Transformation Partners in Health and Care

NHS Barts Health NHS Trust

Embedding and Connecting Prevention in Specialist Pathways

2025

A Toolkit on how to embed community-led prevention such as social prescribing in secondary care specialist or acute pathways, to explore whole-system approaches in NHS Trusts across London.

Delivered in collaboration between

Barts Health NHS Trust

Community Led Prevention Team, Transformation Partners in Health and Care (TPHC)

Foreword

In England, more than 1 in 4 people are living with long term conditions (LTCs) (Nuffield Trust). Over the next fifteen years the number of people living with major illness in England is projected to increase by 37% (The Health Foundation). This will have a profound impact on patient activity across the whole patient journey, including in specialist and acute care pathways.

At Barts Health, we take our role as a community anchor institution very seriously, and partner with community and volunteer colleagues to deliver integrated care, health promotion and prevention. Barts Health NHS Trust are committed to embedding the Healthy Hospital agenda, to tackle health inequalities, engage with communities and residents, and develop a sustainable model of care. At Barts Heart Centre, we have studied the impact of social conditions on heart disease for many years, and our teams work towards embedding prevention and community support into their clinical practice.

Community-led, proactive and personalised approaches to prevention such as social prescribing, focus on a holistic approach to health, empower residents in self-management of their own health and wellbeing, and form links with the wider health care system and community. Addressing the wider social determinants of health will help reduce pressure on the NHS, have a positive social impact and reduce health inequalities.

This Toolkit documents how Barts Health have implemented social prescribing into heart attack care and other specialist pathways. We hope that our experience may be valuable to other specialist teams, and that together we can improve outcomes for all our patients.

Andrew Wragg,
Medical Director, St Bartholomew's Hospital at Bart's Health NHS Trust.

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Executive Summary

Preventing ill health in local populations is vital for reducing health inequalities, improving population health outcomes and saving time and costs by reducing the resource burden on the NHS.

Social Prescribing (SP) is one example of a personalised, community-based intervention supporting prevention through tackling the wider determinants of health, with services being supportive, preventive and promotional. Patient pathways span both primary and secondary care, therefore enabling community-led, non-clinical prevention like SP in secondary care ensures needs are addressed at every stage in a patient's journey.

Barts Health has a strong history of clinical prevention interventions, including leading clinical initiatives in cardiovascular, maternity and children and young people, as well as a strongly embedded public health department that engages tobacco and alcohol counselling in many different patient groups. Alongside this, Barts Health are developing community-led, non-clinical interventions including SP in specialist and acute pathways to strengthen links with primary care and the community, as well as support patients with the wider social determinants of health.

Embedding a whole-system approach to prevention will be a key enabler of developing Integrated Neighbourhood Teams (INTs) where secondary care is an integral part in delivering equitable care for all. INTs are a key area of focus for the NHS - see the Fuller Stocktake Report.

About the Toolkit

About this Toolkit

This Toolkit summarises the key ingredients needed to embed non-clinical preventative approaches, such as social prescribing, in specialist or acute pathways. It also provides an example of how to develop a Trust-wide prevention strategy.

This learning has been developed based on the approach to community-led prevention and a Trust-wide strategy developing at Barts Health NHS Trust (Barts Health) in London.

The Purpose of this Toolkit is to..

- Provide the tools and guidance to developing a culture shift to prioritising the prevention of ill health in **NHS Trusts across London and nationally**

- Support acute hospital trusts and specialist services across London and the UK in embedding **initiatives like social prescribing that tackle health inequalities** and **move prevention upstream**

- Showcase **integrated and innovative projects** at Barts Health, spotlighting community-led preventative services in:
  1. **Cardiovascular Disease (CVD)**
  2. **Children & Young People (CYP)**
  3. **Diabetes specialist pathways**

This Toolkit can support you to...

- Understand the **impact of social prescribing and other approaches to community-led prevention in secondary care** on wider health and social care delivery and population health outcomes
- Find and connect with **secondary care services at Barts Health delivering impactful prevention projects** that connect patients to support in the community, reduce service demand and cost, and improve population health
- Explore **challenges and enablers, as well as top tips and guidance** to help understand how to set up and embed interventions in secondary care pathways that support prevention and more integrated care

Who is it useful for?

This Toolkit will be most useful for people in **leadership and strategic positions at NHS Trusts in and outside of London**, including but not limited to:

- Chief Executives and Directors of Transformation and Strategy
- Medical Directors, Consultants and their Teams
- System-wide and Service Improvement Teams

It can also be useful for **organisations outside of secondary care to support the development of partnerships and Integrated Neighbourhood Teams (INTs)**, including:

- Personalised Care, Public Health and Population Health ICB, ICS and Borough Leads
- Operational Delivery Networks and NHS England
- Hospital Trust Charities
- Local Authority and Public Health
- Local Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations

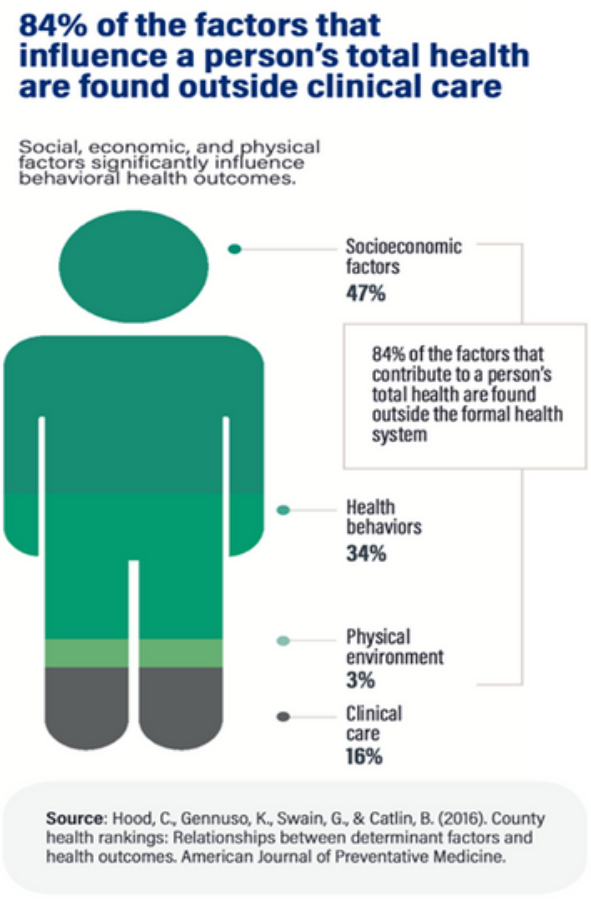
However, the Toolkit aims to be useful for anyone with an **interest in addressing health inequity experienced by people accessing secondary care services.**

