HEALTH INEQUALITY STRATEGY DEVELOPMENT IN SUTTON

REDUCING HEALTH INEQUALITIES CASE STUDY

THE REDUCING HEALTH INEQUALITIES INTERVENTION

The service

The four Primary Care Networks in Sutton, South West London (SWL).
A Sutton-wide approach to personalised care to help reduce the impact of health inequalities.
Delivery ongoing.

Target population

Locally identified groups who are most affected by health inequalities.

The intervention

Setting up local outreach teams of health coaches and social prescribers led by the health inequalities lead in each PCN.

Key drivers of success

Bringing all health and community stakeholders together to buy into the concept.
Stop doing what is not adding value to general practice to free up resource to learn about proactive care.

[5 minute video on the Sutton Population Health Summit event]

RESOURCES

An informal guide to building a PHM community of practice

King's fund guide: Understanding integration: how to listen to and learn from people and communities

The health creation alliance

Key contacts: Laura Rodrigues-Benito, Sutton Clinical Lead for Population Health Management; Nadine Wyatt, NHS engagement lead

THE CHALLENGE

- How best to utilise the personalised care roles to reduce health inequalities, having a flexible but structured approach across the four Sutton PCNs.
- Capatalising and sustaining the relationships built during the COVID-19 pandemic and vaccine drive.

THE ACTION PLAN

- Held Population health summit for local stakeholders
- Population health agreed a priority for Integrated Care Board (ICB).
- Population health board set up with the Sutton public health team - a subcommittee of the Integrated Care Place (ICP).
- Important links made e.g. NHS South West London Clinical Commissioning Group, Sutton Senior Engagement Manager in SWL CCG.
- Local outreach team formed in each PCN, to draft a year-long community care plan, focused on health inequality and population need. Starting with one specific topic in each PCN (e.g. isolation and frailty).

BARRIERS AND TOP TIPS

Partnership working in the community

- Build relationships by allocating a weekly community development day for the personalised care roles.
- Acknowledge it takes more resource and time than business as usual - engage fellowship GPs to dedicate leadership/resource to it.
- Use existing relationships (e.g. community engagement leads, health champions, volunteers during the COVID-19 pandemic).

Population health strategy being understood across primary care

- Invest in training to develop PCN leads for Health Inequalities, learn from more developed areas.
- Use what you have (e.g. manually link datasets, use community intelligence).
- Bring in strategic partners e.g. colleagues from Integrated Care Systems (ICS), public health and community engagement.
- Learn from the voluntary sector who work close to communities.