Transformation Partners
in Health and Care

Embedding Community Led Prevention in Secondary Care

Using a proactive and personalised care approach to address health inequalities and deliver population health

TPHC Community Led Prevention Team

Foreword

As our Integrated care systems (ICS) continue to mature, there is an imperative that we are working together to deliver against our population health objectives. **84% of factors contributing to total health are socioeconomic factors, health behaviors and physical environment with only 16% of factors attributable to the health system** (Hood et al., 2016). So to reduce inequity in our population and support people to live longer with a better quality of life, we need to focus on the wider determinants of health as well as people's health needs.

Over the next fifteen years the number of people living with major illness is projected to increase by 37%. This will have a profound impact on patient activity across the whole patient journey and to address this demand we need to ensure that prevention becomes everyone's business, wherever they are seen, so that we can shift from a sickness service to a health service that builds on people's strengths.

There is evidence that demonstrates that social prescribing can substantially reduce pressure on the NHS, including through reduced GP appointments, reduced hospital admissions and reduced A&E visits. For example, a **2023 NASP rapid evidence review** on the economic impact of social prescribing identified evidence that social prescribing can save money and have a positive social impact, **with a social and economic value of between £2.14 and £8.56 for every £1 invested.**

Over time, as we shift the dial on prevention, patients with the low levels of knowledge, skills and confidence to self-care and those who continue to experience the greatest inequalities are more likely to be seen in the hospital setting. To better prepare for this demand, we need to support our specialist providers with the skills to work in partnership with patients and their carers, identifying what matters to them and empowering them to take an active role in their own care. In addition, through providing them with resources such as social prescribers, care coordinators and health coaches, we can ensure residents are supported to access resources in their local communities and voluntary sector to better address their concerns closer to home. By doing this we make every contact count, support our patient's holistically, encourage and enable residents to improve their health and wellbeing by addressing their wider needs.

Personalised population health is everyone's business and now is the time to make this a reality.

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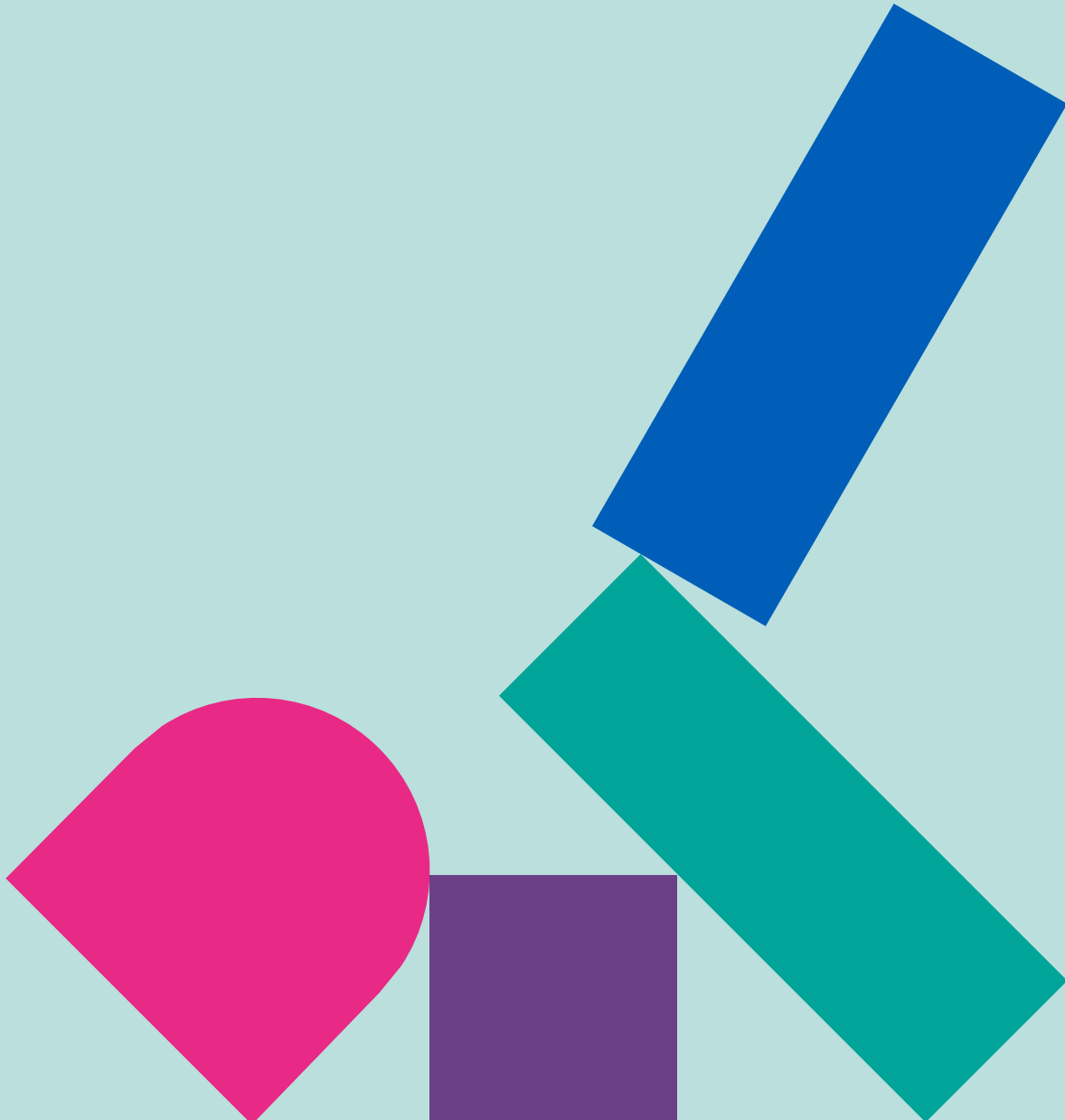
About this document



About this Strategy Document

This document summarises key messages that support the embedding of preventative approaches, such as social prescribing in specialist or acute pathways.

This learning has been developed by the TPHC Community Led Prevention Team, alongside our Secondary Care Community of Practice and all of our partners.

The purpose is to:

- Raise awareness and develop wider understanding of the impact of prevention in secondary care on wider health and social care delivery and population health outcomes
- Support acute hospital trusts and specialist services across London in embedding initiatives like social prescribing that tackle health inequalities and address upstream prevention
- Find and connect with secondary care services across London delivering impactful prevention projects that connect patients to support in the community, reduce service demand and cost, and improve population health
- Explore challenges, enablers and raise awareness of the impact of highlighting evidence and case studies that would support the introduction or expansion of prevention approaches
- Showcase integrated and innovative projects happening across London

Who is this document useful for?

This strategy document will be most useful for people in **leadership and strategic positions to support the development of partnerships and Integrated Neighbourhood Teams (INTs)**, including:

- NHSE London, ICB, ICS and Borough Leads, including health equity and inclusion, personalisation, prevention, proactive care, out of hospital and care in the community teams
- Provider collaboratives, Acute and Mental Health Trusts and Hospital Trust Charities
- Community Providers, Local Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations

However, this document aims to be useful for anyone with an **interest in addressing health inequity experienced by people accessing secondary care services.**

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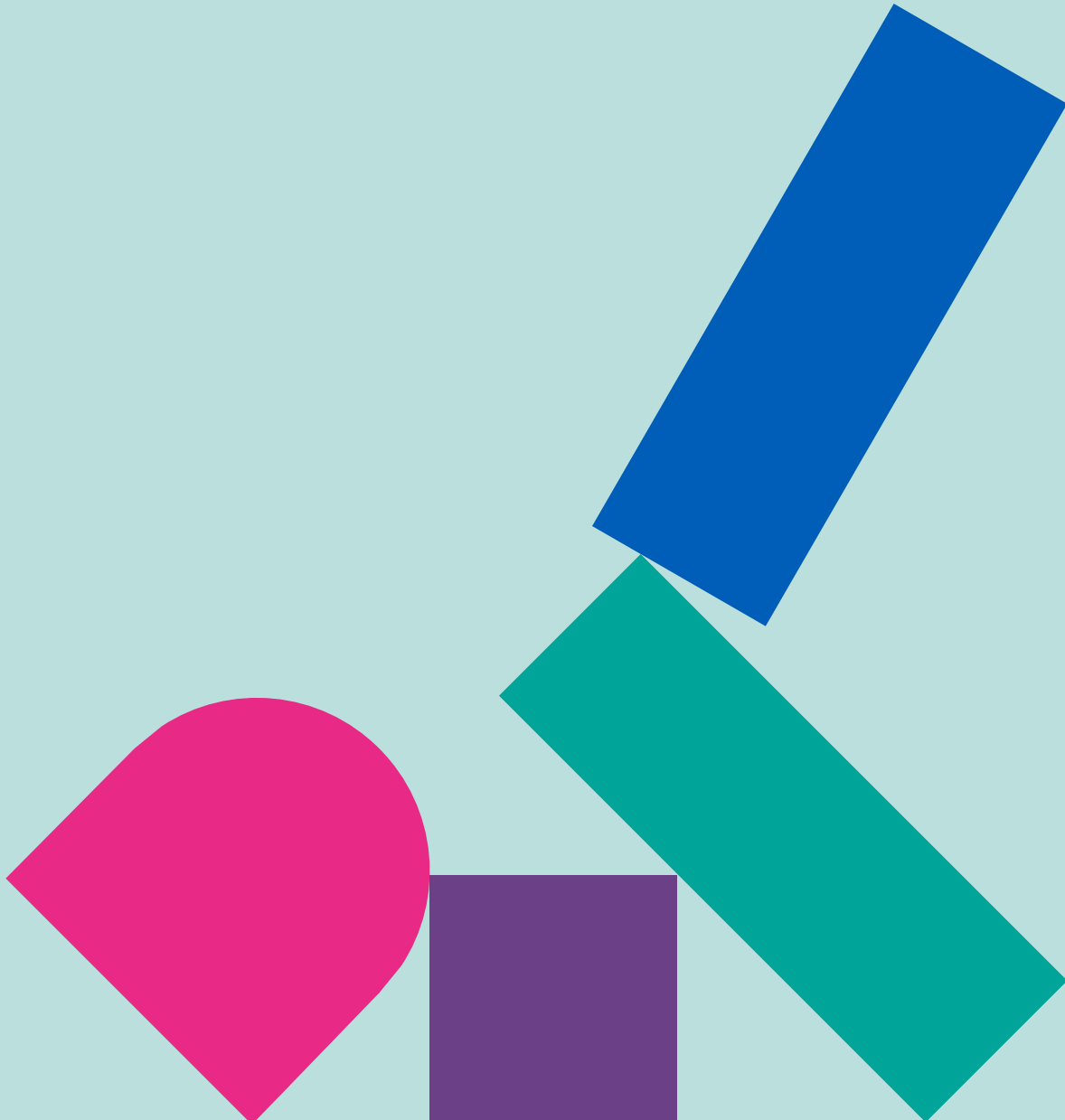
Health Inequalities

