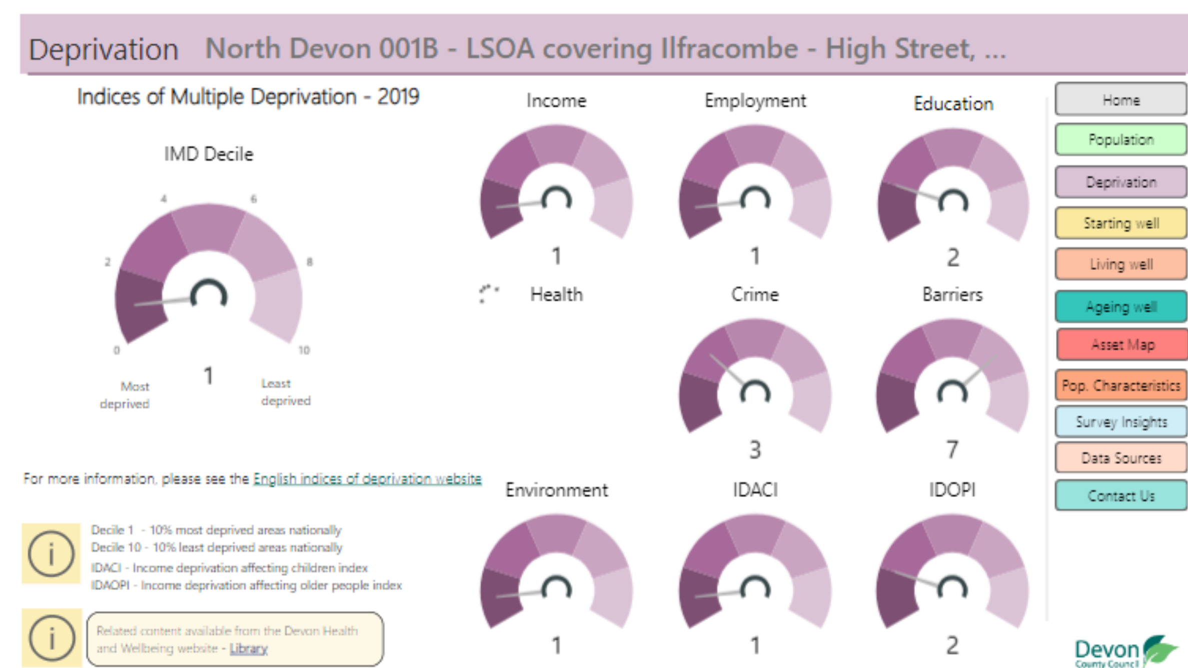
Belle’s Place Primary Care Outreach Clinic

‘Coastal communities, the villages, towns and cities of England’s coast, include many of the most beautiful, vibrant and historically important places in the country. They also have some of the worst outcomes in England, with low life expectancy and high rates of many major diseases.’ (Whitty, 2021)

Background

Ilfracombe is in one of the most beautiful parts of the country, but its stunning coastline, bustling harbour, seafront, and beaches mask the harsh realities of deprivation and health inequalities. Ilfracombe’s electoral wards are in the top 10% most deprived areas in England (figure 1). People living in Central Ilfracombe have a 15-year lower life expectancy than people who live in more affluent parts of Devon. (One Devon, 2023)

Figure 1. Ilfracombe deprivation (Devon County Council, 2021)



A key issue driving health inequalities in Ilfracombe is housing. Ilfracombe has a strong Victorian heritage and many of the large Victorian hotels and homes have been split into poor quality, privately rented flats and houses of multiple occupancy. There is a low availability of social rented accommodation within Ilfracombe. Many people have found their way to Ilfracombe through temporary housing by local authorities outside of the area, due to the relative availability of cheap private accommodation. These individuals often have complex health and social needs but lack any social support network within the town.

Belle's Place

At Belle's Place, a community hub on the seafront, over 200 people are provided with a safe and nurturing place to eat a meal and socialise. In addition to food, they can access practical support e.g. clothing and showers, as well as be supported to connect with housing, drug and alcohol services etc. Belle's Place is almost entirely run by volunteers.

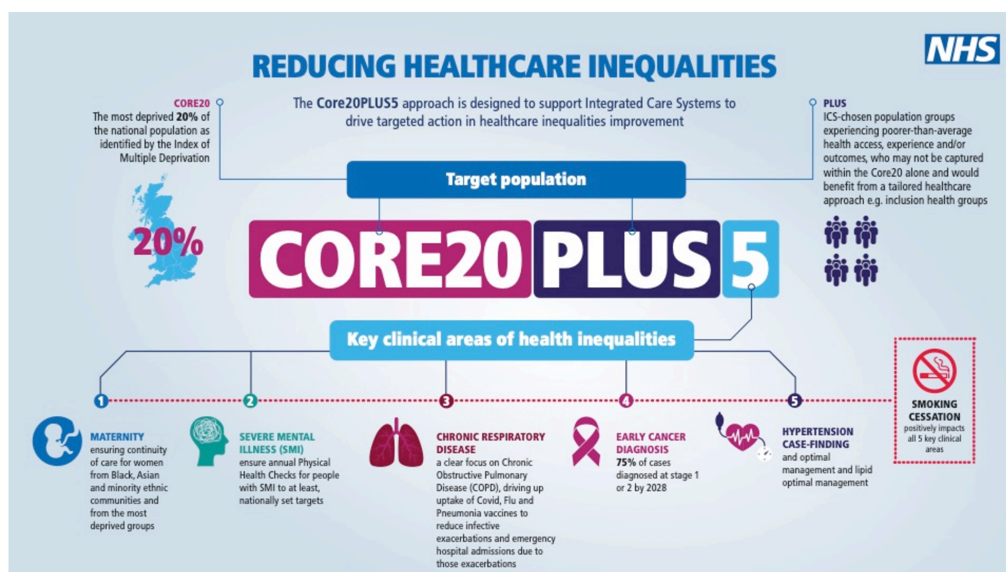
Many people attending Belle's Place are either homeless or housed in insecure rental accommodation. A significant proportion experience poor mental health, and many have drug and/or alcohol dependencies. These individuals are at high risk of poor health and have a low life expectancy.

Some of the most vulnerable individuals attending Belle's Place struggle to access healthcare via the traditional routes. The reasons for this, identified through interviews with clinic attendees, were variable. Some of the barriers are practical: lacking access to mobile phones and credit to book appointments; finding it difficult to stick to fixed appointment times; or lacking the disposable income needed to attend hospital appointments 15 miles away. Other identified barriers are psychological: individuals experiencing severe anxiety within the clinical waiting areas; feeling stigmatised and "looked down upon"by staff and other patients; not feeling listened to by the GP.

Project Overview

A proposal was developed for delivery of a 12-month Primary Care Outreach Clinic at Belle's Place. The primary aim of the pilot was to overcome the barriers to accessing healthcare and re-establish trust between service users and primary care. A secondary aim was improved health outcomes, with a specific focus on four of the five key areas identified in the Core20PLUS5 approach to reducing healthcare inequalities:

- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding and optimal management and lipid optimal management



The pilot was jointly funded by Devon ICS and NHS England's Innovation for Healthcare Inequalities Programme. Staff time was provided by Health Innovation South West, One Northern Devon, One Ilfracombe and Combe Coastal Practice.

Clinical sessions were delivered in the meeting room at Belle's Place on a twice monthly basis. Each clinic was 3 hours in length, running between 12-3pm, when the centre was open for lunch. Two GPs from Combe Coastal Practice were funded to deliver the clinical sessions.

