Clinical Effectiveness South East London

NHS South East London

Clinical Effectiveness South East London (CESEL): Impact report 2024-25

'Making the right thing to do the easy thing to do.'

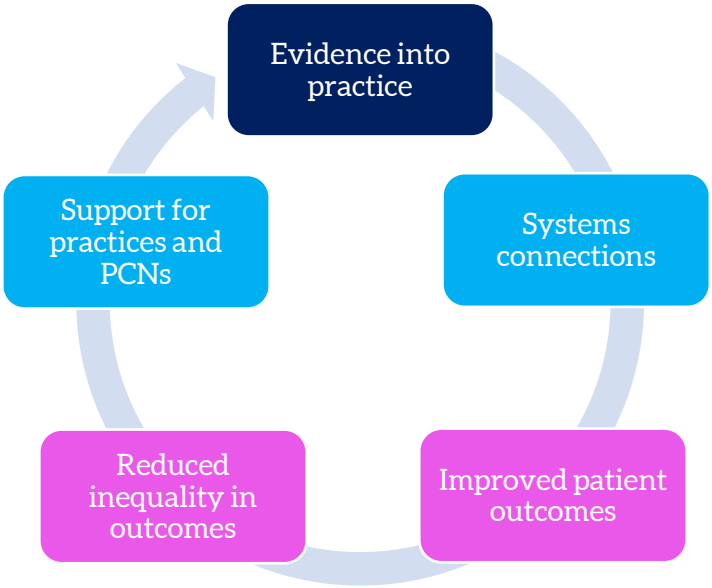
May 2025

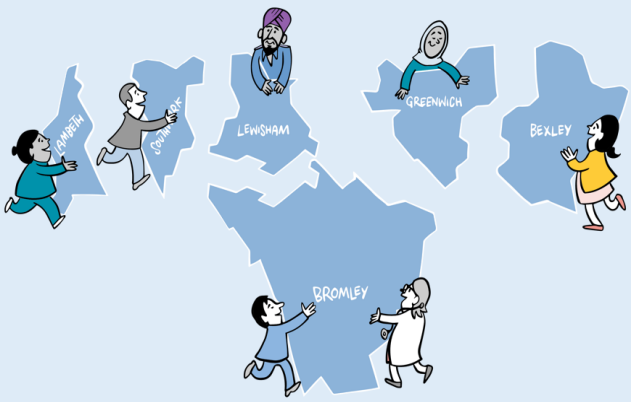
What we do

CESEL supports front line teams across southeast London with the evidence, tools, data and skills to drive improvement from within for sustainable change.

CESEL empowers staff to learn from the care they provide and from one another, leading to continuous improvements in the care they deliver.

CESEL adapt, refine and embed ideas and innovations to work for local teams and bring people across SEL together, to collaborate, learn, challenge and improve.





Local Teams

CESEL teams across each SEL borough collaborate to develop and provide resources and supporting local teams, by adapting their approach based on local feedback.

CESEL Clinical Areas

CESEL focus on high prevalence long term conditions, important to our communities, that have a significant impact on health outcomes and where teams can positively impact on inequalities and improve outcomes.

- Hypertension
- Asthma
- Depression and Anxiety
- Vital 5
- Type 2 Diabetes
- Chronic Kidney Disease
- Atrial Fibrillation

Delivery in 2024-25

CESEL develops and delivers an aligned set of high-quality tools designed to support improvement, whilst adapting and responding to feedback from practice teams

CESEL methodology

Guides + Education
Help people know what is best-practice

Templates + Searches
Help people put best-practice into action

Data + Analytics
Help people know how about progress

Facilitation
with PCN and practice teams to improvement support efforts

Investment

CESEL delivered

7 **Clinical guides**

40+ **Education sessions**
Face to face and virtual

Across SEL **Templates**
Aligned, localised EMIS clinical templates for all CESEL conditions*

220+ **Data packs**
to support primary care network and practice teams

200+ **Facilitation visits**
Face-to-face and virtual

£200k **Rewarding**
Extra resource brought into the system for practices and community partners for improvement work

CESEL: Developing the offer with our partners

CVD Inequalities Scheme: CESEL worked with the Health Innovation Network, Kings Health Partners and South London Cardio Network to provide £200k to PCNs, to enhance Quality Improvement (QI). CESEL helped staff to identify and address multimorbidity associated with CVD. This included tailored support to empower multi-professional teams to deliver proactive care management.

Community Blood Pressure screening tool: Designed to empower healthcare professionals and community members to collaborate to deliver effective, culturally sensitive blood pressure checks in their communities. CESEL provided CVD best-practice to design the tool.

The ' Vital 5': CESEL supported the Kings Health Partners **Vital 5** initiative - addressing the 5 key preventable factors that contribute to poor health - smoking, weight, high BP, alcohol and low mood. CESEL produced a Vital 5 guide for steps that staff can take to support their patients.

Synnovis response: In response to the cyber-attack on Synnovis (pathology services), CESEL mobilised support (e.g. webinars, support resources) to help practices in mitigating the impact on long term conditions while there were limited pathology services available.

Integrated Neighbourhood Teams (INT): CESEL piloted an approach in Lewisham to provide education to community-based teams on steps to reduce the impacts of CVD in their communities, supporting INT development.

CESEL Guides: Updated in 2024/25, providing SEL wide best-practice, with dedicated borough pages. Guides include practical steps to address inequalities, plus a focus on long-term conditions (LTC)in younger people, especially during pregnancy.

Digital and data partnerships: CESEL worked with NE London's Clinical Effectiveness Group (CEG) to embed digital solutions (APL tool) to help practice teams to identify patients with CKD and to optimise their care.
CESEL also produced a CKD dashboard.

CESEL feedback

	User ratings
Guides	4.4
Education	4.4
Visits	4.7
Data	4.5

5 = excellent, 1 = poor

- CESEL asked teams to rate the CESEL offer out of 5 for each of the support functions – guides, education, facilitation visits and data.
- CESEL scored an average 4.5 (90%) across the four domains with our visits offer being the most valued by our colleagues with a score of 4.7/5 (94%).

What people said about CESEL

' I find all CESEL events and learning very relevant... find the team knowledgeable... and explain things in a nice, easy way'

'clear explanation of targets and best practice which includes handy packs to refer to'

Tinu (CESEL Facilitator) significantly improved my diabetes management. The educational sessions and resources provided was invaluable..'

