South East London Integrated Care System

Improving outcomes for patients with Long Term Conditions (LTCs)

NHS South East London

Overview of our current system

SE London is diverse and vibrant, but faces significant challenges to achieving good health and care outcomes for people living with LTCs. There are high levels of deprivation in SEL, particularly in the 'inner' boroughs (Lambeth, Southwark, Lewisham and Greenwich), but also much deprivation variation within each, which contributes to significant health inequalities. The proportion of the population who are black and minority ethnic ranges from 19% in Bromley to 46% in Lewisham. Preventable mortality, smoking prevalence and alcohol related hospital admissions are higher for most of our boroughs than the London average. SEL is the worst performing London ICS in terms of good control of blood pressure and 5 out of the 6 SEL boroughs have higher-than-London average levels of childhood obesity at school reception age. However, it is served by excellent secondary care providers and there is also much high quality, innovative out-of-hospital care, focused on improving or preventing LTCs. The population's needs are complex, requiring a combination of consistent and reliable core offers to residents in some aspects of care and very bespoke and locally responsive approaches in others. SEL ICS has a clear strategic focus on addressing the health inequalities that exist within the geography as well as pursuing a prevention agenda focused on the 5 biggest mortality/ morbidity risk factors (the 'Vital 5')

Strengths / opportunities

- SEL ICS's key priority focus on improving performance against the 5 biggest risk factors (the 'Vital 5') for morbidity/ mortality (blood pressure, smoking, alcohol, poor mental health, obesity)
- Framework of LTC care in development ICS-wide, resulting in a shared vision and outcomes for LTC care and a shared commitment to the key principles of LTC care
- High quality workforce across health and care, including acute, MH, community and primary care systems, including use of HCP outside established pathways
- Innovative examples of integrated LTC across the patch that can be built on

Challenges

- Pressure on workforce (high vacancy rates, high demand) across our health and care providers
- Significant demand and waiting lists across health and care providers, with little spare capacity in any parts of the system
- Although there are many examples of excellent care, there is also large variation in health outcomes across SEL, with significant variation in health outcomes
- Significant financial pressures on SEL ICS system – requiring innovative approach across system partners

What we've heard from the public

- Public engagement exercises carried out in 2021 and 2022 demonstrate that all patients consulted desire a person-centred, holistic approach to care, which is well coordinated across care settings. Specific to the Black African/Caribbean and South Asian population, there was a desire for culturally tailored services and advice; which also recognised issues of race and racism and the impact of this on perceptions and beliefs about the NHS.
- Patients using new technology informed the ICB that they were happy to use this, once the rationale was well explained and the technology worked smoothly for patients
- We have also heard that integrating services and improving primary care and community care is particularly important for people with long term conditions and complex needs and to address health inequalities. For example, targeted engagement work with Black people with chronic pain found that a holistic approach involving multiple professionals is required to address complex needs of chronic pain patients (PEACS/IMPARTS, COMUZI and KHP, 2022).

LTCs - Our vision and objectives

Our vision

Our overall aim is to develop a framework of care for patients with one or more Long Term Conditions across SE London, that is coordinated, integrated, person-centred, prevention focused, and diverse and tailored to all our communities. We will ensure parity of physical and mental health care for everyone with an LTC. We will create ICB-wide standards of care which are culturally tailored and supported by effective risk-stratification and excellent real-time data and information ('Population Health Management'). Planning of localised services will be delegated to place, while outcomes, equity and access aim to be consistent across the ICB. This will align with our vision for Neighbourhood-based Care, where we are currently defining shared outcomes and standards and undertaking collective strategic planning to ensure neighbourhood teams are enabled to succeed and to hold each other to account for the delivery of improved outcomes for our patient in South East London.

Our key objectives – what we want to achieve over the next five years

Our priorities over the next five years include:

1. We will develop a Population Health Management (PHM)-based **framework of care for multi-morbidity, frailty and LTCs**, by working with patients, NHS and Local Authority staff, commissioners and voluntary and community groups across the ICB, in a series of workshops to both understand challenges and develop solutions – creating a shared vision for our new model of care based on **multi-disciplinary case management and care coordination** principles and a fully integrated way of working across community and acute for LTCs with agreed baselines and targets to ensure care is measurably coordinated, integrated, person-centred, prevention focused, and diverse and tailored to all our communities, with parity of physical and mental health care.
2. We will build on work which has already been undertaken across South East London, with **improved access to timely diagnostics**, clinical decision making tools and guidance, and **tailored self-management support** for patients.
3. Undertake a systematic programme of **end to end pathway reviews** of the single or grouped long term conditions in South East London which could be better managed. Each review will aim to co-produce an effective and efficient clinical pathway, supported by a suite of supportive tools and aligned incentives across our system.
4. We will seek out opportunities to work with other programme boards across our Integrated Care System to **strengthen our approach to the prevention and early detection of long term conditions** through the lens of tackling health inequalities, including the 'Vital 5', top 5 risk factors for poor health (smoking, mental health, blood pressure, obesity and alcohol)
5. As part of the emerging Integrated Care System governance, and as an output of the series of LTC workshops, we will put in place a Long Term Conditions Steering Group which will be responsible for **monitoring the impact of changes to agreed pathways on patient outcomes and experience**, as well as overseeing the implementation of a strategic framework for the management of Long Term conditions within South East London.

LTCs - Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1

Multiple LTCs / Frailty

- Develop an agreed Framework of Care for LTCs across the ICB based on the care principles of being: coordinated, integrated, person-centred, prevention focused, and diverse and tailored to all our communities - with agreed baseline and targets across a 5-year period
- Conduct Pathway Reviews for single and combined LTCs, with responsibility for planning agreed at Place
- Further develop integrated multimorbidity teams, with multi-disciplinary case management and care coordination principles to risk stratify, case manage and develop integrated care plans, to improve outcomes and patient satisfaction through a fully integrated way of working across community and acute for LTCs
- Develop an LTC Steering Group to oversee pathway reviews, consider outcomes and recommend actions to ensure consistency
- Develop a cohesive risk-stratified model to support patients at risk, or living with, frailty

2

Diabetes and Obesity

- Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation (‘levelling up’ the poorer performing practices) in core diabetes outcome/ care process measures
- Develop our ambitious diabetes prevention offer, working with SWL and NWL ICSs, with the longer term aim of developing a comprehensive LTC prevention platform
- Focus on establishing innovative pilots (e.g. HEAL-D, Up! Up!) addressing poorer outcomes in hardly heard communities currently most at risk of health Inequalities
- Implement outputs of Vital 5 obesity strategy development – maximising preventive services across our 6 boroughs, including our 'tier 2' obesity services
- Develop core principles for an integrated community Diabetes model with community and acute diabetes team members working with PCNs to shift care closer to home

3

Cardiovascular Disease (CVD)

We will undertake an end to end pathway review of patients suffering from Cardiovascular Disease, including:

- Develop core principles for an integrated community Cardiac model with community and acute cardiac team members working with PCNs to move care closer to home.
- Developing a coordinated and personalised prevention offer coordinated across multiple agencies
- Improving identification of, and earlier intervention for, patients at risk of cardiovascular disease
- Improving the effective management of blood pressure, lipids and stroke prevention
- Reviewing demand and capacity at all points of the pathway (including diagnostics) and develop approaches to better manage demand through integrated care models
- Understanding the impact of variations in clinical practice and move towards common standards and approaches.
- Improve the current pathway and package of support for patients following a cardiac event.
- We will deliver against the 2 national 23/24 Operating Plan targets around Hypertension and Lipids

LTC priority action 1– multiple LTCs

Multiple LTCs

★ ICS Strategic Priority

Working with patients, community groups and system partners, particularly primary care at place, to develop an ICB-wide Framework of Care for single and multi-LTCs, with an agreed vision for consistent standards to support holistic, person-centred and proactive care. The Framework of Care for LTCs will be based on the NHSE House of Care model, with pathway reviews undertaken to understand challenges and possible solutions for priority LTCs: Diabetes, CVD, CKD, Chronic Pain and Respiratory (COPD and Asthma). We will develop integrated multimorbidity teams (continuing good work that has already begun at place/ PCN level), with multi-disciplinary case management principles to risk stratify, coordinate care (ideally through a lead point of contact for the patient) and develop integrated care plans, in order to improve LTC outcomes and patient satisfaction through a fully integrated way of working across community and acute. Wherever possible, we will streamline our prevention services to give maximum benefit for the patient with multiple LTCs. Our work will incorporate medicines management optimisation, polypharmacy and maximising the opportunities of new drugs. We will then work with partners to co-produce a standardised approach to identifying and recognising frailty, risk stratifying our population and delivering integrated care models for those living with frailty.

