South East London Integrated Care System

# Our Community Based Care Value Proposition: Integrated neighbourhood working for people with multiple long term conditions

November 2024

South East London
Integrated Care System

# National and System Context

# National Policy Context - Neighbourhood Health Service

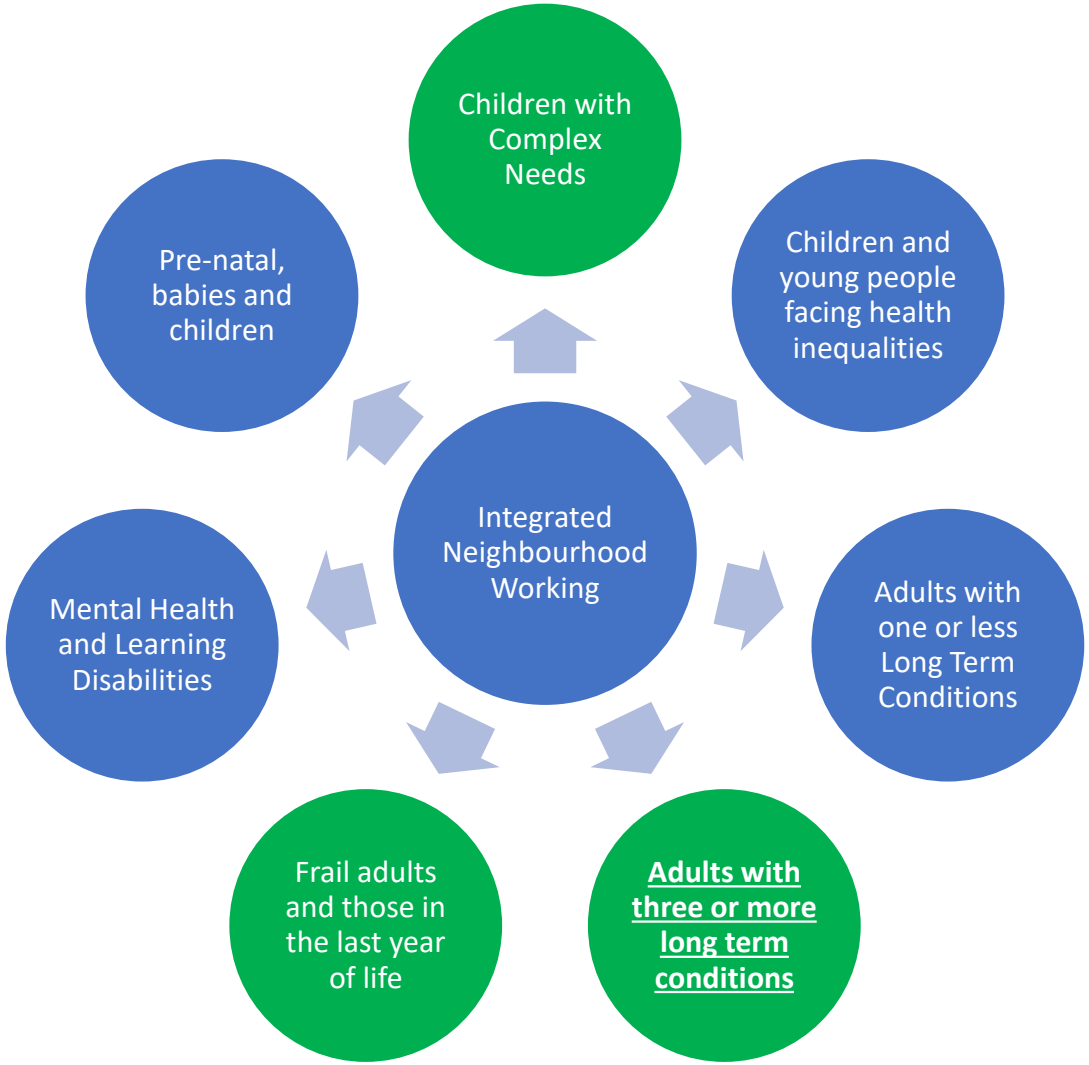
South East London Integrated Care System

- National policy - moving more care out of hospital into primary care and community services; better use of technology and data; and boosting prevention by supporting people to stay well, reducing health inequalities and helping people stay in work (SoS - July 24). The new government's evolving articulation of a Neighbourhood Health Service, whilst not yet fully defined, gives a clear direction of travel.
- The implementation of the **Fuller Report** sets out how this will improve outcomes and saves costs in acute care through a **preventive, integrated, and community-based approach**. Through better management of chronic diseases, reducing unnecessary hospital admissions, improving urgent care access, working through a multi-disciplinary team and leveraging digital tools, the strain on acute care services is reduced.
- This can lead to significant savings by preventing high-cost interventions and maximising efficiency across the healthcare system.
    - Focus on **proactive, holistic, personalised care** for people with more complex health needs, such as those with long-term conditions. This involves shifting towards population health management approaches, with more preventive measures and tailored interventions for patients, especially those in vulnerable groups.
    - Integrated urgent care pathways to ensure patients can easily access timely care, whether that's through their GP, out-of-hours services, or urgent care centres.

# Integrated Neighbourhood Working – One Model, numerous population lens

South East London Integrated Care System

- Through **Integrated Neighbourhood Models**, multidisciplinary professionals can come together to design and deliver holistic, patient-centered care by integrating services across health, social care, other public services and voluntary sectors for specific population health groups
- The broad approach to integrated neighbourhood working remains consistent across all population groups, but the **specialist input and resources** that needs to be levered into the neighbourhood will vary.
- Each neighbourhood will have a **different starting point** based on their current asset base.
- There is a need to stage implementation of integrated neighbourhood models to prioritise the populations where the opportunity for improvement is greatest, enabling a genuine and sustainable shift in investment across the system. Varying investment will be required by neighbourhood dependent on their starting position

