

South East London multimorbidity model of care (MMMoC)

Phase II summary evaluation report

Prepared by the MMMoC evaluation working group

We are a partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and the voluntary and community sector



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Executive summary

The South East London (SEL) multimorbidity model of care (MMMoC) was developed to test and evaluate a whole-system approach to improving care for people living with chronic kidney disease (CKD) and wider cardiovascular renal metabolic (CRM) long-term conditions (LTCs). Across SEL, the model sought to shift care from reactive, fragmented and hospital-based provision towards proactive, preventative, integrated and person-centred care delivered closer to service users and communities. The work aligns strongly with national ambitions to move care from hospital to community, from sickness to prevention, and towards more digitally enabled models of care.

The programme brought together five interdependent workstreams across the renal and CRM pathway: targeted prevention, detection and early disease optimisation; complex case management; multi-specialty pharmacists (MSPs); consultant geriatrician input; and palliative and end-of-life care. Together, these workstreams created a model spanning early identification of CKD, proactive optimisation of treatment, holistic management of complex multimorbidity, specialist medicines support, frailty-informed decision-making, and earlier access to palliative and supportive care.

The evaluation demonstrates that the model delivered meaningful improvements across clinical optimisation, workforce capability, multidisciplinary working, care coordination and service user experience. Early disease work improved CKD monitoring, sodium-glucose transport 2 inhibitor (SGLT2i) prescribing, blood pressure (BP) control and outpatient utilisation. Complex case management delivered statistically significant improvements in prescribing, monitoring, BP control, mental health screening, and reductions in outpatient and GP activity for high-need populations. Consultant geriatrician input supported a major shift towards supportive care pathways for older frail service users with advanced CKD, while also identifying unmet frailty, cognitive and holistic needs. Palliative and end of life care (PEoLC) interventions improved staff knowledge, confidence and readiness to initiate earlier advance care planning conversations. MSPs acted as cross-cutting enablers, supporting medicines optimisation, workforce education, multidisciplinary team (MDT) decision-making, pathway redesign and movement of appropriate care into primary and neighbourhood settings.

Taken together, the findings show that integrated neighbourhood-based care can improve outcomes for people with CKD and multiple CRM LTCs when population health management, specialist expertise, multidisciplinary working and holistic care are brought together in a coordinated model. The evaluation also demonstrates that different parts of the pathway must be considered as a connected whole: prevention and detection reduce future disease burden; case management supports people with complex needs; pharmacy expertise enables safe optimisation; geriatrician input supports older frail people to make informed decisions; and palliative care strengthens quality of life, planning and person-centred support as disease progresses.



The next phase should focus on embedding the strongest components of the model into integrated neighbourhood teams (INTs), scaling the interventions and the learning across SEL, strengthening evaluation capability and ensuring sustainable funding for the workforce and specialist input required. There is a clear opportunity to use the model as a blueprint for wider LTC transformation across SEL and beyond.

This report summarises findings from the SEL MMMoC evaluation programme, including evaluations of targeted prevention, detection and early disease optimisation, complex case management, multi-specialty pharmacists, consultant geriatrician input and PEO LC. To read the full reports on each of these topics, please visit <https://www.selondonics.org/icb/healthcare-professionals/mmmoc/>.

At a glance

Workstream	Core focus	Selected headline outcomes
Targeted prevention, detection and early disease optimisation	Early detection, risk stratification, digital and community testing, proactive optimisation.	964 community screening tests (45% abnormal); 3283 targeted digital remote tests (40% abnormal); 296 point-of-care clinic reviews; 64% fully optimised in clinic or community pharmacy.
Complex case management	Holistic MDT-led support for service users with CKD and complex multiple long-term conditions.	1,050 service users seen; improved prescribing, monitoring, blood pressure control and mental health screening; reduced outpatient and GP activity.
Multi-specialty pharmacists	Specialist pharmacy expertise across renal, diabetes and cardiovascular pathways.	292 holistic reviews; 684 clinical interventions; 70 MDT meetings; more than 215 case discussions.
Consultant geriatrician input	CGA, frailty expertise and shared decision-making in advanced kidney care clinics.	129 service users reviewed; supportive care choices increased from 5% before review to 74% after review.
Palliative and end of life care	Staff education, confidence-building and earlier person-centred palliative care conversations.	220 survey responses analysed; 62 staff trained in workshops; 70 percentage point confidence increases in sensitive conversations measures.



Structure of the MMMoC

This diagram illustrates the structure of the South East London (SEL) MMMoC from the perspective of the subsequent evaluation and can be used to support understanding throughout.