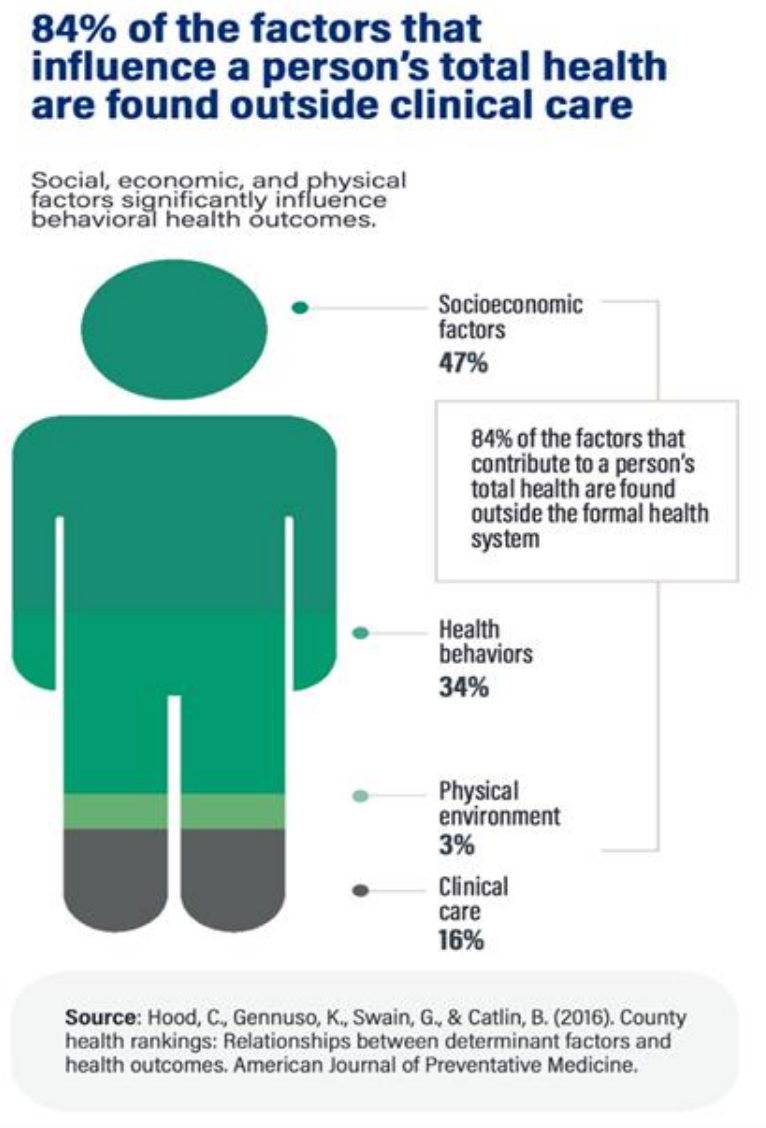


Wider determinants of health

- **84%** of factors contributing to total health are **socioeconomic factors, health behaviours and physical environment** with only 16% of factors attributable to the health system (Hood et al., 2016). This means that the lifestyles factors and the conditions in which people live have a greater impact on total health than healthcare. These risk factors are known as the **wider determinants of health.**

- Substantial evidence suggest that risk factors for ill health are **unequally distributed** in a population and this can present at a young age. Impacts of risk factors on health outcomes is therefore unequal, **leading to health inequalities**.

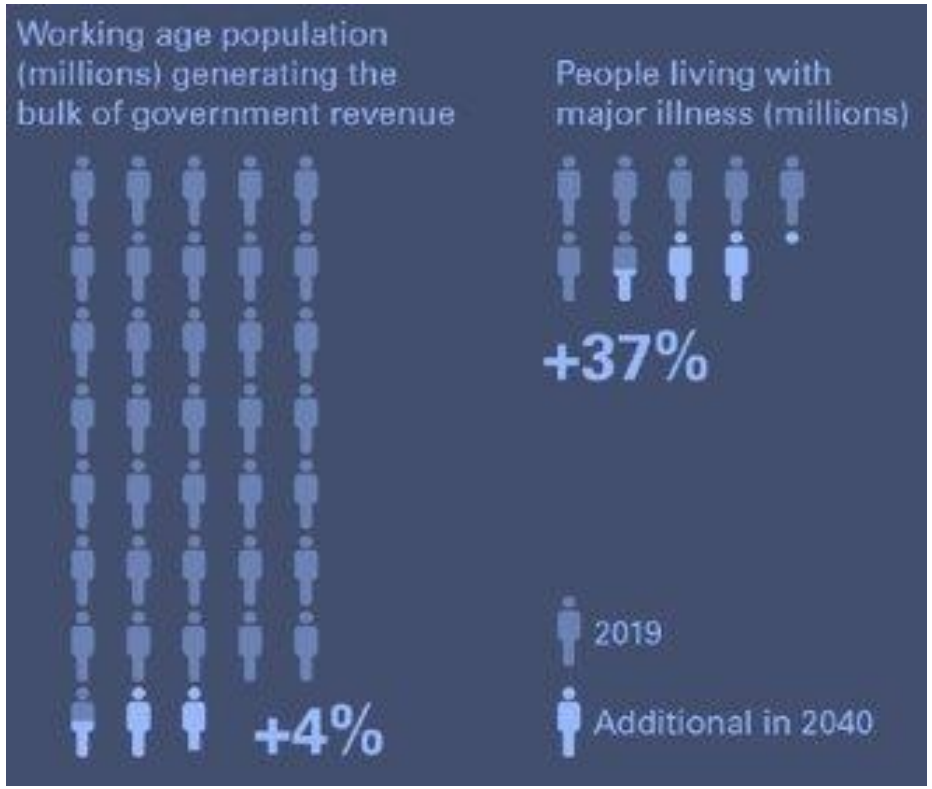
- Wider determinants of health contribute to the development of **Long Term Conditions (LTCs)** and limit a person's ability to manage such conditions. People with LTCs make up **more than 25% of the population** and account for **70% of the costs in health and social care services** in England (Nuffield Health)



Current context and system challenges

- People are living longer with more complex long-term conditions and co-morbidities
- The NHS is facing backlogs and long waiting times for patients to receive care/treatment
- Existing challenges across the healthcare system have been exacerbated by the COVID-19 pandemic
- Workforce are under significant stress with rising demand and limited capacity, leading to burn out, recruitment and retention issues, hence staff shortages
- Insufficient funding putting a strain on resources and limiting ability to manage an increasing demand for services
- Rising cost of living crisis is causing a fall in living standards, impacting physical and mental health and exacerbating existing conditions. Those with greatest health inequalities are most impacted

Widening access to personalised care interventions at more contact points with the NHS could extend reach and bring important benefits



<u>Analysis by the Health Foundation</u> suggests that the number of people living with major illness is projected to increase by 37% by 2040 (from 6.7m to 9.1m).

Why is prevention essential?

There is substantial policy and evidence (see slides 11 and 12) in support of a shift towards a preventative and personalised model of healthcare that delivers early intervention driven by meaningful conversations centred around what matters to individuals and communities. **Prevention needs to be everyone's business across service, organisation and system level to deliver high quality, sustainable, person-centred care**.

