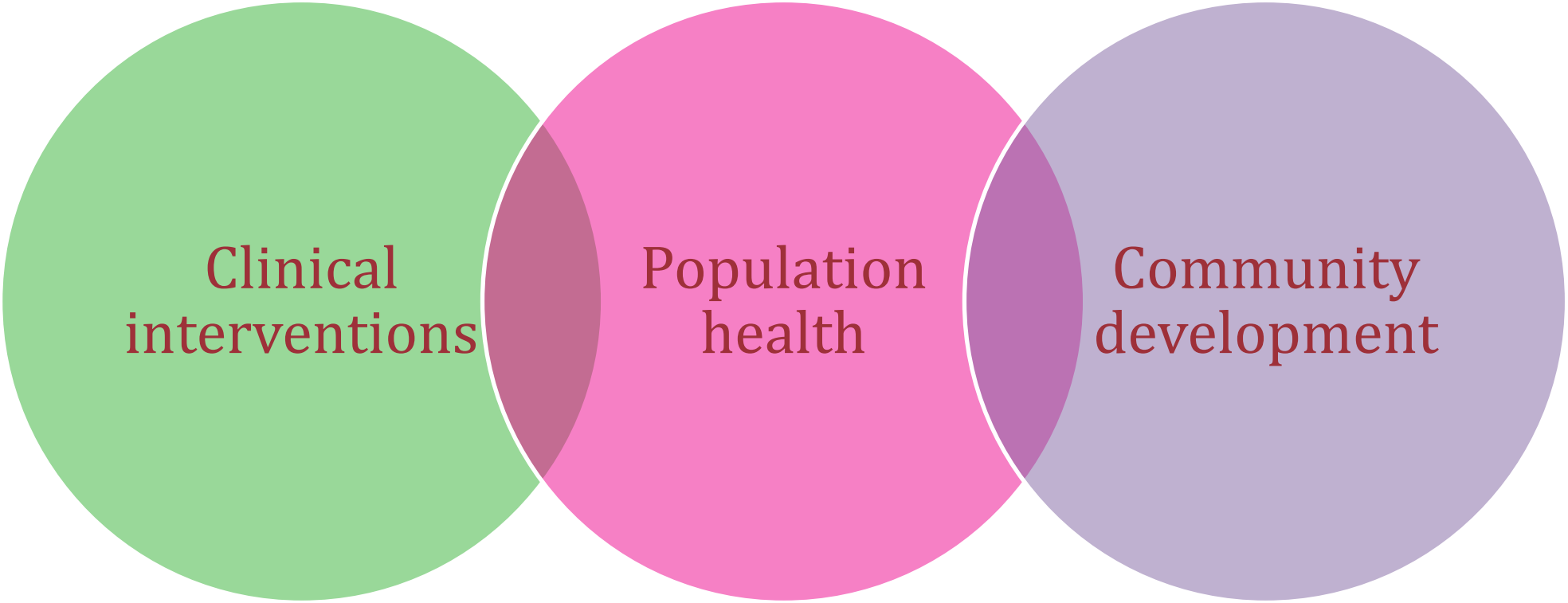


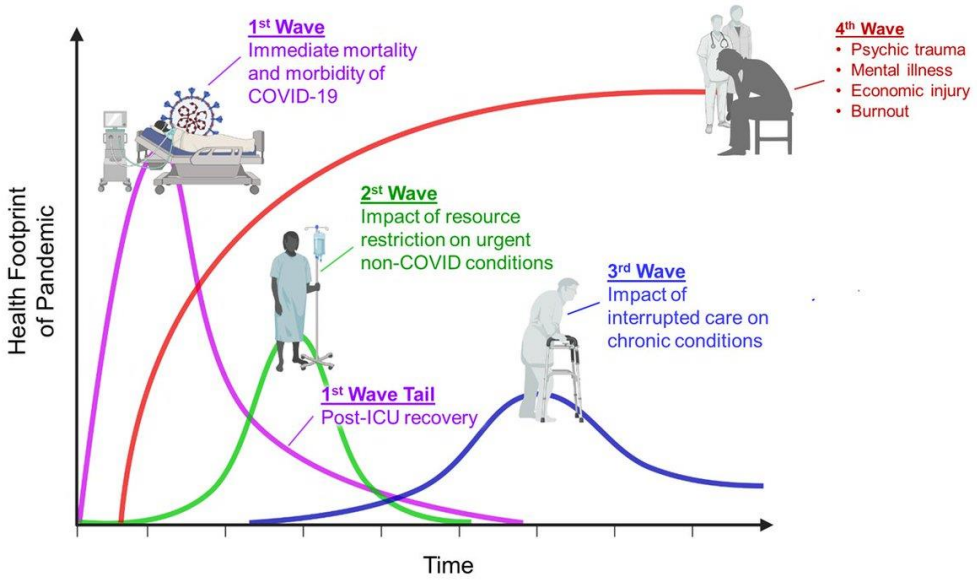
Responding to Covid-19:

Interim report on innovation in the Bromley by Bow service model

Emma Owen-Amadasun, Sophie Imber, CR Stocks-Rankin, Ian Jackson, Rob Trimble / June 2020

Introduction

“For those fortunate enough not to have lost loved ones to a grim and lonely death, or to be one of the millions requiring food aid, there is vital debate as to what will come to be seen as the prevailing coronavirus mood. Will it be mild breadmaking disappointment, or faux self-deprecation about the homeschool pupils being cleverer than the teacher? It’s certainly a dilemma. But can I go for neither? It feels more likely that the spirit of the times will be a mass choosing-to-forget – a vast absent-mindedness that will settle over the cock-ups like a psychic pall. Why don’t we expect better? I guess it saves time” (Marina Hyde; The Guardian; 28 April 2020).