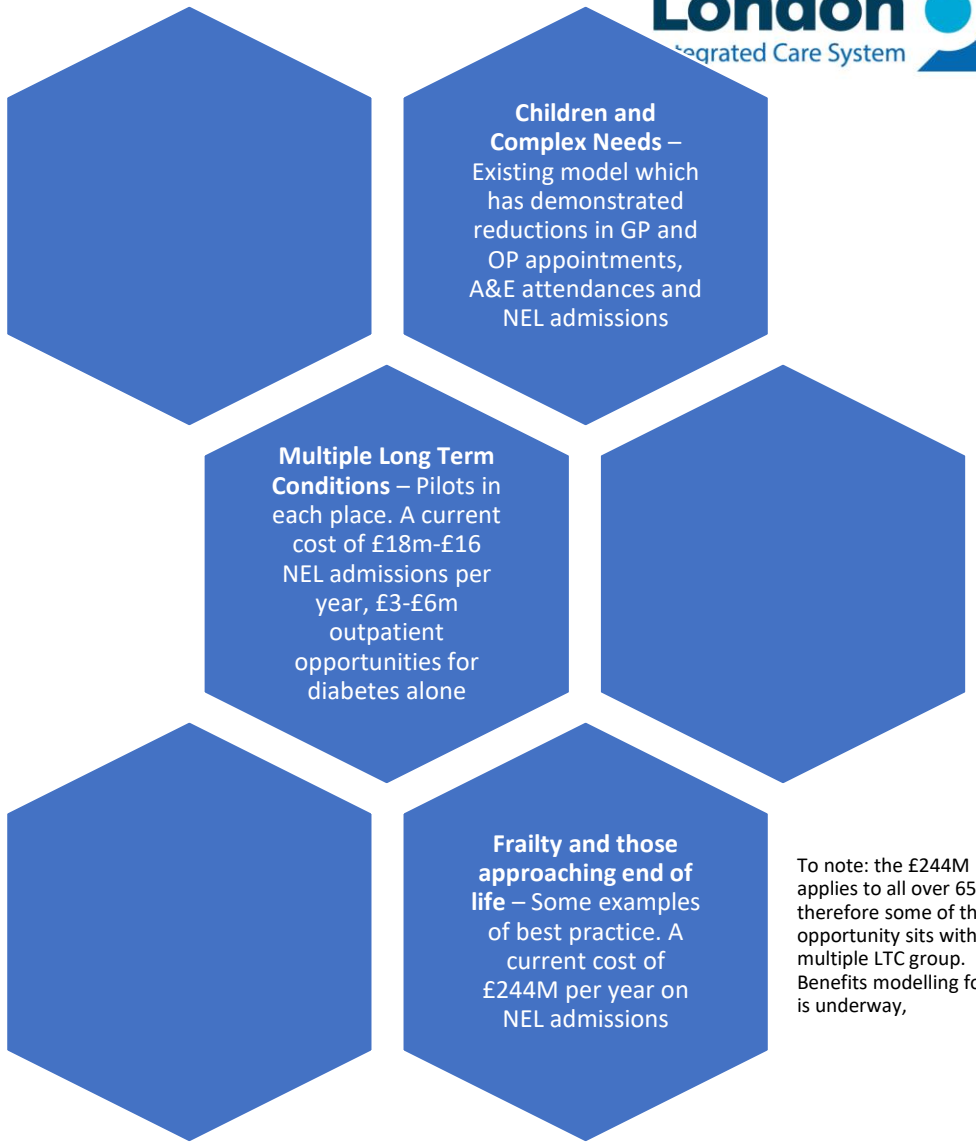


# Integrated Neighbourhood Working – Initial Priorities

The primary goal is to improve care coordination, enhance patient outcomes, and reduce unnecessary demand on the health system,

- **Improved Patient Outcomes** – focus on prevention, earlier intervention, with specialist advice as needed
- **Improved Care Coordination** - reduced duplication, fragmentation, handoffs and multiple referrals, improved patient experienced of care
- **Cost-Effectiveness**: By reducing unnecessary hospital attendances, outpatient referrals, hospital admissions , general practice appointments and promoting care at home
- **Improved staff experience** – improving connection across multi-disciplinary professionals and sharing care

The expansion of integrated neighbourhood working across SEL needs to happen consistently across our places to maximise the impact and maintain investment in the model. However, it is recognised that the models need to be scaled over time. The ICS has identified three population groups which provide the biggest system opportunity at this initial stage.




To note: the £244M applies to all over 65s and therefore some of this opportunity sits with the multiple LTC group. Benefits modelling for all is underway,

South East London
Integrated Care System

# Developing our Multiple LTC approach

# What is the problem?

South East London Integrated Care System

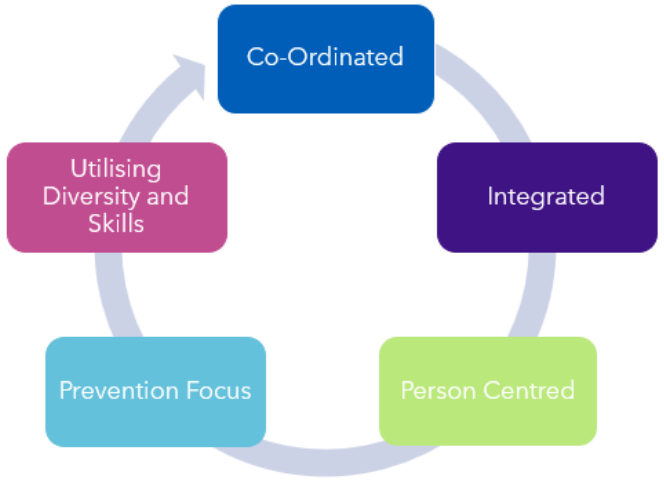
- Analysis of data from 2014 to 2016 for 300,000 people in England found that one in four adults had 2+ health conditions, equating to approximately 14.2 million people in England. Understanding the health care needs of people with multiple health conditions - The Health Foundation
- Over half (55%) of NHS costs for hospital admissions and outpatient visits and over three quarters (75%) of the costs of primary care prescriptions were for people living with 2+ conditions Understanding the health care needs of people with multiple health conditions - The Health Foundation
- In the least-deprived fifth of areas, people can expect to have 2+ conditions by the time they are 71 years old, but in the most-deprived fifth, people reach the same level of illness a decade earlier, at 61 years of age. Understanding the health care needs of people with multiple health conditions - The Health Foundation
- One study projects a rise in the prevalence of two or more conditions in people aged over 65, from 54% (2015) to 68% (2035). This is alongside the number of people with four or more conditions doubling by 2035 to nearly 2.5 million (17%) (Kingston et al., 2018).
- Despite considerable diversity in disease profile and circumstances, people with multiple conditions may share common problems including reduced mobility, chronic pain, shrinking social networks, incapacity to engage with work, and lower mental wellbeing. There is growing evidence that having multiple conditions is a more important driver of costs in the health and social care system than other factors such as age (Kasteridis et al., 2015).
- The multimorbidity trend presents challenges to the entire medical profession, from general practice and community care to acute and long term hospital settings. Greater specialisation, especially for hospital based doctors, has improved our ability to treat single diseases, but unless we react to the increase in multimorbidity it will disadvantage the increasing proportion of patients with multiple seemingly unrelated diseases.
- Treating each disease in a patient as if it exists in isolation will lead to less good outcomes and complicate and duplicate interactions with the healthcare system.7 Good vertical integration exists from bench to bedside for a single condition or disease, but there is little or no horizontal integration between diseases that often coexist.8
- There was a recognised need to develop a strategic approach to how as an ICS we would better manage people with multiple long term conditions