Up until now, primary care and community services have led the way on prevention and personalised care. However, a **whole-system approach to prevention** that takes into account the whole patient journey is required to deliver **sustainable impacts**, such as:

- improving population health outcomes
- improving patient experience
- improving access to health care in the right place at the right time
- reducing health inequalities
- reducing healthcare usage and demand, savings costs for the NHS
- improving staff health and wellbeing, job satisfaction and retention
- strengthening collaboration and strategic partnerships to support development of Integrated Neighbourhood Teams (INTs)

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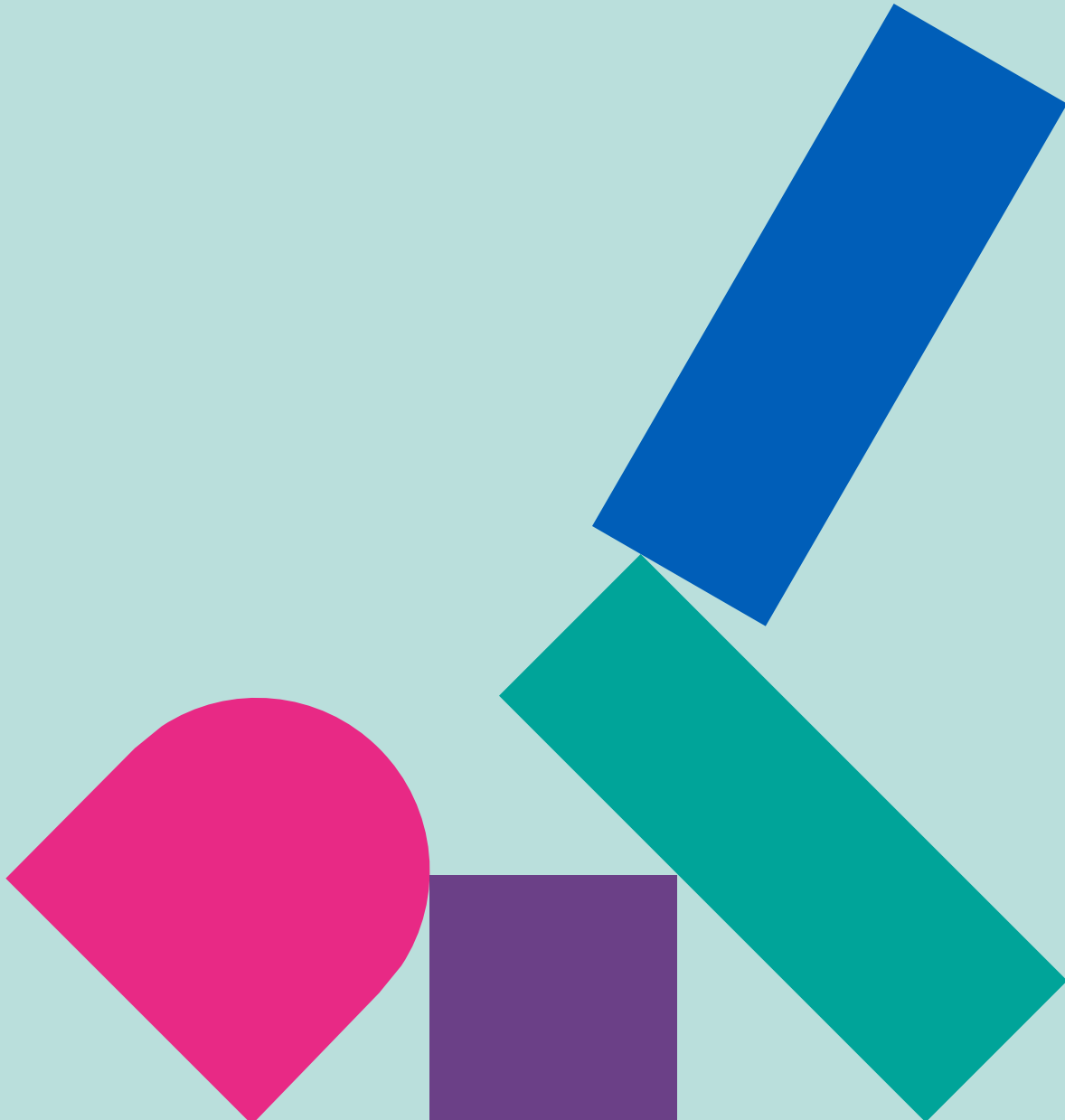
Policy context



Policy context and drivers

- **The Labour Manifesto (2024)** states that the NHS must also reflect the change in the nature of disease, **with a greater focus on the management of chronic, long term conditions'** and 'Labours reforms will shift our NHS away from a model geared towards late diagnosis and treatment, to **a model where more services are delivered in local communities'.**

- **The Darzi Review (2024)** points to the need for **shifting care from hospitals to the community**, advocating for **social prescribing and preventive measures to alleviate pressure on acute services**. By shifting care from hospitals to community settings, the NHS can tackle root causes of poor health, reduce hospital pressures and enhance patient outcomes. **Preventive initiatives, such as social prescribing in secondary care are highlighted as essential tools to address disparities.**

- **ICB Operational Planning Guidance (2024/2025)** calls for recovery plans for primary care, elective services and urgent care, while addressing health inequalities in children and young people and inclusion groups. The guidance also stresses building workforce capacity, directing ICB funding to target those in greatest need, **with a focus on proactive care, admission avoidance, and smoother hospital discharges.**

- **NHS Long Term Plan (2019)** emphasises the importance of **community-led prevention and integrated care to address health inequalities and reduce pressure on clinical services.** The plan promotes integrated community and secondary care, with multidisciplinary teams delivering proactive tailored interventions, especially for underserved groups. **These measures aim to shift from reactive to preventive care, improving health outcomes and reducing health inequalities.**

Policy context and drivers

- **Hewitt Review (2023)** underscores a need to "**shift focus from treating illness to promoting health and well-being**" and emphasises empowering people as active participants in their health, aligning with principles of prevention.

- **NHS England 2025/26 Neighbourhood Health Guidelines** highlights the need to shift care from **hospital to community**, and from **treatment to prevention** through promoting earlier intervention and health literacy. It advises **local acute services** on how they can contribute to neighbourhood health through **embedding person-centred care** and collaborating with other parts of the system as well as **community-based teams**.

- **Prevention Guidance for Secondary Care (more information can be found on page 11 of the Secondary Care Prevention Toolkit):**
  - **Making Every Contact Count (MECC)**: a national initiative and evidence-based approach to improve health and wellbeing through **promoting health-related behavioural change**. Evidence suggests that training front-line staff in brief interventions, has potential to support behavioural change in a large number of people, leading to **population health shifts over time and reduction in chronic disease**. (J Health Psychol. 2014)
  - **Healthy Hospitals Guidelines**: The International Network of Health Promoting Hospitals and Health Services 2020 Standards include:
    - **Promoting health in the wider society:** working to support health needs of the population via collaboration with public health and outreach services
    - **Enhancing people-centered health care and involvement:** holistic consideration of patient care needs and wider determinants of health

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Why prioritise Community Led Prevention in Secondary Care

Why prioritise community led prevention in secondary care?

Prioritising community-led prevention approaches in secondary care is essential because it supports high-risk and complex patients by addressing the social determinants of health that drive poor outcomes. **This approach reduces hospital admissions, length of stay, builds and drives stronger partnerships, and improves patient flow in acute settings.**

There is supporting evidence demonstrating the impact of social prescribing and community interventions in secondary care, such as:

- **Economic benefits:**
  - Newcastle's "Ways to Wellness" programme reported a 9.4% reduction in hospital costs, while other programs have achieved up to a **39% reduction in A&E costs** (Impact of social prescribing on health service use and costs, NASP)
  - Programmes across the UK have demonstrated **reductions in annual healthcare costs ranging from £77 per patient to over £1.5 million across large cohorts** (Impact of social prescribing on health service use and costs, NASP)
  - A social prescribing link worker can support **up to 300 patients** to better manage their health every year, this is **equivalent to the cost of one stent used to support heart surgery** (Findings from Barts Health Cardiac Model)
- In Newcastle, **secondary care costs in 2019-20 were 9% lower** than a matched-control group where social prescribing was not available (Impact of social prescribing on health service use and costs, NASP)
- **System Benefits:**
  - Reductions in demand for health services were particularly high for frequent users. In Kirklees, social prescribing support for frequent users **reduced GP appointments by 50% and A&E attendances by 66%** (Impact of social prescribing on health service use and costs, NASP)
  - In Rotherham frequent users**' A&E attendances were reduced up to 43%** (Impact of social prescribing on health service use and costs, NASP)
  - In secondary care settings, **social prescribing link workers act as intermediaries**, integrating care pathways and ensuring patients are directed to community or voluntary services, **which alleviates pressure** on clinical staff while addressing underlying social determinants of health. **This also enhances integrated neighbourhood working**

Why prioritise community led prevention in secondary care?

