Clinical Effectiveness South East London

NHS South East London

Clinical Effectiveness South East London (CESEL)

Impact report 2025-26

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

clinicaleffectiveness@selondonics.nhs.uk

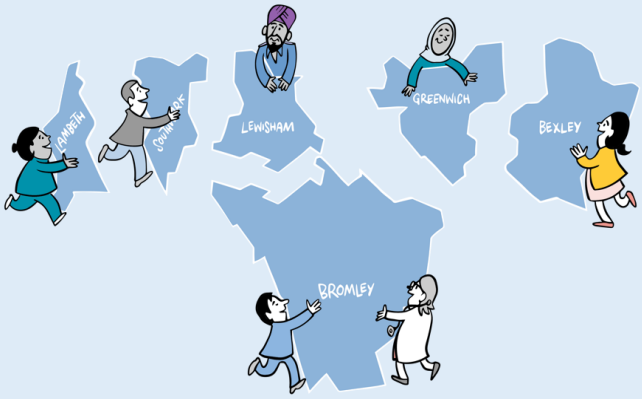
June 2026

What we do

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

CESEL supports staff to learn from the care they deliver, and from each other, and improve the care they deliver as a result.

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



Local Teams

CESEL teams in each SEL borough collaborate to develop and provide resources and support for local teams, adapting their approach based on local feedback.

CESEL clinical areas

CESEL focus on clinical areas that are important to our communities, where general practice can make a difference, and on-the-ground teams tell us they want to improve.

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

Delivered in 2025-26

CESEL develops and delivers a coordinated, high-quality tools to support improvement, constantly adapting in response to feedback from on-the-ground 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 to understand progress

Facilitation
improvement support for on-the-ground-teams

Investment

CESEL delivered

7	**Clinical guides**
40+	**Education sessions** Face to face and virtual
Across SEL	**Templates*** Aligned, localised clinical templates for all CESEL conditions
220+	**Bespoke data packs** to support primary care networks (PCNs) and practice teams
200+	**Facilitation visits** Face-to-face and virtual, practice and PCN level
£200k+	**Additional rewards** Extra resource brought into the system for practices and community partners for improvement work

*Ardens® clinical templates localised to SEL

CESEL feedback

User ratings	
Guides	4.4
Education	4.4
Visits	4.7
Data	4.5

5 = excellent, 1 = poor

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

Survey results and feedback taken from CESEL annual survey carried out in March 2026.

CESEL: Developing our offer with our partners

Cardiovascular Disease (CVD) Inequalities Scheme: Health Innovation Network, King's Health Partners, and South London Cardiac and Stroke Network partnered with CESEL to provide £250k to strengthen Quality Improvement initiatives. Projects for 2025–26 were designed by place leads. In Lewisham, CESEL was invited to focus support on the lowest-performing practices, leading to notable improvements.

Community Blood Pressure screening: CESEL partnered with Health Innovation Network, Kings Health Partners and the South London Cardiovascular Network to support the delivery of a CVD quality improvement that addresses inequalities across SEL. The scheme enabled BP screening events, identifying over 200 patients for onward management. Support was also provided to lower performing practice in Lewisham, leading to blood pressure control performance improvement.

Integrated Neighbourhood Teams (INT): CESEL has responded to an ask by the emerging INTs to develop resources for multiple long-term conditions, frailty and chronic pain.
CESEL has worked with Lewisham INT's to co-deliver CVD awareness events, provided frailty education in Greenwich and supported Lambeth and Southwark's National Neighbourhood Health Implementation Programme (NNHIP).

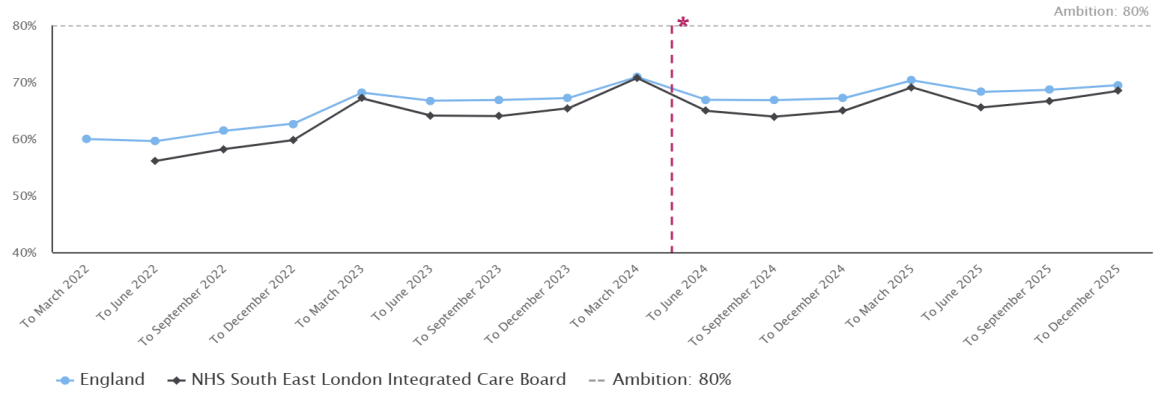
The ' Vital 5': The Vital 5 Programme tackles the top five causes of poor health. CESEL provide practical support for teams to use the CESEL Vital 5 guide in their daily practice.

Digital and data partnerships: The CESEL Chronic Kidney Disease (CKD) dashboard has supported improvements in CKD detection and management, helping lower patients' risk of heart attack, stroke, and kidney failure.
CESEL collaborated with digital teams and Ardens to leverage high-quality primary care data for improvements

Healthy Hearts: CESEL is working with the Health Innovation Network, Kings Health Partners, Kings College London and ICB Sustainability Team to support teams to rapidly optimise care for their patients with CVD risk conditions.

