Complex long term conditions service in North Central London

Early Learning from the Development and Pilot Phase

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Acknowledgements

This report was written by Kate Cheema, Megan Morgan, and Sara Sekelj.

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How to read this report

This report presents findings from an evaluation undertaken while the Complex Long Term Conditions Service (CLTCS) was still in the early stages of its development. The data collected reflects activity, processes and outcomes at a particular point in time, and it is important to note that the service has continued to evolve since the period in which data was collected. Readers should therefore interpret the findings within this developmental context: they are not an assessment of the current or future form of the service, but an account of its functioning and impact during an early implementation phase.

As the CLTCS was rapidly adapting and iterating at the time of collection and analysis, this report includes learning points, emerging insights and modelled outcomes that are indicative rather than definitive. These are intended to support ongoing refinement, inform decision-making, and highlight areas of promise or challenge that were visible at the time. While the evaluation aims to provide a robust and balanced assessment, the dynamic nature of the service means that some processes, structures, and outcomes described here may have since changed, sometimes substantially.

To aid interpretation, readers should view this report as part of a broader learning journey rather than a summative assessment. The insights presented are most useful when considered alongside local operational knowledge, subsequent service developments, and the wider system context in which the service operates.

This report should also be understood as a time-bound account based on the evidence available to the evaluation team during the development and pilot phase. The evaluation team has sought to analyse those data in a robust, objective and representative way; however, the findings can only reflect what participants reported to evaluators and are unlikely to encompass the full range of perspectives and experiences associated with the service.

Summary

The Complex Long Term Conditions Service (CLTCS) was created to address fragmented care for patients with long-term conditions, who account for a significant proportion of healthcare expenditure. The service model involves multidisciplinary collaboration between primary and secondary care, supported by community links and holistic care principles. It is based on three phases: identification of appropriate patients for the service; multidisciplinary team (MDT) meetings to assess needs and plan activities; mobilisation to ensure changes are made to improve care.

UCLPartners have conducted a mixed methods evaluation across four Primary Care Networks (PCNs) in North Central London (NCL) who participated in the initial phase of the service implementation. Data sources for evidence used in the evaluation included 21 stakeholder interviews, service activity metrics, and pathway mapping. Data was gathered up to July 2025 and this report reflects findings at that point, where the service was in an ongoing development process.

Key findings

Overview of the service

The CLTCS has identified a cohort of patients who have a disproportionate impact on health service use. In the 18 months prior to review in the CLTCS, this relatively small number of patients had a large number of appointments, prescribed medications, emergency department visits, and inpatient stays. During the evaluation period, 318 patients were identified for desktop review across 4 PCNs. Of these, 261 were discussed at MDTs. Patients commonly presented with multiple overlapping conditions, particularly hypertension, diabetes, and chronic kidney disease. Coordinator support was essential to service delivery, though staff raised concerns about time demands and IT access. Electronic Patient Record (EPR) systems lacked interoperability, requiring manual review of clinic letters and hindering MDT preparation.

There was variation in the way of working across pilot PCNs, with some PCNs nominating a single representative and others operating at practice level with representatives from multiple practices. Regardless of the way of working across a PCN, staff members highlighted the importance of the programme focusing on staff wellbeing, including safeguarding processes, and embedding a process of checking-in with MDT staff, providing learning opportunities, and having an active feedback system.

Service impact

Between December 2024 and June 2025, 26 MDTs were held, with an average of 12 patients per meeting, resulting in 28 mobilisation actions per meeting. As a result of the MDT discussion, 31% of patients had inappropriate appointments recorded, 17% had appointments or diagnostics cancelled, and 16% had follow-up appointments coordinated. Coordinating appointments included changing the order of appointments, removing duplicate appointments, and scheduling tests that are necessary prior to an appointment. Half of the patients were referred to new services (predominantly community services), most commonly weight management and smoking cessation. Nine patients were discussed at MDTs with no resulting actions.

Effective team communication and teamwork in the project was seen as extremely positive. Staff identified several potential benefits of the service, including: reducing the administrative burden by resolving patient pathway blockers; introducing expert input for complex cases; enabling holistic care beyond single-specialty management; and proactively identifying patients who ‘fall through the cracks’ in care services. Improved collaboration between primary and secondary care was also identified as a key benefit, with an increased understanding of processes and opportunities for learning.   Later analysis work, not included in the scope of this evaluation, also found benefit in relation to treatment to target.

The current model is delivered by administrative and clinical coordinators, Consultants and primary care representation from GPs, practice nurses or pharmacists. There was significant variation of views among staff regarding this way of working, in relation to the input and support from both secondary and primary care.-Some consultant and primary care colleagues described elements of the coordination function as relating to administrative or routine follow-up tasks, which required appropriate clinical oversight but were not necessarily viewed as requiring direct Consultant leadership in every case.