- **Patient benefits:**
  - Newcastle's "Ways to Wellness" program has shown **measurable improvements in patients' mental and physical health**. For example, in a cohort with long-term conditions, patients experienced an **11% improvement in their Wellbeing Star scores, reflecting better overall health and life satisfaction** (Impact of social prescribing on health service use and costs, NASP)
  - The NAPC found that Social Prescribing and Care Coordination support **led to increased activation, less hospital admissions, less falls, less GP contacts.**
  - MacMillan Community Link Worker Service in Wandsworth, Merton and Croydon demonstrated a **statistically significant increase in life satisfaction,** in feeling life was worthwhile and in happiness and **a statistically significant decrease in anxiety,** evidenced by ONS4 scores. See slide 23 for case study.
  - The Barts Diabetes services **reduced DNA rates by 26%** and supported young people to complete their education, move into safe housing or move into employment. See page 24 in the Secondary Care Prevention Toolkit.
- **Clinical Workforce benefits:**
  - **Improved efficiency**: Social prescribers handle non-clinical issues, such as housing, financial problems, or social isolation, allowing clinicians to focus on diagnosing and managing medical conditions more effectively
  - **Improved patient outcomes**: Addressing social determinants of health through social prescribing complements clinical interventions, leading to holistic care and better long-term health outcomes
  - **Enhanced patient satisfaction:** Patients benefit from having a dedicated professional to guide them through social issues, which improves their overall experience and trust in the healthcare team
  - **Streamlined care pathways**: Social prescribers create links between healthcare providers and community resources, ensuring patients receive timely and appropriate support outside clinical settings
  - **Reduction in repeat visits**: By addressing underlying non-medical causes of frequent healthcare use, social prescribers can help reduce unnecessary GP appointments and hospital visits

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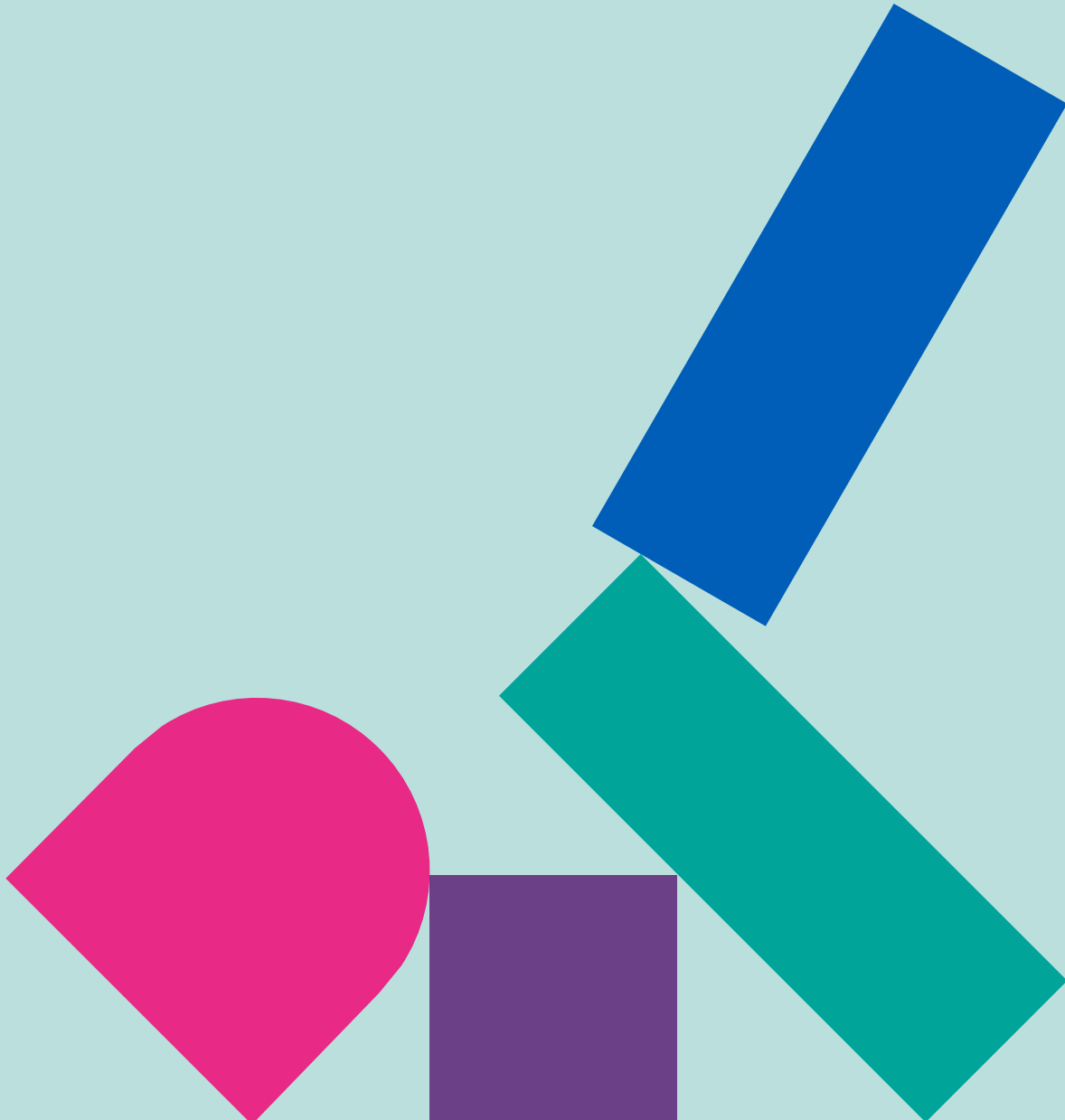
Case Studies



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Supporting High Intensity Use

H4ALL High Intensity Use Service Hillingdon - Case Study 1

Aim: For professionals, the initiative aims to reduce unnecessary and unplanned visits to GP, A&E, and hospital services, free up clinical time, and streamline access to a wide range of preventative services through a Single Point of Access and referral. For residents, it focuses on addressing non-medical challenges with social solutions, empowering individuals to manage their own care, supporting them to remain at home, and identifying issues early that may have previously gone unnoticed.

Cohort: Local residents who are over 18 with long term health conditions, loneliness or social isolation, frailty and/or higher than normal use of health service.

Background: With the aim of reducing unnecessary attendances and admittance's, the team work collaboratively with professionals central to the patients care including; multi-speciality clinical teams, GPs, London Ambulance Service, London Borough of Hillingdon Adult Social Care, Community Mental Health Teams, IAPT services, Metropolitan police and broader third sector providers.

Impacts:

- **38% reduction in GP appointments**
- **32% reduction in In Patient admissions**
- **37% reduction in A&E costs**

- **£2.03 return on investment for every £1 spent**
- **Potential saving of £1,149 per patient to the local health economy**

- **Average Loneliness Measure Score of 4 (out of 12)**

A High Intensity User Service for individuals with complex needs in NCL – Case study 2

Aim: To tackle health inequalities through promoting integrated working with teams across hospital, community, primary care and mental health services, London Ambulance Service, Local Authority (LA) & VCS organisations in Enfield and Haringey.

Cohort: High intensity users (HIU) who attend the emergency department in North Middlesex University Hospital more than 15 times a year or more than 5 times a month, and who often have complex needs.

Background:

- HIU or frequent attenders of emergency departments often have complex needs and multiple disadvantages, exacerbated by wider social determinants of health.
- Use of different systems across the boroughs in NCL makes sharing patient data between primary and secondary care a challenge.

Funding:

- Funded by NCL ICS for a one-year pilot between January 2022 and January 2023, which was renewed for another year until 2024.
- Third party contract with Mind funding care coordinator roles.

Delivery:

- The team based in North Middlesex University Hospital receive a report of patients over attendance threshold (120 top high intensity users of A&E identified utilising A&E data systems) then triage to identify patients who would benefit from support.
- Use of a personalised, person-centred approach focusing on the individual's issues, identifying, de-medicalising, de-criminalising and humanising their needs to uncover the core reasons for attending A&E or an admission.
- Where beneficial to patients, they are linked with a Care Coordinator who meets with patients to identify unmet needs.
- After 12 weeks on the programme, patients are discharged into community or voluntary support services

- **Increased wellbeing by 20-25% (Warwick Mental Well-being Scale)**
- **30% reduction rate in ED attendances (400 reduced attendances to ED within a five month period)**

Read more here.

Community Approaches to A&E: Working with Clinical Coaches in the Royal Borough of Kensington & Chelsea (RBKC) - Case study 3

Aim: High Intensity Use (HIU) patients were included to mirror a similar piece of work (Community Approaches to A&E on next slide) in North Westminster in conjunction with Community Champions, aiming to reduce patient risk of hospitalisations in RBKC.

Cohort: Adult patients over 18 years with long term conditions (LTCs), frailty and miscellaneous other conditions who would benefit from coaching, and HIU in primary care (who have had five or more GP attendances in the recent three months and two or more LTCs).

Background:

- A clear correlation was seen between sudden high use of secondary care services and a rising use of primary care services in the preceding months.
- Health Navigator, a partner organisation delivering health coaching, were commissioned to provide Clinical Coaches.

Delivery:

- Health Navigators were commissioned to provide four clinical coaches for one year (trained nurses providing support to empower and enhance selfcare for patients, thereby reducing risk of hospitalisations).
- It was a remote service via telephone, video call, WhatsApp.
- A therapeutic relationship with patients developed over three months.
- In Clinical Supervision Meetings for PCNs, HN introduced the service, explained the process and explored how to work together and share information.

Funding model: Winter access funding: £130k for rising risk and HIU patients.

Evaluation: Evaluated the service through tracking patient progress and sharing thematic outcomes in discharge summaries.

Health Navigators demonstrated a 41% reduction in clinical contacts by patients receiving the service. This activity decrease persisted 6 months after conclusion of the service.

Read more here.

Community Approaches to A&E: Working with Community Champions and Wellbeing Coaches (WBC) in Westminster - Case study 4

Aim: A 12 month pilot aiming to provide community-based alternatives to patients attending A&E & UEC services to reduce frequency of attendances in the Biborough (Royal Borough of Kensington & Chelsea, and North Westminster).

Cohort: High Intensity Users (HIU) classified as having visited A&E or UEC departments more than five times in any recent 12 month period.

Background:

- Unnecessary A&E visits cost NHS £2.5Bn per year (source: British Red Cross).
- Prevalence of HIU residents correlates with deprivation in NWL boroughs: over 75% of HIU residents live in neighbourhoods of highest Index of Multiple Deprivation (IMD).
- The highest concentration of HIU residents was found in the north of borough of Westminster

Funding model: Community Champions engaged through a funding pool jointly held with local authority and match funded by local NHS borough teams. Wellbeing Coaches (WBCs) were funded through winter access funds.

