North East London Health & Care Partnership

NHS North East London

Developing a system wide approach to reducing risk and management of Long Term Conditions

To support everyone living with a long-term condition in North East London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community

January 2025

Introduction

This Slidepack sets out how we are working as a system to support everyone living with a long term condition in North East London to lead a longer, healthier life and to work to prevent conditions occurring for other members of our community. Our aim is to improve outcomes and tackle health inequalities with and for the **681,144 people in NEL (or 34% of the population aged over 15 years and over)** who are diagnosed with one or more long term condition.

Long term conditions is an umbrella term for a wide range of conditions with no cure currently. The impact of these conditions on those affected can often be alleviated or delayed when identified early and managed effectively, and some of them can also be prevented entirely through healthier behaviours. As the definition provided by the Department of Health and NHS is wide, multiple interpretations of specialities are included within the long term conditions definition, including severe depression and cancer. We are working collaboratively with a wide range of partners and with programmes across the system in recognition of the broad scope and the need for prioritisation and delivery of our key areas of focus.

In this Slidepack we focus on the prevention and management of those specialities which are NEL's core areas of focus in 2024/25 and map our future priorities for the years ahead: Diabetes and Cardiovascular disease

Background

Social determinants of health are known to have an impact on 80% of chronic disorder health outcomes. Across North East London, areas of significant deprivation are linked with an increased prevalence of long-term health conditions, longer years in ill health and lower life expectancy.

The pandemic and the increased cost of living have disproportionately affected our population in NEL. People living in deprived neighbourhoods and from specific ethnic backgrounds for example are more likely to have a long term condition and to suffer more severe symptoms. For example:

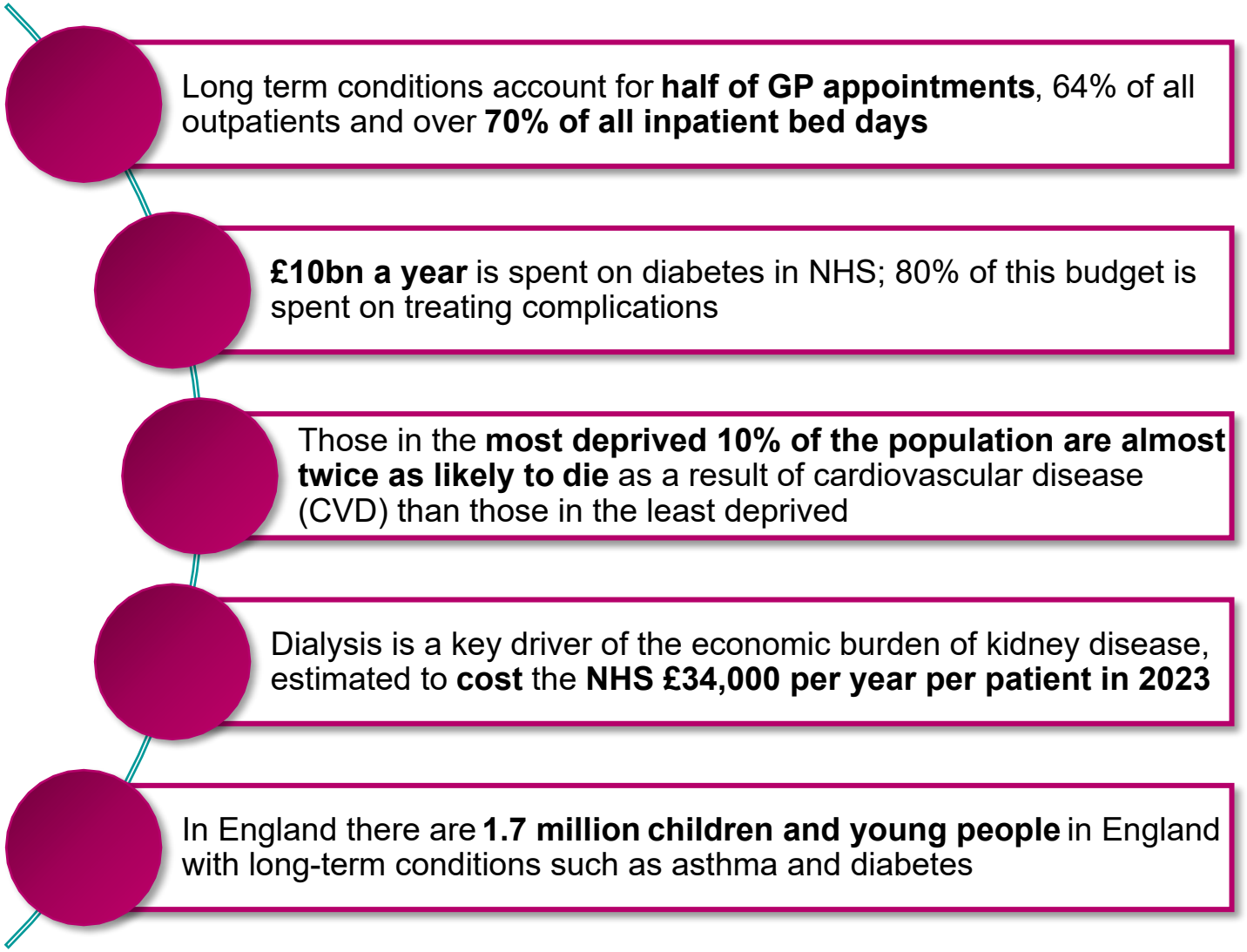
- **The poorest people in our communities have a 60% higher prevalence** of long-term conditions than the wealthiest, along with a 30% higher severity of disease
- People of **South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease**
- People with an **African or Caribbean family background are at greater risk of sickle cell disease**
- Obesity is a significant risk factor for long term conditions – we know that around **1 in 10 adults in NEL are obese**, a rate higher than the London average. Barking and Dagenham has the highest adult obesity rate in London and that in Barking & Dagenham, City & Hackney, Newham and Redbridge, levels of **childhood obesity are worse than England at reception and in year 6.**

