medical Centre has been highlighted as CORE20Plus5 in the East of England to the 20% of the most deprived practices nationally.

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	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

Colchester Medical Group PCN

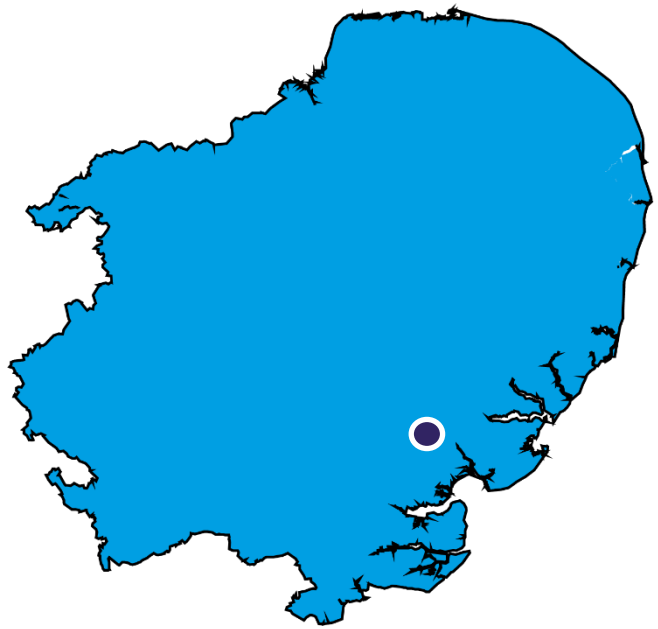
Colchester Medical Group PCN comprises four fully-merged surgeries serving 38,500 patients. The PCN covers the majority of Colchester and includes the wards with the highest deprivation indicators. The patient demographic is nearly identical to the national picture.

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	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

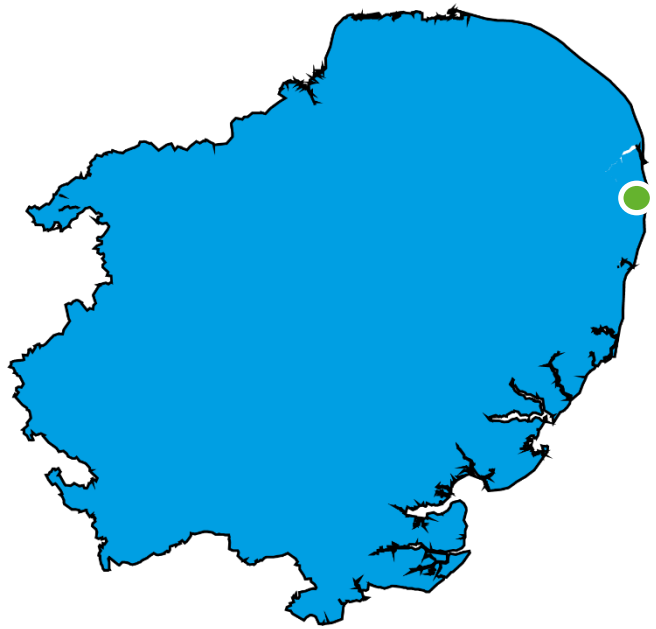
East of England region:
Lowestoft PCN

Lowestoft PCN

Lowestoft PCN serves a population of c. 80,000 supported by 7 practices. Approximately 50% of this population live in areas of high deprivation and there is a high impact on resource utilisation of those who are housebound.

A data driven population health improvement approach is to be undertaken through a multi-professional team to address the health inequalities experienced by a defined cohort of people in Lowestoft. These are people living with multimorbidity and largely housebound in neighbourhoods with high indicators of deprivation.
Local Health and Wellbeing partnerships including local council and wider community services will be supporting this work.

The aim is to provide improved clinical reviews and screening for this patient cohort and involving LPCN health and wellbeing coaches/care coordinators to make initial contact with all patients. By building stronger relationships and trust with this often marginalised, seldom heard group of people we hope to not only improve care outcomes but increase resilience and selfcare within this population group.



Phase 2	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

East of England region:
Norwich PCN

Complete Care Community

Norwich PCN

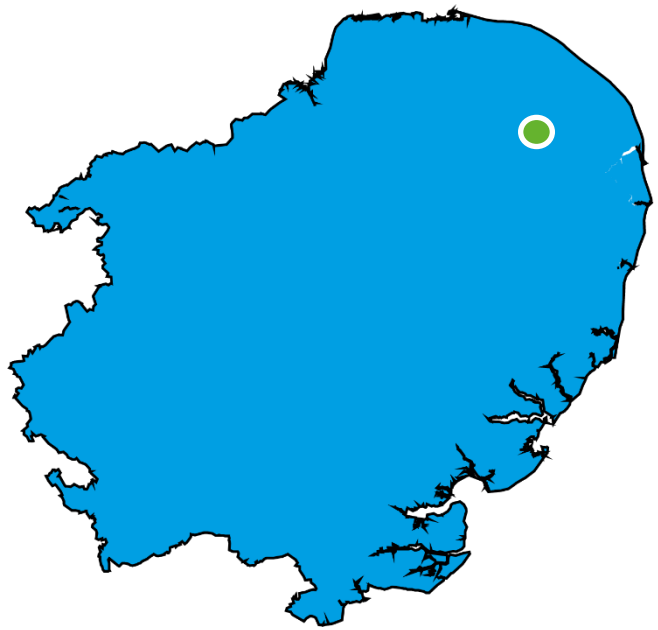
Norwich has one large PCN serving a population of 237,000 with 4 neighbourhoods. Our “central” neighbourhood incorporates the boundaries of 6 practices within a 3-mile area of the city centre, supporting around 70,000 people. It touches on two of our RITAs (Reducing Inequalities in Target Areas) - City Centre West/East and Mancroft) which are a key focus for targeted inter-agency activity. Our key focus is on prevention and the creation of health and wellbeing rather than the treatment of illness.

Our deliverables are:

- The Wellness Hub at Castle Quarter shopping centre in Norwich delivering COVID vaccinations and accessible services to meet the needs of the local population.
- The PCN has developed a range of services to address health inequalities for targeted communities which will be linked to this Wellness Hub.

We will co-produce services by listening to our community through the established Norwich Place Plus programme and work collaboratively with partners and community connectors to develop their hub.
We will bring together resources from our PCN, our local businesses, our communities and our VCSE colleagues and other partners with the ambition to offer accessible Health on the High Street, shaping delivery to meet local needs.