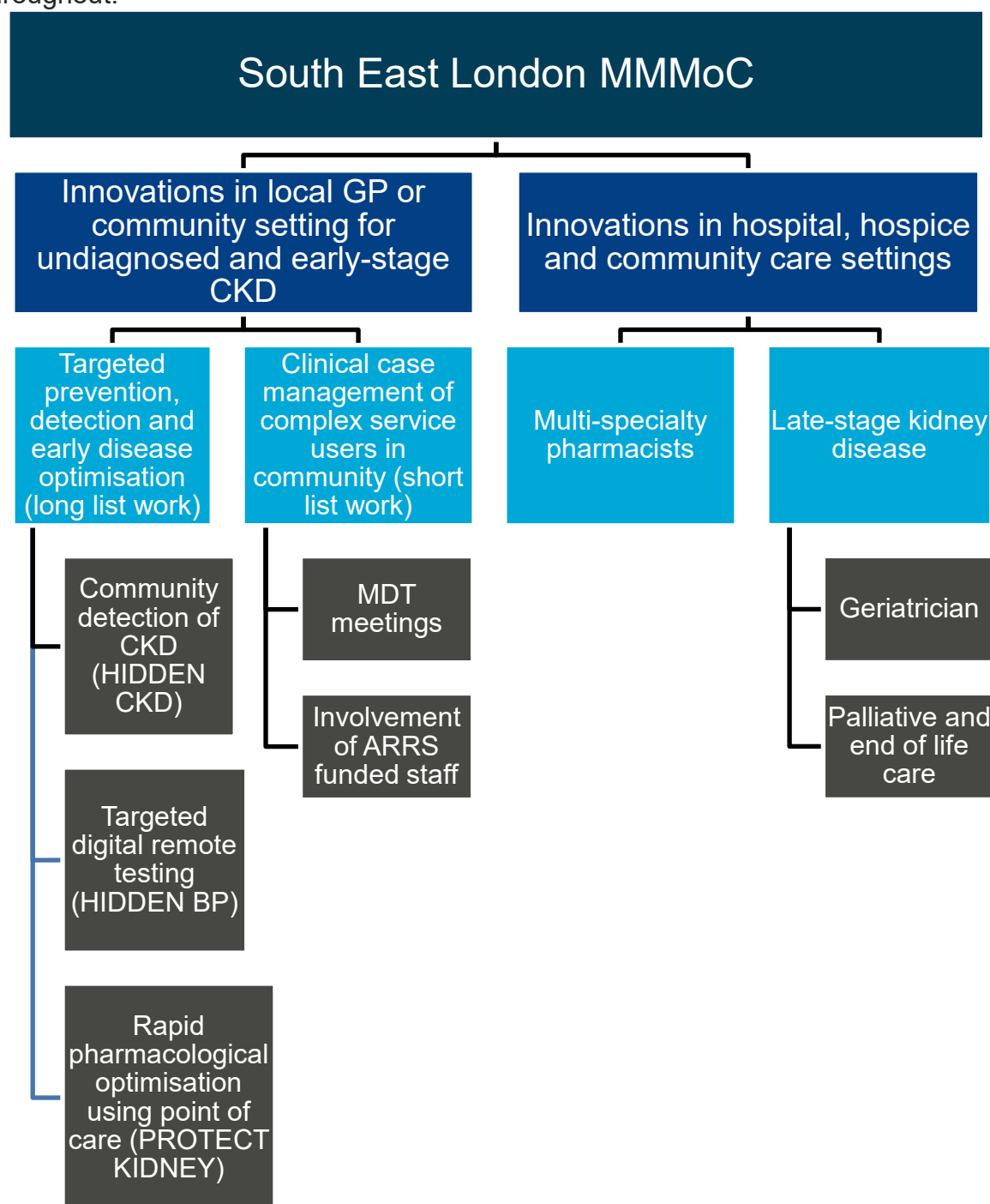


Figure 1: Structure of the multimorbidity model of care (MMMoC)



1. South East London multimorbidity model of care (SEL MMMoC)

Describing the intervention

The SEL MMMoC was a system-wide transformation programme designed to improve care for people living with CKD and multiple long-term conditions (mLTCs) across all stages of the renal care pathway. The model focused on CKD as a key lens through which to redesign care because it is common, underdiagnosed, closely linked to cardiovascular disease, diabetes and hypertension, and associated with significant health inequalities and future dialysis demand.

The model was built around the principle that CKD does not exist in isolation. Instead, it forms part of a wider CRM cluster, where kidney disease, cardiovascular disease, diabetes, hypertension, frailty, mental health needs and social complexity frequently interact. The programme therefore sought to move away from single-condition, single-specialty care and towards coordinated, holistic and prevention-focused models that respond to the whole person.

Across SEL, the model was delivered through a combination of neighbourhood-based and specialist pathway interventions, as shown in Figure 1. These included targeted prevention, detection and early disease optimisation; complex case management; multi-specialty pharmacists; consultant geriatrician input; and PEO LC.

The model brought together primary care, secondary care, community services, hospices, voluntary and community sector partners, clinical effectiveness groups, academic partners, pharmacists, geriatricians, renal teams, palliative care teams, care coordinators and Additional Roles Reimbursement Scheme (ARRS)-funded roles. This strengthened both horizontal integration across professional groups and specialties, and vertical integration across primary, community, hospital and hospice settings.

Key outcomes

- Improved early detection and medical optimisation through targeted prevention and early disease work, including improved urine albumin-creatinine ratio (uACR) testing, SGLT2 inhibitor prescribing and BP control.
- Supported 1,050 service users through complex case management across six boroughs and 12 primary care networks (PCNs), delivering improvements in prescribing, monitoring, BP control and mental health screening.
- Demonstrated the value of MSPs through 292 holistic patient reviews, 684 clinical interventions, 70 MDT meetings and more than 215 case discussions.
- Improved decision-making and holistic care for older frail people with advanced CKD, with 74% of service users choosing supportive care after geriatrician-led comprehensive geriatric assessment and shared decision-making.



- Improved staff confidence and culture around palliative care, including increased confidence in advance care planning (ACP), Universal Care Plan (UCP) discussions and sensitive conversations.

The model demonstrates that integrated, neighbourhood-based care can deliver measurable improvements in clinical outcomes, care processes, professional collaboration and service user experience. The approach was particularly effective where it combined population health insight, proactive case-finding, specialist input, longer holistic appointments, medicines optimisation and MDT decision-making.