Patient engagement

Staff members supporting the programme reflected that the engagement appears to stay low among patients who routinely miss appointments. Further engagement with the Advisory Group, which consists of people with lived experience of LTCs, could explore the drivers of this. Staff suggested exploring options to include the patients' voices are part of the programme, including the options of inviting patients to MDTs, to involve them in decision-making. This may not be an entirely practical suggestion and shows a balance to be struck between earlier patient involvement in the pathway, with its potential benefits for anticipatory support, and the practical implications this had for the efficiency and resource intensity of the intervention.

Recommendations

For any future implementation of the service, one focus should be sustaining coordinator support and integrating mental health support to MDTs. Exploring a neighbourhood-level caseload model may be beneficial to support effective follow-up of patients who are being reviewed as a part of this service. To resolve some of the barriers to implementation, onboarding materials should be developed and key learnings should be shared across all PCNs in NCL.

Continued engagement with the Advisory Group is essential to understand patient priorities and barriers to care. Including patients in MDT discussions should be explored as a way to support engagement and fully address patients' needs. Along with technology improvements, data collection processes should be reviewed in light of these evaluation findings, to support follow-up planning, standardised timeframes and outcome metrics. Once confirmed, a detailed health economics analysis should be performed to fully understand the cost consequences of implementing and scaling up the CLTCS pathway. Finally, communication with other care providers across NCL should be increased to promote visibility and system-wide engagement.

Background

It is estimated that approximately 70% of healthcare spend is on managing patients with long term conditions (LTCs). In addition, patients with LTCs and co-morbidities often experience fragmented and inefficiently co-ordinated care. By tackling these issues, there is a significant opportunity to improve patient experience and outcomes.

The Complex Long Term Conditions Service (CLTCS) is a programme designed by the North Central London Health Alliance (NCL HA) to address this. The programme is testing new models of care in order to improve the management of LTCs, which should lead to benefits including fewer appointments, better decision making and easier access to services for these patients.

The CLTCS is being delivered as a partnership between primary and secondary care, with administrative and clinical coordination provided by NCL HA. The CLTCS process is based on the identification of complex patients with long-term conditions, who may benefit from better coordinated care, and the review of these patients in a multi-disciplinary team (MDT) meeting.

Out of all people registered with a GP, the CLTCS focuses on those people in scope of the the Long Term Conditions Locally Commissioned Service (LTC LCS). The LTC LCS is an enhanced service providing a consistent and holistic approach to the delivery of proactive, personalised care and support for people with long term conditions. The LTC LCS also aims to deliver better use of system resources by supporting a shift toward prevention and early intervention for conditions which are in scope of the service.

The pathway for patients in the CLTCS has three distinct phases:

- **Identification** of appropriate patients for the CLTCS
- **Multidisciplinary Team Meeting** (MDT) to assess needs and plan activities
- **Mobilisation** to ensure changes are made to improve care

The Identification phase identifies and reviews patients that might be eligible for the service and might benefit from an MDT review. In this phase the team takes into account both the LTC LCS list, and the high intensity service users across NCL, which incorporates A&E visits, outpatient, community and mental health appointments, and inpatient stays. The combination of information from these two sources forms the long list of patients eligible for a desktop review. This longlist is then further refined by age; number of long-term conditions; medications; BMI and smoking status.

The MDT meetings involve a range of clinicians who can undertake a comprehensive review of patients' needs and instigate actions to improve care. The Mobilisation phase covers all activities arising as a result of a patient being reviewed in the MDT, including, for example, making referrals, medication changes and communication with patients, as appropriate.

Key principles of this approach include strong links to community services, a holistic approach to care and a long-term conditions team with both specialist and generalist skills sets. The key staff roles involved in this service are:

- Administrative coordinator (Band 5)
- Clinical coordinator (Band 8a)
- Consultants
- GPs/Pharmacists, as representatives of primary care

The administrative coordinators are involved in the beginning and end of the process: they gather the information on patients and put them on the lists for review at MDTs, they then follow up the patients post-MDT. The clinical coordinators provide the links with consultants and they attend the MDTs.

To support this new programme, the Evaluation and Insights team in UCLPartners have designed and delivered a mixed methods evaluation of the CLTCS programme. This document reports on the evaluation of the CLTCS undertaken during an early phase of its implementation. At the point of data collection, the programme was being delivered across four pilot primary care networks (PCNs) in North Central London (NCL):

- South Islington
- Welbourne
- Kentish Town Central
- Enfield Care Network

The CLTCS was designed over a period of around six months and went 'live' (meaning here that the first MDT meeting was held in a PCN) in December 2024. The four PCNs joined the programme at different times, with the final PCN included in this evaluation joining in April 2025.