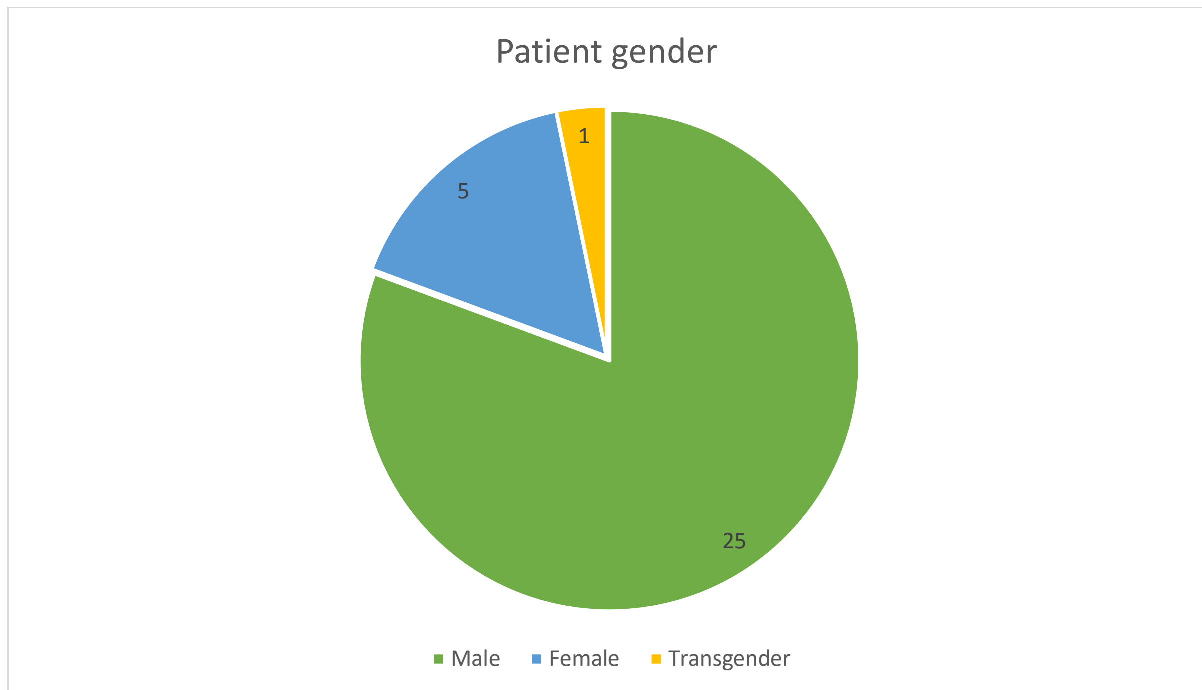
Service design was strongly influenced by Carol Parkin, Belle's Place director and centre manager, given her detailed understanding of the patient group, along with

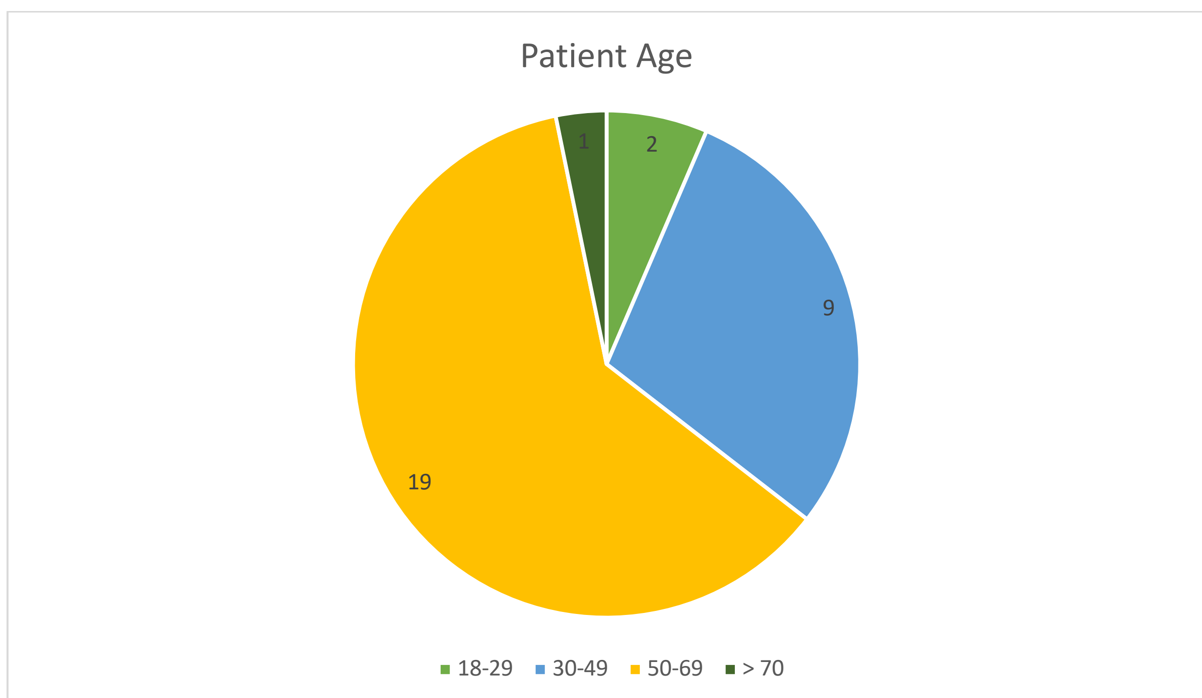
John Thornton, Public Health Outreach Team, who had delivered a success vaccine outreach programme at Belle’s Place. Additionally, Dr Nigel Moody and Louise Scantlebury (RN) from the Freedom Centre in Barnstaple provided guidance and expertise in developing an inclusion health service, along with supporting with set up costs through through providing equipment – blood pressure machines, saturation probes etc.

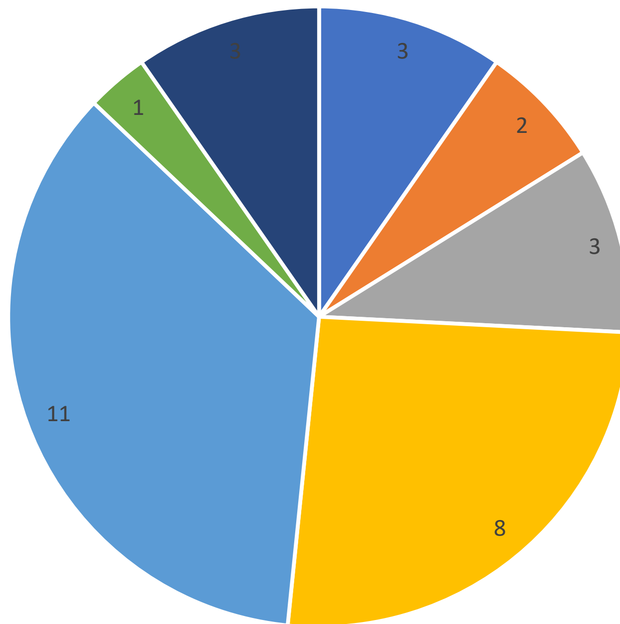
Andrea Beacham (Royal Devon University Healthcare Trust), Marie-Joelle West (Health Innovation South West) and Nic Ferreira (Health Innovation South West) were instrumental in designing the service evaluation, as well as contributing to service design. John Thornton (OneIlfracombe) and Dr Jennifer Rogerson (University of Plymouth) supported delivery of the qualitative evaluation.

Patient demographics

31 individuals have been seen over the course of the pilot to date (10 months). Most of those attending were middle-aged/older males. Approximately one quarter were classed as homeless, and another quarter live in Houses of Multiple Occupancy (HMOs). The remainder live, in the majority, in private rental accommodation. None of those seen lived in social rented accommodation.





