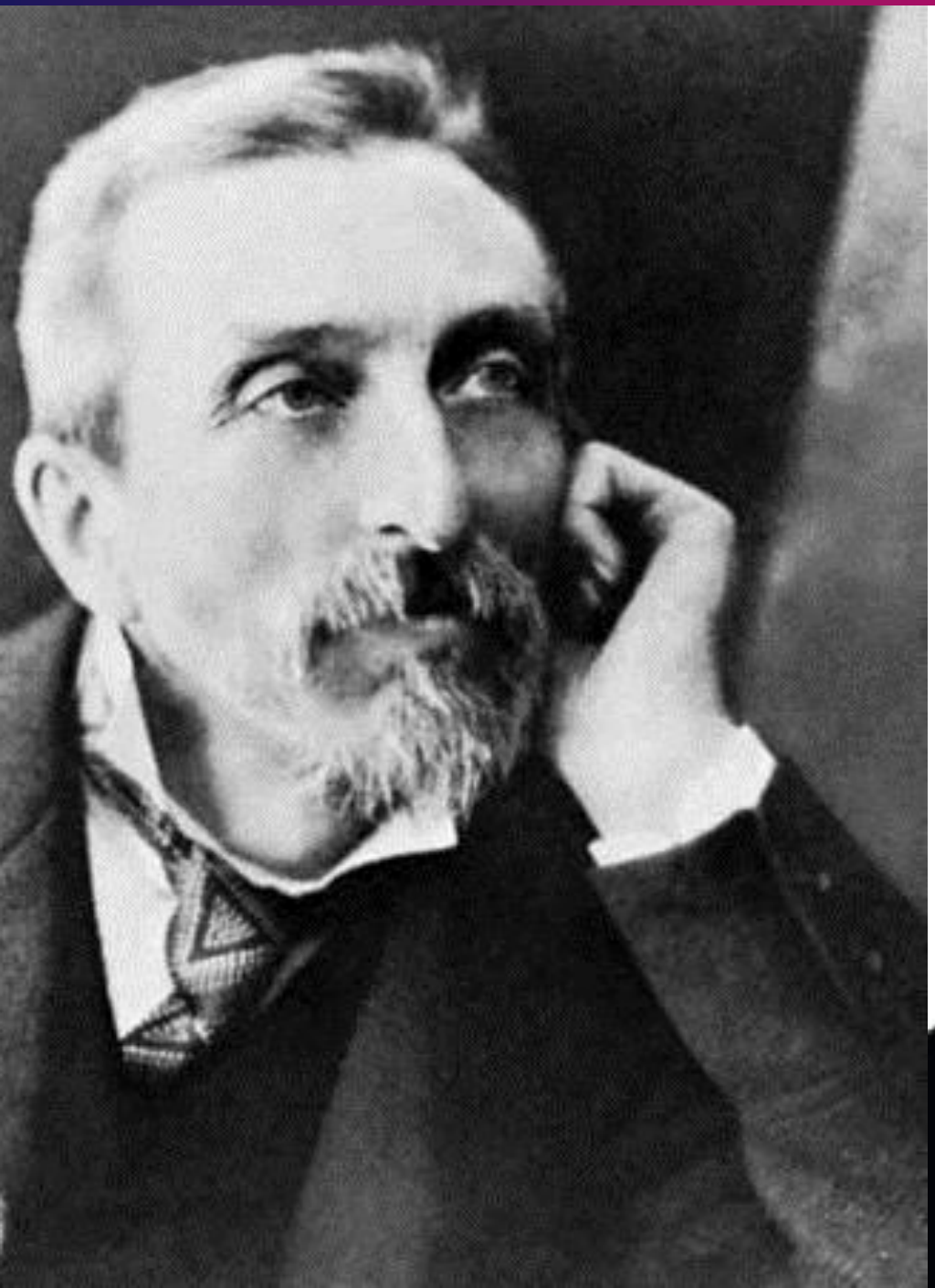
Bromley by Bow Health Partnership

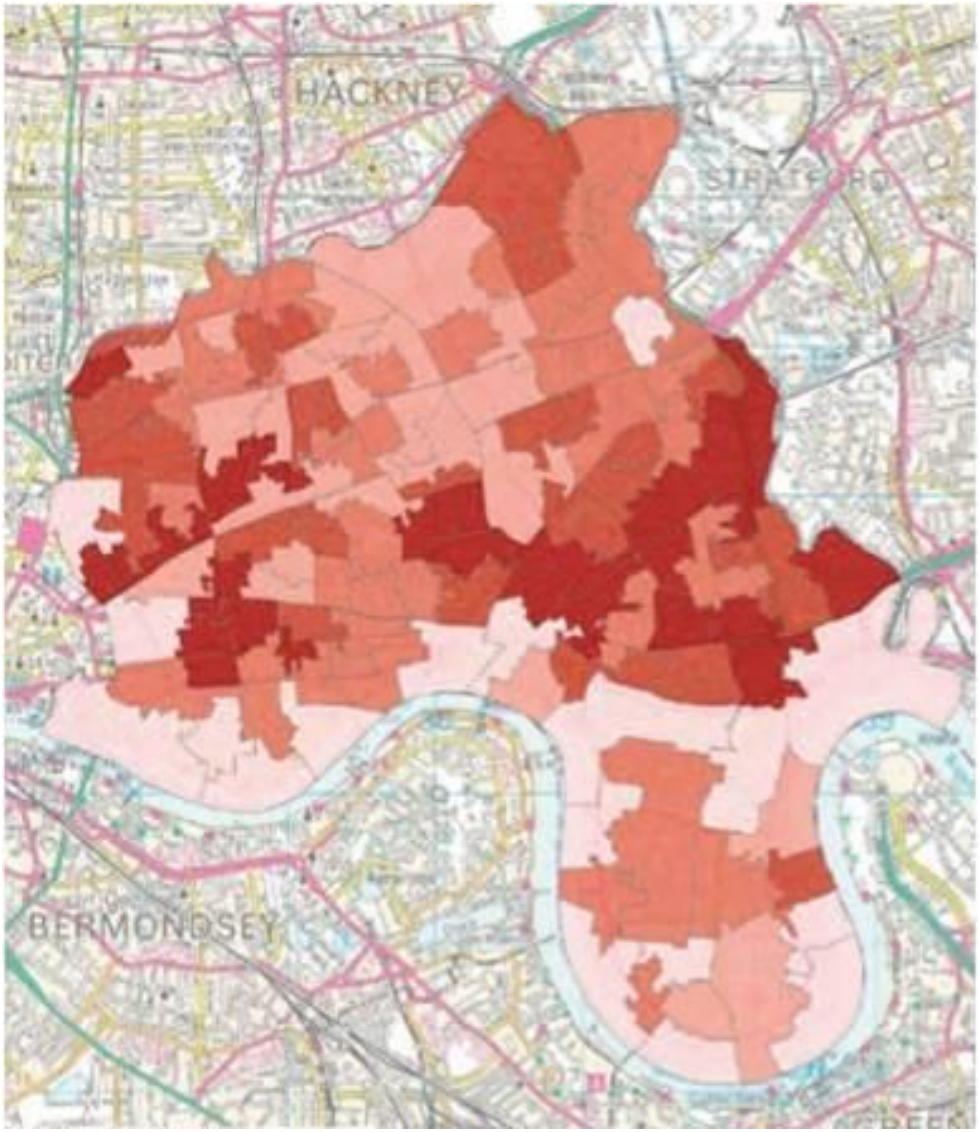
where is Bromley by Bow?


70% of our community are amongst the 20% most deprived in England
Money Shop
Bureau de Change
WESTERN UNION



Charles Booth's poverty map 1898

- Lowest class
- Very poor
- Poor
- Mixed
- Fairly comfortable
- Middle class. Well-to-do
- Upper-middle and Upper classes. Wealthy



Index of Multiple Deprivation 2010

Dimensions of deprivation:

Income deprivation,
employment deprivation,
health deprivation and disability,
education, skills and training deprivation,
barriers to housing and services,
living environment deprivation,
crime.

Today 28% of Londoners live in poverty, with 40% of children living in poverty.

Tower Hamlets is the 7th most deprived local authority area out of 326 local authority districts in England.

16 out of 17 of its wards are amongst the 20% most deprived in the country with 12 wards in the 10% most deprived wards.

almost 50% of children in Tower Hamlets live in poverty.