Inclusion criteria

Eligible patients for the CLTCS need to meet the following criteria:

- Adults (aged 18 or over) who are registered with an NCL GP
- Who have a diagnosis of more than one of the health conditions in the scope of the NCL LTC LCS[1]:
- Who have other complexities, either physical and/or mental health co-morbidities or complex biopsychosocial needs[2]
- OR who are accessing secondary care across multiple specialties

Exclusion criteria

Exclusion criteria for CLTCS are as follows:

- Patients under 18 years of age and over 90 years of age
- Patients not registered with an NCL GP
- Patients who have withdrawn consent for record sharing

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[1] The following conditions are in scope of LTC LCS: Cardiovascular Disease (CVD), covering Ischaemic Heart Disease (IHD), Stroke, TIA, Peripheral Artery Disease (PAD) Heart Failure (HF); Atrial Fibrillation (AF); Hypertension (note that those with Hypertension only whose blood pressure is well controlled are not in scope); Diabetes (Type 2); Diabetes (Type 1); Chronic Kidney Disease (CKD); Non-Alcoholic Fatty Liver Disease (NAFLD); Chronic Obstructive Pulmonary Disease (COPD); Asthma – Adults and Childhood (note that adults with Asthma only who are well controlled are not in scope)

[2] The CLTCS team review clinical details for each patient and decide whether their needs meet the criteria for inclusion for the CLTCS programme

Our approach

Evaluation aim and objectives

The overall purpose of this phase of evaluation is to understand the impact of the complex long-term conditions service pilot in supporting the management of, and improving outcomes for, people living with complex long-term conditions. The evaluation established an aim and a set of questions that are of interest in the context of the pilot (note that, at this stage in the development of the CLTCS, it is not feasible to measure impacts on health outcomes):

1. Staff acceptability
    a. What are the CLTCS staff (coordinators, secondary care clinicians and wider team) perceptions and experiences of the service?
    b. What are the staffing requirements needed to operate this service?
2. Healthcare service utilisation
    a. How has the CLTC service changed the patient pathway?
    b. What additional needs have been identified for this cohort of patients by this service?
    c. Has the CLTC service reduced low-value appointments for eligible patients?
3. Health and wellbeing changes
    a. For relevant long term conditions, is there an increase in number of people treated to target at pilot PCN sites compared to baseline?
    b. Is there an increase in number of people taking up preventative offers at pilot PCN sites compared to baseline?
4. Conditions for implementation
    a. What are the key factors that facilitate or hinder the implementation and scale-up of the CLTC service?
    b. What are the primary care, secondary care, mental health care and community care staff perceptions of future implementation and scale-up of the service?
5. System impact
    a. What is the impact of the CLTC service on understanding of the patient pathway from a primary care perspective?
    b. How has the CLTC service contributed to streamlining patient care for this cohort?

This report summarises the progress made during the early, establishment phase of this programme. Data collection took place up until July 2025, giving a maximum of 6-months' data for the earliest joining PCNs. This document presents the findings and learning from the evaluation activities to that point, and it sets out recommendations for further implementation and scale up of this service.

Logic model

To support the evaluation approach, a logic model was developed, to explore what outcomes are important to stakeholders and what activities will be taking place as a part of this pilot programme. The logic model was developed through work with the team form NCL HA who were developing the programme, and external stakeholders including clinical leads and primary care leads.

A logic model in an evaluative context serves as a visual tool to clarify the relationships between resources, activities, outputs, and desired outcomes of a programme. It helps evaluators systematically assess whether program activities lead to the intended results and identify potential areas for improvement. By mapping out these connections, it supports effective planning, monitoring, and evaluation, ensuring alignment between programme goals and outcomes and the final logic model serves as a basis for developing the evaluation framework (Figure 1).

