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Crisis Social Prescribing at Bromley by Bow

Interim report on reach and impact: Calls made between March 25th – June 3rd

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Introduction

The Bromley by Bow Health Partnership and Bromley by Bow Centre are a pioneering health and well-being outfit in the heart of East London, delivering services to one of London's most deprived areas.

The Partnership provides primary health care services to more than 30000 registered patients, which accounts for approximately 10% of the Borough of Tower Hamlets' population. The partnership is located across three different general practices, and has been established for over 30 years. The Bromley by Bow Centre is an internationally recognised charity supporting thousands of clients each year in a range of aspects from gardening to getting online.

Through a range of experiences we have developed an approach to caring for local communities that understands the diverse and changing needs of populations, and inherently takes into consideration the broader social determinants of health. Together, we are the home of break through interventions such as Healthy Living Centres, Social Prescribing, DIY Health and Public Health England's flagship embedded research project, Unleashing Healthy Communities.

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Introduction

As the pandemic worsened and lockdown measures were introduced, The Bromley by Bow Health Partnership and Centre wanted to adapt and implement support for local people that would meet the changing and growing needs of our community in the most holistic way possible.

The aim of our Crisis Social Prescribing work was to **contact** those who needed support and **connect** them to a range of initiatives – from foodbanks, to legal aid, befriending and online activities.

What did we do?

- Pooled staff together from various teams across the Health Partnership and Centre to make one team of ‘Crisis Social Prescribers’.
- Proactively identify cohorts of patients who we believed would be at additional risk of social and economic vulnerability due to lock down measures, including but reaching beyond those who were identified as Extremely Medically Vulnerable (shielding).
- We encouraged referrals for those in need of social, emotional and practical support, introducing a faster turn around for immediate issues.
- Implemented telephone-based support, signposted and referred patients and offered and delivered ‘Home Packs’ to help people navigate and manage during the lock down period.

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Aim: Share data and insight on our crisis response to Covid-19

This slidedeck includes:

1. The reach of Crisis Social Prescribing Service
2. The strengths, as well as the needs, of people who we have reached through this service.
3. The interventions we have offered people.
4. The reactions and outcomes to these interventions.
5. Methodology for analysis and learning.

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Who have we spoken to?

Reach of the Crisis Social Prescribing Service

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Who are we speaking to?

512
Total number of people spoken to to date

704
Total number of calls made to date

Breakdown:

	BBBHP Vulnerable Patients	*St Andrews Shielded*	*BBB Shielded*	*TOTAL*
Total number of people spoken to	256	120	136	**512**
Total number of calls made	448	120	136	**704**

54
Total average age of patients

299 F : 221 M
Total gender ratio

9-90
Age range of patients spoken to

Average calls made by team per week

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Example week 1

	27-Apr	28-Apr	29-Apr	30-Apr	01-May
Average no. calls (initial contact)	1	8	3	23	4
Average no. calls (callbacks)	10	8	1	0	4

Example week 2

	04-May	05-May	06-May	07-May	08-May
Average no. calls (initial contact)	5	1	7	9	0
Average no. calls (callbacks)	1	6	5	4	0

Example week 3

	11-May	12-May	13-May	14-May	15-May
Average no. calls (initial contact)	4	4	2	16	5
Average no. calls (callbacks)	5	6	2	2	8

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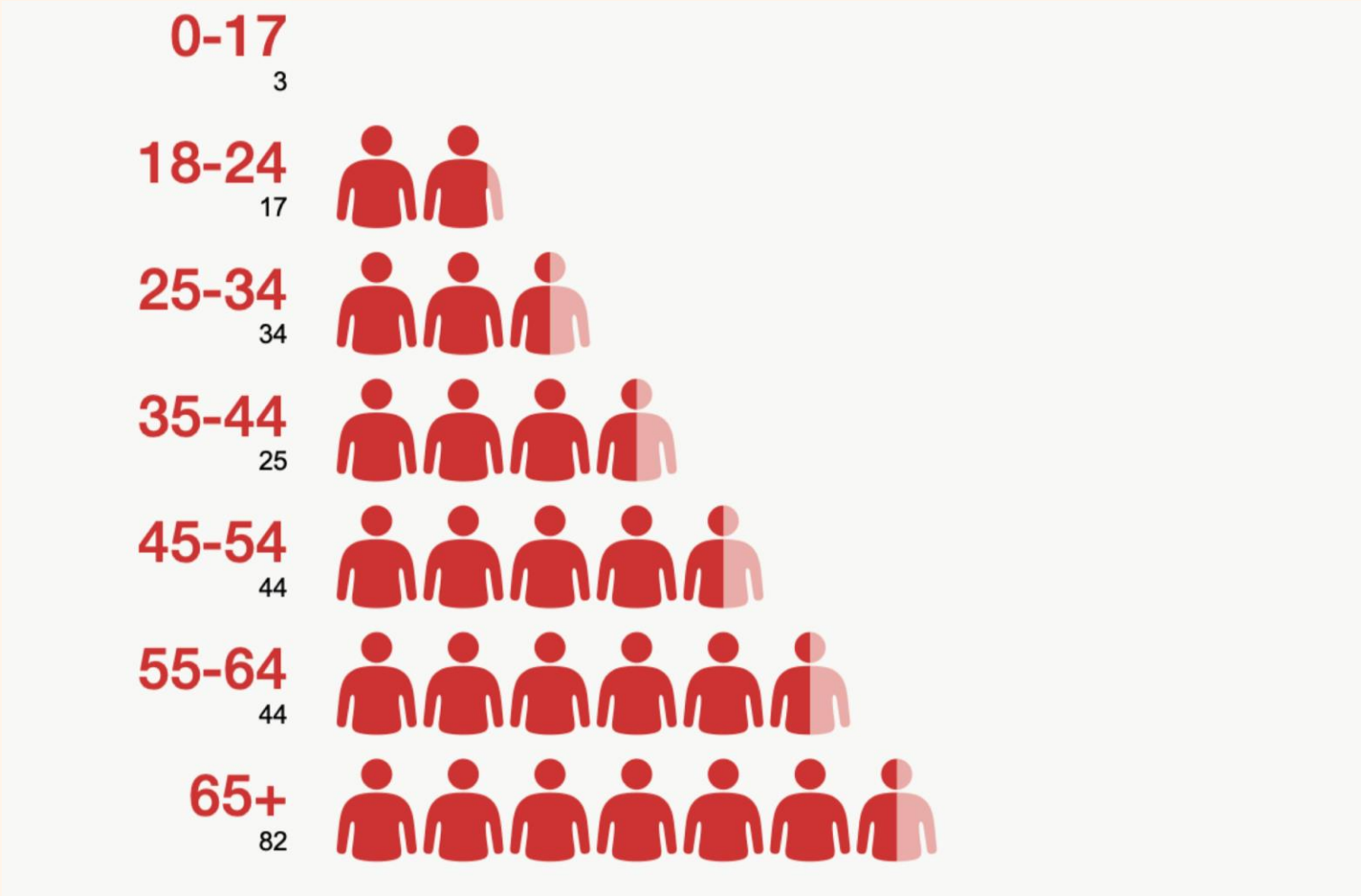
Age range *(patient sample size of 249)*



