South London Achievements So Far

NHS South London Office of Specialised Services

BLOOD BORNE VIRUSES

All South London ICBs provide emergency department testing for blood borne viruses (BBV), conducting **4.6 million tests** and reaching communities that typically do not use traditional testing methods.

HIV
750 people newly diagnosed
519 people previously diagnosed, who can now be re-engaged in care

HEPATITIS B
3,600 people newly diagnosed

HEPATITIS C
1,040 people newly diagnosed

Treatment and management will reduce the risk of liver cancer and cirrhosis

"I think that there are still misconceptions around people living with HIV in this country. Early diagnosis is really key to living well and now having been on HIV treatment, I live a full life and am able to enjoy all the things I love."

System benefits of diagnosis and re-engagement

Keeping people living with HIV healthy and reducing the likelihood of onward transmission provides an estimated

system benefit of £220,000 per person

(£140,000 of cost avoided through treatment plus £80,000 avoided by reduced onward transmission).

In Croydon, newly diagnosed HIV positive patients and partner notification / testing have **reduced hospital stays from 35 to less than 3 days** (on avg), and **avoided 23 onward transmissions** -- **saving £1.84M**.

SICKLE CELL DISORDER

The London Sickle Cell Improvement Programme is ensuring that people with sickle cell receive optimal and integrated care in every setting.

Emergency department bypass
Providing rapid access to specialist sickle cell care for patients in crisis
79 patients were seen in just ONE ED bypass unit -- in just ONE month (August 2024)

Enhanced community services
Tailored local approach by ICBs for an enhanced community model of care, with more nurses and specialist access (dieticians, psychologists, pharmacists, physiotherapists)
530+ patients used the new community services in just 1 month! (face to face and virtually)

Peer support for young people
Lived experience sharing and signposting by those with sickle cell
178 mentees linked with **22** mentors, **5** lead mentors, and **5** clinical leads

Universal care plan
Extending the digital care record to all settings of care
5,540 London sickle cell records uploaded to the digital UCP
92.3% of all people with sickle cell in the capital

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NEUROSCIENCES

Leveraging a data-led, population health approach, we are **integrating neurology care across two regions** as a national pilot for **better patient outcomes, access, and experience, closer to home**.

A networked approach with system-wide pilot roles for complex case management and support which is generating significant returns on investment for South West London and Surrey Heartlands ICBs.

Functional neurological disorder (FND) impairs nervous system function and is the second most common reason for neurology consultations after headaches.

FND care advisor

In 6 months, the FND care advisor achieved:

- **110** community referrals
- **416** patient related actions
- **£14K** ONE case saved in inpatient tariff costs (high value example)

Motor neurone disease (MND) leads to nerve cell degeneration, resulting in muscle paralysis, and eventually affects swallowing and breathing.

MND care advisor

In 7 months, the MND care advisor achieved:

- **3** avoided admissions
- **110** community referrals
- **£113K** ONE case saved in inpatient tariff costs, with LOS reduced by **70 days** (high value example)

Myasthenia gravis is a rare condition where abnormal antibody production causes fluctuating muscle weakness, slurred speech and swallowing problems.

Myasthenia gravis CNS

In 7 months, the certified nursing specialist (CNS) achieved:

- **33** patients on steroid therapy
- **76** MG patients with special nursing care
- **£11K** ONE CASE saved in inpatient tariff costs through early intervention and avoided admission (high value example)

RENAL

South London ICBs are creating customised strategies for cardiometabolic conditions, offering comprehensive treatment and efficient care, while also addressing integration of care at acute sites.

"The colleague who I saw today explained everything and how to move forward with my multi-health problems. Unexpected, she also followed up to see how I was feeling and managing with my medicine."

CKD prevention and screening

SEL

7 Integrated neighborhood teams

- Bexley
- Bromley
- Greenwich
- Lambeth
- Lewisham
- N Southwark
- S Southwark

SWL

6 Place based teams

- Croydon
- Kingston and Richmond
- Merton and Wandsworth
- Sutton

350 patients seen in complex case management clinics

112 GP practices have launched the pilot

Management in the community

- Holistic patient assessments
- Coproduced care plans
- MDT-led reviews and project-led clinics
- Education and training
- Community engagement

Integrated acute care

- Renal-cardiometabolic MDTs
- Supportive care
- Complex discharge

"A really person-to-person experience with health professionals giving me an ear, ready and willing to listen to my health concerns. I am truly grateful and pleased."