A key conclusion is that the management of chronic kidney disease and mLTCs requires care models that span the whole pathway. Early identification and optimisation are essential to reduce future disease burden. However, for people already living with complex needs, the model must also provide case management, specialist pharmacy input, frailty assessment, shared decision-making and anticipatory care planning.

The evaluation also shows that system change depends heavily on workforce capability and relationships. The programme relied on trust-building across organisations, MDT working, ARRS-funded roles, specialist pharmacists, geriatricians, palliative care specialists and care coordinators.

Finally, the model provides evidence that care can be shifted closer to home without simply transferring workload from hospital to primary care. Where properly resourced, neighbourhood-based MDTs can resolve need more appropriately, reduce duplication and limit onward referral.

Implications for neighbourhood working and next steps

- Embed population health tools to identify people at risk of CKD, cardiovascular disease and multimorbidity earlier.
- Protect time for MDT-led case management with clear role definition and sustainable workforce support.
- Embed specialist expertise, including multi-specialty pharmacists, renal specialists, geriatricians and palliative care teams, within neighbourhood pathways.
- Use holistic assessment that includes physical, mental health, social, functional and service user-priority domains.
- Strengthen routine data capture of holistic outcomes, service user activation, social prescribing and mental health follow-up.
- Continue longer-term evaluation to understand impacts on emergency care, dialysis demand, disease progression, quality of life and inequalities.



2. Targeted prevention, detection and early disease optimisation

Describing the intervention

The targeted prevention, detection and early disease optimisation workstream focused on improving early chronic kidney disease identification, risk stratification and medicines optimisation for people at risk of kidney and cardiovascular disease. CKD registers in SEL were estimated to be around half their expected size, indicating a significant detection gap. The intervention was therefore designed to identify people with undiagnosed or under-monitored CKD, optimise evidence-based treatment and reduce future cardiovascular, renal and inequality-related burden.

The workstream was delivered across six sites and 12 PCNs and included four complementary programmes: community detection of chronic kidney disease with peer educators (HIDDEN CKD); targeted digital remote testing of at-risk groups (HIDDEN BP); comprehensive proactive medical reviews in primary care (long list work); and rapid pharmacological optimisation using point-of-care testing (PROTECT kidney).

Community detection delivered CKD education and uACR testing in community settings, particularly within underserved and higher-risk communities. Targeted digital remote testing used MinuteKid digital remote uACR testing kits to identify albuminuria among people with hypertension who had not had a uACR test in the previous five years. Long list work involved identifying service users with coded or likely uncoded chronic kidney disease and delivering holistic reviews focused on diagnosis, understanding of chronic kidney disease, monitoring and medicines optimisation. Point-of-care (POC) clinics used rapid creatinine, estimated glomerular filtration rate (eGFR) and potassium testing to support immediate medication optimisation during extended appointments.

This combined approach aimed not only to find CKD earlier, but to ensure that detection was followed by active optimisation and care planning.

Key outcomes

Overall (evaluated through interrupted time series analysis):

- MMMoC sites saw accelerated SGLT2 inhibitor prescribing, with a post-intervention increase of 0.21 percentage points per month, equivalent to approximately seven additional service users per site per month above the pre-intervention trend.
- BP control improved most clearly among those receiving more intensive intervention, with the long list cohort seeing an immediate 2.98 percentage point increase and the short list cohort seeing a 5.62 percentage point increase.
- uACR testing improved significantly. The long list saw an 11.65 percentage point immediate increase, (approximately 428 additional service users), while the short list saw a 19.54 percentage point increase (approximately 209 additional service users).



- Outpatient attendances fell significantly in the long and short list, with reductions of 26.18 and 38.13 attendances per 1,000 population per month respectively

Specific programmes of work:

- HIDDEN CKD performed 964 uACR tests in community settings, 373 (38.7%) had abnormal initial albuminuria results and CKD was confirmed in 231 (23.9%) with 171 (17.7%) being new cases.
- HIDDEN BP supported 3283 digital remote tests to be done at home, with 40% of completed tests identifying abnormal or high abnormal results requiring follow-up.
- PROTECT KIDNEY reviewed 296 service users, of whom 190, or 64%, were fully medically optimised in clinic.
- The community pharmacy proof of concept demonstrated feasibility, with 24 service users attending and 63% receiving rapid treatment optimisation.

This workstream demonstrates that integrated neighbourhood approaches to CKD detection and optimisation are feasible, acceptable and effective. The evaluation shows that combining community outreach, digital testing, proactive primary care review and rapid medicines optimisation can improve CKD monitoring and treatment at scale.

A key conclusion is that detection alone is insufficient. The strongest model is one in which targeted testing is linked directly to diagnosis, follow-up, education and medicines optimisation. Without this, detection risks create additional workload without delivering improved outcomes.

The work also demonstrated the importance of equity. Community testing through peer educators reached communities at higher risk of underdiagnosis and poorer outcomes, including residents from Black African and Caribbean backgrounds. This model helped build trust, improve accessibility and deliver culturally congruent education outside traditional healthcare settings.

The evaluation also highlighted the value of innovation in care delivery. Digital remote testing improved access for people who may not otherwise attend routine testing, while POC clinics allowed medicines to be optimised rapidly and safely in the community.