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Where have we been referring people?

Top services the team have been making referrals to (Total number of referrals = 249)

Referral e.g. GoodSam / food banks	Number	Reason for referral
BBBHP Homepack delivery	106	Feeling down, wanting additional ideas of things to do, keeping family entertained
Government support	40	Council isolation form, completed online vulnerable form, requested gov food package
GoodSam (food)	14	Patients worried about shopping, low on shopping supplies as cant leave the house
3 Friends	11	supporting letter for friend to do shopping, shopping for elderly
Mutual Aid	10	shopping / medication pick-up, donating books
BBBC Services (Active Together, CDC Photography, Chatter Matters Whatsapp Group)	10	Weight concerns, wanting advice on how to keep occuiped during the day, feeling isolated
Family Playrooms	9	Keeping families with young children entertained
Samaritans	8	Patients feeling anxious and low, suicidal thoughts
First Love Foodbank	5	Patient had no food and no money to pay mutual aid groups for food, patients self-isolating and short on supplies
GoodSam (medical)	5	Buying specific nappy brand, hospital appointment, pick up medication
Tower Hamlets money service/Advice team	5	Worriedd about paying bills, referral for rent arrears, housing support
BBBC Legal Advice team	4	Advice on housing application (homeless patient), temporary accomodation and rights
MIND	3	Mental health support anxious since wife returned to hospital
GoodSam (regular chat)	3	Feeling isolated
Local foodbank	3	No food in the house (filled out LBTH form), unable to access money due to card being blocked
GoodSam (other)	2	Reasons not specified
Social prescribing	2	Victim of domestic violence
ACAS	1	Patient can't afford to stay at home so went back to work. He can't read or write and works as a cleaner at Stratford International. He has not been given gloves or any other protection until this morning.
Silverline	1	Support for elderly
AgeUk East London	1	Patient wanting extra help to support wife
Tower Hamlets housing support	1	Patient at risk of being made homeless (domestic incident)
Neighbours Poplar	1	Hot meal delivery
Carers Centre	1	Food package delivery
Talking Therapies	1	Stress and anxiety

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How have we mapped the needs and the strengths of our community? Outcomes Framework

Outcome	Definition
Basic needs	This outcome is about to helping us to address the most urgent issues that are affecting our life. E.g. access to services, Health (physical and mental health), money – and getting a job
Connected to others	This outcome describes what happens when we meet new people and build relationships. E.g. supportive relationships
Built knowledge, skills and opportunity	This outcome is about connecting to our existing resources, knowing where to go and how to access learning opportunities and developing our knowledge and skills. E.g. knowing about new opportunities, learning new things
Personal resources	This outcome is about how we feel in ourselves and what these inner resources help us to do in the world around us. E.g. wellbeing, confidence, resilience
Connected to a place or community	Connection in to place or community works in three ways: feeling known and trusting people, shaping community and place, and having a sense of belonging. This outcome is about your relationship to a physical place and/or your relationship to a group of people.
Contributed	This outcome describes what happens when we're able to offer our talents and assets in a way that is meaningful to ourselves and others – and when we're able to take action for ourselves.