# Multiple LTCs: Building from a base

South East London Integrated Care System

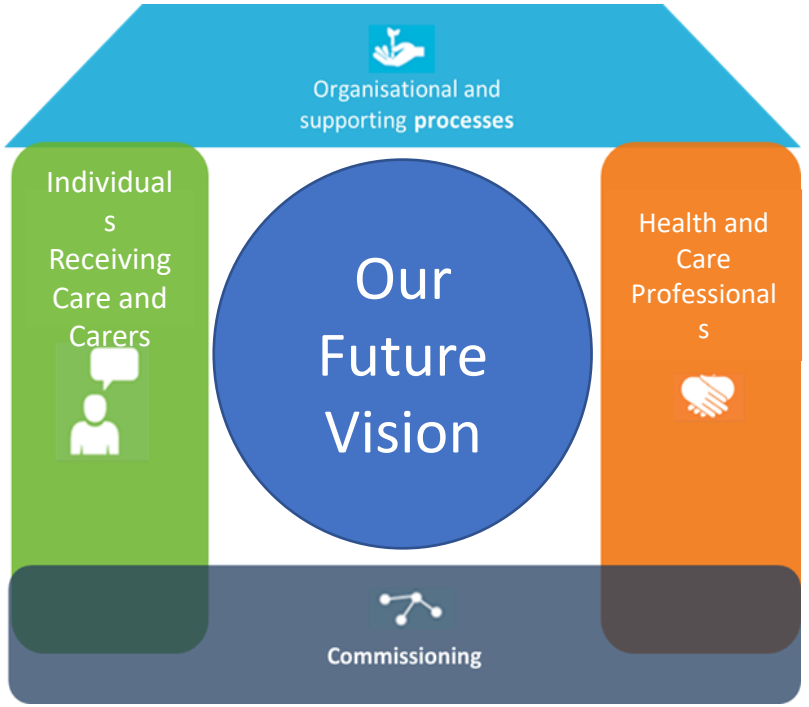
The South East London Framework of Care was developed in 2022/23 over a series of 3 workshops involving 110 people working and receiving care in South East London. Through the workshops, five core values and seven essential components of LTC care were agreed.

**Core Values**




**Essential Components**

- Equitable and joined-up approach to prevention
- Early detection and proactive support for newly diagnosed patients with LTCs
- Risk stratification and data-driven approach to prioritisation of care, specifically addressing health inequalities
- Patient centred, personalised care planning approach, with high quality self-management support
- Holistic, proactive care approach, including clear focus on mental health & wellbeing and outcomes that matter to people
- Closer working between health and care professionals, including voluntary and community sector, through an Integrated Neighbourhood Team approach
- Shared care records across care professionals and organisations



# Multiple LTCs – Testing and evolving

- In 2023, ICS were asked to identify opportunities to test changes to the pathway for three specialised commissioning areas, one of which was specialist renal care. This provided a unique opportunity to test ways of improvement multiple long term conditions across acute specialities as well as testing out our framework of care for long term conditions through integrated neighbourhood working.
- We worked across 7 Primary Care Networks and our 3 acute trusts to develop a model of care to improve outcomes for patients with cardio-metabolic conditions focussed on CKD, Diabetes and Hypertension initially due to initiation of the funding.
- Our approach has aimed to test person centred, holistic, horizontally and vertically integrated model of care for people with multiple LTCs across the pathway. This has been on a test and learn basis, with a focus on team and professional integration

**Prevention and Screening**

- Use healthy.io resource and renal registrar support to proactively identify patients
- Community work (aligned with previous project, Hidden CKD) to enable further CKD identification targeted at our underserved communities
- Accurate coding post diagnosis
- Use of CEG APL risk stratification tool to identify patients who need further screening to potentially update their CKD coding
- Build a 'long list' of patients to be screened and coded with CKD → medicines optimisation piece at this scale. In the process of working out how to personalise this offer at scale.
- CESEL CKD guidelines

**Clinical case management in community**

- 'Short list' of complex, multi-morbid patients identified
- Patients onboarded and given an in person, holistic assessment
- Patient activation including a co-produced care plan, with ongoing engagement and support
- Mental wellbeing / MH screening (PHQ2 & GAD2)
- ARRS funded roles work together to support patient – including MH practitioners, dieticians, podiatrists, pharmacists, care coordinators, social prescribers etc.
- MDT-led reviews and clinics led by project leads e.g. multi-morbidity primary care specialists (GP). Includes secondary care input

**Integrated acute care**

- Consultants and multi-morbidity pharmacists support into community MDT
- Consultants and multi-morbidity pharmacists support the upskilling of primary care colleagues (e.g. for medicines optimisation, for complex cases)
- Secondary Care-based MDT Case Management to enable acute integration
- Geriatrician input to support decision making and holistic approach in upstream care
- Supportive care aspect also being developed

# Moving from pockets of best practice to a scaleable model: CBC Value Proposition

- In early 2024, our 6 places came together and agreed the need to work together to develop a proposition for the Integrated Care System on how to maximise the value of community based care.
- This stemmed from a collective recognition that there were real and undeniable pressures across community based care provision including across general practice and primary care more broadly, within community services and across our voluntary and community sector.
- It also recognised that there was a lack of consistency in our stated commitment to community based care and variability in delivery across our 6 places which made it challenging to identify and demonstrate the impact that our community based care models have on the rest of the system
- Led by Place Executive Leads, with design via cross-SEL workshops, it was agreed to develop the next stages of integrated community-based care for people with multiple long term conditions. The outputs of this work is set out in the slides overleaf.
- Alongside the work across all 6 places to coproduce our approach to community based care, there have been discussions at both an ICS and national level that have complemented this work and demonstrated its importance in the reform of the NHS. At an ICS level, integrated neighbourhood working for different population groups (including those with multiple LTCs) has been identified as a key opportunity under the System Sustainability Programme. At a national level, we are seeing an emerging definition of a Neighbourhood Health Service which shares a number of principles with our local work.