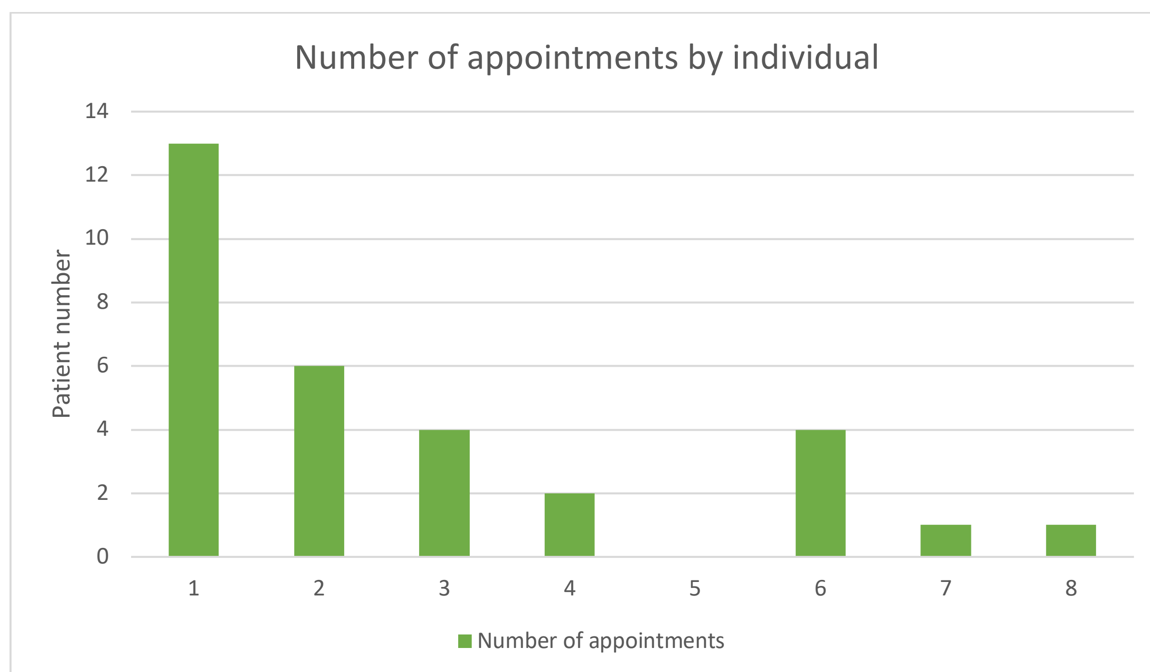

Housing status
3
2
3
8
11
1
3
Homeless (rough sleeping)
Homeless (sofa surfing)
Homeless (temporary accomodation)
HMO
Private rental
Residential care
Temporary resident/unkonwn

Appointments

84 appointments have been delivered over a total of 19 clinical sessions.

Appointments were offered on a first come first served basis, with no set appointment time. Appointment duration was not measured during the pilot, but generally first appointments took between 45-60 minutes, and follow up appointments between 10-25 minutes.

During their first appointment individuals were offered a comprehensive holistic review focussing on their identified health concerns, as well as a discussion around the social determinants impacting upon their health. Subsequent appointments were more targeted, focussing on individual health issues as well as preventative health, annual reviews etc.



The number of appointments required by an individual was variable. One third of patients attended for a single appointment only and a proportion attending for 6 or more appointments.

Reasons for attending a single appointment only included:

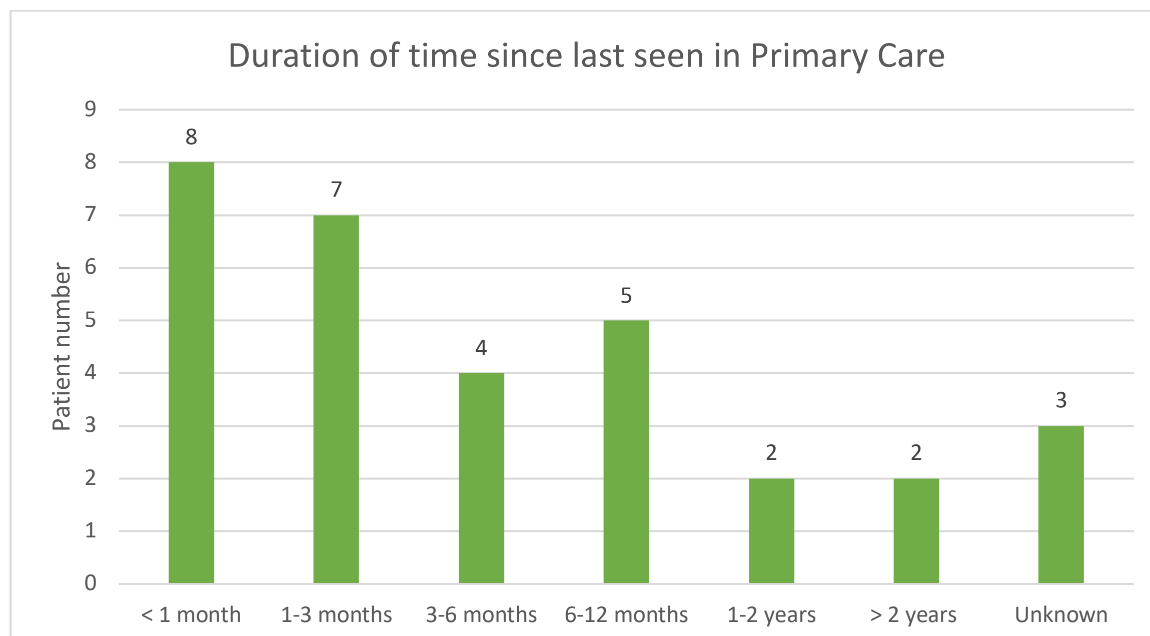
- Individuals seen for the initial comprehensive assessment in Belle's who were happy, and able, to continue their care at the surgery.
- Individuals who sought support while temporarily housed in Ilfracombe before being moved elsewhere for alternative accommodation.
- Individuals who chose not to continue to engage with the service.

- Individuals who attended Belle’s Place infrequently, so struggled with the drop-in nature of the clinic.
- 2 individuals seen for the first time on the final clinic included in the evaluation who have since had further input at Belle’s.

The service design, from the outset, was flexible. Pre-booked appointment slots were introduced at one stage to see if this helped facilitate access for individuals who attended Belle’s Place less frequently. These were under-utilised however, hence the service reverted to the original ‘first come first served’ drop-in service. Service users were generally respectful of each other and were happy to wait in turn for their appointments. This was made easier by the fact that the café was offering lunch at the time, hence service users would have a meal and a chat with other users before attending their appointment.

A small proportion of individuals attended 6 or more times. In several cases this was deemed clinically appropriate. However, a couple of individuals needed to be actively discouraged from attending the clinic ‘for a chat with the GP.’ Carol acted as a gatekeeper for appointments to ensure they were, as much as is feasible, clinically indicated.

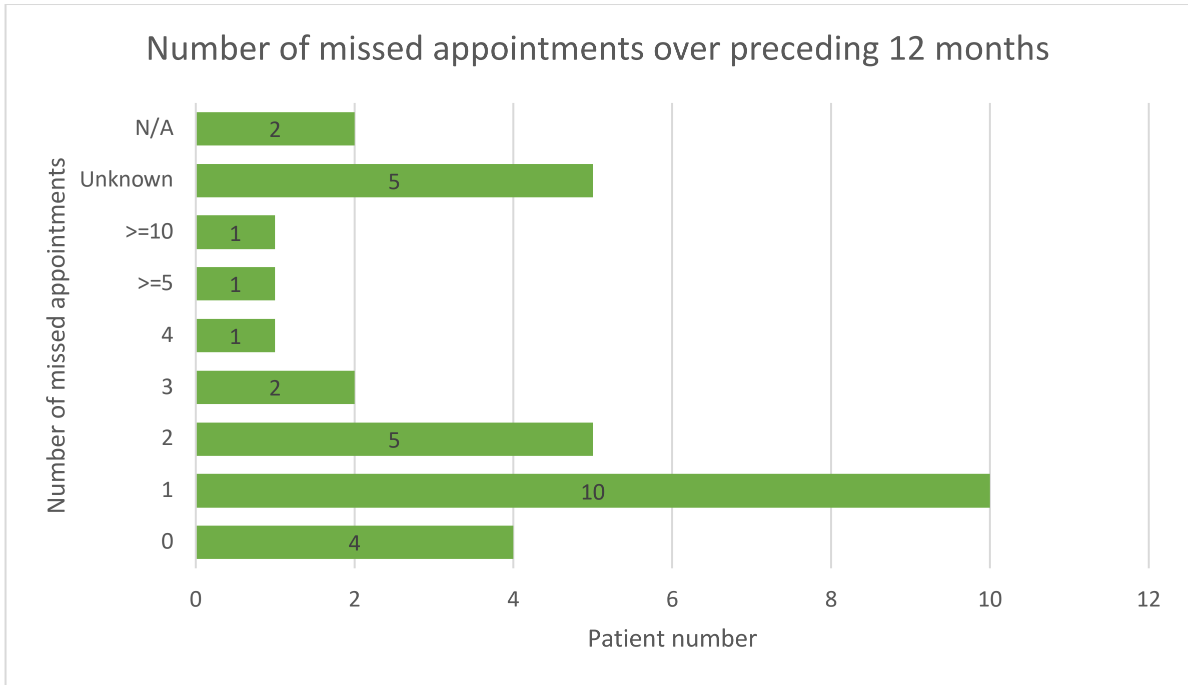
Previous engagement with Primary Care



Almost half of individuals seen in the clinic at BP had had contact with the surgery within the preceding 3 months, and almost all within the preceding year. It was notable, however, that a sizeable proportion of these consultations had been very transactional e.g. requests for additional medication, as opposed to focussing directly on health issues. Several individuals regularly accessed nursing services at the surgery e.g. wound dressings, but not attend to see their GP.