How we will secure delivery

Actions for 23/24

- Develop an ICB-level Framework of Care for LTCs, through a series of system workshops - with agreed baseline and target positions to ensure care is proactive, holistic, person-centred and culturally tailored
- Formation of a SEL ICB LTC Steering Group, with place-based commissioning and clinical leadership membership, to oversee LTC strategy and delivery
- Develop and agree methodology for place based LTC Pathway Reviews and baseline / recommend targets – initially focussed on Diabetes and CVD, but covering further priority LTCs in future years (e.g. Respiratory)
- SEL ICB Diabetes and Obesity Dashboard will incorporate metrics to measure Outcomes that Matter to people with diabetes and serve as an exemplar for other LTC

Actions for 24/25

- Pathway review work will incorporate pathway and process mapping, demand and capacity modelling at each stage of the pathway, gap analysis against clinical best practice and guidance, mapping of commissioning arrangements and clinical audit of non-elective admissions
- Using the SEL ICB LTC-related Dashboards, we will ensure LTC strategy focuses on health inequalities, taking into account vital 5 work and Core20plus5
- Develop a SEL model of care for patients living with frailty through a series of system workshops, with a focus on consistent approaches to the identification, risk-stratification and management of frailty delivered through integrated neighbourhood teams.

Intended outcomes in 5 years time

- We will create stronger links between acute and community-based care, resulting in a lower trajectory for unplanned admissions and A&E attendances
- Patients from Black, Asian and Minority Ethnic communities backgrounds will have a range of bespoke, tailored health and education services to match cultural needs
- We will develop co-produced proactive models to engage with underserved communities and those experiencing health inequality, resulting in improved health outcomes for these cohorts
- The majority of SEL patients diagnosed with an LTC, including frailty, will receive an holistic review of their care, proactively identifying their physical and mental wellbeing needs and where necessary psychological care will be provided
- Care for people with LTCs and frailty will include as standard MDT working, named coordinators for all patients, (with co-produced and person-centred care plans, shared with acute teams, 111 and LAS) and seamless handovers between care providers, optimising the use of diagnostics and remote monitoring
- Patient reported 'Outcomes that Matter' will demonstrate year on year improvements

LTC priority action 2 - Diabetes and Obesity

Diabetes and obesity

★ ICS Strategic Priority

To enhance current integrated diabetes and obesity pathways within SEL which improve outcomes and prevent disease, helping to recover (and then exceed) 'core offer' diabetes care and outcomes to pre-pandemic performance (particularly diabetes treatment outcomes and related care processes, where SEL had been excellent performers pre-pandemic). This will be done in part through agreed diabetes and obesity strategic priorities, in part by the development of a SEL-wide LTC Framework of Care, being taken forward over the next 6 months and in part by building on the good work at place, PCN and neighbourhood level in terms of integrating diabetes care.

How we will secure delivery

Actions for 23/24

- Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures
- Develop our ambitious diabetes prevention offer, working with SWL and NWL ICSs, with the longer term aim of developing a comprehensive LTC prevention platform
- Focus on establishing innovative pilots (e.g. HEAL-D, Up! Up!) addressing poorer outcomes in underserved communities SEL wide, most at risk of health Inequalities
- Implement outputs of Vital 5 obesity strategy development – including maximising preventive services across our 6 boroughs, as well as SEL-wide 'Tier 2' preventive obesity/ diabetes offers

Actions for 24/25

- By end of 24/25, implement the diabetes prevention platform, alongside other London ICSs, with the intention of expanding to wider LTCs within 3 years
- Working with LCPs to ensure the maximum impact of the SEL-wide diabetes outcome scheme
- Embed improved integrated pathways for diabetes and obesity, including integration of mental and physical healthcare, developed during 23/24 as part of ICS LTC Framework of Care development process
- Implement the Type 1 Diabetes Outpatient Transformation framework, including the delivery of a population health risk register and a multi-agency, MDT review
- Work to integrate mental and physical healthcare for both diabetes and obesity by joining up care pathways between physical and mental health settings
- Evaluate, review and integrate pathways for both Tier 2 and specialist obesity services and ensure equitable access

Intended outcomes in 5 years time

- Comprehensive, culturally tailored, integrated pathway framework established for all major LTCs, with clear SEL-wide principles, but with local autonomy in terms of delivery
- Patient empowerment, through a comprehensive prevention offer, primarily through the diabetes/ LTC prevention platform, including tailored offers to hardly heard communities, most at risk of suffering health inequalities
- 'Best-in-London' performance against national diabetes outcome measures (e.g. 3 Treatment Targets)
- Optimal utilisation of preventive weight management offers (i.e. tiers 1 and 2) to allow specialist obesity capacity to offer timely interventions for those most in need
- Strong commitment and performance against person centred outcome measures, through a consistent promotion and use of holistic care planning
- Reduced conversion rate from pre-diabetes to diabetes, through identification and take up of preventive offers, including excellent tailored services to our underserved communities