This initiative will be supported by the learning from Norfolk and Waveney ICS successful collaboration with local councils and wider community services to develop the Wellness on Wheels initiative (Wow bus).
This is a roving bus service which has been taking health and care services into communities with high indices of deprivation and with a focus to support inclusion health groups. It has already been delivering a secure and ongoing vaccination programme and incorporates an opportunistic approach to addressing wider medical and socio-economic issues. We are developing a hub and spoke approach with the Wellness Hub and incorporating a Making Every Contact Count approach to addressing wider health and socio-economic issues in a holistic, person-centred way, but we see the potential to engage with many more Core20plus communities which the CCCP programme will support.



Phase 2	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

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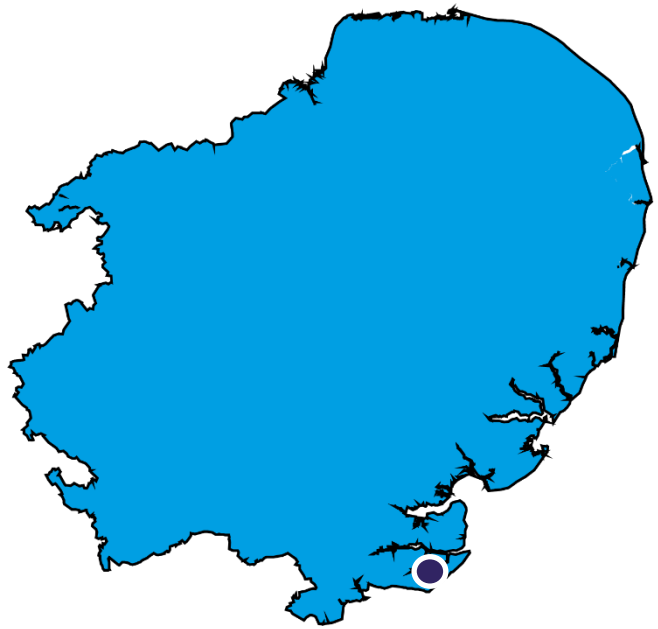
Southend Victoria PCN

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

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	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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

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

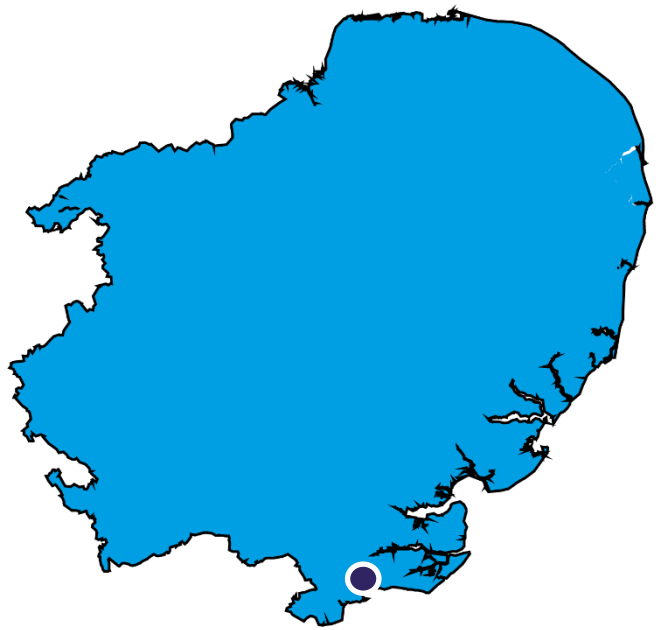
Population health management findings of the two PCNs record circa 13,357 adults currently living with obesity and 97% of those have not received a weight management service (WM). Obesity is a chronic relapsing condition that requires a behavioural change in the long term. Traditional 12 week WM services 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	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

East of England region:
West Basildon PCN

Complete Care Community

West Basildon PCN

Following on from the original work of Central Basildon PCN a collaboration has been developed between West and Central Basildon. Most of our practices are within the CORE20Plus5 profile. This now increases the number of practices involved in this programme to 16 with a combined list size of approximately 100,000.

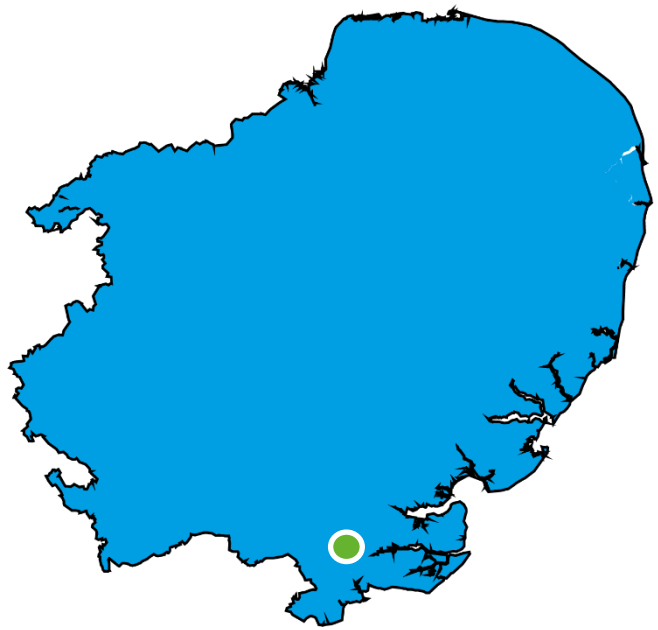
We provide activity and well-being sessions for Care Homes and in the local community. Mid and South Essex, Central Basildon PCN and partners, Basildon Council and Essex County Council, via Active Essex as a system collaborative, are now expanding this work as well as developing several new projects.

The original project has now been active for over a year, deploying Latin dance styles as an intervention to improve psychomotor skills to benefit children still undiagnosed who are inside of the neurodiverse lens with the school SENCO in several primary schools in Basildon. Most evaluation of this challenge of the programme is in its early stages. It is evident from the first cut that children have gained confidence, have become more coordinated, and their attention span has improved simply by being interested and happy to participate in the dance sessions.

This next phase has provided this project with an opportunity to expand to help this local population group in the Basildon community with this collaborative approach with West Basildon PCN (is this correct?). We hope that this will enable a scaling up to a broader demographic in the Basildon area.

