Long Term Conditions (1/6)

South East London Integrated Care System

Vision

We want holistic, personalised, proactive care for people living with one or more Long Term Conditions (LTCs) in SE London. We want that care to be coordinated, integrated, person-centred, prevention-focused, delivered by diverse health and care professionals and tailored to the needs of all our SE London communities. We also want to ensure parity of physical and mental health care for everyone with an LTC. We want this LTC care to be mainly delivered through **Integrated Neighbourhood Models**, where multidisciplinary professionals come together to design and deliver holistic, patient-centered care by integrating services across health (primary, community, acute, Pharmacy, MH), social care, other public services and voluntary sectors for specific population health groups.

Deliverables / Improvements since 2023/24

- **Co-designing and delivering 6 multi-morbidity pilots** across each of our boroughs (reflecting the core principles of the SEL LTC Framework of Care and Integrated Neighbourhood Working) aimed at delivering person-centred, holistic and integrated care. This has been done on a test and learn basis, with a workforce focus on team and professional integration.
- **Improving Blood Pressure Control across SE London**, moving SEL ICS from 5th bottom in national performance to a strong mid-range position
- **Reducing variation (whilst improving performance) in the key 8 Care Process diabetes metric**, through strong collaborative working and specific incentivisation to reduce variation
- Working with a local CIC to create an **SEL LTC Community Engagement group**, to help inform our LTC service offer
- Leading a **SEL-wide Obesity Pathway Review**, to address fragmentation of Specialist Weight Management Services and consider a future Community Based Care offer

Key Challenges / Opportunities Remaining

Challenges

- Changing current Community Based Care LTC care into more holistic, integrated neighbourhood ways of working, requires significant behaviour and culture change, in both Primary and Community Care and Secondary Care
- Primary Care is currently challenged in a number of significant ways, including the backlog reduction work resulting from the SE London cyberware attack, national collective action, workforce recruitment and retention challenges
- SEL ICS needs to deliver a £300m deficit reduction programme, which will require a huge savings programme – however, this level of savings also offers opportunities for radical and innovative transformation

Opportunities

- Delivering the transformational Integrated Neighbourhood Model change requires enabling change of a similar transformational nature, e.g. Moving to Point of Care testing for people with LTCs, increasing use of tech and an improved data approach to LTC care and stratification
- Long-term health gain from medicines optimisation of LTCs
- Work on diabetes 8 care processes and Blood Pressure improvement has shown health inequalities variation can be addressed through specific and target approaches.

Long Term Conditions (2/6)

	What are our priority areas for 2025/26 (Max 4)	Why has this been identified as a priority areas?
1	**Spreading & Scaling holistic, personalized, proactive multiple LTC care across SE London** All six SE London Place leaderships have agreed to have a consistent Integrated Neighbourhood Working approach, focusing on the two agreed, consistent cohorts of multiple LTCs and rising risk of frailty	LTCs are one of the 5 key strategic priority areas in the SEL ICS Strategy. The Fuller Stocktake report describes the need to provide proactive care for people with multiple LTCs, via integrated neighbourhood working, which aligns with the clear new direction of travel highlighted in the recent Darzi review.
2	**Reducing health inequalities and unwarranted variation in LTC care across SE London** SE London-wide incentivization of the 8 diabetes care processes has demonstrated a targeted approach to Health Inequalities can reduce unwarranted variation. The integrated neighbourhood working approach allows flexibility for each borough and Primary Care Network to identify and address specific Health Inequalities needs	Reducing Health Inequalities and unwarranted variation is a 'golden thread' priority for SEL ICS. SE London is diverse, with much variation in LTC outcome linked to either ethnicity, deprivation or other vulnerability
3	**Identifying support and enablers needed for Integrated Neighbourhood Team working (creating a "Neighbourhood Health Service") with a focus on multiple LTCs in SE London – through fostering cross-system collaboration** Integrated neighbourhood working promotes both horizontal and vertical integration (e.g. with hospital-based staff), as shown by recent multiple LTC pilots.	A consistent framework and methodology is required across SE London to reduce unwarranted variation/ Health Inequalities in LTC care. The transformation required for effective integrated neighbourhood working requires support and enablers to be consistently offered and applied across each of the 6 boroughs

