



# RICHMOND HEALTH IN YOUR HANDS SERVICE

**Ruils Independent Living**

April 2025 - March 2026

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# Introduction

**“The Wellbeing Coordinator helped me lower my stress levels and consequently keep my blood pressure under control. Thank you for listening patiently to my story, offering assistance and keeping in touch. At my age of 76, the support is an enormous help.”**

Lesley- A patient at Hampton Medical Centre

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 focuses 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. Additionally, we have hosted Health and Wellbeing Fairs and worked with GPs to contact patients with Long Term Health Conditions and mental health comorbidities.

This report outlines the outcomes of the above work, including health check metrics, risk prevention approaches, and collaborative working with GP surgeries and the community sector. It also presents one-to-one casework data, covering appointment types and volumes, client satisfaction, and case studies. In addition, we highlight our Health and Wellbeing Fairs and in-reach activity, alongside key learnings, successes, and challenges encountered over the past year.

The service was initially delivered by 2 FTE Wellbeing Coordinators, this decreased to 1 FTE from September 2025 due to funding. This report provides an update on the service delivery from 1st April 2025 to 31<sup>st</sup> March 2026.

# Data Collection

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

Through participating in the CLEAR Programme and close collaboration with Dr Eley Squire, Clinical Director for Sheen and 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 1<sup>st</sup> 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, in Q2 of this reporting period, 3 of the 5 Primary Care Networks (PCNs) ended their subscription to the Joy system. This meant that Wellbeing Coordinators no longer had 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.