There is a palpable change happening. Over the last week traffic on the roads has increased significantly. Yesterday, for the first time in weeks, you could smell the fumes on the Mile End Road. Shops are tentatively opening their doors.

In a morbid sign of the yearning to return to “normal” the Chief Executive of KFC said in a radio interview that they were planning to reopen restaurants to coincide with the reopening of schools. There are clear signs that while paying lip service to the “scientific advice” the government is now planning to move into easing lockdown measures.

And, of course, we can all feel the personal drive to return to some sort of normality in our personal and social lives. But surely not a the cost of what Marina Hyde calls “a mass choosing-to-forget”

We are taking this vital opportunity to take stock of what we have learned, and how we can use this experience to shape the next generation of life at Bromley by Bow.

This report was produced collaboratively between the Bromley by Bow Health Partnership and the Bromley by Bow Centre.

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, employability and skills training to social enterprise. 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.

What has the pandemic meant for our community?

Clinical need

Even before the Covid-19 pandemic, we knew that our communities were predisposed to a range of vulnerabilities based on the socioeconomic and historical profile of the area. As we entered the heights of the pandemic, we were faced with the challenge of identifying who was most at need and what support was possible and appropriate, and to flex our service to meet the needs of our community.

- Approximately 600 people identified as being extremely vulnerable and needing to shield, based on analysis of BBBHP patient demographics.
- The borough experiences a lower life expectancy and the average age of onset for chronic or long-term illness is approximately 45 which is 10 years earlier on average than other parts of London and England.
- Significant health challenges with higher rates of cancer linked to poor uptake of screening and late presentations; and a higher rate of mental ill-health than the borough as a whole.
- 20% of our population considered at risk of flu (6000 patients)

An unprecedented challenge has arisen with the introduction of social distancing. Our highest consultation rates across the General Practice aspect are for depression and anxiety (19% of appointments fro 6% of the population) and so removing social contact has presented huge challenges for those experiencing mental ill health across the spectrum. Low mood has been exacerbated for many, and chronic isolation has had devastating effects for some.

Social determinants of health

Before Covid-19, many people in our community were already in urgent need, with a large number of those we support experiencing crisis on a daily basis.

- Large proportions (over 50-55%%) of residents live in social housing in the Bromley North, Bromley South and Mile End Wards. This is above the average for the Borough (40%). [1]
- 65-69% of the residents in each of the practice's wards are from BAME communities. Approximately 40% of the population in these wards is Bangladeshi. [2]
- Four in ten households are living in poverty. This is the highest poverty rate across in England and Wales, and almost double the national average. [1]
- Almost half of older people live in deprivation, the highest rate in England. [3]
- Six out of ten children are living in poverty, the highest rate of child poverty in Great Britain. [4]
- Tower Hamlets has the highest unemployment rate in London, at 7.7% [5]
- Bromley North, Bromley South and Mile End have some of the highest unemployment rates in Tower Hamlets [6]
- One of five households experiences overcrowding Bromley North, Bromley South and Mile End [7]

Different starting points: Health inequalities and Covid-19

Health inequalities are impacing the risk of infection, severity of symptoms and death rate.

- In March and April 2020, 90% of the people who died from Covid-19 had at least one pre-existing condition. [8]
- There have been higher death rates in Black and Asian populations. An inquiry led by Public Health England has been launched. [9]
- BME workers make up a disproportionate number of key workers in London [10]
- Not all key workers are getting access to personal protective equipement [11]
- People on a lower income have to travel for work. Only one in ten of the lower half of earners say they have the option to work from home during the lockdown [12]
- A high risk of expose, and needing to travel is exacerbated by high levels of overcrowding in communities with high levels of deprivation.

Health inequalities will impact people's resilience to the detrimental social impacts of the pandemic. The Health Foundation has highlighted the following four areas which need investment and attention during the subsequent waves of the pandemic:

1. Unmet clinical need
2. Financial hardship
3. Education and social mobility
4. Protective factors offered by local government and businesses

Meeting need: What are the existing challenges for primary care and community anchors?

Before the pandemic, those working in primary care and community anchors to support deprived communities faced significant challenges.

Funding

- The Carr-Hill formula, which determines the level of funding for GP practices, has been criticized for failing to adequately account for deprivation [13][14]
- A high level of charities have reported cross subsiding their government contracts with other income (2/3 in a recent survey by NPC) [15]
- NCVO has forecast that charities could lose £4.3bn in fundraising income between March and June 2020 [16]

Workforce skills and roles

- "Between 2008 and 2017, the number of GPs working in the most deprived 20 per cent of areas fell by 511, in contrast to the wealthiest 20 per cent, where 134 additional GPs were recruited." [17]
- There is a growing recognition that a blend of skills and professions is needed to meet need holistically, and cost-effectively.