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STRENGTHS AND NEEDS OF OUR COMMUNITY

STRENGTHS AND NEEDS	BBBHP Vulnerable Patients	St Andrews Shielded	BBB Shielded
Basic needs	155	55	28
Connected to others	94	20	6
Built knowledge, skills and opportunity	36	76	77
Personal resources	60	14	3
Connected to place and community	23	14	0
Contributed	10	0	1

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BBBHP Vulnerable Patients

Deep dive

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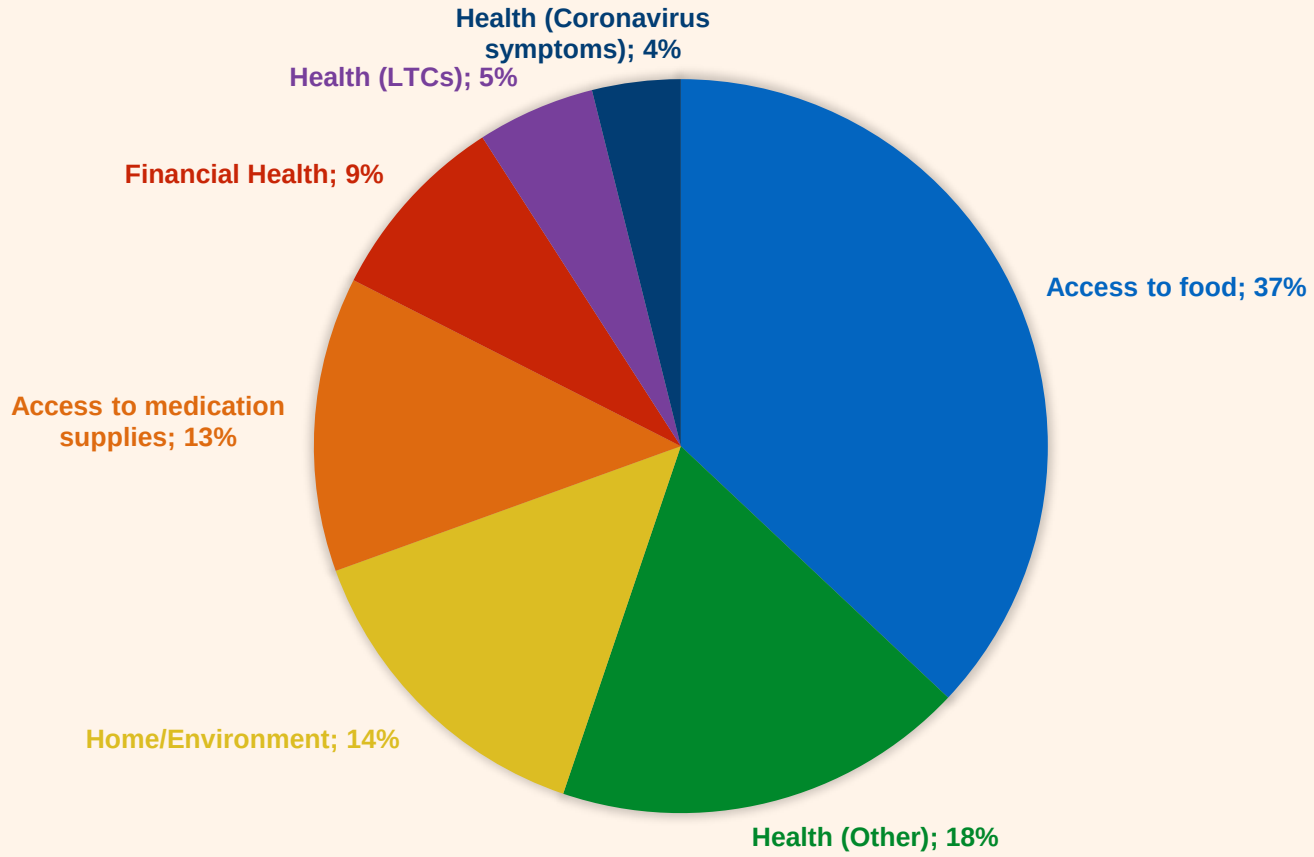
Strengths and needs of our community