'useful to hear about how we had improved, and our efforts had paid off...and to hear about how other surgeries had achieved targets'

How people would like to see us improve

Help in how we could support improvements at a PCN level

Data slides in advance, for every meeting, would be helpful

Shorter but more frequent meetings

CESEL's response to previous feedback

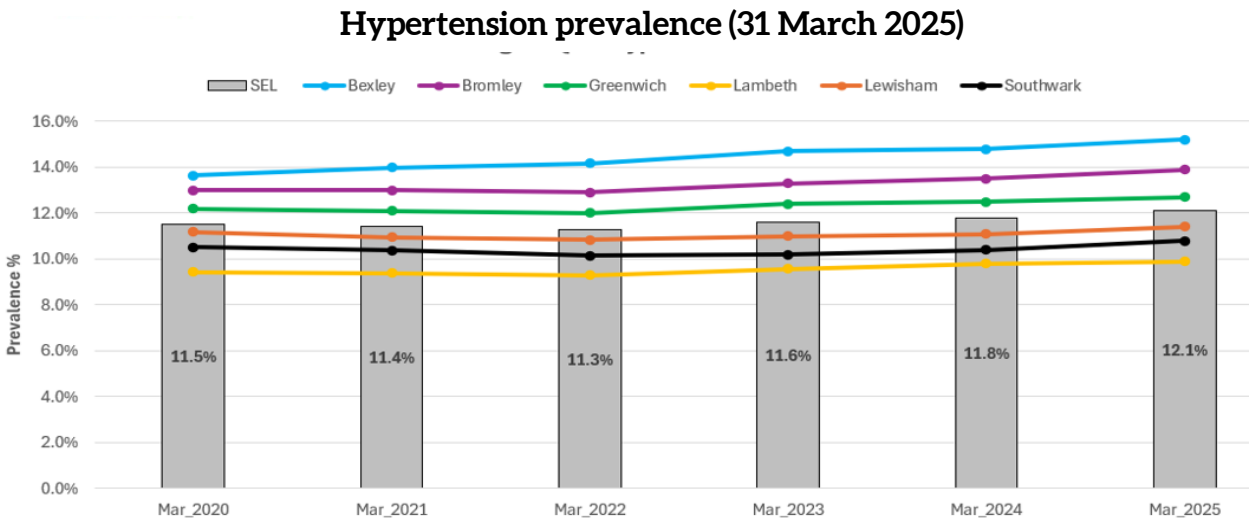
Data: CESEL now produce regular summary data packs for each PCN, designed to keep practices sighted on how they are getting on compared to local peers.

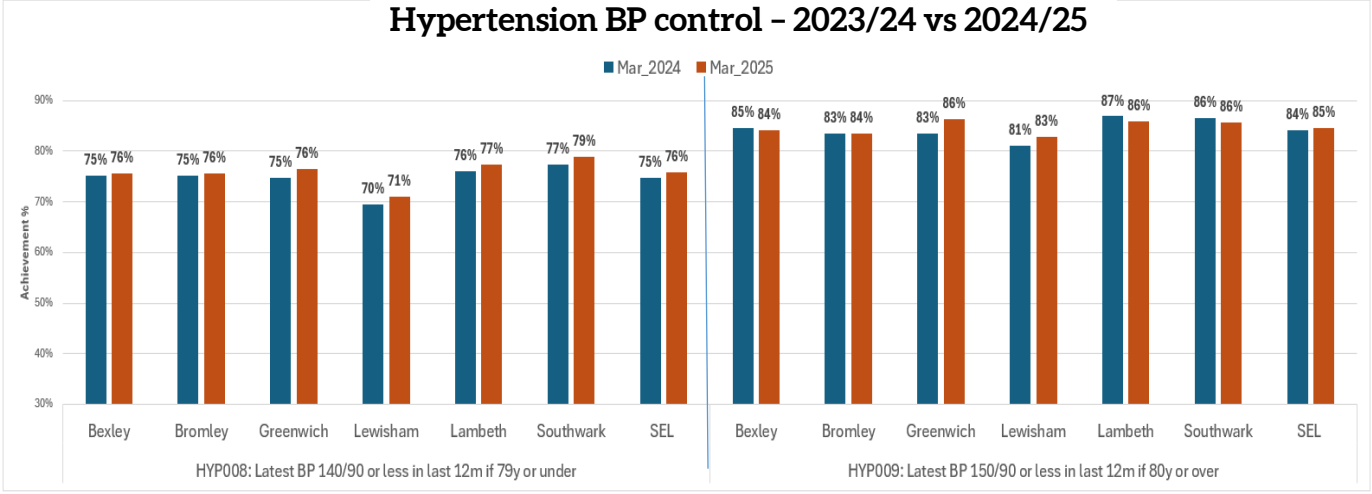
Guides: moving from borough to SE London guides enable the team to find additional capacity for education and support visits.

Visits: Team have stepped up the number of face-to-face visits for those practices wanting in-person support. The team also tailor visit frequency and approach based on local preference and need.

Survey results and feedback taken from CESEL annual survey (30 completed) and CESEL visit feedback forms

Hypertension



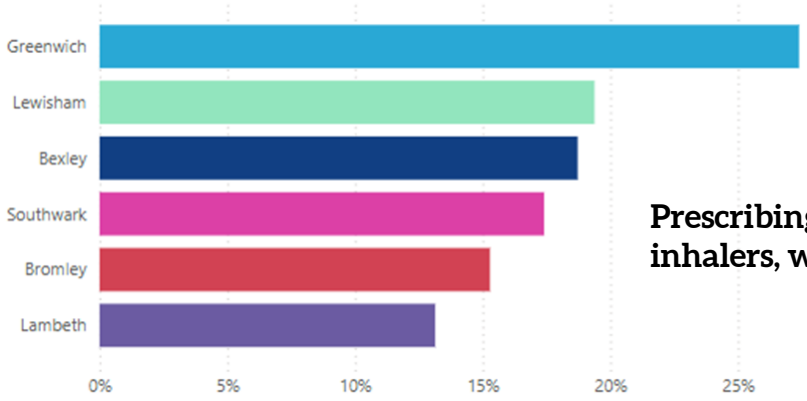


Improvement headlines include:

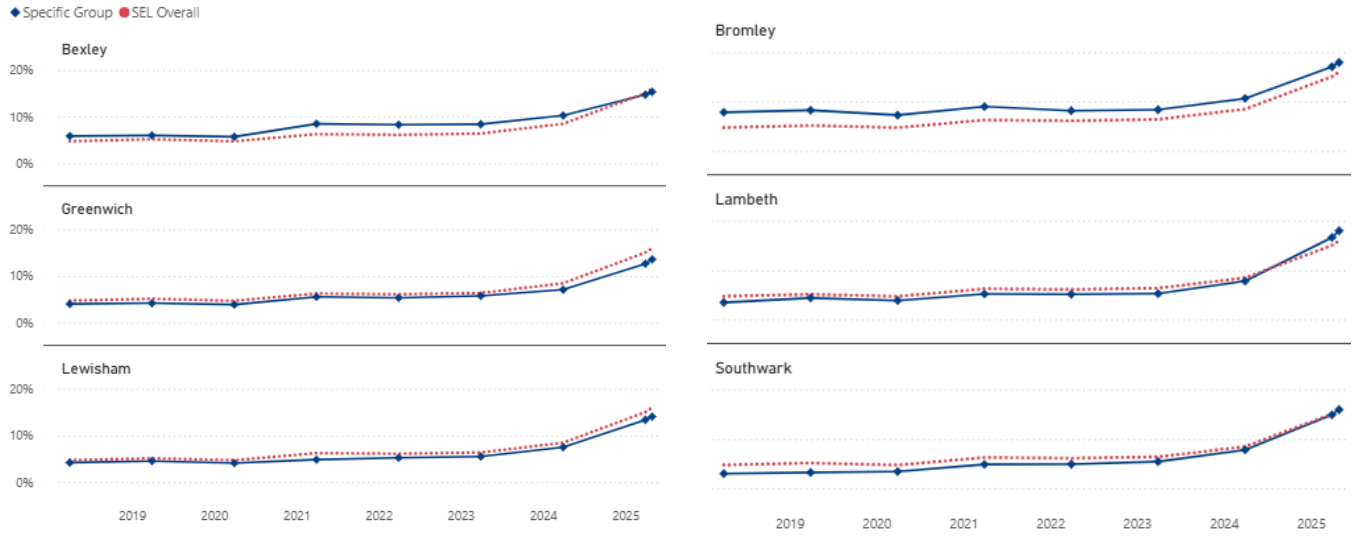
- Increase in (QOF) hypertension prevalence.
- Improved BP control for both over and under 80's (across SEL).
- Under 80's BP control improvement by each borough.

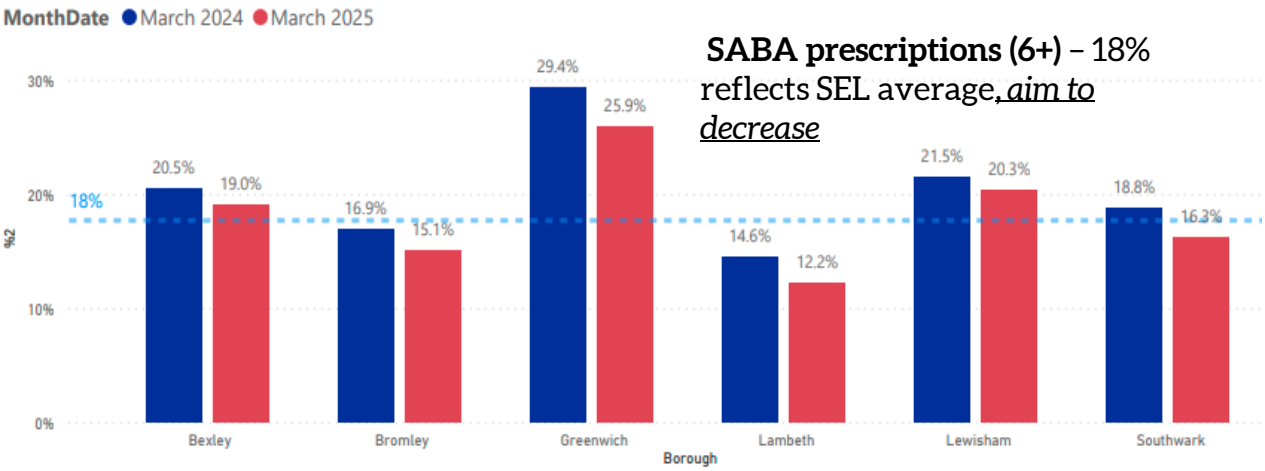
Year end data (31 March 2025): Prevalence provided by CESEL team using EMIS searches.
ICB's Business Intelligence Units (BIU) dashboard provide BP control

Asthma



Prescribing of combined ICS/Formoterol inhalers, without any SABA prescription





SABA prescriptions (6+) – 18% reflects SEL average, *aim to decrease*

Improvement headlines include:

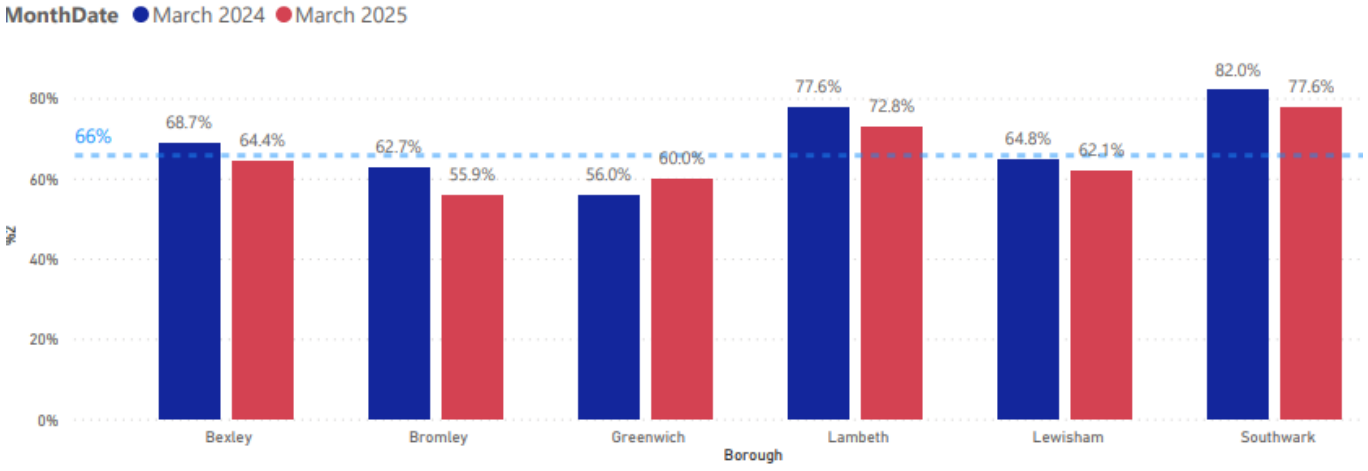
- Best-practice inhaler prescribing (combined ICS/Formoterol) has improved, though variation remain across SEL
- Overprescribing of SABA's has reduced across all SEL boroughs

Year end data (31 March 2025): Prescribing of combined ICS/Formoterol inhalers without SABA prescription data provided by Respiratory dashboard, hosted by the ICB Business Intelligence Unit (BIU) and SABA (+6) provided by CESEL team using EMIS searches.

