

BRIDLINGTON INTEGRATED NEIGHBOURHOOD TEAM (INT) OLINDA ROAD CASE STUDY



Assertive Outreach in an Area of High Deprivation

BACKGROUND

In August 2024 Bridlington INT agreed to explore ways to engage with the public in order to create new population health approaches on a local level. Inspired by a recent pilot in Selby, allowing for creativity at place. Learning from Selby, applied to the Bridlington pilot included:

- Taking a can-do approach
- The requirement to design engagement questions as a ready-made tool doesn't exist
- Local people, in-person doing the engagement
- There will be rejection and not everybody will engage the first time or after multiple attempts
- Managing expectations of stakeholders

ENGAGEMENT NARRATIVE

Olinda Road was identified as the focus area. The street comprises of 36 households, residing in mainly terraced housing and a small number of flats.

Prior to any engagement taking place, primary care data was reviewed to gain an understanding of the households. Assertive outreach by the Primary Care Network Social Prescribing team then started, initially in the format of letters to each dwelling and telephone calls from the office. Following limited engagement with these methods the team visited the street and used feedback from residents to adapt their engagement approach:

"When we revisited and did knock-ons, feedback was that we got the letter but didn't take any notice of it."

This led to proactive visits to the street, knocking on doors between November 2024 and February 2025. Ongoing personal-level conversations led to an understanding of the street dynamics, and getting to know the residents, their broad ranging issues and how they would like to be supported.

"People would say no straight away initially. When you then enquired a little bit, asked questions, they would start to talk about themselves a bit. They didn't invite us in but we spoke on the street."

"One household that everyone had parcels delivered to, knew who was there. Like the neighbourhood watch, having an eye on everything and geographically located in the middle of the street. When we found them, it opened a few doors. She was the heart of the street."

"You start talking to people and the situation relaxes. More individuals started to open doors – if you spoke to the right person then you were let into the family."

AIMS

- To trial a Population Health Pilot taking inspiration from Selby model and Brazilian Model of Community Health Workers
- To improve health and wellbeing outcomes for the cohort defined
- To develop evidence base / best practice for this community
- To co-produce models of care and support with the cohort



GETTING TO KNOW THE RESIDENTS

28 households responded to the outreach, with 8 accepting support, equating to 23 residents.

We asked what helps keep people happy:

- Physical activity
- Family
- Socialising outside the home

One person said that their responsibilities keep them going, but not happy

We asked what makes things harder to access:

- Lack of knowledge and awareness of what's available
- Transport, particularly for outside of the town
- Housing issues (environmental health like damp)
- Health conditions
- All of the respondents described having caring responsibilities

We asked how much choice people felt they had:

- Two thirds said they felt they had little to no choice
- Several people described feeling they do the same thing every day

We asked how people get out and about:

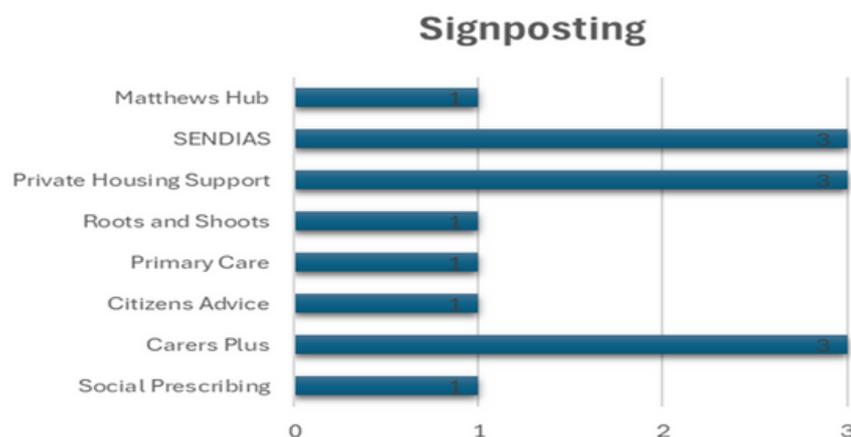
Walking was the most popular, and people reflected that access by foot to Bridlington amenities was good

We asked what else was good about Olinda Road:

- Accessible
- The beach!
- Close to town amenities

INDIVIDUAL BENEFITS

All households who accepted a visit received signposting, often to multiple organisations. Individual needs have been supported. One household had little outdoor space and the resident was growing plants in pots outside. They really wanted an allotment and the team supported this to happen.