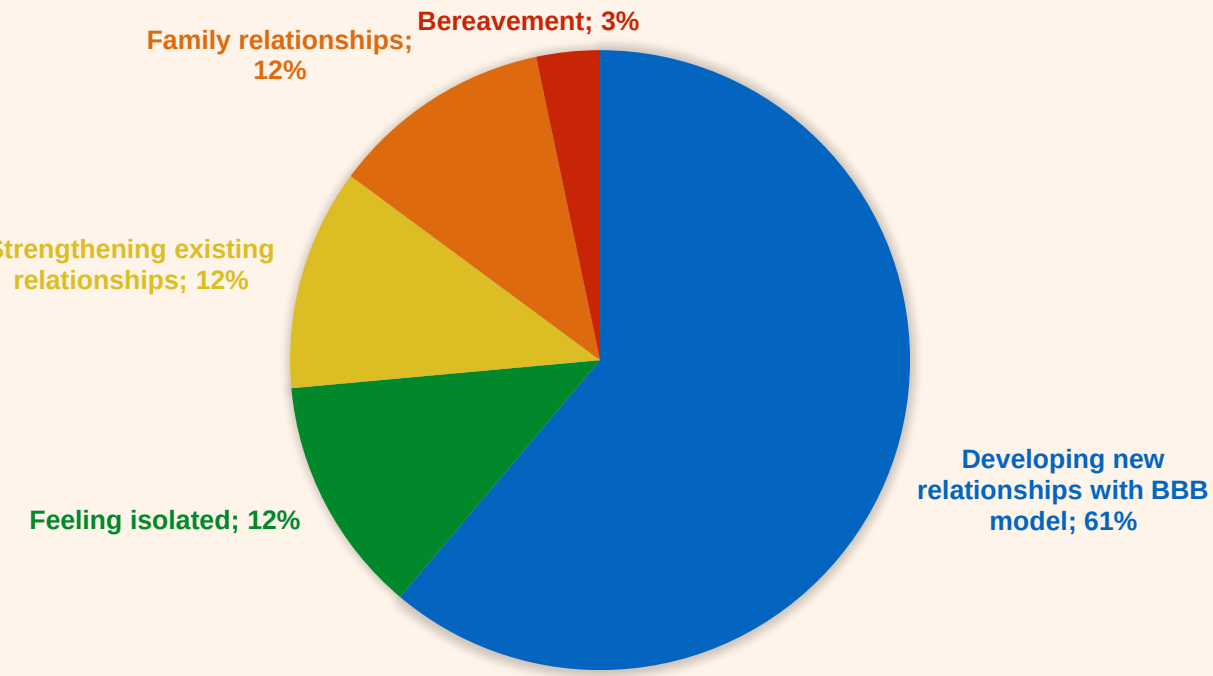
Basic needs

THEMES	TOTAL NUMBER
Access to food	57
Health (Other)	28
Home/Environment	22
Access to medication supplies	20
Financial Health	13
Health (LTCs)	8
Health (Coronavirus symptoms)	6



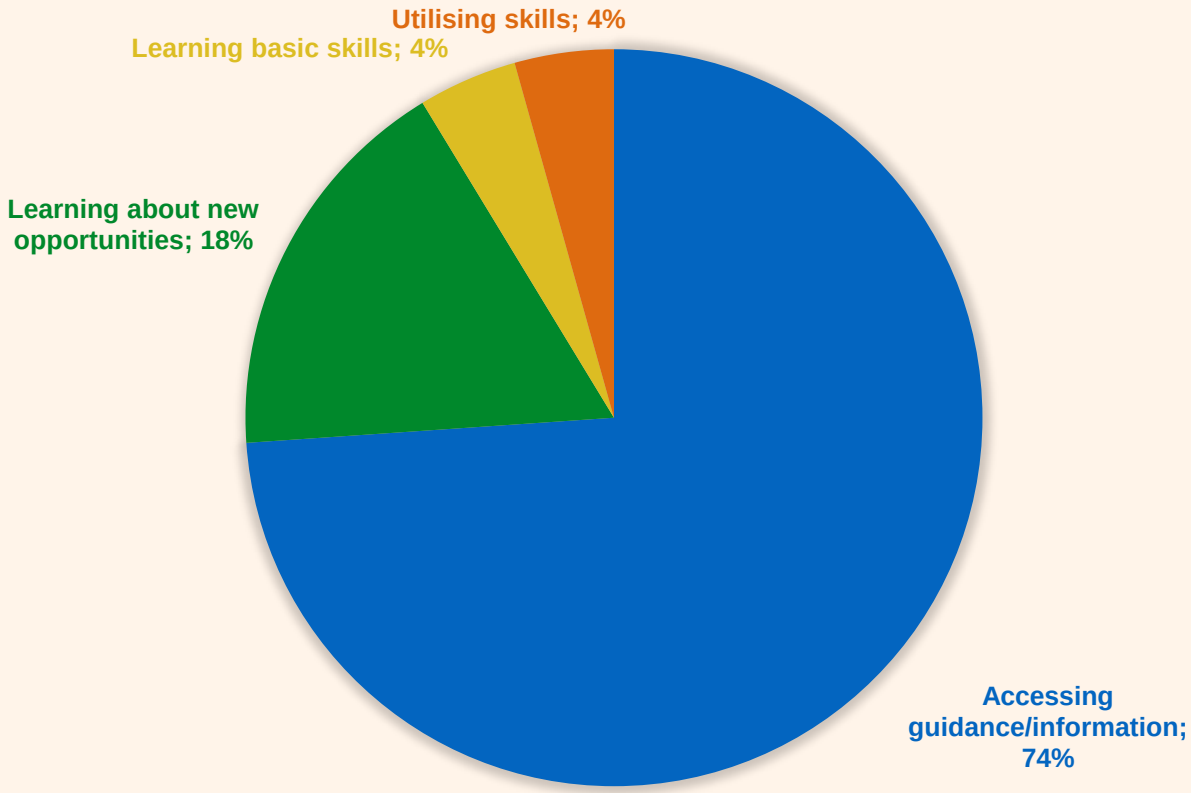
Connected to Others

THEMES	TOTAL NUMBER
Developing new relationships with BBB model	74 at least one callback with recorded data (32 people have had at least 4 callbacks after initial call)
Feeling isolated	15
Strengthening existing relationships	14
Family relationships	14
Bereavement	4