Implications for neighbourhood working and next steps

- Scale learning from POC kidney clinics through the Healthy Hearts Pathway.
- Complete economic evaluation of the POC kidney clinic by the end of 2026.
- Complete service user-level analysis of digital remote testing to inform future neighbourhood rollout.
- Continue and scale HIDDEN CKD community testing and produce return on investment analysis.
- Embed successful interventions into neighbourhood models with strong evaluation and quality improvement processes.



3. Complex case management

Describing the intervention

The complex case management workstream focused on service users living with CKD and complex mLTCs whose needs were not being adequately met through existing pathways. The intervention, referred to as the short list, was delivered across six SEL boroughs and 12 PCNs through INTs.

Service users were identified using the Clinical Effectiveness Group (CEG) active patient link (APL)-renal risk stratification tool, CKD staging guidance and local clinical knowledge. The cohort included adults with CKD, at least one other LTC such as diabetes or hypertension, and additional complexity such as social housing, caring responsibilities, severe mental illness, chronic pain or other locally defined factors.

The model provided holistic, person-centred case management led by senior pharmacists, nurses or general practitioners (GPs). Every service user received a longer initial holistic assessment, usually lasting 30 minutes, with care planning shaped by service user priorities. Appointments incorporated physical health review, medicines optimisation, education, mental health screening using patient health questionnaire-2 (PHQ-2) and generalised anxiety disorder-2 (GAD-2), and care coordination.

MDT meetings were central to the model. Between April 2024 and September 2025, more than 100 MDT meetings took place, with over 425 cases discussed. MDTs included GP clinical leads, social prescribers, care coordinators, advanced nurse practitioners, clinical pharmacists, project managers, MSPs, renal and diabetes consultants, and in some cases cardiology specialists, mental health nurses, data analysts and digital transformation leads.

Key outcomes

- 1,050 service users were supported, with an estimated did not attend (DNA) rate of around 6%.
- The short list cohort experienced an immediate 15.48 percentage point increase in SGLT2 inhibitor prescribing and a 4.32 percentage point increase in statin prescribing.
- Monitoring improved, with a 19.54 percentage point increase in uACR testing and a 4.38 percentage point increase in eGFR testing.
- BP control improved significantly, with an immediate 5.62 percentage point increase in the short list cohort, equivalent to approximately 47 additional service users with controlled BP.
- PHQ-2 and GAD-2 completion increased by 46.60 percentage points in the short list cohort, equivalent to around 510 additional service users screened.
- Outpatient attendances reduced by 38.13 attendances per 1,000 population per month, and GP appointments reduced by 27.96 appointments per 1,000 population per month.



- Of 126 service user survey respondents, 88% said they would recommend the service, 85% rated their overall care positively, 69% felt personal and social needs were understood, and 81% felt involved in decisions about their care.
- Among 71 staff respondents, 84.5% agreed that the model improved holistic care, 80.3% reported increased trust in MDT working, and 70.4% reported improved job satisfaction.

The complex case management evaluation provides robust real-world evidence that INT-led care can improve clinical optimisation, holistic support and service utilisation for people with complex mLTCs.

The model worked because it changed the nature of care. Instead of short, single-issue appointments and repeated referrals, service users received longer, holistic reviews supported by MDT discussion and specialist input. This allowed teams to address multiple needs together, unblock barriers to care and reduce duplication.

The reduction in outpatient activity suggests that embedding specialist expertise within MDTs can help manage more needs in primary and community settings. This does not mean removing specialist input, but rather relocating elements of specialist knowledge and decision-making closer to the service user.

The evaluation also shows that integrated care can benefit staff as well as service users. Staff reported improved trust, confidence, collaboration and job satisfaction. This is important because sustainable neighbourhood models depend on a workforce that feels supported, connected and able to manage complexity.

However, routine datasets do not adequately capture holistic outcomes such as social prescribing, patient activation, mental health follow-up or community-based support. Longer follow-up is also needed to assess whether improvements translate into reduced emergency care, slower CKD progression and lower dialysis demand.

Implications for neighbourhood working and next steps

- Scale neighbourhood-based case management across SEL, with a focus on areas of greatest need and deprivation.
- Embed MDT case management into routine practice, with protected time, role clarity and sustained specialist input.
- Sustain culture change away from siloed single-condition care towards integrated, person-centred practice.
- Improve routine capture of holistic care, including social prescribing, patient activation, mental health follow-up and wider non-clinical outcomes.
- Continue longer-term evaluation of emergency care, admissions, disease progression and dialysis-related outcomes.



4. Multi-specialty pharmacists

Describing the intervention

MSPs represented a new and innovative pharmacist role within the programme. Two posts were created to work across diabetes, renal and cardiovascular services, bringing specialist pharmacy expertise across organisational and specialty boundaries. The role was designed to support medicines optimisation, improve patient safety, contribute to multidisciplinary decision-making, deliver education and workforce development, and ensure service users received care in the most appropriate setting.

MSPs worked across primary, community, intermediate and secondary care settings, acting as clinical integrators between specialties and care settings. The model responded to a recognised challenge in LTC management: people living with CKD, diabetes, hypertension and cardiovascular disease often require complex medicines optimisation, yet care is frequently delivered through separate pathways and organisations. MSPs helped bridge these gaps by bringing specialist CRM expertise into MDTs, clinics, pathway redesign programmes and workforce development initiatives. Beyond direct patient care, MSPs delivered education, contributed to multidisciplinary case discussions and led service and quality improvement initiatives focused on medicines safety, pathway redesign and delivery of care closer to home.

