


Newham Primary Care Networks implementing the Fuller Report



" Fuller recommendation: to ensure that primary care truly engage with, and understand the local patient population and tailor interventions and services to support them accordingly. This included supporting key cohorts who had health inequalities such as vulnerable or frail residents, those with poor mental health and children as well as establishing wider determinants of health. These interventions were innovative and made links with secondary care to ensure systems working."

Read about the following PCNs and their work in identifying and planning to address health inequalities in their patient population.




Docklands PCN
Understanding Population Health

- Care coordinator role employed to focus on patient data.
- Care coordinator also held regular meetings with member practices to check on target progress and develop plans for Long Term Conditions (LTC) interventions and improvements
- They reported at network meetings and presented clear population health information to ensure clinical directors had oversight.


South 1, NE2 and Docklands PCN
Tailoring support for patients with poor mental health /loneliness/ isolation

- These PCNs have, or are in the process of, developing community gardens.
- These gardens have predominately been developed, supported and delivered by the personalised care roles.
- The aim was to use grey / green spaces at practices for the benefit of patients' (and staff) health and wellbeing.


Docklands and South 1 PCN
Diabetes and Weight Management

- Docklands promoted, participated and encouraged patients to be physically active by participating in Park Run and provided free water bottles to those who took park.
- South One patients were referred to weight management support with the PCN now looking to provide a healthy cooking programme.
- NW2 provided one to one and group support to patients who were recently diagnosed with pre diabetes
- North Newham highlighted and encouraged patient engagement with community and voluntary sector healthy lifestyle offers






NE2 PCN
Supporting patients and children with dental health Information

- Aware of the increasing demand to support patients with oral health emergencies NE2 worked with Newham Oral Health Partnership to ensure key messages and existing pathways were promoted and communicated to primary care staff and patients.
- Secured the provision of dental health kits for parents of young children. These were available on site for distribution.



NW2 PCN
Supporting access to services with the learning disability (LD) community

- Targeted patients with a learning disability and organised an event to raise awareness of local health and social care services.
- Now planning to look at LD Health Checks quality and benchmark good practice delivery.

NE1 PCN
Cancer Early Identification

- NE1 PCN provided support to patients with the psychological impact of a cancer diagnosis.
- They also held a health and wellbeing event to raise awareness of cancer services. The event included Respiratory Yoga, a talk on diet, and information on diabetes prevention and social prescriber support.

Stratford PCN
Working with Secondary Care Services

- Working with a multi agency, community and secondary care team Stratford PCN provided advice and guidance to residents identified as having moderate and severe frailty.
- Supported residents to remain healthy and independent in their own homes for as long as possible.
- All patients received information and advice at fortnightly engagement sessions as well as a personalised care and support plan.