Aims and Objectives:

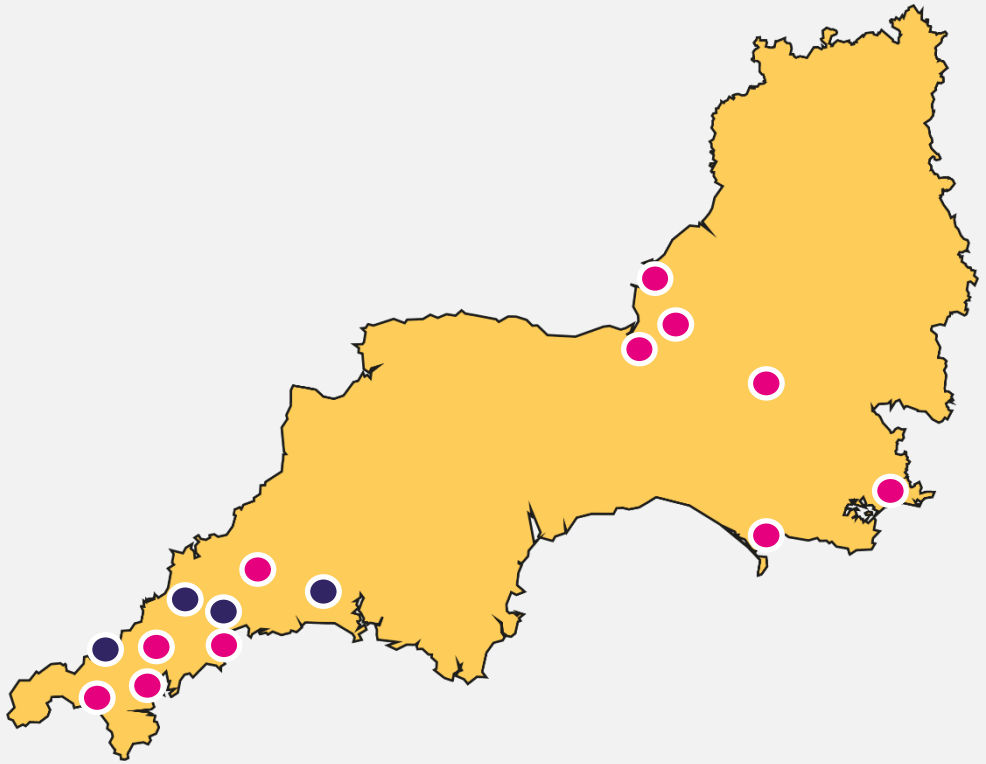
- Work with a broader span of local schools to provide for 12 to 15 children per class, with dance tutors in a 45-minute Latin dance session after school for primary school-age children for three months.
- Explicitly targeting undiagnosed neurodiverse children and may also be designed to include parents to support parents, guardians and children together.
- Incorporate a clinical and academic evaluation following the end of the second tranche; it is hoped that the local community asset teams will fund further tranches following the third tranche of this programme.
- Through the collaboration of the partner organisations assisted in this programme, for example, Basildon Council, we will look to foster more significant relationships with the regional Essex County Council children and families team to promote and embed this programme into the fabric of after-school incentives for primary school children in the local Basildon area.



Phase 2	Phase 3
• Central Basildon PCN • Colchester Medical Group PCN • Southend Victoria PCN • Stanford-le-Hope and ASOP PCNs	• Braintree PCN • Lowestoft PCN • Norwich PCN • West Basildon PCN

Complete Care Community

South West region



Phase 1		Phase 2
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN	• St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

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

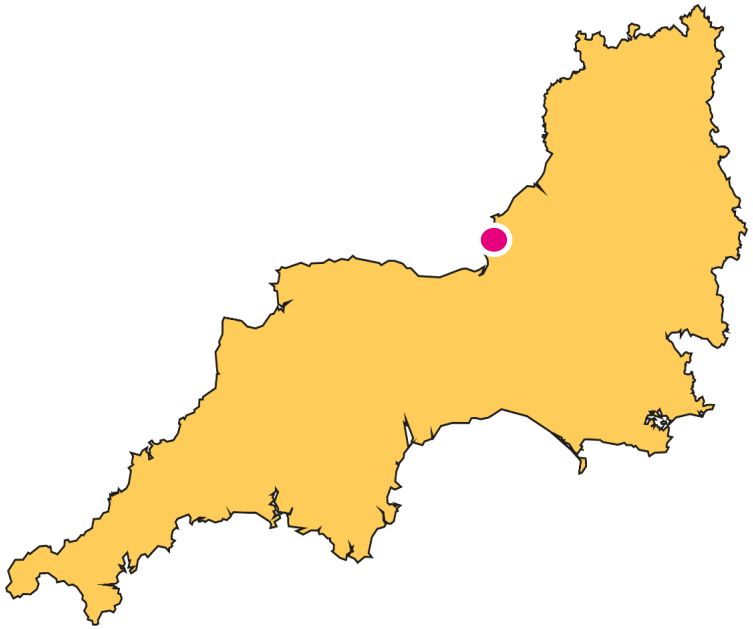
Pier Health, Weston-Super-Mare PCN

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Somerset - Bridgwater Bay PCN

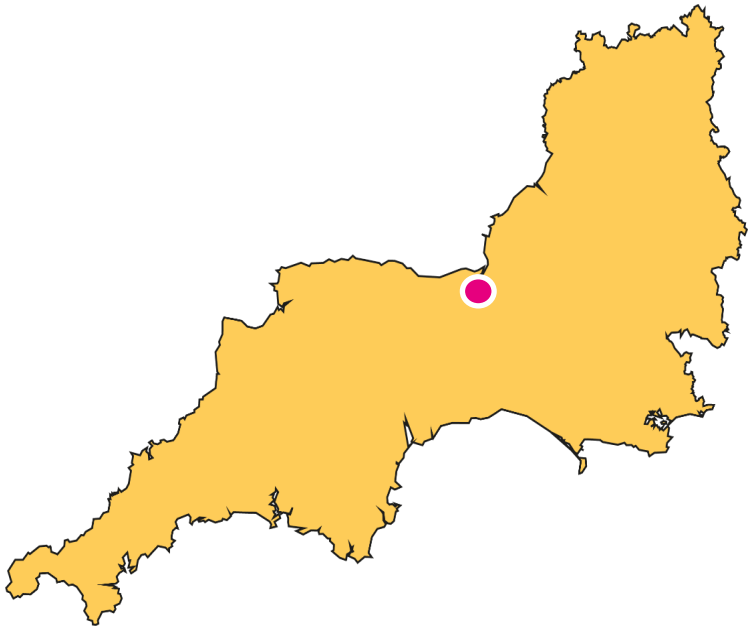
Bridgwater Bay PCN

Comprises 9 Practices with a population of over 80K patients.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Somerset - North Sedgemoor PCN

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.