Key outcomes

- MSPs delivered 11 targeted primary care education sessions and seven specialist secondary care education programmes, reaching more than 900 healthcare professionals across SEL.
- They completed 292 holistic patient reviews and delivered 684 clinical interventions to improve CRM outcomes. Interventions included optimisation of evidence-based prognostic medications, such as angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers, SGLT2is, medications for lipid management and finerenone. MSPs undertook wider medicines optimisation for both BP and diabetes.
- MSPs provided input into over 70 multidisciplinary meetings and more than 215 complex case discussions, helping deliver specialist expertise closer to service users and strengthening multidisciplinary decision-making.
- Within a pharmacist-led CKD and CRM medicines optimisation clinic, prescribing increased across all four pillars of evidence-based therapy. During the period reviewed, 91% of service users had achieved optimisation of four-pillar therapy, demonstrating the contribution pharmacists can make to accelerating implementation of evidence-based treatment.
- MSPs developed and implemented a novel 'Right Care Pathway' to identify service users who could be safely managed in primary care with MDT support. Across four hospital sites, 67 of 222 reviewed service users (30%) were identified as suitable for



supported transfer from specialist services to primary care. This helped release specialist capacity while maintaining appropriate oversight and follow-up arrangements.

- Medicines safety reviews identified service users with advanced kidney disease who were at increased risk of hypoglycaemia because of declining kidney function and use of insulin or sulfonylureas. Reviews resulted in a combination of treatment de-escalation, insulin dose education, enhanced glucose monitoring and wider patient safety interventions intended to reduce avoidable harm.
- Service redesign initiatives generated significant savings through improved use of specialist capacity, alongside wider anticipated benefits associated with increased uptake of evidence-based therapies known to reduce progression of kidney disease, cardiovascular and diabetes complications.

The evaluation demonstrates that MSPs should be viewed as more than medicines optimisation specialists. Their contribution extended across clinical care, workforce development, service redesign, quality improvement and system integration. While direct patient reviews generated substantial clinical interventions, the wider impact of the role was felt through pathway redesign, MDT working, education and development of new approaches to delivering care closer to home.

The evaluation also highlighted the important role pharmacists can play in delivering wider system priorities. The Right Care Pathway demonstrated opportunities to safely transfer appropriate care from hospital to primary care settings, while medicines optimisation, patient safety initiatives and education programmes contributed to the broader ambition of shifting care from sickness to prevention and from fragmented delivery to integrated care. MSPs therefore functioned both as specialist clinicians and as enablers of system transformation.

Implications for neighbourhood working and next steps

- Expand MSP roles across SEL INTs to support CRM care, medicines optimisation and complex case management.
- Embed MSPs routinely within MDT meetings, intermediate care services and neighbourhood pathways to strengthen specialist support closer to service users.
- Build on the Right Care Pathway model to support safe transfer of appropriate activity from specialist services to primary care with MDT oversight.
- Continue workforce education programmes and further develop CRM education frameworks to strengthen capability across primary, community and secondary care.
- Expand pharmacist-led medicines safety and optimisation service improvement initiatives, particularly for people with advanced CKD, multimorbidity and complex medication regimens.
- Continue evaluation of impacts on prescribing, medicines safety, patient outcomes, healthcare utilisation and system efficiency.



5. Consultant geriatrician input

Describing the intervention

The consultant geriatrician input workstream focused on older, frail service users with advanced CKD attending advanced kidney care clinics (AKCCs) at Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH). This group often faces complex decisions about treatment options, including dialysis and supportive care, in the context of frailty, multimorbidity, cognitive impairment and wider functional decline.

Consultant geriatricians were embedded within a renal service for eight hours per week, equivalent to two programmed activities (PAs), at each trust. As part of this work, they were able to run a fortnightly AKCC geriatrician assessment clinic. The geriatricians role was to provide comprehensive geriatric assessment (CGA), support shared decision-making (SDM), facilitate ACP, identify unmet needs and help align treatment decisions with what matters most to service users.

The target cohort included service users over 60 with a Clinical Frailty Score (CFS) of five or more, service users over 80 regardless of frailty score, those with suspected cognitive impairment affecting decision-making, and those where service user or family expectations of treatment or prognosis were considered unrealistic based on clinical judgement.

The model recognised that dialysis may not always provide meaningful benefit for older frail people with multimorbidity and may increase treatment burden. Geriatrician input provided time and expertise to support more balanced conversations about dialysis, supportive care, prognosis, quality of life, independence and personal priorities.

Key outcomes

- 129 service users were reviewed by geriatricians across the two trusts.
- Before CGA and SDM, 50% of service users were intending to pursue renal replacement therapy (RRT), 5% had chosen supportive care and 35% were uncertain.
- After CGA, 74% chose supportive care, 8% chose RRT and 19% remained uncertain.
- At GSTT, 48 service users made a new choice for supportive care, increasing from five to 53 service users. At KCH, 41 service users made a new choice for supportive care.
- CGA identified substantial unmet need, including new diagnoses of cognitive impairment in 31% of service users at GSTT and dementia or mild cognitive impairment in 29% at KCH.
- At KCH, around 50% of service users received medication optimisation for non-CKD conditions, and 47% were referred to additional frailty-related services.
- Family members or representatives were involved in 84% of KCH cases, and 29% required a formal best-interest decision due to impaired capacity.



