“Never let a good crisis go to waste.”

Winston Churchill

Bromley by Bow Centre

Bromley by Bow Health

Crisis Social Prescribing at Bromley by Bow

Interim report on reach, impact and learning of the Social Prescribing support between March 25th – June 3rd

June 5th 2020

Authors: Sophie Imber, CR Stocks-Rankin and Emma Owen-Amadasun

Bromley by Bow Centre

Bromley by Bow Health

What was the problem we were addressing?

How can we adapt to implement support for local people that would meet the changing and growing needs of our community in the most holistic way possible?

As the pandemic worsened, we were faced with a number of challenges:

- **How do we identify** those most in need and what support was possible and appropriate? And how can we maintain a patient asset-based approach?
- **How do we define what** 'vulnerable' means for our community?
- **How do we use data?**
- **How do we work together** across the Centre and Partnership in the most effective way?

Bromley by Bow Centre

Bromley by Bow Health

What did we do?

- **Team re-configuration** 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 reaching beyond those who were identified as Extremely Medically Vulnerable (shielding).
- We implemented **telephone-based social prescribing support** (including a fast turnaround for immediate issues), signposted and referred patients in need of social, emotional and practical support. We also designed and delivered **‘Home Packs’** to help people navigate and manage during the lockdown period.
- **We embedded a researcher** within our team to support service design, weekly quantitative data reporting, and led regular reflective learning sessions. We applied our **Unleashing Healthy Communities** stretch outcomes measures to analyse needs.
- **We sought to maintain a Social Prescribing approach** – building personal and human connections – rather than a brief check-in call

Bromley by Bow Centre

Bromley by Bow Health

The reach of our service

150

Patients/clients are supported by BBB Social Prescribing service

each quarter.

600

Patients/clients have been supported by the Crisis Social Prescribing service

to date.

We have supported more patients/clients through the combined social prescribing service in the past 3 months than we normally would in a year.

Bromley by Bow Centre

Bromley by Bow Health

Needs of our community

Access to food

Physical and mental health

Home/Environment

Feeling isolated

Access to guidance/information/advice

Bromley by Bow Centre

Bromley by Bow Health

Our learning & looking to the future

Bromley by Bow Centre

Bromley by Bow Health

Key features of BBB model's response

WHAT made our response so effective?	WHY was it effective?
• **Targeted** - Targeting outreach in line with population need and social determinants of health. • **Time to prepare**, pre-training and webinars. • **Integrated response** – BBBHP and BBBC coordinating a shared response. • **Integrated data** – sharing patient data and producing shared monitoring and impact data across BBBHP and BBBC. • **Learning and evaluation** built-in to the model's response and intervention.	• **Clarity of vision within the BBB model** • **Building team confidence - understanding who we are, the role we play and our boundaries.** • **Peer support and knowledge sharing** • **Building evidence of impact of service to engage and grow the profile of work** • **Providing opportunities for team to learn from each other and apply these learnings, and respond rapidly to change (action learning approach)**

Bromley by Bow Centre

Bromley by Bow Health

Where do we go from here?

WHAT we will do	HOW we will cement this way of working
• **Re-designing our patient pathway** for those with long-term conditions (wellbeing first approach) • **Implementing Reflective Practice** across the board in all teams • **Greater integrated working** between the Health Partnership and the Centre (outcomes framework) • **Maintaining a wider and more integrated** Social Prescribing practice and team that covers long-term, urgent as well as pro-active, preventative and anticipatory data/intelligence led social prescribing • **Increased online provision** and use of video consultations	• **Maintain a reflective, iterative learning process** that is consciously designed and implemented with patients and practitioners • **Developing a shared vision** of what needs to be delivered and being flexible and adaptable • **Coproducing with our patients,** building trust in change • **Considering the qualities, skills** and experience of those undertaking the role and ensure relevant training • **Using, synthesise, analysis to report** a range of data where possible. Involve whole team in data reporting and knowledge sharing (have ownership over work and encourage learning)