Long Term Conditions (3/6)

South East London Integrated Care System

Priority Area:

Spreading & Scaling holistic, personalized, proactive multiple LTC care across SE London

What are the actions we will deliver in 2025/26

- Supporting Place to implement integrated neighbourhood working for people with multiple LTCs, through a consistent Implementation Framework, consistent priority populations (i.e 3+LTCs and frailty) and a mix of support funding/ resourcing
- Development of a new primary care/ community-based offer for obesity, including some access to new obesity drugs, incorporating the principles of integrated neighbourhood working
- Further cardiovascular disease (CVD) prevention work, improving Blood Pressure control, reducing Atrial Fibulation and Cholesterol

Population Health and Inequalities Impact

- Implementing transformational approaches, such as Point of Care Testing and systematic risk stratification and medicines optimisation of lower risk patients will see significant longer term health outcome gains for people with LTCs
- Targeted approach to areas of HI (e.g. The diabetes 8 care processes scheme approach) can deliver reductions in unwarranted variation

System Sustainability Impact

- The consistent INW approach to 3+ LTCs and rising risk of frailty, including better medical optimisation, will release savings ‘downstream’ in acute and community services in the medium/ longer term – however, it will require a ‘left-shift’ in investment back into Primary Care, as flagged in the recent Darzi report

Priority Area:

Reducing health inequalities and unwarranted variation in LTC care across SE London

What are the actions we will deliver in 2025/26

- Replicate proven approaches to reducing unwarranted variation (i.e. Diabetes 8 care processes outcome scheme)
- Ensure that the developing community-based offer for obesity prioritises groups at risk of experiencing HIs
- Tailored approaches across LTC services that specifically address the needs of communities at risk of suffering His
- Insights delivered from new SEL Community Engagement group will be used to inform improved LTC service offers

Population Health and Inequalities Impact

- Ensure better us of data, initially focused on agreed integrated neighbourhood working priority populations that allows a targeted approach to risk stratification that reduces health inequalities
- Improving data collection for areas where Health Inequalities exist, but where known data is not robust (e.g. obesity in primary care)

System Sustainability Impact

- Healthcare utilisation of those experiencing the poorest outcomes is higher and starts at an earlier age – by focussing on reducing unwarranted variation in population cohorts, will drive better ‘ageing well’ and reduce utilisation of healthcare, including acute services.

Long Term Conditions (4/6)

South East London Integrated Care System

Priority Area:
Identifying support and enablers needed for Integrated Neighbourhood Team working (creating a "Neighbourhood Health Service") with a focus on multiple LTCs in SE London – through fostering cross-system collaboration

What are the actions we will deliver in 2025/26
Support all 6 SE London boroughs to spread and scale integrated neighbourhood working, with a focus on multiple LTCs, by: • Producing Toolkits and other support resources (podcast tutorials, PLT training, video resources) showcasing the work done by the mulit-morbidity pilots • Supporting expanded Point of Care testing for people with LTCs, building on the Test and Learn work in each of the mulit-morbidity pilot sites, including support for follow up optimisation of medicines

Population Health and Inequalities Impact
Ensure better use of data for agreed integrated neighbourhood working cohorts that allows a targeted approach to risk stratification that reduces health inequalities

System Sustainability Impact
The consistent integrated neighbourhood working approach to 3+ LTCs and rising risk of frailty, including better medical optimisation, will release savings 'downstream' in acute and community services in the medium/ longer term – however, it will require a shift in investment back into Primary Care, as flagged in the recent Darzi report in the longer term.