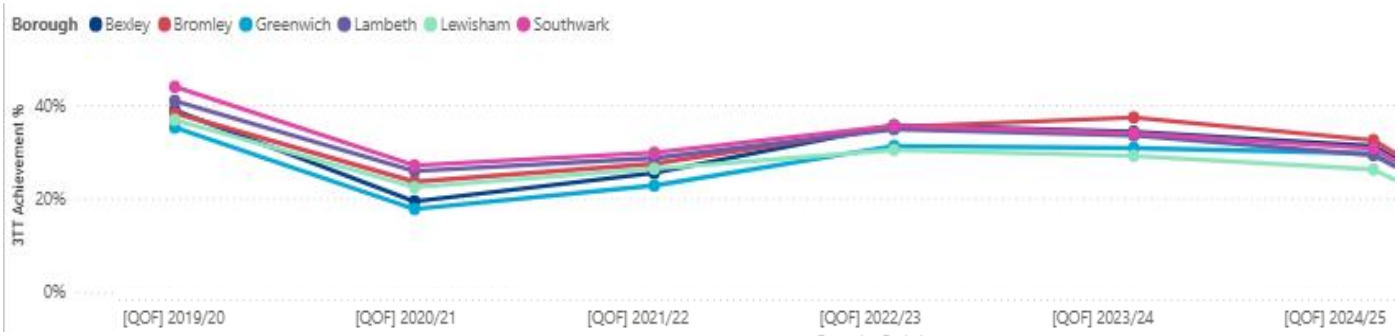
Diabetes

Diabetes 8 Care processes (8CP) achievement (year-end 2023/24 and 2024/25

66% reflects SEL average



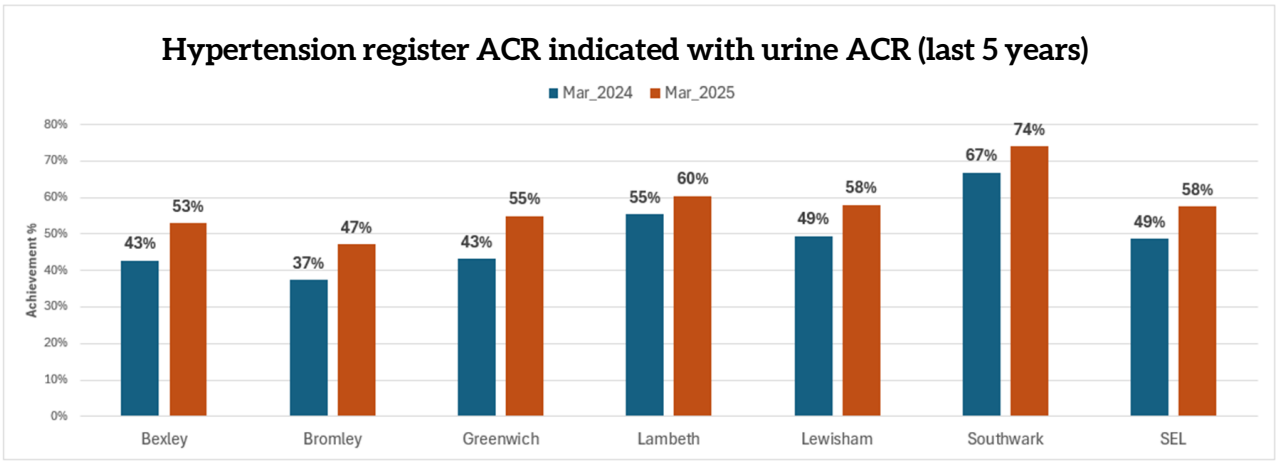
Diabetes triple-treatment target (3TT) achievement (6-year view, up to 31 March 2025)

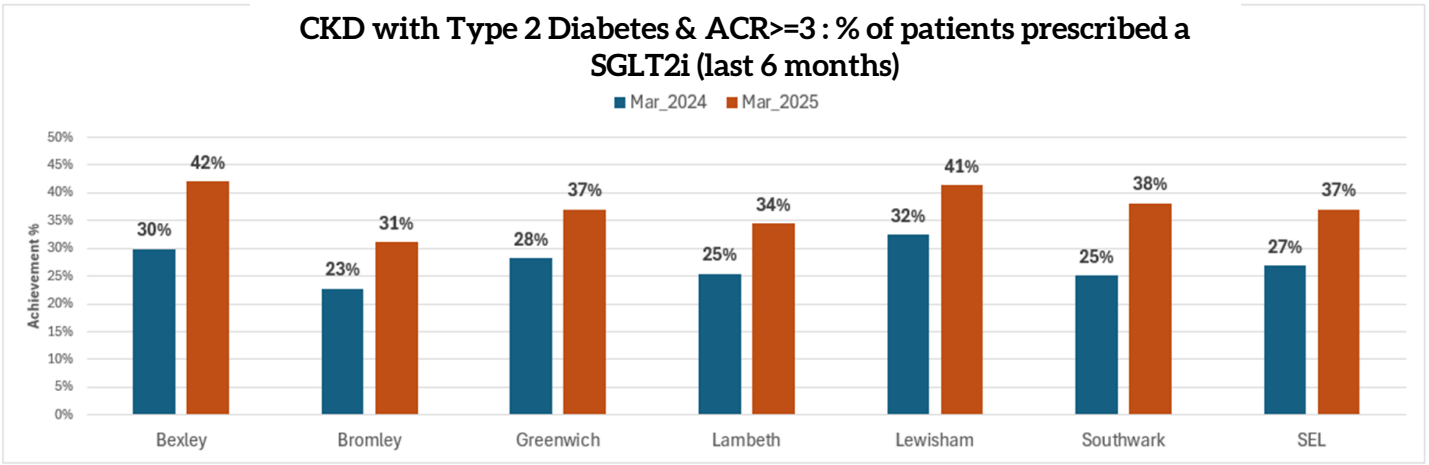


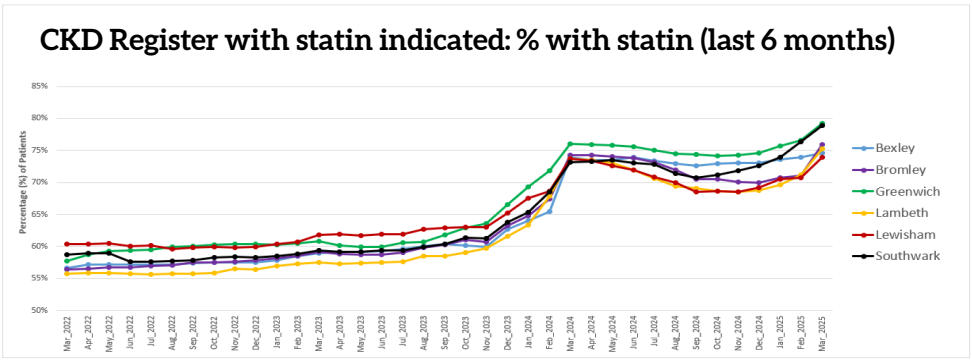
- A challenging year for practices to maintain 2023/24 achievement due to the Synnovis cyber-attack, with some boroughs more effected due to the recovery sequence.