LTC priority action 3 - Cardiovascular disease (CVD)

CVD prevention and improvement

★ ICS Strategic Priority

To develop and implement integrated Cardiovascular Pathways and Services within SEL which improve both the clinical and care outcomes for patients living with CVD and also the prevention of CVD within the broader population. We will also focus on actions which have a specific impact on preventing Coronary Heart Disease (CHD), with a focus on AF and HF detection/ management, support the full Elective Recovery of cardiac surgery position and reduce inequality of cardiac outcomes.

How we will secure delivery

Actions for 23/24

We will undertake an end to end pathway review of patients suffering from Cardiovascular Disease, including:

- Developing a personalised prevention offer coordinated across multiple agencies
- Improving identification of, and earlier intervention for, patients with or at risk of cardiovascular disease
- Improving the effective management of blood pressure, lipids and atrial fibrillation
- Reviewing demand and capacity at all points of the pathway (including diagnostics) and develop approaches to better manage demand through integrated care models
- Understanding the impact of variations in clinical practice and move towards common standards and approaches.
- Improving the current pathway and package of support following a cardiac event
- Delivering against the 2 national 23/24 Operating Plan targets around hypertension and lipids

Actions for 24/25

- Undertake an equalities health review of CVD and identify priority actions to reduce health inequalities
- Develop and test integrated out of hospital models of care for the management of heart failure which integrates workforce, processes and clinical management across primary, community and acute care settings
- Undertake a review of stroke and neuro-rehabilitation.
- Work with the Cardiac Network to improve timely access to electrophysiology and ablation
- Embed the learning from SQUIRE pilot to improve stroke rehabilitation in SEL

Intended outcomes in 5 years time

- Reduce Under 75 mortality from Cardiovascular Disease
- 80% or more of the expected number of people with hypertension are diagnosed
- 80% or more of the total number of people diagnosed with hypertension are treated to target as per NICE guidelines
- 60% or more of the total number of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent are prescribed lipid lowering therapies to 60%
- 85% or more of the expected number of people with AF are diagnosed
- 90% or more of the total number of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029 - reducing stroke incidence in SEL
- Increase referrals to cardiac surgery to align more with the London average
- Improve Transcatheter Aortic Valve Implantation take-up across black and minority ethnic populations
- Reduction in unwarranted variation across the system, including a narrowing of the differential between White and Black, Asian and Minority Ethnic communities groups in terms of hypertension control

LTC enabler requirements

Workforce

- Working with Place, maximise utilisation of Additional Roles Reimbursement Scheme (ARRS) roles, ensuring integrated team working and innovative approaches across ICS partners to problem-solving recruitment challenges
- Flexing workforce so that people are seen in the right place, right time, by the most appropriate support person – this includes utilisation of currently under-used parts of the workforce, e.g. community pharmacy, social prescribers and care coordinators.
- ICS partner commitment to valuing their workforces, making SE London a great place to work

Digital

- SEL ICB will spread existing well-evidenced technology, such as digitally assisted pathways, self-management and remote monitoring tools (including safe and earlier hospital discharge for patients requiring clinical monitoring), automation software and better use of shared records
- To support the digital offer to our citizens, SEL ICB will work with other London ICSs to develop a diabetes/ LTC prevention portal to empower LTC self-management in SE London
- The further development of Population Health Management (PHM) analytics (including predictive tools) is a critical enabler

Estates

- Working with system partners, SEL ICB will ensure sufficient estates capacity out of hospital across the whole SEL geography
- Appropriate modernisation of current estate to enable teams to integrate and to work more flexibly together (e.g. offer group consultations) – ensuring bigger, more digitally connected, and with a variety of sized clinical spaces, to ensure the implementation of Fuller review recommendations

Data

- Adoption of a SEL-wide Population Health Management (PHM) approach, which builds on the early success of SEL wide LTC platforms (i.e. the LTC co-morbidities dashboard and the diabetes and obesity dashboard), offering SEL-wide insights and drill-down across LTC areas, which are used at SEL, Place and PCN level
- PHM insights-led commissioning approach, at both SEL and Local Care Partnership levels