NHS South West London

Health in your hands

Health inequalities report
April 2024


ruils
independent living
Supporting local disabled people to live independent lives
Getting the Right Start
Living Independently
Connect to Community
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1) Introduction

‘Health in your Hands’ is a health inequalities project, reaching and supporting people at risk of long-term health conditions (LTCs), who are experiencing social deprivation. It reaches and supports people to draw on primary health services, addresses the factors underlying poor health such as housing, poverty, diet and disconnection and helps people to be a stronger position to take a more active role in looking after their own health.

It is focused on reaching people earlier with a view to avoiding clinical intervention down the line and on tackling health inequalities. It does so through community outreach and the adoption of a highly personalised and holistic view of the drivers of and solutions to people’s health and wellbeing, including through social prescribing.

This paper, written by the charity In Control and based on a range qualitative and quantitative information and data, describes the features of the project, outlines the approach and work carried out to date and draws learning about its impact from stories of some of the people supported.

2) About the project

2.1 Background and aim of the project

The Health in Your Hands project emerged from a group partnership in South West London Integrated Care System. The project originated from the Integrated Care Board's Long-Term Conditions (LTCs) programme and aligns with Richmond's Core20 work, the national NHS initiative designed to prioritise support in the most disadvantaged communities and work to alleviate health inequalities. The approach to the project follows NHS England's Comprehensive Model of Personalisation, focusing on 'what matters' to people and their individual strengths and needs. Through doing so, the project has looked beyond the health system to understand and respond to the factors shaping the health and wellbeing of those from the most disadvantaged communities, such as in relation to income and housing.

The project is delivered by the Independent Living charity Ruils, working closely with Richmond Primary Care Networks, supporting them to outreach into their most disadvantaged populations. As such, the team leading the project is embedded in and working with the wider social prescribing team.

Health in your Hands aims to identify and to reach local people at risk of LTCs including diabetes, cancer, asthma, depression and high blood pressure, as well as those impacted by the cost-of-living crisis and/or who are experiencing isolation or loneliness. It supports increased diagnosis and treatment for those who have not had contact with their local health services in the past, identifies and strives to resolve non-health factors underlying their health conditions, and works with people to adopt healthier behaviours.

2.2 How does Health in Your Hands work?

Health in Your Hands is focused on reaching, engaging and supporting people who are otherwise being missed by primary health to improve their health and wellbeing. It also works with patients living with multiple LTCs registered with local GP practices, giving them targeted 1:1 support. It does so by:

Identifying those most at risk: Ruils identified three Core20PLUS localities in the Borough of Richmond Upon Thames where health inequality was most pronounced

- **Reaching people and building relationships and trust:** Health in your Hands has involved bringing primary health services to people where they live (in the identified areas), creating touchpoints through themed health 'events' in different local communities as well as offering home visits. As well as delivering Ruils organised events, Ruils' connectors establish a presence at other relevant events, with resident organisations and 'on the ground' connectors to broaden our understanding of the challenges faced by residents. Key to success is building trust through return visits to the areas.

- **Exploring people's health and wellbeing:** Health in Your Hands has offered basic health checks and has conducted surveys with residents to better understand how they view their health, their ease of engagement with primary care, how the cost-of-living crisis is impacting their health and wellbeing and their levels of regular physical and nutritional intake.

- **Referrals and diagnosis:** where necessary and appropriate Health in Your Hands has referred people to GPs and other primary care for consultation, assessment and treatment.

- **Personalised, holistic support to address the underlying causes of ill health:** Through its engagement and conversations, Health in Your Hands has identified factors underlying risk of serious ill health, such as in relation to illiteracy, income, energy costs, access to food, housing and disconnection and has worked with people and other agencies to address them.