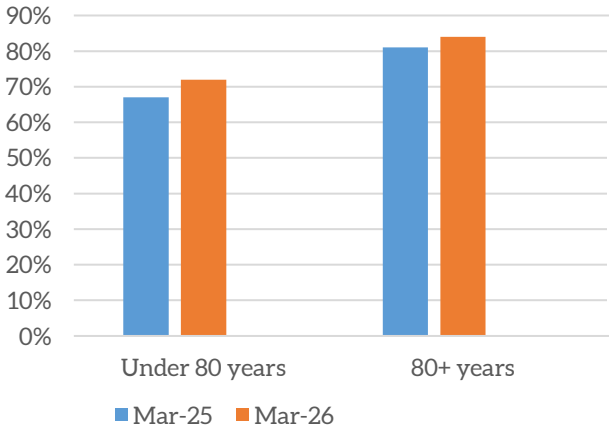
Hypertension: Improvement highlights

SEL has **improved blood pressure (BP) control across all groups**, with a 12.5% improvement since 2022 compared to a 9% improvement nationally



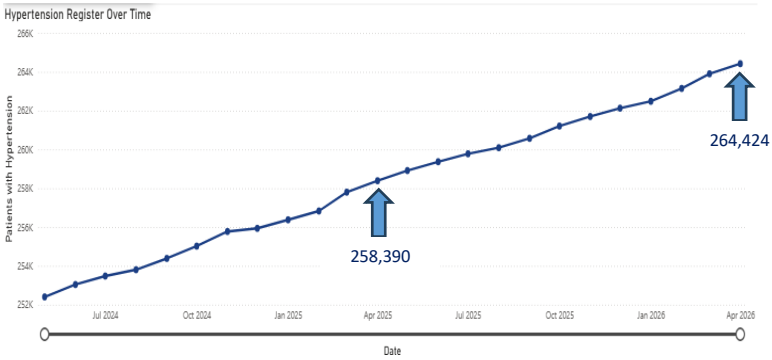
SEL hypertension control

Improvements over last 12 months



SEL continues to improve year on year in hypertension control, but there remains variation across practices and Primary Care Networks (PCNs). CESEL uses data to identify teams with the greatest challenges and provides bespoke support to improve outcomes for the populations they serve.

SEL hypertension prevalence

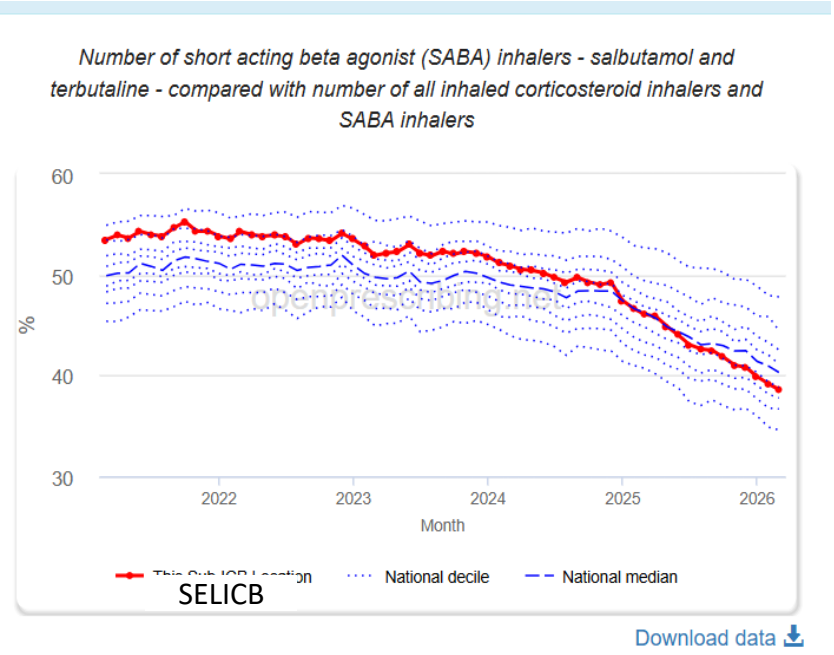


Improved hypertension control has occurred alongside increased detection of hypertension with an additional 6,000 patients added to the SEL Hypertension Register in the last year.

CVD Prevent data accessed May 2026
SELICB Hypertension dashboard data

Asthma: Improvement highlights

Overuse of short-acting-beta-agonist (SABA) inhalers (e.g. salbutamol) is associated with poor asthma control. A CESEL focus in 2025-26 has been to move away from prescribing SABA alone to support transition to the SABA-free pathway - a combined inhaled corticosteroid and beta-agonist inhaler (ICS/Formoterol). Working with colleagues from specialist respiratory teams and the ICB Medicines Optimisation Team, CESEL promoted the use of the SABA-free pathway resulting in a dramatic reduction in SABA prescribing compared to our peers nationally.

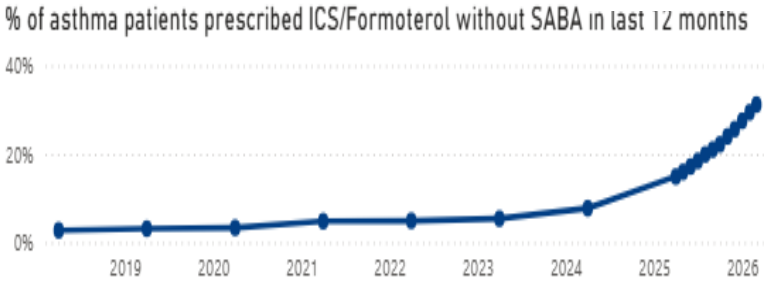


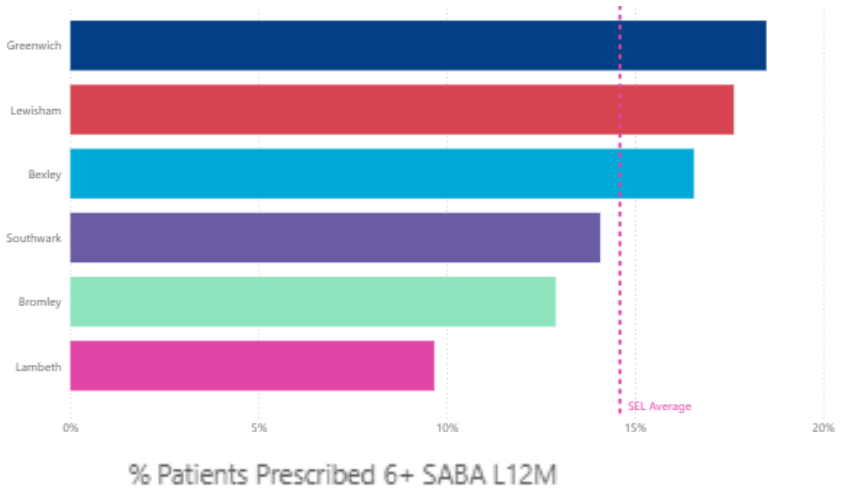
We have seen an alignment between:

- Reduced SABA prescribing,
- Increase SABA-Free prescribing (ICS/ Formoterol)

and

- Reduced asthma exacerbations





CESEL will continue to tailor support for local teams to transition to SABA-free prescribing with a focus on a reduction in the variation we see across SEL

Year end data (31 March 2026): Data provided from Respiratory Dashboard and Asthma Dashboard hosted by the ICB Business Intelligence Unit (BIU)
Open prescribing data

Type 2 Diabetes (T2DM): Improvement highlights

All T2DM indicators improved in all boroughs over the last year.

