South East Clinical Senate

South East

Clinical

senate

Developing a shared vision for the future of healthcare with a focus on linked long-term conditions

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Foreword

The South East Clinical Senate and Public Health NHS England South East are pleased to share the findings and recommendations of a review panel drawn from primary and secondary care in the South East, public health, patients and public, and independent external key opinion leaders.

The panel were tasked to consider options for responding to the future health needs of the South East population. In particular, linked long term conditions including obesity, diabetes, hypertension, hyperlipidaemia, chronic kidney disease and cardiovascular disease in the context of the three key shifts of care outlined in the 10-year Health Plan, captured in the five transformation pillars of the South East Region Strategic Framework. In doing so, to also relate to how integrated community care of the linked long term conditions are central to the future of health and wellbeing in South East England.

This region has an ageing population with rising multimorbidity, coastal and rural inequalities, workforce shortages, and significant variation in access in all senses of the word. These all converge to create a clear imperative for proactive, coordinated care that is rooted in the communities served.

This report brings together the latest evidence and local learning to address these linked long term conditions which are major contributors to the gap between healthy life expectancy and life expectancy across the region. The report also identifies structural barriers such as inconsistent interoperability, misaligned incentives, and the challenge of delivering equitable care across a region that spans affluent commuter belts, rural villages, and some of the most deprived coastal communities in England.

The recommendations set out here are designed to strengthen neighbourhood-level care delivery, embed population health management, support the prioritisation of high value evidence-based interventions, enable data-sharing across organisational boundaries, and invest in the workforce and community assets that make integrated care possible.

As systems across the South East region continue to evolve, the recommendations aim to support leaders, clinicians, local authorities, and community partners to build models of care that are resilient, inclusive, equitable, sustainable and genuinely centred on the people and places they serve.

Paul Stevens
Chair South East Clinical Senate

Mohit Sharma
Consultant in Healthcare Public Health

Glossary

ACR	urine albumin to creatinine ratio, marker of kidney damage
CKD	chronic kidney disease
CVD	cardiovascular disease
CVDACTION	smart tool for cardiovascular disease prevention
CVDPREVENT	national primary care audit related to cardiovascular disease
CVRM	cardiovascular renal metabolic
DPP	diabetes prevention programme
DWMP	diabetes weight management programme
EHR	electronic health record
GFR	glomerular filtration rate, measure of kidney function
GLP-1RA	glucagon like peptide 1 receptor agonist
HLE	healthy life expectancy
KLOE	key lines of enquiry
LE	life expectancy
LTC	long term condition
MASLD	metabolic dysfunction associated steatotic liver disease
PCN	primary care network
PHOF	public health outcomes framework (fingertips data tool)
PPIE	patient and public involvement and engagement
QOF	quality and outcomes framework
RAS	renin angiotensin system
SGLT2i	sodium glucose co-transporter 2 inhibitor

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1. Executive Summary

This Senate and Public Health review seeks to build options for responding to and mitigating the long-term outlook for the health of the South East Region,[1] with a particular focus on the linked long-term conditions (LTCs) that contribute to what has been termed cardiovascular renal metabolic (CVRM) syndrome in the upcoming Cardiovascular Disease Modern Service Framework.[2] These include obesity and overweight, hypertension, diabetes, chronic kidney disease (CKD), metabolic dysfunction associated steatotic liver disease (MASLD) and cardiovascular disease (CVD). With an increasing and ageing population across the South East, these conditions will make up a significant proportion of multiple LTCs and health service demand across the region. Designing and maintaining a sustainable health system to serve the needs of the South East population for the future must recognise that the projected growth in burden and management of these linked CVRM conditions will be predominantly in primary and community care. The NHS 10-year plan,[3] the Medium-Term Planning Framework[4] and the South East Region Strategic Framework[5] all focus on three shifts to build a health service fit for the future, namely, moving care from hospital to the community, making better use of technology and moving the focus from treatment to prevention of illness. New models of care need to be developed to support these three shifts and the changing population healthcare needs in the South East. The review aimed to develop an understanding of the future needs and the services most impacted and inform the development of clinical consensus on service models to meet these needs, focussed on areas/changes in the highly inter-related CVRM LTCs. At the outset of the review the panel were posed 3 general questions in the terms of reference:

What are the future healthcare needs of the population of the South East region? (with particular focus on key inter-related areas / changes in CVRM LTCs).
What are the implications of the future healthcare needs on clinical outcomes for patients and the organisation and delivery of health services?

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[1] NHS England South East, *Tomorrow's Region: The long-term outlook for the health of the South East Region*, (NHSE, September 2025).
[2] Cardiovascular Disease Modern Service Framework, accessed January 30, 2026. The UK's Cardiovascular Disease Modern Service Framework is a strategic initiative by NHS England and the government to significantly reduce premature deaths from heart disease and stroke by improving early detection, treatment, and management through better data, innovation, and consistent care across the patient journey, with publication expected in 2026.
[3] NHS England, accessed January 30, 2026, Fit for the future: 10 Year Health Plan for England.
[4] NHS England, accessed January 30, 2026, NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29.
[5] NHS England South East, *South East Region Strategic Framework*, (NHSE January 2026).

What advice can the Clinical Senate offer to enable development of models of care and the required workforce in order to meet future healthcare needs and mitigate and improve adverse clinical outcomes?

The first of these is described in detail by the Tomorrows Region report.[1] Key messages are that the South East population is a growing and ageing population, predicted to grow by 9.4% (~879k people) in the next 20 years with the proportion of people aged 75+ increasing from 10% to 14% (~474k more people).

Whilst the South East has the smallest gap between life expectancy (LE) and healthy life expectancy (HLE) of any English region, roughly 18–19 years of life spent in poor health on average, this has increased over the previous decade with an ageing population spending longer in poor health. Affluent districts (e.g., Waverley, Hart, Sevenoaks, Tunbridge Wells) sit near the top national HLE values, whilst deprived coastal districts (Hastings, Thanet, Portsmouth, Southampton) fall 20+ years behind affluent areas in healthy life years.

The highest prevalence of frailty in people aged 50+ in the South East is mainly found in deprived urban and coastal areas and across the region healthcare demand for those conditions that contribute to the highly inter-related CVRM LTCs is increasing. Diabetes, hypertension, CKD and CVD are all in the ten conditions with the highest projected impact on future healthcare use and mortality by 2040, all underpinned by obesity as a common risk factor.

Tackling CVRM LTCs requires multidisciplinary integrated care models (Figure 1), not siloed disease programs, with investment in shared risk reduction (weight management, blood pressure control, lipid lowering, glucose management and kidney health).

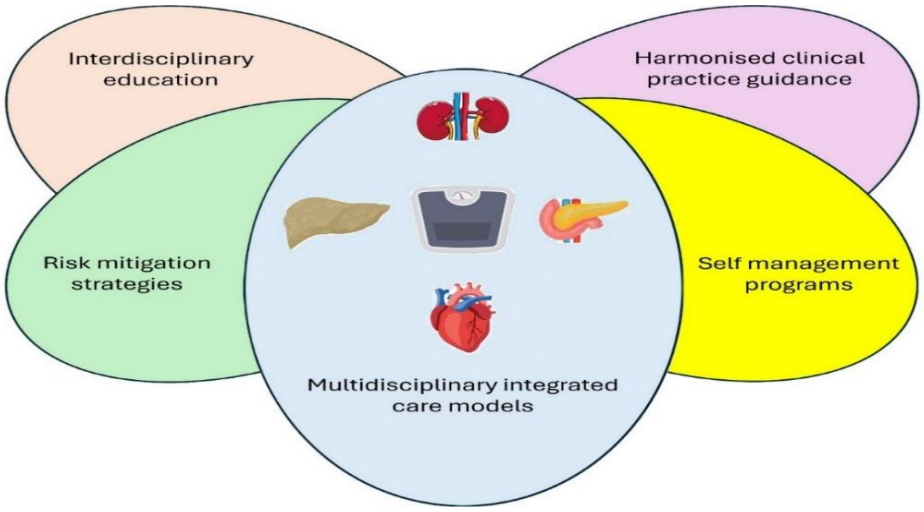

Figure 1. Integrated Cardiovascular Renal Metabolic Long Term Conditions Model (adapted from[6])

Harmonised clinical practice guidance recognises that key evidence-based treatment targets and treatments to achieve those targets are shared by the separate LTC components contributing to CVRM. A revised skill set, interdisciplinary clinical education, workforce redesign and system partnering is required for the effective management of chronic diseases[7] and to grasp the opportunity to improve outcomes at scale, reduce system costs and address inequities. Population health management tools to segment the population and identify groups at risk also identify those suitable for self-management programs.

Despite the interconnected nature of the CVRM LTCs where the onset or progression of one disease often exacerbates another, local and national guidelines, formularies, healthcare provider education and care pathways tend to be siloed by disease. This demands a more integrated approach to care. Aligning policies with the realities of patient care will improve outcomes for those living with these complex conditions. These models require local, regional, and national coordination to implement the necessary changes to ensure long-term sustainability.

[6] Rangaswami J, Tuttle K, Vaduganathan M. Cardio-Renal-Metabolic Care Models: Toward Achieving Effective Interdisciplinary Care. *Circ Cardiovasc Qual Outcomes* 13(11) (2020):e007264.
[7] Van Servellen G, Fongwa M, Mockus D'Errico E. Continuity of care and quality care outcomes for people experiencing chronic conditions: A literature review. *Nursing and Health Sciences* 8 (2006):185-195.

2. Recommendations

Clinical and System colleagues' commitment and determination to collaborate to provide recommendations for integrated best practice to optimise patient outcomes in the immediate and longer term was at the forefront of the panel discussions and the review panel were cognisant of the significant financial and operational pressures existing across the NHS. This was articulated in the desire to do the right thing, for the right person, at the right time which will require a system that moves from a disease centred approach to an integrated patient centred approach. Critically one that is proactive rather than reactive.