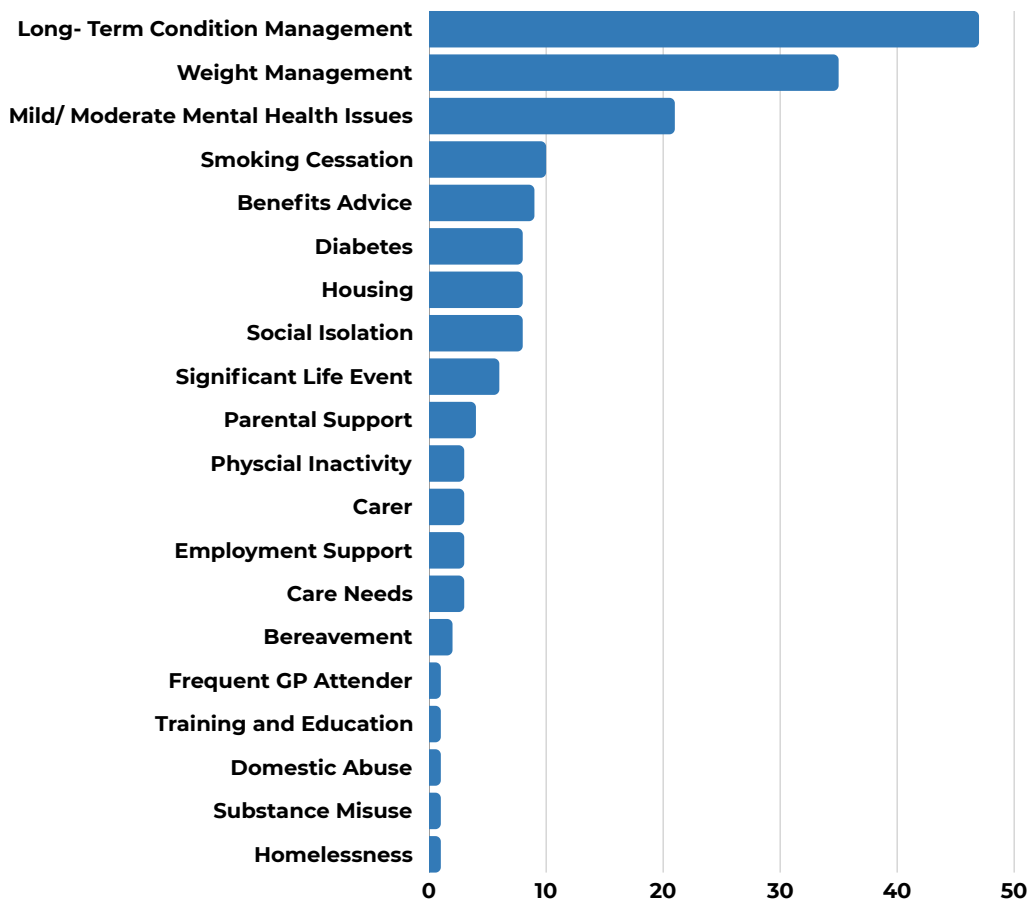
# Community Health Checks

The Wellbeing Coordinators have conducted 336 community health checks within the community. They have received health check training and follow the clinical guidance provided by GPs. The Wellbeing Coordinators also offered ongoing one-to-one support for clients on social factors that improve health and wellbeing. In addition, the team have offered health promotion advice and increased health awareness, for example, around vaccinations and screenings.

## The main reasons clients engaged with the service were:

- Long Term Condition Management (47)
- Mild to Moderate Mental Health Issues (35)
- Benefits Advice (21)