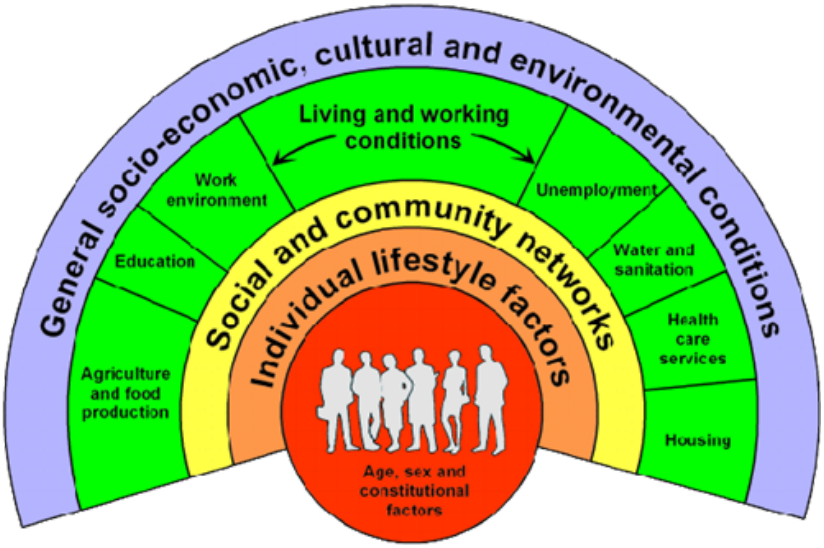
Introduction and Background

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 suggests 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).

Health Inequalities

Health inequalities can be defined as ***'unfair, avoidable and systemic differences in health between different groups of people'*** (The Kings Fund).
Risk factors for ill health are unevenly distributed in the population, contributing to inequalities in health outcomes as well as experience of healthcare services. Social deprivation is associated with higher prevalence of obesity, smoking and alcohol, and there is an **18-19 year gap in life expectancy** between the most and least deprived areas in England (Office for National Statistics 2022).

Prevention

Disease prevention aims to minimise the burden of disease by reducing associated risk factors through interventions that are population-based, specific, and holistic.

Health promotion aims to empower people to take control over their own health and its determinants by addressing behavioural risk factors through interventions such as health literacy, supported health management, education, and health and wellbeing coaching. Many of these interventions are delivered by community sector services.

Prevention and health promotion activities are essential personalised care interventions to **address the wider determinants of health** and health inequalities, yet are more frequently embedded in primary care and the community than in secondary care across London. For example, through personalised care interventions such as social prescribing, health and wellbeing coaching, and other community-led approaches. For more information about community-led or community-centred approaches, see the Public Health England Guide.

Some population cohorts such as inclusion health groups, people with mental health issues or elderly people, may **struggle to access primary care**. Introducing a **whole-system approach to prevention, including secondary care,** will increase the opportunity to **make every contact count** and identify people with **unmet needs and higher risk factors of disease**.

Why Embed Prevention

There is substantial policy and evidence (see pages 10 & 11) 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. For example, the Darzi Report sets out how **demand for healthcare services has increased** due to an **underinvestment in the community** and in tackling social determinants of health.

There are lots of ways to deliver prevention initiatives but up until now, primary care and community services have led the way on **non-clinical prevention and personalised care**. A **whole-system approach to prevention** that takes into account the whole patient journey is recommended 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 **Place-Based Partnerships and Integrated Neighbourhood Teams (INTs)**

The Barts Health diabetes prevention service **reduced DNA rates by 27%** and supported young people to complete their education, move into safe housing or move into employment

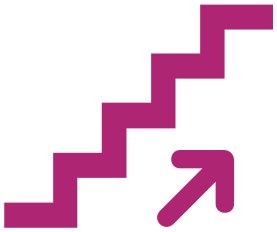
30% of all patients treated after acute myocardial infarction (heart attack) at Barts Health also reported **financial insecurity**

It is estimated that established smoking cessation services at Barts Health will result in **9 bed spaces** saved per day, **£106M** and **345 lives saved annually**

Non-clinical prevention is important in secondary care, to better support individuals who are most unwell and who generate the most cost to the system. Holistic support can improve the conditions of people's lives that will positively impact health and wellbeing.

National Policy drivers

- **National policy** supports a cultural shift across health and social care, away from a biomedical model of care to a more biopsychosocial model of care, facilitated by **community leadership, collaboration and prevention**



The Labour Government Manifesto states '*[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 '*Labour's 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 Report** highlighted how how population health outcomes are declining with the most vulnerable populations **disproportionately affected**
- **The NHS Long Term Plan** stipulates that the NHS needs to improve **prevention** in an **integrated** way that complements local government
- **Hewitt Review** underscores a need to **"shift focus from treating illness to promoting health and well-being"** and empowering people as active participants in their health, aligning with principles of prevention
- **Core20PLUS5** is an National NHS England approach to support ICSs in reducing healthcare inequalities for both adults and children at system level - PLUS5 refers to **target populations facing greatest health inequalities**, decided by each ICS, and the five key clinical areas of health inequalities
- **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

- **NICE Guidelines** for acute, maternity and mental health services in treating tobacco dependence emphasise the role of secondary care services in **preventing uptake and providing behavioural support** to stop smoking
- **Core Service Descriptor for Alcohol Care Teams (ACTs)** in acute trusts, developed in collaboration between NHS England and Public Health England, based on the substantial evidence for **effectiveness of ACTs in acute settings**

Alcohol-related attendances comprise 12-15% of A&E visits

(Emergency Medicine Journal)

ACTs have been shown to significantly reduce avoidable bed days and readmissions

(Public Health England)

- **Government guidance on Alcohol and Tobacco services in Inpatient settings highlights high cost and resource burden of alcohol and tobacco use on the NHS, as well as mortality, morbidity and health inequalities**

A Cochrane review shows that smoking cessation interventions are **effective for hospitalised patients** regardless of the reason for their admission, with **quit rates from 15-20%** for those referred to services compared to those not referred.

