# Improving outcomes for patients with Long Term Conditions (LTCs)

*This LTC Programme section should be read in conjunction with the Primary Care Programme section*

## 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. Through the establishment of the newly formed Neighbourhood Based Care Board (NBCB), SEL ICS will have a clear strategic focus on ensuring that proactive and integrated neighbourhood-based care models exist to embed the integration and personalisation principles of the Fuller Stocktake, address the health inequalities that exist within the geography and pursue a prevention agenda focused on the 5 biggest mortality/ morbidity risk factors (the 'Vital 5')

## Strengths / opportunities

- Development of integrated neighbourhood care model for multimorbidity, utilising Fuller principles of personalisation, person centred care and primary/secondary integrated care
- 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)
- SEL Framework of Care for LTCs to be overseen by a new SEL LTC Steering Group and co-produced with strong Place involvement
- High quality workforce across health and care, including acute, MH, community and primary care systems, including use of HCP outside established pathways
- Expansion of SEL community members group, utilising community champions to advise ICB of further opportunities for cultural tailoring of pathways and services

## 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 unwarranted 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
- Developing a standardised patient reported outcome tool to measure patient experience of the LTC Framework of Care across the system has proved challenging

## 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 needs.

# LTCs - Our vision and objectives

## Our vision

Our overall aim is to develop a neighbourhood-based 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 improvements in outcomes, equity and access aim to be consistent across the ICB. This will align with our vision for Neighbourhood-based Care (NBC), where we will co-produce enhanced integration across LTC pathways and aim to reduce unwarranted variation. The SEL LTC Framework of Care has defined the shared outcomes and standards to ensure neighbourhood teams are able to succeed and 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. Through the LTC Steering Group. we will support the introduction of the LTC Framework of Care (a Population Health Management (PHM)-based **framework of care for multi-morbidity, frailty and LTCs**) at place, by working with patients, NHS and Local Authority staff, commissioners and voluntary and community groups across the ICB, to ensure that LTC 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. Building on the pathway review work already underway for obesity, we will 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. Through the NBC Board, we will scope priority areas of strategic focus and 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) as well as ensuring improved integration and personalisation
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**

- Build on our SEL Framework of Care for LTCs, working with Place colleagues to ensure care is proactive, holistic, person-centred and culturally tailored aligned with this framework and the wider work around NBC and INTs.
- Implement trailblazer multi-morbidity model of care projects within our neighbourhood teams, continue to engage stakeholders in the process to build true integration and seek to develop a single definition of an Integrated Neighbourhood Team (INT)
- Formally stand up the LTC Steering Group to oversee pathway reviews, consider outcomes and recommend actions to ensure consistency and reduce unwarranted variation
- Complete the end-to-end Obesity Pathway Review for single and combined LTCs, and consider further LTC pathway reviews with responsibility for planning agreed at Place
- Evaluate the interim outcomes of the 6 multi-morbidity model of care INT pilots in order to spread and adopt the model at scale across SEL
- Develop a cohesive risk-stratified model to support patients at risk, or living with, frailty
- We will develop a self-care hub for key LTCs, including multi-morbidity, which will act as a resource guide for people with LTCs

2

**Diabetes and Obesity**

- Continue the SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation for 3TT ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures
- Complete the end-to-end Obesity pathway review, resulting in recommendations for pathway and triage improvements and enhanced integration across the tiers
- Focus on establishing innovative pilots (particularly for SEL's South Asian communities) to address unwarranted variation and poorer outcomes
- Take forward the Diabetes & Obesity Delivery Board's strategic priority areas, as detailed in the Board's workplan

3

**Cardiovascular Disease (CVD)**

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

- Continue our focus on improving Blood Pressure control, building on the work undertaken in 23/24
- 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.

# LTCs – Our progress to date

## Key Successes in Delivery in 2023/2024

- Co-designed a SE London Framework of LTC Care with stakeholders and patients founded on the principles that care is coordinated, integrated, person-centred, prevention focused, and diverse and tailored – aligning with the key proactive care principles in the Fuller Report and existing Place LTC strategies
- Worked with all 6 SEL Place teams to think through the Framework of Care and the implications for local delivery
- Secured significant funding to allow 6 large pilots in each SEL borough, testing a model for Integrated Neighbourhood Team (INT) working, focussed on multiple LTC patients, testing vertical and horizontal integration, with a focus on spread, scale and sustainability in the longer term
- Brought all SEL Hypertension stakeholders together throughout 23/24 to work through how to meet the key NHSE Hypertension target, including SEL-wide webinar sessions and working with CESEL on a Hypertension resource pack for Primary Care
- Brought together diverse stakeholders to commence a SEL-wide Obesity Pathway Review, with a timeline for recommendations in mid-24/25, that seeks to bring coherence to our fragmented specialist and non-specialist obesity services

## Key Challenges to Delivery in 2023/2024

- Management Cost Reduction (MCR) exercise has put a significant strain across all parts of the ICB and wider ICS – the implications of workforce loss will be a  key risk going forward into 24/25 and beyond
- Our ambitious plan for a London wide LTC Prevention platform, driven by SEL, SWL and NWL ICBs, with the support of the HIN, has found London-wide consensus challenging in this difficult year – we will be deferring timelines on this, but renewing our approach to this important Prevention strategy in 24/25
- Workforce pressure, in both primary, acute and community care has impacted on all parts of the ICS and each of the 6 LCPs
- Significant system-wide financial pressures across the ICS
- Operational delivery pressures, particularly for our acute partners, in terms of very long elective waiting lists, implications of industrial action and movement of GSTT and KCH to a new EPR system have contributed to a very challenging set of circumstances across 23/24 – with implications for all other ICS partners.