Data and evaluation

- There are significant challenges for the charitable sector in using data to understand and evaluate their work.
- There remain barriers to sharing data and to creating shared data systems across different organisations providing services and support to the same community.

Bromley by Bow re-design in response to Covid-19

Key features of BBB model's response to Covid-19:

1. **Increased outreach** – Crisis social prescribing service.
2. **Targeted** - Targeting outreach in line with population need and social determinants of health.
3. **Specialism** – Retaining specialist services and using outreach to refer people to those services/support (within BBB and wider).
4. **Support at a distance** – digital spaces to hangout, online courses, delivery packs, phone calls, video consultations.
5. **Integrated response** – BBBHP and BBBC coordinating a shared response.
6. **Consistent first contact** – that considers the whole person, their strengths and their needs (rather than contacting based on individual project).
7. **Integrated data** – sharing patient data and producing shared monitoring and impact data across BBBHP and BBBC.
8. **Learning and evaluation** built-in to the model's response and intervention.

Enablers for this reponse

- **Clarity of vision within the BBB model,** which defines vulnerability according to the Marmot Principles and the social determinants of health. This clarity of vision ensured that that the model's leadership proactively identifyed people at risk (before the DoH and CCG provided lists of shielded patients).
- **An integrated team** ensures that the model makes use of the networks, skills, and experience from BBBHP and BBBC.
- **Identification of need –** Many of the social determinants of health, e.g. housing or education status, are not coded within the EMIS database, so identifying people at risk is a challenge. Decision to initially focus on people who have reported 'low mood' (a psychosocial approach to health).
- **Prioritisation of need –** Initial estimates suggest the 90% of the total number of patients registered with BBBHP are vulnerable according to a social determinants of health, e.g. poor housing, social isolation, employment status etc. Staff capacity to make outreach calls to these patients is a challenge.
- **Strengths as well as need –** A core focus of Bromley by Bow's reponse is to work with people's assets and strengths as well as their needs.
- **Learning and data analysis** – For example: the crisis social prescribing team includes learning and weekly data analysis as core to the service innovation.
- **Strong working relationships** and trust across the formal divisions of the model enabled for robust strategic planning and adaptations.
- **Quick actions** have been enabled by periods of reflection both at the strategic level and for team members delivering services.
- **Confidence of leadership –** "Our confidence has come from believing we are doing the right thing for our community … This work has accelerated what we wanted to do anyway".

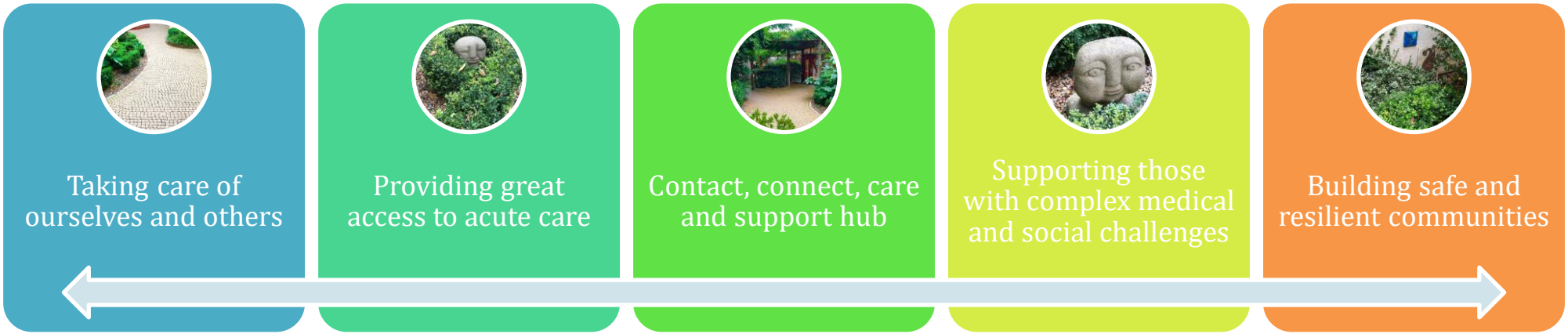
An emerging model

At the health partnership, our purpose is creating healthy, connected communities together

The covid 19 pandemic has afforded an opportunity to understand how this purpose needs to be applied and amplified in a future situation which will compel us to adapt our way of working to take account of new realities and old realities made more relevant.

In particular –

- Together with everyone else we know how important it is to take care of our physical, mental and emotional health, to boost our wellbeing and stay safe
- We can see how our emphasis on the social determinants of health has played out in terms of the epidemic impacting disproportionally on economically and socially deprived communities and on those with certain protected characteristics – e.g. older people, BAME communities
- We understand more acutely the importance of a population health approach; of looking long term, of supporting preventative agendas, of basic public health ways of operating
- Because we have had to restrict physical access, we can see more clearly how important it is to have excellent digital and remote access for dealing with acute problems
- We have had to re-think our approach to managing long term conditions moving to increased remote consultation methods
- We have been in close contact with a wide range of patients supporting them to be resilient and connecting them to other sources of community support such as mutual aid groups
- We have discovered new ways of being together, of collaborating, making decisions and working at pace to deliver change



At the Centre, our focus in the pandemic is on thriving, not just surviving, communities

Bromley by Bow Centre

Community Hub LIVE

New and comprehensive delivery model in response to the Covid-19 crisis lockdown

Crisis Social Prescribing

Covid-19 Response Programme

A new dynamic social prescribing programme focused on proactively contacting patients and other local residents in our community who are most vulnerable during Covid-19 lockdown. The focus is on providing telephone support to those identified as being at the highest immediate risk (medically or socially), driven by the data collected by both our clinical health team and by the Centre's community support teams.