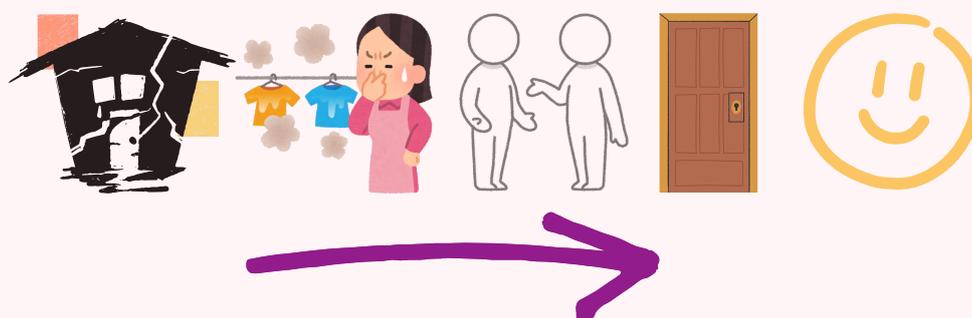


Case Study

A family shared that their biggest issue was **the gap in their front door...**

Their house had a large gap at their front door and their landlord wasn't actioning a solution, although it was their duty to make it secure. As a result, family weren't taking great care of their home. The social prescribing team supported the family by contacting the private sector housing team, putting pressure on the landlord to take responsibility and action. As a result, the landlord agreed to a replacement front door.

The family appreciated being supported and feeling that someone has helped them. Their home is now more secure and there will be benefits in heating costs. They now feel more confident and empowered to tackle their damp issues now and can contact private sector housing themselves.

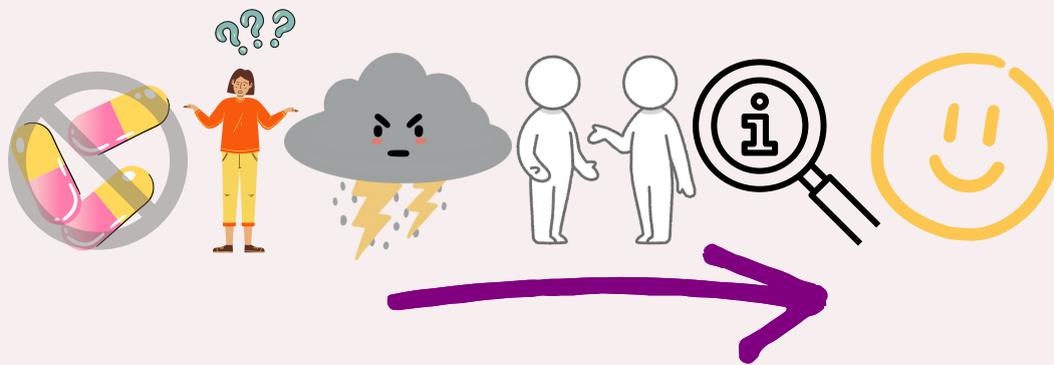


Case Study

A resident shared that their biggest issue was **access to medication...**

The resident was struggling to get the diabetic medication that they believed they needed. The social prescribing team supported the resident to understand why the medication was unavailable and what alternative support was available.

By supporting the resident to navigate the health system, they are now better informed, have a better understanding of their medication and are happy with the support they are receiving for their health.



LEARNING

- **Processes need to adapt** as engagement and insight develops, learning what does and doesn't work

"Doing things and being open with ourselves if things don't go right is good. We can see mistakes and we know that it's a pilot. You're not feeling massively deflated if one idea doesn't work."

- **Language is important**, being able to communicate with people in a local voice ('Brid Talk') helps to build trust, especially during initial engagement

"Now then, we were wondered if you'd received a letter. We just wanna clarify what we're doing."

- **To achieve trust and outcomes, you need somebody with the skillset** to manage difficult conversations, be able to navigate what's happening locally and be patient such as Social Prescribers

"Friendly, consistent, familiar faces."

- **Adequate workforce resource is essential**, including capacity for a dedicated lead. The pilot found that you could not rely on an unpaid voluntary workforce due to the skills and commitment required
- **Long term commitment** – It takes time to build trusting relationships and to co-produce solutions. An enabling factor is the maturity mindset to give 'permission' to trying something new, being open to taking positive risk and learning from it, which takes time
- We need to bring identified organisations in and then evaluate if it makes a difference

CHALLENGES

Data collated from GP notes was time consuming but not always relevant

"Data was useful for finding out who was in the household, but the detail of health data wasn't used. We couldn't go and talk about who's not vaccinated."

Governance can hinder moving at pace, for example it took time to get letters to send to residents signed off



Rich picture evaluation activity conducted with professionals to gain an understanding of the reach and different perspectives of the work

INTEGRATION BENEFITS

- INT conversations are going beyond health to social and wider determinants such as housing
- Need is being better identified and understood for example the level of caring responsibilities
- More meaningful relationships between partners have developed

"We actually had a proper conversation about the INT with private sector housing. We have a relationship but never had a proper conversation."

- Utilising relationships that have already been developed through social prescribing has enabled quick responses to identified need, for example being able to ring social care contacts directly for support.

CONCLUSION

The project built trust, strengthened inter-agency collaboration, and highlighted the value of assertive outreach. Key lessons included the need for adaptive approaches, skilled staff, and long-term commitment. Despite challenges, the initiative improved health and housing outcomes and empowered residents. It demonstrated that personalised, community-based engagement provided by a skilled local professional embedded within the Primary Care Network is a viable option for addressing wider health determinants if sustainably funded.

"The exciting part about this project is working with other people and having that open door to other services, we're all doing this together, not in little silos. If we can work better with all the agencies, then it just makes our job easier."