- Early findings suggested supportive care service users averaged 1.3 admissions and 11.2 bed days in the last year of life compared with 2.6 admissions and 31.5 bed days for haemodialysis service users

The evaluation demonstrates that embedding consultant geriatrician input within AKKCs improves the quality of care for older frail service users with advanced CKD. Geriatrician-led CGA and SDM provided time, expertise and structure to support decisions that better reflected service user priorities, quality of life and overall health status.

The major shift towards supportive care following geriatrician review indicates that many service users may choose differently when given balanced information, holistic assessment and support to consider treatment burden alongside potential benefit. This has important implications for both service user experience and system sustainability.

The intervention also demonstrated that geriatrician input adds value beyond treatment decision-making. CGA identified undiagnosed cognitive impairment, frailty-related syndromes, medication issues and social or functional needs that may otherwise have remained unrecognised in a renal pathway.

Geriatricians also played an important role in family involvement, capacity assessment and best-interest decisions. This is particularly important for older service users with cognitive impairment, where treatment choices may be complex, uncertain and emotionally difficult.

From a system perspective, the model supports more informed decision-making which in turn reduced avoidable treatment burden and support more appropriate use of NHS resources, particularly by avoiding dialysis where it is unlikely to provide meaningful benefit. However, longer follow-up and larger cohorts are needed to confirm impacts on admissions, bed days, costs and quality of life.

Implications for neighbourhood working and next steps

- Secure funding to continue and embed geriatrician input within AKKCs.
- Explore expansion of embedded geriatrician input to other pathways and specialties.
- Align geriatrician input with INTs to support coordinated and locally responsive care.
- Explore opportunities for joint primary and secondary care working to support highly frail, multimorbid service users with advanced CKD to continue their management solely in a community setting.
- Embed CGA and SDM as routine components of care for frail service users with advanced kidney disease.
- Strengthen ACP, capacity assessment and family involvement processes.
- Continue evaluation using larger cohorts and longer follow-up to understand impacts on treatment decisions, healthcare utilisation and service user outcomes.
- Continue investing in supportive care education for renal staff to build wider confidence and capability, ensuring specialist geriatrician expertise is used where most needed.



6. Palliative and end of life care

Describing the intervention

The PEOLC workstream focused on improving access to earlier, more equitable and person-centred support for people with advanced kidney disease, particularly those living with multimorbidity and frailty.

The work was developed in response to evidence that people with late-stage kidney disease often experience high symptom burden, frailty, clinical uncertainty and fragmented care, but may not access palliative care until very late. Misconceptions that palliative care is only for the final days of life, or only for people with cancer, can delay conversations and referrals.

The workstream aimed to improve staff and service user understanding of palliative care as an additional layer of support, not just end of life care. It sought to normalise earlier conversations about what matters to people, increase confidence in advance care planning and improve use of the UCP.

A multi-pronged programme of activity was delivered from June to November 2025 across renal services at GSTT and KCH. The interventions included hospice education visits, a staff webinar, ward-based tea trolley dashes and sensitive conversations workshops. The programme was co-designed by a multidisciplinary project team and delivered with input from PEOLC specialists, UCP leads, hospice teams and renal supportive care nurses.

Key outcomes

- The pre- and post-campaign staff survey showed increased confidence across all measured PEOLC domains among staff who engaged with campaign activities.
- The largest improvement related to confidence discussing the UCP with service users, which increased by 36%.
- The proportion of staff who reported never having ACP discussions reduced from 52% pre-campaign to 14% post-campaign.
- Across hospice visits, tea trolley dashes and webinars, 125 survey responses were collected. Overall, 81% rated activities as excellent, 17% as good and no respondents rated them poor or very poor.
- Almost all respondents reported learning something new: 99% learned something about PEOLC, and 97% learned something about hospice care.
- Sensitive conversations workshops had particularly strong impact. Of 30 respondents, 90% rated the workshops as excellent and all respondents said they would recommend the workshop to colleagues.
- Confidence in initiating conversations about palliative care and responding to service users or carer-led advance care planning discussions increased by 70% for both measures.



- Referral data from Community Hospice and St Christopher's Hospice showed sustained renal referral activity but no clear, attributable change in referral volumes during the intervention period. Further data would need to be analysed.

The PEOLC evaluation demonstrates that targeted, multidisciplinary engagement can meaningfully improve staff confidence, capability and culture around earlier palliative care in renal services.

The workstream successfully addressed common misconceptions about palliative care, particularly that it is only for cancer, only for the final days of life, or cannot be provided alongside active treatment. This is important because these misconceptions are key barriers to timely access for people with advanced kidney disease.

The strongest impact appeared to come from combining informal ward-based engagement with structured education and skills-based workshops. Tea trolley dashes created a visible and approachable campaign presence, while workshops gave staff practical language, confidence and rehearsal opportunities for difficult conversations.

The evaluation did not demonstrate a clear attributable change in hospice referral volumes. However, this is unsurprising given the short follow-up period, data limitations and incomplete capture of hospital-based and community palliative care referrals. The most important early impact was therefore cultural and behavioural: staff confidence, understanding, communication skills and readiness to initiate earlier conversations.

The findings align closely with the wider ambition to support proactive, integrated and person-centred care. Earlier PEOLC conversations can help reduce crisis-driven care, support service users to remain in their preferred place of care and avoid unwanted or burdensome interventions.