- **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:

1. **Promoting health in the wider society:** working to support health needs of the population via collaboration with public health and outreach services
2. **Enhancing people-centred health care and involvement:** holistic consideration of patient care needs and wider determinants of health

Social Prescribing (SP)

SP is a preventative and personalised approach connecting patients to **non-clinical support** in the community to address the wider determinants of health. Patients often have unmet non-clinical needs that create **barriers to leading a healthy lifestyle or managing existing conditions**.

NHS England have committed to building the infrastructure for SP in primary care. All Primary Care Networks (PCNs) are required to **provide access to a SP service** according to the 2024/25 Network Contract DES. PCNs must also work in **partnership with commissioners, Local Authority, SP schemes and voluntary sector leaders** to build on existing schemes and deliver **proactive care**. SP and prevention are key commitments in the NHS Long Term Plan and the Universal Personalised Care plan.

SP in Secondary Care

Introducing SP in secondary care:

- creates **patient pathways** between secondary care and community services.
- ensures **every contact counts.** Evidence shows it can lead to substantial **reductions in GP appointments, hospital admissions and A&E attendances**.
- **frees up time for clinicians** to address the elements of care they have been trained to deliver.
- enables clinicians to support patients to **address their social determinants of health without referring them back to primary care.**

Models for SP in secondary care are **varied and tailored to local need.** Services can connect to existing SP services via new pathways or directly to community services via social prescribers based in hospital settings.

A new NASP report on the impact of social prescribing found that social prescribing directly improves people's health, strengthens communities and offers value for money, evidencing a 42.2% reduction in GP appointments and a 15.4%–23.6% reduction in A&E attendances in areas of England.

Barts Health NHS Trust Prevention and Social Prescribing Networks

A Trust-wide approach to prevention recognises that **health inequity and social deprivation** play a role in **health outcomes** and addressing these issues is an **integral part of excellent care delivery**.

Barts Health NHS Trust are one of a number of Trusts developing a **joined-up approach to prevention** across the Trust. Barts Health is delivering prevention across specialties, patient groups and hospital sites, all working in **partnership under key groups/networks providing governance and strategy**. There is a breadth of prevention networks and workstreams across the Trust, brought together under the Barts Health Prevention Multi-Disciplinary Team (see page 15), a few of which are listed below.

Social Prescribing in Secondary Care Network (S2B)

To create a sustainable network that facilitates social prescribing, decreases health inequity and supports creative methods for decreasing the burden of disease.

Health Improvement Programme

Includes treating tobacco dependency and reducing harm from alcohol.

Equity Programme & Addressing Inequalities in Care Meeting (AIIC)

Playing an advisory and advocacy role across the organisation to enact positive change in health inequalities.

East London Cardiovascular Prevention Group (ELoPE)

A range of initiatives to support Cardiovascular Disease (CVD) prevention in hospitals, primary care and the community.

Children & Young People (CYP) Prevention Program

To support CYP with goal setting and connecting to community services to address social, emotional, and medical needs holistically.

Barts Health NHS Trust Prevention and Social Prescribing Networks

Social Prescribing in Secondary Care Network (S2B) Objectives
Develop links between primary care networks, secondary care networks and community stakeholders to facilitate an integrated social prescribing (SP) infrastructure
Embed access to digital resources of primary care and community service into pathways in secondary care
Create a well-resourced team to facilitate biopsychosocial awareness, education, programmes, and SP at Barts Health
Develop screening programmes to identify both inpatients and outpatients in need of wider non-clinical support (social/financial) and pathways to channel them to resources
Create a culture of understanding, embracing the bio-psychosocial needs of patients so all members of Barts Health see the value and facilitate access for patients

There are fortnightly Social Prescribing Link Workers Peer Support Network meetings, for all Social Prescribers across the Trust to connect, share learnings and provide peer support.

Trusts will benefit from acknowledging the ongoing challenge of addressing health inequalities and development of cross-sector partnerships to move prevention upstream.

Barts Health NHS Trust Prevention Multi-Disciplinary Team (MDT)

A strategic steering group is being set up as a **Multi-Disciplinary Team (MDT)** with the goals to:

- review existing prevention activity and assess impact
- review equity of current offer and conduct a **gap analysis**
- **engage with North East London Integrated Care System (NEL ICS) and place-based systems** in considering responsibilities for prevention, including links with the Voluntary and Community Sector
- develop the prevention strategy in terms of a comprehensive programme with core themes, including **interventions and services for patients** but also **education for staff** to make every contact count and links to **sustainability**
- consider the patient information pathway with a view to improve the **connectedness and speed of referral**
- work with Barts Charity and other funders to develop an effective **evaluation and coordination framework**
- consider how best to consider **patient experience and input**
- consider how best to **engage staff in the process** and how to **share best practice**, including recognising great work already happening, and by maximizing the impact of those dedicated to improving good health in local communities
- consider approach to linking and improving **secondary/tertiary prevention**
- consider how to **advocate for prevention and challenge the system** where needed

Representatives from different **patient pathways**, including specialist groups and services. with coordination from the **Barts Health Public Health Team.**

The Group is chaired by the **Chief Medical Officer**. Upcoming priorities are sharing good practice, developing the governance and engaging stakeholders.

A **Senior Responsible Officer** from each Hospital Executive Board will sit on the MDT, report back and act as a conduit between the MDT and hospital site exec teams. The MDT will work in **partnership** with stakeholders including: NEL Integrated Care Board (ICB), regional NHS leads, place-based partnerships, Local Authority (LA) Commissioners, public health leads, primary care and voluntary and community sector services across NEL.