The focus of this work is on providing a swift and practical triage service over the phone which assesses the range of needs and vulnerabilities that individuals have. It allows our skilled social prescribing team to then create a bespoke support package that prioritises the most urgent issues being faced. This approach creates a blended response which can combine both medical interventions led by our clinical team, alongside vital emotional support, practical advice on a broad range of topics provided by Centre staff.

This approach sums up the whole Bromley by Bow model which recognises that health is principally driven by social factors and tailors a holistic response that meets the complex needs of our most vulnerable local residents.

Over 6,000 patients have already been flagged as potentially vulnerable and priority is now being given to those who are deemed in most urgent need of support and those with complex long-term conditions. Whilst the short-term focus is on those in greatest need, it is already clear that there is a massive set of complex needs that will require a medium-term long-term response.

An integrated team from across the charity and the GP Partnership has been recruited and trained and includes the redeployment of staff from the Centre's Communities Driving Change, East Xchange and Active Lives projects, as well as specialist clinical support and volunteers. The team is collecting detailed data to build a picture of emergent need and measure the effect of our support through impact reporting. Early evidence suggests that the depth and range of needs are extremely complex and at times harrowing and many clients already require intensive support and will do so for months and years ahead.

Community First

Integrated Wellbeing Support Project

This comprehensive expert model of community social prescribing builds on the Centre's long-standing experience and is focused on supporting people to improve their health and wellbeing and to make positive life changes. This is done through sustained long-term engagement. It is known that 80% of good health is determined by social factors and this means that during the Covid-19 crisis there is a particular challenge for those with the highest levels of existing social needs, exacerbated by additional stress and physical illness.

The project is aimed at the whole community, but it has a strong focus on supporting people with their mental health needs. It aims to provide soft entry points and gives local people time to explore what's important to them and identify issues and challenges they'd like to address in their lives and then find services and activities to support them in the community. Most commonly this involves befriending and coaching, individual and group social chat sessions, healthy lifestyle advice and referral into our new 3BC-Online projects and many other services.

In addition, the Centre has created nationally-recognised specialist Social Prescribing Link Worker training modules that are available to organisations in Tower Hamlets and other London boroughs and more widely across the UK.

Social Welfare Advice

Telephone triaging and specialist support service across our normal range of areas including benefits, universal credit, money management, utilities arrears, housing issues and generalist advice. The work ranges from emergency intervention for clients (eg with Foodbanks) through to regular support and advice sessions.

The service is supporting local residents who have been severely impacted by the loss of employment, often made more complex by people having a number of part-time jobs and living on the breadline. Much of this work relates to PIP calculations and liaising with DWP for clients who are often have poor digital skills. It is already clear that clients are struggling to access vital services they need and will require support from Centre staff who are known and trusted by the local community.

Food Distribution Centre

Plans are coming together to use Pie in the Sky café, the Centre's main hall and church premises as an integrated food preparation and distribution hub. Discussions are in progress with Tower Hamlets Council and Bow Foodbank.

Social Care

Ongoing remote support for adults with learning disabilities in our social care programme. This project is highly innovative, working with the Bromley by Bow artistic community to create ArtBoxes that are delivered to clients' homes and who are then supported in 1:1 workshops with their tutors online. This is a real lifeline service during the Covid-19 crisis.

Employment & Learning Support

Our employment and learning team are providing vital ongoing support for clients seeking work, with the service now more orientated toward training, skills improvement, IT and digital, confidence-building and online courses. This includes our ESOL learners who are being supported remotely through online workbooks and tutorials. Many of our learners are themselves vulnerable and face considerable practical and social issues as a result of the crisis. We have a wider duty of care toward these learners and proactively support them across their range of needs.

3BC-Online

New programme of Bromley by Bow online activities

- Virtual community choir
- Virtual Family Playroom
- Online Photography classes
- Active Health - fitness sessions
- Art Space 2020 Online

Enterprise Support

Our 2020 Beyond Business incubation programme has been postponed until October. However, the team are providing an extensive range of advice and support to existing Beyond Business enterprises across East London during this challenging period.

Bereavement Counselling

This is a new service we are planning as a result of Covid19, working in partnership with the excellent **City & East London Bereavement Service** team. The need for this type of support is very significant and we hope that a partnership between our two organisations will mean more counsellors can be trained and allow the service to expand.

Bob's Park

Community recreation space open for daily exercise and engagement with the natural environment. A vital lifeline for local residents.