## Learning and Implications for Future Delivery Plans

- MCR has enabled revision of structures and directorates within the ICB – there are important opportunities for a more coherent Community-Based Care directorate, which the LTC team now sits under, and which aligns with new governance around Neighbourhood-based Care (NBC)
- The implications of MCR require important and significant OD work to ensure all parts of the ICB are effective, efficient and understand roles and responsibilities
- The LTC Steering Group, which will emerge from the Framework of Care co-design work – which will be stood up in Q1 24/25 and will sit under the NCB Board - will both offer a structure to take forward the LTC Framework of Care, coherent INTs and a consistent approach to proactive neighbourhood-based care and Fuller implementation

# LTC priority action 1– multiple LTCs

## Multiple LTCs

★ ICS Strategic Priority

We have worked with patients, community groups and system partners, particularly primary care at place, to build 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 LTC Care aligns with Place-based work on proactive care and our wider strategic vision for Neighbourhood-based Care (NBC) and Integrated Neighbourhood Teams (INT). Via the LTC Steering Group, which will be formally stood up in Q1 24/25, we will also undertake pathway reviews to understand challenges and possible solutions for priority LTCs, starting with Obesity. We are developing 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. For instance, our multi-morbidity model of care project embodies these principles across SEL for our population with CKD and other morbidities and/or complexities. Wherever possible, we will continue to streamline our prevention services to give maximum benefit for the patient with multiple LTCs. Our work incorporates medicines management optimisation, polypharmacy and maximising the opportunities of new drugs. We are working 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 24/25**

- Build on our ICB-level Framework of Care for LTCs
- We will galvanise system colleagues to ensure care is proactive, holistic, person-centred and culturally tailored aligned with this framework and the wider work around NBC and INTs.
- Formation (in Q1) 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 Obesity and Diabetes 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
- Implement trailblazer multi-morbidity model of care projects within our neighbourhood teams and enable spread and scale across SEL in the latter half of 24/25, continue to engage stakeholders in the process to build true integration and seek to develop a single definition of an Integrated Neighbourhood Tea

**Actions for 25/26**

- 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.
- Continue to spread and scale the multi-morbidity model of care work across the SEL geography

## 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 attends
- 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
- Clinical and non-clinical staff working to meet the needs of those with multiple LTCs will work in an integrated manner, benefiting from the streamlined nature of care that is normalised across SEL.
- 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

We will work 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 implementation of the SEL-wide LTC Framework of Care, being taken forward with Place and building on the good work at place, PCN and neighbourhood level and in part by our wider work implementing NBC, INTs and proactive care.

## How we will secure delivery

**Actions for 24/25**

- Expand our SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in unwarranted variation ('levelling up' the poorer performing practices) with a focus on improving diabetes treatment targets
- Take stock on our ambitious diabetes/ LTC prevention offer, working with SWL and NWL ICSs, with the aim to drive forward the development work for an LTC Prevention platform, either London wide or through a collaboration of early-implementer ICBs
- Focus on spreading and scaling innovative pilots (e.g. HEAL-D, Up! Up!) addressing poorer outcomes in underserved communities SEL wide, most at risk of health Inequalities
- Conclude the SEL-wide Obesity Pathway review – finalising recommendations for improving the coordination and delivery of SEL obesity services, including use of new pharmacotherapies and work with ICS partners on an implementation/ commissioning approach.
- Implement improvements for patients with Type 1 Diabetes including the delivery of increased technologies (i.e. CGM and Hybrid Closed Loop) and patients with early onset Type 2 diabetes

**Actions for 25/26**

- By end of 25/26, 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 multiple LTCs, including diabetes and obesity, and including integration of mental and physical healthcare, developed during 23/24 as part of ICS LTC Framework of Care and MMMoC workstreams

## Intended outcomes in 5 years time

- Comprehensive, culturally tailored, integrated pathway framework established for LTCs, with clear SEL-wide principles, but with local autonomy in terms of delivery
- Significantly reduced unwarranted variation in outcomes for patients with diabetes across SE London
- 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, with effective use of obesity pharmacotherapy
- Strong commitment to 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

We will work to improve detection and early treatment of people with CVD, i.e. Atrial Fibrillation, raised Blood Pressure and raised Cholesterol (the 'ABCs'), with a particular focus on communities at risk of health inequalities, seeking to reduce variation in health outcomes. We will develop and implement integrated Cardiovascular Pathways and Services within SEL which improve both the clinical and care outcomes for patients living with CVD and other LTCs and also the prevention of CVD within the broader population. We will support the full Elective Recovery of cardiac surgery position and reduce inequality of cardiac outcomes.

## How we will secure delivery

**Actions for 24/25**

We will:

- Continue our focus on improving Blood Pressure control, building on the work undertaken in 23/24
- Develop a personalised coordinated prevention (e.g. SEL Decathlon pilot)
- Improving identification of, and earlier intervention for, patients with or at risk of CVD
- 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

**Actions for 25/26**

- 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 – we will work with LTC stakeholders to maximise use of existing PHM tools within the SELBI environment

## 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