Prevention Initiatives in Secondary Care

Preventative approaches like social prescribing (SP) can and have been embedded in secondary and specialist pathways across London and the UK. Barts Health NHS Trust sets an example of where specialist departments have taken a **collaborative and joint up approach** to developing **prevention pathways**.

Barts Health NHS Trust Prevention Initiatives and Services

Below are summaries of some examples of the prevention programmes across the Trust, including **SP and other projects connecting patients to their community**.

- SP pilot in Royal London for **CYP with sickle cell, Thalassaemia and medically unexplained symptoms** - see more detail in a case study on page 23
- Trust-wide Healthcare Transition Nurse Specialists championing **HEEADSSS framework**: *'an internationally recognised tool used to structure the assessment of an adolescent patient.'*

- Collaboration with **Renaissance Foundation** to support your people living with health conditions and young carers
- Quality Improvement project in Newham supporting children with **learning difficulties and Autism**
- Opportunistic identification and **management of obesity** in the Paediatric Emergency Department in Whipps Cross Hospital

Barts Health NHS Trust Prevention Initiatives and Services

Tobacco Dependence Services

20%
conversion to quit

What?	Evidence-based opportunistic brief interventions identifying **smoking status** on admission to hospital, prompting **referral and pharmacotherapy** to treat nicotine addiction	
Service examples	Inpatient service: of 1500 referrals received in 2023/24, **356 people remained tobacco free and 153 reduced the amount they smoke**	Smoking in pregnancy service in partnership with Queen Mary University London (QMUL) community stop smoking service: **100% of referrals are seen**

Alcohol Care Teams

What?	Evidence-based opportunistic brief interventions identifying **alcohol risk** upon admission to hospital, prompting brief advice and/or referral to an **on-site Alcohol Care Team (ACT)**
Service example	Piloting a **7-day week ACT service in Royal London Hospital** with funding from the **NHS Long Term Plan** for hospitals with the highest rate of **alcohol dependence-related admissions**

Barts Health NHS Trust Prevention Initiatives and Services

Social Prescribing Pathways

NHS Barts Health NHS Trust S2B

A Social Prescriber embedded in the **Cardiac Pathway at Barts Heart Centre** to support patients following myocardial infarction with **wider social and economic factors** influencing their health and wellbeing by **connecting them to community support services**. Case study on page 22.

A **Young Adult Diabetes (YAD) Service** funded by NHS England embedded a Social Prescriber in a **cross-site team** alongside a specialist nurse, dietician, clinical psychologist and youth worker to **integrate medical, psychological and social services** and tailor to individual needs for **16-25 year olds with type 1 and type 2 diabetes**. Case study on page 24.

All new patients starting **haemodialysis** at Royal London Hospital from September-December 2023 were screened on self-reported difficulties in **finance, housing, food and their support network** and **73% were connected to additional support services** by a Healthy Living Advisor.

A 12 month project underway to embed a Social Prescriber in **Cardiac Rehab** aiming to increase access and uptake of rehab, in order to **reduce isolation and increase physical activity**. Case study on page 25.

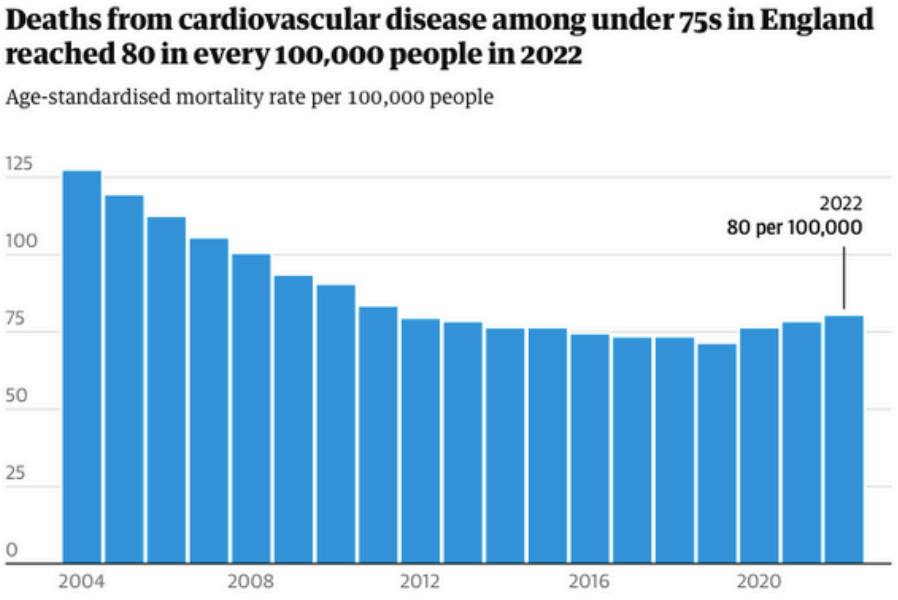
Barts Health NHS Trust Prevention Initiatives and Services

ELoPE

ELoPE
East London Cardiovascular Disease Prevention

A **Secondary Care Led** population-health programme for reducing **premature mortality and health inequalities** across NEL. Find out more here.

Guardian Graphic,
Source: British Heart Foundation



ELoPE Initiatives

Secondary Care	Primary Care	Community
Staff CVD health checks and health promotion	Supporting CVD risk factor management and medication optimization in primary care	Community engagement, health drives and education
Healthy working enviroment and active hospitals	Case finding of high-risk patients - AF, HT and Familial Hypercholesterolemia	CPR and early defibrillator training in the community
'Every Contact Counts' in hospital to reduce risk in all	Nurse led CVD prevention and cardiac rebiliation initiatives	Screening initiatives for high risk communities
Social prescribing in secondary care linked to primary care		

Integrated Community Sector Partnerships

Through their prevention networks and pathways, Barts Health are developing **integrated partnerships with voluntary and community services, and LA-commissioned services** across NEL.