# Multiple LTCs: Ensuring collaborative development

- Building on the **workshops** undertaken in 2022/23 (on the framework of care), 2023 (on the multi-morbidity model of care pilots), a further 2 workshops were undertaken in 2024 on building this into a South East London wide community-based care value proposition.
- There have been two **specific Task and Finish Groups** to develop the detail of the South East London community based care value proposition. The first of these has focussed on data and population definition, the second has focussed on the functional operating model and the gaps in current provision across SEL.
- **Place Executive Lea**ds have led the development of the work, with specific local work undertaken in and between South East London wide workshops and task and finish groups. This has been supported by Local Care Partnerships.
- The **Neighbourhood Based Care Board** has provided oversight on the development at a South East London level recognising the deep links into the Fuller Review implementation and the connections into other areas of Fuller implementation such as work underway in each place around Integrated Urgent Care and Same Day Access. The Board has also supported engagement with the Community Provider Network and the People programme on the strategic direction being signalled via this work.
- Whilst **clinical leadership and cross-sector professional representation** has been present in most stages of development, we were keen to ensure a focussed discussion on the proposals (as developed to date) with cross-sector clinicians from across all of our places. A meeting is being held on 27 November 2024

South East London Integrated Care System

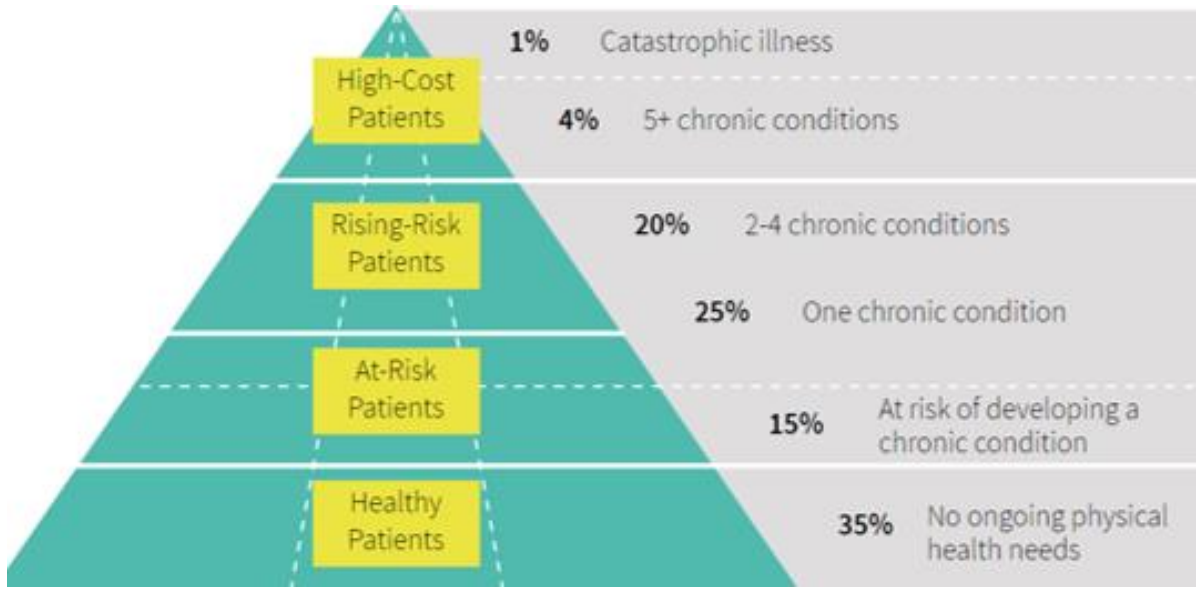
# Model articulation

# Model Aims

- Take a population health driven approach to the delivery of improved care for those with long term conditions that addresses health inequalities and improves health and wellbeing outcomes for our population.
- Promote and support neighbourhood working to build on and add value to work already delivered, or currently underway in each place
- Reduce avoidable activity in acute settings to reduce costs to the system and support long term sustainability and improve the working life for staff working in our community-based care system.
- Provide resources to support the capacity and resilience of primary care (general practice in particular) and community based care services over the longer term, including making the case for increased investment where this is required.
- Develop and deliver a consistent approach across South East London that ensures the scale of coverage required to demonstrate the value of Community Based Care, and Primary Care as part of that, to the residents and partners across the ICS.
- To support the development of our workforce across South East London including the organisational and cultural change required to genuinely deliver integrated care.

# Population Focus

- Population group to focus on:
  - Using a risk stratification triangle it was agreed that there should be a focus on people in the “rising risk” category.
  - Those with more than one LTC, and considering any evidence based clustering of LTCs.
  - To be looked at through the lens of Core 20.
  - This population group will require support from all partners within Neighbourhoods and in particular, the VCSE and public health.
- Alongside this there would also be a need to think about those already frail as a way to generate savings to support ongoing investment in prevention initiatives. A separate but aligned piece of work is underway with places to consider our common approach to Frailty.
- A data task and finish group was initiated to define the population group further from the initial definition reached via our workshops
- The task and finish groups has particularly focussed on defining the “rising” risk element of the model, as well as working through the LTCs to be included and any exclusions



# Defining the population – Inclusions and Exclusions

South East London Integrated Care System

| Include | Exclude | Present Separately | Take into Consideration (?additional Venn Diagram circles) |
|---|---|---|---|
| 27 LTCs (see next slide) | Palliative Care | SMI (excluded from main data) | CORE 20 |
| | Care Home Residents (where possible) | LD (excluded from main data) | Ethnicity (Non-White British) |
| | eFrailty Index (Severe) | Age Groups | No Care Related Encounters in Last 18 months |
| | | | Healthcare Utilisation (more than two admissions in last 18 months or more than 3 ED attendances in last 12 months) |
| | | | High Risk Conditions (depression, chronic pain) |
| | | | Vulnerabilities (see relevant slide) |

# Population Definition – Inclusion Areas

South East London Integrated Care System

## Long Term Conditions included

| | | | | |
|---|---|---|---|---|
| Atrial Fibrillation | Stroke and TIA | Chronic Kidney Disease | Chronic Obstructive Pulmonary Disease | Coronary Heart Disease |
| Dementia | Depression | Diabetes Mellitus | Epilepsy | Heart Failure |
| Hypertension | Peripheral Arterial Disease | Rheumatoid Arthritis | Asthma | Multiple Sclerosis |
| Osteoarthritis | Osteoporosis | Parkinsons Disease | Sickle Cell Disease | Bronchiectasis |
| Cystic Fibrosis | Inflammatory Bowel Disease | Sarcoidosis | Systemic Lupus Erythematosus | Chronic Pain |