The recommendations from the panel discussion and responses to key lines of enquiry are summarised below separated into:

- key recommendations
- strategic commissioning and integrated care
- population and neighbourhood health
- workforce development
- digital, data and evaluation
- engagement.

The recommendations link to the Medium Term Planning Framework[4] and to delivery of the five pillars of transformation described in the South East Region Strategic Framework[5] but critically also address workforce development.

Key Recommendations

1. Clinicians must work with finance to facilitate funding flows to support a shift of resources to primary care, community, and preventative services, taking a long-term approach to investment in prevention (both primary and secondary) through integrated cardiovascular renal metabolic (CVRM) long term condition (LTC) care pathways.
2. Mandate early identification of people requiring healthcare advice and intervention for linked CVRM LTCs through establishing and maintaining (where indicated) a minimum dataset in the shared electronic healthcare record (example in Table 1), driven by policy and incentivisation.
3. Integrate CVRM LTC healthcare contacts into 'one stop shops' led by a clinician with the appropriate competencies with access to the wider multidisciplinary team as required.
4. Assess and standardise the competencies and skills required for delivery of the identified new models of care in neighbourhood teams. Use and refer to

the NHS Long term Workforce Plan and the 10-year workforce plan to develop a regional workforce plan to meet future healthcare needs that provides a blended multidisciplinary workforce, including extended roles, who share these competencies and skills.

5. Identify one to two important evidence-based outcomes such as treating hyperlipidaemia to target and control of high blood pressure or weight management. Align systems and interventions to focus on achieving the desired standards (tracked via CVDPREVENT)[8] and then address the next most important evidence-based outcomes.
6. Regionally adopt an approach underpinned by the principles of value-based healthcare. Develop and scale up a systematic approach to identifying adoption of high value interventions and de-prioritisation of low value interventions with prioritisation processes based on evidence of effectiveness and cost-effectiveness.
7. Set regional standards allied to national for coding, high quality data recording, data sharing, and recalls across primary care networks (PCNs) and providers, ensuring interoperability, transferability, governance and standardised data-sharing agreements across providers.
8. Produce a stakeholder map at the outset that ensures involvement of all those affected using co-design with staff and Patient and Public Involvement and Engagement (PPIE) groups, including youth panels, to refine digital content and access so that services are co-created.
9. Ensure non-digital alternatives remain available for those unable to access digital healthcare whilst also identifying and mitigating barriers to use of digital healthcare.
10. Ensure that ICBs and all providers deliver green plans that meet their statutory legal duties to consider emissions and environmental targets as set out in The Health and Care Act 2022.[9] [10]

[8] NHS England, accessed February 12, 2026, Cardiovascular Disease Prevention Audit (CVDPREVENT) - NHS England Digital.
[9] NHS England, accessed January 30, 2026, https://www.england.nhs.uk/long-read/green-plan-guidance/.
[10] GOV.UK, accessed February 9, 2026, Health and Care Act 2022 - GOV.UK.

Table 1. Minimum dataset example

Domain	Data
Demographics and clinical context	Age, sex, ethnicity, postcode (for deprivation quintile) Smoking status and physical activity Frailty score Alcohol intake
Physiological and Metabolic	Weight, BMI and waist circumference for overweight/obesity status Blood pressure HbA1c or where not valid fasting glucose (diabetes or prediabetes) Lipid profile (LDL-C, HDL-C, triglycerides) Liver profile for MASLD (including ALT and AST)
Kidney	Estimated glomerular filtration rate (eGFR) and urine albumin:creatinine ratio (ACR). History and or family history of kidney disease
Cardiovascular	Hypertension status History of CVD (ischaemic heart disease, heart failure, atrial fibrillation, stroke, peripheral vascular disease)

BMI, body mass index; HbA1c, glycosylated haemoglobin; LDL-C and HDL-C, low and high density lipoprotein cholesterol; ALT, alanine transaminase; AST, aspartate transaminase

Strategic commissioning and integrated care

11. Align incentives and prescribing to the components of the CVRM LTCs pathway to provide continuous, accessible, integrated person-centred care, with commissioning and incentivised collaboration across sectors for optimal cost and outcomes.
12. Reduce unwarranted variation by standardising protocols and dashboards for evidence-based identification and integrated management of CVRM LTCs in community settings. Implement cost-effective therapies to reduce cardiovascular risk and risk of CKD progression (including statin-based lipid lowering therapy, renin angiotensin aldosterone system blockers and generic SGLT2i).
13. Promote recognition of obesity as a long-term condition and integrate management into CVRM frameworks with consistent, equitable implementation of referral criteria for bariatric surgery and GLP-1RA/incretin mimetic therapies.
14. Monitor health inequalities in the implementation and delivery of CVRM care pathways to ensure inequities are not widened. Develop a systematic

approach to assessing and addressing variation and inequalities with early identification of issues and introduction of appropriate mitigation. Strong leadership and good quality data are essential to support this.

15. Support the use of specific tools and technologies such as risk prediction tools and clinical decision support to assist in clinical adoption of high value care pathways and drive guideline directed medical treatment.
16. Support the development and adoption of specific multi-disciplinary care pathways across organisational boundaries operationalising a shift to community-based care and to preventative care for CVRM LTCs.
17. Develop and operationalise a systematic regional approach to the assessment of cost and quality in the decision making and development of models of care.
18. Commission pathway-based contracts using prescribing alerts embedded in electronic health records (EHRs) to drive implementation of guideline directed medical therapies with risk/gain-share implemented at scale (any overspend or surplus shared equally).
19. In line with National medicines optimisation opportunities, address overprescribing and oversupply while supporting patients in greatest need, taking a shared decision-making approach and personalising care.[11]

Population and neighbourhood health

20. Drive regional adoption of population health tools such as those for identifying patient need (Johns Hopkins Adjusted Clinical Groups system), frailty (Rockwood frailty scores), and CVRM LTCs.
21. Regionally develop and support use of data across health and social care to support action at local and neighbourhood levels.
22. Develop models of care delivery at neighbourhood levels for CVRM LTCs with patient reviews and diagnostics where clinically appropriate.
23. Regionally prioritise implementation of national clinical strategies that enable an integrated approach to care delivery for CVRM LTCs.
24. Resource the development of models of care delivery for populations at neighbourhood levels.
25. Consider net zero principles in all service change, reconfiguration programmes and pathway redesign.

[11] NHS England, accessed January 30, 2026, https://www.england.nhs.uk/long-read/national-medicines-optimisation-opportunities-2023-24/.

26. Reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects in line with the Government's Design for Life programme.[12]

Workforce development

27. Support development of the required workforce and scale independent prescribers (pharmacists, nurses, allied health professionals) with funded education, upskilling, supervision and governance for integrated CVRM LTC management and prescribing.
28. Regionally work with education providers to meet the learning and training requirements of the required workforce.
29. Identify a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance at system level[13]

Digital, data and evaluation

30. Prioritise sustainability in the procurement, design and management of digital services at system level[14] [15]
31. Develop the skills for evaluation of evidence for effectiveness, cost effectiveness and economic modelling to support decision making.
32. Support the implementation of digital tools for the identification and management of CVRM LTCs.
33. Embed evidence-based and validated risk prediction tools in EHRs together with clinical decision support to drive guideline directed medical treatment and management.
34. Support implementation and widespread adoption of digital programmes such as digital interventions for weight management.
35. Promote implementation and usage of the expanding functionality of the NHS app as it becomes available to seamlessly support self-referrals, results with explanations, education packages and facilitate 2-way flow of data and integration of data from wearable health technologies.
36. Encourage providers to explore opportunities for joint management (clinician and patient) of clinical conditions and management of risks via better utilisation of self-care through digital health interventions.

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[12] GOV.UK, accessed January 30, 2026, Design for Life roadmap - GOV.UK.
[13] NHS England, accessed January 30, 2026, NHS England » Green plan guidance.
[14] NHS England, accessed January 30, 2026, What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate.
[15] GOV.UK, accessed January 30, 2026, Greening government: ICT and digital services strategy 2020-2025 - GOV.UK.

37. When utilising AI correct and mitigate any AI bias and systematic error in the training, development, testing, implementation and monitoring stages.

Engagement

38. Implement promotion of healthy lifestyle through working with Directors of Public Health, local authorities, healthcare organisations, third sector organisations (such as the British Society of Lifestyle Medicine)[16] and engagement with the local population.
39. Engage with NHS staff who live with the same risks and inequalities as local community groups and encourage them to lead by example, championing health lifestyle programmes such as staff health checks, weight management and smoking cessation.
40. Prioritise communication for population risk awareness and leverage healthcare organisations for health education and screening.
41. Engage with staff and service users to inform workforce planning and person-centred care, considering people's needs and preferences and giving them the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals.

3. Introduction and aims of the review

The review aimed to provide a description of the future health needs for the population in the South East Region, with a particular focus on CVRM LTCs. It sought to build options for responding to this future need to maintain a sustainable health system that would serve the needs of the population over the next decade. This review will inform models of service delivery and how they will need to change in the future. The background section provides an overview of national and regional policy direction, presents the case for the burning platform that is the need to link care pathways for CVRM LTCs and provides the context and reason for application of a value-based healthcare approach to problem solving.

The Clinical Senate is well placed to inform and advise the NHS in the region and beyond on the future needs (building upon the work undertaken on 'Tomorrows Region'), the steps needed to achieve this change for key services, the broader strategic considerations on incentivisation and managing the shift of resources to enable this, as well as the workforce needs for the future service models.

[16] British Society of lifestyle medicine, accessed February 12, 2026, BSLM - Transforming Healthcare Through Lifestyle Medicine.

The questions posed were:

- What are the future healthcare needs of the population of the South East region? (with particular focus on key inter-related areas / changes in CVRM LTCs).
- What are the implications of the future healthcare needs on clinical outcomes for patients and the organisation and delivery of health services?
- What advice can the Clinical Senate offer to enable development of future models of care and the required workforce in order to meet future healthcare needs and mitigate and improve adverse clinical outcomes?