Trust wide collaboration with Renaissance Foundation to support young people living with health conditions and young carers

YAD SP service is working with community services to deliver healthcare outside of hospital

The CYPSP service has built strong relationships with CYP community resources and activities in NEL

A novel integrated pathway was developed, involving specialist input from a multidisciplinary team where specialist hospital pharmacists work directly with primary care teams, to manage cardiovascular risk factors

See page 27 for more detail on impacts.

As part of the Prevention MDT, Barts Health are bringing together a **cross-sector steering group** with representation across ICS, LA, primary and secondary care, and community services. Going forward the group also aims to engage with local charities, Universities, private sector or other funders.

It will provide **intersectoral leadership and governance** over all prevention and personalised care activity across the Trust, and enable **stakeholder collaboration** to **coproduce a strategic case for Trust-wide prevention**.

Social Prescribing Project Case Studies

This Toolkit aims to support acute hospital trusts and specialist services across London and the UK in embedding initiatives like social prescribing that **tackle health inequalities and move prevention upstream.** See upcoming pages for case studies on social prescribing pathways in Barts Health.

Below is a checklist of key steps to take for anyone thinking about setting up preventative approaches like social prescribing in secondary care. This checklist has been developed based on learnings from Barts Health projects.

Checklist

- [ ] **Identify the problem and population**
  Using population health or hospital data to identify the target cohort or problem to address, disagregating data to understand population differences
- [ ] **Identify all stakeholders and ensure collective understanding**
  Engage all involved in the problem across the patient pathway, including patients and the community to discuss and agree a common understanding
- [ ] **Investigate and collaborate**
  Research good practice examples in similar pathways, connect and share learnings. Build/join an intersectional network of people interested or working in this space
- [ ] **Coproduce**
  Collaborate across sectors to co-design a pathway, integrating primary care, secondary care and relevant voluntary and community sector services
- [ ] **Test, learn and adapt**
  Pilot the project with a thorough data collection and evaluation plan to record outcomes and impacts for securing further funding and to enable quality improvement

Cardiac Social Prescribing Pathway

Project Background & Overview

- **28%** of Barts Health 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

Structure & Model

- 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 proactively contacted by the **Social Prescribers (SP)** embedded in the Heart Centre Pathway
- The SP sees patients, taking time to understand **'what matters to them'** and refers to community services, with regular patient follow-ups

Challenges & Enablers

- SPs **manually send appointment notes** to the Barts Health patient record and are unable to input appointments
- Challenges of **double booking clinical & non-clinical appointments** due to lack of a combined system
- **No case management system** specific for SP
- **Larger geographical footprint** of patients: challenges with home visits or accompanying patients to services - the team have **focused resource** where the highest number of patients are coming from with **two Social Prescribers**
- **Lack of spaces** to meet with patients in hospital
- **Long waiting lists** for some community services
- **Language barrier** for patients who don't speak English - **Social Prescribers can dial the language line**
- The SP role was **isolated in a new field** - created a **biweekly team meeting** to discuss the service

Contact Information

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Tara Mastracci, Complex Aortic Endovascular Surgeon and Lead for Social Prescribing at ELoPE, Barts Health NHS Trust: tara.mastracci@nhs.net

Funding & Governance

- **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
- The SP receives Line Management from an ELoPE Project Manager and further supervision provided by the Bromley By Bow Centre (BBBC), as well as a **psychotherapist to talk through any challenges**

Partnerships

- The model was **co-designed** with BBBC, with support from TPHC
- Developing strong relationships between **community services in North East London and secondary care**

Evaluation

- **Plan Do Study Act (PDSA)** parameters set
- Analysis of **Barts Health 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

Impacts

- **Over 1100 patients** screened so far (25-100 per week)
- **228 patients** have been helped and supported
- **84%** of those accessing the social welfare services are **men**
- Patients are engaging **more in financial and social welfare assistance** but less in health behaviour change or psychological support
- DNA patients with **no/incorrect phone number** in the system were **unaware of their appointment**
- Top areas of concern include: employment/money, food, fuel, housing, carer responsibilities
- A high number of people working on zero hour contracts with no sick pay
- **50 referrals to Talking Therapies**

Find out more!

National Academy for Social Prescribing (NASP): ***Social prescribing a "priority innovation" for hospitals: an unconventional approach to supporting patients after a heart attack***

Barts Heart Centre x Bromley By Bow Centre, Impact Report, November 2024.

CYP Social Prescribing Pathway

Project Background & Overview

- 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

Structure & Model

- **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 them to the SPLW and **asked if they're interested** in being referred
- 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

Challenges & Enablers

- Increased referral rate through **proactively raising awareness:** speaking directly with **consultants** and identifying **key meetings** to present about the service
- The Hospital was **unaware of many community services** - importance of building relationships: managed the caseload to build capacity for **active engagement** and networking
- A **separate work phone/laptop** was important for the SPLW to communicate with patients
- Lack of guidance around best practice, hospitals would benefit from a **Trust-wide orientation and induction programme** for SPLWs
- **Clinical influence and buy-in** is essential to **advocate and champion** for the service
- **Adapted the risk assessment** form and process to have **regular check in calls after each patient consultation** - to raise any risks

Find out more!

Social Prescribing for Children in Hospital, Children & Young People Now
Street Games Children & Young People's Social Prescribing Toolkit
Barts Charity: Piloting a model of social prescribing for young people

Funding & Governance

- **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**
- **Weekly meetings** to discuss who had accepted support and **monthly referrals review** to understand patient's progress

Partnerships

- ☑ Strengthened partnerships between **primary and secondary care**: SPLW embedded in the **Multi-Disciplinary Team (MDT)** and shared outcomes letters with **secondary care clinicians and the GP**
- ☑ Strengthened partnerships with **community services** through networking, building relationships and developing a **patient pathway from secondary care into the community**

Evaluation

- Used the **HEADSSS model** to frame the initial conversation with the young person
- Used **Outcomes STAR Framework** to establish goals and measure confidence across different measures
- Captured **unmet needs** throughout the project
- **Outcomes letters** developed during discussion with the young person were circulated around the MDT and with the GP

Impacts

- **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 and 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

Contact Information

Neil Fletcher, Roald Dahl Teenager & Young Adults Transition CNS, Barts Health NHS Trust: neil.fletcher6@nhs.net