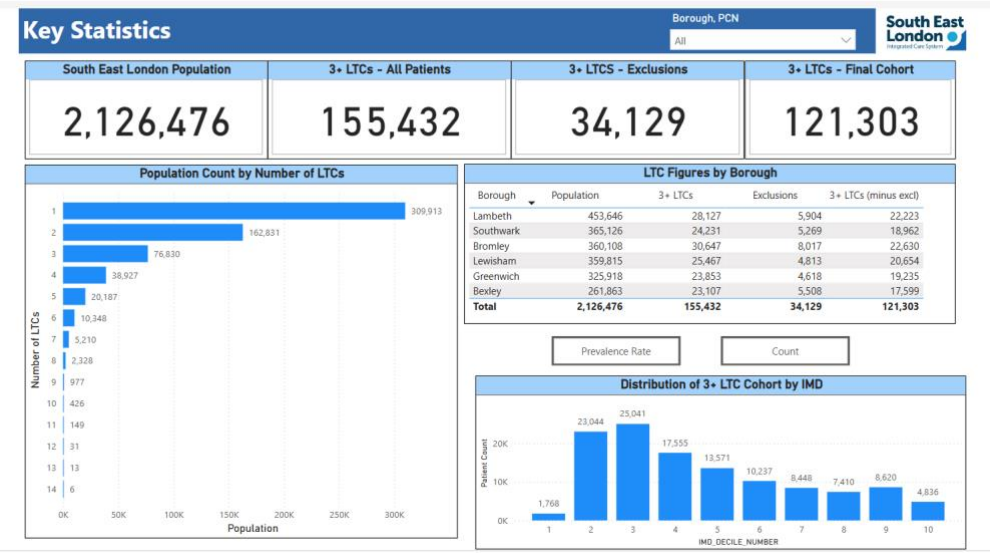
Chronic Liver Disease (Cirrhosis of Liver Only)

Obesity (BMI >40)

## Vulnerabilities supporting rising risk identification

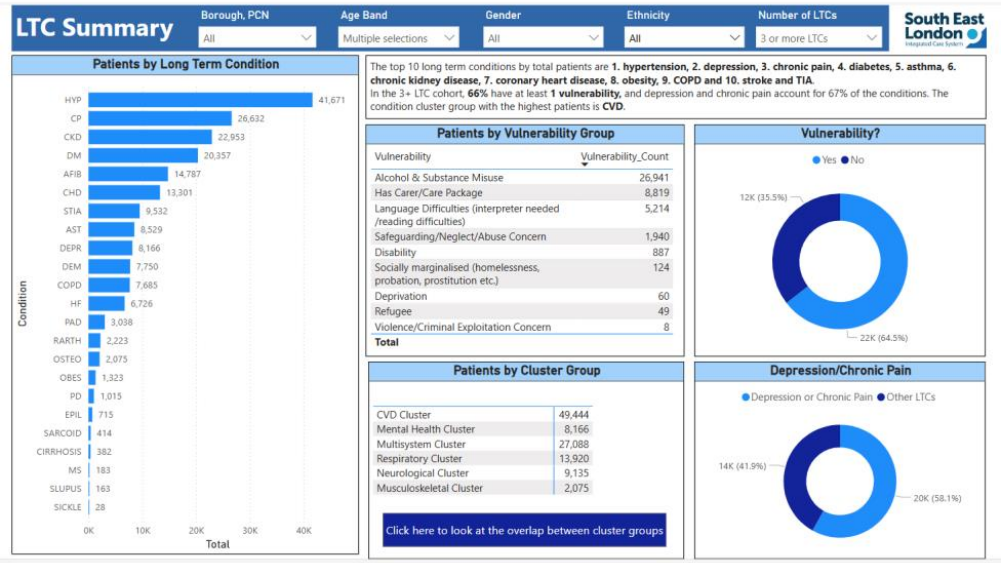
- Alcohol & Substance Misuse
- Deprivation
- Disability (includes sensory impairment)
- Has Carer/Care Package
- Language Difficulties (interpreter needed /reading difficulties)
- Refugee/Asylum Seeker
- Safeguarding/Neglect/Abuse Concern (needs to be active problem)
- Socially marginalised (homelessness, probation, prostitution, no recourse to public funds etc.)
- Violence/Criminal Exploitation Concern
- LGBTQ+

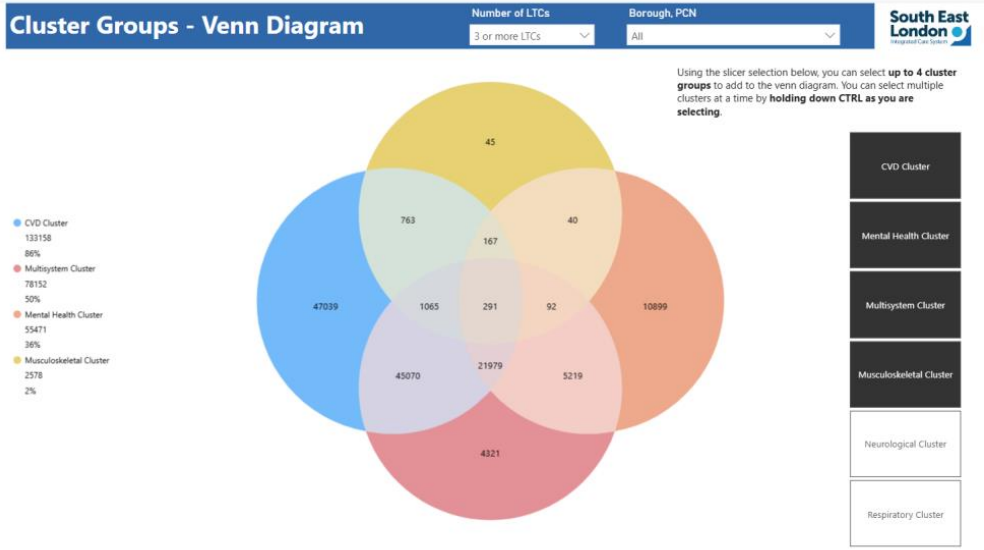
# Multiple Long Term Conditions Dashboard




A dashboard has been created which provides practices, PCNS, LCPs and the ICS with consistent insight into the multiple long term condition population, this includes:

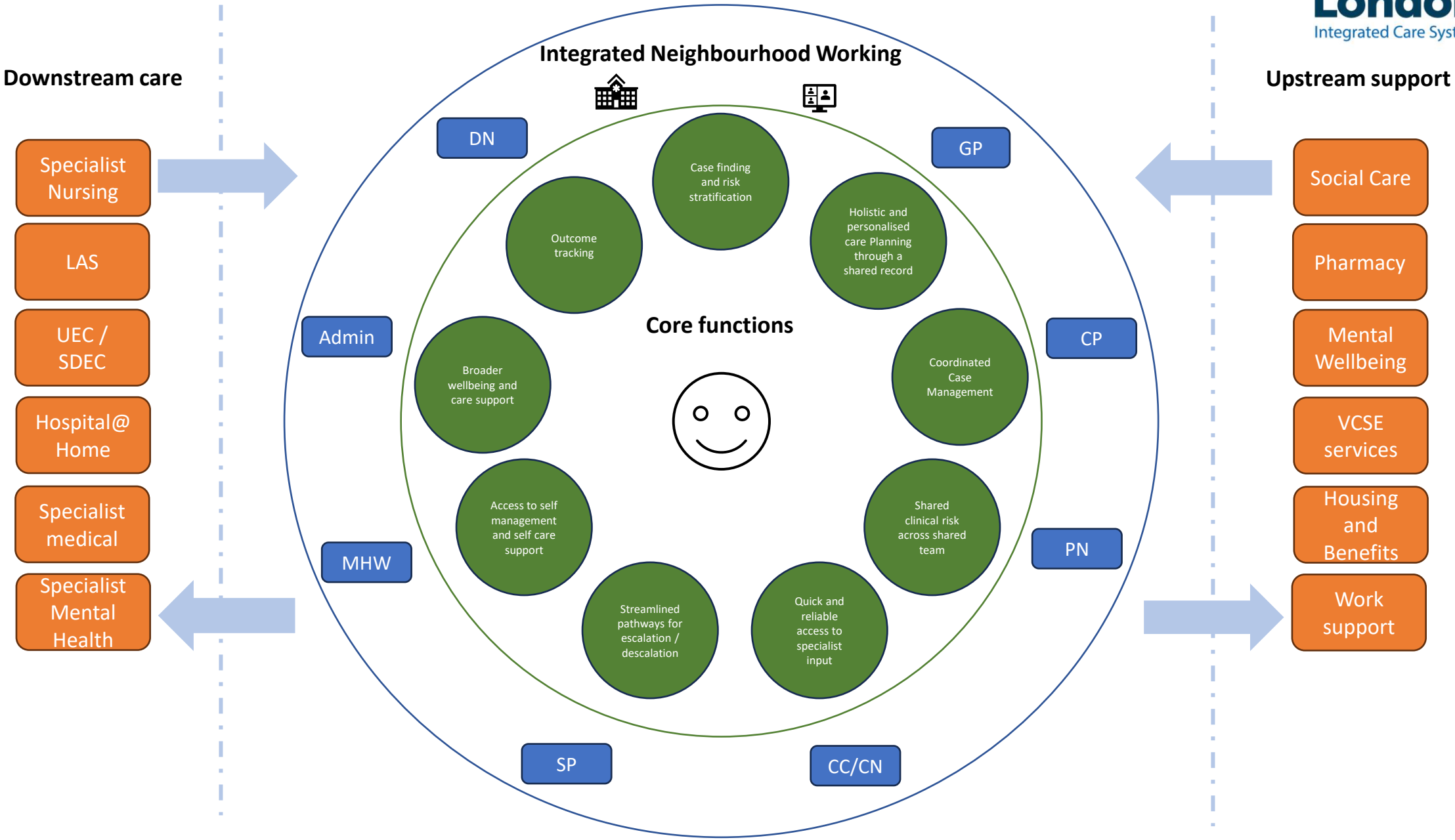
- The size of the population, key demographic information and inequalities
- The vulnerabilities experienced by the population that may increase complexity
- The clustering of diseases across the population
- Care usage across the population and the ability to identify and understand variation within this



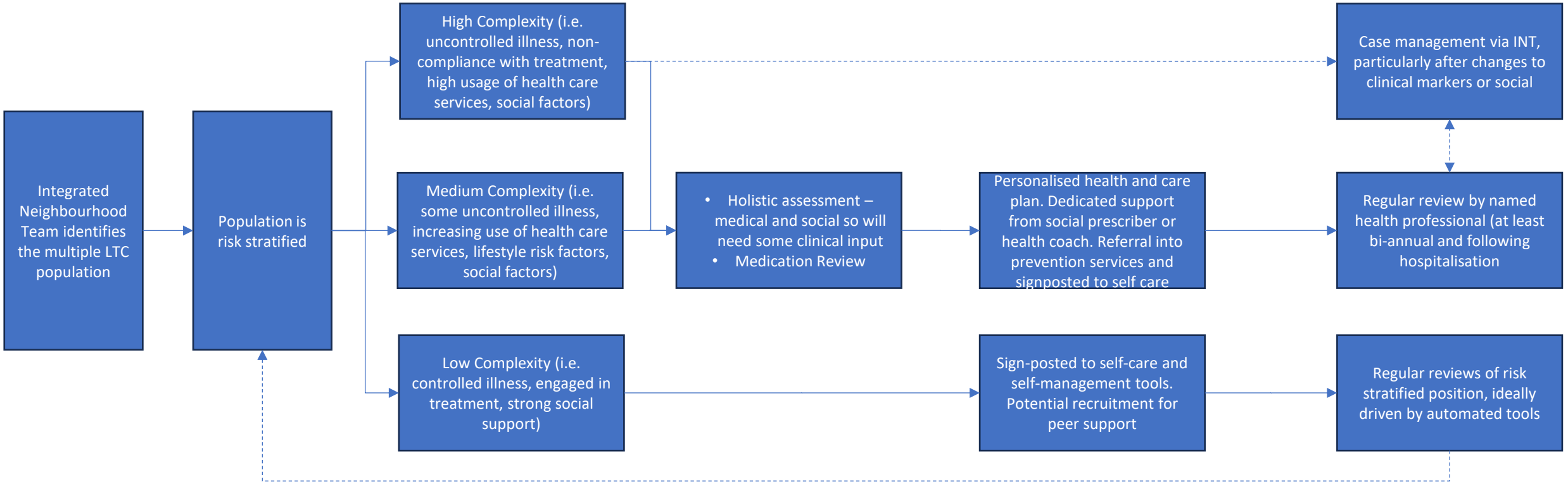



# Proposed Model of Care

South East London Integrated Care System



# Proposed pathway for proactive care




Tools:
- Multiple LTC dashboard
- Development of Arden's search

IDEAL: Population Health Tools that automate search and stratification

Tools:
- Assessment template and guidance
- Universal Care Plan
- Use of ARRS roles

IDEAL: Development of SEL self care and self-management platform where patient can interact with support, self-refer to preventative services and monitor their conditions

Tools:
- Accumail or other way to communicate across MDT
- Virtual meeting functionality
- A&G

IDEAL: Automation so that patients are continually assessed and automatically flagged to MDT for review