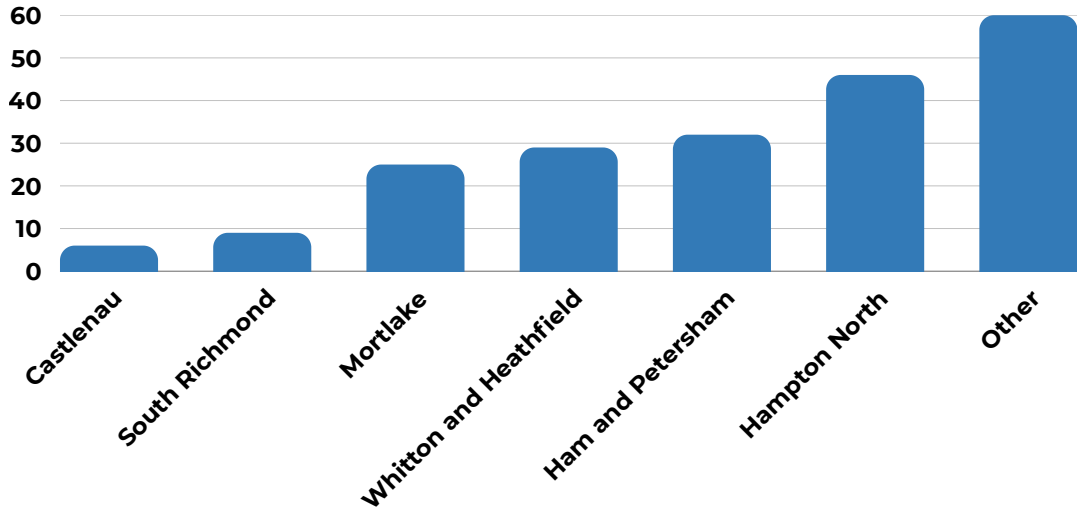
Figure 1: HIYH Reasons for Referrals



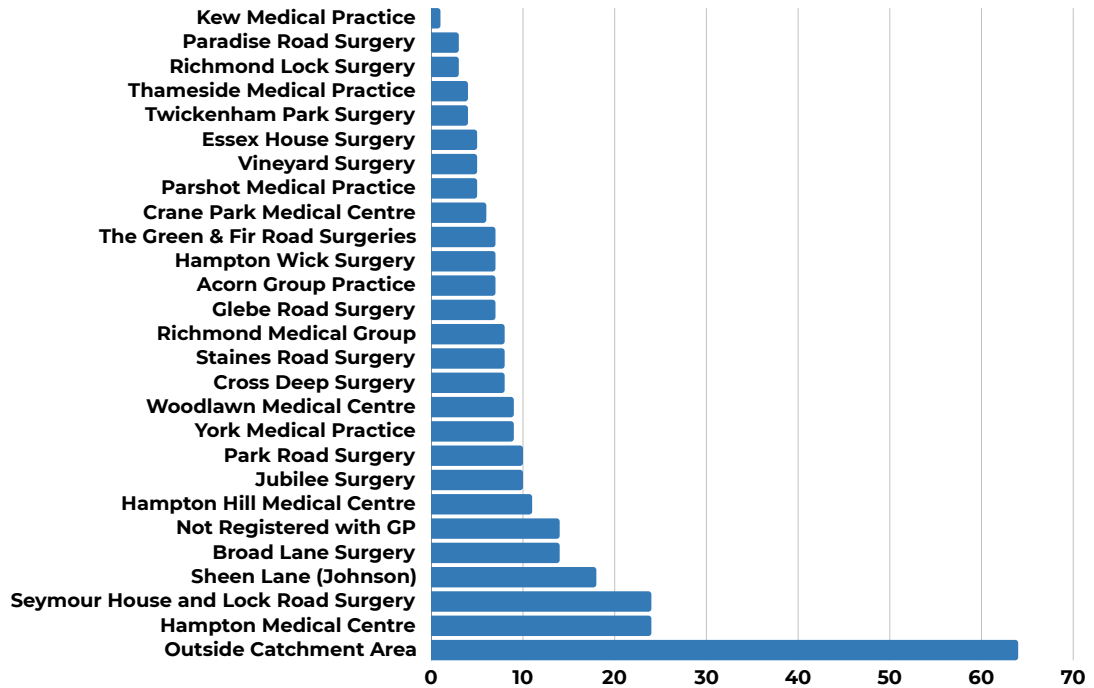
We also saw that the majority of clients engaging with Health Checks were women, with 74% identifying as female and 26% male. We will be looking at different ways we can improve our engagement with the male cohort in the future.

**Figure 2: HIYH Area of Community Health Checks**

Since using MS Forms on 29th July 2025, we have been able to record what general area health checks have been taken up in. These reflect pockets of deprivation within Richmond Borough.



**Figure 3: Client's GP Surgery**



As shown in Figure 3, clients who took up community health checks came from a range of Richmond Surgeries, though the majority (64) either lived outside of the Richmond Borough or were not registered with a Richmond GP.

**“Having support from a Wellbeing Coordinator helped me increase my confidence using technology, including using it for upcoming health appointments via Zoom. The service has helped me out a great deal.”**

**- Craig, Hampton Hill**

# Outcomes and Risks

“Wellbeing Coordinators follow clinical guidelines and training to provide community health checks. These include recording individuals’ Body Mass Index (BMI), Diabetes Risk Score, Blood Pressure and Electrocardiogram (ECG). For the purpose of this report, we are collating data from two different platforms. This includes Joy data from 1st April to 28th July 2025, and MS Forms data for the remainder of the reporting period.