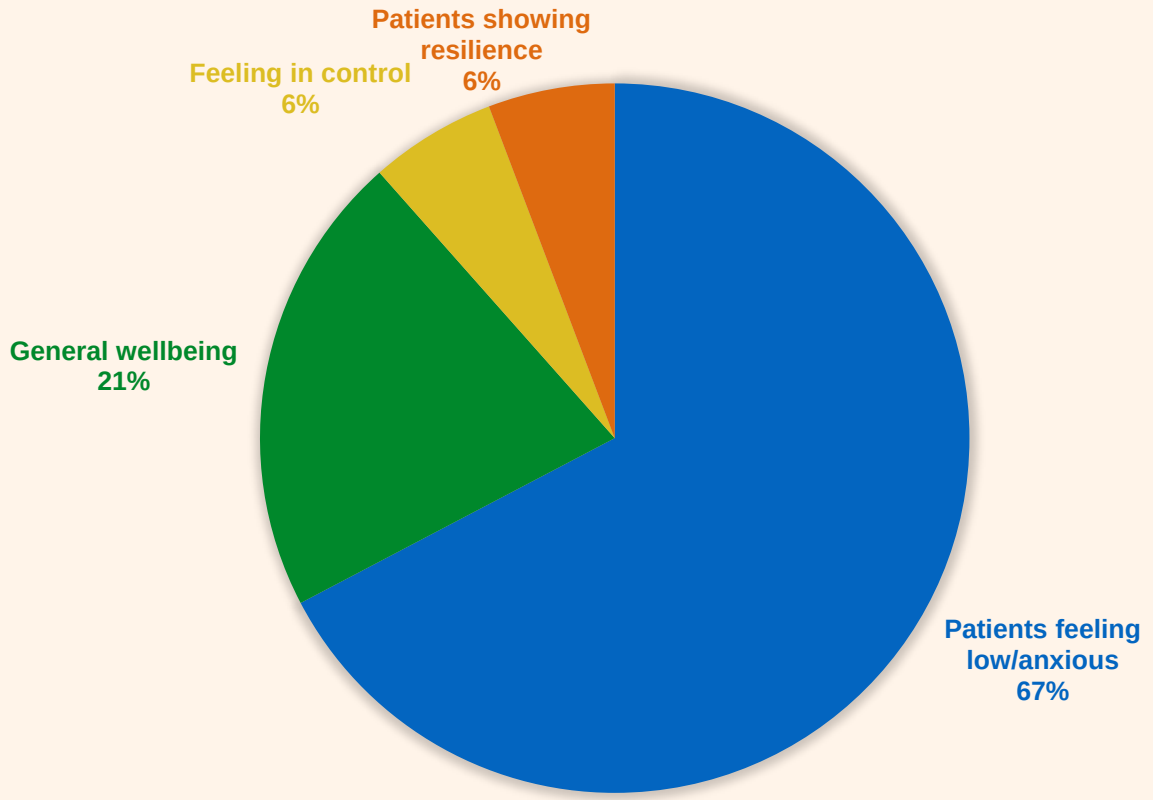
Built knowledge, skills and opportunity

THEMES	TOTAL NUMBER
Accessing guidance/information	17
Learning about new opportunities	4
Learning basic skills	1
Utilising skills	1



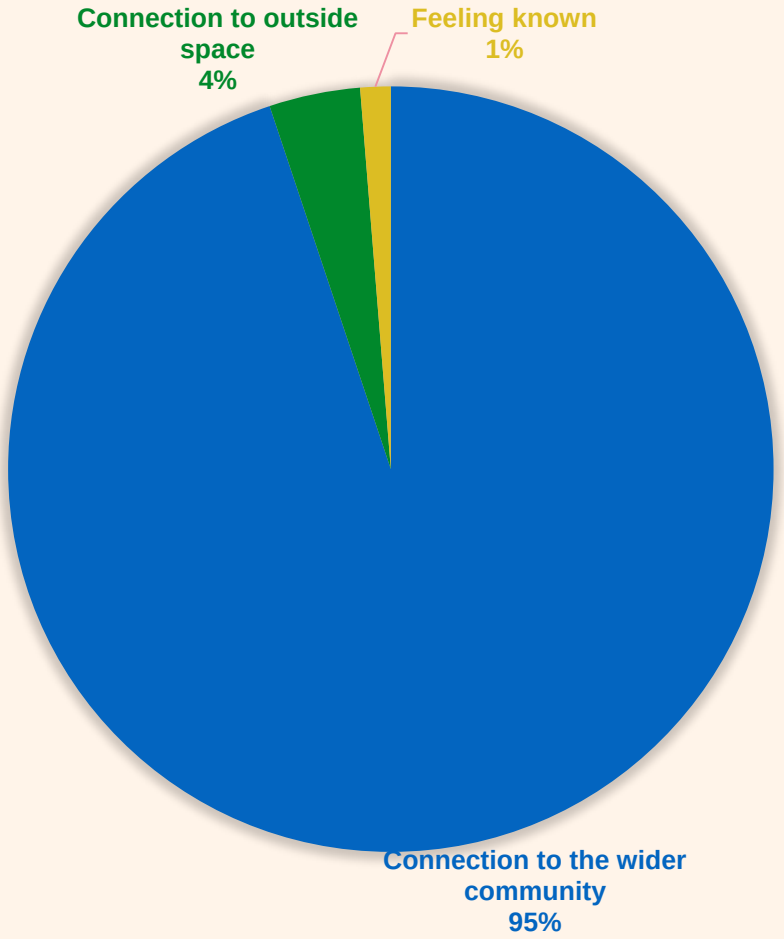
Personal resources

THEMES	TOTAL NUMBER
Patients feeling low/anxious	35
General wellbeing	11
Feeling in control	3
Patients showing resilience	3



