bromley by bow centre

SOCIAL PRESCRIBING – TOWER HAMLETS NETWORK 6

Interim Report

April 2017 – September 2017

Glossary of terms
SP = Social prescribing
SPC = Social prescribing coordinator (client-facing)
BBBC – Bromley by Bow Centre
HCP = Health care professional

Index

Introduction

Social prescribing (SP) in Mile End East and Bromley by Bow (CCG Network 6) is a service set up to help address problems caused by the social determinants of ill health and to support people with non-medical needs. The service provides a one-to-one personalised intervention and links people with a wide range of community services to provide them with on-going help and support to improve their health and wellbeing.

The Bromley by Bow Centre (BBBC) is one of the early adopters of social prescribing (SP). Self-funded for some years, the service has been funded by Tower Hamlets CCG and the Mile End and Bromley by Bow GP network since 2013. It operates across five GP practices with a joint patient population of just under 37,000.

Tower Hamlets has the highest overall poverty rate and child poverty of all London boroughs. Rates of infant mortality and premature mortality are also significantly above the London average. Private rent affordability continues to deteriorate with rent at 76% of lower quartile monthly gross earnings[1]

These social determinants result in poorer health outcomes for residents in comparison to the general population. The SP service aims to help address these inequalities through the approach outlined in this report.

Borough-wide roll out of social prescribing

The scheme now forms part of a wider roll-out across Tower Hamlets borough, commissioned by Tower Hamlets CCG via the GP Care Group (CIC). It is one of six pilots which cover eight GP networks. An eight-month evaluation of the borough scheme, Dec 2016-July 2017 has been undertaken by public health consultants from Tower Hamlets Together, a partnership of local health and social care organisations, and is due to be published in March 2018.

It is expected funding of the service across the borough will be confirmed until March 2019 by Tower Hamlets CCG. However, this will be approximately 35% lower than the cost of the full year pilot. A full business case for increased funding did not proceed past an options appraisal phase. It is likely that individual networks will have to match fund to continue providing a full service throughout the funding year. Capacity and access criteria are under review at borough level.

[1] https://www.trustforlondon.org.uk/data/boroughs/tower-hamlets-poverty-and-inequality-indicators/

Highlights from this period

1. A new 0.6 FTE Bengali/English link worker was recruited this period as part of pilot managed by a 1.0 FTE social prescribing manager in post since January 2018*
2. The service started accepting self-referrals.
3. **314** referrals were received into the service this period
4. **213** face-to-face holistic interventions were delivered between April and Sep 2017.
5. **379** onward referrals to 85 different community services were made. (266 referred and 113 signposted)
6. Links were made this period with a new Red Cross service in Tower Hamlets providing home visits for patients with complex needs and Disabled Living Foundation who provide equipment for patients with mobility issues.
7. **95%** of survey referrer respondents in network 6 believe social prescribing brings wellbeing to their patients and 100% wish to see the service continue according to evaluation research
8. MYCaW patient wellbeing outcome measures show a meaningful change in wellbeing and positive impact on self-identified concerns after the SP intervention[2]
9. The network 6 service forms part of a pan borough roll-out of social prescribing. A representative from the BBBC SP team is a member of the Tower Hamlets steering committee.
10. Social prescribing in London is a focus area. The GLA and the Healthy London Partnership are considering ways to develop social prescribing across the city and a new SP network for London is being established as part of the regional network programme.

*Additional trust funding has since secured and extended this role for two years to 1.0 FTE from 1st January 2018

Areas of innovation

SPCs have been EMIS trained for direct access to patient records when working in practice to increase efficiency and update consultation notes directly with service feedback. SPCs adhere to Caldicott principles and permission to access patient health records is sought on initial contact with the client.

Peer group support and supervision has been set up across the borough to encourage reflective practice and enable SPs to share learning and development. SPCs in Network 6 also attend peer supervision with Macmillan Social Prescribers at BBBC in order to share best practice and support staff wellbeing.

Self-referral processes were piloted at St Paul's Way with dedicated materials. SP was incorporated into new patient checks at St Andrew's. Both pilots have provided good learning and enabled further adjustments to ensure appropriate referrals are being received. Self-referral was introduced for the whole service and eleven were received this period.

Good voluntary and community sector liaison is being augmented by facilitating the'E3 breakfasts' with local providers and Tower Hamlets SP forums that bring together pan-borough providers with SPCs.

The delivery team continues to support UK wide knowledge-share events on occasions as many organisations continue to attend the Bromley by Bow Centre to learn more about social prescribing. BBBC has been commissioned to scope delivery of SP link worker training for NHSE with UEL and has consulted on delivery for new staff on the UCL Social Prescribing service in connection with Dr Bryn Lloyd Evans[3]

[2] Extracted from Tower Hamlets social prescribing evaluation Dec 2017- July 2017

[3] http://www.ucl.ac.uk/psychiatry/research/epidemiology/community-navigator-study

Training

Training undertaken in this period has included two-day ASSIST suicide prevention, Mental Health First Aid training, motivational interviewing and Making Every Contact Count.