A closer look: Integrated Crisis Social Prescribing

One of the responses that we would like to look at in more detail is out Integrated Social prescribing offer that has developed out of the response to the pandemic, but fulfils many of our long term ambitions around proactive contact and case management on a larger scale and integrated team working across the General Pracice provision and Community Centre teams. It is a new dynamic social prescribing programme focused on proactively contacting patients and other local residents in our community who are most vulnerable during the Covid-19 lockdown, using a range of insights to predict vulnerability. The focus is on providing telephone support to those identified as being at the highest immediate risk (medically or socially).

The focus of this work is on providing a swift and practical triage service over the phone which assesses the range of needs and vulnerabilities that individuals have and connecting them to the most appropriate source of support – whether it be Mutual Aid, welfare benefits advice, food banks, or longer term support from the Social Prescribing service.

This approach sums up the whole Bromley by Bow model which recognises that health is principally driven by social factors and tailors a holistic response that meets the complex needs of our most vulnerable local residents. Over 6,000 patients have already been flagged as potentially vulnerable and priority is now being given to those who are deemed in most urgent need of support and those who will be facing acute challenges at this time – older people, those with existing mental health needs, vulnerable families. Our criteria for identifying vulnerable people to work with is built on the insights and feedback gathered in the calls made.

Whilst the short-term focus is on the people in immediate need, it is already clear that there is a massive set of complex problems that will require medium-term and long-term responses using the same approach for months and years ahead.

Key actions and timeline for design and delivery of Crisis Social Prescribing

circa March 2nd	**Information sharing** with patients – Posters on COVID-19 placed within BBB Health Partnership facilities.
circa March 16th	**Changes to service delivery** – Cancellation of all non-essential services, including face-to-face groups such as patient and student groups.
	Analysis of patient need – e.g. people with a long-term condition (6000+ registered patients across BBBHP).
	Leadership on concept of 'vulnerability' – Use of Marmot principles to determine vulnerability based on the wider determinants of health, e.g. social isolation, low mood, etc.
	Leadership on value of local knowledge – Borough mandates BBB Social Prescribing to move to a centralised Urgent Care Centre. BBB argues for retaining the team at BBB.

	Analysis of patient need based on Marmot principles *and* EMIS codes to determine a list of 'vulnerable' people within the BBB catchment area.
	Strategic planning between Centre and Health Partnership to determine the community's need and the model's response.
	Decision on prioritisation – People who have presented with 'low mood' are put on a priority call list of 'vulnerable' patients. BBB adopts a psychosocial approach to health in prioritisation, with aspirations to widen the scope.
March 25th	**Calls begin** at BBBHP – Population Health Team begins to call people on 'vulnerable patients list' .
	Infrastructure is developed to enable the Crisis Social Prescribing Team to form, including recruitment of team members based on particular skills, role descriptions, FAQs and data sharing procedures.
	New service created – an integrated Crisis Social Prescribing Team is formed which involves outreach via phone calls, signposting and support over the phone, referral to other services.
April 14th	**Guidance from DoH and CCG is released**, which provides a list of 'shielded' patients for the Health Partnership to engage and support.
April 16th	**Calls begin at BBBC** – additional capacity from the Centre team moves the intervention from a 'reactive' to a 'proactive' response.
	Reflection and evaluation are included as an integral part of the service, i.e. weekly reflective practice sessions and analysis of data on calls made.
	464 conversations have been had with people are on the DoH shielding list as well as the BBB model's list of vulnerable patients.
	Weekly analysis of data and reflective practice to capture leaning and opportunities for service development as well as challenges, which is shared as part of the weekly impact report.
May 4th	**Stocktake** – reflection, analysis of weekly impact reports and identification of key learning

Crisis Social Prescribing: Summary of service reach and impact

Who are we speaking to?

	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

Total average age of patients: 54
Total age range of patients: Ages 9 – 90
Total gender ratio of patients: 299 F : 251 M

What are we speaking about?