Implications for neighbourhood working and next steps

- Secure continuous funding to embed PEOLC awareness, education and communication skills interventions within renal services.
- Explore rollout to other LTC specialties where similar gaps in confidence and access exist.
- Align PEOLC approaches with INTs to support locally responsive multidisciplinary care and improved continuity.
- Sustain collaboration between renal teams, hospice services, community teams, primary care and palliative care specialists.
- Embed early ACP, UCP use and what matters to you conversations as routine components of care.
- Continue data collection over longer periods, including referral data, UCP activity, service user outcomes and hospital utilisation.



7. Cross-cutting implications for neighbourhood working and next steps

Across all five workstreams, the programme provides a strong case for scaling integrated neighbourhood-based models of care across SEL. The evaluation demonstrates that better outcomes are achieved when care is proactive, targeted, multidisciplinary and supported by specialist expertise in the community.

Build neighbourhood models around population health need

The programme used population health data and risk stratification to identify people who needed earlier detection, proactive optimisation or complex case management. Future INTs should continue this approach to identify those at greatest risk of deterioration, avoidable hospital use, underdiagnosis or inequitable access.

Embed specialist expertise within neighbourhood teams

The model shows that specialist input can be brought closer to service users without relying solely on referral into hospital-based services. MSPs, renal specialists, geriatricians and palliative care teams all supported MDT decision-making and strengthened local capability.

Shift from single-condition care to whole-person care

Service users with CKD and mLTCs often experience overlapping physical, mental health, social, functional and medicines-related needs. The model demonstrates the value of longer, holistic assessments and care planning shaped by what matters most to the individual.

Strengthen medicines optimisation as a central function of neighbourhood care

Medicines optimisation was a key driver of impact across the programme. SGLT2 inhibitor prescribing, statin prescribing, BP control, renal medicines optimisation and safer prescribing for people with reduced renal function were all central to the model. MSPs should therefore be embedded as core members of INTs.

Build workforce confidence and shared culture

The programme delivered impact partly because it invested in relationships, education and confidence-building. Staff feedback showed increased trust in MDT working, improved confidence managing complexity and increased job satisfaction. PEO LC training also improved confidence in sensitive conversations.

Improve routine data capture for holistic care

The evaluation highlighted limitations in capturing social prescribing, patient activation, mental health follow-up, ACP outcomes and wider holistic care activity. Future evaluation should strengthen data infrastructure so that neighbourhood models can evidence outcomes beyond traditional biomedical indicators.



Continue longer-term evaluation

Several outcomes need longer follow-up, including non-elective admissions, accident and emergency (A&E) attendances, dialysis demand, cardiovascular events, quality of life, place of death and cost-effectiveness. The programme has created a strong evaluation foundation, but further work is required to understand longer-term system impact.

8. Overall conclusion

The South East London multimorbidity model of care demonstrates that integrated, neighbourhood-based care can deliver measurable improvements for people living with chronic kidney disease and multiple long-term conditions. Across prevention, complex case management, pharmacy, geriatrician input and palliative care, the model improved detection, optimisation, holistic assessment, shared decision-making, staff capability and care coordination.

The programme shows that the future model of care for multimorbidity should not be organised around single diseases or separate organisational boundaries. Instead, it should bring together population health management, multidisciplinary neighbourhood teams, specialist expertise, medicines optimisation, frailty-informed care and earlier planning conversations around what matters most to service users.

The model provides a practical and scalable blueprint for how South East London can deliver national ambitions: shifting care closer to communities, strengthening prevention, reducing fragmentation and making better use of specialist resource. The next phase should focus on embedding the model into integrated neighbourhood teams, securing sustainable workforce investment, expanding multi-specialty pharmacist and specialist support, strengthening evaluation and scaling the approach across South East London and wider long-term condition pathways.



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- Queen Mary's APL-Renal Risk Stratification Tool
- South East London Integrated Care System
- South East London Workforce Development Hub



- South London Office of Specialised Services
- South London Health Innovation Network
- St Christopher's
- The Community Hospice
- Universal Care Plan
- Vital 5

The artificial intelligence platform, Microsoft copilot, has been used to support the write up of some elements of this report.

10. References

This report summarises findings from the South East London multimorbidity model of care evaluation programme, including evaluations of:

- Targeted prevention, detection and early disease optimisation
- Complex case management
- Multi-specialty pharmacists
- Consultant geriatrician input
- Palliative and end of life care

You can access the full reports at <https://www.selondonics.org/icb/healthcare-professionals/mmmoc/>.

11. Appendices

Further and full information including appendices are in the full reports, accessible at <https://www.selondonics.org/icb/healthcare-professionals/mmmoc/>.

12. Glossary

The following definitions and abbreviations are key for understanding the contents of this report:

Term	Full term	Definition
A&E attendances	Accident and emergency attendances	The number of visits to an accident and emergency hospital department.
ACP	Advanced care plan	A voluntary, person-centred process to record an individual's values, preferences and intentions for future medical care.