How the scheme works

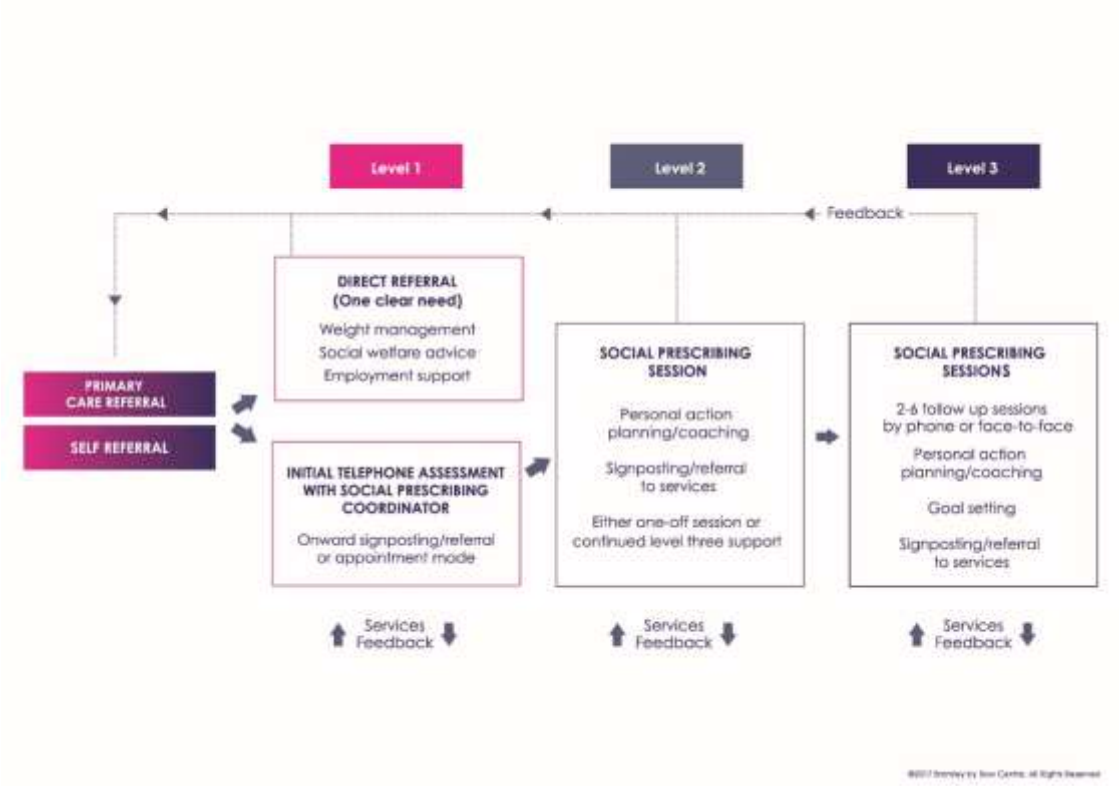
The scheme takes referrals from health care professionals (HCP) across five practices in Network 6 (Mile End East and Bromley by Bow). Using a self-populating referral form found on EMIS (see appendix 1) Referrals are emailed from practices via secure NHS email to the social prescribing (SP) team. The form offers the option of requesting an assessment by the SPC and/or selecting some direct services such as employment support, welfare advice or Fit for Life (weight management). The scheme also takes self-referrals by phone and email for people registered at one of the five practices.

Where a specific service is ticked on the form, clients are directly referred in order to ensure efficient and timely processing of referrals. Patients referred to the social prescribing coordinator are contacted by phone initially by a member of the SP team. Where an assessment is possible over the phone and needs are identified, relevant support services are recommended. These may be signposted or via onward referral and communicated to the client via text, email or letter as requested.

All clients referred to the SP service are offered an initial face-to-face or telephone SP session, either at BBBC or in one of the practice locations. During the first session, motivational interviewing and goal setting techniques are used to support patients to manage anxiety and help identify problems to be addressed, as well as agree next steps. A MYCAW measure is carried out during the first session where feasible and appropriate (See outcomes). A further measure is taken to track progress at a follow up or final face-to-face session when possible.