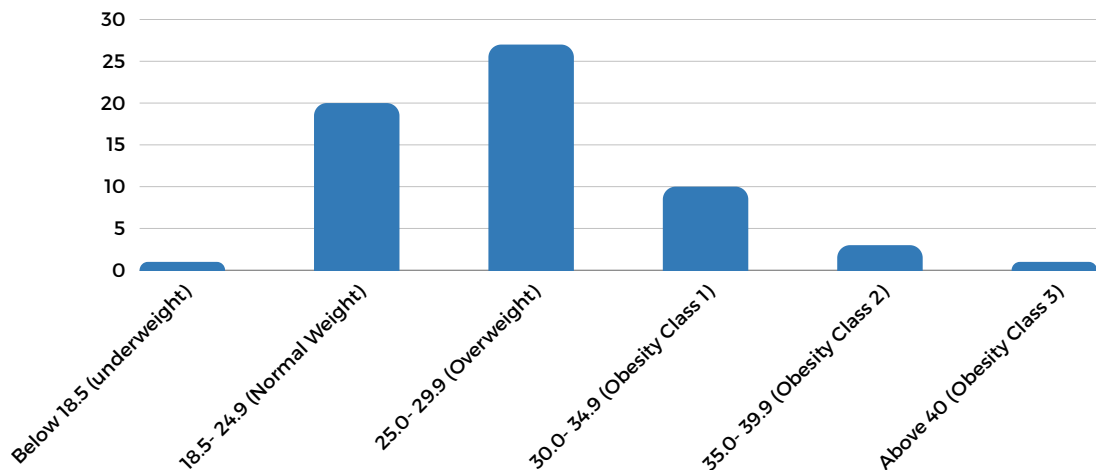
Out of **292 Blood Pressure checks**, 21% of people were signposted to their GP for further investigation due to high or severely high readings, which includes blood pressure equal to or greater than 140/90. These people were given targeted health promotion literature from Blood Pressure UK.

Out of **67 Diabetes UK Risk Scores** taken, 52% of people required further investigation due to high or severely high scores and were given targeted health promotion literature.

Out of **158 ECG recordings**, 16% of people required further investigation from their GP due to the following readings; Possible Atrial Fibrillation (AF), Bradycardia (slow heart rate), Tachycardia (fast heart rate) and Unclassified.

The Wellbeing Coordinators also recorded **99 BMI calculations**. Since recording on MS Forms, we are able to refine by the following categories:

**Figure 4: BMI**



Individuals classed as overweight received lifestyle advice centring around diet and exercise. Furthermore, individuals classed as obese received signposting and/or referral to Tier 2 Weight Management programme, as well as health coaching.

**“Having support from a Wellbeing Coordinator helped me to balance my diet, give me support in moments of real struggle, both financial and psychological and supported me with how to talk to people in a more understanding way and enriched my life.” - Arthur, Glebe Road Surgery**

## In Reach Lists

The Health in Your Hands programme has previously delivered targeted in-reach activity through GP surgeries, focusing on individuals living in areas of deprivation and experiencing comorbidities such as depression, hypertension, diabetes, asthma, or COPD. Similar in-reach initiatives were offered across the Primary Care Network (PCN); however, uptake was limited.

Teddington PCN identified 11 patients who were not engaging with diabetes management services. Following referral, two patients have engaged with a Wellbeing Coordinator. Multiple attempts have been made to contact the remaining patients, but these have not received a response.

Since April, 1 patient has been supported to register with a GP after relocating outside the Richmond area.

## Ruils Health & Wellbeing Events

At the start of 2026, Ruils received funding from Public Health Richmond to deliver a series of Health Fairs in partnership with Live Karma Yoga. Three Health and Wellbeing events were subsequently held in Whitton, Mortlake, and Ham.

Each event offered a core provision of a free, nutritious hot meal alongside a range of activities and support services, including massage therapy, yoga taster sessions, henna art, and access to community health checks. The first event took place in Ham in early February. There was good attendance of 14 local residents.

Participants engaged well with what was on offer and reported a positive experience overall. 6 health checks were completed, all with residents registered with Richmond GP practices, and an additional conversation with one further resident about their health and wellbeing.

Later that month, the Whitton event focused on mental health, with organisations including Chronically Marvellous, Richmond Mind, and the Richmond Wellbeing Service in attendance to provide advice and support. 15 residents attended and 6 health checks were completed. Key discussion areas included diabetes risk, weight management, blood pressure (both high and low), and the importance of screenings and vaccinations. Lifestyle advice was also provided, including guidance on physical activity and smoking cessation.



The Mortlake health fair took place in March and focused on cost-of-living support. 16 residents attended, including four children. The event was well received, with a positive and relaxed atmosphere throughout.