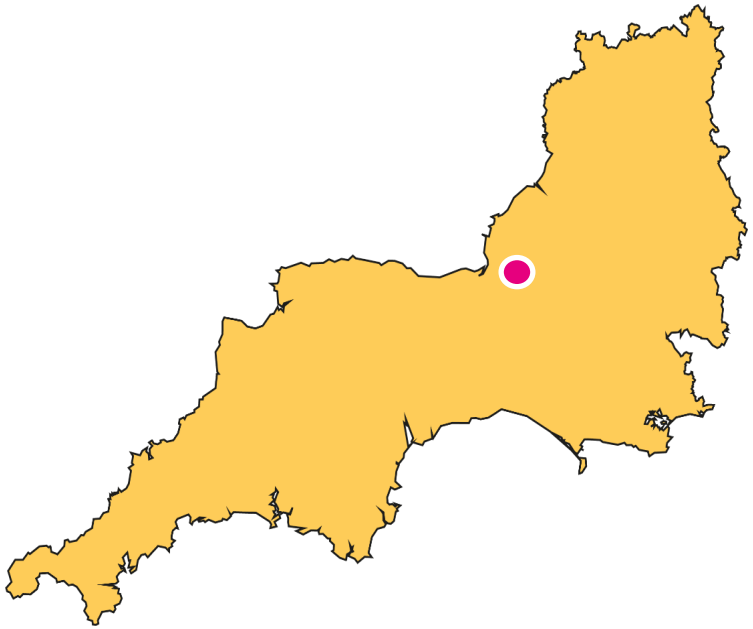
To offer a seamless 'One Team' approach to the care of patients registered within the PCN

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Dorset - The HealthBus Trust**, Bournemouth, Christchurch and Poole**

Complete Care Community

The HealthBus Trust, Bournemouth, Christchurch and Poole

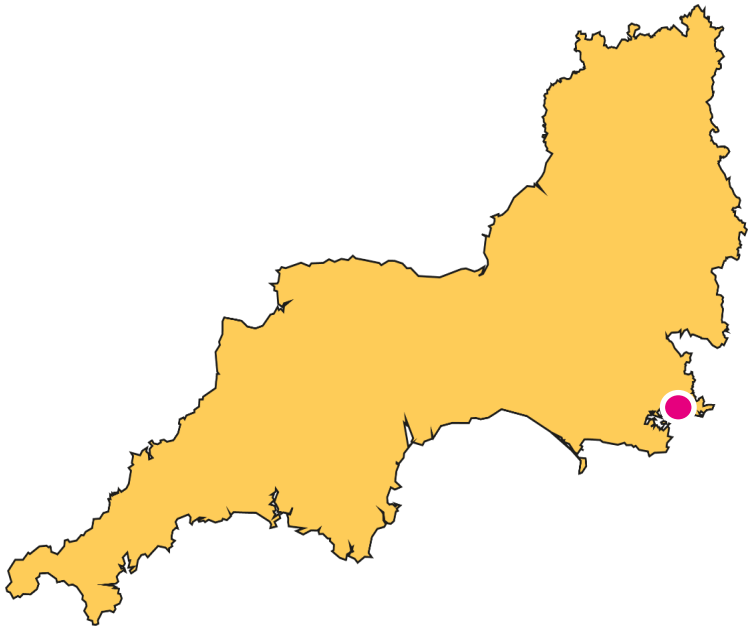
HEALTHBUS

The HealthBus Trust is a charity that provides accessible and appropriate specialist healthcare to people experiencing homelessness in Bournemouth, Christchurch and Poole. Operating a mobile GP-led service, in collaboration with a multidisciplinary NHS team, local authority and third-sector providers of homeless services, the HealthBus delivers care at the point of need.

This novel approach to care delivery recognises the value of relational aspects of healthcare. It is patient led in identification of needs for the homeless population who are under-served by traditional healthcare services. The mobile clinic is the start of a recovery and reablement journey to foster trusting relationships with healthcare providers, promote individual value and self-worth, and develop agency plus confidence in personal health-related decision-making.

The service reduces demand on NHS secondary care and other service providers and collaborates with hospital teams to reduce the 'revolving door' syndrome characterised by repeated A&E attendance and hospital admissions. This frees up resources for the wider community.

The HealthBus model is improving engagement with healthcare, reducing health inequalities and is inspiring service providers around the country to do the same for their vulnerable populations. The CCCP has offered a learning network with support through mentoring and evaluation. This is facilitating sustainable development through integration into the wider care system.



Phase 1	Phase 2
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Complete Care Community

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.

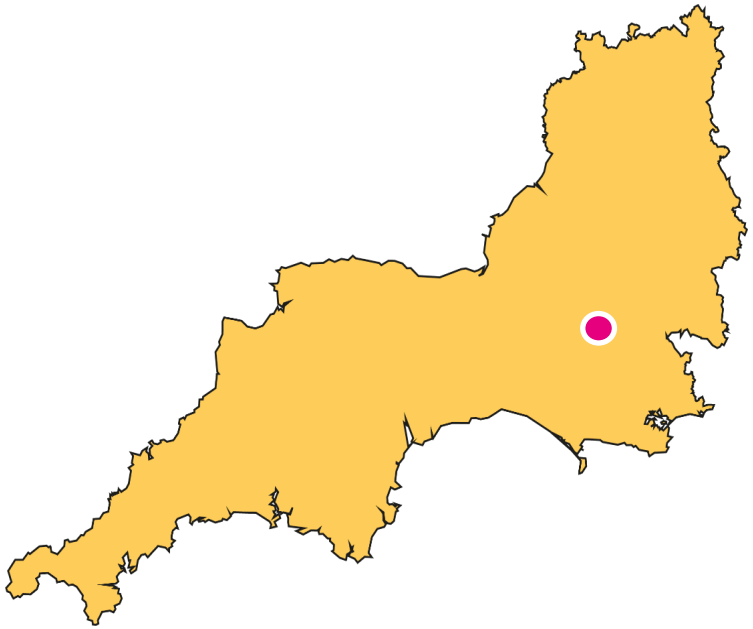
A Population Health approach to reducing falls risk and improve confidence in our frail population identified at being at risk of social isolation exacerbated by Covid 19.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