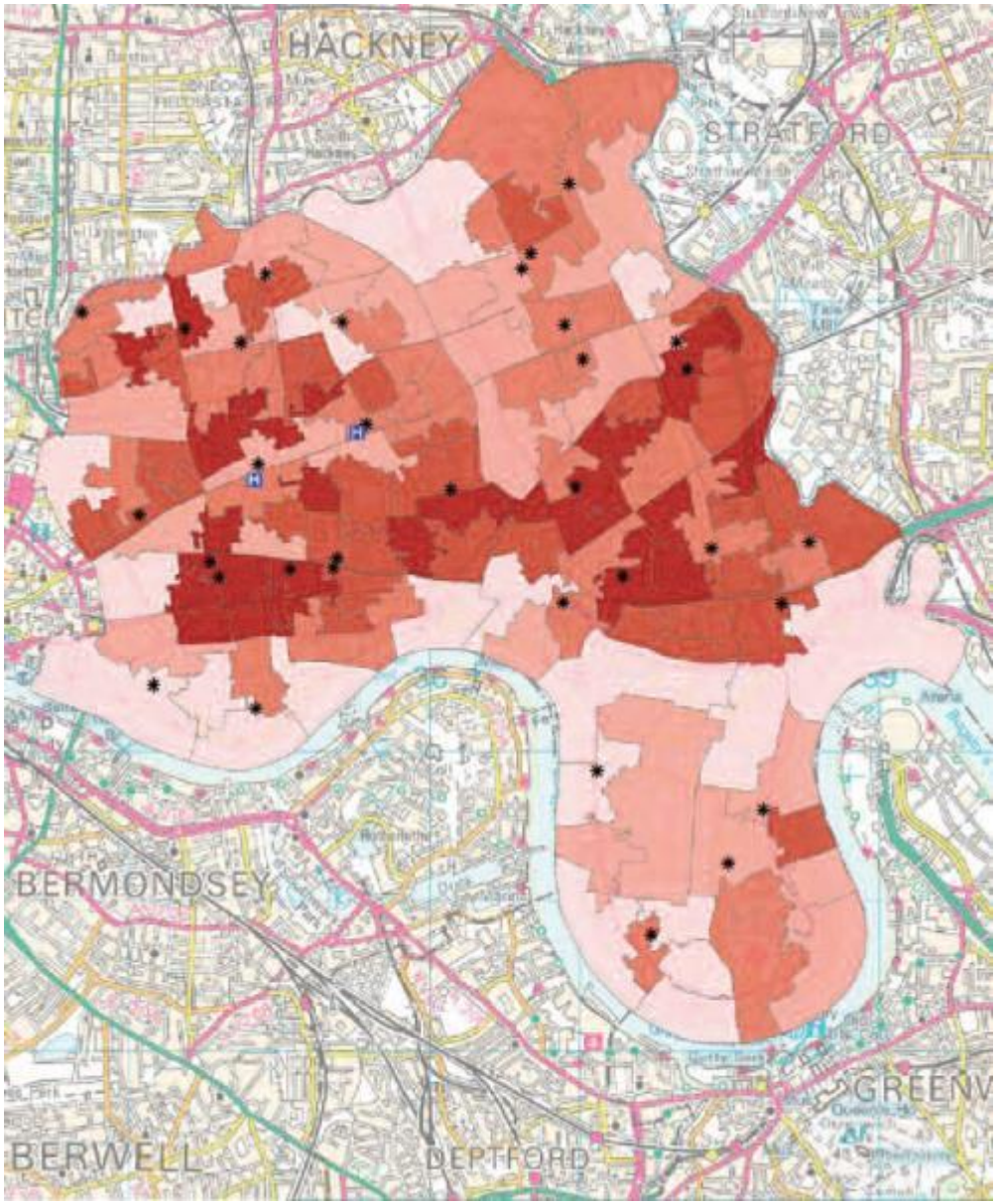
Behaviour: the 4 healthy lifestyle factors in Tower Hamlets

Clustering within individuals, aggregation within communities

For those living in social housing

In Tower Hamlets 40% of residents live in social housing, in Bromley by Bow, almost 60%.

- Chance of being a current smoker is 1½ times higher
- Chance of having a BMI of 30+ is 1.4 times higher
- Chance of being physically active 3 times a week is 20% lower
- Chance of drinking 2+ units a day is 40% higher



The *effects* of the social determinants of health…..on health

Map shows high risk of diabetes, 15-17% (darker shaded areas)

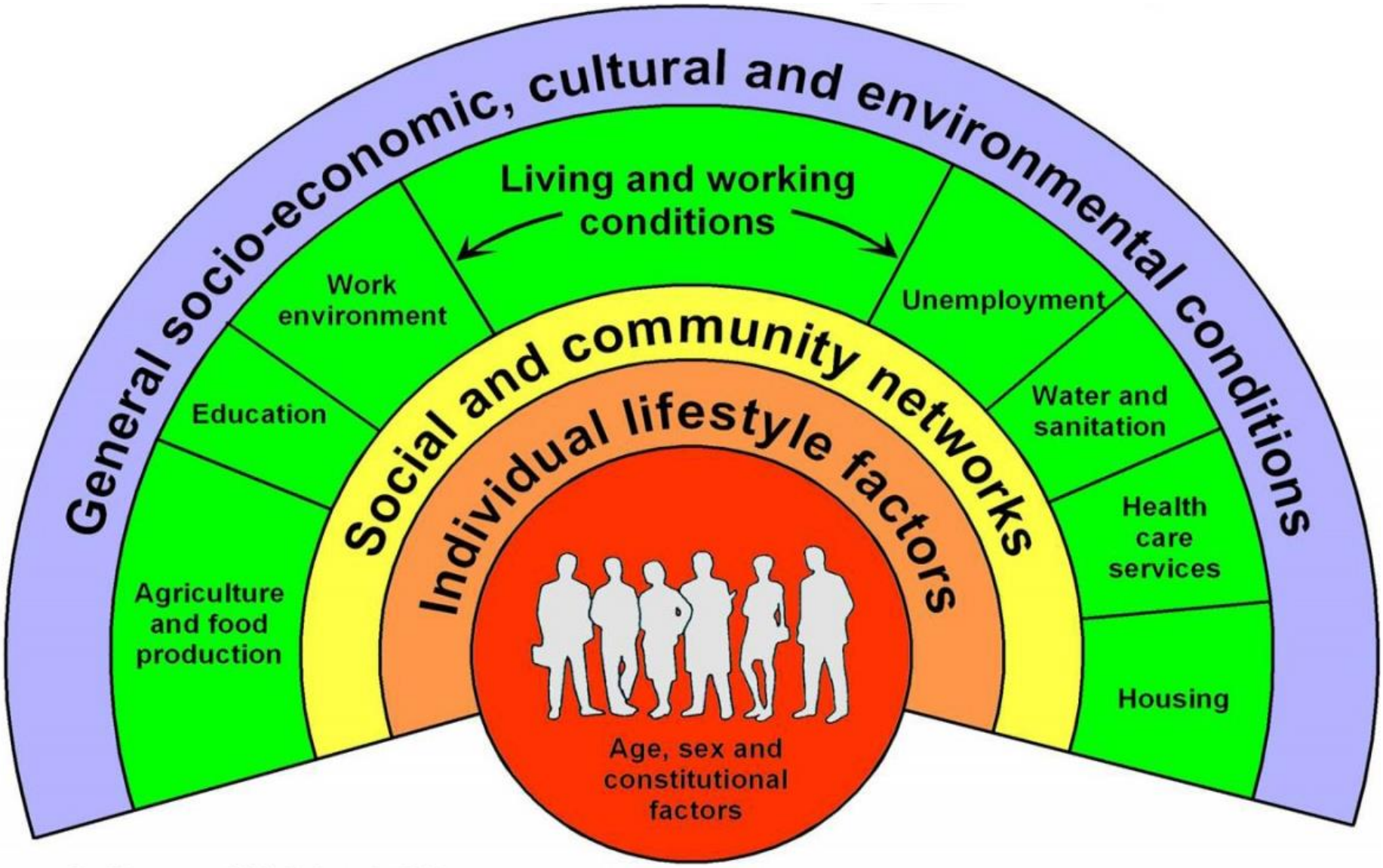
2nd highest rates of premature death in the UK from circulatory disease, cancer and respiratory disease (conditions which constitute 75% of all premature deaths)

10% of adults diagnosed with depression (4th highest in London), 7th highest level of mental health hospital admissions in London

