DEPRIVED AREAS AND LONG TERM CONDITIONS IN RICHMOND

REDUCING HEALTH INEQUALITIES CASE STUDY

AT A GLANCE

The service

Hampton Primary Care Network (PCN). Specialist Social Prescriber working with patients with long term conditions in deprived pockets of the PCN.

Target population

Top 20% deprived population at risk or living with a long term condition.

The intervention

Social prescribing support, onwards referral, community outreach and engagement.

Key drivers of sucess

Engaging community partners and residents to work together to find solutions that improve health and wellbeing.

Ensuring GPs involved in the decision making process and agree the target cohort.

Find out more about the Complete Care Communities Programme and the NHSEI Health Inequalities (HI) strategy

RESOURCES

Blog: Practical steps for PCNs to tackle health inequaltities by CCCP

How to influence GPs of the value of the personalised care roles and population health video

Complete care in the communities summit recordings

Key contacts: Liz Ayres, Transformation Project Manager, NHS South West London

THE CHALLENGE

- Identify pockets of health inequality in the borough on Richmond.
- Statistics at PCN level mask pockets of deprivation.
- Engage Partners and residents to agree a common vision on the proposed plan.

THE ACTION PLAN

- Engaged in national Complete Care Community programme, after CCG recognised need to look at HI.
- Used local population health management data tool - HealthInsights, to identify pockets of top 20% deprived.
- Deployed outcomes tools to ensure continuous. assessment of improvement was undertaken.
- Agreed focus on long term conditions with GPs, clinical directors and social prescribing to support social determinants of health.
- Recruited Social Prescribing Wellbeing Co-ordinator, focused on this population group, with dedicated time for community outreach work.

BARRIERS & TOP TIPS

Bringing GPs on board

- Include them from the beginning, so priority areas are shaped jointly.
- Identify clinical leads and GPs who already understand the vision who can bring others on board.
- Utilise existing programmes e.g. the CORE20PLUS5, to access funding and support.
- Link it to existing targets or GP burden e.g., GPs dealing with a lot of mental health patients, Impact and Investment Fund targets, Network Contract Directed Enhanced Service.

Capacity of Social Prescribing services to work with specific groups

- Start with mature systems who may already have links into the community, some ground work is done.
- See if the borough, ICS or region can offer transformation project management support.
- Specialise personalised care roles to work with specific cohorts, hire new roles through health inequality funded pots or staff underspends.