National priorities are focusing on work to address long term conditions

Long term conditions have a national and regional focus as a core component of the Long Term Plan and are one of our four priorities as NHS North East London. Furthermore, as long term conditions are both a symptom and a cause of inequalities, a significant element of our work touches on addressing health inequalities and we support projects such as Core25Plus and the Innovation for Healthcare Inequalities Programme.

Having a long term condition significantly affects employment opportunities. **Approximately 2.8 million nationally people are economically inactive due to sickness**, and individuals with LTCs are less likely to continue working once diagnosed and or symptomatic compared to the general population.

Data from the Department of Health and Social Care (DHSC) reveals that long term conditions are more prevalent among those in unskilled occupations (52%) than in professional occupations (33%). This disparity may be linking their role to risk factors such as respiratory illnesses, sedentary lifestyle such increases risks of cardiovascular disease (CVD) and diabetes



Our local population are more susceptible to developing a long term condition, which has a big impact on them and on our health and social care system

Working with colleagues, we have utilised local knowledge, and the whole-population segmentation model as a cornerstone of a population health approach. Segmentation enables a system-wide perspective when considering and understanding needs, planning services or targeting interventions. The population segmentation model has identified:

- Only 19% of patients aged 18-44 have at least one long term condition, while half of those aged 45-64 have a long term condition, 4 in 5 of those aged 65-84 have a long term condition and more than 9 in 10 of those aged 85 and over have a long term condition.
- **A higher proportion of black patients (44%)** have at least one long term condition when compared to white (36%), Asian (32%) and mixed (31%) patients.
- **A higher rate of female patients aged 18 – 64 have a long term condition** compared to male patients, contributing to the overall higher proportion of females with at least one long term condition.

People with a long term condition in the population have higher levels of take up of services and activity across the system. In north east London, this accounts for about a quarter of the population. Analysis has demonstrated impact on the system, but also impact on people's quality of life attending multiple appointments and unplanned services:

- **A&E attendances** by long term condition patients are **almost double the attendance per capita of healthy patients**
- In all places except Newham, the rate of **hospital admissions for asthma (under 19 years) is above the England average.**
- **Emergency admissions per capita** increases **almost fourfold for those with one or more long term conditions.**
- **Elective admissions** per capita are **10 times higher** than those of healthy patients.
- **Outpatient attendance** per capita are **four and a half times higher** for long term condition cohort compared to healthy cohort.
- Patients with a long term condition are almost **three times more likely to have a GP encounter or contact with community services**.

Rapid and Significant Population Growth

The population growth in north east London, driven by population demographics and local housing plans, underpins forecasts that between 2022/23 and 2041/42 the number of people set to be living with one, two, or three long term condition is expected to grow by **20.4%, 34.5%, and 49.3%,** respectively. Barking and Dagenham, along with Newham and the City of London, are forecasted to experience the highest growth in both the general population and the number of people living with long term conditions, **at 51.7%, 42% and 39%,** respectively.