High quality T2DM care can be measured by achievement of

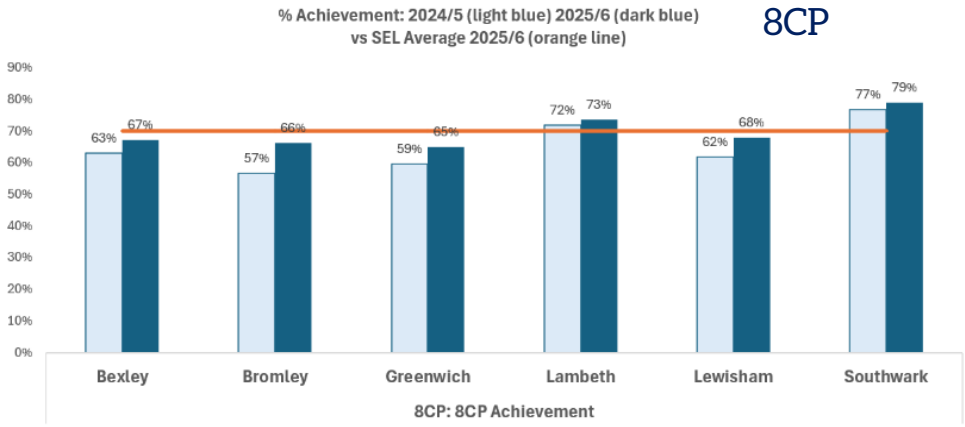
- 8 care processes (8CP) – the 8 important diabetes measures e.g., BP and lipids

and

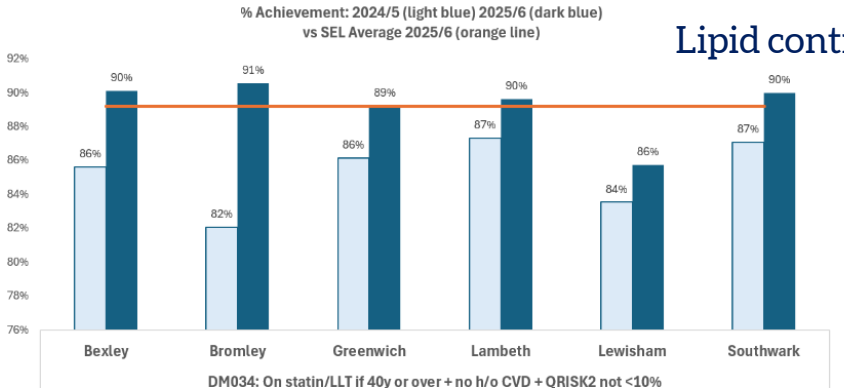
- Diabetes **control** measures for blood pressure, lipids and glucose control (HbA1c)

CESEL have offered teams support for achieving these measures and improvements have been made across all these indicators in all SEL boroughs.