4. Review Methodology

The Clinical Senate in collaboration with Public Health NHSE South East established a review team drawn from healthcare clinicians and subject matter experts both from within and outside the South East region, including senate council members and public health, and patient and public representatives to consider the three questions posed. All South East region Integrated Care Board (ICB) primary care clinical leads were also contacted and invited to take part in or nominate a representative for this review. The senate review team membership is listed in appendix A. Great care was taken to avoid conflicts of interest, and all review team members were required to sign confidentiality and declaration of interest agreements.

The senate and public health project team provided panel members with background documentation for the clinical areas under review to highlight available literature, orientate and provide context for the review.[17] [18] [19] The documents were circulated to the whole panel (TEAMS review day and desktop review participants).

A pre-meet was held on 25th November 2025 (via Microsoft TEAMS) for review team members. This served to discuss the Key Lines of Enquiry (KLOEs) listed in appendix B, to appraise review team members of the purpose of the review and to outline the critical friend nature and difference between this request and a clinical senate assurance review.

[17] South East Clinical Senate, accessed February 18, 2026, Tomorrows-Region-Overview_The-long-term-outlook-for-the-health-of-the-South-East-Region_v.Final_.pdf
[18] South East Clinical Senate, accessed February 18, 2026, South-East-Clinical-Senate__Developing-a-shared-vision-for-the-future-of-healthcare__Background-information_v.Final_-corrected_181125.pdf
[19] South East Clinical Senate, accessed February 18, 2026, Examples-of-Best-Practice-Case-Studies-_for-illustrative-purposes_v.Final_.pdf

A full day virtual panel review meeting via MS TEAMS was held on 3rd December 2025. The agenda for the day is shown in appendix C.

To facilitate the greatest number of contributors those unable to attend the TEAMS panel review undertook a desktop review. The notes from both reviews were synthesised into a first draft which was circulated to all for comment on 27th January 2026.

Scope

The scope of this review will be focused on the South East region however it is recognised it may have wider applicability.

5. Background

The National Health Service in England is under severe pressure with rising demand for services. A key driver for this is the changing demographic of the population, described for the South East region in the 'Tomorrows Region' report developed by the Office for Health Improvement and Disparities (OHID), presented to the South East Clinical Senate council in January 2025 and updated in October 2025.

The report outlines the demographic changes and the potential future impact of these on health care need. The population in the South East is forecast to grow by 9.4% over the next 20 years with the proportion of those aged 75 years and older increasing from 10% to 14% (or 474k more people). This changing demographic accompanied by a decline in healthy life expectancy will be a key driver in the increasing healthcare needs of the population, with people in the South East predicted to live for more years in poor health.[20]

A recent landmark study of the English population assessed the prevalence of multiple LTCs at 14.8% with a marked gradient by age and socioeconomic deprivation.[21] The prevalence of multiple LTCs rose from 0.9% in the 0-19 years age group to 68.2% in the over 80 years age group, and from 13.7% in the least deprived to 16.1% in the most deprived population deciles of the population.

[20] Office for National Statistics, accessed January 30, 2026, Health state life expectancy, all ages, UK - Office for National Statistics.
[21] Valabhji J et al. Prevalence of multiple long-term conditions (multimorbidity) in England: a whole population study of over 60 million people. *Journal of the Royal Society of Medicine* 117(3) (2023):104–117.

The causes and most frequent combinations of multiple LTCs vary by age. Asthma and depression are most frequently associated at younger ages. With rising age cardiovascular disease, CKD, metabolic disease and osteoarthritis are dominant. CVRM LTCs are projected to contribute significantly to the growth in demand for healthcare use across England over the next 10-15 years.[22]

Combined, the two factors of a demographic shift to an older population in the region and nationally and a rising prevalence of multiple LTCs will continue to contribute to pressures on the NHS. This is implicitly recognised by policy makers and articulated as the '3 shift ambition' in the NHS 10 Year Health Plan.[3] These shifts are conceptualised as:

Shift 1: Moving care from hospitals to communities
Shift 2: Making better use of technology
Shift 3: Focusing on preventing sickness not just treating it

These also resonate with the regional desire to influence each of these shifts to manage the demand of the present and near future. Guided by the 10-year Health Plan, the South East Strategic Framework[5] will focus on five transformation pillars to rapidly deliver transformational change:

- Prevent ill health. Slow down the rise of disease and reduce the burden of poor health.
- Care close to home: Build strong neighbourhood services so people can get help right in their community.
- Fair care for all: Improve support for disadvantaged groups who need it most.
- Quality that lasts: Make services better, more reliable, and sustainable for the future.
- Smart technology in action: Harness digital tools and innovation to boost productivity and transform care.

Implementing these shifts will require a substantial change in how NHS services are provided and the workforce and technologies needed to deliver these. This will need to be accompanied by a sustained and consistent shift in funding to enable this transformation to manage current demand and meet the needs of the future.

This Clinical Senate work is intended to be complimentary to and inform wider decision making in the application of this framework and operationalise the implementation of the three shifts through new models of care. It is anticipated that the new models will encompass neighbourhood healthcare, a model of care that

[22] The Health Foundation, accessed January 30, 2026, Health in 2040: projected patterns of illness in England | The Health Foundation.

brings health and social care services closer to people's homes, focusing on integration, prevention, and community-led delivery.[23] Allied to this is the proposed major shift from analogue to digital in the NHS, modernising outdated systems to improve patient care, efficiency, and safety. The tenet is that digital tools enable faster access to patient information, reduce duplication, and free up staff time for direct care.

Sustainability must be central to all transformational changes. The Health and Care Act 2022 introduced legally binding duties on all NHS organisations to have regard to the Climate Change Act 2008 and Environment Act 2021 in the decisions they make. The 10-year Health Plan reiterated a commitment to future decarbonisation. However, despite the legal mandate and the wealth of evidence at the intersection of climate and health, healthcare systems under strain continue to perceive sustainable healthcare as a desirable but dispensable goal that comes at an additional cost.

6. Cardiovascular-renal-metabolic (CVRM) long term conditions

The strong associations between hypertension, diabetes, hyperlipidaemia, chronic kidney disease (CKD) and cardiovascular disease (CVD) have been known for over 3 decades.[24] [25] [26] [27] [28] The importance of albuminuria as a risk factor for adverse outcomes and the relationship between level of kidney function as assessed by glomerular filtration rate (GFR) and adverse outcomes have also been well described since the 1990s.[29] [30] [31] [32] Over the last 3 decades there has also been an

[23] "The Kings Fund," Morris L, Baird B, Charles A, accessed January 30, 2026, What Is Neighbourhood Health? | The King's Fund.
[24] Shulman, N. B. *et al.* Prognostic value of serum creatinine and effect of treatment of hypertension on renal function. Results from the hypertension detection and follow-up program. The Hypertension Detection and Follow-up Program Cooperative Group. *Hypertension* 13 (Suppl.) (1989), s180–s193.
[25] Parfrey PS, Harnett JD, Foley RN. Heart failure and ischaemic heart disease in chronic uraemia. *Curr Opin Nephrol Hypertens*.4 (1995):105-110.
[26] Harnett JD et al. Congestive heart failure in dialysis patients: prevalence, incidence, prognosis and risk factors. *Kidney Int*. 47(1995):884-890.
[27] Foley RN et al. Cardiac disease in diabetic end-stage renal disease. *Diabetologia* 40 (1997):1307-1312.
[28] Foley RN, Parfrey PS, Sarnak MJ. Clinical epidemiology of cardiovascular disease in chronic renal disease. *Am J Kidney Dis* 32 (1998):S112-9.
[29] Hillege et al, Urinary albumin excretion predicts cardiovascular and noncardiovascular mortality in general population. *Circulation* 106 (2002):1777-1782
[30] Go A et al, Chronic kidney disease and the risks of death, cardiovascular events, and hospitalisation. *N Engl J Med* 351(2004):1296-1305.
[31] Weiner, D et al. Chronic kidney disease as a risk factor for cardiovascular disease and all cause mortality: a pooled analysis of community-based studies. *J. Am. Soc. Nephrol*. 15 (2004):1307–1315.
[32] Grams M et al. Estimated Glomerular Filtration Rate, Albuminuria and Adverse Outcomes: An Individual- Participant Data Meta-Analysis. *JAMA* 330 (2023):1266-1277.

increasing incidence and prevalence of overweight and obesity in the population, together with sedentary lifestyles with little physical activity. Data clearly demonstrates that obesity (elevated body mass index, waist circumference, and waist-to-height ratio) is associated with increased risk of GFR decline and mortality in people with and without CKD.[33] [34] In sub-groups of those with diabetes, hypertension and CVD being overweight associates with more advanced CKD (stages 4 and 5).

The burden of these related noncommunicable diseases (NCDs) is immense, and they are among the most significant public health concerns, both in terms of impact on individual patients and the impact on the health economy. This was described in detail in the background documentation provided to panel review members together with the evidence-based management of the CVRM LTCs.

7. Value Based Healthcare

The long-term outlook for the region sets out the key challenges; namely: an ageing population with multiple LTCs leading to a rising demand for services and healthcare. This leads inevitably to increased volume and intensity of clinical practice in the wider context of constrained and shrinking resources. In addition, this overlays a persistent pattern of inequitable distribution of health conditions and determinants of health leading to underuse of some interventions and overuse of other interventions.

Value based healthcare aims to use available resources to best achieve health goals for a population in a transparent, sustainable and equitable manner. It provides a useful framework for explicit decision making to achieve health goals with available resources. In the context of severely constrained resources, it is helpful to consider value in all its dimensions to maximise the health benefit for the population. Figure 2 outlines how quality in healthcare can be conceptualised by different stakeholders. Some of these apply at individual level and others at population level, but all are relevant and need to be considered with the development of consensus for the chosen options. The barrier to value based healthcare is that our systems are forced to operate within a one year financial envelope. This discourages investment in any healthcare which does not produce a one year financial return, regardless of the

[33] Herrington WG, Smith M, Bankhead C, et al. Body-mass index and risk of advanced chronic kidney disease: Prospective analyses from a primary care cohort of 1.4 million adults in England. *PLoS ONE* 12(3) (2017): e0173515.
[34] Chang AR et al. Adiposity and risk of decline in glomerular filtration rate: meta-analysis of individual participant data in a global consortium. *BMJ* 364 (2019): k5301.

longer term significant health gain and financial returns which could be realised if we recognise and address this.