Developing a system wide approach to reducing risk factors and LTC via NEL LTC Portfolio

In light of the Lord Darzi review, which emphasises shifting the focus from treating sickness to prioritising prevention and delivering care closer to home, there is a significant opportunity to collaborate with system colleagues to address the needs of patients with long term conditions. By fostering a preventative approach and enhancing community-based care, we can provide holistic and accessible services that empower patients to manage their health effectively.

The Long Term Condition portfolio is both complex and far-reaching, encompassing every aspect of the North East London system. Across the seven boroughs in NEL, local priorities are shaped to meet the specific needs of their populations and deliver sustainable healthcare. Meanwhile, the NEL programme focuses on driving large-scale national and regional projects, facilitating transformative initiatives, and providing support to local areas in delivering their tailored projects.

Speciality – CVD, Diabetes and respiratory
Pathway – prevention and secondary prevention including early identification, stratification and medicine optimisation

Speciality – CVD, Diabetes, respiratory CKD
Pathway – prevention, secondary prevention and coordination of care

Speciality - healthy weight and obesity. Further work on speciality level
Pathway – better management of people living with LTCs, improved diagnosis

Speciality – CVD, Diabetes and respiratory
Pathway – prevention and secondary prevention, including early identification and optimisation

Speciality – CVD, Diabetes and CKD
Pathway – prevention and secondary prevention including early identification and optimisation

Speciality – CVD, Diabetes and respiratory
Pathway – secondary prevention including early identification and stratification and condition management

Speciality - Focus on hypertension, diabetes and respiratory. Along with a healthy weight and obesity across B&D
Pathway – prevention and secondary prevention including early identification and optimisation with a key focus on the future of the local incentive scheme

Developing a system wide approach to reducing risk factors and LTC via NEL LTC Portfolio. Cont

The newly established NEL Long Term Condition Strategic Board brings the system and place perspectives and work together, along with partners across NEL to develop a comprehensive understanding of long term conditions in NEL, which informs our decisions related to the allocation of long-term funds and resources to support the transition to upstreaming services. Chaired by Mathew Cole, Director of Public Health in London Borough of Barking and Dagenham and Charlotte Pomery, Chief Participation and Place Officer at NEL ICB, the board focuses on:

- Share expertise and research on preventing residents from developing Long term conditions, and if they do, **reduce the likelihood of developing co-morbidities** through education and early identification of risk factors
- Bring together **learning through listening to communities** to understand how we can support people in managing their own conditions and support careers
- Design **more joined-up and sustainable services**, if desired, commission services across more than one place
- Advocate and work together to **move funding toward upstream prevention and supporting people to live well with a long term condition**

We have structured our end-to-end pathway work into four themes, encompassing the full spectrum of care. This begins with primary prevention of long-term conditions in collaboration with neighbourhoods, local public health teams and the Voluntary, Community, and Social Enterprise (VCSE) sector and extends to tertiary prevention, which focuses on enabling people to live well with an existing long-term condition. The latter involves working with specialised services and social care, addressing the correlation between uncontrolled progression of long-term conditions and the increasing demand for complex care. These specialised services, such as renal dialysis and HIV treatment, cater to a smaller proportion of the population and are set to be delegated to the Integrated Care Board (ICB) in April 2025.

Based on evidence, we have selected two priority areas of focus for the year ahead: diabetes and cardiovascular disease.

Cardiovascular disease:
We see high and growing prevalence in north east London for both conditions across our populations and believe we can work differently and more preventatively to change the outcomes for people with these conditions. This could include for example, work to identify hypertension (high blood pressure) which is the biggest risk factor for cardiovascular disease and one of the top five risk factors for all premature deaths and disability. It is estimated that the prevalence of blood pressure is being underestimated with nearly half of the population with hypertension being unaware that they have it therefore not taking steps to reduce the risk of cardiovascular disease.

Diabetes:
Prevalence of both Type 1 and Type 2 diabetes is increasing across north east London, with a risk of complications and demand for other services.

Why is cardiovascular disease (CVD) our priority?