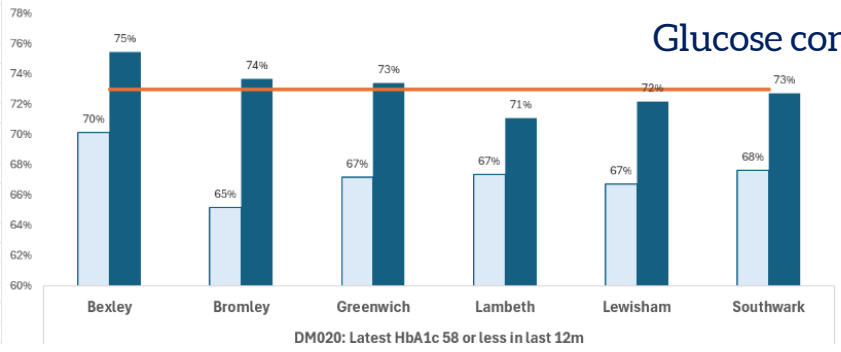
8CP



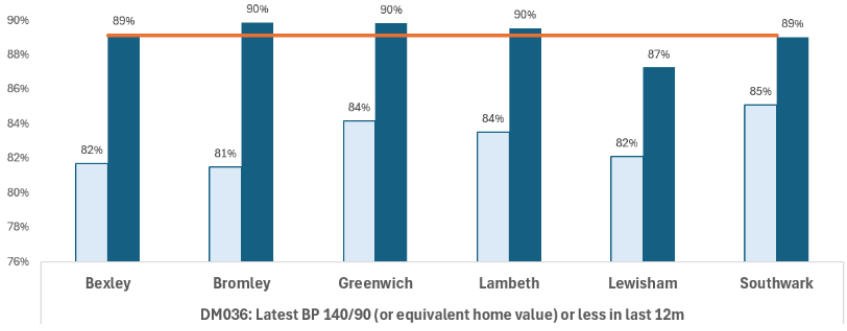
Lipid control



Glucose control



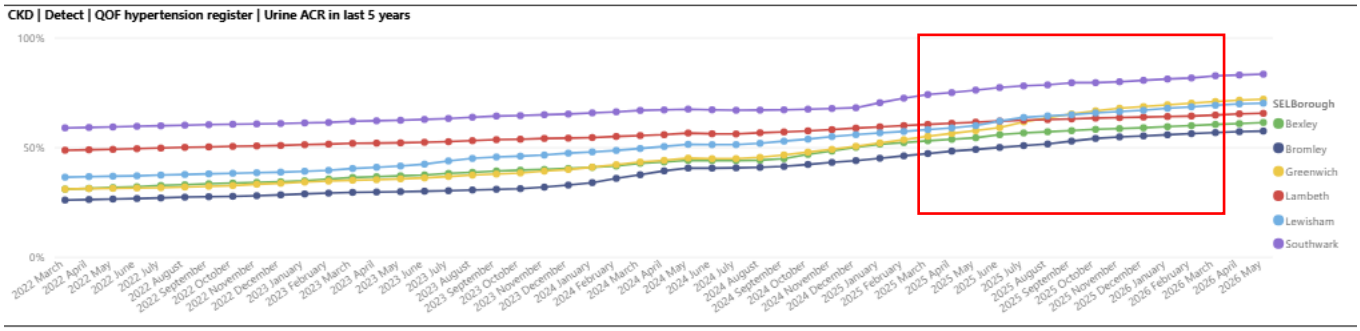
BP control



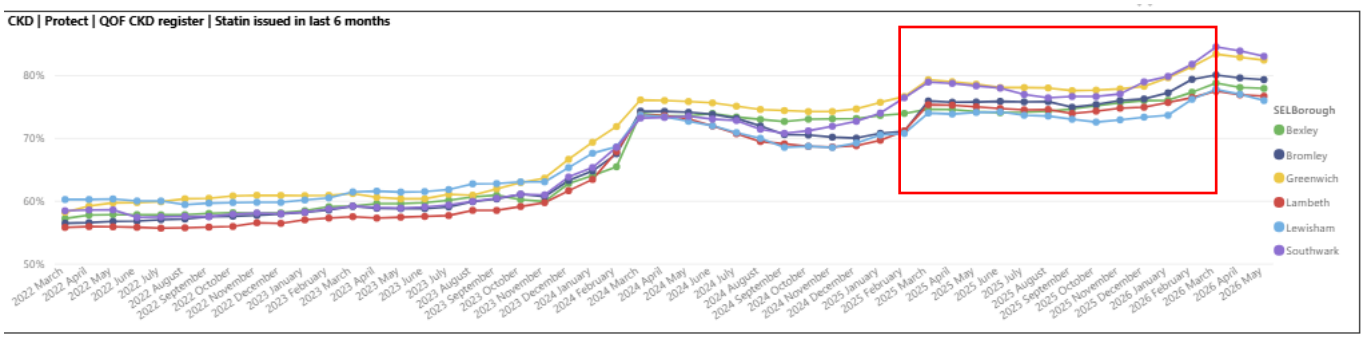
Year end data (31 March 2026) : Data extracted from the Diabetes BIU dashboard and reformatted.

Chronic Kidney Disease (CKD): Improvement highlights

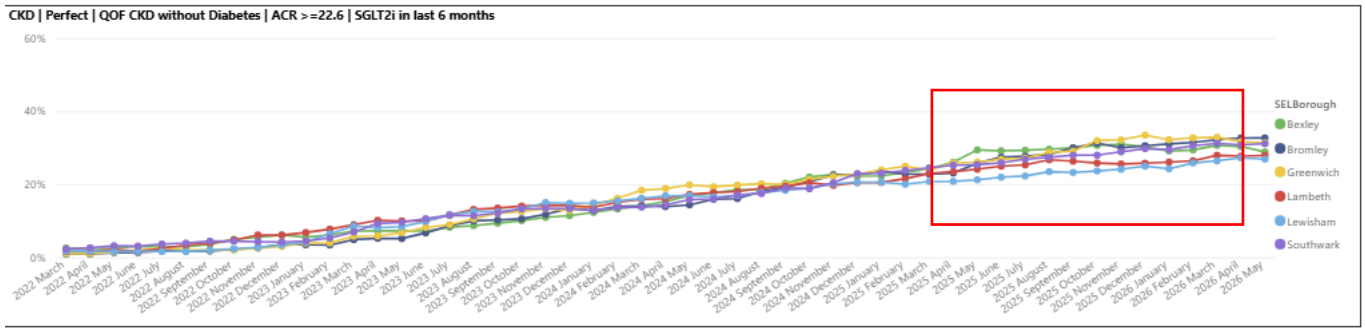
All CKD indicators continue to improve across all SEL boroughs



Case finding: Increased number of patients with hypertension who had a urine ACR completed (in the last 5 yrs), in 2025-26. Improvement identified across all 6 boroughs.



CKD on a statin: Increased number of patients with CKD, prescribed a statin (in the last 6 months), in 2025-26. Improvement identified across all 6 boroughs



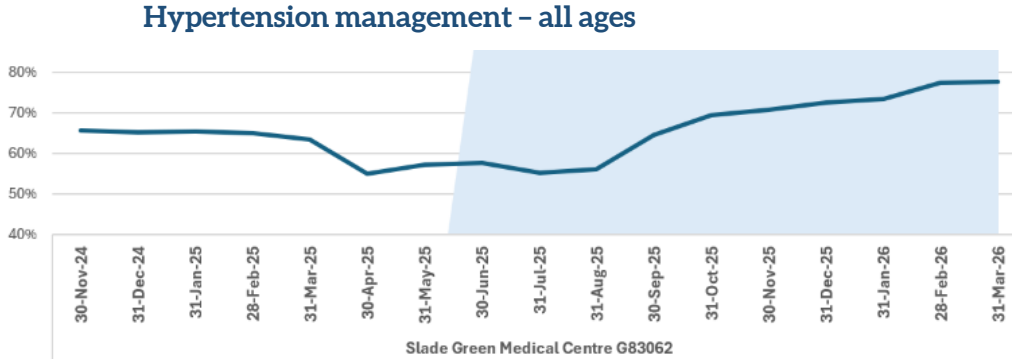
CKD on an SGLT2i : Increased number of patients with CKD and diabetes receiving SGLT2 inhibitors (SGLT2i), where ACR reading is >3mg . Improvement identified across all 6 boroughs

Year end data (31 March 2026) provided by the CESEL CKD dashboard, available via the ICB's Business Intelligence Units (BIU) dashboard portal