Sessions are person-centred in approach and SPCs work in a safe and supportive way with the issues and concerns a patient brings. SPCs inform all patients of the safeguarding procedure regarding confidentiality during the contracting section of all one-to-one appointments (see appendix 5)

Pathway showing levels of intervention



Referral Figures

Table 1: Total referrals (patients) by month and practice Apr – Sep 2017

Medical Practice	Apr	May	June	July	Aug	Sep	Totals
Bromley by Bow	14	23	18	3	9	20	**87**
St Paul's Way	4	3	8	8	7	9	**39**
Merchant Street	1	3	8	3	2	2	**19**
St Andrew's	31	31	25	22	19	16	**144**
Stroudley Walk	3	4	3	4	0	0	**14**
Self-referral	2	3	1	1	2	2	**11**
Total	**55**	**67**	**63**	**41**	**39**	**49**	**314**

Note:

High referral figures for St Andrew's Medical Centre continued this period related to introduction of social prescribing into the new patient registration at the practice, previously mentioned (Innovation). All these referrals were contacted by the service and the process subsequently adjusted to manage appropriate referral numbers to match SP capacity. The next reporting period is expected to show a further return to a more realistic monthly number. This report has excluded 203 new patient registration referrals from St Andrew's in the figures above. These referrals were received, processed and contacted via text to inform them of the service with no subsequent intervention.

Table 2: Total referrals by job responsibility

Health care professional	Totals
GP	183
Practice nurse/nurse practitioner	42
Health Care Assistant	18
Patient assistant/receptionist	57
Practice Manager	3
Pharmacist	1
Self-referral	10
Total	**314**

Number of different referrers this period

62 different health care professionals referred in to the scheme during this period. This included 35 GPs which equates to approximately 100% of the GP population of the network. There were a small number of GPs not referring at that time but the service also received referrals from locums and those on shorter term contracts.

The social prescribing intervention

When a referral is received, it is processed by the team and initial referrals requested by the referrer are made (see referral form appendix 1). If the client is referred to the Social Prescribing team, phone contact is attempted three times followed by a letter regarding the referral and including service contact details if contact has not been possible. If contact is successful, an initial triage conversation identifies whether a 60-minute face to face session or phone call is required. If client needs are clear and an appointment is not requested, signposting and referrals are made and the case is closed. If an appointment is appropriate, signposting and referrals may also be made at this point to address urgent and practical needs and an appointment is booked to discuss the issues further. Clients are seen at GP practices and at the Bromley by Bow Centre and are offered a maximum of six sessions.

Table 3: Levels of intervention

Service	Patients Referred	Percentage
Level 0 - unable to make contact (after three attempts) or client declined service	**67**	**21%**
Level 0 – Unable to attend (UTA) or did not attend booked appointment (DNA) and did not access service	**15**	**5%**
Level 1 (D) direct referral (see table 4 below)	**107**	**34%**
Level 1 – phone support	**38**	**12%**
Level 2 – one face-to-face session	**41**	**13%**
Level 3 – two or more face-to-face sessions	**46**	**15%**
Total patients referred	**314**	**100%**

Face-to-face support

The cohort of patients referred in the period received **162** face-to-face sessions (at the time of reporting)

213 face-to-face sessions were carried out in this period which includes on-going work with patients from previous reporting periods.

Level 0 (DNA/DNE) represents 28% of overall referrals,

Table 4: Direct referrals by service type

This box represents direct referrals only. These occur when a HCP indicates one of the services included on the SP referral form and doesn't tick the box for direct contact by the SPC.

Service directly requested by health care professional	Current period Apr 17 – Sep 17
Health Trainers	**51**
Fit for Life	**48**
Social Welfare Advice	**62**
Employment	**12**
Macmillan social prescribing	**3**
Social care	**2**
TOTAL	**178**

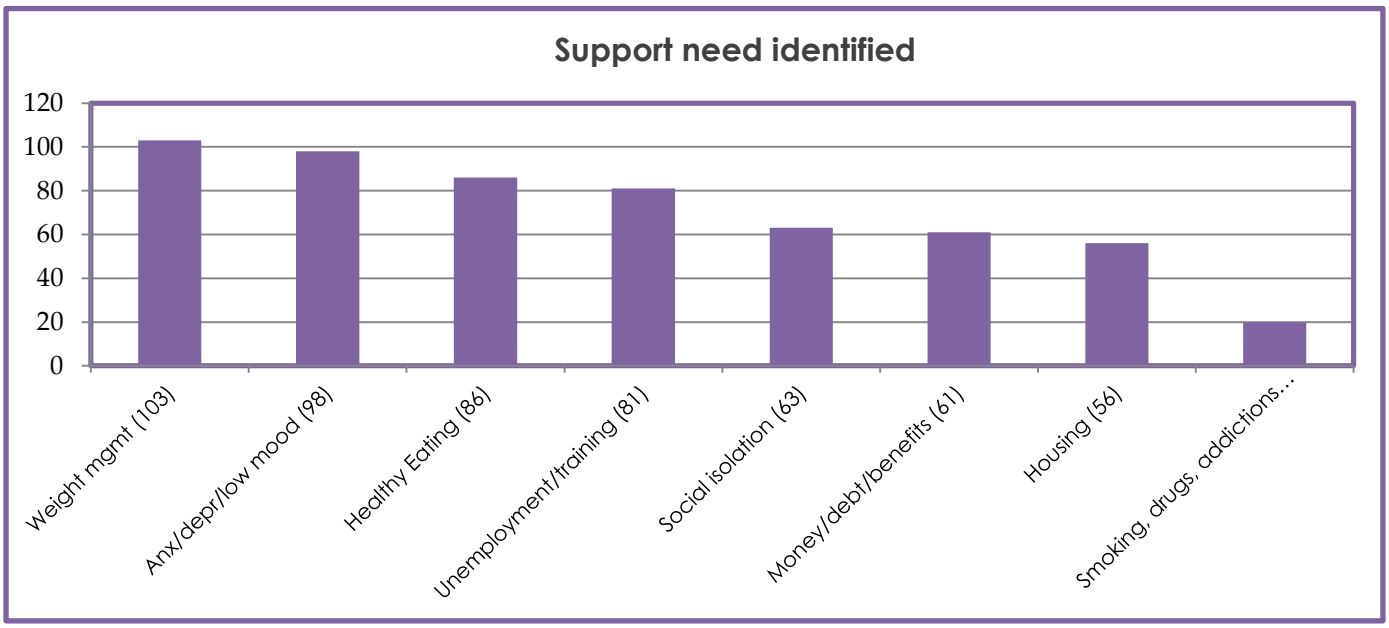
Contact by social prescribing coordinator requested on form	**203**