- **Social prescribing and self-management:** Where appropriate, Ruils has offered services such as our Health in Your Hands, befriending and community activities to help support residents to live as independent and enriched lives as possible. Ruils has used technology developed by Signal to deliver this support: https://clearsignal.org/news/social-prescribing-gets-personal-with-signal/

2.3 Reach and impact in numbers

During the period April 2023-February 2024:

Reaching people

- 60 GP registered patients were contacted from 1:1 list and offered support from the Health in Your Hands project
- The team attended 37 community events and proactively organised 8 community events

Advice and health checks

- 248 people received health promotion advice at outreach events
- 310 people had mini-health checks

Detection and referral

- 108 have had further investigations for blood pressure
- 78 have had further investigation for diabetes
- 6 have had further investigation for Atrial Fibrillation
- 223 people have been referred to specialist advice from voluntary and communication organisations concerning mental health support, blood pressure, diabetes, weight management and hypertension
- 63 have been referred for an NHS Health Check
- 110 have been referred to their GP for further investigation concerning blood pressure, diabetes or Atrial Fibrillation

Social prescribing and personalised support

- 17 people have been referred to local community-based activities (social prescribing) following a health check

3) Stories of impact

Below are a number of extracts from case notes, providing a flavour of the different ways Health In Your Hands has reached and supported people.

3.1 Reaching people at serious risk of escalating ill health

- ‘A gentleman attended our Great Mental Health Day event in Whitton and received a health check. His BP was elevated to 177/94 mmHg. This gentleman said that he is hypertensive, but hasn’t been to the GP for a review of this in nearly 2 years. I advised him to visit his GP urgently for a check-up and for his BP medication to be reviewed. As we repeated his BP reading after a 30 min interval, he used this time to take part in a mindfulness session. He also won a health-fitness watch in our raffle, which he was entered into as a result of receiving a health check. When I saw this gentleman a few weeks later at the Community Centre, he informed me that he’d booked an appointment with his GP.’

- ‘A lady received a health check, and her BP reading, according to protocol set by GPs, indicated severe hypertension and immediate action needed to be taken. I contacted the on-call GP at Crane Park to seek medical advice. The GP booked her in for a same-day emergency appointment. One of the leading GPs on this project reported that this intervention could potentially save this lady from having a stroke or heart attack in the future, and could have potentially saved her life.’



3.2 Identifying and addressing the underlying causes of poor health

‘A new client, who was contacted via the GP patient list, was encouraged to attend the Hampton Community Health Fair (HCHF) event to access support and be signposted to services. She was referred into 2 organisations that will be supporting with her energy bills and accessing benefits/financial support she didn’t know she was entitled to. She then also received a health check, which indicated that her BP was elevated. This has been passed onto her GP and she has been advised to keep a 7 day diary to measure her BP. She will now be referred into additional support from HIYH and will be linked in with social support, such as befriending.’

- ‘Contacted this client via the GP patient list and currently supporting with managing her diabetes, hypertension, COPD and mental health. When having 1:1 meetings, this client opened up about past trauma and disclosed that she cannot read or write, both of which she has never told anyone before. She also expressed that she doesn’t like to book in with the GP, due to her literacy challenges and not wanting to ‘bother’ GPs. With consent, I spoke with Dr Koka about this and booked her in for an appointment. She has now been referred into IAPT, received a medication review and will complete a BP diary. I will provide support around requesting medication and writing a letter for daughter to advocate. I will also be coaching this client on diabetes management by providing video/audio resources and diagrams for what a healthy, balanced diet is.’

- ‘Another client contacted via the GP patient list also expressed that he cannot read or write. He is struggling to manage his diabetes and mental health, disclosing that he feels lonely and isolated due to poor mobility, obesity and not often leaving the house. I have referred him for a telephone befriender, with the goal to progress to meeting in a café/park to encourage this client to leave the house. Also coaching on diabetes management with video/audio resources and diagrams for what a healthy, balanced diet is. Client requested cooking tutorials on YouTube, which I am currently gathering.’

- ‘Contacted a married couple via the GP patient list who both need support around managing their diabetes and hypertension. The husband has poor mobility, so requested a home visit. Both had expressed they were struggling with their mental health due to their 13 year old son, with a diagnosis of ASD, having challenging behaviour that they cannot manage. Upon visiting their home, I discovered that they like in a 1 bed flat where they all sleep in the same room, and the same bed. The husband receives dialysis treatment in hospital 3 times a week, and has a dialysis line fitted in his chest. Their son can often pull on this line during the night. Their home also has chronic mould and damp, which their housing association is yet to act upon. I have supported by making referrals into Children and Adult Social Care to try gain more support for the family and the husband’s medical needs. I have signposted to activities for their son to give the parents respite, and referred the wife to a low-cost Pilates class to support with weight management’

3.3 Encouragement and support to adopt healthier behaviours

- ‘A lady received a health check at the HCHF event, and her BMI indicated obesity. She consented for a follow-up from HIYH. From this follow up, the lady explained she knows her weight is negatively impacting her heart condition. She asked for information about a healthy diet and to be referred into some low-impact exercise classes, and will receive ongoing support to help maintain this.’