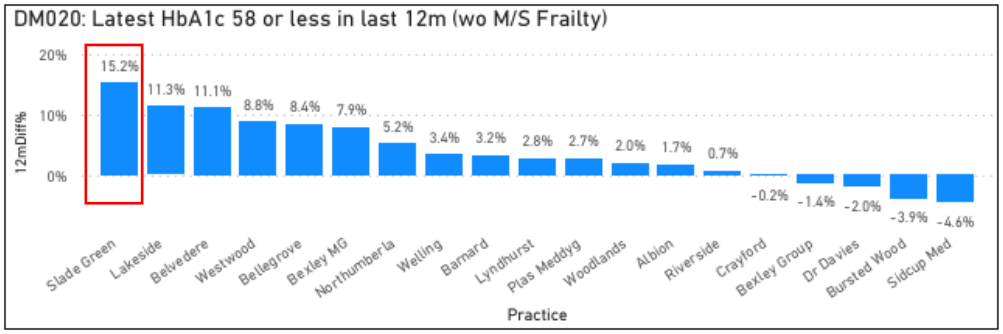
Bexley Case Study: Slade Green Surgery

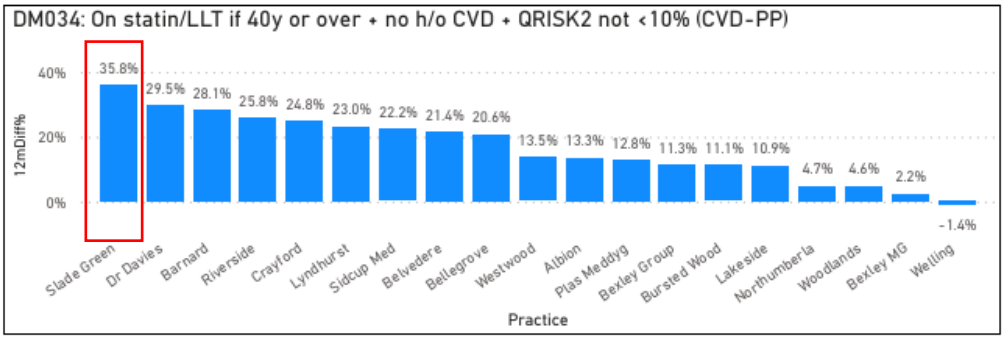
CESEL support visits were delivered in June and September 2025 covering hypertension, lipids and diabetes 8 care processes
Both clinical and non-clinical staff participated in quality improvement visits and subsequent actions.

The practice made improvements in their management of hypertension.



Improvements for both Hba1c control (QOF DM020) and lipid lowering therapy for diabetic patients (DM034) , resulting in the practice having the highest borough achievement for these two indicators





Key Learning
1 - Involving the whole team and focusing on practice systems and processes was key to improvement
2 - A combination of data and quality improvement support from the CESEL team helped deliver change

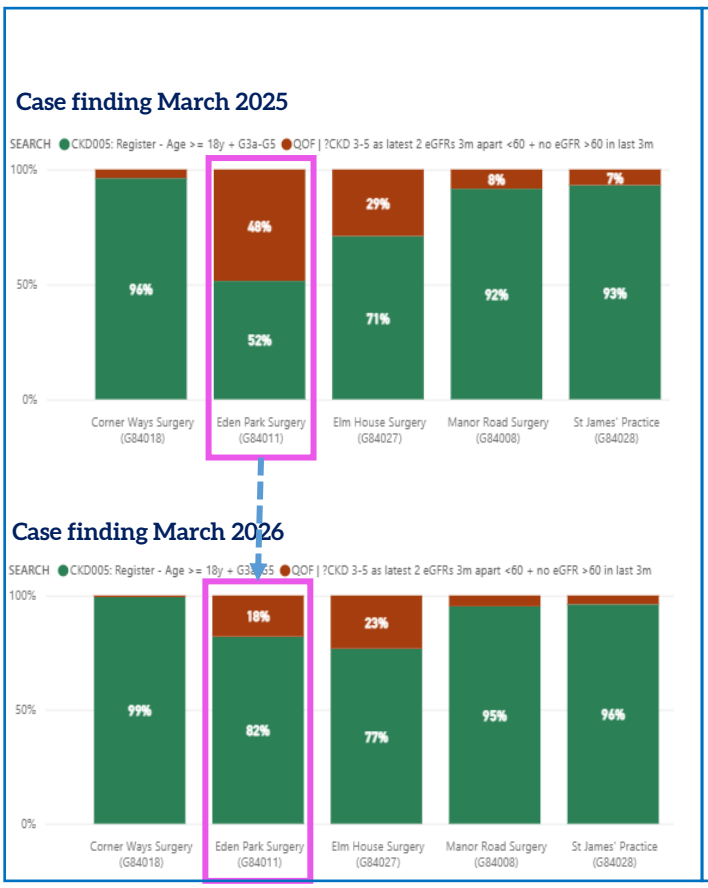
Year end data (31 March 2026) produced by CESEL, from EMIS searches

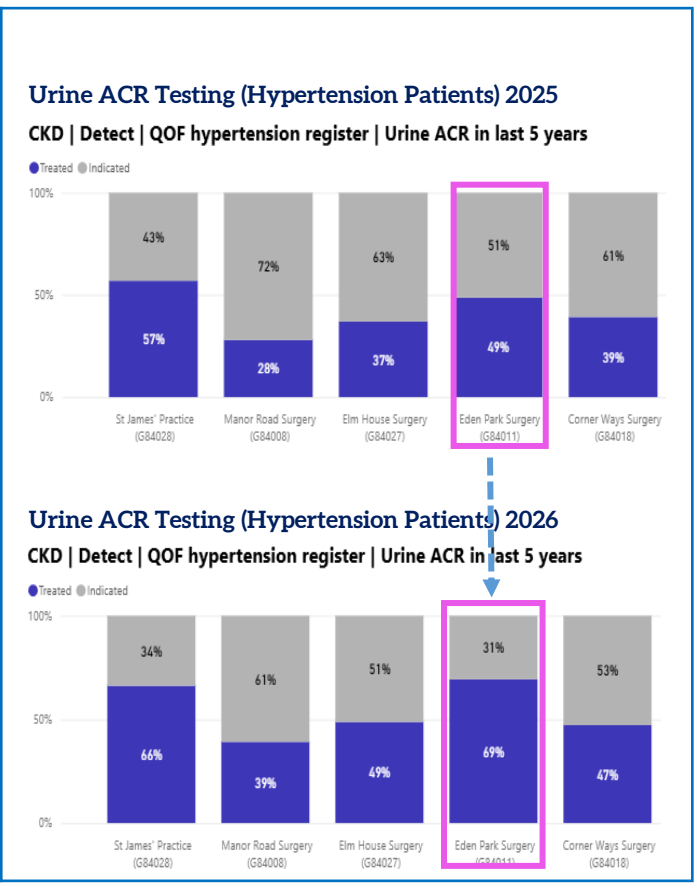
Bromley Case Study: Eden Park Surgery

Collaborating with the CESEL team, the practice identified nearly 100 additional patients with chronic kidney disease (CKD) over 12 months. This was achieved through targeted case finding, enhanced staff training, and use of the APL tool (CKD search tool) to identify potentially uncoded patients.