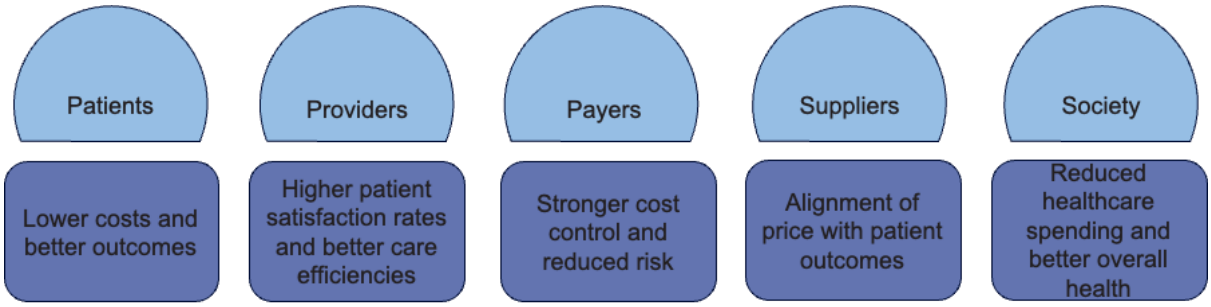

Figure 2: Conceptualisation of value from different stakeholder perspectives[35]

What creates good value healthcare

Aiming to enable people to live healthy and fulfilling lives free of illness maximises value and implies that focusing on prevention or limiting the sequalae of disease increases value. This has the added advantage that more preventive interventions are often of lower cost and therefore should be prioritised. Interventions that are not effective or cost effective and are unlikely to provide good value should be considered for discontinuation.

Implications for the NHS

Value based healthcare helps define our core values in times of change and constrained resources and provides a framework to guide improvement. The framework can be used to assess the broad allocation of resources across a pathway of care or between programme areas and further developed into methodologies for resource allocation within and between programme areas.

It is through the lens of value based healthcare that the panel was encouraged to consider making recommendations.

[35] "NEJM Catalyst", What is Value-Based healthcare?, accessed January 30, 2026, What Is Value-Based Healthcare? | NEJM Catalyst.

8. Best practice and models of care examples

The panel discussion, KLOE feedback and background research identified several examples of best practice and new models of care aligning with one of the three shifts in the NHS 10-year Health Plan summarised below under the applicable shift headings:

- Hospital to community
- Analogue to digital
- Sickness to prevention

Hospital to community

Neighbourhood healthcare pilots

The first wave of neighbourhood healthcare pilot sites includes several from the South East region (East Kent, East Sussex, East Surrey, East Berkshire and Slough, Portsmouth and Buckinghamshire). Sites were chosen to represent areas of highest deprivation and health inequality, with shorter life expectancy and longer waiting times. Each site will host a neighbourhood health team built around general practice, integrating GPs, nurses, hospital doctors, pharmacists, dentists, optometrists, paramedics, social prescribers, and voluntary sector partners. The aims are to improve access, reduce hospital reliance, and tackle health inequalities by coordinating care at the local level.

Folkestone and Hythe neighbourhood health pilot

The Folkestone and Hythe neighbourhood health pilot covers an ageing population of c. 100,000 in a coastal area of Kent with significant health inequalities. The ambition and vision are to bring everyone who supports the community's health and social care into one team giving care that is personal, proactive and close to home. Focussing on prevention and health and breaking down organisational barriers (Figure 3). This is also an example of a scale up of independent prescribers at a neighbourhood level, with a third of all staff being prescribers, including pharmacists, nurses and physiotherapists.

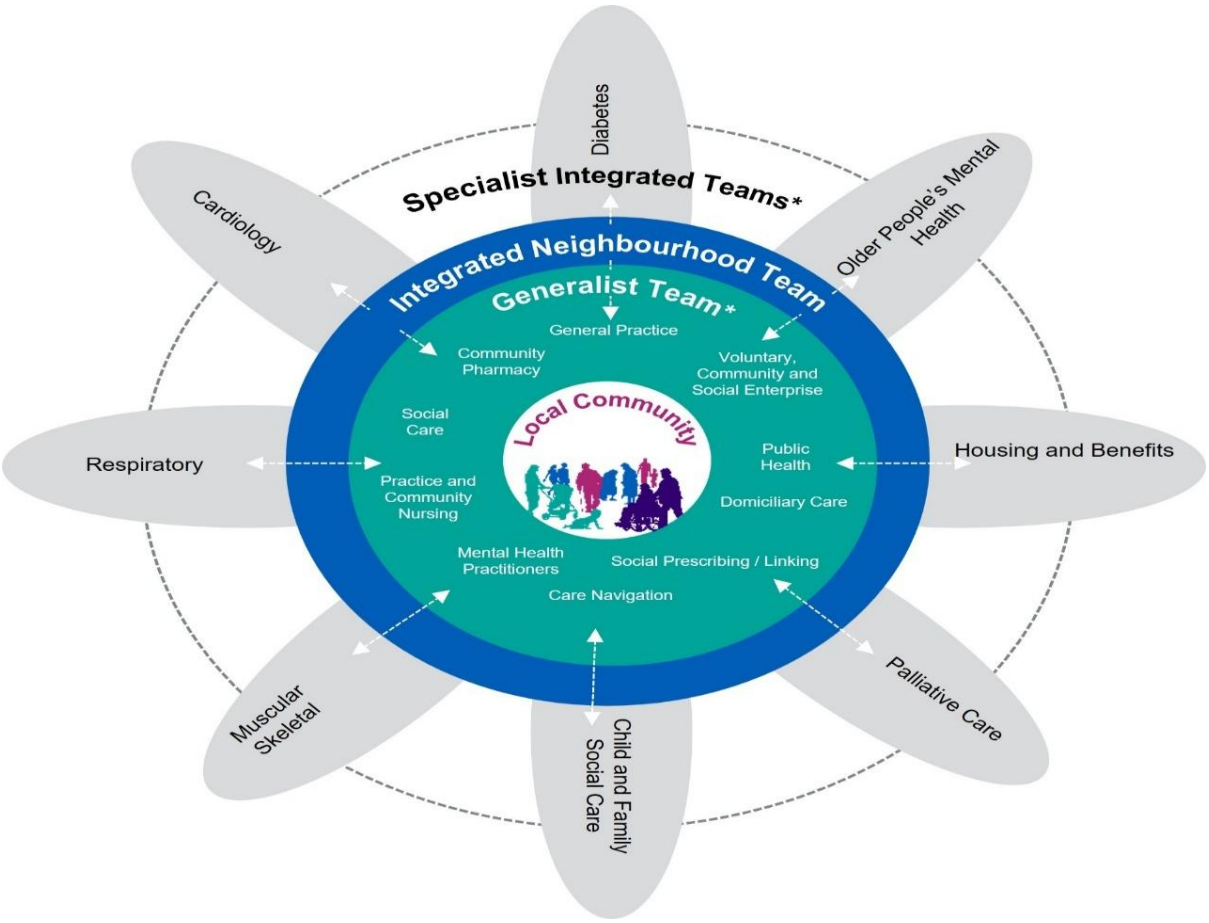

Figure 3 Folkestone and Hythe Neighbourhood Health Vision

The population is segmented and stratified by the Johns Hopkins patient need groups. Patients in high population needs groups 10 and 11 with frailty and complex multimorbidity (roughly 3.7% of their population) start with proactive care including active case finding, comprehensive geriatric assessments,[36] structured medication reviews and advanced care planning all recorded in the Kent and Medway Care Record and visible to all providers. Where required remote monitoring and a responsive service designed to promptly address the escalating or exacerbating needs of patients is the next level of (reactive) care before escalation to a frailty virtual ward, hospital admission or step-up facility if clinically appropriate. All with a single point of access/assessment. Moderate risk needs groups 5-9 comprise 26.5% of their population and include those with a dominant LTC and multimorbidity of medium complexity. The remaining 69.8% of their population are in the low risk needs groups 1-4 and include those with multimorbidity of low complexity. Key

[36] "British Geriatrics Society", Comprehensive Geriatric Assessment (CGA) Hub, accessed February 9, 2026 Comprehensive Geriatric Assessment (CGA) Hub | British Geriatrics Society.

enablers for their model include digital transformation and interoperability and shared records.

Integrated primary and secondary care optimises the management of people with CKD—the LUCID* project

*LUCID is defined as 'Leicester, Leicestershire, and Rutland Chronic Kidney Disease Integrated Care Delivery Project'.[37]

The LUCID programme has demonstrated that an integrated programme of CKD care involving close collaboration between primary and secondary care clinical teams can improve the delivery of evidence-based care for people living with CKD.

Integrated care through neighbourhood teams: addressing gaps in care for people with multiple long-term conditions in South East London

300,000 people in South-East London Integrated Care System (ICS) were known to be living with multiple LTCs.[38] The high prevalence of cardiometabolic disease in the ICS meant that 350,000 people with hypertension, diabetes or both were also at heightened risk of CKD. Care pathways for multiple LTC patients were fragmented with inefficiencies in service coordination, and the ICS had substantial financial challenges with a large system deficit. The ICS developed a multimorbidity model of care to address the significant gaps for people with multiple LTCs, specifically CVRM LTCs, through integrated neighbourhood teams integrating primary, secondary and community services. These teams comprised multi-disciplinary staff with clinical and non-clinical roles working across service boundaries to care for patients within a defined neighbourhood. The model comprised three delivery pillars: Pillar 1- Prevention and targeted testing: community outreach for proactive testing, digital remote testing, point of care testing and review of coded and uncoded patients. Pillar 2- Case management of complex patients in the community: holistic assessments to encourage patient activation; screen for additional social or mental health needs, unblocking barriers to care, referral onto appropriate integrated neighbourhood team members. Pillar 3- Integrated care: renal, diabetes and cardiology consultant input into MDT meetings, as well as multi-speciality pharmacists supporting across the integrated neighbourhood team.