Long Term Conditions (5/6)

South East London Integrated Care System

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring out impact?
Spreading & Scaling holistic, personalized, proactive multiple LTC care across SE London	- Improving healthy life expectancy - Improving overall life expectancy - Improving patient activation (how engaged a patient is with their health and care)	• Improvement in clinical indicators/ outcome measures associated with LTCs • People with Lived Experience see an improvement in their experience of care • People with Mental Health Lived Experience see an improvement in their experience of care • Reduction in healthcare utilization • Improved staff experience of delivering care • Increase in primary care prescribing cost - Via a range of existing SE London data dashboards

Reducing health inequalities and unwarranted variation in LTC care across SE London	- Improving healthy life expectancy
	- Improving overall life expectancy
	- Inproving patient activation (how engaged a patient is with their health and care)
	- Reducing the variation in the above outcome measure for different population groups, especially for those at risk of health inequalities
		• Reduction in variation between:
		  • Intra-Primary Care Network LTC outcomes
		  • Different deprivation deciles
		  • Different ethnicity cohorts
		  • Gender (where applicable)
		  • Other vulnerabilities (as described in the 3+LTC dashboard)

Identifying support and enablers needed for Integrated Neighbourhood working (creating a “Neighbourhood Health Service”) with a focus on multiple LTCs in SEL – through fostering cross-system collaboration	- Improved ways of working and collaboration markers - Earlier identification of disease particularly in core20plus 5 populations - More proactive care planning of patients with multiple long-term conditions	Through improvements to the neighborhood outcomes framework (once developed) including: • Numbers of people on long term condition registers and overall disease prevalence by population group • Numbers and usage of care plans • Number of multi-disciplinary team contacts • Reduction in unplanned healthcare utilization • Patient experience • Staff experience

Long Term Conditions (6/6)

South East London Integrated Care System

What do we need from enablers and partners to deliver?

- Strong collaborative working with system partners, most importantly Place LTC and Primary Care colleagues, but also community care, secondary care, social care, Voluntary & Community Sector and community assets – noting that the vertical integration with secondary care will need strong enabling support
- Much better use of data, either via a central SEL Population Health Management offer or consistent-level (but differentiated) offers via Place
- Strong digital support (e.g. new tech such as remote monitoring, AI tech, Point of Care testing) and excellent IT infrastructure support (e.g. the enabling of results or monitoring to be seamlessly shared between key partners
- Transformational behaviour change support, including bespoke training, education, toolkits and other resources (provided by SEL-wide teams to Place)

How will we work in collaboration with our system?

- Seek to build on examples of great practice such as the 6 pilot sites of the 3MOC project, which all built in horizontal (PCN level) and vertical (PCN-acute) integration, but with subtle variation – insight/ 'Lessons Learnt' report specifically on the vertical integration element expected by April to inform SEL INW spread and scale work
- The new SEL LTC Steering Group will include integration as a specific priority within its first 12- month workplan
- Transformational behaviour change support, specifically around collaborative working and vertical and horizontal integration to be made available to SEL stakeholders

How will we engage with our population?

- Let's talk Health and Social Care platform – SEL wide public engagement platform with multi-engagement functionality
- New SEL Community Engagement group (Diabetes and other LTCs), facilitated by local CIC, 360 Lifestyle (commissioned by SEL LTC team)
- Place-level and Neighbourhood-level engagement events (e.g. the Greenwich 100-day Sprint engagement at Glyndon)
- Obesity Pathway Review – Living with Obesity Group have been engaged to provide people with lived experience insights that will help inform key principles/ key recommendations
- Type 2 Diabetes in the Young Insights Report and short-life engagement group – providing insights for young adults with diabetes (including living with Obesity)

How will we monitor and share progress?

- Spread and Scale roll-out of integrated neighbourhood working will have process and outcome measures agreed
- Multi-morbidity pilots Theory of Change model can be utilized and expanded to provide a toolkit on evaluation and measuring success
- The SEL LTC Steering Group (and associated groups) will hold the ring on outcome monitoring and sharing experience across the 6 SEL boroughs.