Note: Some clients are directly referred to more than one service so the total represents a higher number than the individual patients directly referred

These same services above are also referred to once the SPC has met or spoken to the patient but these additional referrals are not included in the table above as this only includes the direct referrals requested by the health care professional on the referral form.

Patient needs

Chart 1: Needs of patients identified by referrer or coordinator on referral form



Note: Needs are primarily those identified initially by the referrer although some additional support needs are ascertained during the holistic intervention by the SP coordinator. More than one need per patient is often identified and some referrers do not select any need on the referral form.

The spread of referrals based on need is consistent with previous reporting. However, those for exercise and weight management are approximately 30% lower than the previous six months. This change is attributed to decommissioning of Tower Hamlets Health Trainers which leaves health professionals without a previously well-used referral route for healthy lifestyles including exercise, weight management and healthy eating for patients whose BMI falls below the threshold of the boroughs Fit for Life service which is 30 BMI (27.5 for South Asian patients). The SPC is making referrals to local physical activity and healthy eating sessions for clients who are no longer able to access Health Trainers (see onward referral services appendix 2)

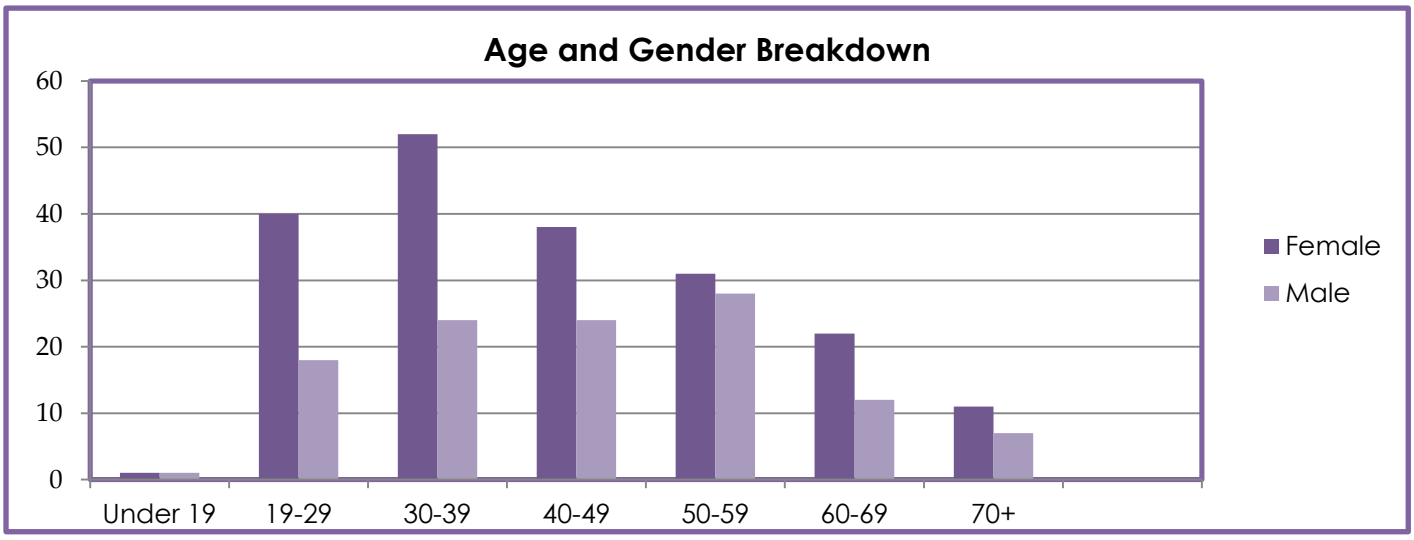
Anxiety, stress and low mood are often ticked by the referrer on the form in conjunction with social welfare and housing needs, suggesting a link between difficult living circumstances and mental ill health.

