



RICHMOND HEALTH IN YOUR HANDS SERVICE

Ruils Independent Living

6 Month Report: April - September 2025

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Introduction

“The Wellbeing Coordinator helped me understand more about my mental health and wellbeing. I am now prescribed medication for high blood sugar levels and diabetes, and taking part in a sleep trial. Although these are ‘tiny’ steps they are important in helping me move forwards.”

Bradley – Hampton Medical Centre

Although Richmond is a relatively affluent borough, there are still significant areas of deprivation where people’s socioeconomic circumstances impact on both their life expectancy.

Health in Your Hands emerged from a partnership with South West London Integrated Care System in 2022. The programme aligns with the national initiative to prioritise support in the most disadvantaged communities and works to alleviate health inequalities. This approach follows the model of personalisation and focusing on individuals’ strengths and needs.



The service has been embedded within Social Prescribing in Richmond. It focuses on prevention, early identification and self-management of long term health conditions for residents facing health inequalities. It offers outreach to existing community groups, providing community health checks and health promotion advice.

The service has been delivered with 2 FTE Social Prescribing Wellbeing Coordinators. This report provides an update on the service delivery from 1st April to 30th September 2025.

Population health data has been central to the programme as it has continued to develop. It has been used to identify the geographical locations for outreach. Often these focus on food banks, surplus food provision, parent and toddler groups, church coffee mornings. Wellbeing Coordinators have been invited to support larger events within Richmond, such as for carers, and Public Health Bus outreach.

Through participating in the CLEAR Programme and close collaboration with Eley Squire, Clinical Director for Sheen & Barnes PCN, Health in Your Hands has had the opportunity to review and refine its approach to service delivery. This has included adapting processes to align more closely with primary care protocols. This has particularly focused on ensuring that patients identified through community health checks engage with their GP. These developments have led to improvements in our documentation processes and information sharing.

In previous years, client data and outcomes were recorded using spreadsheets. However, from 1st April 2025, the service transitioned to using the Joy case management system to log client outcomes. This platform enabled streamline communication with GP surgeries and allowed outcome data to be shared directly into clinical records.

However, as of this reporting period, three of the five Primary Care Networks (PCNs) have ended their subscription to the Joy system. This has meant that Wellbeing Coordinators no longer have access to a centralised digital platform for case management.

To address this, from 29th July 2025, community health checks have been recorded using Microsoft Forms. This alternative method has enabled continued data collection and, in some cases, allowed for the capture of additional health and risk indicators that were not previously recorded.

Community Health Checks

Social Prescribing Wellbeing Coordinators have provided 215 community health checks within the community. They have received additional training and follow clinical guidance, provided by GPs. Wellbeing Coordinators offer ongoing one-to-one support for clients on social factors that improve health and wellbeing.

Previously, Health in Your Hands has offered in reach through GP surgeries to those living in identified areas of deprivation with comorbidities of depression and hypertension, diabetes, asthma or COPD. Primary Care Networks have focused on their patients who have uncontrolled diabetes and are not engaging with primary care.