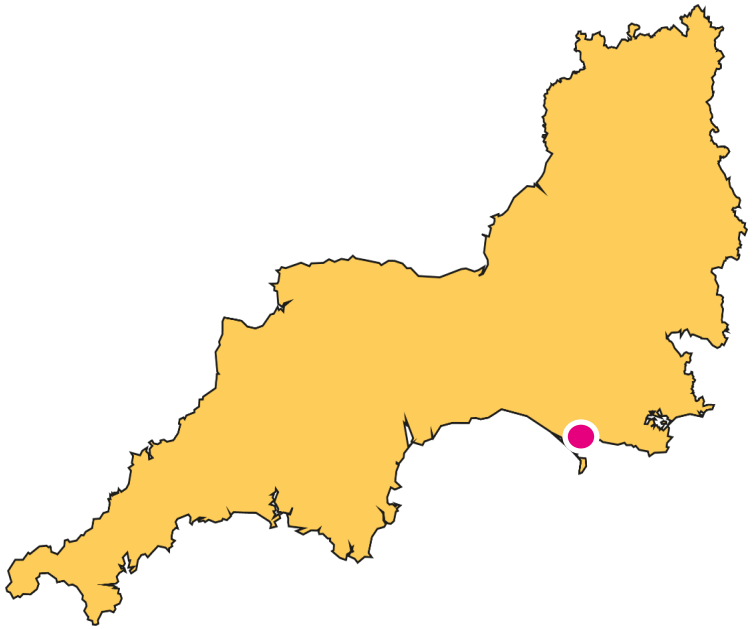
Weymouth & Portland Two Harbours Healthcare PCN

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

South West region:

Cornwall - Arbennek Healthcare PCN

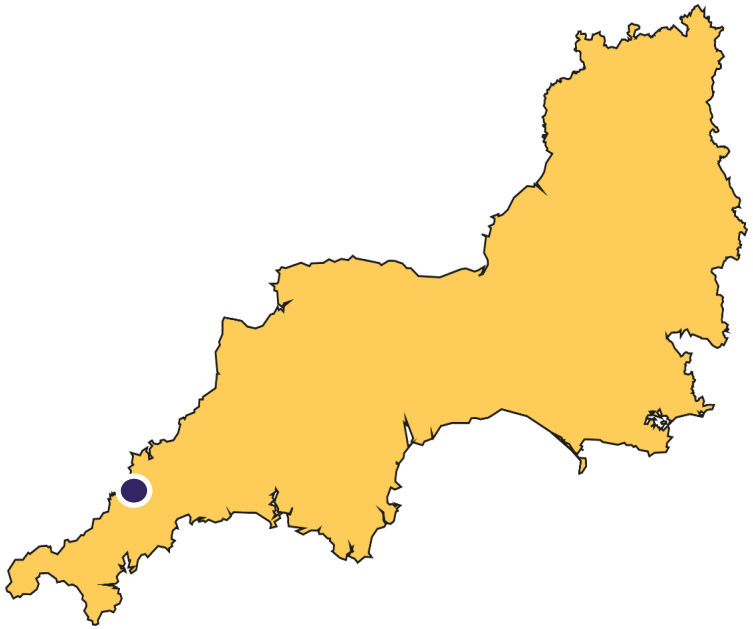
Arbennek Healthcare PCN

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Complete Care Community

Bosvena and Three Harbours PCN

Bosvena and Three harbours has 2 GP practices that serves a population of 42,595 patients.

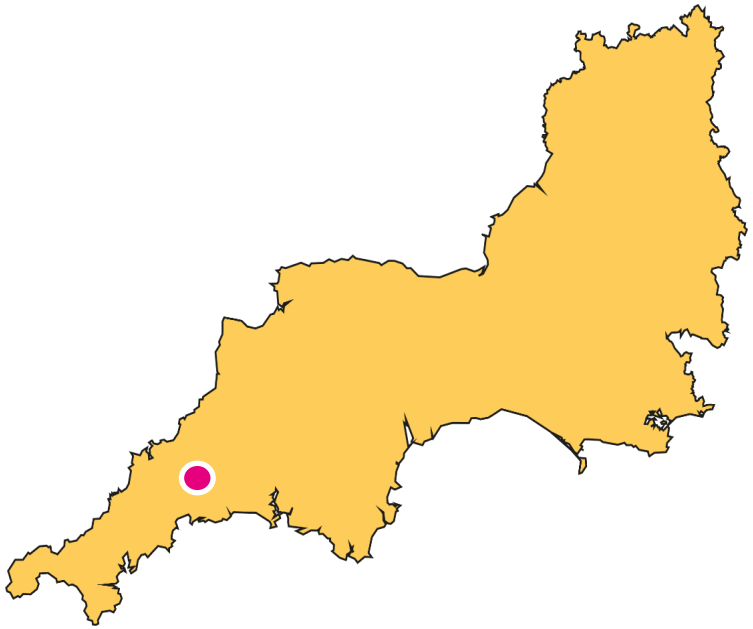
The area is rural with significant distances for patients to travel to the main acute hospitals.

We have undertaken an integrative project aimed to prevent and explore the connection between cardiovascular disease and learning disabilities. The team set out to 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, our LD consultant, Bowden Derra Park, Polyphant and Cromarty House, Bodmin.

We commenced our project with stakeholder events and progressed to an LD patient survey, which identified that patients wanted to be able to get out in the community, meet friends and have a coffee, and seek out links with local organisations and groups. Our project was delayed during COVID because of activities not taking place and being suspended for a time, and the lack of links to information and an accurate local 'Directory of Services' to support this.

We worked with 'Help at Hand' and their team to explore an LD version of the App to support patients and share information.

Since this initial work, we have widened out Health inequalities work within our PCN and are now working on plans to progress with a Health Hub using a Hub and Spoke model within our rural PCN, with the intention to bring services together at place, and offer patients an alternative way to access services including mental health, health and wellbeing, social prescribing, and volunteer organisations.



Aims and Objectives:

Our initial aims and objectives were:

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

Following initial work, we have moved forward and have goals of:

- Integration of support services within community spaces, bringing together teams and maximising improved care and access for patients.
- Establish a network of local voluntary sector groups, and resources to integrate with our Wellness Hubs.
- Consider how we can use our Health Hubs to reduce health inequalities and support those patients with higher levels of deprivation, transport or other related issues, to obtain access to care and support that best meets their needs.