Connected to a place or community

THEMES	TOTAL NUMBER
Connection to the wider community	74
Connection to outside space	3
Feeling known	1



Contributed

THEMES	TOTAL NUMBER
Understanding what you can offer / Giving back to the community	8

Examples

Understanding what you can offer / Giving back to the community	Patients wanting to get creative / get involved in groups / iused to enjoy creative activites Patients reporting they would like to get involved with groups when Covid is over. Patients wanting to create pieces for practice

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Interventions to work with people's strengths and needs

2
0

Interventions

Ensuring people have the right information

- Health literacy
- Signposting to other services and supports

Helping people with immediate needs

- Support to fill out forms/receive shielding letter
- Ordering medication
- Receive home-pack

Emotional and psychosocial support

- Emotional support and listening ear
- Call backs to ensure people are safe and well
- Empowering people to connect to their existing strengths
- Tasks offered to people to help them keep busy

Referral

- To BBB services
- To Council support
- To other community supports
- To social prescribing

Interventions needed w.b. 27th April

(out of a total of 64 calls)

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	TYPE OF INTERVENTION	NUMBER
Ensuring people have the right information	Health literacy	8
	Signposting to other services and supports e.g. to GP	6
Helping people with immediate needs	Support to fill out forms/receive shielding letter e.g. vulnerable form, council food form	5
	Ordering medication	1
	Receive home-pack	19
Emotional and psychosocial support	Emotional support and listening ear	24
	Call backs to ensure people are safe and well (or taking number to call if needed)	23
	Empowering people to connect to their existing strengths e.g. encouraging people to paint for the practice	2
	Tasks offered to people to help them keep busy	6
Referral	To BBB services e.g. Talking Therapies	1
	To Council support e.g. money/housing advice, council grant scheme	3
	To other community supports e.g. foodbanks/GoodSam/mutual aid	7
	To social prescribing	2

No Intervention needed i.e. people are okay and coping well = 7

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Interventions

In order to respond effectively to the needs of the community, the team at the Bromley by Bow Health Partnership have made a number of interventions that include, but are not limited to, the following:

- Acting as a sounding board for a patient i.e. patients reporting that “they wanted to offload from someone from the outside”
- Helping patients with immediate needs i.e. topping up mobile phone credit, helping to top up electric key
- Signposting to community services e.g. GoodSam for shopping/medicine supplies, mutual aid groups
- Befriending services
- Signposting to charity services e.g. MIND, Samaritans, Silverline for further support
- Referring to BBBC services e.g. exercise classes, mental health sessions, photography classes
- Filling out extremely vulnerable government online form
- Referrals to social prescribing
- Referral to advice services / legal team for housing support, support with money issues and career guidance

It is also important to note how thankful the community have been for these calls – there has been a high number of callback requests to check in with patients weekly/fortnightly, and patients have been very grateful – one patient commented that if it hadn’t been for the call our team made she was “worried that she would be forgotten about altogether”.

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Reactions and actions to these interventions

Reactions & Actions

Most calls have focused on a person's need or strength. As a result, the majority of comments in the data give an indication of the person's context rather than their reaction to the call itself.

Reactions to the call	Frequency	Stretch Outcomes for BBB
Request for call back	22	Connected to others
Very positive/grateful	3	Strengthened personal resources
Ambiguous response to call, e.g. patient put phone down during the call.	5	
Total number of reactions in data	30	

Actions that people have taken after the call	Frequency	Stretch Outcomes for BBB
Action: Request for more info and resources	11	Built knowledge, skills and opportunity
Action: Attending new community groups	3	Connected to place and community
Action: Problem resolved	1	Basic need met
Total number of actions in data	15	

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Needs over time

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Different needs and strengths in a series of call backs

- Each call can raise different needs and different strengths.
- Some people start out feeling well and face challenges in subsequent calls.
- Others start with a series of challenges which are quickly resolved.
- And other people have a new challenge at each call.

- **The ‘call-backs’ seem to be responding well to the whatever is presented, whether that is a person’s strengths or their need.**
- **Clear efforts to build on the strengths week on week and ensure urgent need is met.**

Patient journey: Example 1

Patient 3 (Four calls in total)

For this patient, the journey of these four calls shows a mostly positive progression. After determining that basic needs we being met, the caller made additional calls that focused more on mental health and supporting the patient with the ups and downs of the lockdown experience. Feeling isolated eventually leads to being able to have a socially distanced gathering.