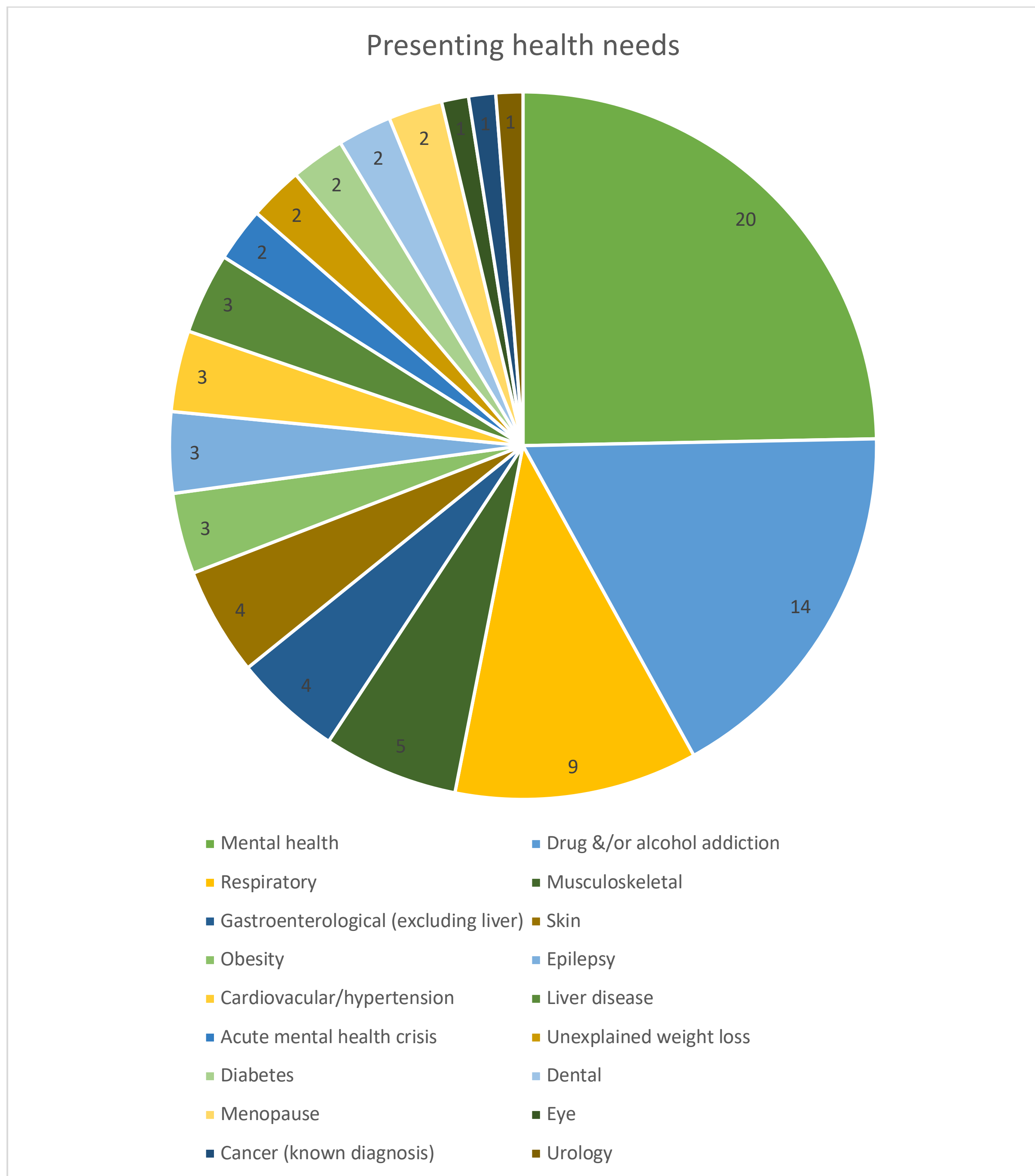
The qualitative analysis identifies the concept of being 'seen but not heard', reflecting the fact that although most individuals had been attending the surgery, they felt unable to address their health issues in that setting.

Almost all individuals had missed at least one appointment in primary care in the preceding 12 months, with a few individuals missing multiple booked appointments.


Number of missed appointments over preceding 12 months
Number of missed appointments
N/A
Unknown
>=10
>=5
4
3
2
1
0
2
5
1
1
1
2
5
10
4
0
2
4
6
8
10
12
Patient number

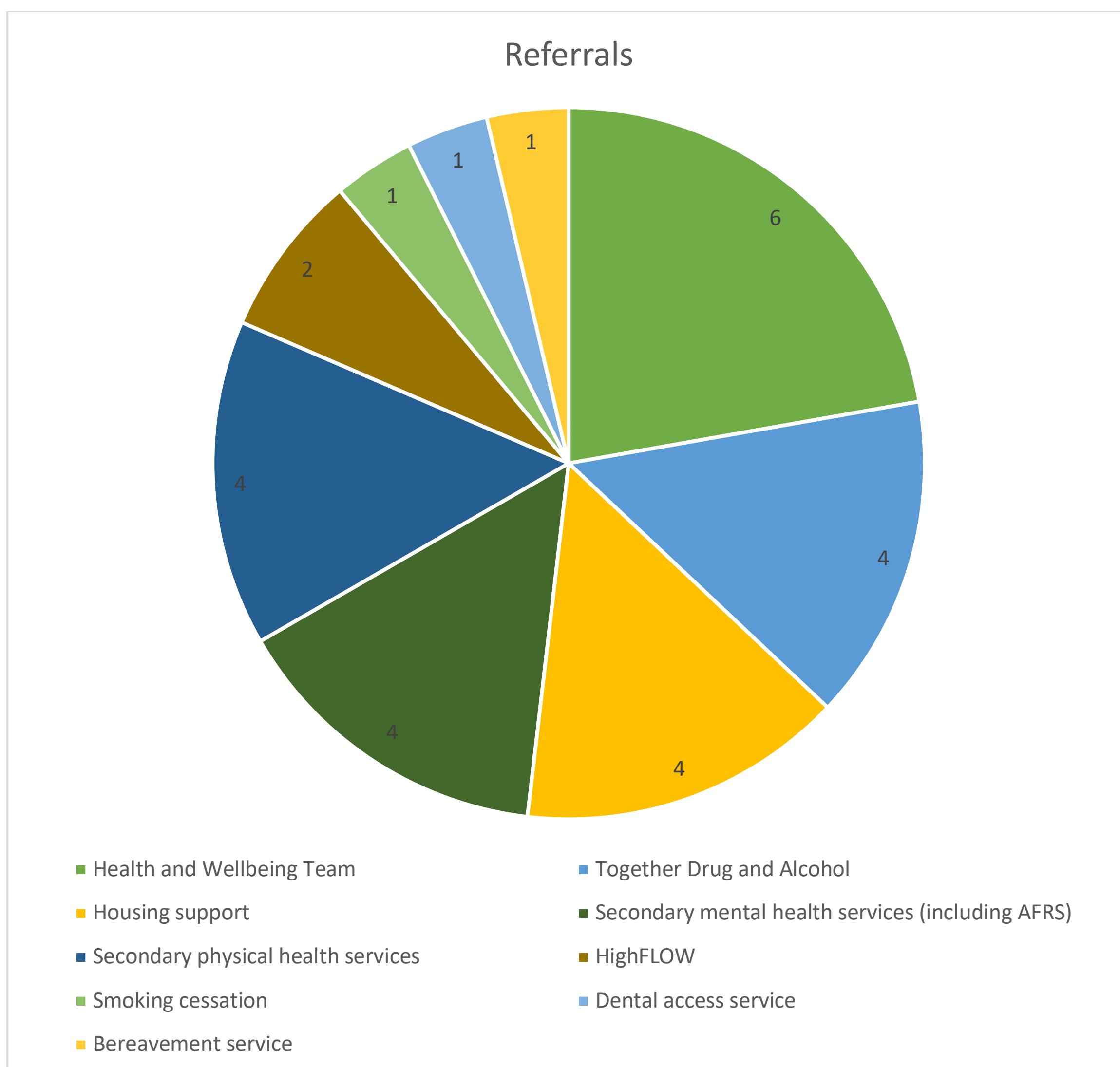
Health outcomes

The primary aim for Belle's Place pilot was to build trust between socially excluded individuals and primary care. We therefore did not try to focus too much on any specific agenda with regards to outcomes, instead choosing to focus on the identified health needs of the individual. These presenting health needs varied from chronic conditions to acute health issues. Many individuals identified multiple health needs.