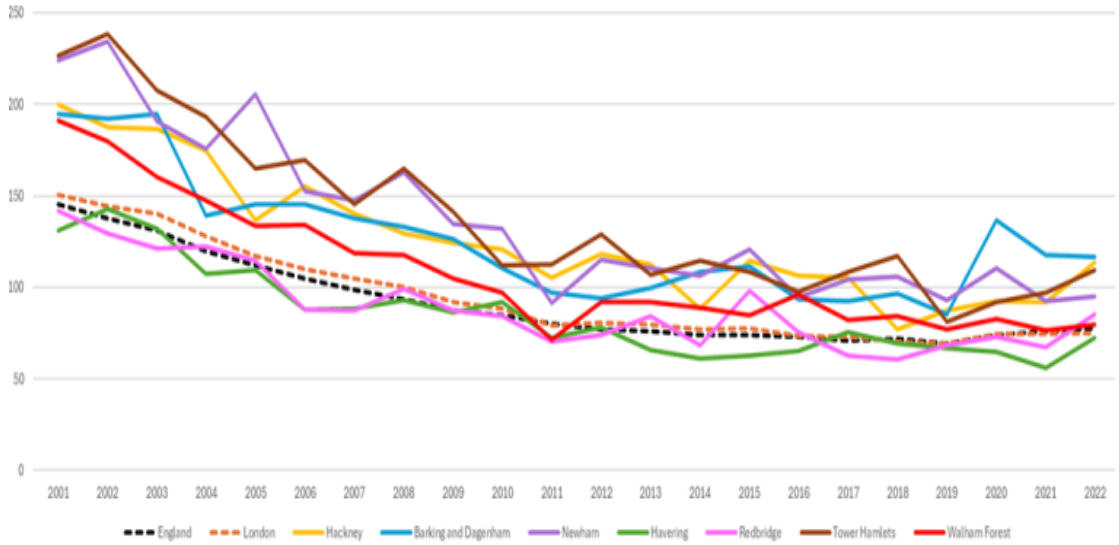
6.6% of people have CVD in NEL which is 127,189 people

(of 1.9m registered NEL patients 18+ in 2023)

This includes all patients diagnosed with at least one of the following conditions, atrial fibrillation, coronary heart disease, chronic kidney disease, heart failure, peripheral arterial disease and stroke.

In NEL the mortality rate for circulatory disease is on a downwards trend aligned to England and London but is **above the England and London value** (per 100,000) in all Places in NEL except Havering (2022).

Mortality rate trend for circulatory disease for all 7 Places across NEL (2001 – 2022)



Cardiovascular disease (CVD) is one of the leading causes of premature death in NEL and in England.

NEL has the **highest under 75 mortality rate** from **circulatory disease** of **all London ICSs** with 92.3 / 100,000 (1,096 people)

Fingertips, 2022

CVD is largely preventable and is often influenced by lifestyle.
1 in 5 people have a diagnosed CVD risk in NEL (hypertension, diabetes, obesity)

There are a wide range of risk factors for high blood pressure, including a range of lifestyle factors such as smoking, excessive alcohol, excess salt, unhealthy diet, obesity and physical inactivity. Those that are physically inactive are also more likely to have high blood pressure.

- NEL has a **higher proportion of adults who are physically inactive** compared to London and England.
- **~1 in 10 adults in NEL have obesity** which is higher than the London average (~191,300). Barking and Dagenham has the highest adult obesity rate in London.
- People with **SMI have a 53% higher risk of having CVD** and **85% higher risk of death from CVD.**
- **Hypertension is the biggest risk factor for CVD** and is one of the top five risk factors for all premature death and disability. It is estimated that the **prevalence of blood pressure is being underestimated** with nearly **half of the population with hypertension may be unaware** that they have it therefore not taking steps to reduce the risk of cardiovascular disease.

Those in the **most deprived 10% of the population** are almost **twice as likely to die as a result of CVD**, than those in the least deprived

In NEL there is a clear **association between premature mortality from CVD** and levels of deprivation. The most deprived areas have **more than twice the rate of premature deaths** compared to the least deprived areas.

- Patients from more **deprived backgrounds and those with Asian ethnicity** are **more likely to smoke** (CVDPrevent).
- People from the **Asian, black, and 'other' ethnic groups were less likely to be physically active** than the national average (Active Lives Survey, 2024). Over 50% of our population comes from a BME background.

Why is diabetes (T1 & 2) our priority?

7,269 NEL population have type 1 diabetes which is increasing and most NEL places have higher prevalence compared to England (2023)

This is 3.0 type 1 diabetes patients per 1,000 registered population in NEL. 51.5% of type 1 diabetes patients in NEL were male.