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[37] Major RW et al. Integrated primary and secondary care optimizes the management of people with CKD—the LUCID project. *Clinical Kidney Journal* 18 4 (2025), Integrated primary and secondary care optimizes the management of people with CKD—the LUCID project | Clinical Kidney Journal | Oxford Academic.

[38] NHS England, accessed February 9, 2026, MASTER Case Studies vFINAL (1).pdf.

Benefits included: improved identification of CKD (a 4% rise in the prevalence of CKD in the populations covered); a 6x improvement in blood pressure control; a 14% increase in SGLT2i prescribing for eligible patients; over 2700 uACR tests in previously untested individuals using home uACR tests; reduced outpatient demand for cardiology, nephrology and diabetes by a third; and reduced non-elective admissions by a third. There were also associated improvements in patient and staff satisfaction. 88% of patients would recommend the new service and 81% felt involved in decisions about their care. Importantly there were also improvements in medicines safety even in those with significantly reduced kidney function. Staff reported increased job satisfaction and greater trust in MDT working, 85% felt that the care delivered was more holistic. There were also system benefits from collaboration, resource efficiency and staff upskilling and confidence building.

Care-at-home Pharmacotherapy Services (CAHPS)

House bound patients frequently miss general practice-based chronic disease annual reviews.[39] CAHPS offers pharmacist technician-led domiciliary home visits for those who are house bound and can help address unmet need in a vulnerable, underrepresented patient population and support appropriate management.

Gloves off campaign – reducing unnecessary single use products

At Manchester Foundation Trust (MFT), approximately 78 million non-sterile gloves are used and disposed of annually. In August 2022, the Gloves Off campaign was launched at MFT to highlight the problem related to inappropriate use of non-sterile gloves in patient care. Through 2022/2023, non-sterile glove use at MFT reduced by 14.6% which equates to over 11 million gloves or approximately 40 tonnes of plastic waste.

In terms of reducing the carbon footprint and financial cost of providing healthcare at MFT, the Gloves Off campaign has contributed to a reduction of 286 tonnes of CO2e and a financial saving of £14,000. Whilst this represents a very small part of MFT's carbon footprint, this is a significant saving for one project.[40]

[39] "Springer Nature Link", Calum Lindsay, David Baruffati, Mhairi Mackenzie, David A. Ellis, Michelle Major, Catherine A. O'Donnell, Sharon A. Simpson, Andrea E. Williamson and Geoff Wong, accessed January 30, 2026, Understanding the causes of missingness in primary care: a realist review | BMC Medicine | Springer Nature Link.

[40] NHS England, accessed January 30, 2026, NHS England — North West » Case study – Gloves-Off.

Analogue to digital

CVDPREVENT Audit Tool

CVDPREVENT is a national primary care audit that automatically extracts routinely held GP data covering diagnosis and management of six high-risk conditions that cause stroke, heart attack and dementia (atrial fibrillation, high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia and chronic kidney disease). The data helps highlight gaps, identify inequalities and monitor improvement and impact on inequalities, as well as enabling opportunities for improvement in diagnosis and management of the high-risk conditions for CVD.

CVDACTION smart tool

CVDACTION is an example of a smart data tool based on CVDPREVENT data which can be utilised by GP practices in the prevention of CVD, providing data that help clinicians prioritise care for patients.[41] The tool actively searches GP records, identifying patients who are not on the right preventive therapy, with structured support for teams to adapt workforce and pathways, and act in response to the data. CVDACTION targets 4 high risk conditions - high blood pressure, high cholesterol, diabetes and CKD - together with 4 substantially underused NICE recommended high impact treatments: blood pressure lowering, cholesterol lowering, renin angiotensin system antagonists and SGLT1i. Modelled projected savings over 3 years of implementing CVDACTION across the South East region are £228 million in productivity and £195 million in Health and social care costs (the modelled costs of implementation include use of CVDACTION, structured support for primary care transformation and the increased medication use).

The Buckinghamshire Lipid Optimisation Programme, an innovative data driven approach

This project, based in Buckinghamshire describes a bespoke, innovative and population level search tool that supports clinicians in identifying those patients who would benefit from cholesterol lowering medications.

Using a database that captures the patient information, the search tool initially identifies patients who are suitable candidates for secondary prevention, removing referral errors and ensuring patients are suitable candidates for lipid optimisation.

[41] “Into-Action.Health” Mallender, J. Cattell, J, accessed February 9 (2026) CVDACTION Impact Report | Into-Action.Health.

Digital weight management programme (DWMP)[42]

A digital programme that supports adults living with obesity who have a diagnosis of diabetes and/or hypertension to lose weight. The resource is currently underutilised in the South East and referral pathways require improvement and integration.

Healthier You NHS Diabetes Prevention Programme[43]

Available as a face-to-face group or as a digital service, with patient choice at referral. The digital service for people with non-diabetic hyperglycaemia offers support through use of digital tools such as wearable technologies, apps with access to health coaches, online peer support groups and electronic setting and monitoring of goals.

NHS App

The NHS App provides access to records, test results, appointment booking, and some self-referral pathways (e.g., weight management, smoking cessation). Work is currently underway to overhaul the NHS App to improve patient information, patient choice and control of their own healthcare.[44]

Health Innovation Wessex has several initiatives aimed at optimising uptake of the NHS App and integrating tools like Lifelight[45] (a vital signs tracking system measuring blood pressure, pulse and respiration using the camera built into smartphones and tablets) for remote monitoring.

Currently the NHS App is a mainly transactional tool but has the potential to provide condition-specific nudges aligned with NICE guidelines (e.g., diabetes, hypertension, CKD, obesity), medication optimisation prompts, screening and monitoring reminders, lifestyle support linked to local services and individual risk information using existing EHR data.

[42] NHS England, accessed January 30, 2026, NHS England » The NHS Digital Weight Management Programme.
[43] NHS England, accessed January 30, 2026, NHS England » NHS Diabetes Prevention Programme (NHS DPP).
[44] GOV.UK, accessed January 30, 2026, NHS App overhaul will break down barriers to healthcare and reduce inequalities - GOV.UK.
[45] Lifelight, accessed January 30, 2026, Lifelight.

SPOT CKD project (Screening, Prevention, Outreach, and Treatment for Health Equity)

SPOT CKD project is a UK-based initiative by Boehringer Ingelheim and Health Innovation North East and North Cumbria to improve early diagnosis and management of CKD, especially in deprived areas with higher health risks like diabetes and hypertension, by using digital tools for screening, providing patient education, and supporting healthcare teams for better, more equitable care.[46] There are similar initiatives in Hampshire Isle of Wight where patients with known risk factors, including people with diabetes, hypertension, and those from Black, Asian and minority ethnic backgrounds are encouraged to access kidney health education, speak to their GPs and manage their lifestyle to reduce their risk, promoting early intervention through timely diagnosis.

Treatment to prevention

Pharmacist-led CVRM service

The premise of the initiative was that single disease models of care may have limitations and potential harms for individuals experiencing multimorbidity and associated polypharmacy. Therefore a holistic approach was deemed necessary to address modifiable risk factors, improve survival and quality of life. The study aimed to scope the potential of a GP practice Community Pharmacist-led intervention to optimise CVRM risk factors in CKD stages 3–4 with 255 participants from two general practices in Glasgow, delivered by two experienced GP practice Community Pharmacists between November 2021 until January 2024.[47] Prescribing interventions included initiation and optimisation of lipid lowering and antihypertensive medications, adverse drug effect management and nephrotoxic medicines deprescribing with improvement in risk profiles.

[46] Health Innovation North East and North Cumbria, accessed 30 January, 2026, https://healthinnovationnenc.org.uk/what-we-do/improving-population-health/cardiovascular-disease-prevention/chronic-kidney-disease/screening-prevention-outreach-and-treatment-spot-for-health-equity/.

[47] Ramos T et al. Evaluating a pharmacist-led cardio-renal-metabolic service to reduce healthcare inequities in a socioeconomically deprived population: a prospective intervention study. *International Journal of Clinical Pharmacy*: 47 (2025): 1395-1405. Evaluating a pharmacist-led cardio-renal-metabolic service to reduce healthcare inequities in a socioeconomically deprived population: a prospective intervention study | International Journal of Clinical Pharmacy.

Royal Berkshire, staff health check programme.

A staff health check project at the Royal Berkshire Hospital was introduced, initially inviting eligible staff aged 40 and over via text message to book an appointment with a health advisor. The health check included measurements of weight, blood pressure, point-of-care cholesterol testing, and personalised risk-management advice with signposting to relevant services. Where necessary, a report was sent to the individual's GP to support follow-up.

The offer was later expanded to staff aged 30 and over and incorporated atrial fibrillation detection using a Kardia device. A subsequent pilot project, delivered in partnership with the local authority and supported by combined funding, further expanded the service to local authority staff. Individuals identified as being at increased risk of diabetes are now invited for targeted follow-up interventions.

Health Innovation Oxford - Cholesterol animations and other resources

As part of the national Lipid Management and Familial Hypercholesterolemia (FH) programme, Health Innovation Oxford and Thames Valley, along with North East North Cumbria HIN, NHS England, Spoonful of Sugar, HEART UK and Creative Connection Animation Studio, worked with patients and clinicians to develop a series of animated videos and leaflets.

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board funded and managed the translation of these resources into other languages including Albanian, Arabic, Hindi, Portuguese, Ukrainian and Urdu.