We aimed to offer a 'one stop' service, undertaking any necessary tests e.g. blood tests, blood pressure checks etc. during the consultation. Home testing kits e.g. QFIT and urine test kits were provided directly to the person. We would only ask the individual to attend for further tests elsewhere if we were unable to offer the test at Belle's Place e.g. ECG, chest Xray.

A proportion of people seen required referral to additional services, both secondary healthcare services but also wellbeing support, health promotion and social support. Referrals to secondary care were regularly declined because of distance and cost to travel to attend appointments, along with anxiety attending the hospital. Where possible we tried to work with the individual to overcome these barriers (see Early Cancer Diagnosis – Case Study 3). The main barrier to accessing health promotion and wellbeing support was the individual's mental health. Despite these barriers, 27 onward referrals were made.



Working in Belle's Place gave the GPs the opportunity to connect directly with other services e.g., homelessness outreach services, who were often present in Belle's Place while clinics were running. Building these personal connections enabled the GPs to provide a more joined-up service for individuals seen at Belle's Place, but also develop professional relationships that can benefit the wider practice population.

An unexpected outcome

Having regular conversations with people at Belle's Place provided the opportunity to identify, and in some cases address, issues that impact upon their health for which they had previously lacked support.

MoMENtum – supporting male survivors of childhood sexual abuse

A number of individuals identified a history of sexual abuse in childhood as being a fundamental driver to their poor mental health +/- drug or alcohol dependency in adulthood. Some had struggled to disclose this previously, or had found support options limited if they had disclosed it to healthcare professionals. It became apparent that finding support for these men was key to enabling them to address their wider health needs.

Off the back of the outreach clinic, and the identified need, we contacted MoMENtum, a Devon-based community interest company, who offer one to one and peer support to male survivors of sexual abuse in childhood. They have been running groups in Exeter and Barnstaple for a number of years. Momentum were open to working in Ilfracombe, and in June 2024 they started an Ilfracombe group. This will provide valuable support, not just to those attending Belle's, but also others within the wider community who are survivors of sexual abuse in childhood.

Reducing Healthcare Inequalities

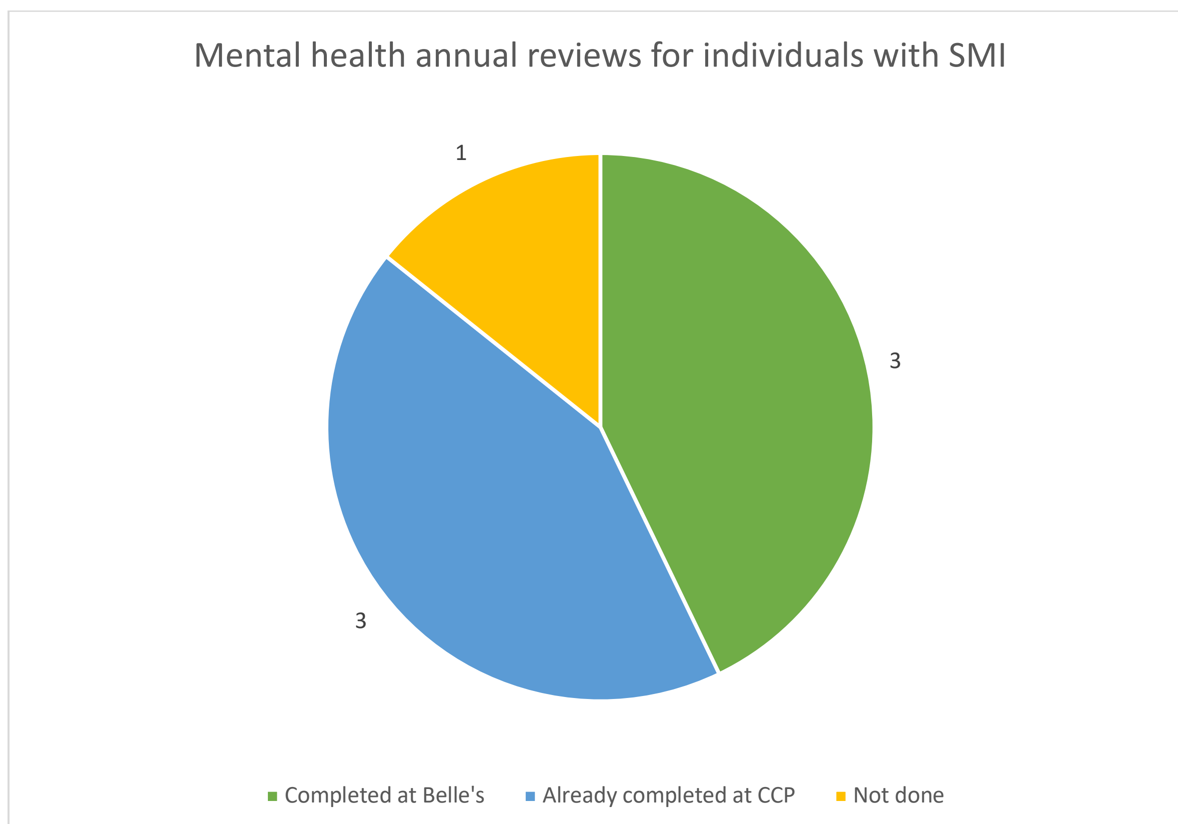
1) Severe mental illness (SMI)

People with severe mental illness die on average 15 to 20 years earlier that the general population and it is estimated that 2 in 3 deaths are from physical illnesses that can be prevented (National Mental Health Intelligence Network, 2018).

Core20PLUS5 target: Ensure annual physical health checks for individuals with SMI to at least nationally set targets.

The health check includes a discussion regarding physical symptoms, a discussion regarding lifestyle, and measurement of physical parameters – height, weight, blood pressure, and blood tests.

7 individuals were seen at BP who had diagnoses of severe mental illness i.e. bipolar affective disorder or schizophrenia/past psychosis.