# Functional model, maturity and investment needs (1/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Knowledge of local services and pathways | Clear and organised summary of NHS services and pathways available for HCPs to refer people for care | Amber | • Maintain Directory of Services<br>• Recurrent investment in core VCSE offer built around the core20plus 5 population in each place |
| Streamlined HCP to HCP communication with one, agreed upon, narrative communicated to people receiving care | Ability for HCPs to identify other HCPs involved in a person's care, with standardised forums and communication channels to discuss the person's care. Leading to a joined up communication approach from HCPs to person receiving care so they are not receiving different information from different sources. | Amber | • Recurrent investment to capacity across neighbourhoods to support completion of UCPs<br>• Non recurrent investment in training, education and support<br>• Ensure ongoing capacity for clinical/Peer Review of UCPs and learning |
| Optimised and co-ordinated pathways | Long term condition care pathways optimised in number and scope and co-ordinated with one and other to provide a clear direction of care from the point of contact to care delivery. Including referral optimisation to reduce duplication of and inappropriate referrals to pathways and services.<br><br>Referrals can be made in a matrix way across the system, and specialists are able to make onwards and additional referrals to care without referring back to primary care, building on the MECC approach. | Amber | • Non recurrent investment to develop trusted assessor model and get endorsement across all main providers<br>• Recurrent investment in key workforce initiatives like "passporting staff"<br>• Specific requirements on acute workplans with ringfenced time for CBC work (particularly important around clusters). This needs to include named alignment to borough/neighbourhood, quick access to advice and into MDT meetings |

# Functional model, maturity and investment needs (2/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Shared repository of VCS organisations and services | Shared repository / hub for HCPs to keep up to date with what VCS organisations and services are provide long term condition care locally. | 3 Green<br>1 Amber | • Recurrent investment in connector / social prescriber roles within neighbourhoods<br>• Non-recurrent investment in VCSE infrastructure development at each place level |
| Single Live Health Care Record | Single Live Health Care Record which includes personalised care plan informing HCPs of what has been agreed by other HCPs involved in this person's care and who else is involved with their care. | 1 Green / Red<br>2 Amber | • See previous section |
| Referral forms including wider care received | Referral forms for services to include as standard whether the person has other long term conditions, and what services they are receiving care for.<br>(A constituent part of a single care record, however, included as separate because it can be implemented within current care referral systems). | 4 Amber<br>1 Red | • Changes to referral forms to be made across all acute trusts to ensure wider conditions are flagged |

# Functional model, maturity and investment needs (3/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Direct Access to Structured Education | Access to high quality structured education and self-support tools which could be open access or accessible via self-referral. | 1 Green<br>4 Amber | • Investment to further develop current digital structured education offer from diabetes to multiple LTCs<br>• Investment in tailored face to face education and management support – focussed around health inequalities groups<br>• Investment in group/peer support building on successful approaches in other areas<br>• Increasing self-referral pathways, which may require some additional investment for triage/ service capacity. |
| Empower people to understand the different options they have for their care | Clear and organised summary of NHS services and pathways available for people receiving care to understand what care is available to them. | 3 Amber<br>2 Red | |
| Peer Support Networks | Access and signposting to appropriate peer support networks to support self-management of long term conditions. This could be via a single-point of access portal. | 2 Amber<br>3 Red | |
| Self-Management Support | Access and signposting to appropriate self-management resources for managing long term conditions. This could be via a single-point of access portal. | 4 Amber<br>1 Red | |
| Self-referral pathways | Provide self-referral pathways to empower people to act on their personalised care and support plans. | 1 Green<br>3 Amber<br>1 Red | |

# Functional model, maturity and investment needs (4/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Co-production of services with people with lived experience and HCPs. | Co-production of services with people with lived experience and HCPs working in those services included as standard in design process with resources attached to this engagement. In particular including people not accessing healthcare services. | 5 Amber | • Recurrent investment in VCSE support |
| Dashboard of health outcomes, service performance and population demographics | Standardised and agreed upon digital dashboard that HCPs and place teams can use which contains long term condition care information e.g. demographics of service users, health outcomes, service performances. | 2 Green<br>1 Amber<br>1 Red<br>1 Green/Amber | • Non-recurrent investment in data infrastructure to get to comparable place across the 6 places.<br>• Recurrent cost of licences etc |
| Engaging with voluntary, community and social care organisations as health and wellbeing partners | Recognising the value of and including non-NHS organisations in community health and wellbeing and facilitating the closer working with non-NHS organisations and providers. | 3 Green<br>2 Amber | |

# Functional model, maturity and investment needs (5/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Prevention across the life course | Systematic approach to prevention across the life course including:<br>- Focus on social determinants<br>- Identify and reduce risks<br>- Early detection of disease (screening)<br>- Reduce risk of complications<br>- Reduce risk of over diagnosis and over treatment | 5 Amber | • Recurrent investment in point of care testing<br>• Increased recurrent investment in primary care and VCSE based support for prevention<br>• Increased recurrent investment in prescribing budgets |

# Functional model, maturity and investment needs (6/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Integrated Care Pathways | Multi-condition care pathways that focus on the person, with mental health included in this. Proactive care is factored into this, not only reactive care. | 5 Amber | • Recurrent investment in MDT roles and capacity across each neighbourhood, including GP time<br>• Non-recurrent programme investment to enable delivery of change (PCN, Place and SEL) |
| Multi-condition contracts and funding pots | Contracts, budgets and KPIs that incentivise and promote integrated, multi-condition, multi-organisation ways of working. | 4 Amber<br>1 Red | • Support from acute and primary care contracting team<br>• Non recurrent investment in external expertise? |
| Shared funding between organisations | Funding mechanisms in place to support providers working closely together | 1 Green<br>3 Amber<br>1 Red | • Supporting from acute and primary care team<br>• Non recurrent investment in external expertise |
| HCPs working, and shared, across care organisation boundaries | HCP workforce working across, and being shared across primary, secondary, tertiary care, community and mental health boundaries. Opportunity to use new ARRS roles | 4 Amber<br>1 Red | • Non recurrent investment in CBC specific workforce initiatives across People Board and primary care workforce programme.<br>• Recurrent investment to manage growing gap in ARRS budget and ARRS actual (unless NHSE position change) |