Our approach

- Strategic planning: Use of CESEL data to set a clear, actionable goals for improving CKD and hypertension indicators during the financial year.
- Case finding use of data and searches to identify at-risk and uncoded patients.
- Tools: staff were trained to use the APL tool to detect and better manage CKD.
- Continuous momentum: maintaining progress through periodic, collaborative data-sharing sessions with the CESEL team

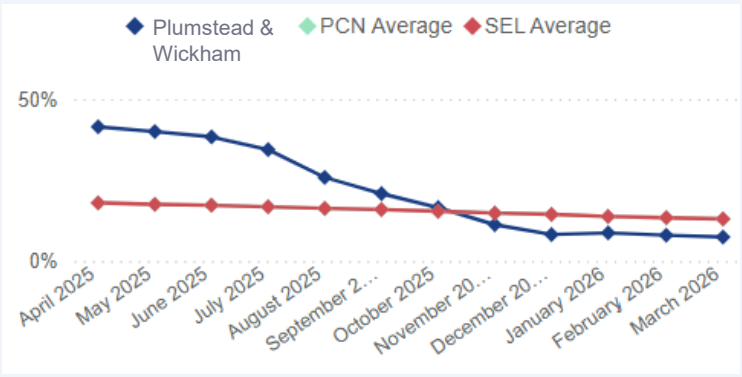




CESEL CKD dashboard, available via the ICB's Business Intelligence Units (BIU) dashboard portal

Greenwich case studies:

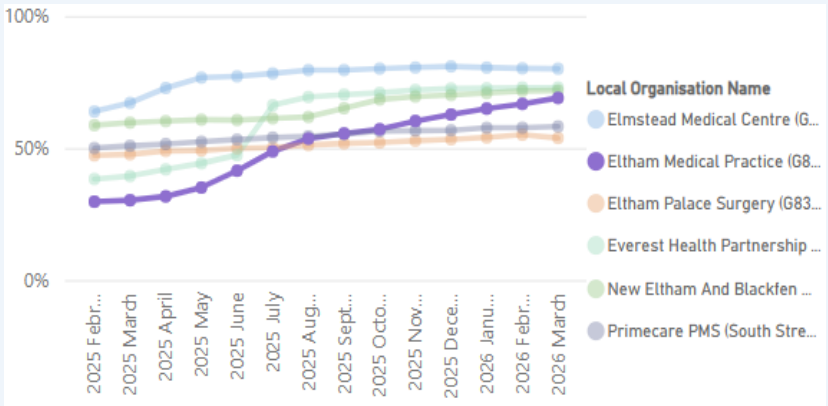
Plumstead & Wickham Lane – 6+ SABA



Reduction in SABA prescribing (6+ inhalers)

- **Accelerated Transition to a SABA-Free Pathway**: Significant reduction in high SABA prescribing.
- **CESEL Support:** 3x practice visits, asthma Lunch and Learn sessions, and quarterly data packs.
- **Practice Actions:** Targeted searches, structured reviews, removal of repeat SABAs, and consistent whole-team messaging.
- **Key Learning:** A focused cohort approach, clear communication and tighter prescribing controls supported safe, sustained improvement.

Eltham Medical Practice – urine ACR in HTN



Increase in urine ACR testing in HTN patients to support detection of CKD

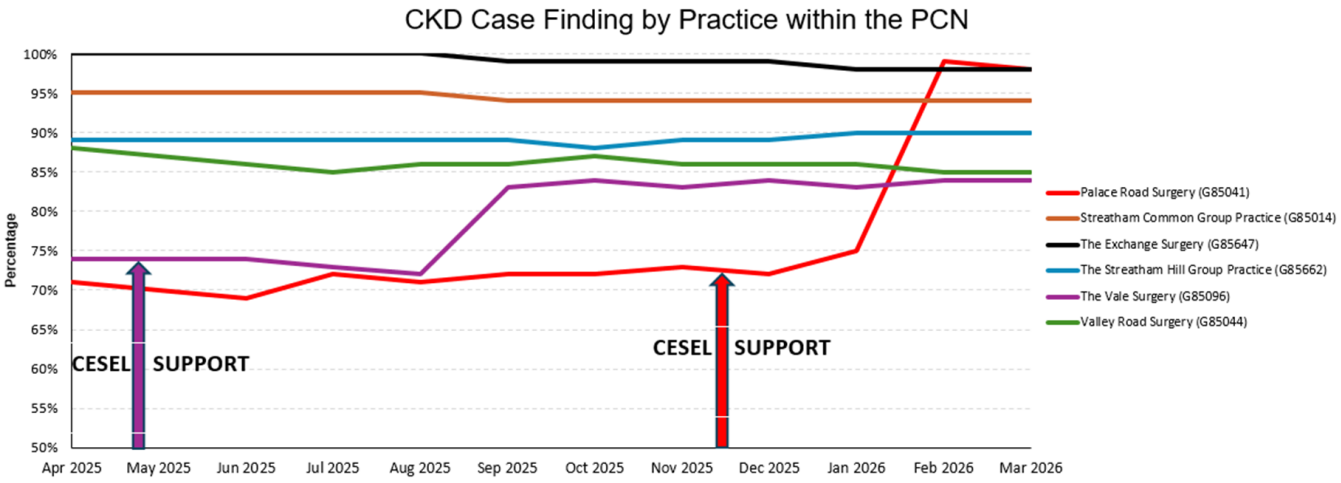
- **CESEL support**: PCN visits (x3), Vital 5 training, quarterly data packs, ongoing targeted support
- **Practice actions**: EMIS case-finding, multi-channel recall, regular data review. CVD inequalities funding enabled additional capacity, accelerating PCN-wide impact (uACR 42% → 62% in 6 months)
- **Improved testing increased CKD detection**: CKD register growth ~3x higher post-intervention (2024–25: 3.7% → 2025–26: 10%)
- **Key learning**: data-driven review, proactive recall, and dedicated resource sustain improvement