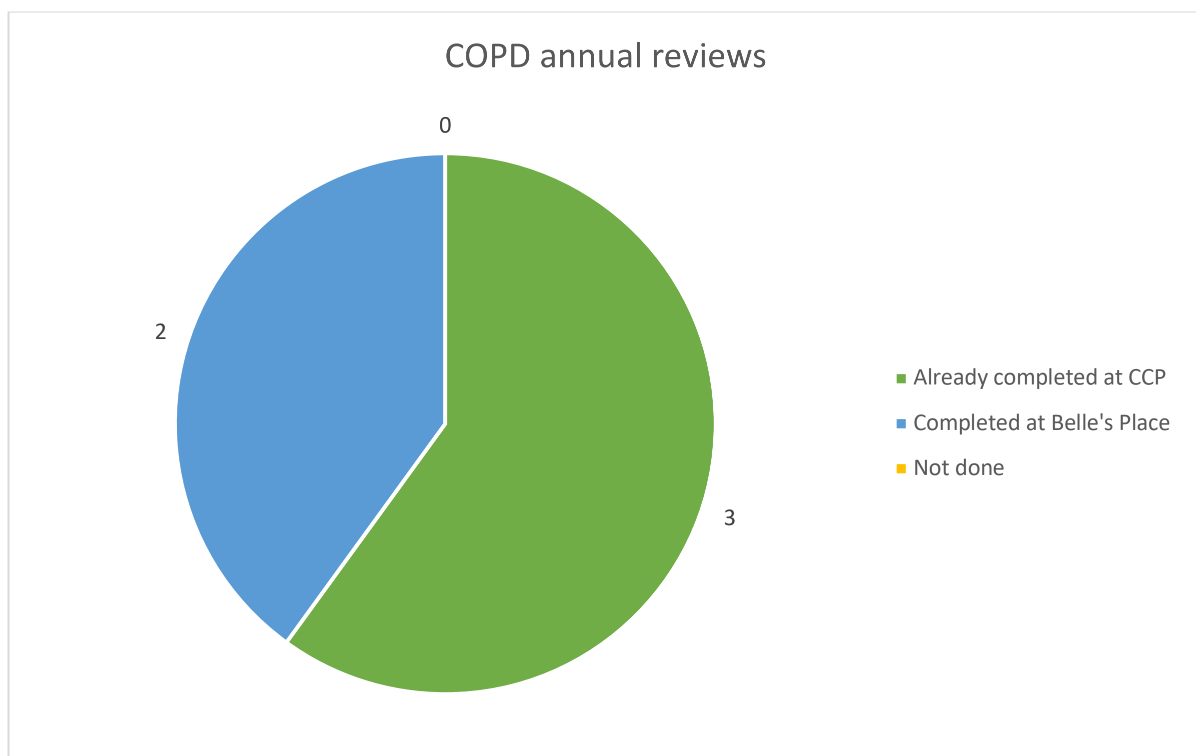
The individual who did not have an annual health check presented in mental health crisis having recently come out of prison. His care was transferred to the Freedom Centre in Barnstaple after an initial appointment at BP where the priority focus was on their his acute mental health needs and homelessness.

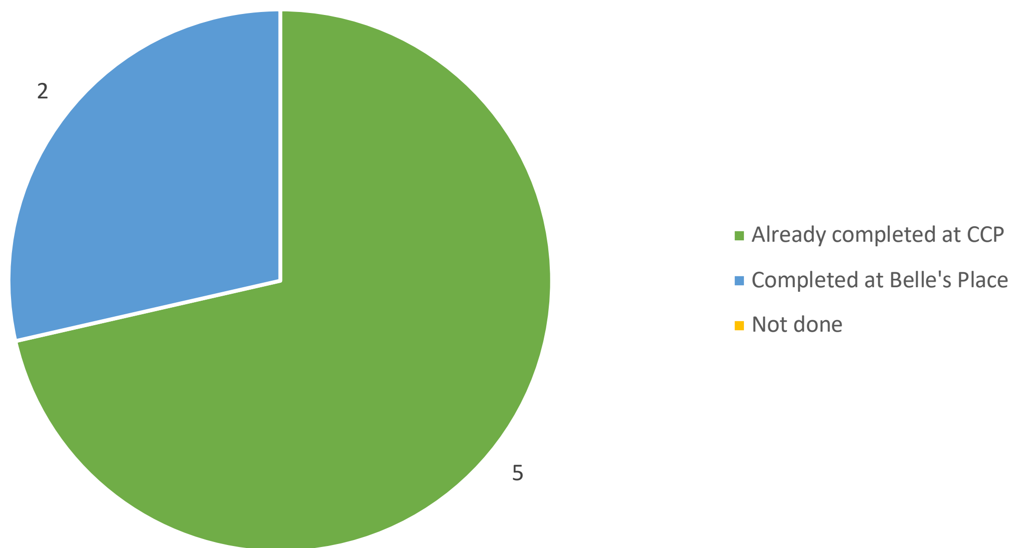
2) Chronic Respiratory Disease

68,000 people a year on average die from respiratory disease in England. Mortality considered preventable was 2.9 times higher in the most socioeconomically deprived areas compared to the least deprived. Specific groups are at significantly higher risk of respiratory illness, such as people with severe mental illness, people with learning disabilities, and the homeless. (www.gov.uk, 2022)

Core20PLUS5 target: A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

Public Health Devon are already working in partnership with Belle's Place on vaccine uptake, with high success rates. For the purposes of the pilot study the focus was therefore on optimising management of chronic respiratory disease, along with supporting individuals to address some of the causes of chronic respiratory disease.





Case study: Housing and respiratory health

James moved into private rental accommodation in central Ilfracombe in January 2023. He is a smoker. He has longstanding poor mental health.

James had a history of recurrent chest infections over recent years but no diagnosis of chronic respiratory disease. He saw a GP at Belle's Place in December 2023, reporting worsening breathing difficulties since moving into his flat, having presented to Combe Coastal Practice on a number of previous occasions regarding his breathing and mental health. He showed the doctor photos of his flat. The clinical notes state the property had 'extensive mould, including a massive fungus growing from one corner of the living room'.

He was diagnosed clinically with suspected COPD and started on treatment with good effect. Smoking cessation support was offered but declined. An urgent letter of support was written to the council to request consideration for priority social housing on health grounds.

3) Early cancer diagnosis

Core20PLUS5 target: 75% of cases diagnosed at Stage 1 or 2 by 2028

Physical examination and investigations were undertaken on all individuals with symptoms that could be the presenting symptoms of cancer - particularly unexplained weight loss and gastrointestinal symptoms. Tests included a comprehensive blood screen, chest X-ray, QFIT testing and urine dip. We aimed to offer blood tests, QFIT and urine testing at the time of contact. Chest X-rays were arranged at the Tyrell Community Hospital in Ilfracombe as individuals struggled to travel to Barnstaple to access services at North Devon District Hospital.

Bowel cancer screening

The bowel screening programme is currently being promoted at Belle's Place. The majority of those who are eligible for the scheme have previously been exempted from the programme having not responded to the screening invitation. Posters have been put up in Belle's and Carol is keeping a list of those who would like to participate in the scheme. The national screening programme have kindly agreed to supply the test kits directly once we know who would like to participate. We are hoping this targeted approach will support an increased uptake in the programme.

1

Case study: Supporting Hepatitis C treatment

Hepatitis C can lead to cirrhosis, which in turn can lead on to hepatocellular carcinoma.

Frank has been living with Hepatitis C for a number of years. He is alcohol dependent and struggles with his mental health. He lives in an HMO in Ilfracombe. Frank had previously been offered, and declined, Hepatitis C treatment.

Frank consented to referral to the Hepatitis C team following a consultation at Belle's Place. The Hepatitis C outreach team saw him at Belle's Place, undertook a Fibroscan, and started him on his 12-week course of treatment to eradicate the disease. Carol looked after his medication at Belle's Place, and supported him to take it on a daily basis when he attended for his meals. He successfully completed the full course of treatment and is now clear of Hepatitis C.

Frank unfortunately struggled with significant health anxiety relating to his Hepatitis C treatment. This led to a temporary increase in his alcohol consumption (now resolved). He has declined support from Together Drug and Alcohol Services at present. He has however continued to engage with the GP outreach service and his long-term goal is to stop drinking.