AKCC	Advanced kidney care clinic	Specialised service for service users with late stage (eGFR <20 ml/min/1.73m ²) kidney disease.
APL risk stratification tool	Active service link risk stratification tool	A tool developed by Queen Mary's University London that organises routine data to help primary care prioritise CKD management tasks, e.g., identifying service users with a diagnosis of CKD but no recent blood test and uncontrolled blood pressure.
ARRS	Additional roles reimbursement scheme	NHS England funding scheme to expand the primary care workforce by providing recurrent funding for specific multi-disciplinary roles at PCN and practice level.
BP	Blood pressure	Blood pressure is the force of the blood pushing against the walls of the arteries as it circulates around the body. A healthy blood pressure is 120/80 mmHg for an adult without underlying health conditions.
CFS	Clinical frailty scale	A nine-point judgment-based tool used by healthcare professionals to summarise the overall level of fitness or frailty in adults aged 65 and above.
CGA	Comprehensive geriatric assessment	A multidisciplinary assessment of medical, psychosocial, functional and social capabilities and needs of frailer older adults.
CRM	Cardiorenal metabolic	The interconnected dysfunction of the heart, kidneys and metabolic system (including obesity and diabetes).
CKD	Chronic kidney disease	A chronic condition where the kidneys cannot effectively filter waste and excess fluid from the blood. It can lead to kidney failure, requiring dialysis or a transplant.
Diabetes	A chronic metabolic disorder characterised by high blood-glucose levels	High blood-glucose (sugar) levels can either be caused because the body does not produce enough insulin, or because the body becomes resistant to the effects of insulin. High



		glucose levels can lead to organ damage over time.
DNA	Did not attend	When a service user misses a scheduled appointment without notice.
DNACPR	Do not attempt cardiopulmonary resuscitation	A documented clinical decision not to attempt CPR if a service user's heart or breathing stops. It is based on clinical assessment and service user wishes.
eGFR	Estimated glomerular filtration rate	A blood-test-derived estimate of how well the kidneys filter waste from the blood. Used to stage chronic kidney disease and guide treatment plans.
GAD-2	Generalised anxiety disorder 2-item	Two-question screening tool for generalised anxiety symptoms.
GSTT	Guy's and St Thomas' NHS Foundation Trust	A large hospital trust in providing specialist and community care in south east London.
Hypertension	High blood pressure	A condition where blood pressure is consistently high. This is often asymptomatic but increases the risk of kidney disease, heart attack and stroke.
ICB	Integrated care board	NHS regional bodies responsible for planning and funding health services across a geographical area.
ICS	Integrated care system	The NHS, council, social services and voluntary services form a partnership across regions to help improve the delivery of health and social care for their populations. An ICB sits within the ICS.
INT	Integrated neighbourhood team	Where all parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – work closely together to support service user's needs more systematically.
KCH	King's College Hospital NHS Foundation Trust	A hospital trust providing specialist and community care in south east London.



MDT	Multidisciplinary team	A group of professionals from different disciplines who collaboratively assess and plan care, ensuring holistic, coordinated, and service user centred management.
mLTCs	Multiple long-term conditions	When a person lives with two or more chronic illnesses at the same time (e.g., diabetes, heart failure, CKD).
MMMoC	Multimorbidity model of care	A person-centred, holistic, and fully integrated model across all care settings delivered through INTs. Aims to shift care nearer to the service user, through community-based INTs and optimising proactive care.
MSP	Multispecialty pharmacists	Innovative pharmacist roles that work across CRM specialities and across care settings to train colleagues, streamline care and enable medicines optimisation. These roles were key integrators, bridging gaps and working collaboratively across SEL in the MMMoC.
NHS	National Health Service	The NHS is the UK's publicly funded healthcare system that provides medical care, free at the point of use for residents.
Non-elective inpatient admissions	Emergency treatment including an overnight stay in hospital	Non-elective refers to the emergency/unplanned element of the visit. An inpatient admission is where a service user is required to stay overnight in hospital.
Outpatient attendances	Treatment received in a hospital or clinic without requiring an overnight stay	Planned attendance at a hospital or clinic without the need to stay overnight. This can be for a consultation, diagnostic test, minor procedure or follow up.
PA	Programmed activity	A standard four-hour block of contractual time allocated to clinical duties, admin, teaching, or service development for medical consultants.
PCN	Primary care network	Groups of GP practices serving populations, working with community, mental health, pharmacy, and voluntary partners to deliver enhanced and shared services.



PEoLC	Palliative and end of life care	Care that focuses on symptom control and quality of life for people with life-limiting conditions, and support for families, especially in (but not limited to) the final phase of life.
PHQ-2	Patient health questionnaire 2-item	Two-question screening tool for low mood and/or depression symptoms.
POC	Point of care	Diagnostic tests delivered at the time of care, enabling faster decision making.
PP	Percentage point	A unit used to describe the absolute difference between two percentages. For example, an increase from 40% to 50% represents a 10-percentage point (pp).
RRT	Renal replacement therapy	Treatment for end stage kidney disease or kidney failure, including haemodialysis, peritoneal dialysis, and kidney transplantation.
SEL	South East London	A geographic area and NHS Integrated Care System covering the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.
SGLT2i	Sodium-glucose co-transporter 2 inhibitors	A class of medications that lower blood glucose levels by increasing glucose excretion in the urine. These medications are protective of the kidney and the heart.
SDM	Shared decision making	A collaborative approach where clinicians and service users make informed healthcare decisions together, combining clinical evidence with the service user's values, preferences, and circumstances.
Statins	A type of lipid lowering medication	The most used medicine to lower cholesterol levels in the blood. Statins have been shown to reduce the risk of heart attacks and strokes and are the recommended first line for people with CKD.
(u)ACR	(urine) Albumin creatinine ratio	A urine test that measures how much protein (albumin) is present in the urine, adjusted for the



		amount of creatinine in the same sample. This is used to screen for, stratify and monitor CKD. A raised ACR is associated with more advanced CKD and is an independent risk factor for cardiovascular disease.
UCP	Universal care plan	A London-wide digital platform that stores interoperable personalised care plans to support coordinated care across services.