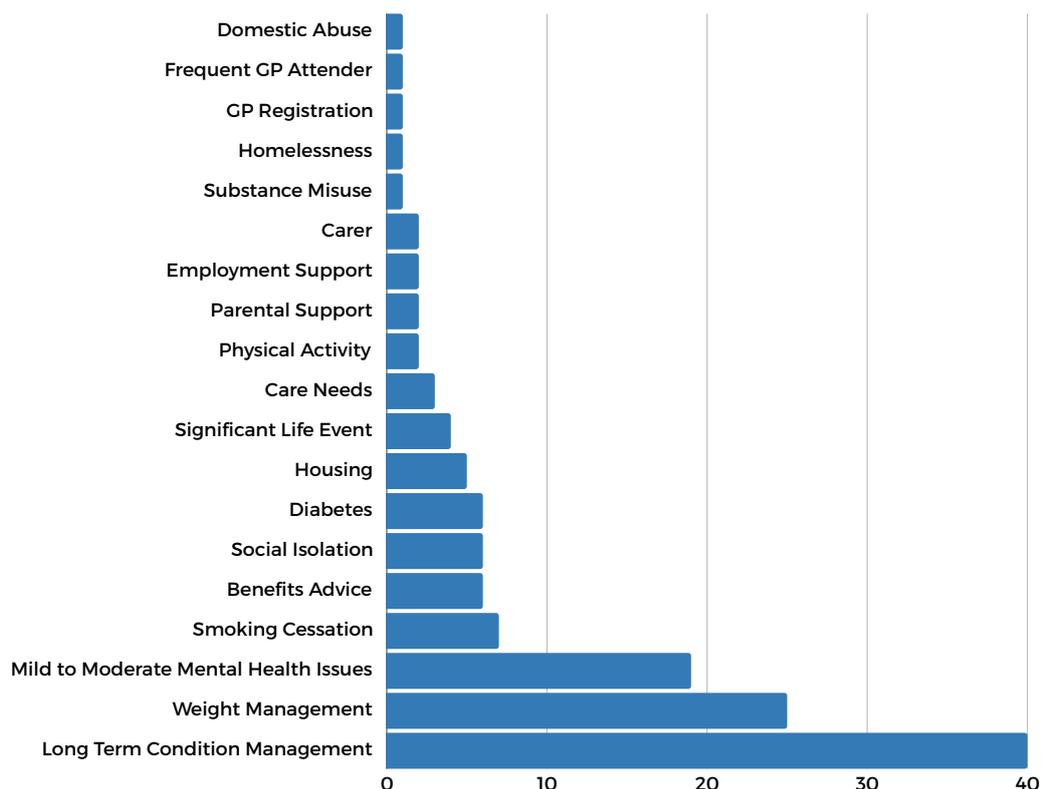
Teddington PCN have identified 11 patients who were not engaging with practices for diabetes management. Since referrals, 2 have engaged with a Wellbeing Coordinator with contact attempted multiple times to the remaining patients who have not responded.

Since April, one patient has been supported with a GP registration, as they had moved out of the Richmond area.

The main reasons clients engaged with the service were:

- Long Term Condition Management (40)
- Weight Management (25)
- Mild to Moderate Mental Health Issues (19)

Figure 1: HIYH Reasons for Referrals



Outcomes & Risks

“I was at my local community centre and not feeling well. I didn’t think much of this but the Wellbeing Coordinator asked if I wanted to check my blood pressure. It turned out to be 223/111! They kindly contacted my GP for guidance and I was sent to A&E. I was prescribed medication which has helped reduce my blood pressure. If I hadn’t have seen your team, maybe I would have been in a more serious situation.”

Wellbeing Coordinators follow clinical guidelines and training to provide community health checks. These include assessing individuals BMI, diabetes risk score and atrial fibrillation.

From 1st April to 28th July 2025, Wellbeing Coordinators completed 119 community health checks and health promotion advice based on individual results:

- 16% required further investigation through blood pressure reading
- 7% required further investigation through diabetes risk score
- 3% required further investigation through electrocardiogram score

From 29th July to 6th October 2025, Wellbeing Coordinators completed a further 96 community health checks. For those who had a blood pressure check, the readings showed:

- 5% required further investigation due to low blood pressure
- 35% required further health promotion due to pre-high blood pressure
- 16% required further investigation due to high blood pressure
- 1% required further investigation due to severely high blood pressure

35 clients were supported to calculate their Body Mass Index scores.

- 3% were below 18.5 and classed as underweight
- 30% were between 25.0 and 29.9 and classed as overweight
- 22% were between 30.0 and 34.9 and classed as obese class 1
- 3% were between 35.0 and 39.9 and classed as obese class 2

Through using Diabetes UK Risk Score, which accounts for special category data in relation to clients health and ethnicity. Out of 23 clients:

- 30% required further health promotion due to a medium risk
- 35% required further investigation due to a high risk
- 26% required further investigation due to a very high risk

Kardia machines are portable, medical-grade electrocardiogram (ECG) recorders that work with a smartphone or tablet and can detect a range of heart rhythm abnormalities. Out of 57 clients:

- 12% of the results were unclassified
- 6% of the results showed possible atrial fibrillation
- 3% of the results showed tachycardia

Service Intervention

Following a community health check, Wellbeing Coordinators meet clients in surgeries, homes or within community venues to provide coaching, goal setting and co-produce action plans. The majority of the clients have complex or multiple needs and receive up to 12 contacts in a variety of communication methods.