Long term health conditions identified by referrer or SPC

21% (n66) were reported to have an identifiable long term health condition by the referrer including mental health conditions, diabetes, heart condition, osteoarthritis, asthma, chronic pain, cancer or COPD.

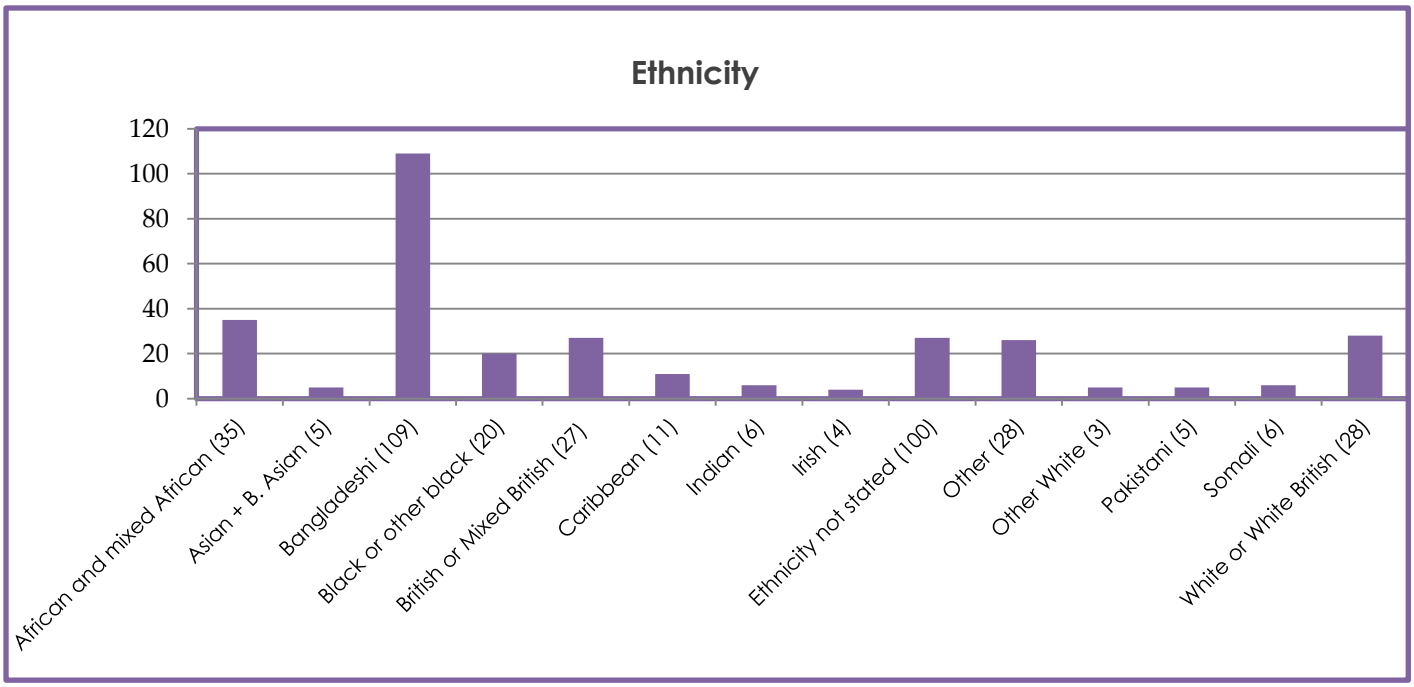
Patient demographics

Chart 2: Age and gender breakdown of referrals



Of the total patients referred, approximately 63% were female and 37% male. This picture is broadly consistent with prior reporting periods. The 70+ age group increased by 200% when compared with the last six-month period to 6% (n18). 4% of the Tower Hamlets population are 70+.

Chart 3: Ethnicity breakdown of referrals



This is broadly consistent with previous reporting periods with the Bengali community representing 30% of referrals. This in line with the overall percentage who identify as Bengali in the Tower Hamlets borough population

Patient consent

Patient consent is obtained by the referrer for each patient referred by ticking the appropriate box on the referral form that indicates the patient consented to the referral and to relevant medical information being shared with the SPC. Clients referred to SP are contacted and consent to access their medical records is obtained if the client is having an appointment in their GP practice. This is so the SP team can access EMIS to record client interaction, intervention activities and outcomes. If clients decline, the service does not access their medical records or use EMIS when working with them.