Phase 1	Phase 2
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

South West region:

Cornwall - Coastal PCN

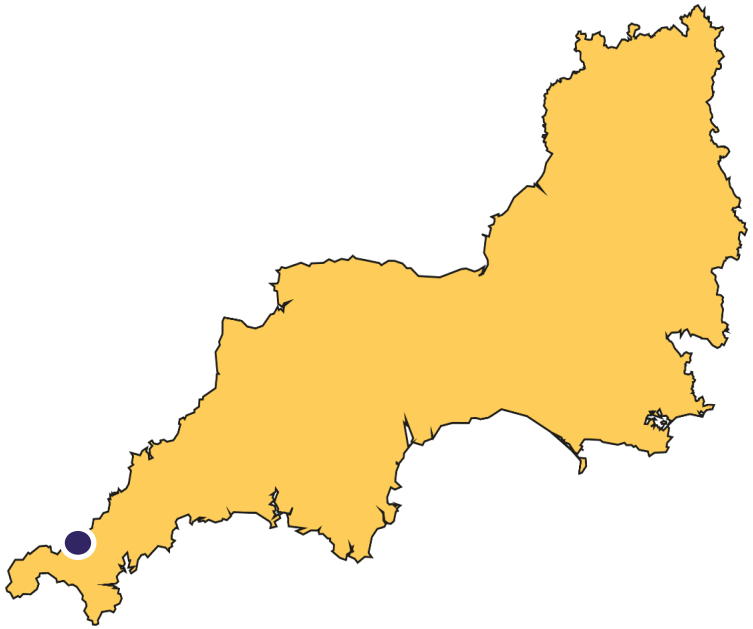
Coastal PCN

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

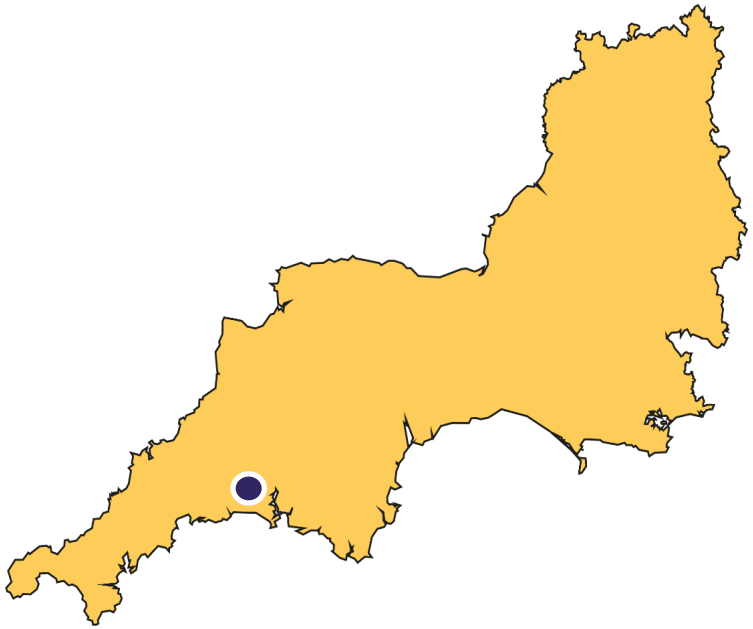
Complete Care Community

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

South West region:

Cornwall - Falmouth and Penryn PCN

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.

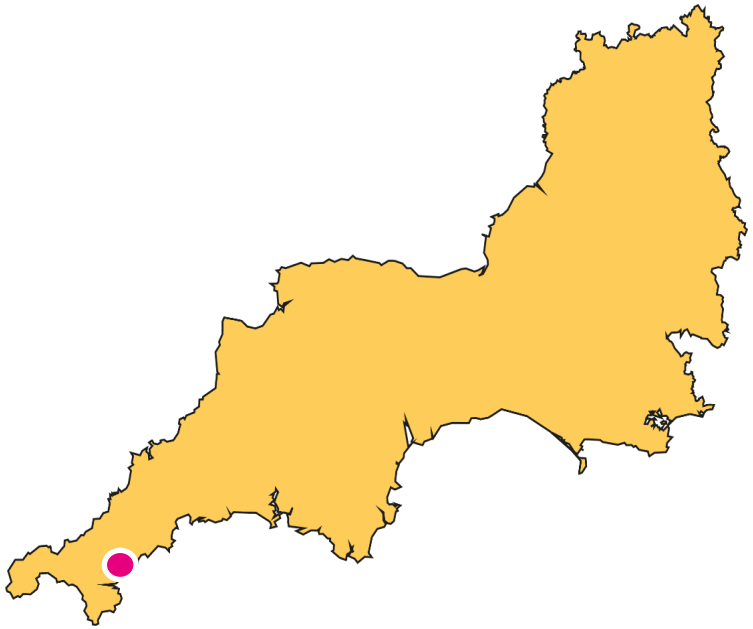
A project focused on providing a comprehensive mental health service in primary care. Aimed at a target population who are not unwell enough for secondary care, enabling them to receive support within the community.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Cornwall - North Kerrier West PCN

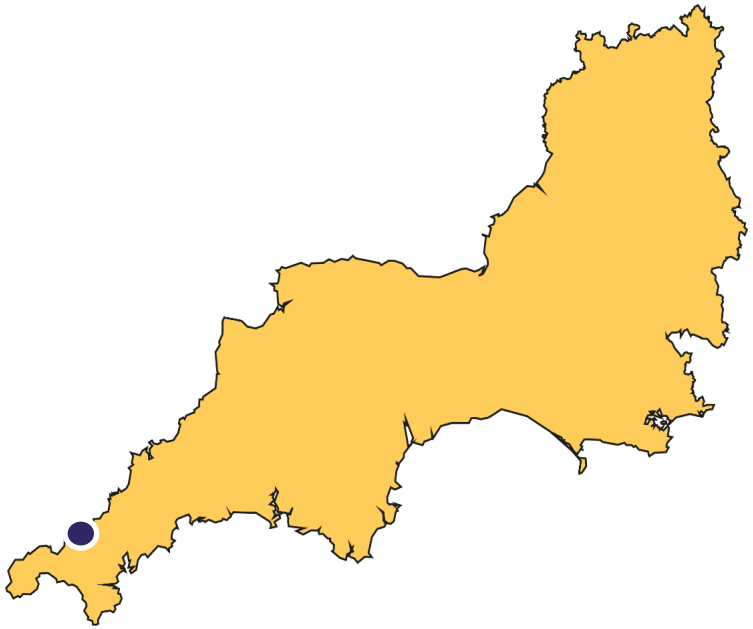
North Kerrier West PCN

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.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Cornwall - Penwith PCN