Overall, Wellbeing Coordinators completed:

271 face to face appointments

467 telephone appointments

1016 follow up contacts

Wellbeing Coordinators use emails, texts and letters to communicate with clients, discussing their research, options and obtaining further information. They have signposted and referred a total of 390 times to 102 different organisations, groups and local services and activities.

The main services referred or signposted to include:

- Richmond Aid Benefits Advice Service (10)
- Enable Adult Weight Management (9)
- Chronically Marvellous Counselling (9)
- Richmond Carers Centre Adult Support (8)
- RB Mind Journey Recovery Hub (6)
- Richmond Stop Smoking Service (6)
- Citizens Advice Richmond (5)
- National Diabetes Prevention Programme (5)
- Space2Grieve Bereavement Support (4)
- Crosslight Financial Advice (4)
- Richmond Wellbeing Service (4)
- South West London Law Centre (4)
- Age UK Richmond Benefits Advice (4)

“I am very glad that someone was interested in helping me and recommending sources of help. I only knew of one organisation but they are often busy and cannot offer appointments. Through accessing Health in Your Hands I know there are other places willing to help.”

Anita - Hampton Hill Medical Centre

Impact on Clients - Feedback

Following intervention with a Wellbeing Coordinator, 41 clients have completed Ruils Outcomes (Feedback) Survey. 20 residents have provided feedback following a community health check.



100%
felt their Wellbeing Coordinator listened to them

100%
felt their Wellbeing Coordinator understood what mattered to them

95%
felt they had a better understanding of their health condition

100%
felt they would know where to go for help and support



92%
felt more confident to access health services

90%
felt their situation had improved

95%
felt more involved in decisions that affect their health

97%
felt more positive about their life



Following a community health check:

- 95% felt they had a better understanding of their current health
- 90% felt more confident in managing their health and wellbeing
- 95% felt they would know where to go for help and support
- 95% felt more confident to access health services

“

“Having a Community Health Check alerted me to high blood pressure and provided me with other useful information. The Wellbeing Coordinator was caring and thorough.”

“

“This alerted me to high blood pressure. The health promotion session has influenced me to keep up to date with my health and also to stop smoking.”

“

“This has reminded me to write down questions to enable to best outcome when I next see a GP and save them time. I am glad I had a Community Health Check as I learnt how to contact services I may need in the future.”

“

“The Wellbeing Coordinator helped me balance my diet and has given me support in moments of real struggle, both financial and psychological. They have supported me with how to talk to people in a more understanding way. It has enriched my life.”

Impact on Clients - Case Studies

Case Study 1

The Wellbeing Coordinator met David at a local food surplus hub. Following an initial discussion about the service and how he was managing his health, he agreed exploring further support would benefit his wellbeing.

The next appointment was scheduled and the Wellbeing Coordinator completed a holistic assessment of his health, finances, housing, employment and support network. David explained he felt overwhelmed by the number of challenges he was facing. Together, they created a prioritised action plan which was emailed to David for reference and clarity.

The first priority for David was his mental health. He explained that he had a history of severe and enduring mental health conditions, including bipolar disorder. David was awaiting a review from the Integrated Recovery Hub which was due four months prior. The Wellbeing Coordinator liaised with them, which resulted in a medication review being booked within two weeks.

David was keen to engage with the community and the Wellbeing Coordinator accompanied him to attend a local allotment group. He was also keen to engage with physical activity. The Wellbeing Coordinator was able to arrange a free swimming pass to support him with exercise. David also had a bike, although was concerned about his safety. The Wellbeing Coordinator accessed the Move and Nourish Fund which provided him with a helmet, light and gloves to cycle safely.