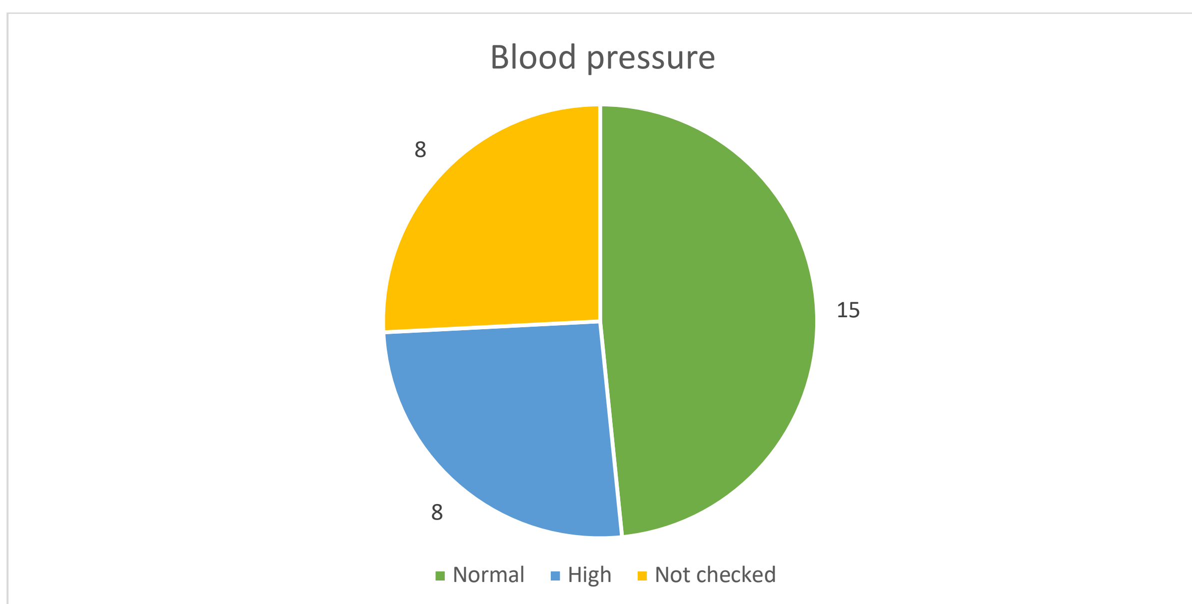
4) Hypertension Case Finding and Optimal Management and Lipid Optimal Management

High blood pressure is the largest single known risk factor for cardiovascular disease and related disability. People from the most deprived areas in England are 30% more likely than the least deprived to have high blood pressure. (Public Health England, 2017)

Core20PLUS5 target: To allow for interventions to optimise blood pressure and minimise the risk of heart disease and stroke

Diagnosis

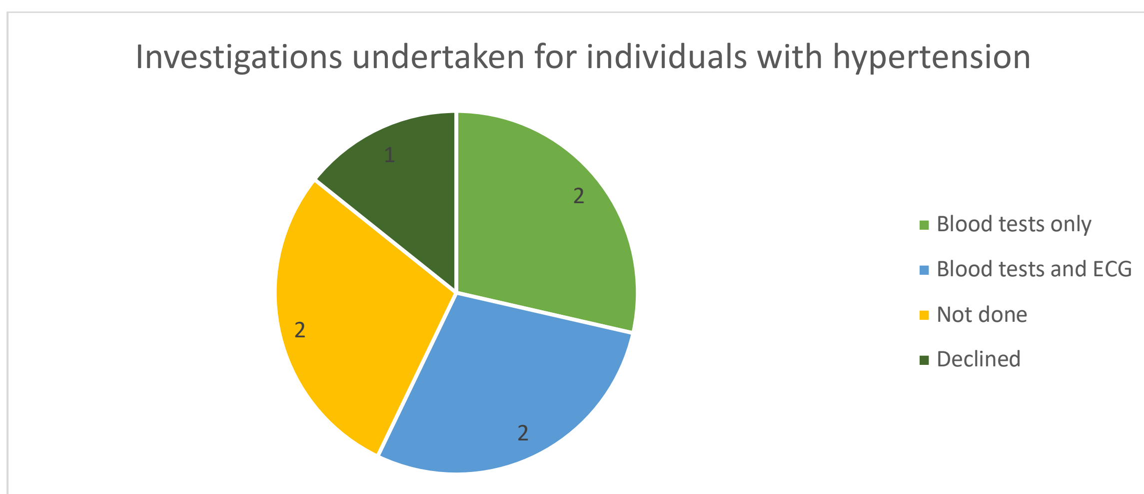
Blood pressure was checked during appointments when clinically indicated, or opportunistically. Additionally, a blood pressure machine was made available within the main café for individuals to check their own blood pressures. Any individual identified as having a single high blood pressure reading was supported to complete additional readings using the café blood pressure monitor to confirm the initial reading and guide ongoing investigation/management.



8 individuals were identified as having high blood pressure during the clinic. 3 were known to already have hypertension but were poorly controlled. 4 were given new diagnoses of hypertension. 1 individual had a one-off high reading but then moved area before repeat readings could be undertaken.

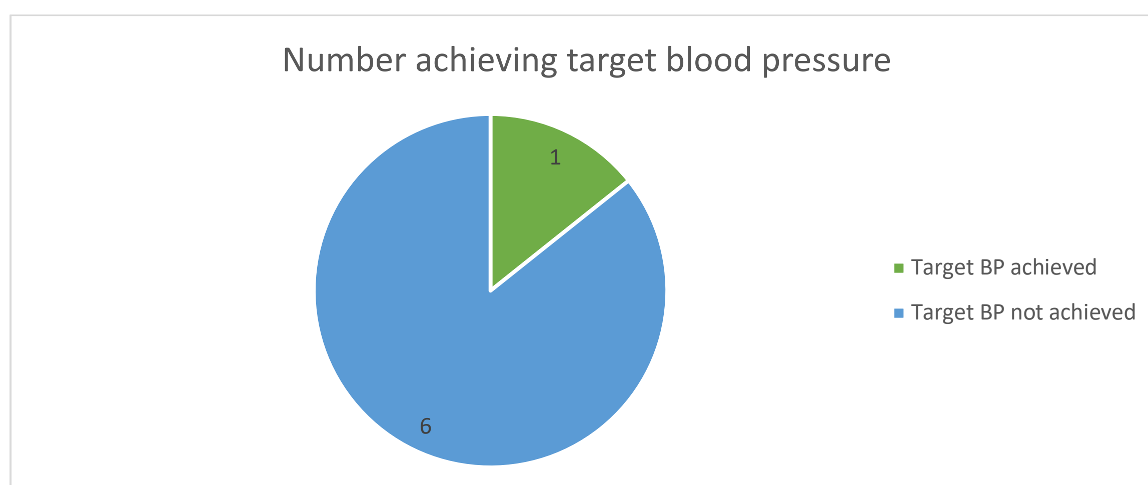
Investigation

All individuals identified as having high blood pressure (either new or previously known about) benefit from blood tests and an ECG to assess for additional risk factors and look for evidence of end organ damage. There was no facility for ECGs at Belle's Place therefore undertaking an ECG required attendance at the surgery. This unfortunately led to poor uptake of ECGs. Additionally, due to logistical challenges relating to the Friday clinic (blood tests could not be taken on this day due to the timing of the clinic) there was also a lower than optimal uptake of tests.



Management

Six individuals identified as having hypertension engaged in lifestyle discussions relating to blood pressure and cardiovascular risk. Five individuals were started on treatment, and one declined treatment. One individual was not started on treatment at the time of diagnosis and then did not attend for follow up. Unfortunately, only one individual has achieved target blood pressure to date.



Making inroads into hypertension management was unquestionably the most challenging element of the Core20Plus5 measures we sought to address. When life is precarious on a day to day basis, encouraging individuals to engage in measures to address a health issue that gave them no symptoms, but may cause a problem in the future, was a challenge. The two case studies below highlight both the successes and challenges of trying to support individuals to optimally manage their blood pressure and/or other cardiovascular risk factors.

Case study 1: Increased patient activation following BP health check

Terry attended the BP clinic to discuss his mental health. However, he also expressed concern regarding his physical health, and consented to a physical health assessment including blood tests and blood pressure check.

Terry had a normal blood pressure but he was identified as having a high cholesterol and QRISK. He consented to starting a statin, but was also very engaged in discussing the lifestyle measures he could instigate to reduce his QRISK. He has since made significant changes to his diet and lifestyle and, to date, has lost over 1 stone in weight. He danced round the clinic room when he realised how much weight he had lost!

Terry is keen to take control of his physical health as much as he can. He has re-engaged with national screening programmes and is now accessing all of his health care at Combe Coastal Practice.

Case study 2: Barriers to engagement

Matt was often in the café while the outreach clinic was taking place, however it took him a number of months before he felt comfortable to attend. He was struggling with severe anxiety due to the imminent prospect of becoming homeless. Additionally, he was very worried about his physical health, as this was something he had neglected for a long time.