Year end data (31 March 2026) provided by the CESEL CKD dashboard, available via the ICB's Business Intelligence Units (BIU) dashboard portal

Lambeth Case Study:
Palace Road Surgery and The Vale

CESEL aligned the two practices (Palace Rd and The Vale) within a PCN, with their local peers by streamlining case-finding, standardising chronic disease monitoring (e.g. CKD and statins) and driving urine ACR testing through interactive clinical dashboards.
The improvement strategy included:

- Proactive case loading: EMIS and Ardens searches for streamlined patient recalls and targeted case-finding.
- Clinical optimisation: driving uptake of urine ACR testing and standardising CKD and lipid management.
- Data-driven tracking: leveraging Ardens Manager® clinical dashboards to track targets and prioritise patient reviews.



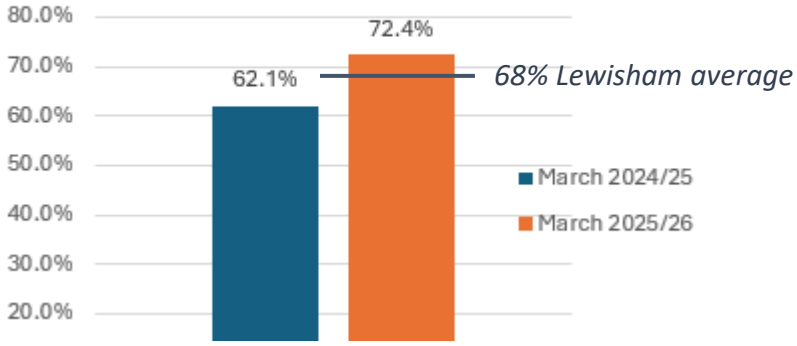
CKD case finding improvements identified at year end (31 March 2026),

- CKD case finding achievement improved from 86.2% to 91.5% between April 2025 and March 2026.
- Variation reduced, showing more consistent performance across the PCN.
- Palace Road Surgery improving from 71% to 98% by reducing its case finding gap from 72 patients to 4 patients.
- The Vale Surgery also improved, increasing from 74% to 84%, helping lift performance across the PCN.

Data provided by CESEL CKD dashboard in November 2025 and March 2026

Lewisham Case Studies:

Modality 8 care process (T2 Diabetes) achievement

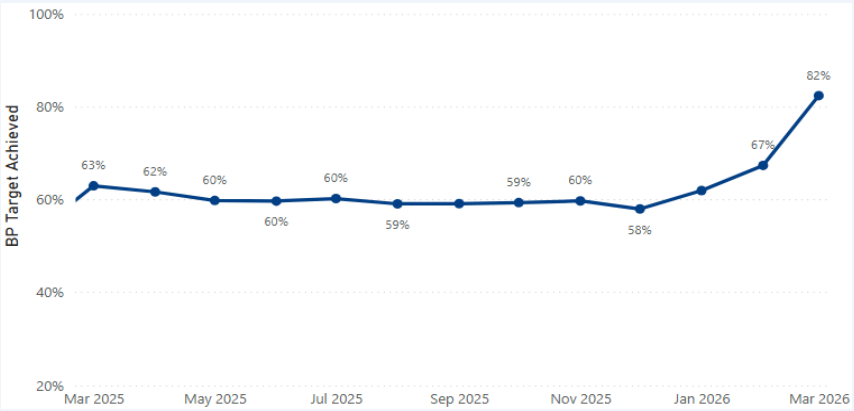


Improvement in 8CP achievement
62% to 72.4% over 12 months.

CESEL support included providing guidance on using case Ardens searches, a template to highlight patients with outstanding care processes, enabling targeted improvement approach.

Advice to support a whole team (clinical and non-clinical) approach to improvement work.

Deptford Medical Centre – BP control in <80yrs



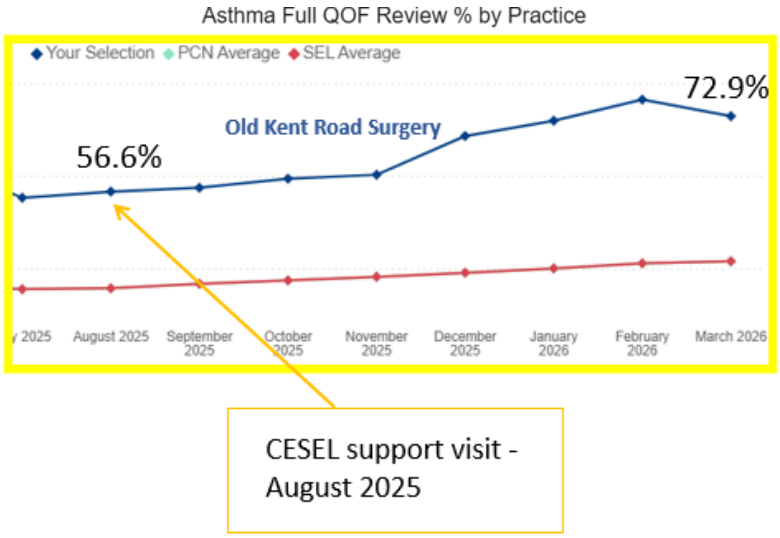
Rapid BP Control Improvement: Increased from 62% to 83% between January and March 2026.
Top Overall Improver: Achieved the largest hypertension improvement across SEL and the greatest combined improvement across Hypertension, Diabetes, CKD and Asthma.
CESEL Support: Targeted practice visits, quarterly data packs and ongoing QI coaching.
Key Interventions: Structured recall, dedicated hypertension clinics, medication optimisation and home BP monitoring.
Team Approach: Whole-team engagement, shared targets and proactive data monitoring.