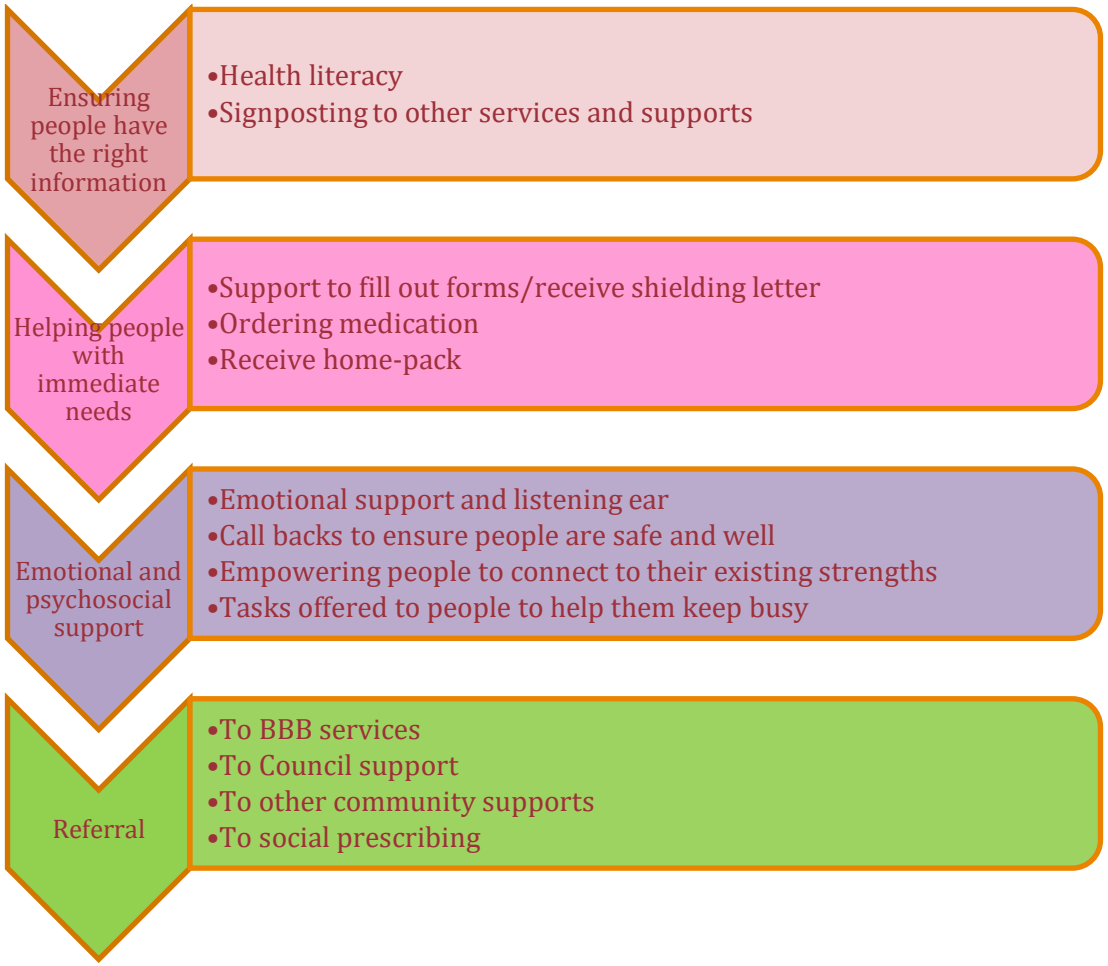
STRENGTHS AND NEEDS	**BBBHP Vulnerable Patients**	**St Andrews Shielded**	**BBB Shielded**
Basic needs	155	55	28
Connected to others	94	20	6
Built knowledge, skills and opportunity	36	76	77
Strengthened personal resources	60	14	3
Connected to place and community	23	14	0
Contributed	10	0	1

*Intensity of colour indicates the *importance* of this issue for the community

What have our calls involved?

The Crisis Social Prescribing service has focused on people's strengths as well as their needs. Calls have involved four main types of intervention.

Types of intervention made during calls:



Examples for week beginning April 27th

Health literacy	8
Signposting to other services and supports e.g. to GP	6

Support to fill out forms/receive shielding letter e.g. vulnerable form, council food form	5
Ordering medication	1
Receive home-pack	19

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

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

What reactions and actions are occurring for people as a result of the intervention?

The majoriy of 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. In addition, there is likely to be some under-reporting of positive reactions as callers from Bromley by Bow are likely to be more focused on the need of the person rather than any praise they've offered.

Reactions to the call	Frequency	Stretch Outcomes for BBB
Request for call back	22	Connected to others
Very postitive/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 in the 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 the data	**15**	

Where have we been referring people?

Top services the team have been making referrals to (Total number of referrals = 248)

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

Learning about the process of delivering a Crisis Social Prescribing Service

Since the start of this piece of work, we have facilitated a weekly check-in call with the entire team to check-in and gather their reflections. The key challenges and enablers that the team have experienced have been thus far as follows:

Challenges for the team

- Making contact with people with minimal background information can sometimes be daunting.
- Most people felt apprehensive at the start before making first calls. We wanted to offer a quality service and do the patients justice.
- Describing 'who' we belong to, how to introduce ourselves and the work we are doing. There is a question around whether we should introduce ourselves as the outreach team.
- Lists of patients need to include the site they are registered at and address, and ideally be uploaded straight into SmartSheet for calls then to be made (which hasn't always been the case).
- Once a referral has been made to another service, there is a question around how this then should get followed up, and who takes ownership of this.

Enablers for the team

- Peer support from other colleagues.
- Integrated team working between the Centre and the Partnership.
- Knowing that there is a team of people working in the same way that you can go to for support.
- Understanding who we are, the role we play and our boundaries.
- Time to prepare, pre-training and webinars.
- Knowing the limits of what we can and can't do.
- Support to let off steam from different calls.
- Regular team meetings to touch base and have conversations as a wider team.
- Applying our learnings from difficult conversations to improve for future calls.
- Good SAM NHS referral scheme.
- Embracing nerves and learning to get comfortable with feeling 'out-of-depth'.
- Embracing new opportunities to learn about our 'clients' in a new way and reach out to people we may have otherwise not been in contact with.

Looking to the future

Guiding Principles

What has been evident from this piece of work is that a meaningful level of integration across the Centre and Health Partnership is possible, and yields extremely positive benefits for patients and staff alike. As it has fulfilled many of our longstanding aspirations of integrated working and joint delivery, we would be remiss not to think about how this work transcends a crisis response to a pandemic and becomes fit for a newly designed way of working that also informs the form and function of both organisations (or maybe even a single organisation!) going forward. In thinking about what next steps look like, we have purposefully avoided thinking that is too boxy and structured – mostly to preserve what we feel has been some of the most important factors of this work: flexibility, adaptability and responsiveness. However, we have started to pin some principles that will help shape the expansion of this work.