Clinical Engagement

The service has attended clinical or MDT meetings at three practices in the last six months. Also attended was a Tower Hamlets PLT session on Social Prescribing. The service holds regular clinics at St. Andrew's, St Paul's Way and Bromley by Bow Health Centre and is soon to recommence sessions at Stroudley Walk and Merchant Street.

Community services

A total of 379 onward referrals and sign postings were made to 85 different community services during this reporting period (see Appendix 2).

Events and networking breakfasts

The E3 breakfast meetings between social prescribers and the wider voluntary sector are now jointly run between network 5 and 6 SP services on a six-weekly basis. This presents an on-going opportunity for local community organisations and groups to meet with SPCs across the borough in a quick and informal way.

Gaps in services/complexity of cases

The service sees a large number of clients who need a higher level of support or are having problems navigating the system. Clients regularly request support to complete and submit forms including; Personal Independence Payments, Universal Credit, Childcare support from Tower Hamlets College for ESOL courses, Council Tax reduction, Disabled Persons freedom Pass form, crisis grant, Dial-a-Ride, Freedom Pass, taxi card and mandatory reconsideration applications. There are limited services in the borough to provide this type of support.

SPCs often reconnect clients with services they have already been connected with but have lost contact, where they've been unable to access the service or don't understand the systems and procedures in place and how they work.

30% of clients seen at level 2 or 3 (29 out of 87) resulted in case work including form filling and service liaison. This level of support is not often acknowledged as part of the Social Prescribing role but is provided due to demand and limitations in services available locally.

Feedback to referrers

Feedback is provided via EMIS consultation notes when clients are seen in practices. The service aims to see all clients in their GP practices and provide all feedback via EMIS, where permission is given, by spring 2018. The service continues to attend clinical meetings and join MDTs when possible in order to provide live feedback on referred clients and discuss future referrals.

Measuring impact

MYCaW wellbeing measure

The MYCaW, Measure Yourself Concerns and Wellbeing tool has been introduced across Tower Hamlets borough and is used with patients in Network 6. The MYCaW tool measures changes in the impact of two self-identified concerns and wellbeing as a result of the SP service intervention.[4]

A baseline measure is taken during the first session and where possible, a follow-up is done approximately 12 weeks afterwards. Patients score from zero (not bothering me at all) to six (bothers me greatly). Theming of concerns has been undertaken at a borough level and will be shared in the full evaluation report.

The small number in this sample is due to the early introduction of the tool in the Tower Hamlets borough scheme and common challenges in securing follow-up measures, particularly in making contact with people previously supported. Typically, many more baseline than follow-up measures were secured.

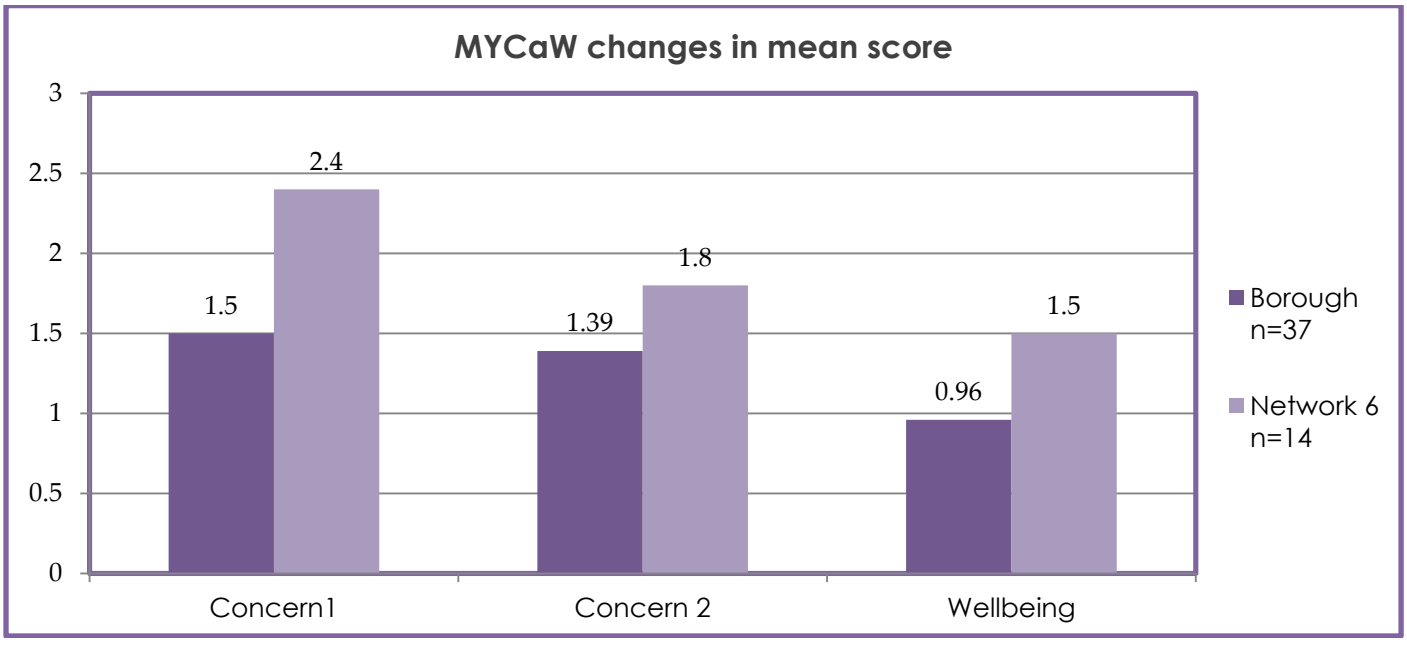
Table 5: MYCaW scores at baseline and 12 weeks