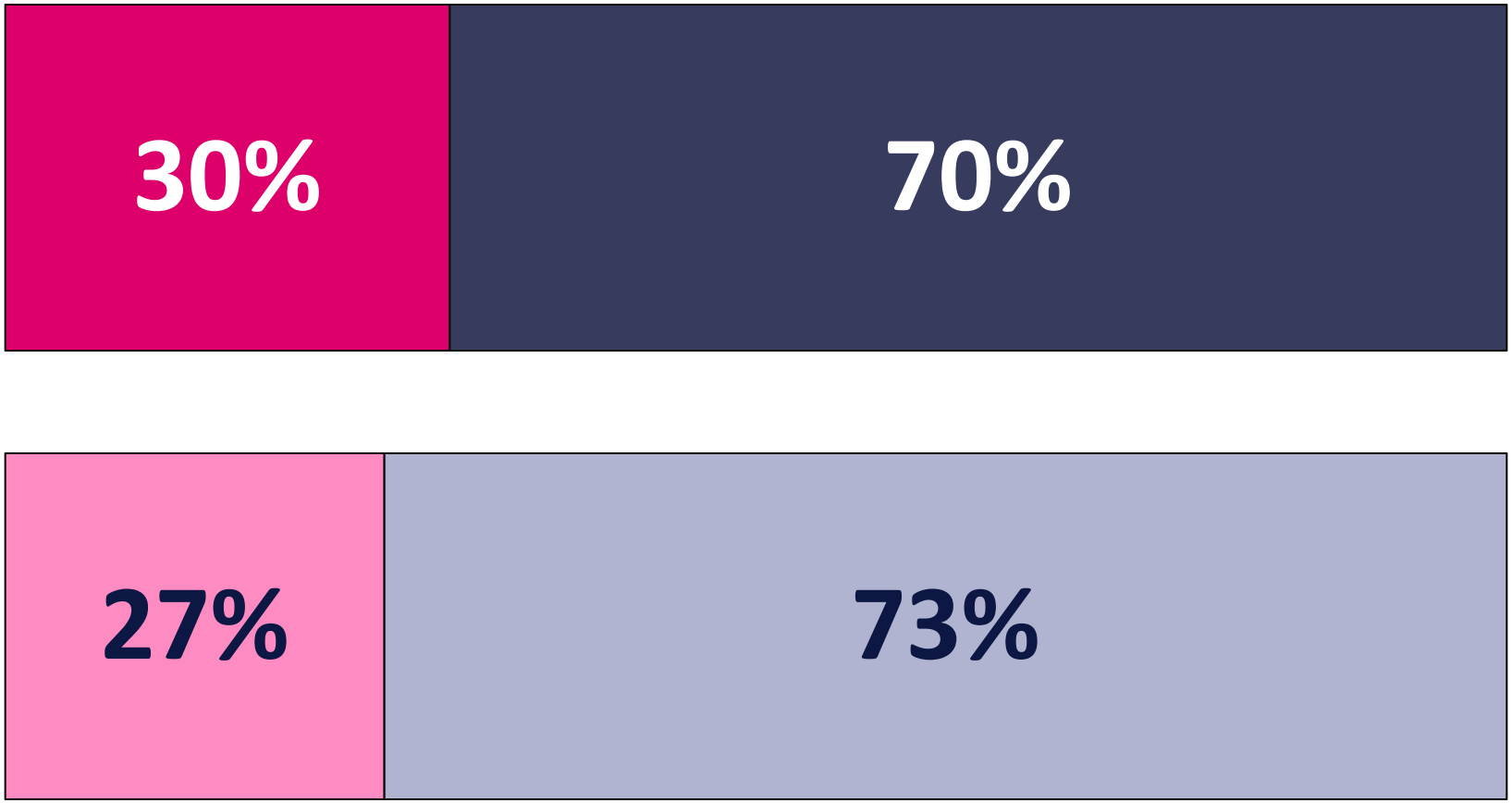
13% of children in reception year are obese (6th highest UK), 25% of 10-11 year olds are obese (9th highest UK)

1 year survival rate for cancer amongst the lowest 10% in the UK

the wider determinants of health, including behaviour, have a greater influence on health outcomes than genetics and healthcare combined



Source: Dahlgren and Whitehead, 1991

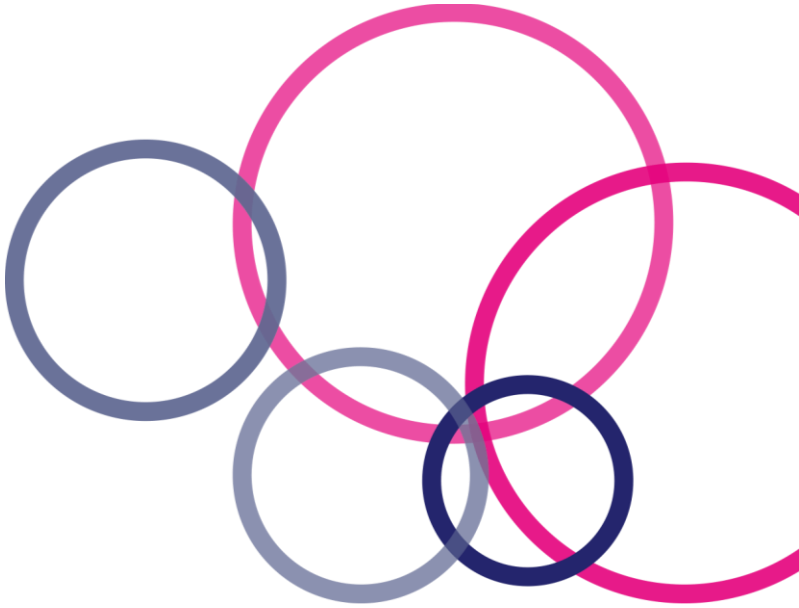

30%
70%
27%
73%

Policy Objectives: The Social Determinants of Health

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
C. Create fair employment and good work for all
D. Ensure a healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill-health prevention

bromley by bow centre

social prescribing service



What is Social Prescribing?

Social prescribing

- a means of enabling health care professionals to refer patients with social, emotional or practical needs to a range of local, non-clinical services in the wider community

For health care professionals

- a single point referral route for all non-clinical services
- a ‘social triage’ service based on a comprehensive and holistic co-produced assessment of need

For patients

- signposting and referral to services that can help
- professional support to set goals, reflect on motivations and needs
- taking control of important changes for health and wellbeing

Social Prescribing Services

Generalist Social Prescribing

Funded by MEEBBB Network, operating in 6 GP practices since 2013

Macmillan SP

Funded by Macmillan, people living with and beyond cancer, operating in 4 London borough's

Healthy Cities

Funded by Morgan Stanley, supporting parents to increase their skills, knowledge and confidence around managing their children's health, operating in 1 GP practice

Referral into the Service

Who refers?

GP's and other healthcare professionals within the Mile End East Bromley by Bow primary care network

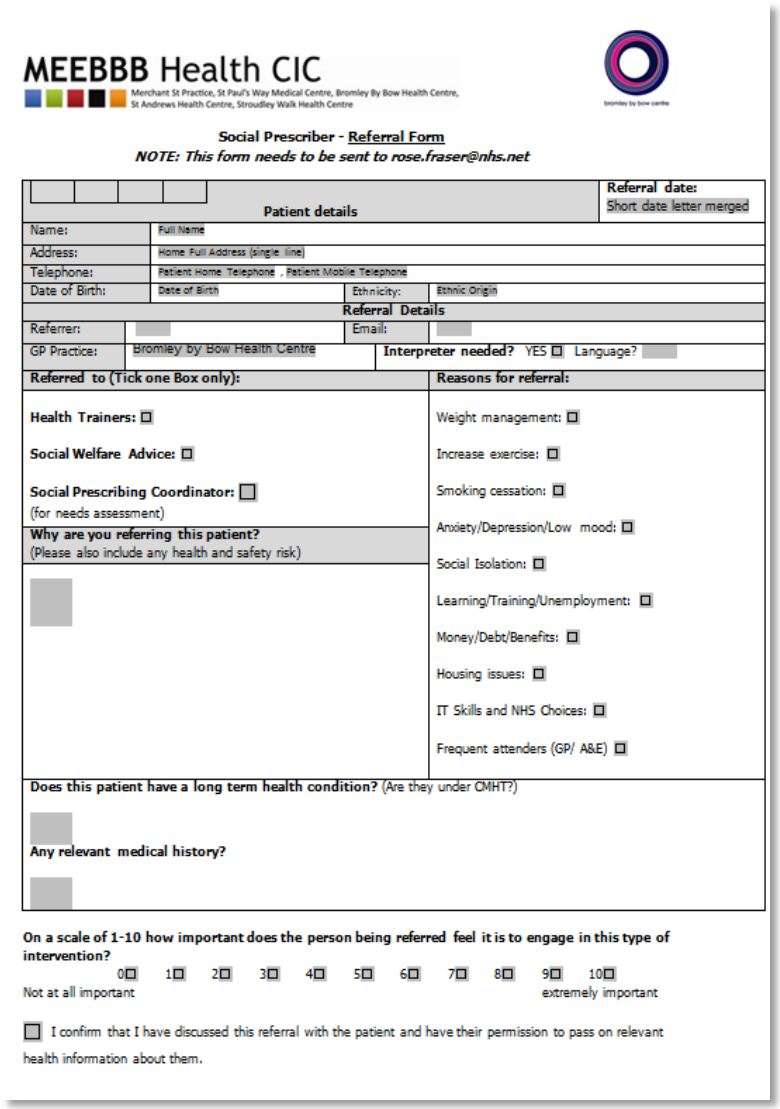
Who can be referred?

Adults 18+ in need of support with issues effecting their physical and/or mental health and wellbeing

How do people refer?

Universal referral form embedded in EMIS and sent to a secure NHS email

Referral into the service



MEEBBB Health CIC

Merchant St Practice, St Paul's Way Medical Centre, Bromley By Bow Health Centre, St Andrews Health Centre, Stroudley Walk Health Centre

Social Prescriber - Referral Form

NOTE: This form needs to be sent to rose.fraser@nhs.net

Patient details			Referral date: Short date letter merged
Name:	Full Name		
Address:	Home Full Address (single line)		
Telephone:	Patient Home Telephone . Patient Mobile Telephone		
Date of Birth:	Date of Birth	Ethnicity:	Ethnic Origin

Referral Details

Referrer:		Email:	
GP Practice:	Bromley by Bow Health Centre	**Interpreter needed?** YES ☐ Language?	