Place	Population	Type 1 patients (count)	Type 1 patients (rate per thousand)
Barking and Dagenham	256,341	685	2.67
City and Hackney	347,476	1,086	3.13
Havering	295,208	1,174	3.98
Newham	466,174	1,114	2.39
Redbridge	361,836	1,032	2.85
Tower Hamlets	388,624	982	2.53
Waltham Forest	329,351	1,196	3.63
NEL	**2,445,010**	**7,269**	**2.97**

The drive towards transforming type 1 diabetes services has primarily been the consistently poorer outcomes for people with type 1 diabetes (T1DM) compared to people with type 2 diabetes.

People with T1DM have on average a seven year reduction in life expectancy compared to people with T2DM.

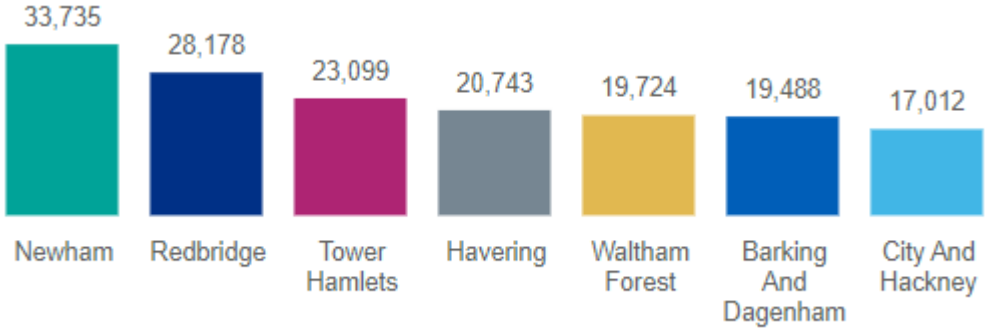
66.4% of the T2 diabetes population and only **35.7%** of the T1 diabetes population received all 8 care processes- this is the worst performing ICB in London (22/23)

Modelling has indicated an expected 63,138 additional residents to be diagnosed with diabetes by 2041/42

7.9% of NEL population have type 2 diabetes which is increasing at a higher rate compared to England and other London ICBs.

£10 billion / year is spent on diabetes in the NHS in England- 80% of this is spent on treating complications. In 2022/23 there were 66m items prescribed for people with diabetes in England, this increased from 42.5m prescription items 10 years earlier (Diabetes UK).

Number of people with diabetes mellitus by borough



Source: Discovery Data Service, NEL CCG system development & data management team, QOF case register, as of July 2024 (161,979 patients with condition)

People of Asian, Chinese, Black African and Black Caribbean ethnicities are 2 – 4 times more likely to have diabetes than White populations- these populations are more likely to develop at lower weight thresholds compared to White ethnicity.

In NEL the number of GP registered with diabetes are:

- 46% Asian or Asian British (73,889)
- 31% white (50,189)
- 17% Black or Black British (27,594)
- 4% 'other ethnic groups' (7,075)
- 2% mixed (2m897)

NHS
North East London

Overview of core themes

1. Primary long term conditions prevention & early identification

The theme recognises individuals experiencing higher levels of socio-economic deprivation tend to have shorter life expectancy and spend a greater proportion of their lives in poor health compared to others. By empowering and enabling residents to lead healthier lives and identify risk factors earlier, we can extend the number of years spent in good health. This not only improves individual well-being but also delivers positive benefits to the local economy and reduces pressure on the health and social care system.

Working in partnership with Local Authorities, the NHS Health Check is an opportunity for people who are aged between 40 and 70 who have no pre-existing condition to meet with a health professional to discuss how to reduce their risk of common long term conditions. Joint working between the organisations has led to 228,762 people in NEL being invited and 87,059 (38%) actually taking up a health check. Whilst take up was above the national average in some places, such as Barking & Dagenham and Redbridge, we're working with Directors of Public Health responsible for health checks across London to identify further opportunities to reduce variation.