Young Adult Diabetes Social Prescribing Service

Project Background & Overview

- Young people (aged 16-25 yrs) with Type 1 and Type 2 Diabetes **struggle to engage with their healthcare** leading to Young Adult Diabetes (YAD) services experiencing **high DNA rates**
- Low engagement is due to **psycho-social factors** and leads to suboptimal diabetes management resulting in longer term complications
- Barts Health YAD cohort is especially vulnerable, with **44% considered high risk**: nonattendance to clinic, recurrent hospital admissions, learning disabilities, mental health & homelessness

Structure & Model

- **2 Youth Workers, 1 Social Prescriber and a psychologist** are embedded in the YAD Multi-Disciplinary Team (MDT), working across all Barts sites alongside a Diabetes Specialist Nurse, Dietician and Administrator
- Aims to **improve diabetes control and cost-effectiveness by improving engagement, reducing DNAs and maximising the impact of each clinical encounter**
- **Co-designed with young people** by to ensure initiatives are relevant
- **Barts Health High Risk Pathway** designed to help engage young people who are not accessing health care. **Youth Workers and Social Prescriber** go into the community and find these young people, build a rapport with them and understand their barriers to accessing healthcare (meet via home visits or in community spaces)
- **The young person's priorities are addressed first** and diabetes is managed once the young person is ready to focus on their health

Challenges & Enablers

- A small percentage of YA don't want to participate at all but it's **important to respect their decisions** - put on a **Patient Initiated Follow Up (PIFU) pathway** and reach out every 6 months
- **Disparity in uptake of the new technology for Diabetes management** - due to being unable to offer to those who DNA, stigma in communities around health and chronic disease, and a lack of understanding
- Evidence for **peer support** having positive impacts on patient outcomes through **reducing isolation and burnout caused by burden of disease** - lack of engagement due to **barriers around timings, transport and finance**

Contact Information

Myuri Kirshna Moorthy, Diabetes Consultant, Barts Health NHS Trust:
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Funding & Governance

- **£300K per year for 2.5 years** from NHS England to:
  1. Support equity across Barts health services
  2. Improve outcomes and reduce health inequalities in young adults with diabetes (16-25yrs)
- Pilot funding is **running out in March 2025**

Partnerships

- Working with **community services to bring healthcare outside of hospital** - contract with Spotlight community centres (3 across NEL providing free meals, music, drama & phsyical activity)
- **Spotlight community centre have a GP practice** embedded in the building called **Healthspot** where young people don't need to be registered
  Monthly high risk MDT includes **experts across specialisms and health and social care**

Evaluation

- Working with **NHS England and the ICB** around data collection, including data inputted by the Social Prescribers and Youth Workers
- Plan to analyse the interventions against impacts for YA with Type 1 to **identify what has worked and what hasn't**

Impacts April 2023-2024

- **Clinic cohort increased by 1.5x**
- **Reduced the rate of DNA from 39-12.5%**
- **Reduced HbA1c in Type 1 YA from 71.5 to 67.9 - slowing the rate to diabetes complication by 30%**
- **Social outcomes for patients:** 20 YA into safe housing, 15 YA into employment and 28 YA receiving financial benefits/student support Staff training to support YA with learning disabilities and diabetes in 3 day centres
- **Reduced hospital admissions by 36%** across all Barts sites
- **Estimated financial savings across all of Barts of £62.5K per year**

Cardiac Rehabilitation Social Prescribing

Project Background & Overview

- 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**

Structure & Model

- Model and structure in development, with help from **Bromley By Bow Centre (BBBC)** and more established social prescribing projects across Barts Health
- Aiming to support patients with **health promotion, reduce isolation and increase physical activity** through **health coaching and social prescribing**
- 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

Challenges & Enablers

- Recognise the importance of asking screening questions **sensitively and respecting** patient's decisions but **leaving the door open**
- The **TPHC-led Pan London Community of Practice around *Improving Access to Personalised Care in Secondary Care*** and the **Barts Health S2B Network** have both been useful in **building connections and knowledge** in Social Prescribing in Secondary Care pathways
- **Bureaucracy and other limitations of a 12 month pilot** project create huge challenges, particularly in **implementation** with delays impacting project timelines, and in **sustaining projects with recurrent funding**
- Essential to **understand the local Social Prescribing services, models and pathways, and build connections** with services
- **Effective collaboration** with local Social Prescribing and community services is vital to ensure new projects are **not reinventing the wheel**, rather **supporting and enabling existing provision**
- Importance of providing a support network for Social Prescribers - planning to **integrate the social prescribers working on Cardiac Rehab with those working in the Cardiac pathway**

Funding & Governance

- **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
- Supervision procured from **BBBC for £60 per session per month**
- Training led by BBBC around a **Social Prescribing Link Worker Specialist Approach**
- **Line management** within the Cardiac Rehab Team

Partnerships

- Developing integrated partnerships with the community which have been useful in supporting implementation, including with **BBBC**
- Working with **NEL ICS and the Barts Health Social Prescribing Network (S2B)** to build connections across the system and with VCFSE

Evaluation

- **UCLPartners** 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

Impacts

- **Impacts will be shared and widely available after the 12 month pilot and UCLPartners evaluation is complete**

Contact Information

Noel Cleary, Senior Sister and Charge Nurse, Barts Health NHS Trust: noel.cleary@nhs.net

Judith Colley, Lead Nurse for Cardiac Rehab, Barts Health NHS Trust, and Chair for NEL Working Group for Cardiac Rehab: judith.colley1@nhs.net

Impacts

Although Social Prescribing and prevention initiatives at Barts Health are at varying stages of implementation and maturity, the projects are **already seeing some amazing impacts**.
This includes **economic and demand savings**, stronger **integrated community networks** and most importantly **improved outcomes and patient experience**.

Reduction in Admissions & Cost Savings

Holistic support for patients **maximises the impact on health and wellbeing**, and as result we can expect a **reduction in non-clinical demands and resource burden** for clinicians and staff.