Referred to (Tick one Box only):

Health Trainers: ☐

Social Welfare Advice: ☐

Social Prescribing Coordinator: ☐
(for needs assessment)

Why are you referring this patient?
(Please also include any health and safety risk)

Reasons for referral:

Weight management: ☐

Increase exercise: ☐

Smoking cessation: ☐

Anxiety/Depression/Low mood: ☐

Social Isolation: ☐

Learning/Training/Unemployment: ☐

Money/Debt/Benefits: ☐

Housing issues: ☐

IT Skills and NHS Choices: ☐

Frequent attenders (GP/ A&E) ☐

Does this patient have a long term health condition? (Are they under CMHT?)

Any relevant medical history?

On a scale of 1-10 how important does the person being referred feel it is to engage in this type of intervention?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Not at all important — extremely important

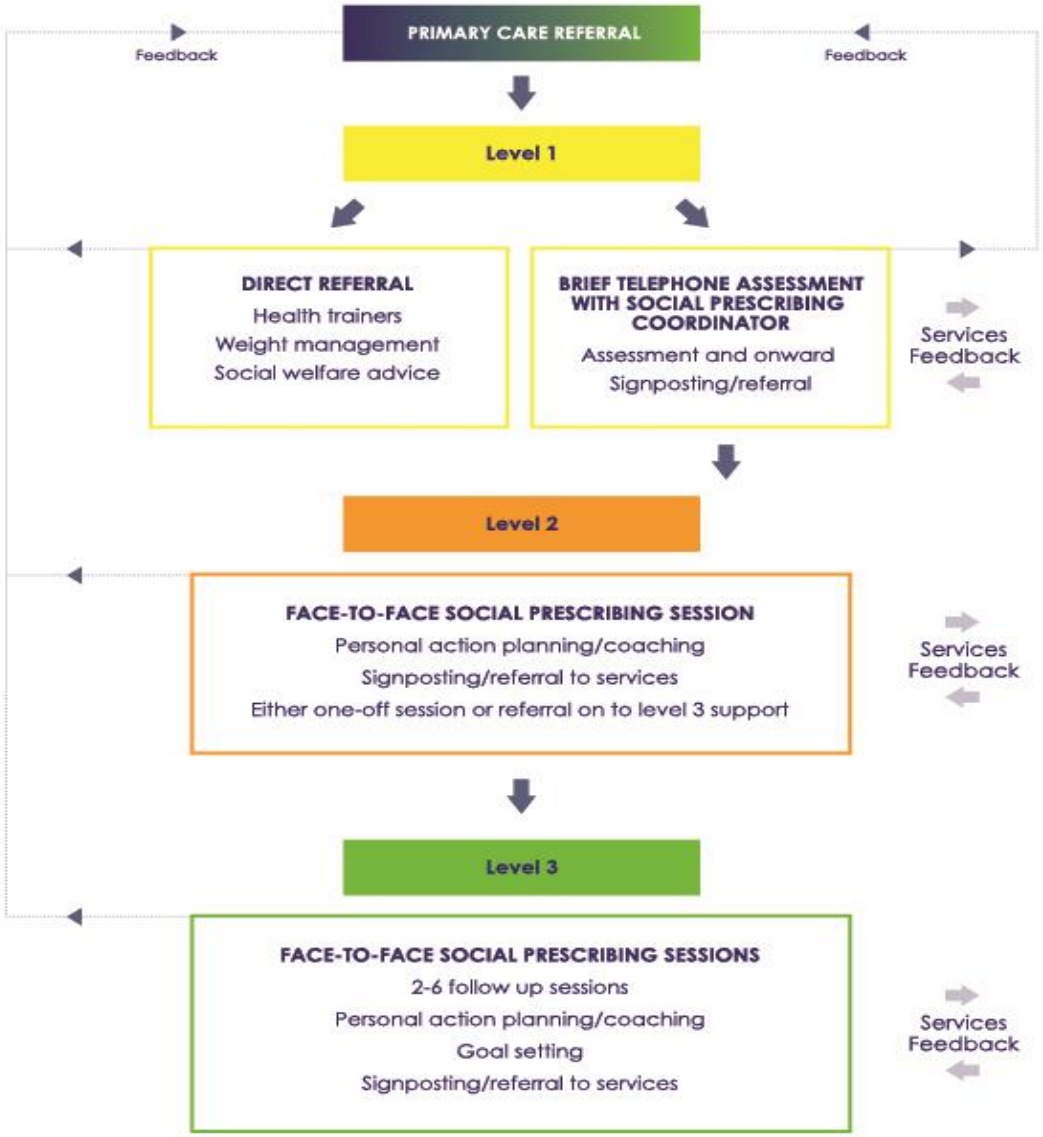
☐ I confirm that I have discussed this referral with the patient and have their permission to pass on relevant health information about them.

Health Trainers
Social Welfare Advice
Social Prescribing Coordinator

Weight management
Increase Exercise
Smoking cessation
Anxiety/low mood/depression
Social isolation
Learning/training/education
Money/debts/benefits
Housing
IT skills
Frequent attenders

SOCIAL PRESCRIBING SERVICE
LEVELS OF INTERVENTION

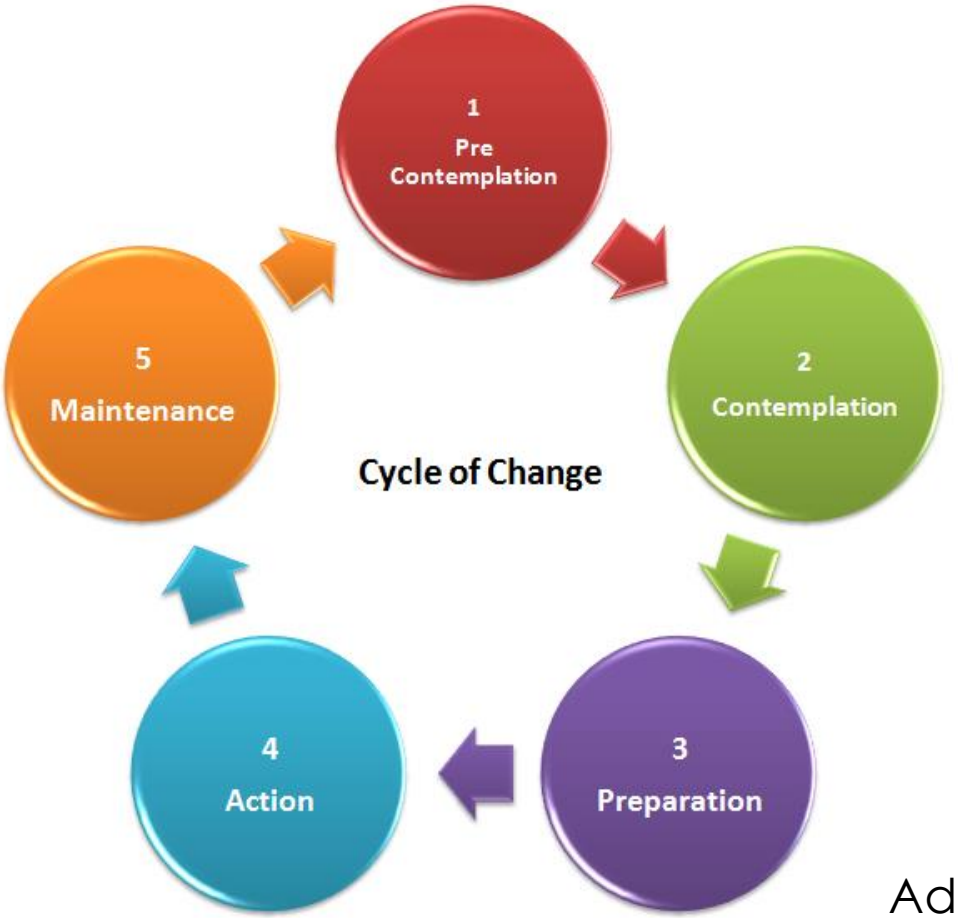
bromley by bow centre
social prescribing service



Level 3 Support
more than a signposting service

- ✓ Time to explore options and think out-loud, motivational interviewing, coaching – GROW model, goal setting as well as signposting/referral
- ✓ Acknowledgment and understanding of psychological barriers e.g. anxiety, lack of confidence and low mood
- ✓ Person centred approach, putting client in the driving seat, changing dynamic from receiving care to making decisions themselves about what is right for their lives, not prescriptive!
- ✓ Time, long term behaviour change takes time, cycle of change

The Cycle of Change



Adapted from Prochaska and DiClemente (1982)

Signposting and Referral

Health, wellbeing and healthy lifestyles
- Health Trainers
- My Weigh/Fit4Life
- Ability Bow

Emotional needs
- Mind
- TH Bereavement Support Group
- Women's Trust Domestic Violence Support
- Asian Women's Lone Parents Association

Community activity and social needs
- Gardening Group
- Art Group
- Digital Inclusion Group
- Massage sessions
- Lunch Clubs
- TH Friends and Neighbours Befriending

Online Resources
- Big White Wall
- MeetUp.Com
- Community Catalogue

Volunteering
- TH Volunteer Centre
- Do.It.Org Volunteering online

Social Welfare, Legal Advice and Money Management
- Social Welfare Advice
- Legal Advice Centre
- Getting on with Money

Adult learning and skills development
- Tower Hamlets College
- City Gateway Women's Project
- Ideastore Libraries
- Active Futures

Employability and employment programmes
- Employment Drop-in
- Capital Talent
- Over 50's Employment Support
- CV Workshop

Service Evaluation

- ✓ Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- ✓ Client feedback questionnaire
- ✓ Case studies – qualitative
- ✓ Annual GP survey

2014-2015 Report

694 patient referrals were processed, managed, and recorded (by one SP coordinator)

The rate of patients attending and utilising services was 41% (against a target of 38%).