Year end data (31 March 2025) produced by CESEL, from EMIS searches

Chronic Kidney Disease (CKD)







Improvement headlines include:

- Increased number of patients with hypertension who had a urine ACR completed (in the last 5 years).
- Increased number of patients with CKD, prescribed a statin (in the last 6 months).
- Increased number of patients with CKD and type-2 diabetes, prescribed an SGLT2i (in the last 6 months)

Year end data (31 March 2025) provided by the CESEL CKD dashboard, available via the ICB's Business Intelligence Units (BIU) dashboard portal

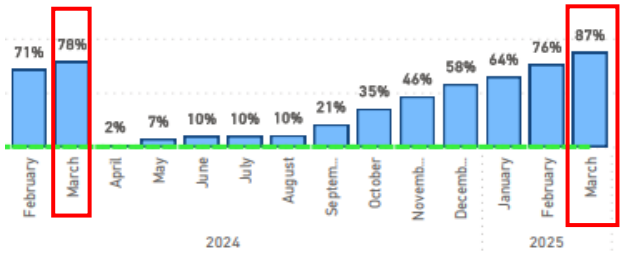
Bexley Case Study: Plas Meddyg Surgery

Practice asked for support in improving their diabetes prevalence, care processes (CPs) and treatment target (TT) achievement.

Actions & Recommendations:

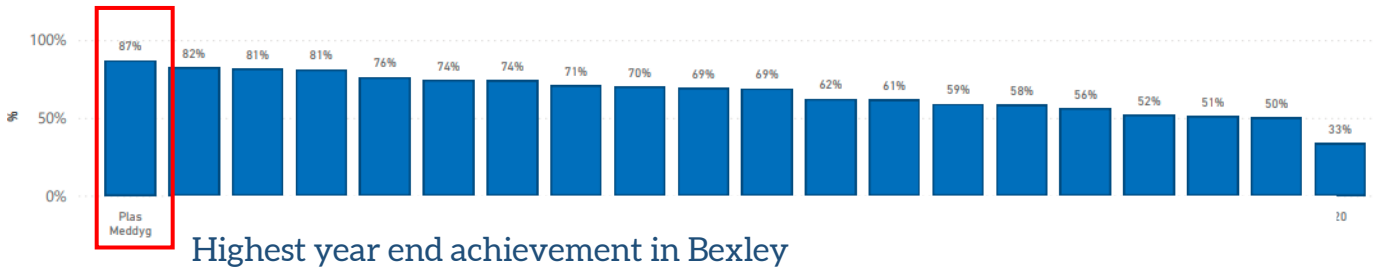
- CESEL visited the practice and provided guidance on using case finder tools to improve diabetes prevalence.
- Recommendation to use 'month of birth' to inform a review and recall system
- CESEL subsequently providing regular diabetes data to track improvements
- Practice embedded an improved recall system in response to the support sessions.

Plas Meddyg Surgery: Diabetes 8 CP – monthly achievement



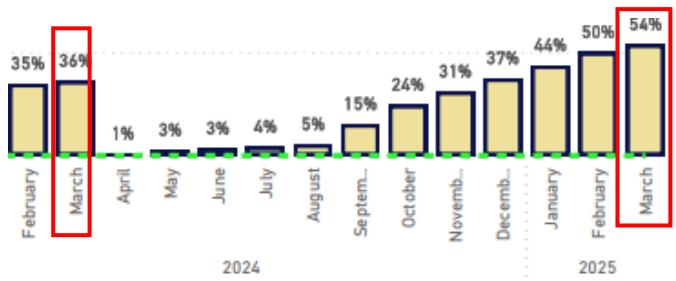
Year end Diabetes 8CP increased from 78% to 87%, for 2024-25

Plas Meddyg Surgery: Diabetes Care process achievement compared to Bexley practices



Highest year end achievement in Bexley

Plas Meddyg Surgery: Diabetes TT – monthly achievement

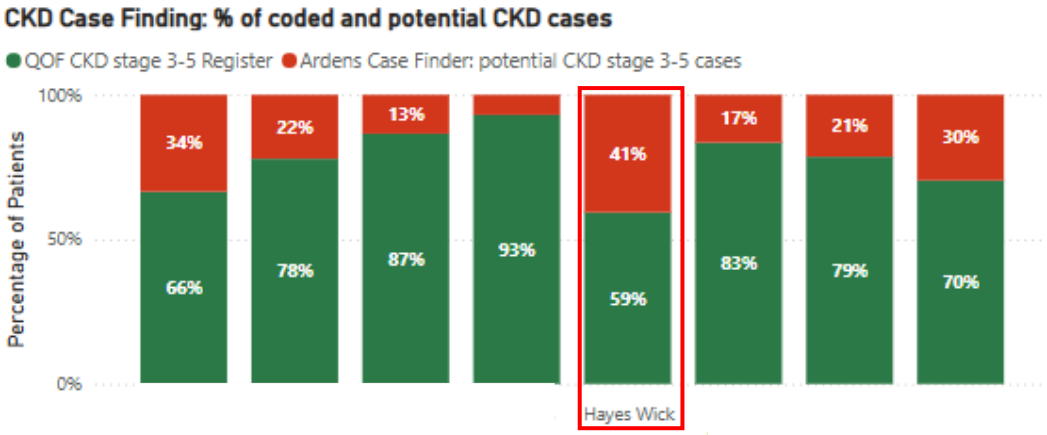


Year end Diabetes TT increased from 36% to 54%, for 2024-25

Year end data (31 March 2025) produced by CESEL, from EMIS searches

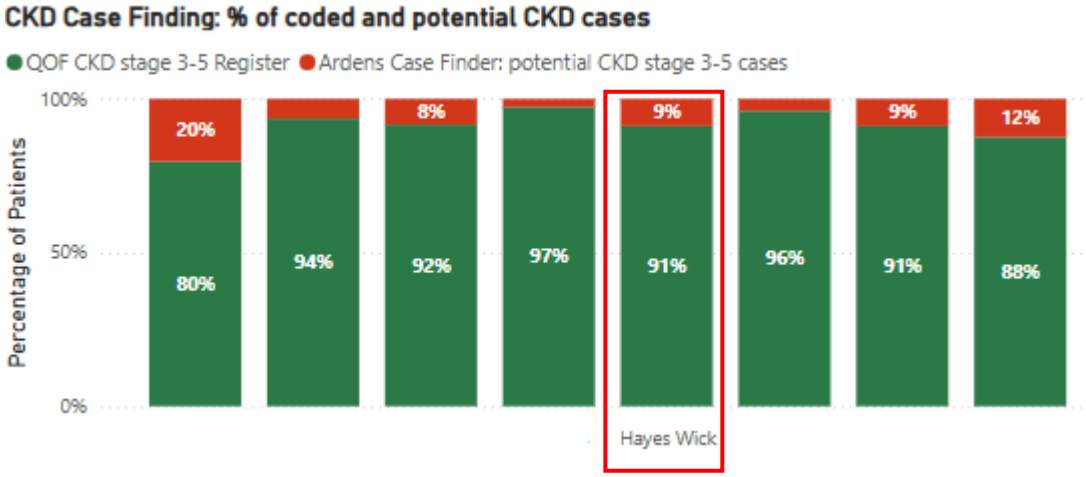
Bromley case study: Hayes Wick PCN

Hayes Wick PCN had below average CKD prevalence, and a low case finding achievement in 2023/24, compared with other PCNs