Organisations in attendance included Crosslight, the South West London Energy Advice Partnership, and the Money Advice Team from Richmond Aid. 8 health checks were completed, with further discussions covering diabetes risk, weight management (including referral to the Enable Weight Management Service, which was present at the event), encouragement to engage with vaccinations and screenings such as bowel cancer screening, and blood pressure advice. Lifestyle guidance was also provided, including support to increase physical activity and quit smoking.

Following the events, the Wellbeing Coordinator carried out follow-up contact with clients, offering health coaching focused on hypertension, diabetes, obesity, and cardiovascular disease risk.

**“Having someone who listened to me understood me and really navigated me to services to help my mental and physical wellbeing. The service was also very swift in their response. I would highly recommend the service.”**  
- Event attendee



# Service Intervention

Following a community health check or through in-reach lists, the Wellbeing Coordinators met clients one-to-one 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 long-term support in a variety of ways.

Overall, the Wellbeing Coordinators made 2281 touchpoints with clients, this includes all appointments and contacts. This breaks down to:

**360** face to face appointments

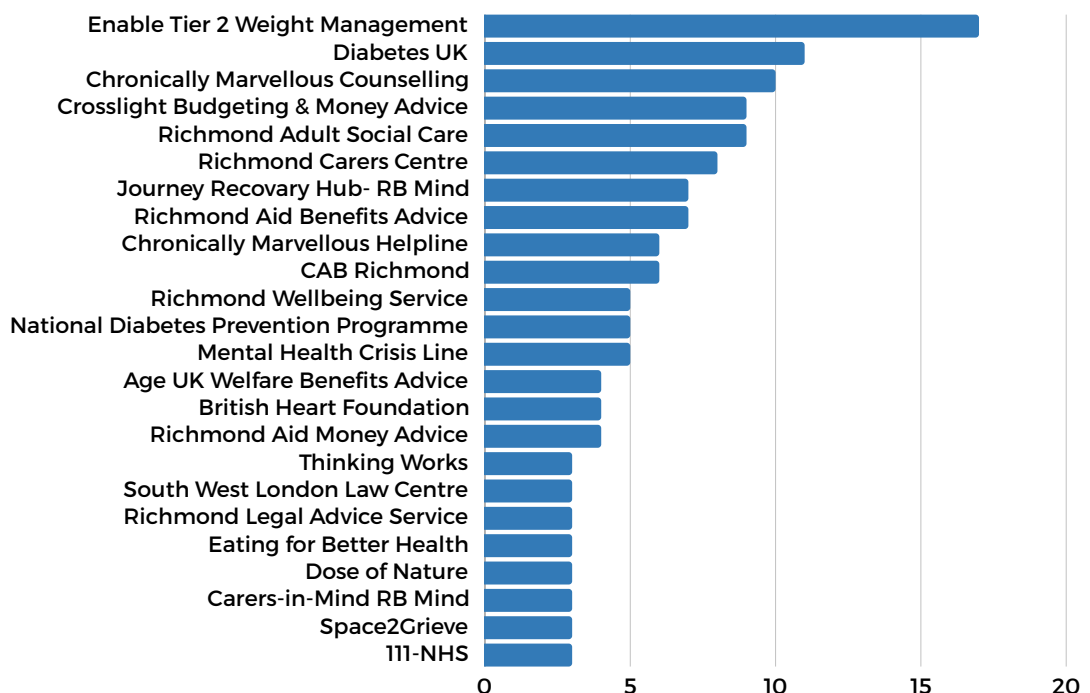
**521** telephone appointments

**1400** follow up contacts

The 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 281 times to 103 different organisations, groups and local services and activities.

The main services referred or signposted to include:

**Figure 5: Signposts and Referrals**



# Impact on Clients - Feedback

Following one-to-one casework with a Wellbeing Coordinator, 15 clients completed the Health in Your Hands Ruils Outcomes (Feedback) Survey. A further 20 residents provided feedback following a Community Health Check.