95% of health care professionals surveyed reported a benefit to their patients and wish the service to continue.

Referrals were made to nearly 40 different community services and organisations.

Male British 55

Referred by GP for help to overcome social isolation

He has bipolar affective disorder and Type 2 diabetes. He has recently moved to a new area and he spends all his time at home

"I feel part of something now. I feel better for several days after the group, it really helps"

5 x sessions with coordinator discussing low mood and feelings of loneliness, space to reflect on what he thought might make him feel better, he identified wanting to feel part of something and to have to get up and be somewhere to do something that mattered.

AS A RESULT OF INTERVENTION

- Attends weekly Gardening group
- Attended Arts on Prescription Programme
- Increased social network
- Routine and structure

Female Spanish aged 51

Referred by GP for help with increasing exercise, anxiety/ low mood and social isolation

"Someone listened to me, I feel I can make changes, I *can* feel better"

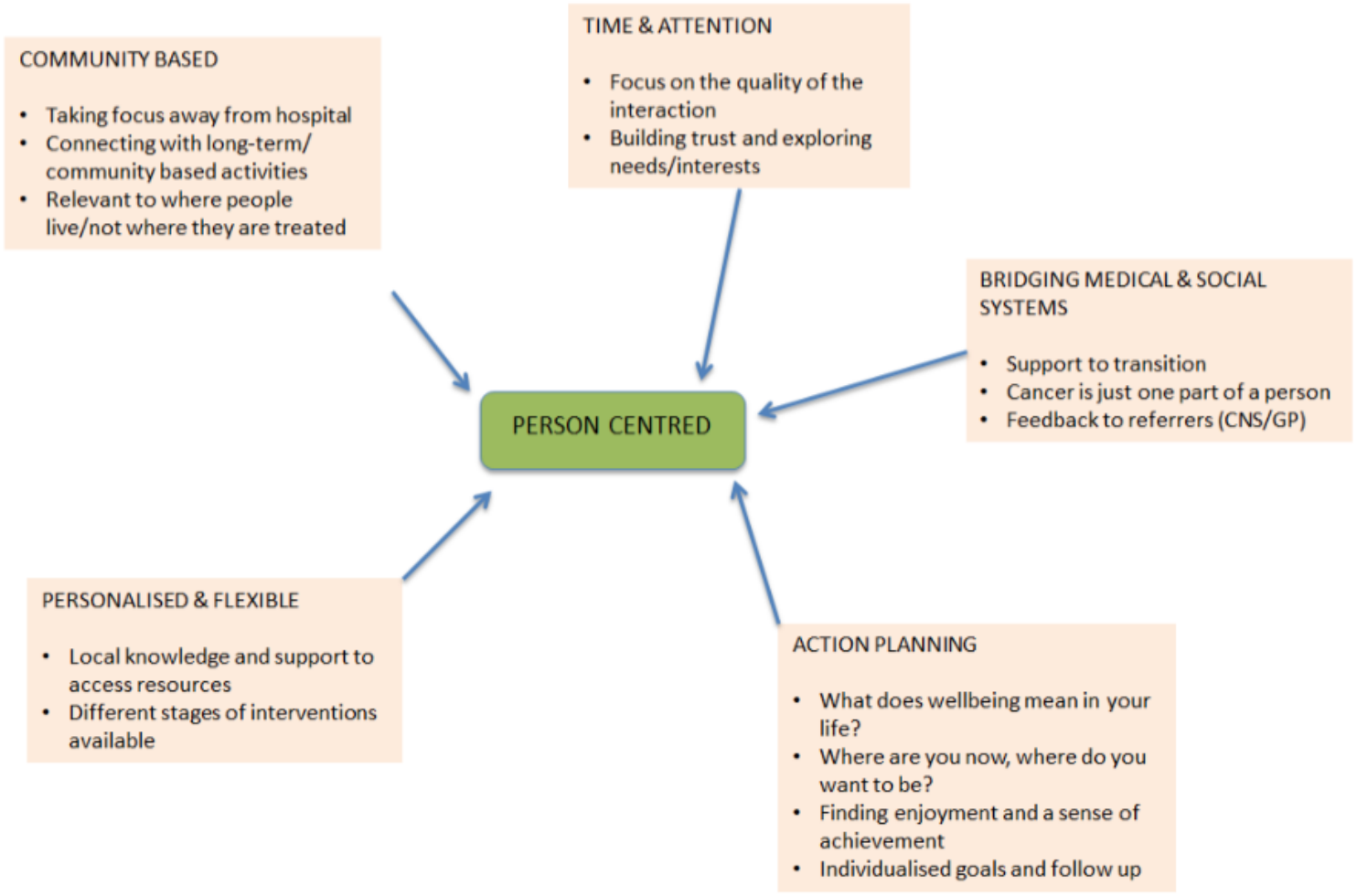
She suffers with PTSD, depression and anxiety and is currently under the CMHT. She also has ongoing back pain and feels low as feels can tell people what she needs.

2 x sessions with coordinator and interpreter where she discussed the barriers she experienced when trying to communicate both socially and with health professionals. She also spoke about her physical health saying she wanted to be more active, to start to feel better about herself again.