The resources are being shared nationally through the Health Innovation Network which runs a wider programme focused on preventing CVD.[48]

9. Senate Review Panel Discussion Summary

Panel day discussion and key information have been synthesised and presented under the Key Line of Enquiry (KLOE) headings for this review.

The findings of the Senate review panel are structured against the core areas the Senate was requested to focus on as set out in the ToR.

[48] Health Innovation Oxford and Thames Valley, accessed January 30, 2026, Cholesterol animations and other resources - Health Innovation Oxford & Thames Valley.

The review KLOEs covered the following areas:

- Clinical Area
- Digital
- Workforce
- Engagement (clinical workforce and patient and public)
- Health inequalities
- Healthcare sustainability

Clinical Area

To allow representation and contributions from clinical experts on the areas under consideration on panel day the agenda had specific sections for Diabetes, Obesity and Overweight, Chronic Kidney Disease (CKD) and Cardiovascular Disease (CVD).

For the purposes of this report a brief overview of the panel discussion for each area is included here. Integrated recommendations for these clinical areas and the other KLOE areas can be found in the recommendations section (pages 8-13).

Summary: Diabetes, Obesity and Overweight

Key Challenges

- Overweight prevalence is high (nearly two-thirds of the population) and rising.
- Type 2 diabetes increasingly affects younger adults (<40), reducing healthy life years and increasing potentially preventable complications in working age adults.
- 25% of the population over 75 have diabetes mellitus
- Management of Type 1 diabetes frequently remains hospital based rather than in community specialist diabetes services
- Frailty and sarcopenic obesity complicate care, even in younger, especially sedentary, individuals.
- Obesity is a lifelong, complex condition requiring ongoing, multi-modal interventions.
- Stigma and language around obesity remain barriers to engagement and treatment.

Data Capture

- Current data collection is inadequate; BMI is inconsistently recorded and waist circumference hardly ever recorded.

- Quality and outcomes framework (QOF) obesity indicator (OB003) was retired in 2025/26, shifting accountability to population-level monitoring via the Public Health Outcomes Framework (PHOF).
- Data gaps exist for children and young people, limiting service planning and referrals.

Prevention

- Early intervention before obesity develops is critical; lifestyle programs are effective but resource intensive.
- Digital lifestyle interventions, including the 12-week NHS Digital Weight Management Programme, are effective for reducing weight and waist circumference and managing obesity-related conditions like hypertension. They utilise technology such as smartphone apps, wearable trackers, and AI-powered platforms to deliver behavioural coaching, monitor diet and physical activity, and provide social support.
- Focus on healthy living (activity, nutrition) rather than weight loss alone.
- NICE evidence supports school-based and family-involved programs for children.
- Policy measures (e.g., sugar tax) and wrap-around lifestyle support for medication use are essential.
- Prevention should occur at all levels—primary, secondary, and tertiary—to reduce sequelae.

Inequalities

- Healthy eating costs disproportionately impact low-income households.
- Obesity prevalence is higher in deprived areas and among vulnerable groups (learning disabilities, severe mental illness).
- Unequal access to obesity pharmacotherapy such as GLP-1RA drugs; some individuals incur financial hardship to purchase privately; the most deprived are the most overweight and the least able to afford GLP-1RA privately.
- Cardiovascular disease drives excess mortality in people with severe mental illness.
- In the National Diabetes Audit achievement of key care processes and treatment targets for people with diabetes in the South East region is lower in more deprived coastal/urban areas. ICBs that have commissioned and actively promoted digital DESMOND/DAFNE and similar offers see better self-management and downstream target achievement.

Current Approaches

- Behavioural and lifestyle interventions remain foundational but show limited long-term success for those living with obesity.
- Digital weight management and Diabetes Prevention Programmes (DPP) need better integration; AI-led DPP shows promising results.
- Behavioural support for obesity pharmacotherapy such as GLP-1RA prescriptions is limited, with strict access criteria.
- Specialist weight management services (Tier 3 and Tier 4) face significant access hurdles, including bariatric surgery and GLP-1RA availability.

Future Models of Care

- Obesity should be recognised as a long-term condition and embedded in LTC frameworks.
- Adopt population-wide systems such as the Lancet commission's classification to evaluate for overweight/obesity and associated health conditions to better target interventions.
- Shift towards value-based healthcare: equitable, proactive treatment rather than reactive care.
- Improve access to effective treatments (e.g., endoscopic bariatric surgery, metabolic/bariatric surgery, obesity pharmacotherapy such as GLP-1RA/incretin mimetics) and address systemic capacity issues.
- Economic case for upfront investment in obesity treatments to reduce long-term costs.
- Shift specialist diabetes care as much as possible into the community to bring care closer to home.
- Prevention needs to start in childhood, walking, exercise, sport in schools for health not just education.

Summary: Chronic Kidney Disease (CKD)

Key Challenges

- CKD is highly prevalent (>10% of UK population), often underdiagnosed and poorly understood.
- Closely linked with obesity, diabetes, hypertension, and CVD.
- Diagnosis requires GFR and ACR assessment; early stages often missed due to lack of symptoms.
- 1 in 5 patients starting kidney replacement therapy have no prior CKD diagnosis.
- Public awareness is low; coding gaps and fragmented care persist.

Data Capture

- Data recording is inadequate; ACR testing rates are low and inconsistent.
- QOF CKD indicators retired in 2025, shifting care to broader LTC frameworks.
- Coding errors lead to missed opportunities for proactive management.
- Embedding clinical decision support in EHRs could improve identification.

Prevention

- Early identification and intervention are key; opportunistic testing during health checks recommended.
- Lifestyle changes (diet, exercise, smoking cessation) and risk factor control (diabetes, hypertension) can delay progression.
- SGLT2 inhibitors (usually added to ACEi/ARB) now foundational for kidney and cardiovascular protection in CKD, with emerging importance of GLP-1RA in diabetic kidney disease.
- Embedding risk equations such as the Kidney Failure Risk Equation in EHRs directs appropriate referral.

Inequalities

- Testing and diagnosis vary by socioeconomic status, ethnicity, age, and geography.
- Lower-income and minority groups face higher CKD risk but lower testing rates.
- Underuse of ACR testing and poor clinician awareness contribute to late diagnosis.
- Coding inconsistencies and lack of system integration exacerbate disparities.

Current approaches

- Pharmacists and AHPs increasingly support CKD care through polypharmacy reviews and deprescribing.
- Examples of initiatives:
    - LUCID Project: Integrated virtual care model combining education, early identification, medicines optimisation, and multidisciplinary management.
    - Pharmacist-led CKD optimisation: Proactive recall for medication optimisation improved BP, HbA1c, LDL-C, and kidney function.
    - SPOT CKD: Digital screening and education targeting deprived areas and high-risk groups.

    - London Kidney Network: Standardising early detection and treatment, promoting RAS blockade, SGLT2i initiation, and BP control.
- Strong consensus to embed CKD within integrated CVRM pathways for holistic multimorbidity management.

Summary: Cardiovascular disease (CVD)

Key Challenges

- CVD remains the leading cause of morbidity and mortality, with significant regional variation in outcomes.
- Less than half of patients with prior CVD events achieve lipid targets. There is poor public understanding of risk factors and persistent misinformation about statins and lifestyle interventions.
- Systemic barriers include reactive care models, lack of integrated referral pathways, and variation in lipid optimisation and hypertension management.
- Frailty and multimorbidity complicate care; frailty assessments are not routinely embedded.
- Hypertension services are unevenly distributed; specialist pathways and validated training are lacking.

Data Capture

- Commissioning and QOF frameworks remain siloed, hindering integrated CVRM approaches.
- QOF incentivises BP checks but lacks follow-up requirements, leading to untreated patients and incomplete data.
- Exception reporting and poor BMI recording (only 63% nationally; 56% in South East) further limit data quality.
- CVDPREVENT audit highlights gaps in hypertension monitoring, lipid management, and ACR recording.

Prevention

- NHS Health Checks target adults over 40, but uptake is variable (52.6% nationally, ranging from 25–85%).
- Risk factors often develop in early 30s; missed opportunities due to perception of low risk and reluctance to embrace lifestyle changes.
- Early identification and management of risk factors can prevent CVD, dementia, and CKD.

- CVDACTION tool supports proactive prevention by identifying high-risk patients and underused NICE-recommended treatments (BP lowering, cholesterol lowering, RAS antagonists, SGLT2i).
- Modelled savings from CVDACTION implementation: £228M productivity and £195M health/social care costs over 3 years.

Inequalities

- CVD accounts for 20% of the life expectancy gap between most and least deprived communities.
- Premature coronary heart disease mortality is twice as high in deprived groups.
- Sex disparities persist with women 16–20% less likely to undergo coronary angiogram or percutaneous coronary intervention.
- Significant sex differences in time to presentation, and revascularization, with under estimation of risk by patients and by health care workers and an average total mean delay to revascularization in ST-segment elevation myocardial infarction of 30 minutes for women compared with men.[49]
- Guidance and access remain less robust for women compared to men.

Current Approaches

- Emphasis on proactive care, e.g., structured medication reviews in Folkestone, Hythe & Rural PCN to tackle polypharmacy and reduce hospital admissions.
- Innovative outreach such as health checks in places of worship to engage hard-to-reach populations.
- Cardiac rehabilitation programmes exist but face resource constraints, psychological support is under-commissioned despite proven benefits.
- Opportunities for collaboration with third sector organisations (e.g., British Heart Foundation) and improved MDT education.
- Need for integrated “one-stop shop” models for holistic review, data capture, and frailty assessment.
- Frailty considerations:
    - Frailty modifies benefits and risks of treatments (e.g., anticoagulants increase bleeding risk; antihypertensives remain beneficial).
    - Non-pharmacological interventions (chair yoga, functional walking) often more effective in frail patients.

[49] Burgess SN. Understudied, Under-Recognized, Underdiagnosed, and Undertreated: Sex-Based Disparities in Cardiovascular Medicine. *Circ Cardiovasc Interv*.;15 (2022)e011714.