1. **Flexible leadership and looser governance**
2. **Agreed vision** – having a clear picture of what needs to be delivered from the outset that is closely tied to the function and practical delivery has been extremely helpful
3. **Personel** – considering the qualities, skills and experience (professional or otherwise) of those undertaking the role. The technicalities can be learned but a natural approach to connecting people to support has been invaluable. Also considering individual capacity alongside other duties and roles.
4. **Data** – The ability to use, synthesise, manipulate and report a range of data has been key and adds to the innovation of this work. Being able to stratify somewhat and provide impact snapshots has helped us to engage quickly and grow the profile of the work. Difficult data systems have not stopped integration.
5. **Impact Reporting –** producing concise reports that the whole team have felt ownership over has been invaluable, as has having a lead to help tell the story behind the data and use it to encourage learning among the team.
6. **Training –** ensuring that the team are adequately prepared to undertake this role with a suitable level of general and bespoke training

Challenges for leadership

- Reactive policy environment
    - ‘Stop and go’ policy environment and changing clinical guidance from DoH and CCG.
- Data security and confidentiality
    - Sharing clinical data with staff outside of BBBHP.
- Identification and prioritisation of need
    - Identification of need – using the Marmot Principles, social determinants of health and EMIS database.
    - Prioritisation of need – e.g. Who is prioritised first? Single parents? People with reported low mood.
- Managing capacity of team and need of community
    - Balancing calls to shielded patients with calls to the model’s own identified list of vulnerable patients.
    - Managing capacity of team and number of calls that can be made per week, without overwhelming staff.
    - Calls made will sometimes require call backs as need is revealed and the service intervention intensifies, which creates a challenge around the depth and breadth of the service intervention.

Enablers for leadership

- Principles and relationships
  - Shared principles amongst strategic leaders – e.g. focus on community need.
  - Strategic use of a social determinants of health lens.
  - Strong relationships – high level of trust and communication between strategic leaders at BBBHP and BBBC.
- Decision-making
  - Quick decisions – e.g. cancel services, plan, create new service, new roles for staff, new process for sharing data, etc.
  - Focus on making a meaningful contribution, despite limitations of social distancing and disruption of services.
- Increased capacity
  - Pause of some services – created capacity to plan a new intervention.
  - Integrated team across BBBHP and BBBC offers more capacity.
- Support
  - Wider network support – conversations within the wider health network offered an opportunity to test ideas and share success stories and failures.
  - Funder support - On the whole funders have been pretty brilliant in terms of flexing funding to be able to adapt services, e.g. Sport England saying ‘do what you’ve got to do’.
  - Support from Year Fellow – ensures that reflection and weekly analysis of service data supports learning for team and strategic leaders.
- Existing knowledge within BBB
  - Complementary expertise and culture of BBBHP and BBBC led to an innovative response which meets need, proactively.
  - Previous learning and tools from the Well Programme and the Unleashing Healthy Communities Programme, e.g. reflective practice and the shared Outcomes Framework.

Measuring Change, Capturing Impact and Learning

A Bespoke Outcomes Framework: Unleashing Healthy Communities

The measurement of this service makes use of intensive research and evaluation conducted with the Bromley by Bow model in 2016-2019. The Unleashing Healthy Communities project was an in-depth embedded evaluation of the combined interventions of the Bromley by Bow Centre and Bromley by Bow Health Partnership. With funding from Public Health England, The Health Foundation and the Wellcome Trust, this project used an innovative methodology to reveal the core mechanisms of this model and its impact on a community facing high levels of deprivation.

Evidence from this evaluation shows that over time, the Bromley by Bow model has held true to its core way of working: where vulnerability exists and stability is needed, the model can respond with concrete and efficient next steps. While the Bromley by Bow model recognises the strengths of the people it serves' as a central feature of its work, it does not deny the very real inequality in its neighbourhood and recognises that people continue to need support to access their legally defined rights and other more fluid support in a time of crisis. The model's balancing of stability and growth is, at its heart, a way of accepting vulnerability and strength as fundamentals of human life.

The original evaluation produced a theory of change for the model's impact, showcasing the combined work of gardening to general practice, nursing to welfare advice, social care to social enterprise. A key output from this theory of change was the model's own, bespoke, Outcomes Framework. This framework is being used to document and categorise the community's need *and* their resources during this criris. The outcomes framework is also being used to capture initial reactions, actions and outcomes as they emerge.

Plans to measure impact going forward + plans to expand to the other parts of the Centre and HP

This Integrated Social Prescribing offer has given us a tangible and succinct way of testing the Unleashing Healthy Communities outcomes. It has helped us to build evidence of need against each of the six outcomes and has allowed us to gain a deeper understanding of what would be required to continue to collect data against these outcomes across more of the Centre and Health Partnership activity. Using what we have learnt, we will also test the outcomes in another integrated area of service delivery at the Centre (e.g. Advice, Learning or Employment).