Matt consented to having blood tests and his blood pressure checked during his first appointment. The tests revealed he was both hypertensive and a new Type 2 diabetic. He was also a smoker.

Matt did attend for a second appointment to discuss the results and the implications on his future health. He consented to starting on medication for both conditions, but felt unable to consider lifestyle change due to stress regarding his housing situation.

Unfortunately, Matt subsequently did become homeless. He has never collected further prescriptions for managing his blood pressure or diabetes. At present he is not attending Belle's Place. Were he to attend Belle's Place again in the future the hope would be that, at that stage, he would feel in a stable place to be supported to address his health needs.

The patient experience

A series of patient interviews were undertaken early on in the pilot to explore the experiences of people accessing healthcare through traditional channels, but also their experience of accessing healthcare at Belle's Place. A number of key themes came from the interviews (see Appendix 1 for full report)

A trusted space

' Society will always look down on people like me. This is a place I can come right, so you're not judged…. Going there (the surgery) is a concern, yeah, so here is safe, here is trusted.'

All participants spoke highly about Belle's Place, and both the level of support they received but also how it was viewed as a safe space. They also spoke about the high levels of trust in which they held Carol, the director. The fact that the primary care clinic was endorsed by Carol enabled a degree of trust to be established right from the outset and this gradually built over the course of the pilot.

Reduced Anxiety

' I find it (the surgery) very unnerving and anxiety provoking because I think it is too clinical right…. Whereas at Belle's Place I feel more relaxed….. Its not an intimidating environment… I feel more able to be open here and be me, not someone who I'm not.'

A number of individuals highlighted the same concern of experiencing high levels of anxiety both when attempting to book appointments, or speak to their GP, by telephone, but also in attending the surgery and other clinical settings. This often meant they were unable to cover the concerns they were hoping to discuss and may explain the fact that, although most of them had been seeing/speaking to their GP, many of their consultations were very transactional and the individual felt their health needs/concerns were not being addressed. Feeling less stressed in advance of their appointment enabled them to speak openly, building a good relationship with the GP and meaningfully address their health issues.

Time

'Everybody else won't be moaning if you need 5 minutes extra time because they might need extra time too.'

The drop in nature of the clinic seemed to really work well for Belle's Place service users. Removing the time pressure enabled open and honest conversations

between the individual and the GP, meaning that all issues could be, as much as practical, dealt with at the time, rather that having to be reliant on attending additional appointments. This model seemed to really work for a community of people whose lives were, at times, chaotic. As identified in the qualitative analysis ‘there seems to be a tacit understanding between Belle’s Place users that they all needed time to talk to GPs feeling unrushed. As such there was a shared unspoken agreement to let others take time, as they all needed to receive healthcare without pressure’.

Challenges of delivering the outreach clinic

Clinical space

Clinics have been undertaken in the meeting room at Belle's Place. This room has multiple other purposes, therefore is unable to become a dedicated clinical space. There is no examination couch, which means abdominal examinations are undertaken standing up, and all clinical records are accessed via laptop which can be temperamental. Intimate examinations such as digital rectal examinations or gynaecological examination/smear tests, are not possible to undertake at Belle's Place. Additionally, we lacked access to diagnostic test facilities that would be readily available at the surgery, most notably access to ECGs.

Whilst, in the most part, we can work around these challenges, we are unable to provide as comprehensive or efficient an assessment as we would like to offer due to the lack of a dedicated clinical area and lack of available equipment.

Clinic timing

Clinic days were determined by the times when Belle's Place is both open and has available space to host the service, and GP availability. The Friday afternoon clinic finishes after the last sample collection from the surgery, meaning no blood tests can be taking during the Friday session. This means the GP is less able to take opportunistic blood samples, having to rely instead on the individual either attending the subsequent Wednesday session, or agreeing to attend the surgery at a fixed appointment time. Several individuals have therefore not received as comprehensive an assessment as they might have done, having not attended subsequent appointments for blood tests etc.

Confidentiality

The clinic room is situated next to the Belle's Place kitchen, where individuals often congregate to make coffee/tea etc. Appointments, at times, will be interrupted by other service users trying to enter the clinic room. Several individuals have expressed concerns regarding the confidentiality of their discussions. It is unclear whether individuals withhold information due to this concern.

Follow up appointments

Follow up appointments were almost always beneficial, particularly to discuss any test results but also to follow up on the plan made during the initial assessment.

Follow up appointments were reliant on individuals being present in Belle's Place at the subsequent clinic session. For a few individuals health concerns may have been identified e.g. high blood pressure, high cholesterol, but without the follow up appointment there was no opportunity to address these issues. Attempts were made to contact individuals where feasible, however this was not always possible, particularly due to the barriers individuals faced with regards to mobile phone access.

Health anxiety

Individuals at Belle's have at times struggled with holding greater knowledge regarding their health. A number have declined any investigations, particularly with regards to preventative healthcare, taking a slightly fatalistic approach to their life trajectory. For those who have engaged more proactively, some have displayed worsening mental health or drug and/or alcohol use, due to anxiety regarding their health. Hence, although their health needs are better understood, and are being addressed, this is causing the individual greater concern than simply not having any understanding of these issues (see Early Cancer Diagnosis – Case Study 2).

Discussion

To reduce health inequalities, general practice needs to be informed by five key principles: involving coordinated services across the system (ie, connected), accounting for differences within patient groups (ie, intersectional), making allowances for different patient needs and preferences (ie, flexible), integrating patient worldviews and cultural references (ie, inclusive), and engaging communities with service design and delivery (ie, community-centred). (Gkiouleka, 2023)

The Belle's Place Outreach Project has provided the opportunity for Primary Care to work with a vulnerable group of people in a way that is impossible within the current design of general practice. This was a service informed by the community, and designed to be flexible and inclusive, to best meet the (at times varying) needs of Belle's Place service users. Having Carol, and leaders within the Belle's Place service user group, champion the service, led to its early acceptance, and supported its success. The drop-in and flexible appointment length was a critical factor in the person-centred approach – enabling trust-building, greater communication between patients and GPs, greater understanding of barriers and access needs, and more effective communication and linking to additional services. Strong partnership working, both with other services based in Belle's Place, but also across the system, ensured that the offer was holistic, and that barriers were overcome, as opposed to being put in place, for people to access healthcare.

Belle's Place outreach clinic has cost £3,420 over 10 months (to date) for GP time. Additionally, funding has been provided to Belle's Place for room hire. Whilst the numbers seen in each clinic were smaller than would have been seen in a standard primary care clinic, we would argue that the progress made with some individuals towards tangible health outcomes, and the reduction in wasted appointments, justified the cost of the pilot.

For a proportion of people attending the Belle's Place clinic, re-building trust with primary care has enabled them to start re-attending the surgery in a productive way. For others, however, the barriers remain. We believe that there is value in continuing the Belle's Place outreach clinic in the immediate term, both to continue the focus on preventative healthcare, but also for earlier identification of new illness which may not present to primary care otherwise.

Recommendations:

Combe Coastal Practice

To consider what measures can be taken within the surgery to address the identified barriers to improve access for vulnerable individuals.

To Commissioners of Primary Care

To continue to fund the outreach clinic model at Belle's Place at a cost of £4000/annum for clinician time.

To recognise the value of Belle's Place in supporting the health and wellbeing of vulnerable individuals in our community through providing statutory support to Belle's Place.

Dr Sarah Williams
GP at Combe Coastal Practice
Devon Health Inequalities Fellow

Andrea Beacham
Senior Programme Manager for Health Inequalities, Royal Devon University Healthcare Trust
One Northern Devon Programme Manager

ALL NAMES AND IDENTIFYING DETAILS OF INDIVIDUALS USED IN CASE STUDIES WITHIN THIS REPORT HAVE BEEN CHANGED TO PROTECT THE CONFIDENTIALITY OF SERVICE USERS.

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Dr Marie Joelle West, Nic Ferreira and Richard Blackwell – Health Innovations South West

Dr Jennifer Rogerson – Postdoctoral Research Associate, Cardiff University; Associate lecturer, University of Plymouth

Dr Nigel Moody and Louise Scantlebury – Freedom Centre, Barnstaple.

John Thornton – Public Health Outreach Team

Nadine Robertson – Combe Coastal Practice

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