Delivery:

- Built with engagement with VCSE: working with Community Champion projects in neighbourhoods in North Westminster under the Right Care Campaign.
- A team of Community Champion volunteers working preventatively with residents to link in with local services to prevent default behaviour.
- WBCs were attached to selected practices, received an HIU referral, provided one to one support and referred onto community activities through engagement with Community Champions and other community resources.
- WBCs were supervised by a Lead GP attached to all participating practices. Community Champion volunteers were centrally trained by Community Champion project leads, and WBCs were trained and managed by One Westminster.

Evaluation: Evaluation involved using a baseline survey at the start and end of intervention given by WBCs, and tracking specific prescription medications.

Read more here.

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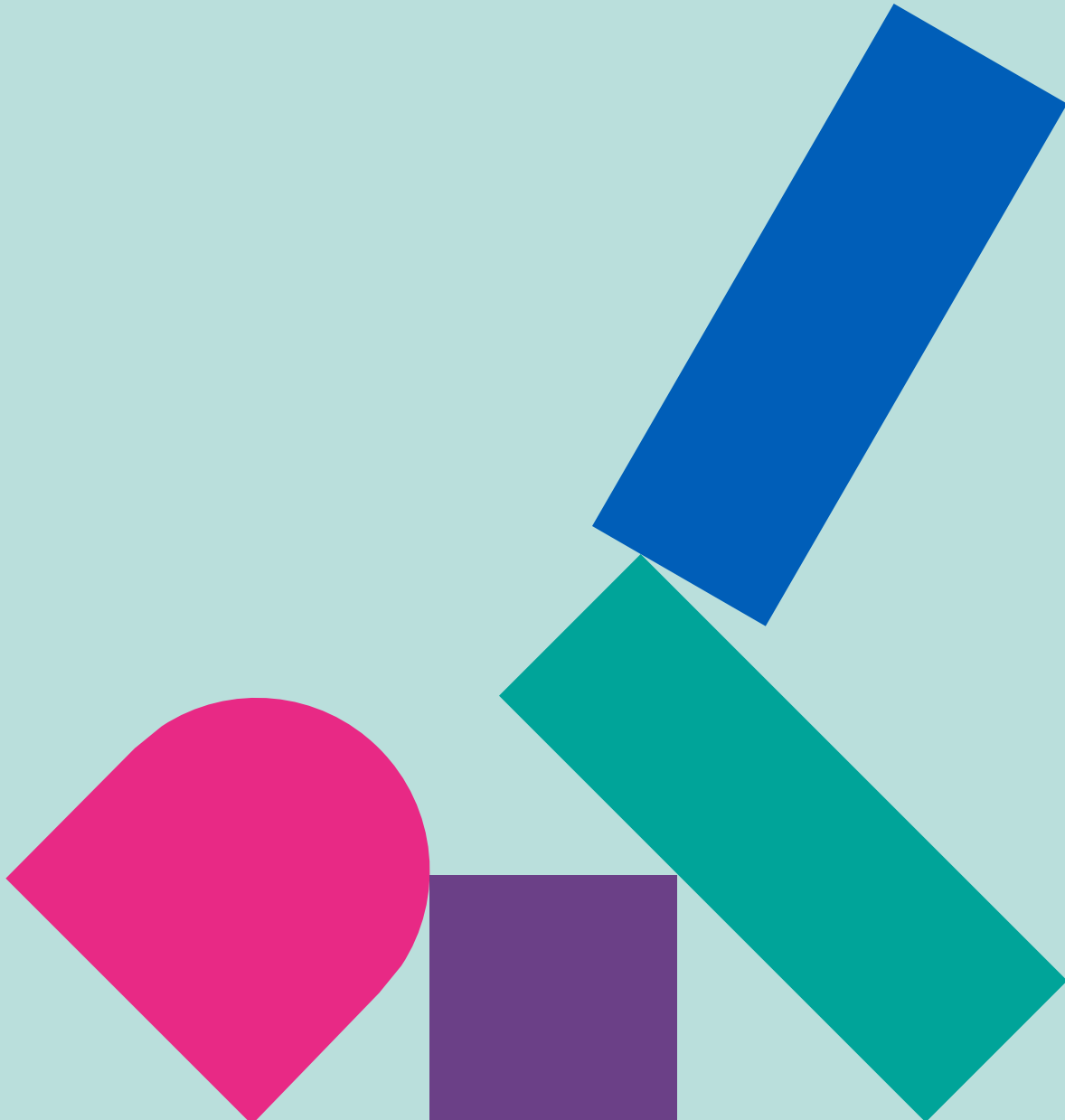
Supporting Cancer Care



Supporting Cancer Care: Case Study 1

Aim: To improve quality of life (QOL) as well as improve the awareness of, access to, and uptake of services available for those living with and beyond cancer.

Cohort: Cancer patients living in Wandsworth, and since April 2023, also those living in Merton and Croydon.

Background:

- Over 70% of people living with cancer need emotional support: two in five are affected by depression and one in ten are affected by anxiety - Macmillan Cancer Support Understanding Social Care Needs.

- 625K people are living with cancer in the UK. One in four of those living with cancer will face poor health or disability after treatment - Macmillan Long-term consequences of cancer and its treatment.

Funding model: Macmillan Community Cancer Link Worker funded by Macmillan.

Evaluation: ONS4, EQ5D and FACT-G tools used to measure outcomes.

Read more here.

Delivery:

- Cancer patients who are struggling to come to terms with their diagnosis, who have financial/employment concerns or family/relationship issues, or who want to improve QoL by keeping active or engaging with local activities, can be referred to the Macmillan Community Cancer Link Worker.
- The service can support anyone with a cancer diagnosis at any stage of the pathway, including carers and family members. All health care professionals supporting residents in the three boroughs can refer.
- The Link Worker will offer an initial one-hour appointment, virtually or in person, to understand individual needs. They can refer or signpost the cancer patient to relevant courses, psychological support, complementary therapies, wellbeing activities, benefits advice, or support groups. As well as regional and national support services and local services dependent on the area.
- The service provides peer support and specialist cancer training to upskill and build GP based link workers confidence in supporting people living with and beyond cancer.

Over 350 referrals and 290 patients were supported over the first 22 months. Comparison of ONS4 scores at baseline and follow-up demonstrated a **significant increase in life satisfaction, in feeling life was worthwhile and in happiness and a significant decrease in anxiety**.

Supporting Cancer Care: Case Study 2

Aim: To improve cancer care by improving information sharing and communication between the multi- disciplinary team supporting patients.

Cohort: Cancer patients living in Tower Hamlets.

Background:

- Patients report having to repeat information about their cancer due to poor communication between all roles in the virtual team surrounding someone living with cancer.
- A clear need to improve communications between the acute and community setting.

Funding model: Funded by Macmillan.

- The service resulted in 191 referrals to variety of services.
- Breast cancer and colorectal cancer patients were most common.
- 46% referrals were received from GPs and 25% received from community health services.

Delivery:

- A Macmillan Cancer Care Navigator (MCCN) was embedded in the Multi-Disciplinary Team (MDT).
- The MCCN proactively established professionals in the virtual team and ensured good communication and information sharing for the MDT to function effectively.
- The team adapted their approach to improve communication with GPs and to increase referrals from primary care.
- Health Needs Assessments (HNA) were produced by Macmillan to identify wider social issues and were completed by the clinical nurse in hospital, then again in the community.
- A personalised support care plan was created and shared with the GP and other professionals in the virtual team. Clinical concerns were passed to a clinical nurse specialist and the MCCN linked to other local and national support services (Macmillan, charities, SP or other agencies) for social needs.
- The MCCN had ongoing contact with the patient, followed up with the GP & virtual team and supported referrals into community health services outside hospital or to alternative support via the virtual team.

Read more here.

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Supporting Children & Young People

Barts Health Young Adult Diabetes Social Prescribing Service - Case study 1

Aim: To improve young people with Type 1 and Type 2 diabetes engagement with health care and improve DNA rates.

Background:

- Young people with Type 1 and Type 2 Diabetes struggle to engage with their healthcare due to psychosocial factors
- Low self management can lead to Long Term Conditions (LTC)
- The Young Adult Diabetes (YAD) service has high DNA rates due to competing priorities, high levels of diabetes related distress and burnout, and associated mental health disorders

Funding model: £300K per year for 2.5 years from NHS England (Pilot funding is running out in March 2025)

- **Increased clinic capacity (1.5x)**
- **Reduced DNA rates (39% to 12.5%)**
- **Lowered HbA1c (71.5 to 57.9)**

Delivery:

- 2 Youth Workers, 2 Social Prescribers and a psychologist are embedded in the YAD Multi-Disciplinary Team (MDT), working across all Barts sites alongside a Diabetes Specialist Nurse, Dietician and an Administrator
- 44% of patients deemed as being high risk (DNA 20% of clinic appointments) also had high rates of learning disabilities, mental health / eating disorders and homelessness and are in and out of hospital
- Overarching aims are to improve diabetes control and cost-effectiveness by improving engagement, reducing DNAs & maximising the impact of each clinical appointment
- Co-designed the interventions with young people by inviting them to brainstorm what is important to achieve. Youth Workers and Social Prescribers engage with young people to understand their barriers to accessing healthcare (meet via home visits or in community spaces)
- The team work with young people on their diabetes management only once they are ready
- Additional support includes a WhatsApp group for YA with Type 1 diabetes, monthly peer supports for Type 1 and Type 2 separately, and a walk and talk group facilitated by the psychologist

- **Cut hospital admissions by 36%,**
- **Estimated financial savings across all of Barts of £62.5K per year**

Read more on page 24 of the Secondary Care Prevention Toolkit.