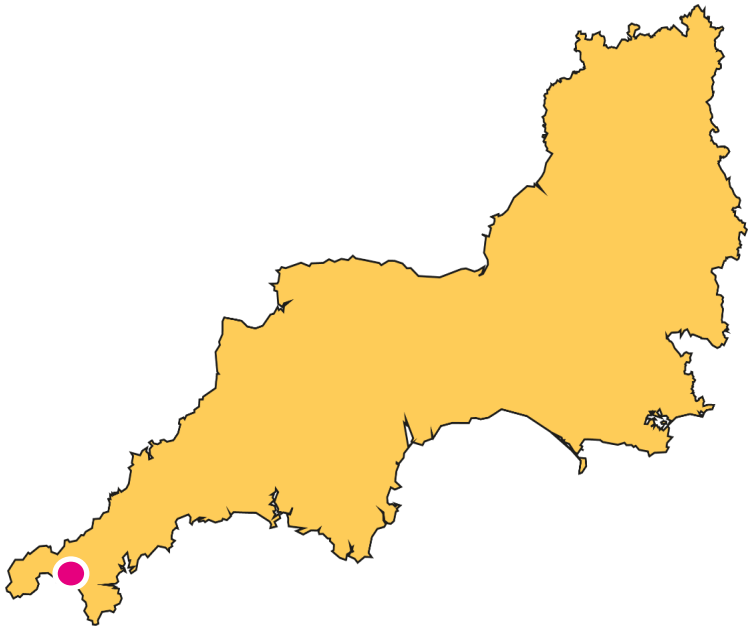
Penwith Primary Care Network

The most westerly tip of the UK, Penwith PCN has a population of just over 67,000 people, living in an area that includes very rural and isolated communities, as well as more densely populated towns, surrounded on three sides by the ocean.

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).

The focus is on tackling health inequalities and the 'gap population', particularly those with poor mental health and wellbeing.



Aims and Objectives:

- Create a mental health & wellbeing service co-located within existing community hubs, at 3 sites across the PCN based on areas of highest need, with an outreach service.
- Grow a team of mental health & wellbeing coaches to work alongside social prescribers to tap into community-based support.
- Improve mental health and wellbeing outcomes for our population, reduce 'high frequency users' of primary care relating to mental health.
- Develop a sustainable, environmentally friendly and place-based approach to personalised care, that centres on 'what matters to you', not 'what's the matter with you'.

Phase 1	Phase 2
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Cornwall - St. Austell PCN

St. Austell PCN

St Austell Health Care PCN has a registered population of 36,378 including 3 city centre

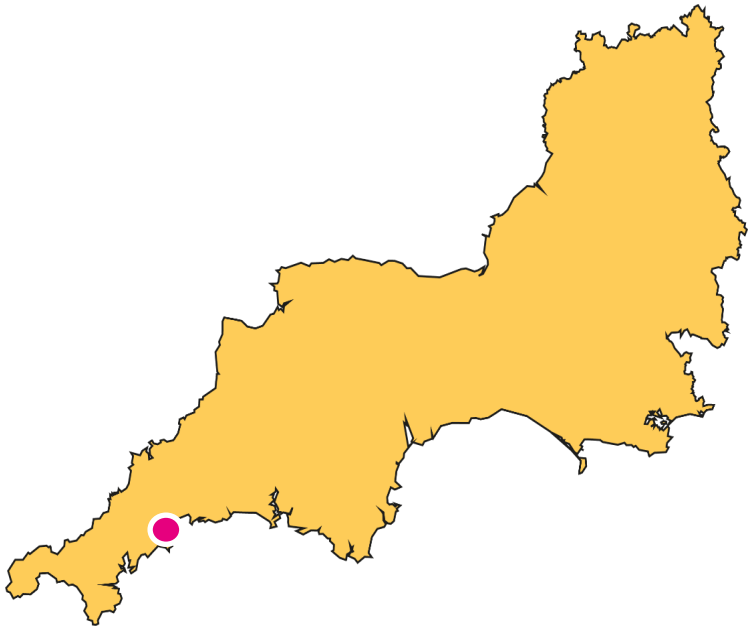
surgeries, one in the coastal village of Mevagissey and one at Foxhole on the edge of China Clay country. Parts of St Austell rank among the 10% of the most deprived areas of the

country. Young People in the PCN also experience the challenges of rural isolation and limited transport.

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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

South West region:

Cornwall - Truro PCN

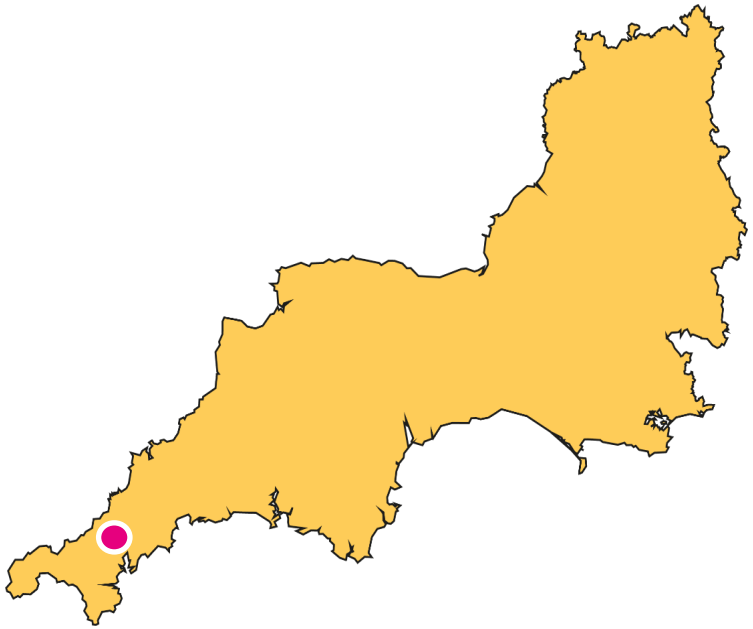
Truro PCN

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.