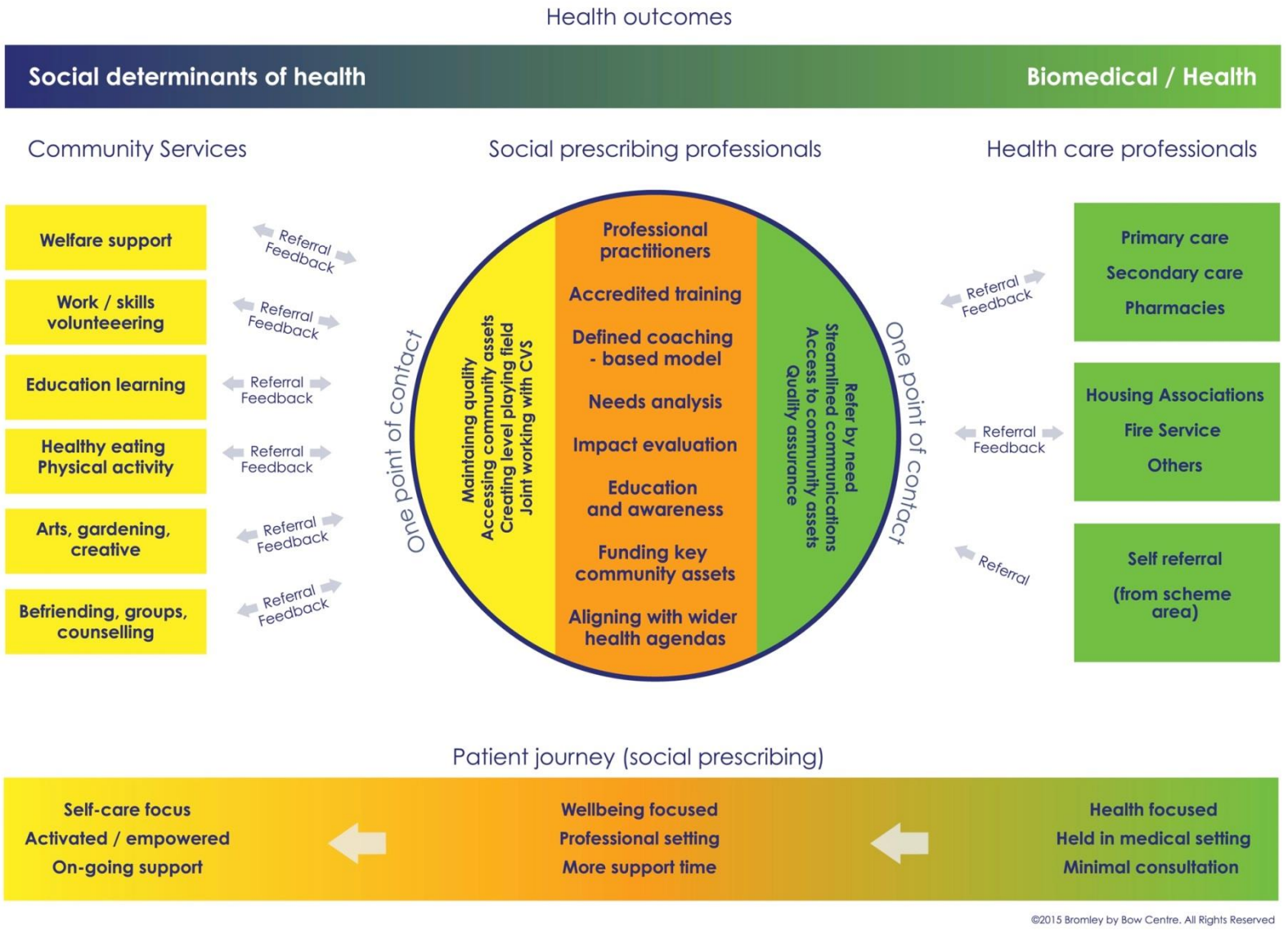
AS A RESULT OF INTERVENTION

- Started ESOL Classes
- Health Trainer Walking group
- Increased social network

Core values


COMMUNITY BASED
• Taking focus away from hospital
• Connecting with long-term/ community based activities
• Relevant to where people live/not where they are treated
TIME & ATTENTION
• Focus on the quality of the interaction
• Building trust and exploring needs/interests
BRIDGING MEDICAL & SOCIAL SYSTEMS
• Support to transition
• Cancer is just one part of a person
• Feedback to referrers (CNS/GP)
PERSON CENTRED
PERSONALISED & FLEXIBLE
• Local knowledge and support to access resources
• Different stages of interventions available
ACTION PLANNING
• What does wellbeing mean in your life?
• Where are you now, where do you want to be?
• Finding enjoyment and a sense of achievement
• Individualised goals and follow up

The Future - social prescribing vision



Other initiatives

- Eczema project
- Health promotion
- Technology support
- DIY Health

Eczema project

Dr Rosie reads reads about ‘Itchysauras’ the dinosaur with eczema.

The children have a go at bathing dinosaurs in emollients and create a poster of what makes them feel better when they are itchy.

Health promotion days – lots of fun and learning too!

Children's day- 50+ attendees and many parents signing up to health trainers

Women's day- promoting screening and more

Mental health awareness day- 60+ attendees. Joint event with MIND, BBBC, CDAT & more

Technology Innovation

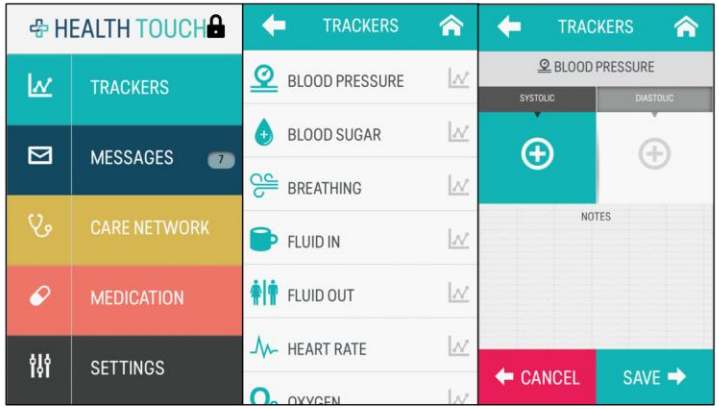
The original pilot was delivered as a poster presentation at the RCGP Conference in Oct 2016

Health Touch App

Do you want to manage your health remotely with the support of your GP?

All you need is an Apple/Android device

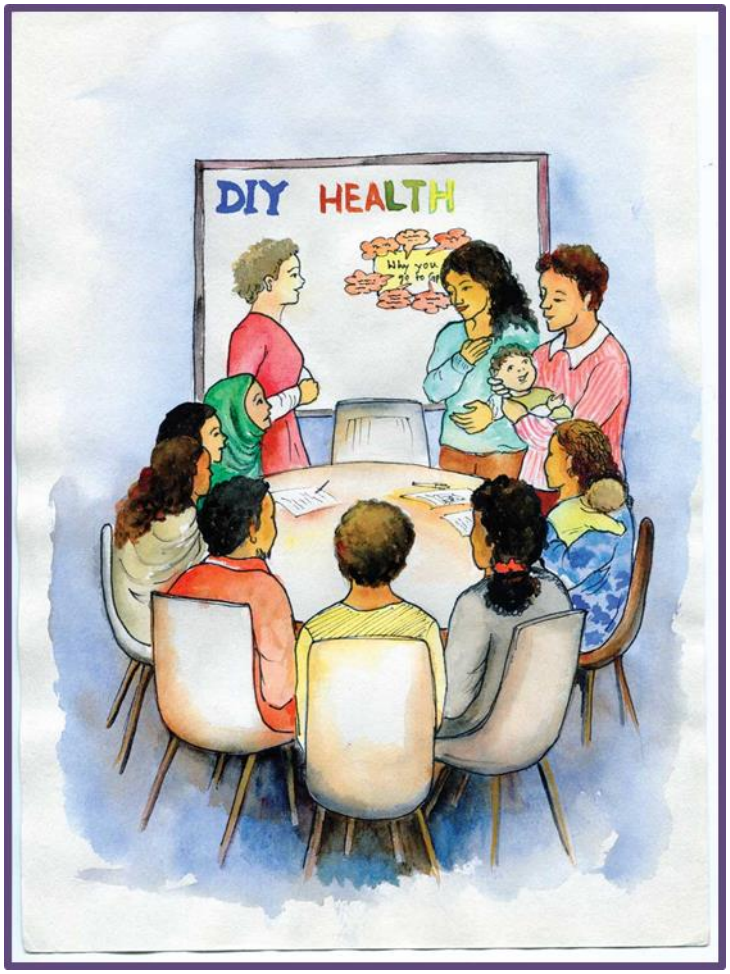
Download Health Touch for free TOADY!!



Allow your Health Care Professional to review your medical data more effectively by using the Health Touch App if you are regularly checking:

- **Blood Pressure**
- **Peak Flow (for asthma)**
- **Blood Sugar Level (for diabetes)**

For further information contact us on 020 89801888 or ask at reception


DIY HEALTH

DIY Health (0-5): Developing and Sharing the Model

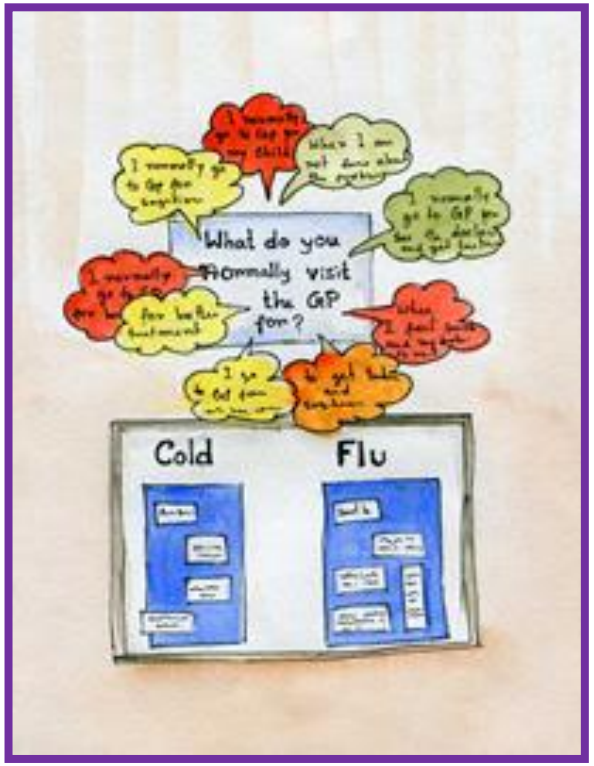
- Funded by HENCEL
- Pilot project in Tower Hamlets
- UCLPartners Children and Young People Program
- Institute of Health Visiting Advisory Group
- Evaluation by The Anna Freud Centre
- Development of a Training Package

Project Partners

- Local Parents
- Bromley by Bow Health Partnership
- Bromley by Bow Centre
- Mile End and Marner Children's Centres
- UCLPartners

Minor Ailments: The Bigger Picture

- 42% increase in children's emergency hospital admissions for minor ailments
- Parents feel they are expected to contain minor ailments at home
- Anxiety and uncertainty surround management of minor ailments
- Department of Health High Priority Area for Health Visiting



Co – Production

- Using knowledge and lived experiences of people and professionals
- Involving ‘service users’ in the design, delivery and evaluation of services
- Establishing partnerships to build resilience in the community through empowerment and education
- Challenging existing relationships and creating new ones

The Pilot Project

- Bromley by Bow Health Partnership
- Tower Hamlets CCG Innovation Bursary 2013/14
- Public Health Tower Hamlets evaluation bursary
- Outcomes
  - ✓ Confidence
  - ✓ Knowledge
  - ✓ Greater partnerships

