HEALTH INCLUSION AND HOMELESSNESS IN LEWISHAM

REDUCING HEALTH INEQUALITIES CASE STUDY

AT A GLANCE

The service

North Lewisham Primary Care Network (PCN).
Inclusion health Care Coordinator (CC) model, supporting health inequalities.

Target population

Health inclusion groups, specifically people experiencing or at risk of homelessness and vulnerable individuals

The intervention

Groundswell, homelessness charity, supported Inclusion health CC with lived experience of exclusion to support individual patients and link with the other personalised care roles, including other types of CCs e.g. digital exclusion.

Key drivers of sucess

Co-designing with ARRS roles, patients and community orgs from the beginning.

Housing all CCs in one center with a senior CC leading on the work.

Find out more about the work Groundswell does across London and how you can refer individuals to services here.

RESOURCES

Referral pathways diagram

Inclusion health Care Coordinator referral diagram

Care Coordinator practice leaflet

Free courses of health inequality for general practice

Key contacts: Aaminah Verity, PCN Lead for Health Inequalities

THE CHALLENGE

- Three GP practices are located at the Waldron Health Centre.
- Vulnerable people, who are often unregistered with GPs, arrive seeking help.
- Those experiencing homelessness and exclusion have poor health outcomes and GP practices may not have the resources to engage and support these patients.
- Connecting these individuals with the right services.

THE ACTION PLAN

- Trained health center receptionist in digital exclusion and care navigation, referrals to CC team, so they can support vulnerable patients who drop in.
- Central CC team acted as the link to social prescribers, community organisations, GPs and specific health inclusion. Care Coordinators, supporting health care navigation.
- Homeless health inclusion CC specifically for people who are homeless or at risk of homelessness, part of Groundswell Homeless health peer advocacy programme.

BARRIERS & TOP TIPS

Shifting focus from targets to inequality

- Fellow and Health Inequalities (HI) lead having dedicated time to engage community organisations and map HI pathways and have conversations with GPs on this.
- Recognise that to prioritise inequalities, other targets may be more difficult to reach, account for this in plans. Agree on common shared goals around reducing inequality and where it fits with incentives.
- Take staff into the community e.g. having a stand about services at local events, creating outreach opportunities.

Care Coordinators as advocates and leaders

- Recruit people from the community, who understand local populations, speak different languages and can build a diverse team.
- Reflect leadership responsibility and specialism in pay, access CCG pots of money to uplift salaries to buy in charity expertise to support specific programmes.
- Provide personalised care and leadership training so CCs can confidently support patients, tap into training hub funding streams and existing programmes e.g. Fair Health programme training on inequality.