**100%**

Would recommend the service to family and friends

**100%**

felt their Wellbeing Coordinator listened to them

**100%**

felt their Wellbeing Coordinator understood what mattered to them

**87%**

felt they had a better understanding of their health condition

**100%**

felt they would know where to go for help and support



**93%**

felt more confident to access health services

**93%**

felt more confident in managing their health and wellbeing

**93%**

felt more involved in decisions that affect their health

**100%**

felt more positive about their life



Following a community health check:

- 100% (20) reported a better understanding of their current health.
- 100% (20) felt more confident in managing their health and wellbeing.
- 100% (20) felt more confident accessing health services.

“

“Having someone who listened to me, understood me, and really navigated me to services to help my mental and physical wellbeing. The service was also very swift in their response. I would highly recommend the service. Thank you for helping me.”

“

“It was encouraging to have this check done, it was easy and straight forward no queuing or making an appointment.”

“

“Having a Community Health Check had a good impact on me as I understood my condition, what is good, what is bad, and the awareness to avoid possible risk in the future”.

“

“This has reminded me to write down questions to enable the 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.”

“

“Having a Community Health Check provided me with useful access points and also allowed me to have my blood pressure measured.”

“

“I was offered info on diabetes and how to access services. Very helpful.”

“

“Has influenced me to keep up to date with my health and to stop smoking.”

# Impact on Clients - Case Studies

## Case Study 1 - One-to-One Support

The Wellbeing Coordinator met Simon at the Public Health Bus in Richmond and later in Hampton North. He presented with several health concerns but, due to general anxiety, had been hesitant to engage with his GP. These included pre-diabetes, poor mobility - he shared that strangers had recently helped him up from a street bench - high blood pressure (he declined a check at the time), and possible high cholesterol.

Simon was also dealing with a difficult living situation, financial concerns, and was receiving benefits and due a review. He also reported low mood.

They started by referring him to a mental health practitioner to support an initial connection with his GP surgery, help prioritise his mental health needs, and attended the appointment with him.

Together, the Wellbeing Coordinator and Simon identified his main priorities as improving his sleep - he had chronic sleep issues, sleeping only a few hours at night and napping during the day - and weight management. He had previously been referred to a community weight management service by a nurse, but this had been declined as his BMI exceeded 40.

The Wellbeing Coordinator attending the GP appointment with Simon was important as it improved his confidence and motivation. The GP confirmed that Simon had type 2 diabetes rather than prediabetes, and although medication had been prescribed, he had not been taking it. His blood pressure was high, and alongside his BMI and untreated diabetes, this significantly increased his risk of stroke, heart attack, diabetic neuropathy, and kidney damage. The GP also referred him to a sleep clinic and arranged a blood test.

The Wellbeing Coordinator and Simon met after the appointment to debrief. Simon said he had thought his weight was lower and appeared to be in denial. He felt overwhelmed by the appointment. With support, they booked his blood test, and he was encouraged to complete a blood pressure diary.

At a subsequent joint GP appointment, it was confirmed that Simon had low B12 levels and he was advised to take supplements. His blood test confirmed type 2 diabetes, and a prescription was sent to the local pharmacy. A follow-up review was arranged, and a referral to a diabetes education course was suggested. After some time to reflect, Simon agreed to a referral to the bariatric team.

His blood pressure remained very high, so the GP started him on antihypertensive medication. He was also diagnosed with sleep apnoea and prescribed a CPAP mask. Simon reported feeling more upbeat and less lethargic. He engaged with a mental health nature prescription, and his risk of developing long-term health conditions began to reduce. This intervention also likely reduced pressure on healthcare services, including emergency and unplanned hospital admissions.

## **Case Study 2 - Community Health Check**

The Wellbeing Coordinator met Martha at the Full of Life Fair in Twickenham, an annual event providing residents of pensionable age and their carers with information and resources from local organisations to support their health and wellbeing. After introducing the Health in Your Hands service, they carried out a Community Health Check together. This included a Kardia ECG, which showed normal sinus rhythm. Atrial fibrillation was explained as a common abnormal heart rhythm, and a leaflet from the British Heart Foundation was shared. Smoking status was recorded, and cancer screenings and vaccinations were discussed.