3.4 Social prescribing

- ‘This client has been engaged with support from HIYH for her mental health for 3 months. She has been referred to RB Mind for mental health support, and referred to other activities such as Art Therapy and Wellbeing Walks. When attending the HCHF event for a health check, it was flagged her BP was slightly elevated. It was advised that she gets this checked out by the GP, which she has already put into action by raising this with her GP in her latest medication review.’

4) Feedback and testimonials

Katie, supported by Health in Your Hands

“Health in Your hands started for me when I was feeling really depressed, unheard and low. Jenny got. my name from the GP. Everything changed from there, it’s been amazing for me. I am now a regular in 2 groups, the CBT long term and another the diabetes group. I would never have just found and gone to these on my own. I also do cooking every Tuesday I just feel much more part of the community now.

As a diabetic I struggle with foodbanks as they tend to provide sugary cereals etc so I now get a food voucher to get more suitable food.

It’s just been really really positive, I go to health checks and meet other people. I have help with energy at home, I have foil put at the back of my radiators and long life light bulbs (that are good and bright). The difference it has made has been absolutely huge. I have still got ill, but the difference this time is I didn’t end up admitted into hospital. I used to give up and just go through A&E.

I think the biggest difference is that Jenny was easy to talk to and is a nice genuine person, she’s been a miracle to me. It’s only been a few months but I have much wider connections to groups and people. Idid find it a bit scary at first, but I embraced it and I am definitely living more of a life and a healthier life now”

Deborah, Practice manager medical centre

“Hampton North Project outreach went into a deprived area where the people weren’t engaging. The community centre had a roadshow to help people think about looking after themselves their own health. The team are great you can always get hold of them and they are able to link people to what is needed for them such as signposting to housing issues which may be the root cause of the health issue. I believe this work will really reduce dependency on health services down the line. People call it a soft approach but its real prevention. The work is impressive and makes a huge difference in people’s lives and wellbeing.”

Dr Adhikari, GP

“The Health in Your Hands project allows people who do not make contact with primary care to access healthcare advice close to their home, which is much needed. The most recent event had arrangements for checking blood pressure and weight to help identify people who may be at risk of heart attacks and strokes at an early stage. The Ruils team was also on hand to signpost people to services that could help improve the visitor’s health and wellbeing.”

Dr Babeeta Stapes, Hampton Hill Medical Centre

“Just to thank you to the Health in your Hands project in helping managing LTC as well as social and psychological support. Through them one patient and his family have been referred for support for housing and mental health needs. Only due a home visit by them was it noted that husband, wife and 13 year old son were all having to sleep in one bed, mould in the property (affecting MH needs) and no mental health support for their 13 year old son who has autism. This patient is well known to the practice but we were not able to pick up on the struggles they are facing at home. Another elderly lady has been loosing weight and confined to bed as a result of limited electricity due to rats having chewed the cables! It was brought to the attention of Health in your hands, as a result she has finally allowed us to visit us, refer to safe guarding as well as start a physical work up. A lot gets missed in the community and we unfortunately as GPs don’t have the time for detailed home visits especially when those with inequalities don’t feel able to access the services or know what services are available. This project is helping to reach out to that cohort and be able to provide a holistic approach into physical, mental and social needs.”

5) Conclusions

Based on available evidence, Health in Your Hands has demonstrated clear preventive impact, reaching and supporting people experiencing deprivation and at risk of serious health complications to improve their health and wellbeing through combining:

- Community outreach and relationship building
- Basic health-checks and referrals
- Exploration of underlying causes which may otherwise be missed by the NHS, including money and debt, lack of appropriate food, poor housing, disconnection
- Supporting people to adopt healthier lifestyles
- Social prescribing, including to help people find connection and purpose


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