- Individualised treatment based on frailty level can reduce over- and under-treatment, improve outcomes and reduce costs.
- Advanced frailty (40–50% mortality within 12–18 months) requires careful treatment decisions to avoid harm.

Summary: Digital Health

Key Challenges

- Lack of interoperability between GP, hospital, and community care systems hinders seamless data sharing.
- Digital exclusion affects older adults, vulnerable groups, and those without devices or connectivity.
- Governance and safeguarding concerns around AI-driven decision support, patient privacy, and clinical safety.
- Fragmentation of apps and poor integration into the NHS App; usability issues limit adoption despite high download rates.
- Large volumes of data from wearables and remote monitoring require robust triage systems.
- Cultural and language barriers reduce usability; there is a need for multilingual and accessible interfaces.
- Risk of widening health inequalities if digital-first strategies lack assisted routes and community engagement.
- Limited evidence base for cost-effectiveness of digital models; NICE Early Value Assessment (EVA) aims to accelerate evidence generation.

Data Capture

- Potential for huge volumes of data with variable quality; need for actionable, accurate data.
- Governance and accountability for abnormal results from remote monitoring remain unclear.
- Opportunity to integrate patient-generated data (e.g., wearables) into clinical records for better self-care and risk management.

Inequalities

- Digital-only solutions risk excluding those without digital literacy, devices, or connectivity.
- Language and literacy barriers require translation and accessibility features.
- Effective digital use can free up clinician time, but risks must be mitigated to avoid digital exclusion.

Current Approaches

- NHS App provides access to records, test results, appointment booking, and some self-referral pathways (e.g., weight management, smoking cessation).
- Digital Weight Management and Diabetes Prevention Programmes show effectiveness but lack integration and have variable uptake.
- Wearable technology adoption is growing, but it requires investment in two-way data integration and training.
- Innovations and pilots:
    - Health Innovation Network initiatives to optimise NHS App uptake and integrate tools like Lifelight for remote monitoring.
    - Remote monitoring pilots using observation kits and national early warning scoring (NEWS) linked to triage hubs.
    - Digital hypertension management combining self-monitoring with evidence-based guided self-management.
    - Clinical decision support tools embedded in EHRs for all areas (e.g., MetAdvice for lipid optimisation, AI imaging for stroke treatment).
    - EHR alerts to improve uptake of guideline-directed medical therapy (GDMT) in heart failure.
    - Use of EHR tools designed using behavioural science principles to significantly increase rates of deprescribing potentially inappropriate medications used by older adults.

Summary: Workforce

Context

- The NHS has faced workforce challenges since its inception. Today, despite a larger and more diverse workforce, services struggle to fill vacancies and meet the needs of an ageing population with increasing LTC prevalence.
- Without action, shortages of skilled staff will impact patient experience, service capacity, and transformation efforts.

Key Challenges

- Knowledge Gaps: Variability in clinicians' understanding of available services, effectiveness, and appropriate language (e.g., weight management pathways).
- Supervision & Governance: New or extended roles require clear supervision structures, clinical oversight, and immediate access to advice to manage risk.

- Generalists vs Specialists: Tension between need for generalists who can manage diverse cases and specialists for complex care; workforce planning must map competencies to service needs.
- Organisational Constraints: Employer policies may limit flexibility, restricting optimal patient care.
- Integrated Thinking: Need for a blended workforce capable of working across professions and services to deliver integrated care models.
- Indirect vs Direct Workforce:
    - Direct workforce: Those delivering new models of care.
    - Indirect workforce: Wider professionals who need to understand and facilitate access to new services.
    - Both require education and cultural awareness to support role developments and service integration.
- Role Insight & Relationship Building:
    - Limited exposure between hospital and community settings; community placements for trainees have shown positive outcomes.
    - Job descriptions and planning often occur post-appointment rather than pre-recruitment, creating misalignment with service priorities.

Current Approaches

- NHS Long Term Workforce Plan (2023) focuses on three priorities:
    - Train: Expand education, apprenticeships, alternative routes, and new roles to meet changing patient needs.
    - Retain: Support staff throughout careers, enable flexibility, and improve culture and leadership.
    - Reform: Build broader teams, adapt training for future needs, and leverage technology to improve productivity.
- Staff Wellbeing: Organisations provide healthy lifestyle support (e.g., weight management, exercise). The ambition is for the NHS to be the healthiest workforce in the UK, reducing sickness absence.
- Flexible Workforce Models: Examples include Age UK nail-cutting service and expansion of non-medical roles to fill care gaps.
- Upskilling Initiatives:
    - Pharmacists managing polypharmacy and leading hypertension/lipid clinics.
    - Link workers and independent prescribers scaled up (e.g., Folkestone & Hythe Neighbourhood: 1/3 staff are prescribers).
    - Pharmacy technicians triaging dementia patients using cognitive screening tools (6-CIT).

- Integrated Care Models: Shared decision-making combining medical and other healthcare professional expertise; wrap-around care involving social care and carers.
- Culture & Governance: Avoid hierarchical systems; promote shared purpose and co-creation of services. Use clear protocols and shared documentation to support role clarity.
- Community Workforce: Nursing and therapy staff play a key role in proactive and reactive care within neighbourhood health models. Upskilling essential as care shifts from acute to community settings.
- Education & Training: Both direct and indirect workforces need training to support delivery of evidence-based care and embed innovation. Extended workforce models require competence and confidence-building before implementation.

Summary: Engagement

Context

- Engagement is essential before any service change to include voices of patients, carers, staff, clinicians, providers, and local communities.
- Legal duty under NHS Act (Sections 13Q and 14Z) requires public involvement and reducing inequalities.
- Authentic, timely engagement builds trust, co-creates solutions, and strengthens governance.

Key Challenges

- Effective engagement with public and staff is difficult, especially for digital adoption (e.g., NHS App).
- Communication strategies must influence behaviour and be impactful; successful campaigns like Act FAST offer lessons.
- Reaching marginalized and inclusion health groups (carers, homeless, refugees, Gypsy/Roma/Traveller, justice-involved individuals, victims of modern slavery) is challenging.
- Language barriers and lack of health and IT literacy hinder engagement; proactive strategies and ethnicity data collection needed.
- Overcoming fear and mistrust (e.g., scam concerns among people with learning disabilities) is critical.
- Engaging young people and addressing digital barriers (e.g., internet access, data allowance for NHS App) is important.

Current Approaches

- School-based initiatives: Blood pressure education videos for Year 6 students, homework involving families; promoting diet and physical activity (e.g., daily mile runs, multiple PE sessions).
- Community engagement: Health Innovation Network projects fostering pride and inclusion; outreach through charities and street-level engagement.
- Staff engagement: Joint working between community services and hospices; collaboration with voluntary organizations (e.g., Headway for brain injury support).
- Public campaigns: Learning from successful examples (Act FAST, NHS 111) and using media channels; exploring grant funding for engagement.
- Consensus: Early, authentic, creative, and proactive engagement is vital for successful service transformation.

Summary: Health Inequalities

Context

- Health inequalities are unfair, avoidable differences in health across populations and groups.
- Tackling inequalities is central to the NHS 10-Year Health Plan and mandated by law (NHS Act 2006, Public Sector Equality Act 2010).
- New models of care must assess and mitigate inequality impacts.
- Core20PLUS approach targets the most deprived 20% and inclusion health groups.
- The NHS key strategic priorities to address inequalities underpinning the National Healthcare Inequalities Improvement Programme (HiQiP) are:
    1. Restore services inclusively
    2. Mitigate digital exclusion
    3. Ensure complete and timely data
    4. Accelerate prevention programmes
    5. Strengthen leadership and accountability

Key Challenges

- Risk of widening inequalities if new models of care do not address vulnerable groups.
- Incomplete data recording, particularly for ethnicity data, limits ability to identify disparities (e.g., higher diabetes risk in South Asian and Black populations).
- Housebound patients often miss preventative care and annual reviews.

- Need for proactive strategies to reach marginalised and inclusion health groups.

Current Approaches

- Equality and Health Inequalities Impact Assessment (EHIA): Identifies at-risk groups and mitigates disadvantage.
- Health Equity Assessment Tool (HEAT): Systematic assessment of inequalities across programmes.
- NHS Inclusion Health Framework: Guides planning for inclusion health groups.
- Accessible resources in multiple languages and formats:
    - Cholesterol animations and leaflets in various languages.
    - Co-produced resources for people with learning disabilities and carers.

Summary: Sustainability

Key Challenges

- Climate change has a direct impact on the ability of health systems to deliver care effectively and efficiently. Unless acted upon, it will result in higher temperatures, more frequent and more severe incidences of extreme weather, increased air pollution and a higher risk of transmission of illnesses such as dengue and yellow fever.
- Total costs of heat-related mortalities from climate change and related socio-economic change in England have been estimated at approximately £6.8 billion per year in the 2020s, rising to £14.7 billion per year in the 2050s.
- The NHS is responsible for around 4-5% of the country's carbon footprint and approximately 30%-40% of all public sector emissions.

Current Approaches

- Nationally, Getting It Right First Time's recommendations for decarbonising care pathways – such as one-stop clinics and reducing equipment waste – demonstrate how making care more sustainable can simultaneously improve patients' experience, improve efficiency and productivity and lowering health system costs.[50]
- Making the NHS more environmentally sustainable could not only deliver progress on the government's health mission but also on other cross-sector commitments. It supports the move to decarbonise the economy by 2050,

[50] NHS England, accessed January 30, 2026, greener Archives - Getting It Right First Time - GIRFT.

improve energy security, become a world leader in technology and innovation, and boost growth.

10. Conclusion

Early detection and management of the linked LTCs contributing to CVRM in primary and community care is essential to reduce the risk of multimorbidity. Collaboration between the multiprofessional team, including specialist providers and primary care, with excellent communication is key. Facilitating such team-based care in integrated models has already been shown in the best practice examples to improve control of CVRM risk factors in people with multiple LTCs.