CESEL support focussed on CKD improvement efforts.. Actions included:

- Case finder searches identified patients at risk of having CKD, not on the register.
- The admin team supported follow-up testing and coordination.
- Diagnoses coded using ACR and eGFR. Renal bloods and Urine reviewed.
- Clinical Pharmacist with an interest in kidney health, recruited to work across the PCN
- Annual ACR testing encouraged during long-term condition reviews.



Impact

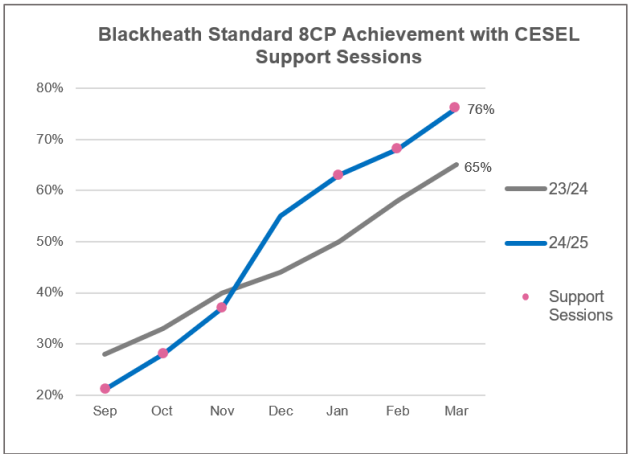
- Improved prevalence from 3.6% to 5.2% over 12 months through case finding work, resulting in 526 newly coded CKD patients in 2024-25

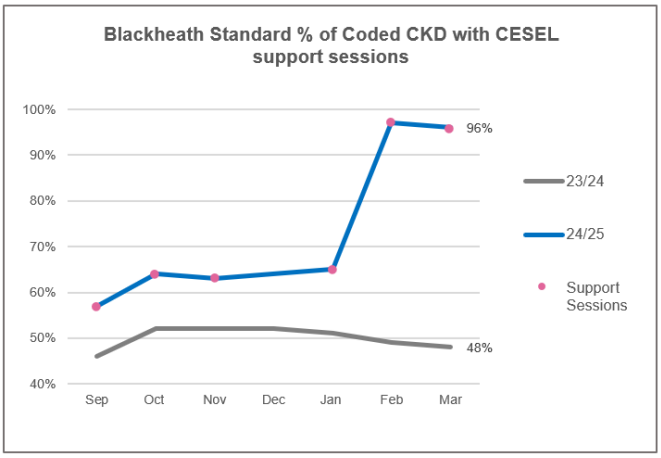
Year end data (31 March 2025) provided by the CESEL CKD dashboard, available via the ICB's Business Intelligence Units (BIU) dashboard portal

Greenwich case studies: Blackheath Standard and All Saints

Blackheath Standard

- Multiple support sessions focusing on CKD, diabetes, and hypertension improvement.
- Demo' use of CESEL 8CP filtering template and Ardens searches.
- Reviewed local care processes and development of an improvement plan (e.g. sending Accurx messages).
- Setting regular goals to support completion of agreed actions.

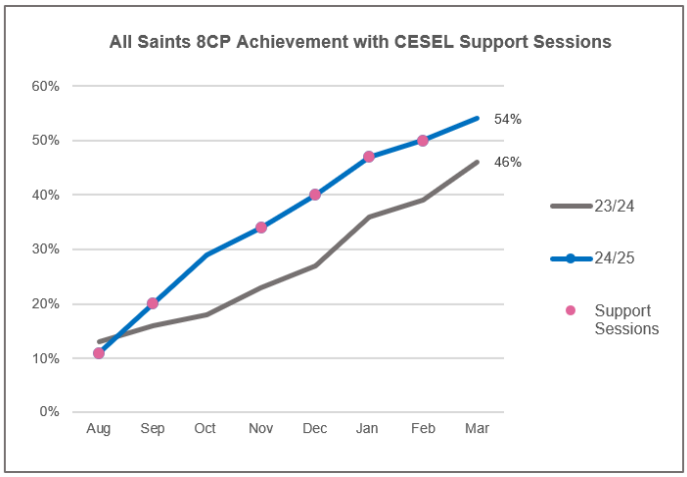




- Diabetes care processes improvement (increasing from 65% to 76%).
- 100% improvement in coded CKD (up from 48% to 96%).

All Saints

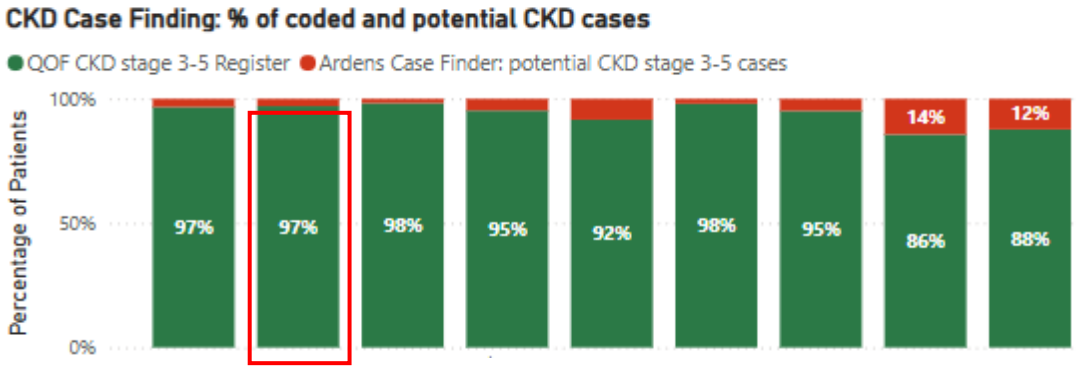
- 6 sessions over Aug 24 – Feb 25 focusing on Diabetes improvement.
- Provided guidance on applying the CESEL 8CP filtering template and approaching care process tasks.
- Established monthly goals/action plan, e.g., sending Accurx messages, delegating tasks to clinical colleagues