Patient journey: Example 2

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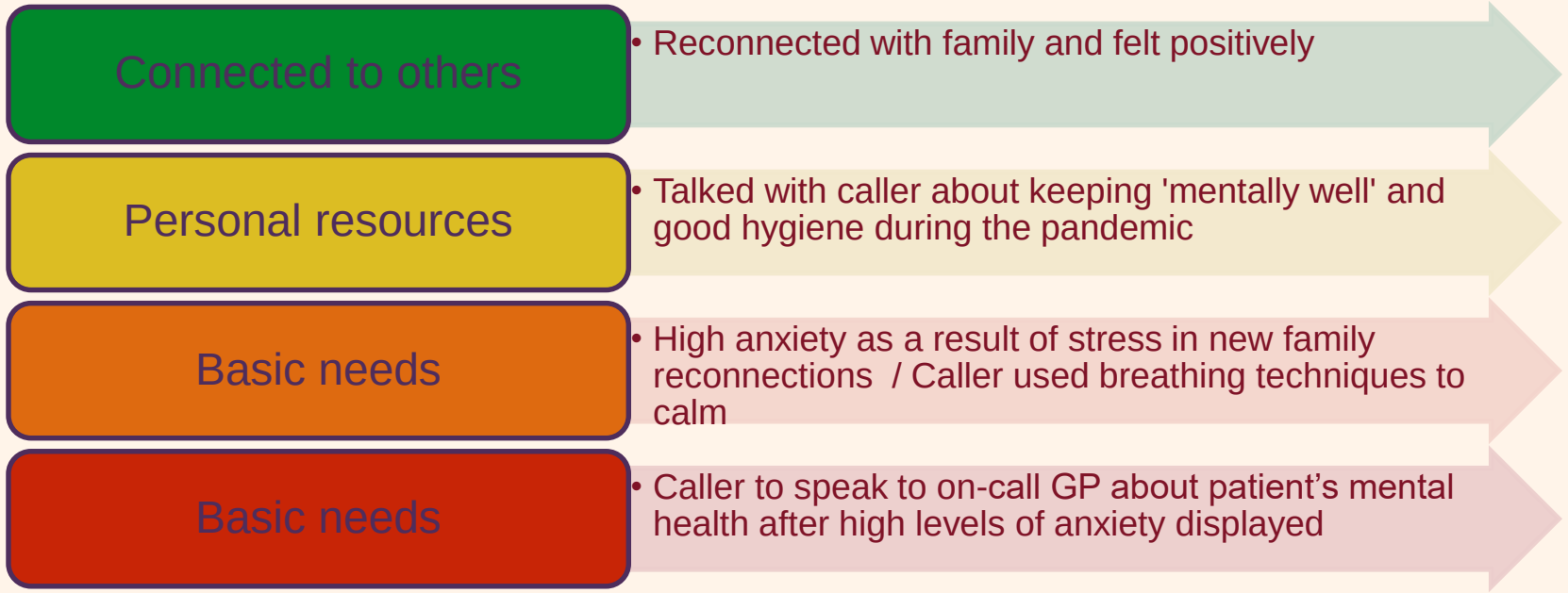
Patient 10 (Four calls in total)



For this patient, the journey of these four calls shows a positive starting point and optimism after being reconnected with family. After some grounding conversations with the caller to talk about coping strategies, the conversation in the later calls take downward turn. High levels of anxiety is expressed and the caller links into a GP for more immediate clinical support.

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Methodology

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Methodology

1. **Learnt the BBB Outcomes Framework:** Read resources produced by the Unleashing Healthy Communities project to *understand* each of the six core 'stretch outcomes' in order to *apply* that framework to the Crisis Social Prescribing data.
2. **Operationalised Outcomes Framework:** Developed codes and sub-codes for each outcome and applied these to the 'needs/strengths' data that was being captured from each call.
3. **Build analysis into service spreadsheet:** Worked with the existing spreadsheet used by the staff team to capture their calls. Added in columns to code, and sub-code, each comment that staff make about their calls.
4. **Developed weekly routine to analysis data and support team learning:** Worked with the team's workflow to ensure that learning was shared on Monday with plenty of time for the team to read and digest the information by Thursday's team meeting. Concentrated analysis on Fridays and Mondays to harmonise with team workflow.
5. **Reflected on learning and captured challenges:** Captured challenges with coding throughout process. Worked with colleagues to reflect on methodology. Documented process so other services can follow methodology and apply outcomes framework.

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Workflow of researcher

1. **Quantify number of calls and demographic details:** Analysis of calls per week in terms of number, age and demographics of person who was called.
2. **Initial coding:** Read comments section of ‘calls’ spreadsheet and code each call according to the six core strengths/needs in the BBB Outcomes Framework, e.g. basic needs, personal resources, etc.
3. **Sub-analysis of each code:** Conduct a sub-analysis of each of the six core strengths/needs to understand the deeper issue, e.g. basic needs may refer to food, an urgent mental health issue, etc**.**
4. **Referral analysis:** Analysis of organisations/groups/services that Callers have referred people onto.
5. **Produce report:** Refine and condense information into a slidedeck. Pull out a key story for the staff team each week to highlight themes and efforts made by staff.

Total time commitment: Approximately 2.5 days/week

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Challenges and learning

1. **What is the difference between 'personal resources' and 'built knowledge, skills and opportunity'?**
    - Decision that the coding of 'personal resources' refers more to a person's internal resources such as mood, memory, resilience and drive. The code for' built knowledge, skills and opportunity' refers more to external acquisition of knowledge and information, skills and opportunities.
2. **What is the difference between 'connect to others' and 'connected to place and community'?**
    - Decision that coding of 'connected to others' refers to connection to services and supports, family members and friends. In contrast, 'connected to place and and community' refers more to being connected to neighbours, gardens, local green space, and other local assets such as cafes.
    - Some ambiguity about where family fits – connected to others and connected to community both work. Likewise, Mutual Aid Groups could fit in both codes.