Barts Health CYP Social Prescribing Pathway – Case study 2

Aim: A 2 year pilot that was young person-led and took a holistic approach to improve health and wellbeing of CYP living with long term conditions (LTC).

Background:

- Children & Young People (CYP) ages 11-18 years with Sickle Cell Anaemia, Thalassemia, Haemophilia or Medically Unexplained Symptoms (MUS), or receiving Renal Dialysis at Barts Health
- Young patients under hospital care often do not have access to social prescribing, which can have significant benefits for health and quality of life

Funding model:

- Barts Charity funding for the first year as a Test and Learn model
- NHS England continued funding for the second year
- Supervision by Allied Health Professionals and Clinicians as clinical supervision was important

Delivery:

- A CYP Social Prescribing (CYPSP) service with a Social Prescribing Link Worker (SPLW) embedded in Royal London Hospital - model shaped with TPHC
- Clinicians involved in the young person's care introduced those who would benefit to the SPLW and asked if they'd be interested in being referred
- The SPLW engaged with young people and their families to help them to identify goals and connect with community services
- In-person meetings where the young person felt most comfortable
- Caseload of 10-12 patients at one time, 4-8 sessions per patient

- **21 referrals to the CYPSP service, 8 rejected and 13 accepted**
- **31 referrals made for young people to services/opportunities/activities in the community: top referrals to Renaissance Foundation and Bright Futures**
- **10 improved their STAR Outcomes Score & 0 reduced in score**
- **Broadened the referral route, accepting referrals from Physiotherapists working with MUS young people**
- **2 young people returned to full-time schooling whilst being supported by the SPLW**

Read more on page 23 of the Secondary Care Prevention Toolkit.

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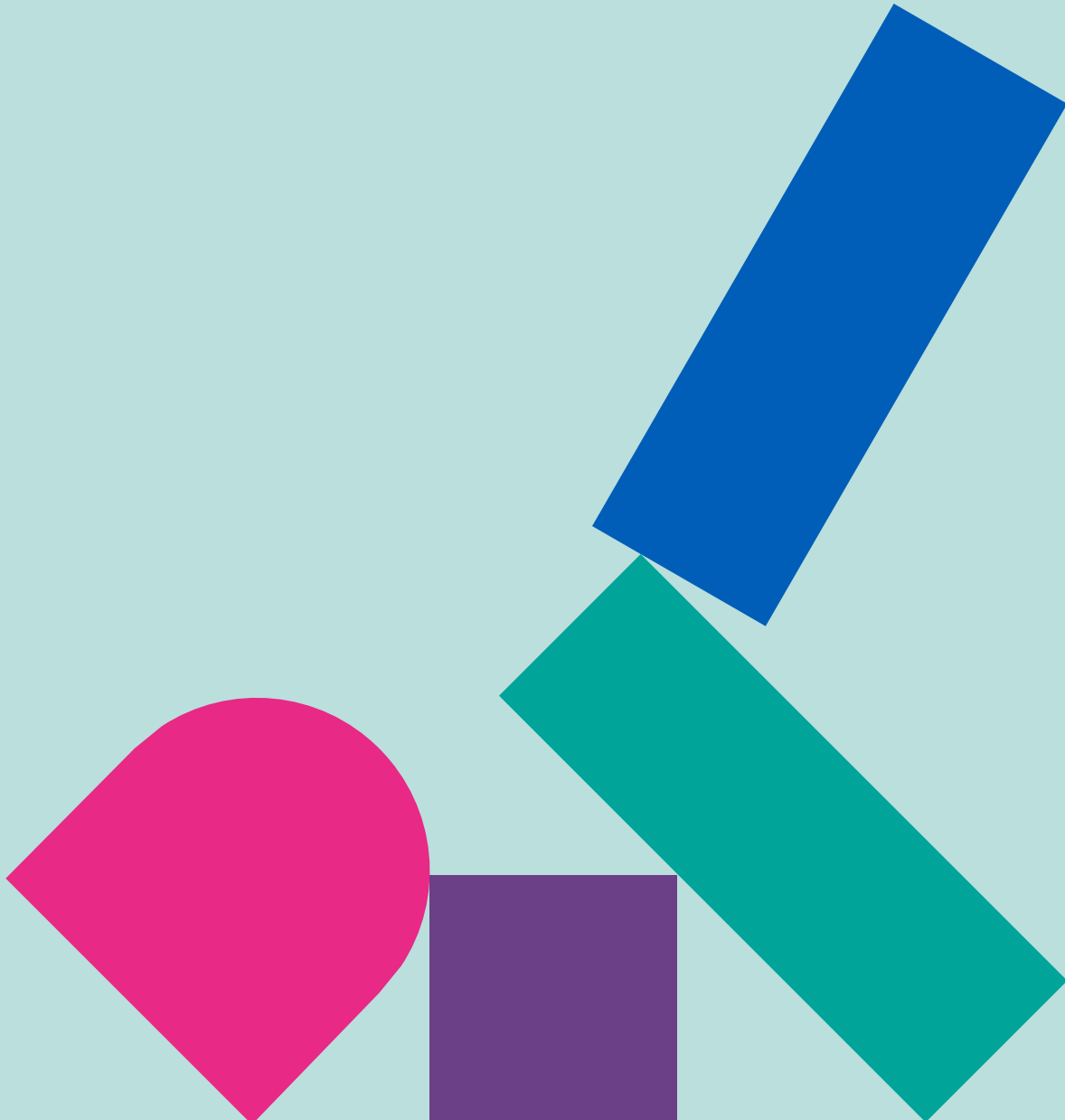
Supporting Cardiovascular Disease (CVD) pathways



Barts Health Cardiac Social Prescribing Pathway - Case study 1

Aim: To identify and support patients at the Barts Heart Centre who have financial difficulties and/or social issues.

Background:

- 28% of Barts Heart Centre patients have financial difficulties and 27% want/need support with social issues
- Such social and economic factors are high risk factors of heart disease and limit a person's ability to manage their condition

Funding model: NHS England funded the first year of the project as part of an Intervention Working Group to support personalised care and social prescribing. Barts charity continued funding for the second year

Delivery:

- A screening tool introduced in the cardiac pathway and given to patients by Advanced Clinical Practitioners (ACPs) asks patients if they have difficulties 'making ends meet' at the end of the month - given 1, 4 & 8 weeks post Myocardial Infarction (MI)
- Patients who meet inclusion criteria or who Do Not Attend (DNA) appointments are referred to the Social Prescribers (SP) embedded in the Heart Centre Pathway to call DNA patients and triage referrals
- Patients are seen by the SP, who takes time to understand 'what matters to them' and refers patients to relevant community services, with regular patient follow-ups

Evaluation:

- Plan Do Study Act (PDSA) parameters set
- Analysis of Barts and primary care data to explore resource allocation
- Measuring impacts on disease and recurrence
- Going forward, a further gap analysis of support limitations in East London: gaps in services and long waiting lists, and focus groups to understand specific population health needs

- **Over 800 patients screened revealed concerns such as employment, housing, and financial insecurity (many on zero-hour contracts without sick pay)**
- **60% accessing social welfare services are men.**
- **50 referrals to Talking Therapies highlighting gaps in primary care support.**

Read more here
And page 22 of the Secondary Care Prevention Toolkit

Barts Health Cardiac Rehab Social Prescribing Pathway - Case study 2

Aim: To support patients with health promotion, reduce isolation and increase physical activity through health coaching and social prescribing

Background:

- Low access and uptake of cardiac rehabilitation due to wider social barriers, including homelessness and financial pressure
- Elderly people struggle to connect with rehab due to frailty and public transport
- Ethnic minority groups are underserved

Funding model: NHS England funding for a 12-month Social Prescribing pilot to reach 80% uptake of Cardiac Rehab.
In conversations with the ICB around recurrent funding and exploring further opportunities

Delivery:

- Model and structure in development, with help from Bromley By Bow Centre (BBBC) and more established social prescribing projects across Barts Health
- Use of a screening tool to understand if patients have difficulties 'making ends meet' at the end of the month, or have other factors influencing their ability to engage (isolation, deprivation, housing, immigration)
- An external Social Prescriber provided by the ICS and an internal Social Prescriber embedded in the pathway

Evaluation:

- UCL Partners will be evaluating the internal Social Prescribing approach against the external Social Prescribing approach to capture the differences and impacts
- Plan to use the same database as the Cardiac pathway for Social Prescribing data input and collection
- Creating a directory to establish pathways for regularly occurring issues in the patient group

Read more on page 25 of the Secondary Care Prevention Toolkit.