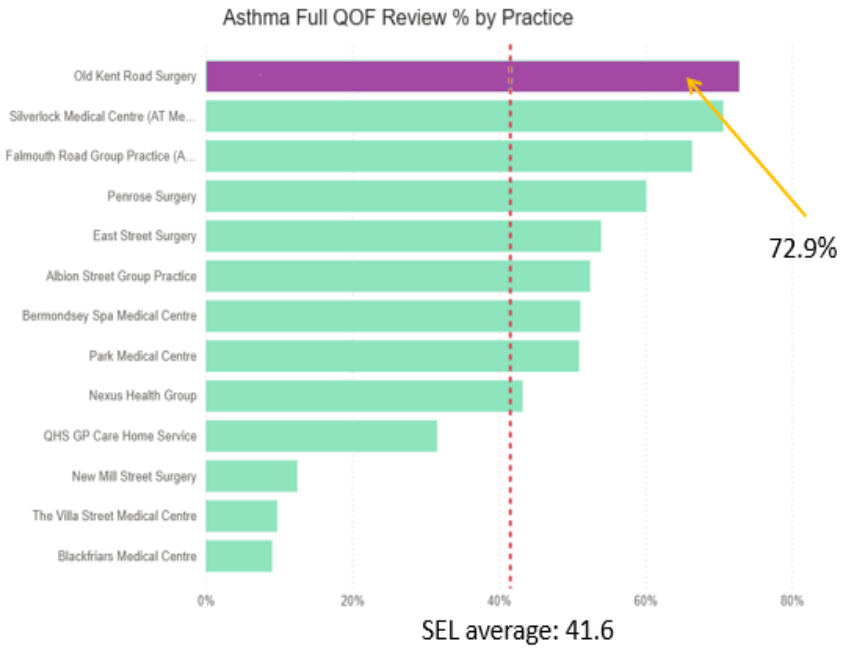
Year end data (31 March 2026) produced by CESEL, from EMIS searches

Southwark Case Study: Old Kent Road

CESEL visited Old Kent Road in August 2025, for asthma improvement support, in partnership with GP Federation. Support included:

- CESEL Asthma Guide best practices and signposting to asthma incentives e.g. QOF
- Data review to help with risk stratification and identifying patients for review using EMIS searches.





Following the visit, the practice increased the number of asthma reviews, and was the highest achieving practice in North Southwark, with 72.9% of eligible patients receiving a full Asthma review.

Year end data (31 March 2025) produced by CESEL, using Ardens searches

Plans for 26-27 and beyond

A team that delivers maximum impact

Transition to a streamlined team structure aligned with NHS Productivity Plan targets to reduce operational costs.

Primary care support & INT transition

Continue to support primary care teams at practice and PCN level while transitioning to INT delivery.

Integrated pathways for multimorbidity

Evolve from single-condition support into holistic, integrated care packages for patients living with multiple long-term conditions (mLTC).

Frailty and chronic pain management

Deliver and embed best practice for frailty and chronic pain.

Support teams to deliver SEL wide improvements across high prevalence conditions

Aim for SELICB performance above England median performance over 36 months in the following:

- Hypertension
  - Patients treated to target
- Lipid management;
  - Primary prevention: on lipid lowering treatment (LLT) if Qrisk≥10%
  - Secondary prevention: on LLT and treated to target
- Type 2 Diabetes
  - 8 care process achievement
  - Glucose, blood pressure and lipid management to target
- Chronic Kidney Disease
  - Patients on ACEi or ARB
- Asthma
  - Low use of SABA inhalers
  - High use of SABA-Free pathways

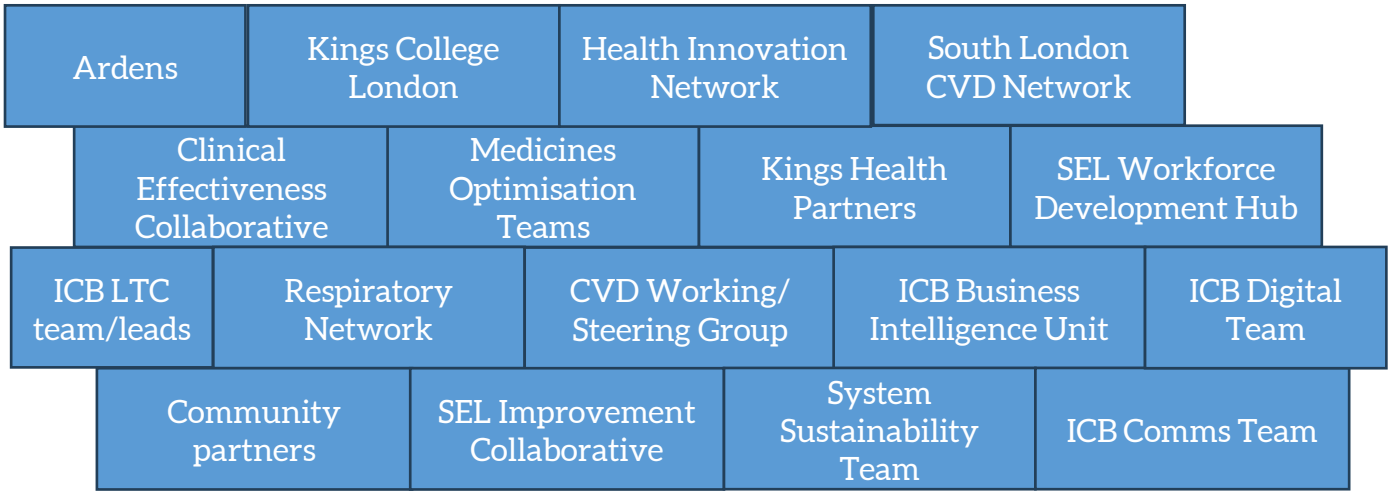
Working with our partners

CESEL actively connects across the SEL health and care system to share best practice, vital as South East London develops integrated neighbourhood teams.

As a founding member of the London Clinical Effectiveness Collaborative, we anchor our work in regional innovation.

We remain highly adaptable—proven by our rapid pivot to INT-focused support—and continually refine our model based on continuous feedback.

Shared learning and success



Thank you to our partners and frontline peers for driving meaningful health improvements in our communities.

This report highlights what can be achieved when stakeholders across the local system collaborate.

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

clinicaleffectiveness@selondonics.nhs.uk