As time goes on, the outcomes framework can be used to document the changing 'waves' of the pandemic, described in the introduction to this report. The framework is sufficiently flexible to capture a wide range of need and opportunity as well as a spectrum of actions and outcomes that will occur for people. In addition, and in the spirit of the learning culture at Bromley by Bow, the Crisis Social Prescribing team reflect week on week about the challegnes and successes of this service intervention. Every week, they document opportunities for development and their learning.

We will also be implementing Reflective Practice across the board in all teams. This will help us to qualitatively capture change and processes that are hidden by quantitative data alone. In this pilot work, it has also proved an invaluable aspect of team integration, cohesion and responding rapidly to change using an action learning approach.

References

1. Tower Hamlets Borough Profile: Appendix Borough Atlas, 2018, p36. Tower Hamlets Council Corporate Research Unit. Available at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_Appendix1_Atlas.pdf [Accessed June 5, 2020].
2. Tower Hamlets Borough Profile: Appendix Borough Atlas, 2018, p6. Tower Hamlets Council Corporate Research Unit. Available at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_Appendix1_Atlas.pdf [Accessed June 5, 2020].
3. Tower Hamlets Borough Profile: Poverty, 2018, p1. Tower Hamlets Council. Available at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_3_Poverty.pdf [Accessed June 5, 2020].
4. Tower Hamlets Borough Statistics, 2019 p1. Tower Hamlets Council Intelligence and Performance Unit. Availale at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Income_poverty_and_welfare/income_2019_l.pdf [Accessed June 5, 2020].
5. Local Indices of Deprivation 2019, p19. Minstry of Housing, Communities & Local Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835115/IoD2019_Statistical_Release.pdf [Accessed June 5, 2020].
6. Poverty and Inequality Data for Tower Hamlets 2020. Trust for London. Available at: https://www.trustforlondon.org.uk/data/boroughs/tower-hamlets-poverty-and-inequality-indicators/ [Accessed June 5, 2020].
7. Poverty and Inequality Data for Tower Hamlets 2020. Trust for London. Available at: https://www.trustforlondon.org.uk/data/boroughs/tower-hamlets-poverty-and-inequality-indicators/ [Accessed June 5, 2020].
8. Tower Hamlets Borough Profile: Appendix Borough Atlas, 2018, p20. Tower Hamlets Council Corporate Research Unit. Available at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_Appendix1_Atlas.pdf [Accessed June 5, 2020].
9. Tower Hamlets Borough Profile: Appendix Borough Atlas, 2018, p38. Tower Hamlets Council Corporate Research Unit. Available at: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_Appendix1_Atlas.pdf [Accessed June 5, 2020].
10. Deaths involving COVID-19, England and Wales: Deaths occurring in April 2020, Section 6. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020#how-many-people-have-died-from-covid-19 [Accessed June 5, 2020].
11. Disparities in the risk and outcomes of Covid-19. Public Health England. June 2020, p6. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890258/disparities_review.pdf [Accessed June 5, 2020].
12. Merrick, R. “Coronavirus: Non-key workers forced to go into ‘risky and distressing’ jobs, MPs reveal”, The Independent, March 26, 2020. Available at: https://www.independent.co.uk/news/uk/politics/coronavirus-key-workers-shops-uk-lockdown-a9426866.html [Accessed June 5, 2020].
13. Health Foundation ‘Will Covid-19 be a watershed moment for health inequalities?’, May 2020, see Figure 2: Black and minority ethnic (BME) workers make up a disproportionately large share of key worker sectors in London. Available at: https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities [Accessed June 5, 2020]

14. Hughes, R. and colleagues, 'Doing more of what it takes: Next steps in the economic response to Covid-19', The Resolution Foundation. April 2020. Available at: https://www.resolutionfoundation.org/publications/doing-more-of-what-it-takes/ [Accessed June 5, 2020].
15. Hughes, R. and colleagues, 'Doing more of what it takes: Next steps in the economic response to Covid-19', The Resolution Foundation. April 2020. Available at: https://www.resolutionfoundation.org/publications/doing-more-of-what-it-takes/ [Accessed June 5, 2020].
16. Disparities in the risk and outcomes of Covid-19. Public Health England. June 2020, p7. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890258/disparities_review.pdf [Accessed June 5, 2020].
17. Fischer, R and Baird, B. "Primary care networks and the deprivation challenge: are we about to widen the gap? "BMJ Opinion. May 8, 2019. Aailable at: https://blogs.bmj.com/bmj/2019/05/08/primary-care-networks-and-the-deprivation-challenge-are-we-about-to-widen-the-gap/ [Accessed June 5, 2020].
18. New Philantropy Capital (NPC) "State of the Sector" May 2020. Available at: https://www.thinknpc.org/resource-hub/stots2020/ [Accessed June 5, 2020].
19. New Philantropy Capital (NPC) "State of the Sector" May 2020, p13. Available at: https://www.thinknpc.org/resource-hub/stots2020/ [Accessed June 5, 2020].
20. The Heath Foundation "A worrying cycle of pressure for GPs in deprived areas". May 8, 2019. Available at https://www.health.org.uk/news-and-comment/blogs/a-worrying-cycle-of-pressure-for-gps-in-deprived-areas [Accessed June 5, 2020].