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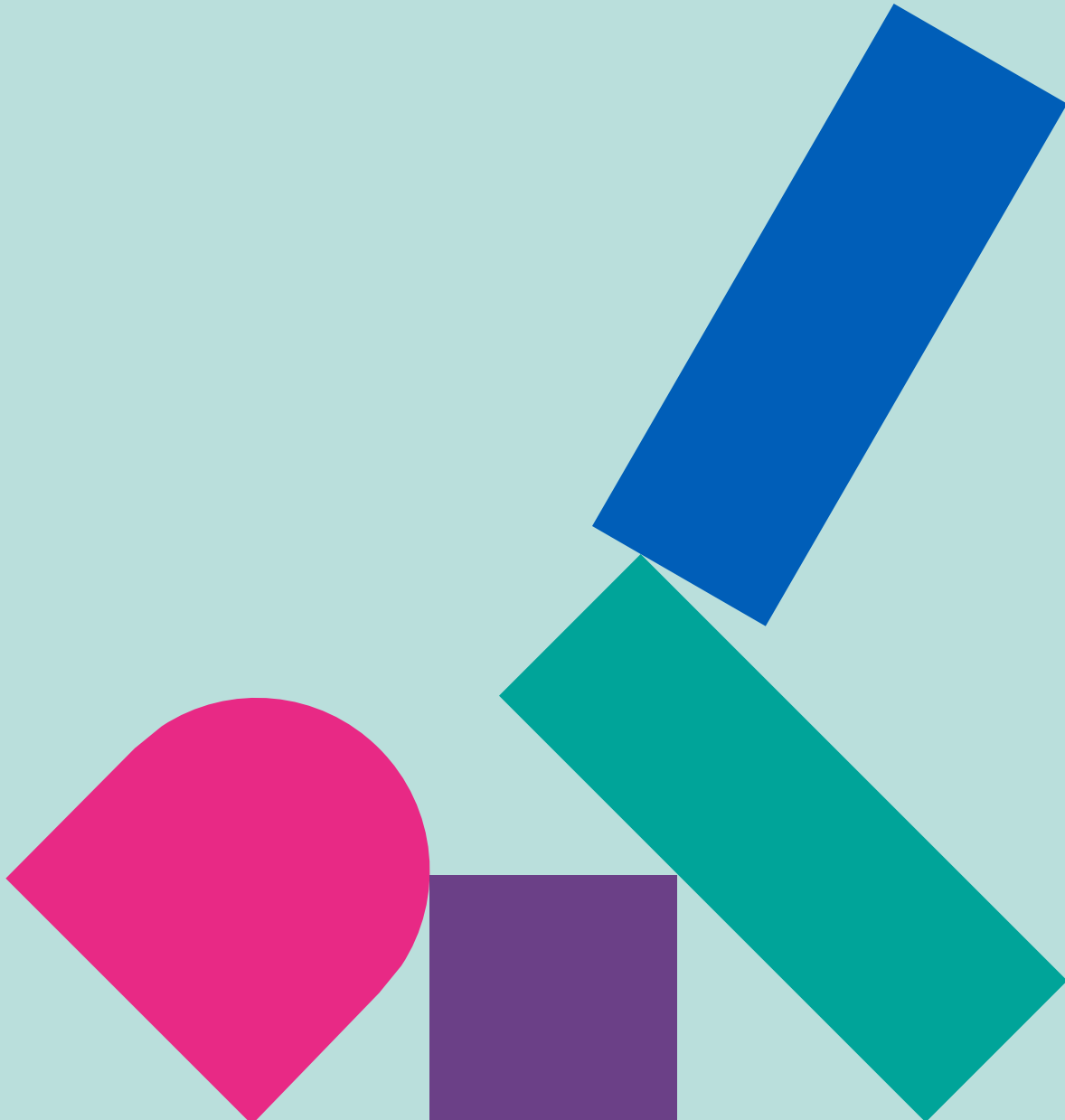
Further information



Further information

- Barts Health have embedded a number of social prescribers in different specialisms across the Trust, including Cardiovascular disease, Children and Young People, Cardiac Rehabilitation and Youth Adult diabetes. To read more about the work that's happening at Barts Health NHS Trust, you can read the Secondary Care Prevention Toolkit here.

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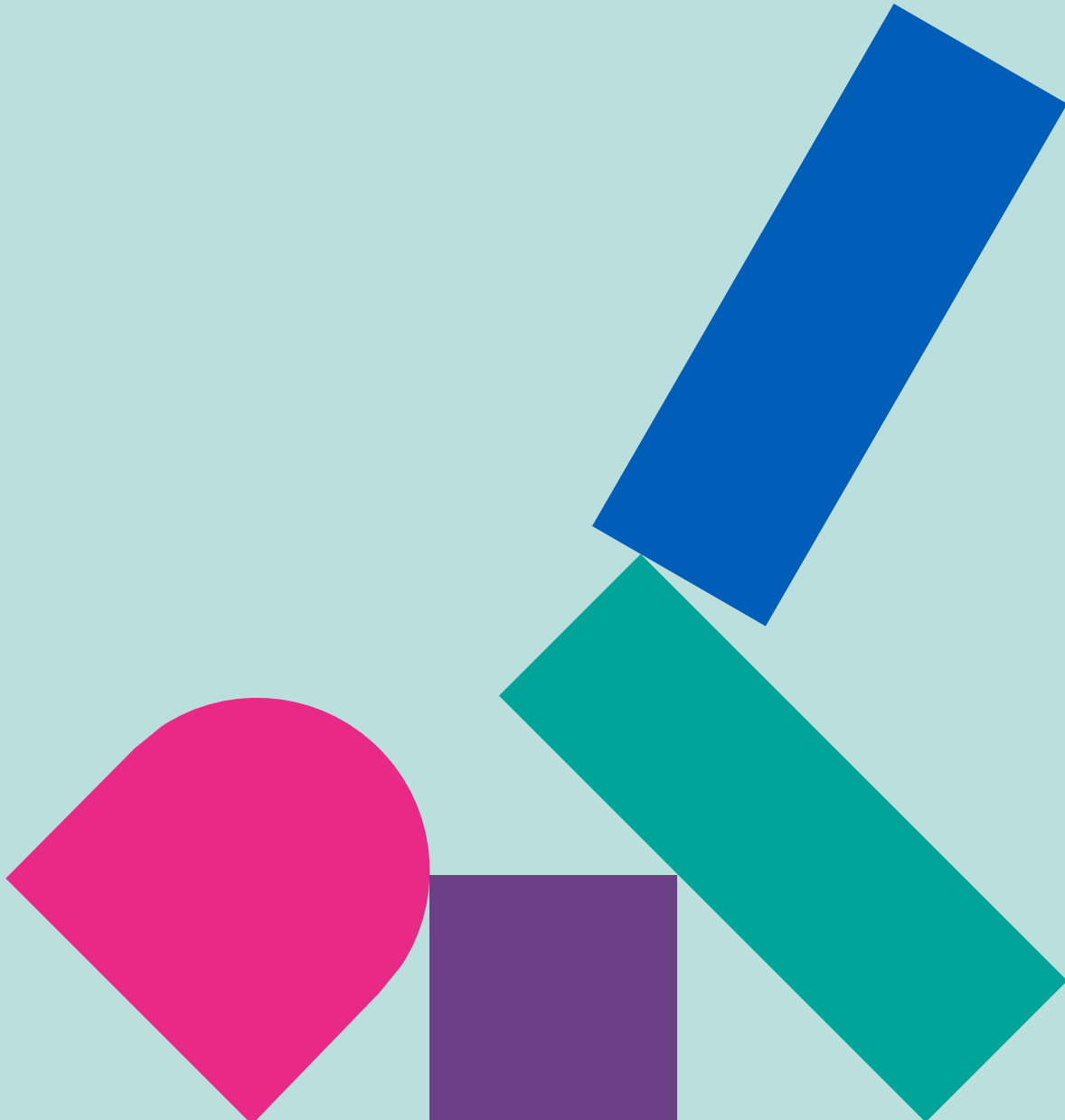
Funding Models



Funding models

As there is currently no NHS ring fenced funding to support preventative approaches in secondary care, projects have used the below funding methods:

- Limited one-off funding e.g. applications through a hospital scheme
- Funding pool jointly held with local authority and match funded by public health
- ARRS or PCN funding
- Winter access funds
- NHSE funding
- Hospital or National Charity funding e.g. Barts charity, Macmillan, Barnados
- Grass roots funding e.g. engagement fund
- ICB/ICS funding e.g. health inequalities or innovation funds