The DIY Health (0-5) Model

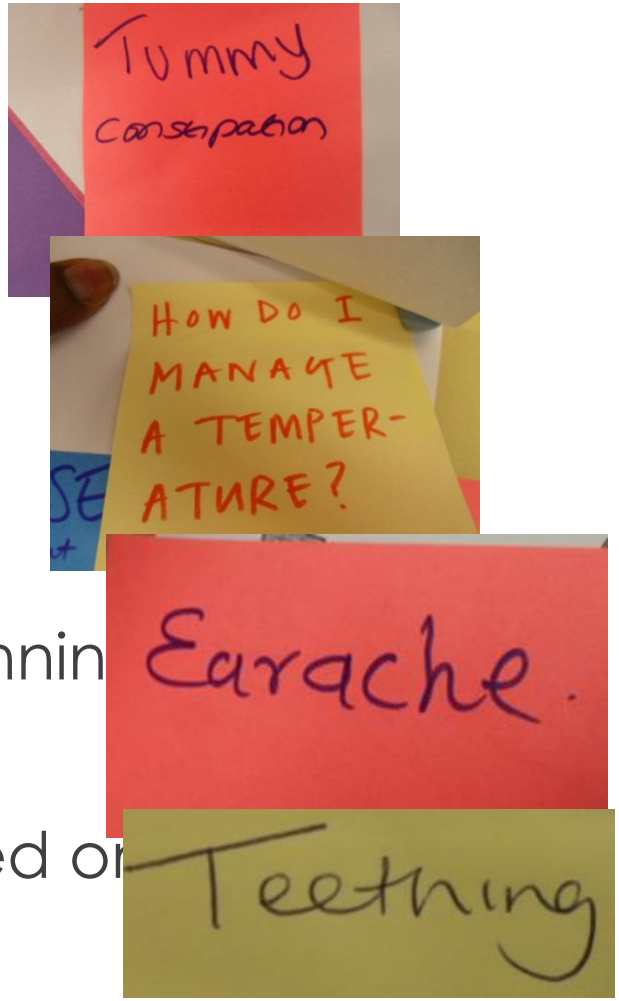
- 12 week educational programme for parents of children under the age of 5
- Co-facilitated by Health Visitors and Adult Learning Specialists
- Co-produced curriculum based on supporting parents to access the right help at the right time for minor ailments
- Drawing on local resources to provide additional support
- Supported by local Children's Centres

The Delivery Team

- Health Visitor
- Adult Learning Specialist
- Children's Centre Play and Learning Workers
- Parents

The Curriculum

- 6 core topics identified locally
  - Cold and flu
  - Diarrhoea and vomiting
  - Fever
  - Feeding
  - Eczema
  - Ear pain
- Priority matching exercise at the beginnin each cohort
- Additional sessions co-produced based o parent identified topics
- Evidence based and community resources



Community Partnerships

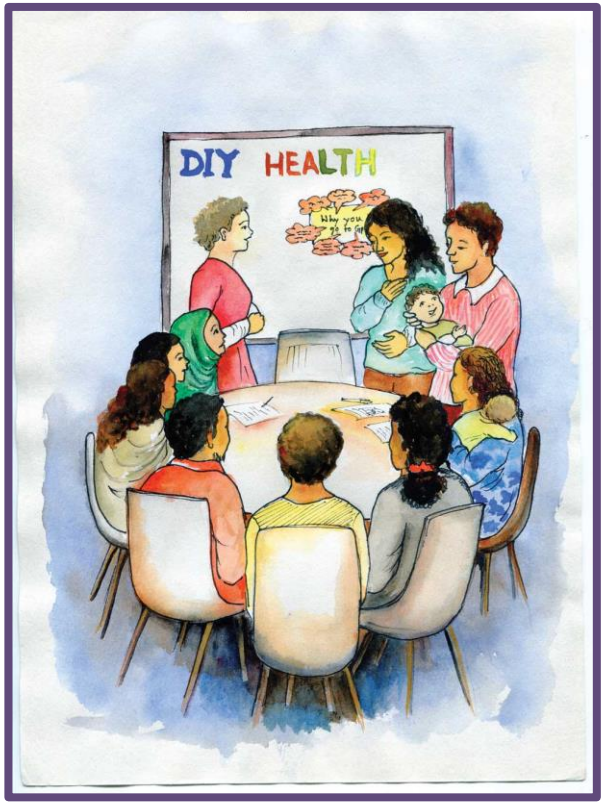
- Local Health Visiting Teams
- London Ambulance
- Greenlight Pharmacy
- Eczema Society
- Tower Hamlets Breast Feeding Buddies

The Training Package

- A flexible model
- Facilitate future delivery of the DIY Health (0-5) model

- **Getting Started**
- **Facilitators Manual**
- **Session Guide**

Available as an Open Source tool via the UCLPartners Website from Summer 2015



Clara's Story

Well: social health

Journeys and learning

Journeys and learning

Journeys and learning

Dr Peter Cawston – Garscadden Medical Centre, Glasgow

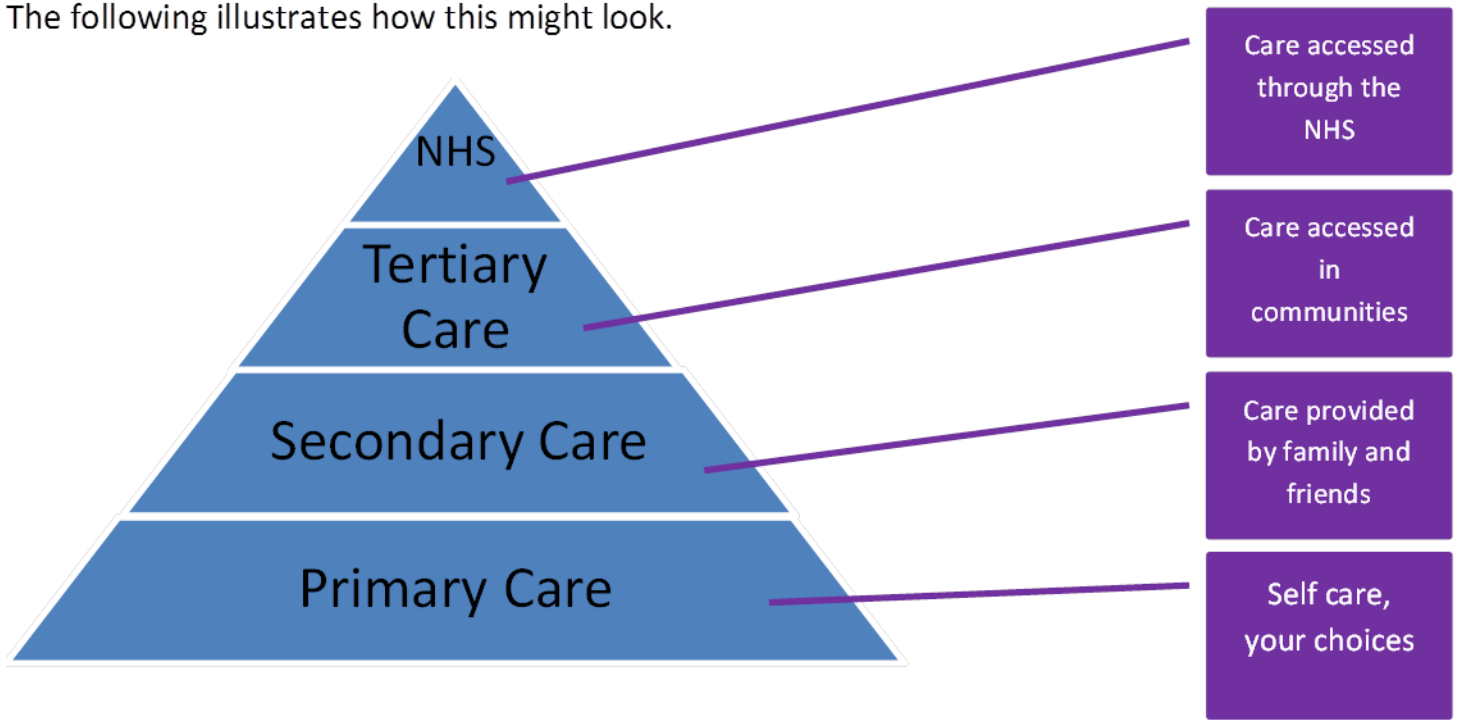
- *"It seems to me the question we were discussing was how a GP Practice can move from being an industrial provider of medical services and prescriptions to becoming an asset within the community that contributes health expertise to the other resources available for people to try and build resilience and hope in the face of socially created adversity."*

Well fundamentals

- Marmot: the 70/30 split
- “patient citizens”
- Co-production
- Behavioural insights
- Relationships and conversations
- “The Well Community”

Fresh thinking about “care”

The following illustrates how this might look.




