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# Mobilising Healthy Communities

**Summary**

In this talk, Ian Jackson outlined the work and philosophy of the Bromley by Bow Partnership, giving examples of its work including social prescribing, the eczema project, a digital app for hypertension self-monitoring and the DIY health group for parents of young children. Ian also described the next part of the partnership's journey as it seeks to continually learn and develop. The Well Programme is a new clinical model seen as the way forward. At its heart is a vision of organisations moving from being primarily providers of services to being primarily in the business of supporting community activity, resilience and connectedness. The talk was illustrated with a useful set of slides that we recommend viewing alongside this summary.

**Introduction**

The story of Bromley by Bow goes back 26 years. It started in a lock-up shop with 2,000 patients, one phone line, an outside toilet and a couple of General Practitioners. It has grown to a three-practice partnership of around 28,000 patients. The most significant partner in the work is the Bromley by Bow Centre charity. The partnership has been working with the Centre for 18 years and this collaboration is a significant part of the story. The Centre offers a mixture of advice, welfare and employment services, services for children and families, and support for start-ups and social enterprise.

Bromley by Bow can be found on the River Thames between the Olympic Park and Canary Wharf. It is a community in the London Borough of Tower Hamlets that is marked by severe health inequalities and deprivation. This is fundamental to the Partnership's approach to primary care. The famous 'poverty maps' created by the social researcher Charles Booth at the end of the 19th century show a similar population profile. Like Glasgow, there is a story here of the persistence of deprivation.

The area served by the partnership is in the top 1% of a whole range of indices such as income deprivation and child poverty. This is very challenging for the people who live here. Of course deprivation interacts negatively with people's 'agency', with their sense of how to control their lives and the choices they are able to make. So, on all the indicators of the wider determinants of health such as smoking, exercise or diet the figures are worse than in other areas. The figures are also high for health indicators, the effects of the social determinants, such as levels of diabetes, premature death from circulatory disease, depression and mental health admissions and cancer survival rates.

This is why, for the Bromley by Bow Partnership, this understanding of the wider determinants of health is so critical. We are not simply in the business of doing primary care

in a biomedical way, offering a service which has health products that can be given to people. What we are interested in is the way in which the wider determinants of health (whether it is housing, employment or skills, the broader environment, or life chances of children) impact on people's ability and capability to actually make choices about health themselves.

This reflects the work of Michael Marmot and the Institute of Health Equality. Marmot talks about what defines our health outcomes. Using a very extensive evidence base he shows that 30% of our health outcomes are a mixture of our genetics and the biomedical support that we may need throughout our life-course. The other 70% is due to the whole range of environmental, social and cultural aspects which are pertinent both to our life chances but also our ability to interact with our own health and wellbeing. The understanding of this 30/70 mix is core to the work at Bromley by Bow. Interestingly, by happenstance rather than design, the combined income of the partnership and the charity is spent in a way that reflects this split: 27% on medical support and 73% on non-medical support services. A reflection of the effort that collectively is being put in to finding resources to support people in the round and to support people to make the choices that they believe will lead to their health. The rest of this talk gives some examples of how this 70/30 split, and the notion of the wider determinants of health, plays out in terms of the things the practices do.

**Social prescribing**

There is a lot of interest in social prescribing at the moment. Bromley by Bow started doing this 26 years ago, because it became very apparent to the first GPs working in the area that the conditions people were walking in with were not medical at all and were beyond the competence and understanding of the GPs. So very quickly, links were made with people and organisations that could better support people.

Social prescribing enables health professionals to refer patients with social, emotional or practical needs to a range of local, non-clinical services in the wider community. For patients it means that their experience of accessing the help they need is greatly enhanced. In Bromley by Bow there are three elements to the social prescribing service: a generalist service; a specialist service for people living with and beyond cancer; and Healthy Cities, a service connecting parents with opportunities to support the development of their children's health and wellbeing.