Other examples of working with local communities and voluntary and community sector colleagues on prevention and early identification include:

General prevention and early identification including health checks via outreach events for communities/individuals who many are not in regular contact with their GPs:

- Across NEL we're partnering with West Ham United Foundation to delivery health checks focused on renal-cardiometabolic and respiratory at football driven events, community events and faith events, as well as social media events
- In Havering we have been deploying equipment in the community to improve the recognition of cardiovascular risk, which includes automated blood pressure machines and medical grade weighing machines installed at community sites such as phlebotomy clinics (3 in number, average use 1200 pa) and larger libraries (four in number, average use 900 pa). In addition, 100 portable blood pressure machines are on loan at libraries for those who want to control their blood pressure.
- Redbridge Council working with partners including NHS deliver health checks to the local community via Healthy Redbridge Bus
- In Barking and Dagenham the well-attended pop-up clinics continue, including populations more susceptible to long term conditions such as the Afro-Caribbean community

1. Primary long term conditions prevention & early identification (cont.)

We are also working with communities to co-design projects focused on jointly developed priorities for the local community and our system, these include:

- British-Bangladeshis are around twice as likely to have Type 2 diabetes than the general population and are at a higher risk of developing type 2 diabetes from a younger age. Across NEL we're working with the London Bangladeshi Health Partnership to co-design a project focused on developing trust within the community initially with a scope of pregnancy during diabetes
- In Barking & Dagenham, levels of health literacy are the lowest in London meaning some people find reading health guidance and medicine instructions a real challenge. We're working with VSCE colleagues to understand the impact of poor health literacy on diagnosis of diabetes, and these discussions will be used to co-design communication and engagement materials on prevention and management of diabetes
- In Redbridge and Havering work continues with local engagement at locality and ward level to improve outcomes and continue with social prescribing initiatives.

In addition, we have implemented new ways of working which have been informed by our local engagement this includes:

- In Havering, Barking and Dagenham to commission a family-based, multi-component lifestyle weight management service to support childhood obesity in areas of highest deprivation
- Working with Primary Care, we received national funding to make every contact count (MECC) by offering health checks at local dental practices to residents at risk of high blood pressure and AF (Atrial Fibrillation) who live in deprived areas who may not otherwise be in regular contact with a GP
- we have worked with all acute providers, local authorities, Fast Track Cities, and Positive East to screen people who attend A&E for HIV, Hepatitis B and C. 133,127 HIV tests have been performed with 42 new diagnosis, 132,249 Hep B with 90 new diagnosis and 133,373 Hep C with 45 new diagnosis (Apr 24 – Nov 24). There is an increase in testing 6% from Q1 to Q2 (2024) For those identified with HIV, Positive East will work with them to develop a client support plan which includes peer support, housing, immigration advice, food bank advice and, trauma-based psychology services for women and skills-building workshops. Through Homerton Jonathan Mann Clinic Peer navigators are provided (positively UK) often helping to connect people to care, offering additional support such as mental health and housing.

2. Secondary prevention and optimisation

The theme recognises that secondary prevention and optimisation are crucial for reducing the risk of disease progression and long-term complications in individuals with existing health conditions. By addressing modifiable risk factors, optimising treatment, and ensuring regular monitoring, secondary prevention improves patient outcomes, enhances quality of life, and reduces the impact on health and social care.

As part of the long term conditions Local Improvement Scheme (LIS), each place has been working across long term conditions and Primary Care teams with GP Practices, PCNs (Primary Care Networks) and Federations to embed care processes and treatment targets for diabetes, which are part of the National high impact recommendations. National data has highlighted that work related to the local LIS, has enabled improvementand NEL is now ranked highest in England for metrics related to CVD such as Atrial fibrillation, hypertension with blood pressure control and 4 diabetes metrics too.

Other examples of working across the system on optimisation and secondary prevention include:

- **Renal-cardiometabolic** - A total of 160 PCN pharmacists have been trained in early identification and management of CKD and Cardiometabolic patients. The trained pharmacists will play an active role in optimising medicine management in primary care therefore reducing the proportion of patients with end stage renal diseases and cardiovascular diseases, which cost the system over £21.3m in preventable admission per year for heart disease.

- **CKD** - Focused on secondary prevention, the virtual chronic kidney disease (VCKD) is a higher acuity integrated Neighbourhood Team, which has been developed with Barts Health NHS Trust to improve the detection and management of CKD within the community and enable patients to have specialist input earlier in the pathway. On average, only 10% of patients referred to the virtual clinic need a face-to-face hospital appointment, with 45% patients discharged back to their GP with advice to manage their CKD in primary care and the other 45% of patients had virtual follow up by the nephrologist. This approach is being implemented at BHRUT in December 2024, initially testing the approach with Havering Crest PCN, with the aim of expanding across Havering, Barking and Dagenham and Redbridge.