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:

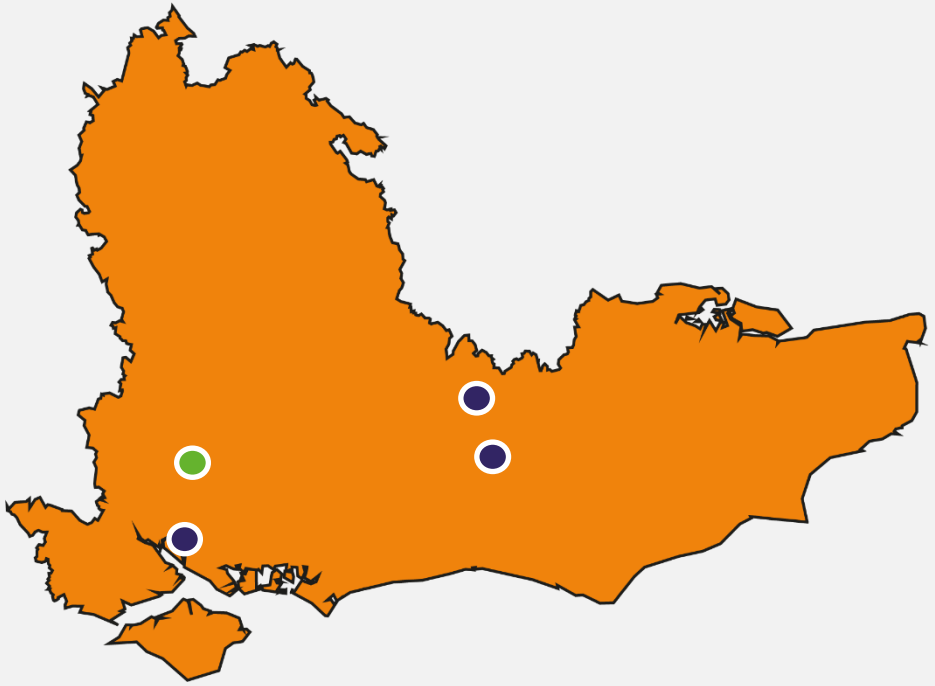
- The project undertook a qualitative research approach underpinned by thematic analysis. Delivered through groups and 1:1 with a mixed front facing and virtual model – to adapt to the COVID climate.
- A systems mapping approach and methodology was used to represent a holistic understanding of the social 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
• Bridgwater Bay PCN • Bosvena and Three Harbours PCN • Falmouth and Penryn PCN • North Sedgemoor PCN • Penwith PCN • Pier Health - Weston-Super-Mare PCN • St Austell PCN • The HealthBus Trust • The Vale (BVP) Network PCN • Truro PCN • Weymouth and Portland PCN	• Arbennek Healthcare PCN • Coastal PCN • East Cornwall PCN • North Kerrier West PCN

Complete Care Community

South East region



Phase 2	Phase 3
• Alliance for Better Care - Crawley PCNs • Alliance for Better Care, Healthy Horley - East Surrey PCNs • Woolston & Townhill PCN	• Dentaid

South East region:

Alliance for Better Care – Crawley PCNs

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.

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).

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	Phase 3
• Alliance for Better Care - Crawley PCNs • Alliance for Better Care – Healthy Horley - East Surrey PCNs • Woolston & Townhill PCN	• Dentaid

South East region:

Alliance for Better Care Healthy Horley – East Surrey PCNs

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.

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.

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	Phase 3
• Alliance for Better Care - Crawley PCNs • Alliance for Better Care – Healthy Horley - East Surrey PCNs • Woolston & Townhill PCN	• Dentaid

Complete Care Community

Dentaid (Winchester)

Dentaid is a Dental Charity that provides dental care and oral health advice for people experiencing homelessness and other under-served communities.

Their seven mobile dental units travel the country visiting soup kitchens, hostels and community centres with volunteer dental professionals providing dental treatment and oral health advice.

The CCCP project will focus on the established clinics being provided in Winchester to people living without shelter and no other access to dental care.

The plan is to evaluate the effectiveness of the delivery model in relation to the on-site care provision, engagement with partnership charities and organisations, patient-led treatments and trauma-informed care.

Phase 2	Phase 3
• Alliance for Better Care - Crawley PCNs • Alliance for Better Care – Healthy Horley - East Surrey PCNs • Woolston & Townhill PCN	• Dentaid

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

Woolston & Townhill PCN

In the latest Index of Multiple Deprivation (IMD) this area was ranked 708 out of 32,844 in England.

Liver disease continues to rise in the UK, with a 400% Increase in deaths since the 1970s. It is now the third leading cause of premature death in the UK, most of which is preventable (c.90%). With the rising obesity crisis, it is now estimated that at least 1 in 3 will have some degree of NAFLD. Evidence has shown, that those living in areas of higher deprivation, have higher rates of liver disease.

This project aims to identify patients with a diagnosis of NAFLD (Non-alcoholic Fatty Liver Disease) in the most deprived areas of Woolston & Townhill PCN and to understand what impacts their health and wellbeing. By eliciting the major influences on their health, we can work together to support them to make changes to improve their long term health outcomes.

Aims and Objectives:

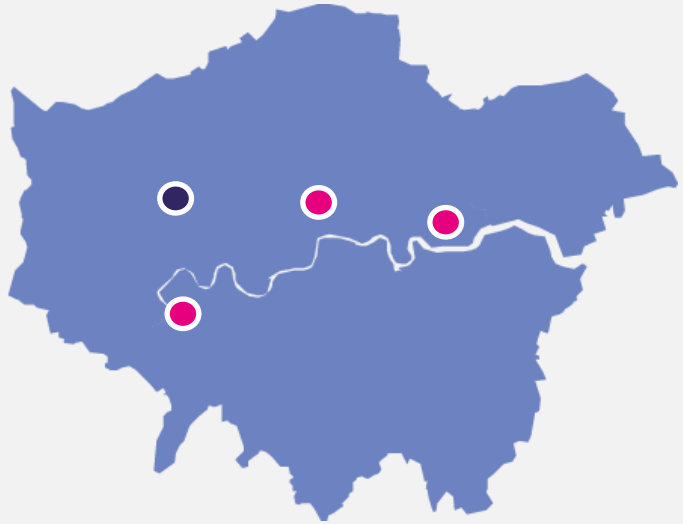
- To identify patients with a diagnosis of NAFLD in the areas of highest deprivation – Quintiles 1 & 2.
- Liaise with individuals to help understand the major influences on their health.
- To provide support to make lifestyle changes with the aid of our Health & Wellbeing coaches and Low carbohydrate cooking classes.
- Utilise other individualised support by using other agencies both internal and external to the practice.
- Continual evaluation of the project to help us to understand what has worked well and what can be improved.

Phase 2	Phase 3
• Alliance for Better Care - Crawley PCNs • Alliance for Better Care – Healthy Horley - East Surrey PCNs • Woolston & Townhill PCN	• Dentaid

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

London region



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

Complete Care Community

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.

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

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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.

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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Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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.

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.

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.

Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

Complete Care Community

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%.

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.

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Welcome
Demonstrator sites
Projects
North East, Yorkshire and Cumbria
North West
Midlands
East of England
South West
South East
London
Bibliography
Contact us

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

Complete Care Community

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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Health and social care systems support

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