The table below compares early results across the borough with Network 6 only:-

MYCaW	Baseline borough (n=37)	Baseline Network 6 only (n=14)*	12 week follow-up borough (n=37)	12 week follow-up Network 6 (n=14)*
Concern 1	5.47	5.13	3.94	2.73
Concern 2	5.58	4.87	4.18	3.07
Wellbeing	4.74	4.37	3.78	2.87

*16% of levels 2 and 3 interventions (see Table 3)

Chart 4: MYCaW changes in mean scores



[4] http://www.bris.ac.uk/primaryhealthcare/resources/mymop/sisters

Initial analysis of the small sample (n=14) suggests Network 6 has a higher positive rate of change. The objective is to analyse a larger sample of MYCaW results at baseline and follow-up in future reporting periods. However, gathering follow up data and analysis is capacity dependent.

Annual survey of healthcare professionals

The annual GP survey developed by BBBC was employed across Tower Hamlets for the borough evaluation. 183 responses were received from 35 Tower Hamlets GP practices in total.

35 responses came from the five practices in network 6 supported by the BBBC SP team. Results are summarised below. The results from the whole borough (n183) are shown in brackets.

Overall responses on the service (Network 6 n=35, whole borough n=183):-

- **100%** (99%) of respondents wish to see the social prescribing service continue
- **95%** (99%) felt that social prescribing brought wellbeing to their patients
- **98%** (98%) felt that social prescribing brought wellbeing to them in their profession

Respondents were asked about the impact if the service was withdrawn (Network 6 n=31, whole borough (n=183)

- **78%** (78%) agreed or strongly agreed that if would affect the ability of their patients to address the social determinants of health
- **78%** (76%) agreed or strongly agreed that it would affect the ability of patients to engage with their health
- **55%** (23%) agreed or strongly agreed they would try to take on some of the support themselves by finding appropriate services
- **35%** (29%) agreed or strongly agreed they would steer away from opening up holistic conversations because they wouldn't have the knowledge/confidence to refer to appropriate organisations.

Feedback to practices

82% of network 6 referrers were happy with the feedback the service provides although some suggestions have been made for improvement

State any improvements you would like to see made to the service

The majority of comments noted relate to the desired growth of the service and expansion of capacity; more sessions, more promotion, more in-practice clinics, evening services, easier access to GP referral, more integration with other health teams, including NIS/care planning, more onward referral services and reduced waiting times for some services

Annual survey of healthcare professionals continued.

Q: In your opinion, what is the best thing about the social prescribing service?

Direct extracts of responses from referring health care professionals entered into the survey from Network 6 are shown below:

It helps clinicians and saves time

- 'Frees GP appointments for admin and saves time and money'
- 'Great supportive service for clinicians who do not have enough time during a consultation'
- 'Addressing social problems that doctors don't have expertise or time to resolve'
- 'Don't have to specify what I think is needed, patients are assessed by the SP team'
- 'Keeping up with the medical services on offer is difficult enough and I wouldn't know where to start with local or third party services'
- 'It is empowering and supportive of people to make positive changes in their lives. It gives me, as a doctor, a better perspective on the impacts of health on people's lives and of their lives on health'

It is good for patients

- 'Sometimes patients need to confidence to go out and try something different but finding the right thing for them as individuals can be very hard. This is where having someone with specialist knowledge can be very useful'
- Patients can be more independent and overall improve their health/mental state'
- 'Patients can find a lot of activities and support that take them out of well-worn habits and generally negative view of chronic conditions'
- 'The patients learn about services in the community available to them and these services can have a positive impact on their physical health'
- 'I think the best thing is the way that the service directly supports patients with issues which significantly affect their health, gives patients time and high levels of support (which is increasing difficult in primary care)'
- 'Promotes patient participation in the community'

It provides an alternative holistic option

- 'Holistic - reduces over-medicalisation and helps self-reliance, gives patients time to discuss issues'
- 'Patient has time to discuss what their needs are and what they think would help them with their overall health and wellbeing'
- 'Patients can have more thorough review/ assessment without as much time constraint and can be signposted to services that I may not have been aware of'
- 'The variety of services, and the competence and commitment of the social prescribers'
- 'Alternative route - instead of patients seeing GPs. This helps patients seek advice and get help quicker and get the right help they require'