- **Diabetes** - The rollout of The NHS Digital Weight Management Programme offers online access to tier 2 weight management services for adults living with obesity or a diagnosis of diabetes, hypertension, or both to manage their weight and improve their quality of life and longer-term health outcomes, personalised to their needs. We are one of the top performing areas in England, having achieved 81.8% (4,204) of our target (4,830) for 24/25 by the end of October.

3. Co-ordinated care and equability of service

The theme highlights the importance of integrated and co-ordinated care for those living with long term conditions. The feedback from the Big Conversation reflects the need to join up care and move forward with a person-focused approach. Via the NEL long term conditions Strategic Board, we are committed to working with partners and those with lived-in experience to review current provisions and reduce unwarranted variation in care across the pathway to improve health outcomes.

NHSE London has supported ICBs in delivering community-based models of care for patients with sickle cell disease. Working with specialised service team, a pilot has been co-designed with The Sickle Cell Society, and acute, mental health, and community providers are working together to enable better coordination across the boroughs and disciplines, increasing access to holistic care through a multi-disciplinary approach with a new team of acute consultants, pharmacists, psychologists, nursing, and advocacy working together to bring care closer to home and ensure optimal community care reducing acute presentations to emergency departments.

This is conjunction with Sickle Cell Society peer support mentoring service pioneered in NEL and expands into a broader advocacy project involving patients, carers, and link nurses, which has demonstrated at the pilot stage to reduce A&E attendances by 45% and inpatient episodes by 47%.

Other examples of working across the system on Co-ordinated care and equability of service include:

- **Stroke (community)** – Utilising national funding, we have worked with the Community Collaborative to employ rehabilitation support workers to increase the available workforce to support the delivery of stroke rehabilitation in the community and release AHP (Allied Health Professional) time to focus on more complex patient delivery. All teams demonstrated better service user experience, and more people received intense intervention. One team increased ESD provision from two weeks to six weeks, resulting in less demand on overstretched CST services; two teams were able to deliver a longer, more intense intervention (average increase of 3 days) and one team increased rapid pick up by nearly 100%.

- **CVD/Cardiology** – working with specialised services teams in NEL and London and the North London Cardiac Clinical Network, we have implemented a remote platform, which has been used across the cardiology pathway for patients who were deteriorating while waiting for cardiac surgery. These patients had treatment brought forward to reduce potential harm; in doing so, we reduced complications, and cost analysis indicated an average saving of £345 per patient. This has now also been rolled out to patients following a heart failure episodes. A total of 56 patients (20 inpatients and 36 outpatients) were successfully onboarded onto the ORTUS platform in November 2024. A total of 50 patients were successfully offloaded on the ORTUS platform in November 2024.

- **HIV** - Working with Fast Track Cities, implemented GP HIV champions are now in post working to collaborate to provide integrated primary and secondary care and support the stigma charter across organisations in NEL. This work aligns with the NEL wide Sexual Health Strategy, co-ordinated and led by local government colleagues.

4. Enabling people to live well with a long term condition and tertiary prevention

The theme focuses on the practical support and management for people living with long-term conditions, emphasising the need to address complexity and shift away from a single-condition approach. In NEL, 3 in 5 patients with a diagnosed long-term condition have only one condition, while 2 in 5 face multiple co-morbidities, with diabetes and hypertension being the most prevalent. Aligning with the regional strategy, we are working across NEL to implement a renal-cardiometabolic approach. This person-centered model aims to support individuals with, or at risk of, diabetes, cardiovascular disease (CVD), chronic kidney disease (CKD), and liver disease, ensuring holistic and integrated care.

Working with specialised services team and Barts Kidney continue to deliver home dialysis for patients across NEL and continue being highest performing ICB. Further work is planned in Q4 with a roadshow roadshows to boost referrals into the training programme.

In addition, due to housing challenges across NEL, work continues the first of its kind dedicated home therapies/ home from home dialysis unit for self-care, which is due to open in April 2025, and will have dedicated a purpose-built unit for young adults on dialysis to improve their experience, reduce crisis admissions and co-locate with other young adults

Other examples enabling people to live well with a long term condition and tertiary prevention include:

- **Rehabilitation** - We are also working with the Community Collaborative to maximise opportunities for recovery and rehabilitation with a focus on stroke, cardiac and pulmonary rehabilitation. Where possible and supporting people to manage their own health both through prevention and ongoing management. As well as empowering and enabling patients, this supports the system in keeping hospital stays short.
- **Cancer** – As part of the successful cancer prehabilitation services, they have been supporting people with one or more LTCs and providing advise and guidance to reduce risk factors. The care plans help residents achieve the most significant health benefits in the pre-operative period including increasing activity levels, healthy eating, and redirect to local stop smoking, this has had a positive impact for those patients who also had one or more long term conditions. There is a further opportunity to work with the Cancer Alliance are being scoped, as 70% of people living with cancer have one or more long term conditions