Due to his mental health, David had fallen behind with household chores and managing incoming post and payments which had led to debt. David had missed appointments and his Personal Independence Payments (PIP) had been suspended. The Wellbeing Coordinator connected David with a local debt support organisation and money advice service. They supported him in attending appointments and submitting necessary documents. David secured a Debt Relief Order and his PIP benefit has since been reinstated. David now reports that he feels more in control and is regularly opening post and answering telephone calls.

The flat had become cluttered and unhygienic. Through ongoing support through telephone calls, text messages and community meetings David felt more motivated and engaged with a local service that provided a deep clean of the property. He actively participated in the process and returned his home to being clean, safe and habitable.

Where David had been seeking support from the Wellbeing Coordinator to connect him with organisations, he has started to contact his housing provided in regards to a longstanding housing disrepair issue. This included sending photographic evidence.

David reports that he feels more positive and in control of his life. He is swimming twice a week, attending a local gym and managing day-to-day tasks more effectively. He has become more connected within the community and shares information about local organisations with the Wellbeing Coordinator that may benefit other clients.

Case Study 2

The Wellbeing Coordinator met Danielle at a residents' housing association event. Danielle had felt anxious leaving her house but after speaking for a while said she felt more at ease and safe. The Wellbeing Coordinator identified her blood pressure was high, and took three readings. They were all very high including a reading of 170/109. Together, they contacted 111 and a clinician agreed to call Danielle back. The Wellbeing Coordinator provided Danielle with a blood pressure information booklet on understanding your risk. They informed Danielle's GP surgery regarding her blood pressure to ensure they were aware.

Danielle was smoking 20 roll ups per day. They discussed her smoking status and the health benefits of stopping smoking. Danielle was open and honest about alcohol intake, with the Wellbeing Coordinator using a visual guide to ascertain how many units she was drinking and using a Drink Aware unit calculator. Together they discussed support options and local services Danielle could access and the barriers she may face. At the time of reporting, another appointment has been organised at home to further explore mental health services and other community organisations that can improve Danielle's health and wellbeing.

Case Study 3

The Wellbeing Coordinator met Alan at a social group in the community and together completed a community health check. This showed that Alan had high blood pressure and an obese body mass index, alongside a high risk of diabetes. The Wellbeing Coordinator contacted the surgery, as Alan explained he does not have a phone or method of contact.

The surgery was able to book for the same day, with the information relayed to Alan to attend. The Wellbeing Coordinator scheduled another appointment in 2 weeks, which Alan then attended. Alan explained that the GP organised blood tests but had not been able to contact the surgery for the results. Using the Wellbeing Coordinators phone, Alan was able to contact the surgery and was informed he needed to see the Practice Nurse for another blood pressure reading and was able to book this appointment. Following this, the Wellbeing Coordinator confirmed with the surgery Alan's contact information as he only communicated through post and an email address which is monitored through the sheltered housing team. Through a discussion with Alan, the Wellbeing Coordinator was able to connect him with a technology service as he agreed to trial a mobile phone through their scheme.

At the time of reporting, another appointment has been scheduled with Alan to explore weight management and review outcomes from GP engagement.

Conclusion

“Having support from a Wellbeing Coordinator helped navigate me to services which supported my mental and physical health. I had someone who listened and understood me. This support was excellent and tailored to me.”

Christine - Thameside

Health in Your Hands continues to demonstrate the critical role of targeted, community based health interventions in addressing health inequalities within Richmond. Despite being a relatively affluent borough, the disparities in health outcomes remain stark in its more deprived areas.

Through a personalised and preventative approach, embedded within Social Prescribing, the programme has reached those who are often underrepresented in traditional healthcare pathways. Wellbeing Coordinators have provided holistic support through community health checks, one-to-one coaching and onward referrals to a variety of local services. The use of population health data has enabled effective outreach.

The feedback from clients reflects a sense of empowerment, increased confidence in managing health and an improved knowledge of local support services. The service continues to evolve and remains vital to maintain strong partnerships across Primary Care Networks.

Acknowledgements

Ruils would like to thank Richmond General Practice Alliance (RGPA), Primary Care Networks and South West London Integrated Care Board for their on-going support of this much needed service, alongside additional projects supporting their patient population.

Ruils would also like to recognise the partnership with Public Health in delivering Social Prescribing within Richmond.

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