We'll share...
We'll Share... sessions give people in our community a chance to meet each other and share ideas, stories, skills or materials.
What would you like to see happen in your community?
What would you like to contribute?
Come and say hello to the Well Community team to tell us your thoughts and ideas - we're here to support a happy exchange!
ST ANDREWS
BROMLEY BY BOW
XX PLACE


Spitalfields City
FARM
Mon
Closed
Tue/Wed/Thu
Fri/Sat/Sun
020 7247 8762
spitalfieldscityfarm.org
NO PARKING

Well vision

- At its heart is a new clinical model—a new way of managing the relationship between patients and professionals, a new way to do consultations, a new way to manage the workload, a new way to support patients to manage their own health.

Well vision

- Moving from a service provider model to a model based on identifying, supporting and growing community assets and capabilities. This is an “Air BnB” model – based not on what we provide but on tapping into the resources already in the community and connecting them. This means that we as organisations are on a journey from being primarily providers of services to being primarily in the business of supporting community activity, resilience and connectedness.

Sharing economy – problems and possibilities

Well vision

- Reimagining our clinical offer as one which focuses more fundamentally on health behaviour change
  - So, for example, seeing long term disease management as a behaivour change process

Well vision

- The Well Community is the community facing element of the Well programme, and seeks to redefine relationships, so that solutions to health issues are co-created.

Well vision

- An active alliance of connected organisations delivering, between them, the range of activity associated with the wider determinants of health

around 90% of consultations in the health system happen in primary care and it's the most under-utilised resource in whole of the NHS

we need to stop building health centres because they are principally focused on illness not health

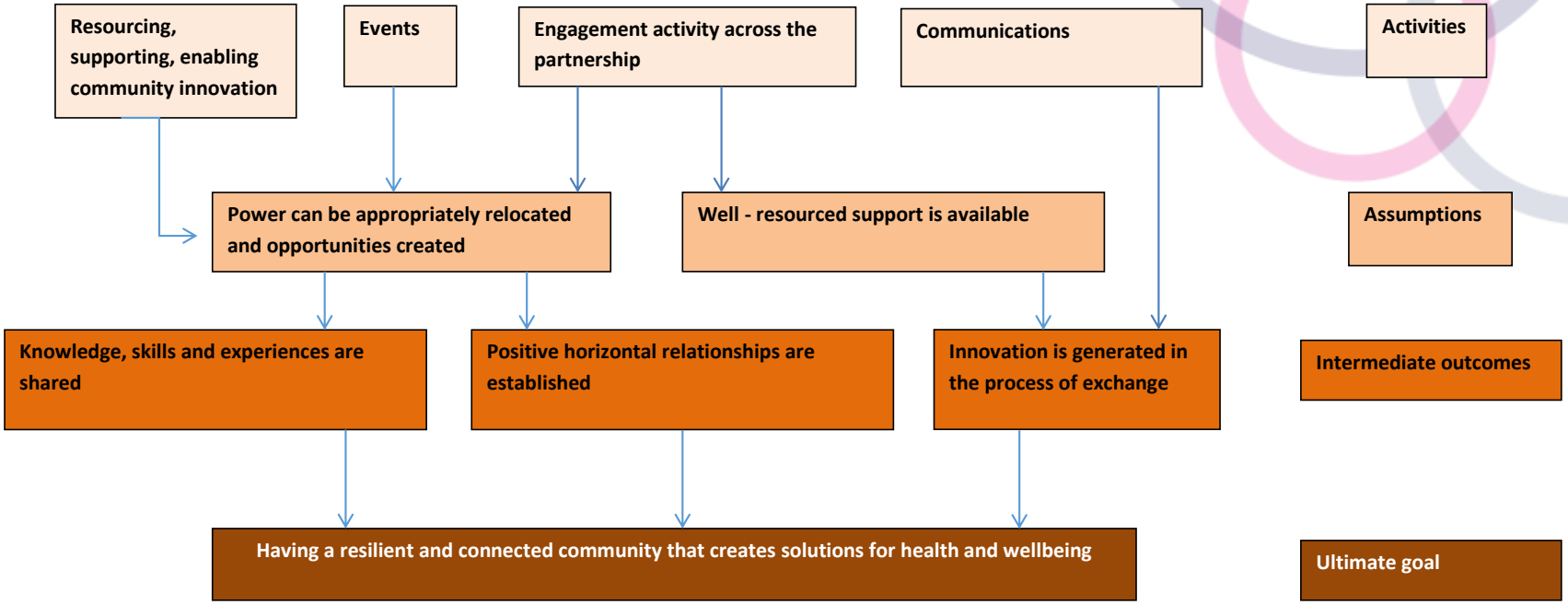
the shape of primary care is pretty much unchanged since 1948…and it needs to change

we seem to continue to believe that our health system should be about responding to biomedical conditions not building healthy communities

despite the fact we know that our health is 70% driven by social determinants…put simply…..

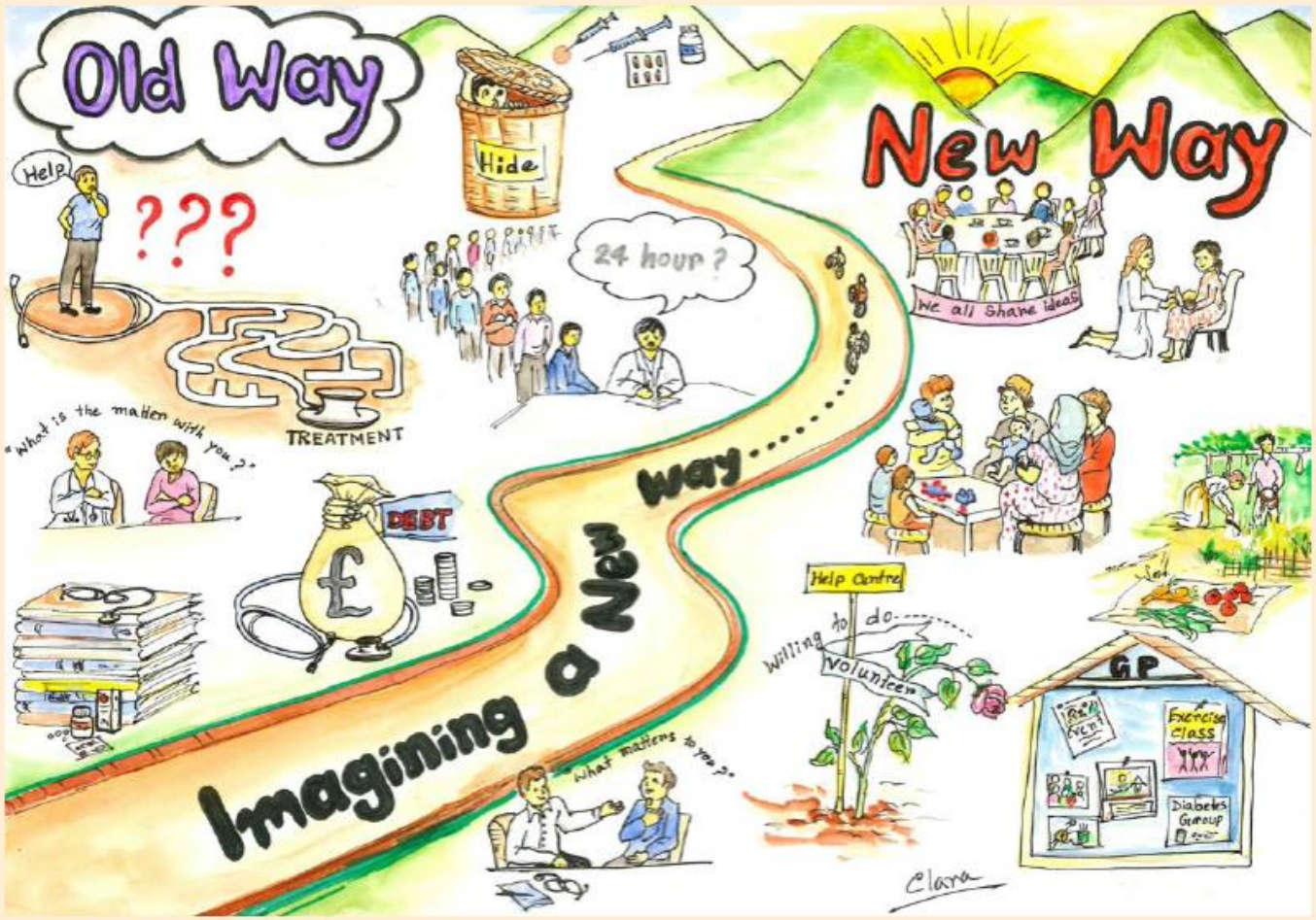
Well: social health

Theory of change



Creating Healthy Communities

Bromley by Bow Health Centre | XX Place Health Centre | St. Andrews Health Centre



About the artist...

'I am Clara, part of the Well Team. Being able to draw or paint is one of my life pleasures. I really value when my art reflects communities through my work. Meaningful pieces of work empower me to walk through a new way in life.'

-Tha Barpi, Health Champion

The Bromley by Bow Health Partnership