North Newham
PRIMARY CARE NETWORK

Newham Health Collaborative
A Community Interest Company

NHS
Providing NHS services

Tackling Neighbourhood Health Inequalities in Newham Primary Care

North Newham Primary Care Network

Project 1: Food Poverty, Weight Management

Aim

To prevent poor health outcomes such as obesity and diabetes.

Main actions

- Provided member practices with information on a healthy weight coach training programme
- Stressed the importance of timely advice and interventions
- Worked with practices to ensure patients were receiving available support
- Considered digital solutions or culturally accessible self-help tools

Key outcomes

- 1161 patients referred to weight management services in 2022/23
- 89 patients referred to the national diabetes programme
- 11 newly diagnosed diabetic patients signposted to Talking Therapies
- Introduced AccuRx self-book tool for patients to access online digital support tools

Next steps

- Continue working with diabetic patients to:
  - Collect feedback on patients' experiences with weight management services
  - Improve their understanding of the disease
  - Increase health knowledge, awareness of self-care and the impact on life expectancy

Project 2: UCLP Proactive Care: Long Term Condition patients

Aim

To better control practice workload and improve patient satisfaction by prioritising patients by clinical risk and need.

Main actions

- Identified clinical and management lead and set up multidisciplinary team (MDT)
- Met with clinical team to review stratification process
- Applied UCLP proactive care framework to address inequalities

Key outcomes

- Estimated 1 out of 5 targeted patients are using the Emergency Department less than the pre-Covid period
- 3 out of 10 of targeted patients have reduced their consultation time with the practice by over 50%.
- Better management of high-risk patients and improved patient satisfaction

Next steps

- To commence projects with other identified cohorts
- Review patients in the first cohort of 'top two priority areas' later in the year

Project 3: Sharing learning of Covax model developed

Aim

To share a model of delivering Covid vaccinations which has clear evidence of sustainability and replicability.

Main actions

- Presented model of delivery member practices and at the GP webinar
- Signed collaborative agreement to bring Covax model to PCN level
- Supported member practices whose patients went to Woodgrange Medical Centre for flu clinic

Key outcomes

- Vaccination uptake for eligible patients increased from less than 40% in January 2021 to over 80% in May 2023.
- Practices worked together to deliver vaccination clinics at PCN level

Next steps

- To share learning through system meetings and online conferences
- Engage with other practice partners to learn from them as to how progress can be secured in different localities

Proactive social prescribing project

Patients who are pre/diabetic & with common mental health illness such as depression

Social prescribers are reviewing this patient cohort's referrals to, and engagement with, voluntary and community services, to better evaluate how best to address their unmet needs.