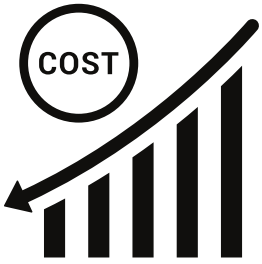
661 fewer admissions

Based on the Ottawa Model, established smoking cessation services at Barts Health will result in...

9 bed spaces saved per day

£106M saved annually

345 lives saved



36% reduction in admissions to YAD

The YAD Social Prescribing service led to

Cost savings, estimating **£62.5K per year**

75% of frequent attenders have **not reattended** since the intervention

Family Liasson Nurse supporting Frequent Attenders to the Emergency Department at Whipps Cross

Impacts

Stronger Integrated Community Networks

Projects at Barts Health have developed and strengthened **cross-sector** links between secondary care and community services. Stronger **place-based partnerships** that address prevention and health inequalities lead to more **integrated neighbourhoods** and **healthier communities**.

YAD SP service is working with community services to deliver healthcare outside of hospital

Spotlight community centre provide free meals and access to activities for **YAD patients ages 16-25**

The CYPSP service has built strong relationships with CYP community resources and activities in NEL

Including: Young Tower Hamlets, Renaissance Foundation, Bright Futures, Westward Football Club, Store Summer School

Stronger partnerships between primary care teams and specialist hospital pharmacists in NEL to manage Cardiovascular Disease risk factors

Trust wide collaboration with Renaissance Foundation to support **young people living with health conditions and young carers**.

Promotion of Ready Steady Go: hello healthcare transition programme, along with championing integrated mental health and physical healthcare.

Impacts

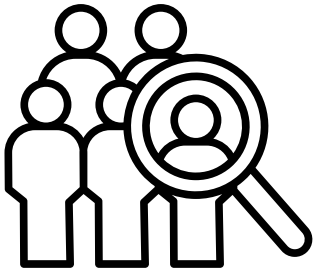
Improved Patient Experience & Outcomes

Prevention, personalised care and Public Health initiatives across Barts Health are already seeing **long-term and significant** impacts on patients' **experience and outcomes**, evidencing positive improvements in **health and wellbeing**.

Clinical Impacts

Over the next 5 years, Barts Health CVD prevention activity is **projected to...**

prevent 43 CVD events



>1500 Barts Health staff **screened**

133 Identified with **hypertension**

177 Given free **blood pressure monitors**

The YAD SP service has led to a **reduction in DNA rates** from...

39-12.5%

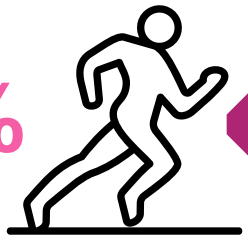
Reduced HbA1c in Type 1 Young Adults slowing the rate to diabetes complication by 30%

Impacts

Improved Patient Experience & Outcomes

Social and Behavioural Impacts

20% of all referrals to smoking cessation **quit smoking** (**31%** of all who accepted support)

76%  of staff **increased physical activity** after staff CVD screening and risk reduction

~12K **pupils** received **Heart Assemblies**

in 198 **schools** across Waltham Forest, Tower Hamlets and Newham

73% of CYP starting **haemodialysis between Sept-Dec 2023** benefited from **referral to additional support services**

The YAD SP service supported young people

20 **into safe housing**

15 **into employment**

28 **into financial support**

Patient Case Studies

Improved Patient Experience & Outcomes

'You've changed my life. I can see the future now. You lot are a godsent. I'm glad you came by when you did. You don't know what you've done... If Ican do it, anyone can do it. I'm not looking back, I'm only going forward...'

58 year old male admitted with chest pain and seen by the inpatient tobacco dependence service who had smoked since the age of 18 and struggled to give up.

Young Person 1 (11yrs old) was referred to the **CYPSP service** after an admission to A&E with a sickle cell crisis. YP1 was **not going to school** at the time, coming to appointments, or taking his medication. YP1's family did not engage regularly with NHS services and were **mistrusting of healthcare services** in general.

The CYPSP service Social Prescriber **built trust** with YP1 and referred him to a **community football summer camp** which he enjoyed.
YP1 and his family are all now **engaging more with clinical teams** including the community nurse and YP1 has **returned to school**.

56 year old woman, 5 years post Implantable cardioverter defibrillator (ICD) implantation, and known to Heart Failure and Obesity Service

Referred to the **Social Prescriber in the Cardiac Pathway** as identified as *'Struggling with care responsibilities which were impacting on the finances of the family'*

2 months after referral, she received:

- Support from NHS Responders
- Benefits advice and is now in the process of applying for PIP and carers allowance
- Referral to local wellbeing hub to discuss health and wellbeing programmes
- Referral to Newham Community Carers for information on carers rights and their monthly training sessions for carers

Key Ingredients to a Whole-System Preventative Approach in Secondary Care

Challenges & Enablers at Barts Health

Challenges	Enablers
Ongoing funding and sustainability of projects - time-limited pilots	Need for larger and longer term grant funding. Barts Health are exploring regional / ICS personalised care, prevention/health inequalities funding, charity or private sector support (social impact bonds)
No contracted requirement for prevention activities in secondary care or Trust-wide strategy	The Barts Health Prevention MDT will work collaboratively across the Trust and with partners to demonstrate the evidence for a long term prevention strategy that aligns and compliments the wider health and social care system. Trust Health Equity Strategic Leadership roles that link prevention and health inequalities activity are essential
Limited capacity within SP and prevention projects to manage the number of referrals and support all in need	Barts Health are working in an integrated way with local partners in the ICS, primary care, VCSE and local authority to ensure patients access appropriate support that is 'right place, right time'
Lack of protected time for clinical staff to prioritise prevention	Funding for new roles in secondary care that specialise in personalised care and prevention, as well as support to embed prevention into routine patient care, will increase capacity for clinical staff to focus on clinical issues
Lack of support for Social Prescribers and lots of prevention activity done in isolation	Connecting to ICS and system support for SP including peer support networks and wider activity is important to enable a whole-system integrated approach

Key Ingredients to a Whole-System Preventative Approach in Secondary Care

The following tips and guidance on setting up prevention or personalised care pathways in secondary care and specialist services have been developed based on the learnings shared by those involved in prevention and social prescribing initiatives at Barts Health.