Within the South East region substantial health inequalities exist and the earlier emergence of CVRM LTCs in deprived populations, our coastal communities and certain ethnic minorities drive the differences in HLE, LE and quality of life across the region. This is compounded by our current system of silo management in single disease models. Transforming our models of care into integrated neighbourhood health models that can cross organisational boundaries when required will aid management of complexity, improve inefficiencies, reduce polypharmacy risks and improve suboptimal patient outcomes. Fulfilling the principles of value based healthcare.

Digital health solutions and harnessing workforce competencies and skills will help management of linked CVRM conditions in a tiered fashion that utilises patient self-management all the way through to the more specialised requirements of complex multiple LTCs. The recommendations from this review are intended to help achieve the required transformative changes and deliver the desired shifts from hospital to community, analogue to digital and treatment to prevention. In turn reducing the overall burden on the health and social care system and reducing the requirement for higher consultation rates and hospital admission.

Clinical Senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the background material and evidence shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to improve the quality of care and access to that care for the population of the South East region.

Appendix A – South East Clinical Senate Review Group membership for Expert Panel Review day

Name	Roles
Catherine Alber	Public Health Registrar, NHS England South East
Lorraine Albon	Consultant Physician, Western Sussex Hospitals Foundation Trust, Lead Bariatric Physician, BOMSS member
Raj Bajwa	GP and Clinical lead for research and innovation in Buckinghamshire, Oxfordshire and Berkshire
Aravinth Balachandran	GP Partner Oaklands Health Centre Clinical Director Folkestone, Hythe & Rural PCN
Nigel Beckett	Consultant Physician in Ageing and Health & General Internal Medicine, Guys and St Thomas' NHS Foundation Trust
Sara Bolton	Chief Allied Health Professions Officer Medical Directorate, NHS England South East
Tim Caroe	MD Primary Care Transformation NHS England South East
Jugdeep Dhesi	President, British Geriatrics Society, Deputy Director, Centre for Perioperative Care, Professor of Geriatric Medicine, Consultant Geriatrician, Guy's and St Thomas' NHS Foundation Trust
Tim Elwell-Sutton	Deputy Regional Director of Public Health, South East OHID, DHSC and NHSE
Pete Green	GP, CVDPREVENT Workstream Clinical Lead, NHS Benchmarking Network and Chair of HEART UK - The Cholesterol Charity
Ruchika Gupta	Deputy CMO Surrey Heartlands
Anita Harrington	Patient and Public member
Pat Haye	Deputy Director Clinical Strategy Regional Medical Directorate, NHS England South East
Katie Lean	Senior Programme Manager – Community Involvement and Workforce Innovation, Health Innovation Oxford
Richard Leigh	Consultant Podiatrist, Royal Free London NHS Foundation Trust Chair English Diabetes Footcare Network Member of the London Clinical Senate Council
David Lipscomb	Consultant in Diabetes, Medical Head of Service Adult Specialist Care SCFT, Course Lead for Diabetes in Primary Care BSMS
Amanda Lyons	Director of System Co-ordination and Transformational Improvement NHS England South East
Rupert Major	Consultant Nephrologist at University Hospitals of Leicester Honorary Associate Professor in the kidney group of cardiovascular science University of Leicester
Sarah Markham	Patient and Public Partner
Andrew McLaren	Consultant Surgeon, CMO Buckinghamshire Healthcare Trust
Helen Muir	Senior Clinical Lead – Cardiac Rehabilitation Service
Kiruba Nagaratnam	Consultant Stroke Physician, Royal Berkshire NHS Foundation Trust
Claire Norfolk	Head of Long Term Conditions, RGN Frimley Health and Care ICS

Temitope Odetunde	Head of Medicines Management / NMP Lead, Caterham Dene Hospital, First Community Health and Care
Patience Okorie	GP and Clinical Director Children and Maternity Services/ Population Health , NHS Sussex
Nikhil Patel	Consultant Cardiologist and Cardiovascular Lead East Sussex Healthcare NHS Trust
Richard Quirk	Acting Chief Medical Officer SECAmb
Alexandra Reece	Patient and Public member Stroke survivor's elder daughter and communication partner
Tania Ramos	Senior Clinical Pharmacist, Pharmacy Services, Glasgow City Health and Social Care Partnership (North East Locality), NHS Greater Glasgow and Clyde, Glasgow
Piya Sengupta	Consultant in diabetes, endocrinology (and obesity), Guy's and St Thomas' NHS Foundation Trust
Mohit Sharma	Consultant in Public health, NHS England South East
Nisha Sharma	Head of Regional Public Health Programmes Public Health Directorate, NHS England, South East Region
Chris Warwick	Primary Care Dean, Deputy Postgraduate Dean & Delegated Responsible Officer, Kent, Surrey & Sussex
Emma Wilton	Workforce Redesign and Innovation Lead Workforce, Training & Education Directorate. NHS England South East
Saloni Zaveri	Consultant in Healthcare Public Health, NHS England, South East
Senate Management Team	Paul Stevens, Chair of South East Clinical Senate Sally Smith, Vice Chair of South East Clinical Senate Emily Steward, Head of South East Clinical Senate

South East Clinical Senate Review Group membership (Desktop Reviewers)

Name	Roles
Hatim Abdulussein	GP and Medical Director, Health Innovation Kent, Surrey, Sussex
Bruce Allan	Clinical Director Primary Care Sussex
Chris Arden	GPSI Cardiology, Mid-Hampshire & Southampton, Director & Council Member Primary Care Cardiovascular Society, GP Chandlers Ford
Geoff Berg	Assistant Director, Integrated Neighbourhood Pathway Development
Nicola Bent	CEO, Health Innovation Wessex
Lea Dehaney	Patient and Public member
David Hargroves	Consultant Stroke Physician/ National Clinical Director for Stroke Medicine – NHS England
Jessie Frost	Senior Net Zero Delivery Manager, Greener NHS National Programme NHSE
Will Herrington	Professor of Trials and Epidemiology of Kidney Disease, Kidney Studies Group, University of Oxford
Rachel Howard	Deputy Chief Pharmacist, NHS Hampshire and Isle of Wight
Lalitha Iyer	CMO Frimley ICB
Sarah Phillips	CMO Kent Community Health NHS Trust
Jade Stacey	NICE implementation consultant (London and South East)
Sarah Steely	GP and Shadow Director of PCN for Care Collaborative. Clinical Lead for Diabetes at Surrey Heartlands Integrated Care System

Appendix B – Key Lines of Enquiry (KLOEs)

Clinical Area

- What are the future needs to address within your clinical area?
- Can you identify any examples of specific services within your clinical area that would be impacted by a change in delivery model by one of the three shifts (hospital to community, analogue to digital, treatment to prevention).
- How would you integrate management of other components of cardiovascular kidney metabolic syndrome with your clinical area?
- How would the potential new model of care be structured?
- How will the potential new model align with one or more of the three shifts?
- How do the proposed new models of care support improvement in health outcomes?
- What are the potential benefits of implementing the new models of care described above?
- What are the potential risks of implementing the new models of care described above?
- Any gaps or other feedback?

Digital

- What are the opportunities for digital innovations for patients and clinicians?
- How will digital technology be used to impact self-management?
- What is the consideration for digital clinical information sharing for identified models of care and alignment of the digital strategies
- What are the anticipated benefits of identified digital models of care?
- What are the barriers to use of digital innovations?
- What are the perceived risks of identified digital models of care?
- How could digital tools both enable and deliver care in this setting?
- Any gaps or other feedback?

Workforce

- What changes in workforce would be required to deliver the proposed changes in the services?
- Is there currently capacity within the clinical area to deliver this?
- Based on the changes in workforce we may identify – what training and education developments would be required to deliver the new workforce?
- Based on the above responses – how do we engage and involve educational establishments and ensure they feel able to co-create with the changes?
- Any gaps or other feedback?

Engagement

- Are there special considerations for engagement about the changes in service delivery with patients?
- Are there special considerations for engagement about the changes in service delivery with staff?

- What are the opportunities for patient self-management?
- How can we maximise patient self-management?
- How might we better engage the inclusion health populations?
- What are the opportunities for working with voluntary sector colleagues?
- Any gaps or other feedback?

Health inequalities

- How do the proposed new models of care address healthcare inequalities including those identified in the Core20Plus5 framework?
- Are the proposed new models of care consistent with patient need and patient choice? Are there any inequities to consider?
- What health inequalities need to be addressed to ensure access and quality outcomes for the most vulnerable?
- What is the potential positive impact on health inequalities and how might this be maximised?
- Any other gaps or other feedback?

Healthcare Sustainability

- What should be considered when developing the shifts to new models of care in terms of healthcare sustainability?
- Any gaps or other feedback?

Strategic

- How can the strategic direction for these changes be enabled regionally, within ICBs and within providers?
- What systems (structures and processes) applied consistently will enable deployment of new models of care?
- What systems (structures and processes) applied consistently will enable quality improvement and identification of waste?
- How can care be shifted from high-cost interventions to low-cost interventions?
- What current good practice should be scaled up to achieve these aims?
- How can resources be allocated from high cost interventions to low cost interventions while maintaining quality of care?
- How should new models of care be evaluated?
- Is there relevant system learning from the COVID-19 pandemic to be taken into account as part of the plans?
- Any gaps or other feedback

Appendix C – Agenda for Panel Day

Item	Time	Item
1.	10:00	Welcome and introductions
2.	10:10	Clinical KLOEs (Diabetes, Obesity and Overweight)
	11:30	**Comfort Break**
3.	11:40	Clinical KLOEs (Chronic Kidney Disease)
4.	12:20	Clinical KLOEs (Cardiovascular Disease)
5.	13:00	Clinical KLOEs (Overview)
	13:30	**Lunch**
6.	14:00	Workforce KLOEs
7.	14:50	Digital KLOEs
8.	15:20	Strategic KLOEs (shift to prevention and shift to community)
	16:10	**Comfort Break**
9.	16:20	Recommendations
10.	16:50	Chair's summary
	17:00	**Meeting Close**