# Functional model, maturity and investment needs (7/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Tailored programmes and interventions | Services specifically tailored to reflect and address different population needs | 4 Amber<br>1 Red | • Recurrent investment to widen scope of digital structured education platform and resources to cover multiple LTCs<br>• Recurrent investment in face to face support at place/neighbourhood |
| Appropriate and tailored self-management resources | Resources tailored to provide support and advice to people of all backgrounds to manage their health, in languages and formats that are accessible to them. | 3 Amber<br>2 Red | |
| Care delivered flexibly | Flexibility in care delivery options to allow for HCPs to give more time, or time in a different way to people receiving care | 5 Amber | • Recurrent investment in capacity to enable longer appointments<br>• Use of best practice models i.e Lewes (an our local adopter site in Greenwich) |
| HCP training for personalised care delivery | Training and services in place to support HCPs with personalising care in an accessible way (e.g. cultural competency training, access to language line and interpreters) | 1 Green<br>3 Amber<br>1 Red | • Non recurrent investment in training and support package and resources |
| Including groups of people known to experience barriers to accessing healthcare in decisions about care service provision. | Including groups of people known to experience barriers to accessing healthcare in decisions about care service provision. Especially people from those who are not accessing healthcare services to pro-actively reduce health inequalities for the most vulnerable in the community. | 4 Amber<br>1 Red | • Non-recurrent investment in outreach engagement at place level<br>• Recurrent investment at neighbourhood level for ongoing capacity building? |

# Functional model, maturity and investment needs (8/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Holistic, multi-condition Personalised Care and Support Plans | Personalised Care and Support Plans created by a HCP who has been trained in personalised, holistic, care planning and making decisions jointly with the person receiving care.<br><br>This should include mental health as standard and be accessible to the person receiving care, and the HCPs involved with the provision of their care. | 4 Amber<br>1 Red | • Recurrent investment in capacity within primary, community and VCSE for care planning<br>• Non recurrent investment in training and support materials |
| HCP time and opportunity to engage with person receiving care | HCPs have the time and opportunity to fully engage with people on the planning and delivery of holistic personalised care plans. | 5 Amber | • Recurrent investment in capacity across neighbourhoods |
| HCP training for shared decision making | Training to support HCPs with joint decision making with the person receiving care | 1 Amber<br>2 Red<br>2 Blank | • Non recurrent investment in training and support materials |

# Functional model, maturity and investment needs (9/9)

South East London Integrated Care System

| Method | Description | Maturity RAG (green fully in place, amber partial, red not at all) | Investment and support needs identified |
|---|---|---|---|
| Continuity of care planning | HCP plans, and care service structuring to allow for continuity of care to be maintained where possible, with the person receiving care involved in this discussion and aware of the outcomes of these discussions. | 5 Amber | • Recurrent investment to enable lead HCP roles and dedicated care coordination/case management support |
| Vertically Integrated Care Services | Services for grouped conditions that span primary, secondary and tertiary boundaries.<br><br>E.g. Integrated Community Cardiology Service: Join up fragmented cardiology services AF, Heart failure, Cardiac Diagnostics with PCN/GPs, Consultant Cardiologist, Community Nurses | 1 Green<br>4 Amber | • Recurrent investment in service capacity (also see ERF funding incentive)<br>• Non-recurrent investment to pump prime integration where required |

# Principles around the financial and commercial model

- There is an agreed need to realign and maximise our existing investment (community contracts, acute contract, ERF incentives, local primary care commissioning, ARRS etc)
- There is an agreed need for some non-recurrent funding to pump prime the model, support and enable change and deliver key improvements in digital, workforce and estates infrastructure
- There is an agreed need for an increase in recurrent funding into primary care (including pharmacy), community services and the voluntary and community sector.
- It is recognised that the recurrent funding will be at least in part contingent delivering agreed impact. This is to ensure that investment remains sustainable over the longer term with risk shared across the system.
- It is also recognised that there needs to be a coalescence between this proposal and other system sustainability proposals to reconfigure and downscale acute services to ensure that impact translates into cash releasing savings
- The aim is for a longer-term contracting arrangement with all parties to provide certainty of income (ideally a minimum of 5 – with a preference for at least 10 years). This will enable scaling up over time, with a cautious approach taken to activity and funding shift. The contracting arrangements should be specific risk and gain to provide confidence and incentive for change.
- Funding needs to be provided in a way which underpins the sustainability and resilience of the providers and services, whilst promoting collaborative delivery of shared outcomes. This will require a share of the funding to be block/capitated, and a share to be specifically linked to outcomes and impact
- Places need flexibility to agree on specific arrangements for their local systems, but it is recognised that there may be a need for specific shared support on potential contract (and commercial) forms aligned to the principles above.

# Potential benefits and impact

- Benefits are expected to be phased over the life of the arrangement. There will be a need for some earlier quick wins to enable recurrent investment to be increased.

| Category | Outcome | Potential Benefit/Impact |
|---|---|---|
| Clinical | Patients with existing long term conditions are proactively screened for comorbodities | Increased and earlier detection of patients – particularly Hypertension, Type 2 diabetes, CKD, depression and chronic pain |
| | Patients with complex long term conditions are medically optimised | A greater proportion of patients are within treatment target range for LTCs |
| | | A reduction over time in patients requiring more specialist interventions such as organ transplant and dialysis. |
| | | A reduction in acute and general practice activity related to exacerbation of disease – i.e A&E attendances, general practice appointments and non-elective admissions |
| Patient | Patients with Long Term Conditions are better able to manage their conditions | A greater proportion of patients are within treatment target range for key LTCs |
| | | Increased patient experience and activation |
| | | Increase in preventative care – such as vaccinations and smoking cessation |
| | Better engagement with healthcare services from traditionally marginalised groups | Reduction in health inequalities across metrics in difference age, sex, deprivation and ethnicity populations |
| | Patients are supported to achieve their goals as set out in their holistic care plan | Improved patient experience |
| | | A greater proportion of patients are economically active |
| | | A reduction in the proportion of patients who are socially isolated |
| | | A reduction in proportion of patients experiencing depression and anxiety |
| Staff | Care is coordinated across professionals and care professionals feel confident and are resourced appropriately to deliver care | Reduction in appointments within general practice, community services and outpatients |
| | | Increased staff satisfaction |

# Next Steps

- November 2024 – Testing with Clinical Development Group
- November 2024 – Gateway 1: Review as part of System Sustainability Programme prioritisation
- December 2024 and January 2025 -
  - Local Care Partnership work to:
    - Detailed local model development in partnership with general practice, primary care, community care and VCSE
    - Finalise analysis on local gaps against the model in workforce, training/support, digital, estates and transformation/change management capacity
  - South East London wide work to:
    - Set up finance task and finish group to identify opportunities to realign investment and to model remaining investment required
    - Set up impact/outcomes task and finish group to co-produce the logic model and quantify expected impact over time. Use this to inform roll-out staging
    - Develop detailed plans for acute interaction with model for discussion and agreement
    - Support to places on commercial/contracting approaches
- February and March 2025
  - Local Care Partnership work to:
    - Development of contractual framework and testing with providers
    - Finalising local programme structures
  - South East London wide work to:
    - Finalise Full Business Case for System Sustainability programme
    - Finalise outcomes and impact phasing and tracking
- Implementation begins April 2025 on a phased basis