3. Limited outcome data

- Calls focused on people's context, the strengths and their needs. The BBB Outcomes Frmk was used to categorize these strengths and needs. But at present, there is a limited amount of outcomes data to analyse with the framework as the intervention is too new to have had a lasting effect.

4. Strength and need captured simultaneously

- Comments from social prescribers focus on positive and negative elements of a person's life – their struggle and their strength. Data analysis mirrored this focus and coded positive and negative comments according to the six outcomes of the framework. As such, there is no current sub-analysis of needs vs strengths.

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Appendix

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Basic needs - Examples

Access to food	Patients in need of shopping supplies Patients worried about shopping Patient unable to do her shopping and worried about passing Covid to family Patients with difficulties getting online delivery slots Worries about food - patients that have no food / hot meals Low income -> no food Issues with food supplies, gone days without eating Patient wants supporting letter for friend to go shopping
Health (Other)	Patients reporting weight concerns (putting on weight/being underweight Patients reporting difficulties sleeping ne patient stopped taking one of her regular medication as believes this will reduce immune function and is in fear of catching Covid Patients reporting recovering from spinal surgery/brain injury/collapsed lung Reporting urine infection Reporting pain due to multiple hospital appointments cancelled Sleep apnea (one patient) Kidney transplant (one patient)
Access to medication supplies	Patient wanted help with requesting/re-ordering/picking up medication
Home/Environment	Patients who are scared to leave the house - haven't left in weeks People feeling restricted whilst being at home Patients who have been made homeless and currently living in temporary accommodation Patients who have been made homeless and seeking support with housing applications Patients as victims of domestic abuse Patients living in crowded housing Patients having family issues and wanting to move out
Financial Health	Patients lack money for food supplies, anxiety around paying bills One patient victim of financial abuse Work environment - patient unable to stop working - no gloves or PPE provided Patients off work due to Covid symptoms/wanting to go back to work after having symptoms Patients having trouble with phone credit/energy key top-up Concerns around whether it is safe to return to work when living with sheltering family member Anxiety around not paying bills on time/whether benefits are enough to cover bills
Health (LTCs)	Patients managing LTCS e.g. chronic pain, COPD, cancer patients, diabetes, ashthma, arthritis
Health (Covid)	Patients recovering from Covid symptoms e.g. pneuomina, cough

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Connected to Others - Examples

Developing new relationships with BBBHP	Patients wanting to offload / speak to someone from the 'outside' / wants a check-in call
Feeling isolated	Patients lviing alone who feel isolated and lonely Lack of family visits (as they are unable to) causing low mood Lack of support network - rarely sees family members and has no trustworthy friends Patients feeling socially isolated
Strengthening existing relationships	Patient worried about keeping in touch with friends/family online Patients caring for sick neighbours / family members Parents who are enjoying spending lots more time with children Carers: reports of carers reducing visits since lockdown, one person wanted his carer to move in with him and employ directly
Family relationships	Patients wanting help to keep children occupied Parents concerned about childrens health Parents anxious to take children outside Young mother who recently moved to London is missing family and feels very alone Patient who recently gave birth and was having an extremely difficult time Parents with autistic children struggling to cope/keep them entertained Husband struggling to cope after wife released from hospital
Bereavement	Patients wanting bereavement support from practice Multiple patients reported feeling low due to family member death – one reported having some support from previous support worker but other support unclear

Built knowledge, skills and opportunity - Examples

Accessing guidance/information	People needed clarity to understand/access information on what to do if contract Coronavirus/show symptoms Clarity needed on shielding and importance of staying indoors (clarifying difference between self-isolation and shielding)- people going out when should be shielding Patient unsure what to do if contracted Coronovirus/has symptoms People needed help to connect to existing resources e.g. mutual aid whatsapp groups
Learning about new opportunities	Patients needed support in knowing where to go for help/being signposted/connected to services/mutual aid groups to meet needs Requesting homepacks for ideas as to how to keep busy
Learning basic skills	Parents who do not read / write concerned about supporting childrens education
Utilising skills	People are making use of existing skills through cooking/reading/gardening, but need some support with new ideas People are using skills to get creative e.g. making a lampshade

Personal resources - Examples

Patients feeling low/anxious	Patient who cannot stop thinking about Covid and are very anxious Patient suffers with panic attacks / low mood / anxiety around Covid (think they have it/will pass it on/reading the news) Patients feeling low due to not being able to see family Patients reporting suicidal thoughts Patients with past history of depression and being used to not leaving the house
General wellbeing	Patients lacking confidence to leave the house People struggling to pass the time / adapt to routine Patients need support with healthy eating/exercising
Feeling in control	Patients wanting to run errands/go out for walks to establish independence, despite guidelines to stay at home
Patients showing resilience	Patients keeping journals to help cope with anxiety Patients making effort to start exercising / healthy eating / keeping routine to improve mood Patient who sometimes feels anxious when he goes out shopping copes by 'using breathing techniques and putting headphones in' when outside

Connected to place or community - Examples

Connection to outside space	Patients missing the outside Patients are afraid of outside Patients enjoying spending time in parks/gardens
Connection to the wider community	Patients being connected to and making use of community services e.g. Poplar Harca Neighbourhood, Stepney Green Jewish Centre etc. People participating in virtual sessions e.g. AA session, coffee afternoon and quizzes
Feeling known	Strong sense that people feel the practice is thinking of patients and cares about them -> callbacks