Plans for the remainder of 24/25 and 25/26

We continue to focus on our existing priorities, CVD and diabetes, as reflected throughout this paper and further integrating working with colleagues in BI to establish impact and trajectories of local and national project

In addition, the NEL LTC Strategic Board, has agreed to focus on the initiatives below to improve the physical and mental health of people at risk of or living with one or more long term conditions. These are:

Stroke - A recent pan London audit highlighted several key areas for improvement in our local response to stroke focused on achieving national standards in acute and community settings. As result the NEL Stoke Improvement Plan has been co-produced with the Community Collaborative and Acute providers and has demonstrated already improvements in thrombolysis as part of system wide improvement network.

Renal pathway - Working with the London Kidney Network (LKN) and specialised service team, we have commenced a deep dive into renal care across the pathway, including short, medium and long-term options for renal dialysis as well as continuing our focus on prevention and early intervention. We are also modelling the impact that interventions along the pathway will have on the medium/longer-term growth anticipated in dialysis capacity.

Integrated Neighbourhood Working and opportunities to support people with multiple long term conditions via renal-cardiometabolic approach – building on existing work focused on Integrated Neighbourhood Teams, in quarter 4 we will work with colleagues across the system to develop our approach for people living with multiple long term conditions. We will explore a potential model of long term conditions hubs integrated into teams at a neighbourhood level to provide a holistic, patient-centred approach to people living with or at risk of developing multiple long term conditions.

Frailty - In early 2025, we will collaborate with system partners to scope and develop a strategic approach to frailty as a long-term condition, moving beyond an age-specific framework. While frailty is often associated with older age, we recognise that it affects individuals at much younger ages in North East London

Maintaining people with long term conditions in employment - Allied to one of our other ICB strategic priorities, we are keen to develop our approach to ensuring that people most at risk of and living with long term conditions are supported to enter and or to sustain employment where of working age. Working with UCLPartners, we are exploring in 2025/26 if we can quantify the impact of CVD on the North East London local economy, along with personal impact of living with an LTC. This builds on the wider focus nationally to create greater opportunities for economic growth by better alignment of health and wellbeing and employment.

NHS
North East London

Risks and issues

Challenges which require a system wide response

The three key issues and risks for long term conditions are complex and intertwined. Significant population growth and increased complexity are driving cost pressures. A system wide strategic shift toward prevention is essential to mitigate rising secondary care demands and optimise outcomes.

1. Variation in performance and service provision

One main focus of the newly established NEL Strategic Board is to reduce variation across North East London. Addressing variation is complex and requires on-going work between Primary Care Collaborative, Places and NEL and targeted recurrent funding. Non-recurrent projects such as Health Inequality Projects in Barking, Havering and Redbridge have demonstrated improvements in reducing variation and towards national standards but have lost momentum or stopped once non-recurrent funding has finished.

2. Non-recurrent funding

NEL is successful in securing National and Regional funds, but unfortunately, these funds are often non-recurrent, usually lasting 12-18 months. The majority of projects outlined in the paper are reliant on non-recurrent funding, and embedding change after this funding has stopped has proven to be difficult.

3. Investment in upstreaming

Analysis in Newham has provided insight into the cost of long term conditions across the systems and highlighted that investment of 2% of the health budget can potentially mitigate demand growth by 25%, partially within GPs and secondary care. This system approach of reviewing funding and moving it towards upstream activities is a focus for NEL, with system-wide work necessary before savings can be made.

In addition, the Tony Blair Institute for Global Change has estimate that a 20 per cent reduction in the incidence of six major disease categories that are keeping people out of work – cancer, cardiovascular disease (CVD), chronic respiratory illness, diabetes and mental-health and musculoskeletal disorders – would have significant macroeconomic benefits. This “improved-health scenario” could raise GDP by an estimated 0.74 per cent within five years – an annual boost of £19.8 billion – and by 0.98 per cent within ten years, equating to £26.3 billion annually. Annual fiscal savings from increased tax revenues and reduced benefit payments could amount to £10.2 billion and £13.0 billion by 2030 and 2035, respectively.