Developing Social Prescribing Prevention Projects in Secondary Care Pathways

- ☐ Develop strong partnerships that involve existing staff, specialist services and external partners - services should be developed with local residents, VCFSE, place-based partnerships and ICBs
- ☐ Co-produce and co-design pathways with patients and lived experience roles e.g. through Patient Journey Mapping to identify successes, challenges and what needs to be improved
- ☐ Codesign evaluation and data collection frameworks with stakeholders to ensure data is being captured from the onset
- ☐ Regularly review the service to ensure it is meeting the needs of the target population, based on demographic population health data and information on who is not accessing services / on waiting lists
- ☐ Provide regular forums for services to engage with resident, patients and partners to gain direct feedback and coproduce service improvement
- ☐ Build integrated, shared data records and data collection systems where personalised care patient records are visible to clinicians and vice versa
- ☐ Adopt a test and change model, with mechanisms in place for regular analysis and review to enable continuous quality improvement
- ☐ Include all social and clinical staff including Social Prescribers that are involved in a patient care pathway in regular Multi-Disciplinary Team (MDT) meetings to discuss complex cases and coordinate care

Evidence-based, opportunistic and personalised care interventions take a small amount of time and training, yet have a significant impact in saving lives and money

Key Ingredients to a Whole-System Preventative Approach in Secondary Care

The following tips and guidance on setting up a sustainable Trust-wide prevention strategy have been developed based on the learnings shared by those involved in setting up the various networks and prevention steering group at Barts Health.

Developing a Sustainable Trust-wide Prevention Strategy

- ☐ Bring together a cross-sector steering group with representation across ICS, LA, primary and secondary care, and community services to review existing activity and identify gaps
- ☐ Develop a strategic case to inform how secondary care prevention complements other prevention activity and financial benefits to the Trust as well as wider benefits to the local community
- ☐ Ensure leadership and governance over all prevention activity across the Trust, with strategies in place for regular reporting on progress and risks
- ☐ Engage with local charities, universities, private sector or other funders to develop thorough evaluation and coordination frameworks
- ☐ Develop a standardised, Trust-wide orientation and induction strategy for new Social Prescribing or similar personalised care roles - to support all new staff with admin and operational process
- ☐ Ensure personalised care and prevention awareness is embedded into induction and mandatory training for all staff across the Trust, with protected time allocated to opportunistic intervention
- ☐ Engage regularly with all staff to understand confidence around personalised care and prevention, as well as coproduction and shared decision making, and ensure continued supervision
- ☐ Training for all staff in opportunistic, personalised care interventions and Making Every Contact Count (MECC). Ensuring allocated time for all staff, with guidance on reporting concerns and progress to line management and during appraisals

Strong leadership and governance over prevention in secondary care will enable successful engagement and collaboration with all local partners and residents to embed a whole-system, integrated care approach

Key Networks

Barts Health Prevention Networks

Networks	Who
SP in Secondary Care (S2B)	Tara Mastracci, Lead for Social Prescribing at ELoPE
Social Prescribing Link Workers Peer Support Network	Remi Apata-Omisore, Social Prescriber
Health Improvement (Public Health), incl. ACT and Tobacco Dependence Services	Katie Gallapher, Head of Health Improvement
East London Cardiovascular Prevention Group (ELoPE)	Riyaz Patel, Professor of Cardiac Prevention
Children and Young People Prevention Programme	Kath Evans, Director of Nursing (Children) Neil Fletcher, Roald Dahl Teenager and Young Adults Transition CNS
Barts Prevention Multi-Disciplinary Team (MDT)	Alistair Chesser, Group Medical Director Ian Basnett, Public Health Director
Addressing Inequalities in Care (AIIC) Meeting	Ian Basnett, Public Health Director Ajit Abraham, Executive Director Inclusion & Equity

See pages 13-19 for more detail.

Key Projects

Social Prescribing Projects

Project	Who
Cardiac SP	Remi Omisore-Adjei, Social Prescriber Sian Barlow, Social Prescriber Tara Mastracci, Lead for Social Prescribing at ELoPE
Cardiac Rehabilitation SP	Noel Cleary, Senior Sister and Charge Nurse
Young Adult Diabetes SP	Myuri Kirshna Moorthy, Diabetes Consultant
Children & Young People Renal SP	Neil Fletcher, Roald Dahl Teenager and Young Adults Transition CNS

See page 18 and pages 21-25 for more detail.

How you can get involved?

If you work in an Acute Hospital Trust and are interested in embedding non-clinical prevention initiatives in specialist pathways or developing a Trust-wide approach to prevention, you can reach out to the Community Led Prevention Team at Transformation Partners in Health and Care to explore further.

Contact the TPHC Team to find out more or be connected to prevention initiatives at Barts Health NHS Trust: bylan.shah@nhs.net

Further Resources

Making Every Contact Count (MECC)

Healthy Hospitals Guidelines

NASP: The impact of social prescribing on health service use and costs

National Academy for Social Prescribing (NASP): Social prescribing a "priority innovation" for hospitals: an unconventional approach to supporting patients after a heart attack

Barts Heart Centre x Bromley By Bow Centre, Impact Report, November 2024.

Social Prescribing for Children in Hospital, Children & Young People Now

Street Games Children & Young People's Social Prescribing Toolkit

Barts Charity: Piloting a model of social prescribing for young people

North Central London (NCL) VCSE Alliance Information Sheet: outlining opportunities for NHS Providers to work with the Voluntary, Community and Social Enterprise (VCSE) Sector in NCL

The Office for Health Improvement and Disparities' All Our Health eLearning Programme provides training to health and social care professionals on how to embed prevention

Acknowledgements

This Toolkit was developed in collaboration between the Community-Led Prevention Team at Transformation Partners in Health and Care (TPHC) and Barts Health NHS Trust. All learning shared is based on the approach to community-led prevention and a Trust-wide strategy developing at Barts Health.

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Transformation Partners in Health and Care

NHS Barts Health NHS Trust