A blood pressure check was carried out, which showed her diastolic reading was in the lower range. A body mass index (BMI) and waist measurement were also taken. Martha was shown where her BMI sat on a visual scale using the NHS website. Both measurements (BMI in the obese range) indicated that she would benefit from losing weight. Weight management advice was shared, including discussion of diet and exercise, and a referral to the Tier 2 Weight Management Service was made.

The Diabetes UK Diabetes Risk Calculator was used to assess her risk score. This showed that Martha's risk of developing diabetes was very high. The contributing factors were explored with her, and she was provided with information on diabetes risk and ways to reduce it.

Martha was encouraged to book a GP appointment to discuss her weight, blood pressure, and diabetes risk, including requesting a blood test. The Wellbeing Coordinator explained what she could expect from the results: if she were pre-diabetic, she could be referred to the National Diabetes Prevention Programme; if diabetic, she would receive appropriate advice, guidance, and treatment. They also mentioned an educational course available for people with diabetes. If her results were normal, she could still follow the advice given to reduce her risk.

She was encouraged to speak with the Enable weight management service and a visual impairment charity, both already present at the fair. Regular follow-up contact was then arranged, including seeing Martha during community outreach and encouraging her to stay in touch with her GP.

Most recently, Martha had booked her GP appointment, engaged with the weight management service, and was attending further courses on healthy eating.

From that initial connection with the wellbeing coordinator, Martha has a better understanding of her health risks and has started taking steps to improve them. This shows growing confidence in managing her health, and a positive move towards making lasting changes with the right support in place.

# Conclusion

Health in Your Hands continues to show how important targeted, community-based health support is in tackling health inequalities across Richmond. While the borough is generally affluent, there are still clear differences in health outcomes in more deprived areas.

The strong link between physical health, mental health, and financial wellbeing is evident and clearly reflected in the primary reasons for referral, which most commonly include long-term condition management, mild to moderate mental health concerns, and financial or benefits-related issues. Similarly, the most frequent signposts, such as weight management, diabetes services, and counselling, alongside widespread referrals to money advice, benefits support, and mental health services, further reinforce this relationship.

The individual case study further illustrates the need for a holistic approach, highlighting how physical health management, mental health challenges (including anxiety and low mood), and financial hardship often coexist. In response to these insights, Health and Wellbeing Fairs have been developed to provide integrated support, including nutritious meals, mental health and cost-of-living assistance, and accessible activities such as yoga and massage that promote both physical and mental wellbeing.

The Wellbeing Coordinators play a key role in delivering this holistic support through flexible appointments, ongoing engagement, and comprehensive assessments tailored to individuals' complex needs. They are particularly effective in reaching those who may not engage with traditional services, including individuals who do not attend GP appointments but access community resources such as foodbanks or free meal services. By maintaining a regular presence in these settings, coordinators build trust and act as a bridge between individuals and appropriate healthcare or support services.

However, there are limitations. Reduced funding has resulted in a smaller team, requiring coordinators to cover larger geographic areas, which in turn limits the level of support available within each locality. Despite this, increased engagement through targeted in-reach lists has enabled better identification and support of individuals who may otherwise remain disconnected from both community and statutory services.

As the service continues to develop, it remains an important part of maintaining strong partnerships across Primary Care Networks and supporting more equal health outcomes across the borough.

# 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.

## References

<https://www.datarich.info/deprivation/map/>

[www.nhs.uk/health-assessment-tools/calculate-your-body-mass-index/calculate-bmi-for-adults](http://www.nhs.uk/health-assessment-tools/calculate-your-body-mass-index/calculate-bmi-for-adults)

<https://riskscore.diabetes.org.uk/start>

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