Anyone working in the health field, including GPs, nurses and receptionists, anyone who gets into conversation with a patient and recognises a need, can refer into the service. There is an electronic system which makes referring quick and easy. Once a referral is received by the Social Prescribing Co-ordinator there are three levels of service available:

- Level 1: For those with relatively straightforward needs that can be met with a little technical advice or signposting. People are signposted to over 40 organisations.
- Level 2: This might involve two or three conversations with the Social Prescribing Co-ordinator to unpick some of the more complex things that are going on behind the presenting issue, which may have been missed by the referrer, and then signpost accordingly.
- Level 3: This is a more extended conversation about the ways people may start to exercise greater control and agency in their lives. This is about exploring options for

people whose circumstances and experiences of the wider determinants of health makes the choices they make, and their ability to make choices, really complex. Level 3 work tries to support people to work these things through and to start to devise their own journey from that particular point. The work is based on a theory of change of how people start to take control of their lives in a way which, for various reasons, may have been very difficult for them to do previously.

The partnership is constantly trying to learn about what it is doing and how this service affects people's sense of wellbeing. There are a whole series of ways that clients feedback, including focus groups and qualitative work, as well as finding out from clinicians what they experience. For example, looking at some figures about referrals it is clear that there is still a large drop-off rate between the number of people who are referred and those who actually attend. The practice is thinking about why that is, and what they might do differently. One thing that is clear is that health professionals love the service because it provides them with a sense that there is something else they can offer people.

The partnership is now thinking of social prescribing in different ways. They are seeing it less as a way of the medical establishment shifting a problem that it is not equipped to deal with to a more appropriate service, and are reconceptualising it as a way of nurturing social connections. People do ascribe value to a particular service but what they say is really important, is the sense that there are people now, in the community, who they know and who understand them and who connect them to wider networks of friendship. This is something that the partnership wants to emphasise that they are seeing this less as a service and more as a way of knitting these community connections together.

**Itchysaurus**

A second example of the work of the practice is the eczema project. 'Itchysaurus' the dinosaur was created by one of the GPs to support parents and children who are living with eczema. One of the surgeries has been turned into a dinosaur playground. Stories are read and the children are encouraged to plaster the toy dinosaurs with emollients. This starts to normalise and de-medicalise the experience of eczema, making it as far as possible, just part of the ordinary way they cope with things. This is part of the Bromley by Bow approach to take the biomedical out of primary care.

**Health promotion and technology**

The practices hold lots of health promotion days both for the general population and also for more targeted audiences. They involve lots of fun activities to help people learn and gain competence around health literacy.

The practices are also trying to offer digital solutions for the population to interact with health services online. 'Health Touch' is an app that has been co-developed with one of the hospitals in London. It started out as a way of people with hypertension doing home monitoring of blood pressure. This is important for a segment of the population who are mobile and want to access services in a way and at a time they can control. The app also actively helps people to think about their hypertension as well. Interestingly just by using the app, 75% of people have reduced hypertension. It has now started to be rolled out for things

like blood sugar monitoring for diabetics and peak flow for asthmatics. We want to see if the effect of people looking after their health at home, dialling in the numbers and being checked up on occasionally, is actually helping people more significantly to take care of themselves.

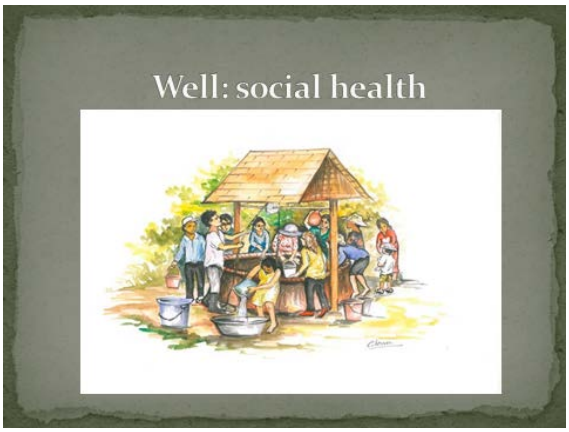
These are both small illustrations of the overall approach, which aims to help people look after their health in their own context, and in whatever way they want.