Lambeth Case Study: Brixton & Clapham Park PCN

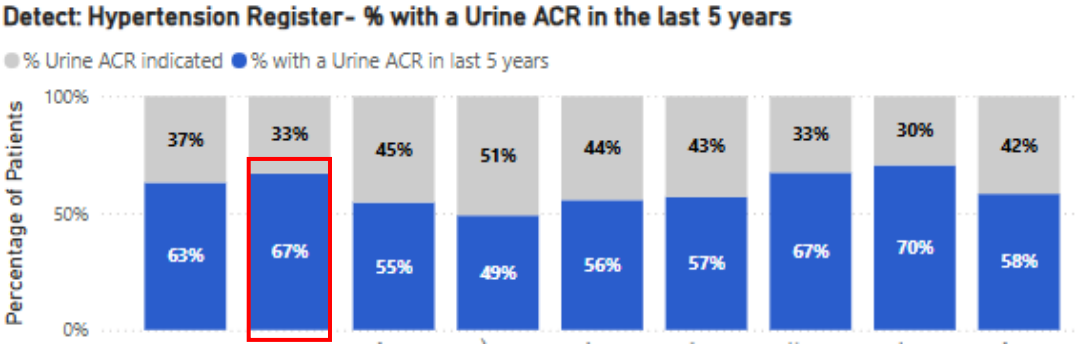
- CESEL provided searches to highlight uncoded or miscoded CKD patients.
- Reviewed ACR testing and helped practices to find these patients.
- Supported clinicians to review CKD registers and initiate appropriate treatments, especially statins and SGLT2is.
- Delivered regular feedback to practices, highlighting achievements and next steps.
- Provided focus support to admin team to call/recall these patients.

CKD Register & Prevalence



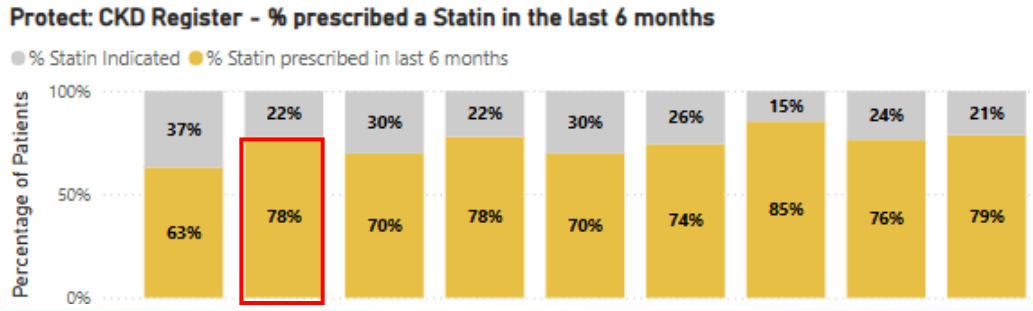
Increased prevalence from 88% to 97% (over 12 months)

Hypertension + ACR Testing



ACR testing within 5 years for patients with hypertension improved from 52% to 67%, helping to detect CKD (over 12 months)

CKD Statin Prescribing



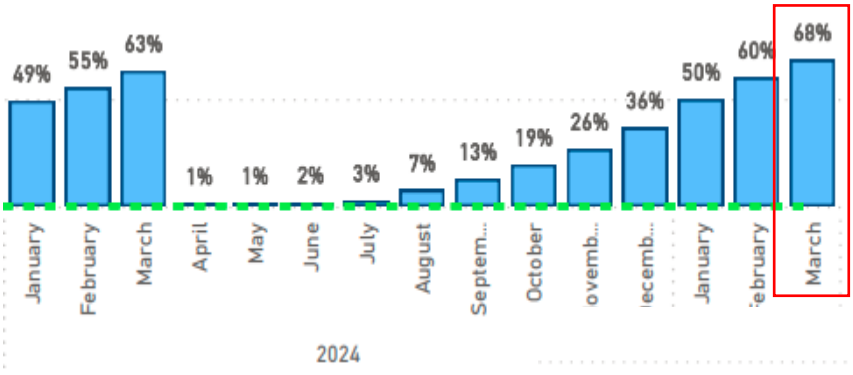
Increased statin prescribing from **70%** to **78%** of eligible patients (over 12 months)

Year end data (31 March 2025) produced by CESEL, from EMIS searches

Lewisham Case Study: Novum

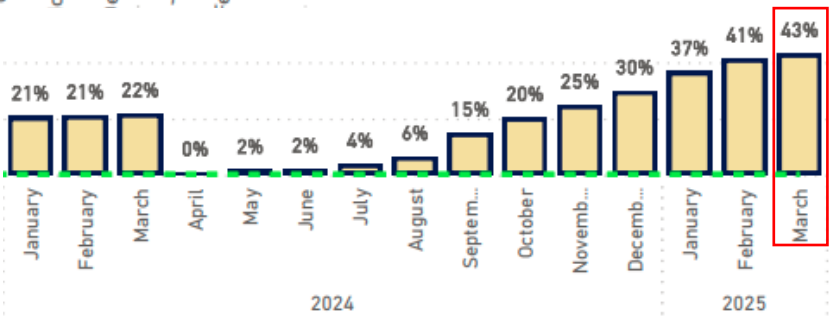
- In response to receiving a CESEL data summary pack, the practice reached out seeking help to make improvements.
- CESEL provided an overview of their performance and gave guidance on using Ardens searches to support improvement work across the conditions, which the practice implemented.

Diabetes achievement

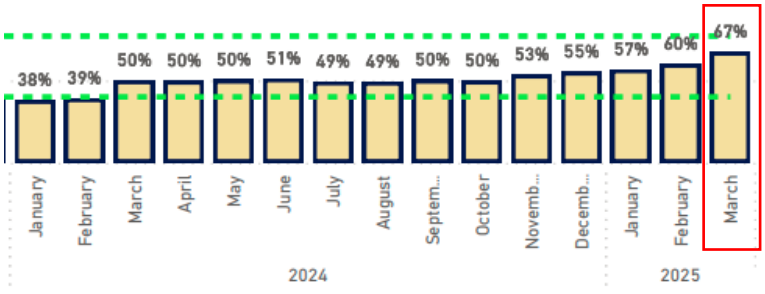


care process achievement increased to 68% as of year end (2024-25)