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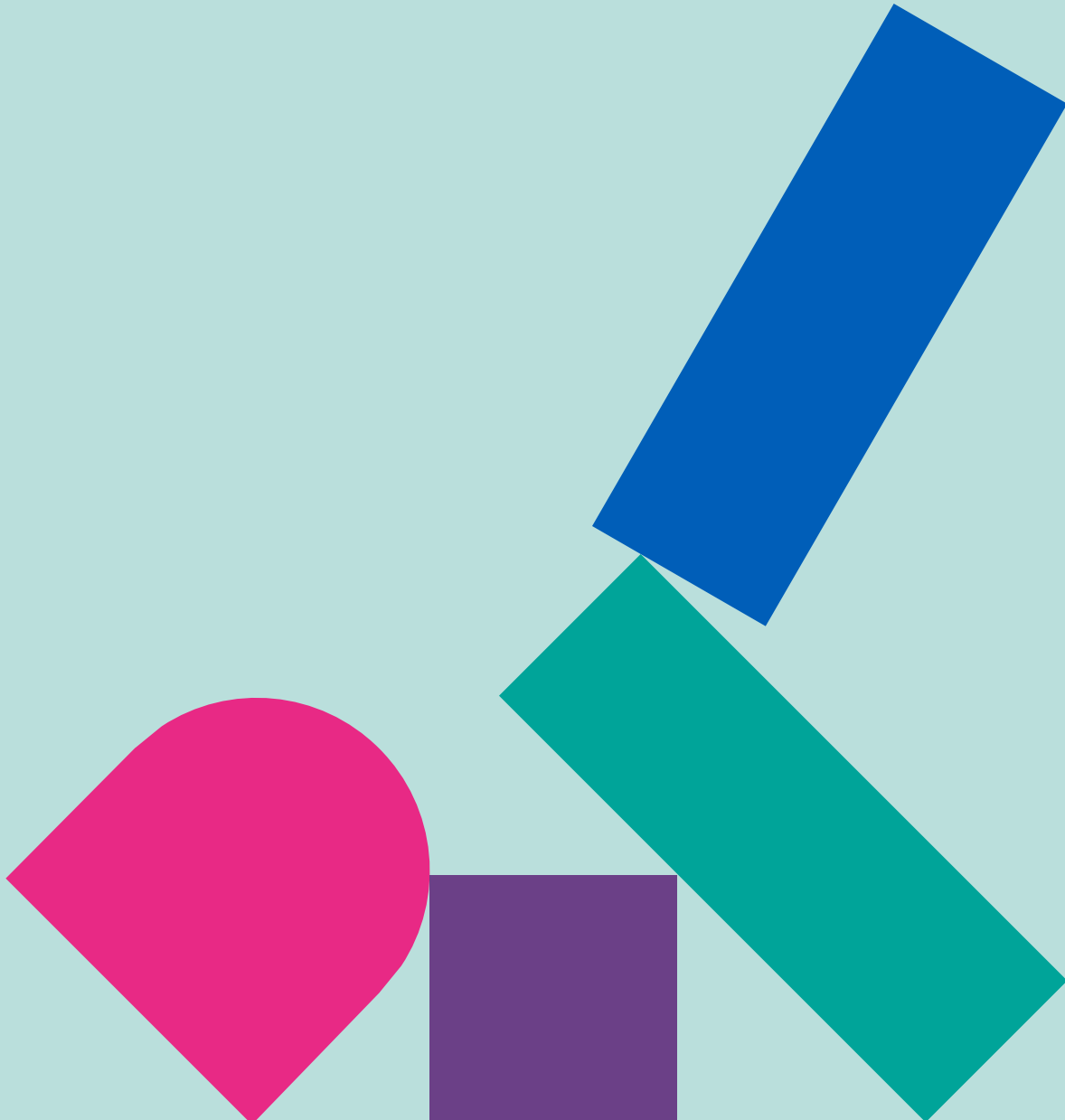
Challenges and Enablers



Challenges and enablers

Challenges	Enablers / recommendations
Sourcing and sustaining funding in secondary care: challenges with short term pilots	Increased funding to sustain longer term projects and allow time to develop trust from healthcare professionals
Limited time available for pilots to demonstrate an impact: limited data/evidence demonstrating impact or best practice	Allocating sufficient budget for thorough evaluations and having strong IT infrastructure for cross-system data sharing
Lack of trust in a new service/pilot means fewer referrals	Increased funding to sustain longer term projects and allow time to develop trust from healthcare professionals
Lack of awareness around the benefits/value of personalised care and education around social determinants for secondary care staff	Bespoke training for secondary care staff and having a lead clinician involved
Funding for the voluntary sector to support increased number of referrals from secondary care	Invest more in VCFSE services e.g. through Community Chest models of funding: shared investment funds joining up money from NHS, local authorities and other sources
Discrepancy across system on role titles and descriptions means harder to promote role value	Sharing learnings to develop a more uniformed approach across secondary care
Limited resource and lack of capacity of personalised care roles to manage demand	Focus on recruitment of specialist or hybrid personalised care roles that can receive referrals from secondary care
Lack of networks to connect and best practice examples for shared learning	Peer support networks at ICS or borough level for personalised care roles in secondary care as well as the existing Pan London Community of Practice
Access to shared platforms and data sharing between secondary, primary care and VCFSE	Developing and strengthening IT infrastructure across ICSs to improve data sharing and continuity of care for patients
Resistance from primary care and community due to burden of increased referrals	Reframing the communication and relationships between primary and secondary care to emphasise collaboration around a common goal
Space to meet patients: outside of hospital setting is preferable	Emphasising the value of embedding personalised care roles in hospitals and continuing conversations around optimising NHS estate

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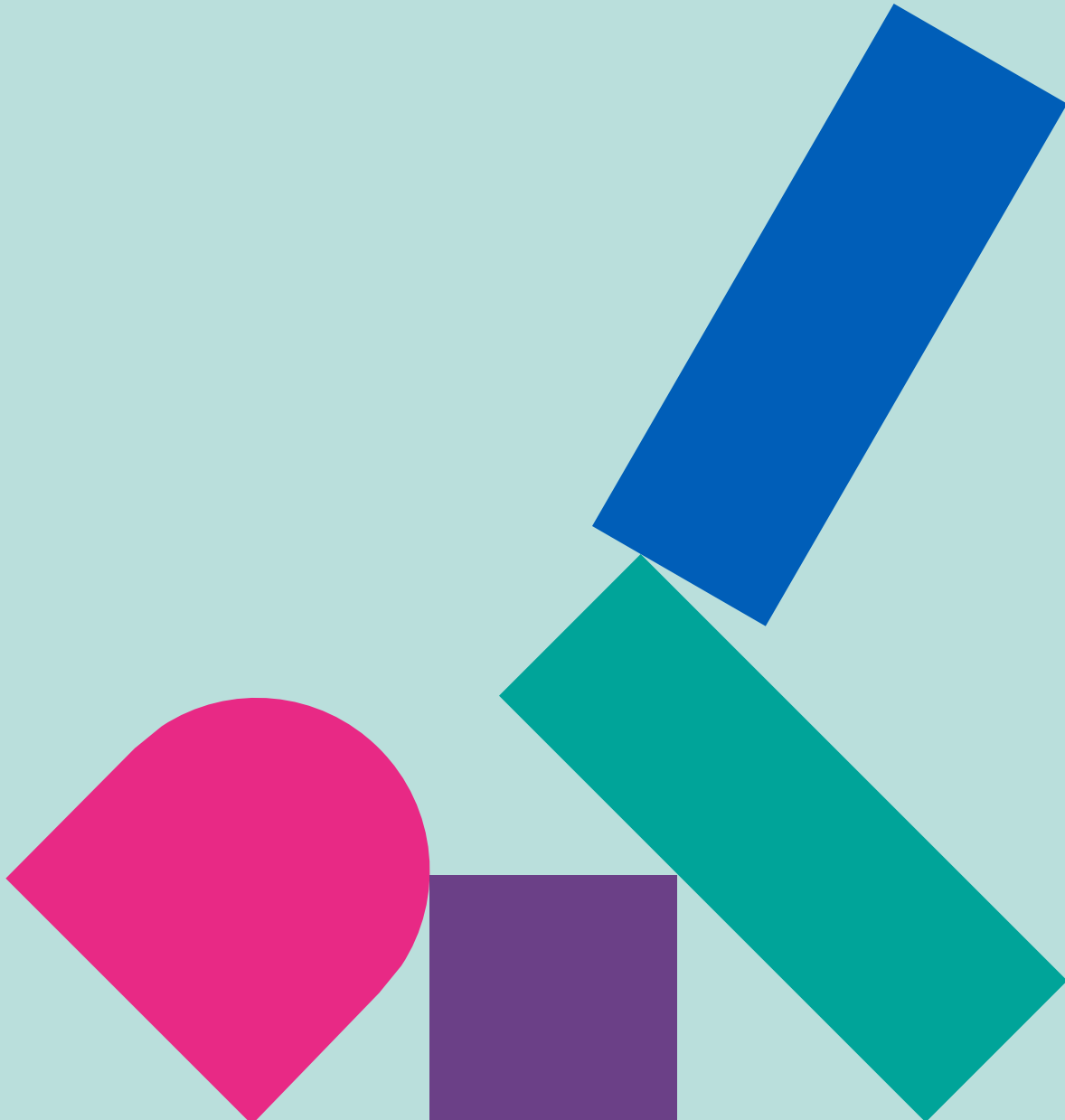
Recommendations



Recommendations to embed community led prevention in Secondary Care

- To ensure **all acute trusts in London have implemented social prescribing services to support patient care and address their wider determinants of health**

- **Raise awareness of the benefits of investing in community led prevention activities** to ensure there is sufficient **capacity closer to patient homes** to address patient needs identified through social prescribing services

- **Raise awareness of the benefits of taking a personalised population health approach to service delivery in secondary care** to ensure an **end-to-end approach to patient care** and **wellbeing is adopted in secondary care**

- Implement **shared system outcomes** that recognise the impact that social determinants have on health, so **all secondary care providers are held to supported to work towards the implementation of preventative care in secondary care**

- **Ensuring VCFSE are active partners** of ICS Provider Alliances to help **shape future ICS planning rounds**

Appendix

- The impact of social prescribing on health service use and costs: Examples of local evaluations in practice. National Academy for Social Prescribing.
- Health in 2040: projected patterns of illness in England
- What influences our health and health inequalities (Hood et al, 2016)
- NASP: Building the economic case for social prescribing
- Health in 2040: interactive chart projections
- Care and Support for Long Term Conditions, Nuffield Health
- Making Every Contact Count (MECC)
- Healthy Hospitals Guidelines