**DIY Health**

A final example is called DIY Health. This is a project for parents of children aged 0-5. It was co-designed by the practices, academic partners, local children's centres and local parents. The aim was to work differently with parents who were coming frequently to the practice worried about minor ailments in their children because they did not know what to do. They worked alongside parents to understand their fears and needs and developed a flexible training package of things they wanted to understand and learn. This has led to a 50% reduction of these parents coming for GP appointments. As with social prescribing, what has been hugely encouraging is that the parents continue to meet for coffee, and phone and support each other even after the course has finished. This model is now being rolled out across Tower Hamlets and beyond, and there is an online resource on the UCL Partners website which tells people about the method and provides tools. It is also being used in other contexts as well, not just with parents of young children.

**The next part of the journey**

Clara was one of the first parents on the DIY Health group. She is also a talented artist and gave the partnership this image of a well. A well where people gather resources, meet, talk, laugh, cry and draw water. It is a resource, a meeting place, a gathering place. And this image has inspired the next part of the partnership's journey. Although we have been working on this for 26 years and have done lots of things, we know we are really just dipping our toes in the shallow end.




Over the last 18 months the partnership has been thinking about how they learn and grow. The partnership has visited other places including: Weston-super-Mare in Somerset, where they learnt about real healthy living through a community café that serves a full fat English breakfast – the focus here is on the wider determinants of health, getting people out of their houses and connecting with each other; Robin Lane in Leeds – the only GP surgery in England that has a licenced bar on the premises, and has a whole army of volunteers who just do things round the community; the Academy Medical Centre in Forfar that is starting to experiment with the Nuka model developed in Alaska by the Southcentral Foundation; and Garscadden here in Glasgow where Peter Cawston and his colleagues talk about how primary care is moving from the sense of being a provider of health services to being partners within the creation of healthy communities. This is a different mindset in terms of primary care.

So the Well Programme at Bromley by Bow is about Marmot's 30/70 split. It is about patient citizens and co-production. It is about behavioural insights, relationships in conversation and

about the community. All this means fresh thinking about care. We think we are in the primary care business but we are not at all. Primary care is about the patient. The patient is surely the source of primary care for their own health. And secondary care is about the patient's connectedness and wellbeing with their immediate circle and tertiary care in the broader community. What we offer in the NHS is just a part of this.

At Bromley by Bow we are doing a lot of sharing. Just listening to people, making connections, having conversations and networking with many more community organisations beyond our immediate circle. Encouraging people to connect. One patient was in the surgery twice a week. One of the receptionists asked her: *"why do you come?"* and she replied: *"Because I am lonely"*. So now she is enrolled on an English as a second language course, won learner of the year, and is in the surgery once every two weeks but as a volunteer doing things with the practice. It is a different relationship.

So this is a new clinical model. This is the health sharing economy, seeing people as assets and as capable themselves. There is an important analogy here with Uber and Airbnb. The problem with Uber is that people have been seen as disposable assets. The strength of something like Airbnb is that it doesn't own hotels or guest houses, these belong to other people. At Bromley we are thinking about this. How do we build on the assets and capabilities that people have? There is a distinction between honouring people's assets and capabilities in terms of a shared economy of health and not exploiting them because we don't have enough money to pay receptionists. It is an important distinction to really dwell on.

Finally, one last point. Ninety percent of consultations in the health service happen in primary care, but in the English NHS primary care receives only about 8% of the entire NHS budget. We need to stop building health centres because they are principally focussed on illness not on health. Things are largely unchanged since 1948 and we believe broadly that primary care is still about responding to biomedical issues. But we know that 70% of our health outcomes are related to the broader determinants of health. So in this sharing economy, social health is really the way forward.