Case studies

Three case studies from this period are attached. See appendix 3

Focus groups and interviews

Nine one-to-one interviews were conducted by a team member not involved in direct delivery of the service. Two of the nine interviews were held in a small group setting, five were face-to-face and four were carried out by telephone. A short extract is shown below. Full report appendix 3

Respondents were asked about the reasons they were referred to SP:

- 'I was extremely anxious and unable to go out'
- 'My GP knew I needed more help'
- 'I want to find work but it's hard with my caring role'
- 'Panic attacks and feeling overwhelmed'
- 'My sister recommended it and I self-referred'
- 'As a working single parent I have housing and money problems'
- 'My Diabetes nurse referred me to improve health and fitness'
- 'I have had many problems with my health'

Asked about the wait for an appointment:

All respondents thought the time it took from referral to being contacted by the SP service was good or acceptable

Experience of the first session with the SPC;

- 'I felt relaxed because it was easy to talk, I wasn't nervous'
- 'The SPC was so understanding and caring. It really warmed my heart, it's a pleasant experience'
- 'I was excited about the possibilities for classes that could help me'
- 'I felt good when I left as I knew there were services that could help me'
- 'I was glad there seemed to be some other things to help me'
- 'I felt listened to and understood'
- 'We talked about many things that could help me'
- 'The SPC is easy to approach and gave me time'

When asked about the services recommended to them:

All respondents said they are accessing recommended services or have plans to do so

Asked how SP has helped them;

- 'It has improved my health and pain levels'
- 'It has helped take my mind off my problems'
- 'It has helped with my anxiety'
- 'Before I couldn't leave the house, now I'm travelling on public transport'
- 'I'm more relaxed and I feel I'm making progress'
- 'Things are beginning to move forward'
- 'It feels like things are possible for me'
- 'I feel more supported'

Funding and the future of social prescribing

Social prescribing has been identified as one of ten high-impact actions in the current NHS Five Year Forward View. The GLA is currently driving initiatives to design a sustainable SP strategy for London with the Healthy London Partnership, NHSE and the UK SP network

The UK Social Prescribing Network has identified over 400 different social prescribing projects in the UK (Polley, 2016) and a review of evidence was published in 2017.

Regional SP networks are growing with BBBC heading up the new London network with The University of East London. These events are well attended by representatives from healthcare, social care, public health, local authorities and community organisations and some funding has been allocated by NHSE to ensure these are maintained and sustainable

However, despite an unprecedented level of attention being given to social prescribing as a cost-effective means to help address the social determinants of health, it is a service that has been unable to secure recurrent funding to ensure long-term sustainability. Growing evidence across the country of the positive impact of SP on people and their communities is not translating into sustainable funding. There is a growing demand for more robust and comparable evidence on health system savings and return on investment but there is little clarity about what evidence would translate to sustained or increased investment in social prescribing. Funding for evaluation research and data capture processes has been piecemeal to date in the UK with no common framework in place and research is often undertaken on services that have short term funding. A common outcomes framework is being developed by NHSE with the National SP Network advising.

NHSE is supporting social prescribing through a £4M VCSE fund for new and expanded schemes which is being assessed at time of writing. Whilst welcome, this is a relatively small fund for a UK footprint, requires match funding to incrementally increase over three years from local commissioners and will benefit only a small number of new and expanded schemes.

Social prescribing remains a fragile service from a national funding perspective despite transformative work going on at a local level across the country.

Summary

The Social Prescribing service in Tower Hamlets Network 6 is designed to work with clients with significant but not urgent needs to support them to access local services to improve their wellbeing and physical health. The number of clients presenting with complex and urgent needs is growing. This may require a reconsideration of waiting list times or a review of access criteria.

BBBC has observed a high turnover of staff in this role in the past three years and is aware of extreme pressures on other SPCs across the borough where staff turnover for the first year of the pilot is at around 50%. At borough steering group level, service capacity, safe working levels and staff safeguarding are under review.

The service continues in the climate of growing demand, insecure short-term funding and an absence of national clarity on evidence. The consistent delivery of the service is due not to policy-makers but to the dedication and professionalism of a small team supported by management at BBBC.

The increasing impact of the social determinants of ill health on patients and primary care and the value placed on the SP service by referrers, shows SP continues to provide an important referral pathway to help patients access wider community services and help alleviate pressure on primary care service providers.

Report Authors

Janet Coan, social prescribing development lead janet.coan@bbbc.org.uk
Anny Ash, Network 6 social prescribing manager anny.ash@bbbc.org.uk

Appendices

1. Referral form
2. List of referred services
3. Case studies x 3
4. Transcript of patient interviews
5. Safeguarding letter