Treatment target achievement increased from 22% to 43% compared to last year

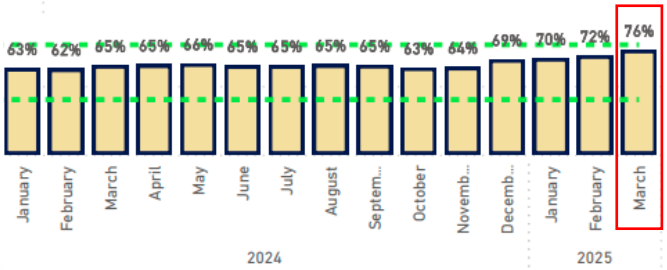


Hypertension achievement



BP control under 80's achievement increased from 50% to 67% compared to last year

BP control over 80's achievement increased from 65% to 76% compared to last year

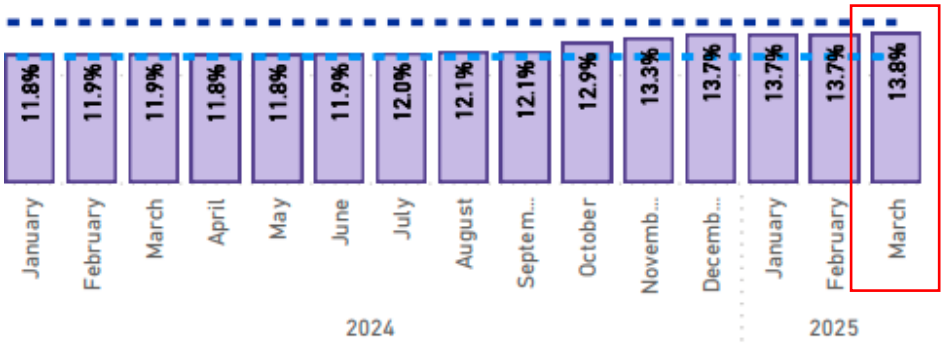


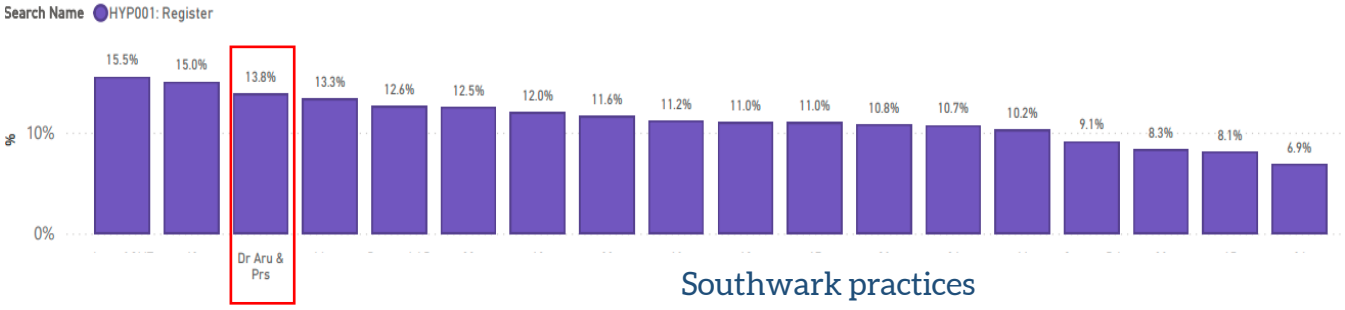
Year end data (31 March 2025) produced by CESEL, from EMIS searches

Southwark Case Study: Aru & Partners

- Further to CESEL's neighborhood session, practice took up individual support offer, receiving several visits to help address local improvements across CVD.
- Support included help with utilizing case finder resources

Hypertension Prevalence





Increased prevalence – 195 patients diagnosed. third highest % in South Southwark

Year end data (31 March 2025) produced by CESEL, from EMIS searches

Building support across SE London

2024-2025

Outputs

- Built a portfolio of support across high-prevalent long-term conditions.
- Increased annual number of support visits and training delivered.
- Practices receiving support continue to make improvements, within a challenging environment (e.g. Synnovis cyber attack).

Feedback

- Positive feedback and useful insights to continuously develop support that meets the needs of local teams and challenges.

Shared learning and success

Partnerships

- Working with system colleagues, including engagement with multi-disciplinary teams across emerging Integrated Neighbourhoods Teams (INTs).
- Strengthened our network of local and regional QI partners to bring innovation to frontline teams

Team

- Cohesive and effective team.
- Shared learning and education.
- Flexible to challenges (e.g. Synnovis)

2025-2026

Partnerships and scope

- Help to maintain and develop a sustainable modern general practice teams
- Shape to meet the needs of INTs.
- Resources to empower communities to engage in health improvements.
- Continue to promote and use a Population Health Management (PHM) approach.

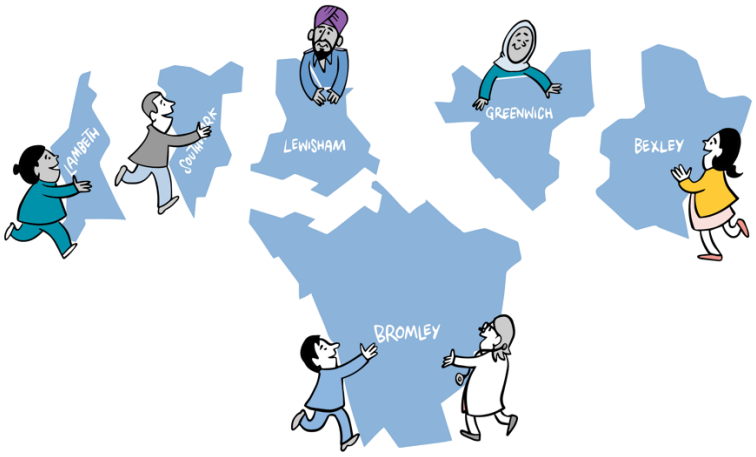
To find out more about any of the content included in this report or share any reflections that may help shape CESEL'S support offer, please check the CESEL webpage **or** email the team at clinicaleffectiveness@selondonics.nhs.uk

Working with our partners

Primary care teams can be overwhelmed by new projects and initiatives. CESEL connects colleagues across the system with the aim of sharing learning and support. This is more important than ever, as SE London works towards developing integrated neighbourhood teams.

CESEL would like to thank all our partners for supporting our programme of work and our peers in the frontline for identifying and delivering improvements that lead to better health for our communities. The achievements described in this report reflect the efforts of stakeholders from across the local system.

Ardens	Kings College London	Health Innovation Network	South London CVD Network	
London Clinical Effectiveness Collaborative	ICB Medicines Optimisation Teams	Kings Health Partners	SEL Workforce Development Hub	
ICB LTC team/leads	Respiratory Network	CVD Working/ Steering Group	ICB Business Intelligence Unit	ICB Digital Team
Community partners	SEL Improvement Collaborative	System Sustainability Team	ICB Comms Team	



CESEL: Making the right thing to do the easy thing to do.