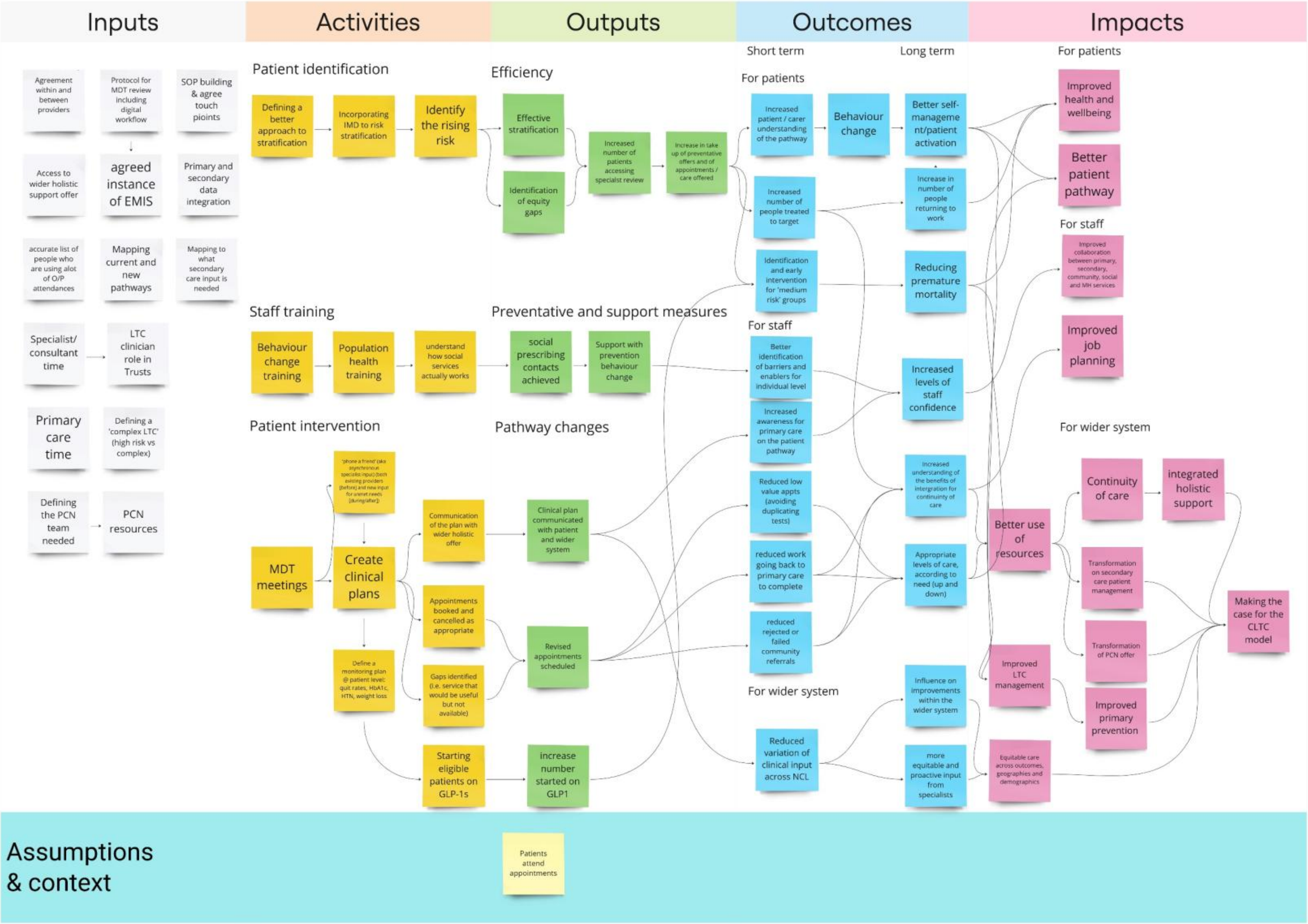

*Figure 1: Agreed logic model for the Complex Long Term Conditions Service (full version available **here**)*

Patient and public involvement and engagement

UCLPartners is committed to meaningful patient and public involvement and engagement (PPIE). To support the development of this service, NCL HA engaged with an Advisory Group of people with lived experience of LTCs across NCL. This group was established to provide advice, guidance, and share their experiences of receiving care.

The team from NCL HA undertook work with the PPIE team in UCLPartners as part of the establishment of the project. Three meetings were held in person with the Advisory Group and the outputs from these were shared with PPIE team. On the basis of this, the spotlight presented below was prepared, drawing out the main experiences and concerns of patients and their carers. A fuller account of the feedback form the Advisory Group can be found at Appendix 4.

This evaluation did not explore patient acceptability of or satisfaction with the CLTCS service. Whilst this is a priority area for both UCLP and the CLTCS team, patients will not be aware their care is being reviewed as a part of this programme unless there is a need to gather more from them, or if the discussion results in significant changes to their appointments. If these changes are identified in an MDT, contact is made with the patient to discuss any proposals and establish priorities in line with the MDT discussions. Once changes to care have been implemented, the patient is informed of them by either their GP or one of the coordinators working in the CLTCS programme.

After careful consideration, together with NCL HA, it was decided not to include patient satisfaction as a part of this evaluation, as it would not reflect experience of this service at this point in time. Instead, we have highlighted key findings from engagement with the Advisory Group and included reference to indirect feedback given to clinicians in this report. In addition, a case study was created by the CLTCS team, illustrating an example of how the programme can improve a patient's journey and this is presented below.

Please note, all personal details in the case study below have been removed and replaced with a pseudo name, age and area of residence.

Paul is a 67-year-old man living in Islington with severe osteoarthritis. He also has a background of asthma, hypertension, hypercholesterolaemia and non-alcoholic fatty liver disease. He is a current smoker with a BMI of 35. He was referred by his GP for a total knee replacement, however this had to be postponed because he was experiencing occasional chest pains and was deemed to be high risk at his pre-assessment. He was advised that his GP needed to refer him to cardiology for investigation prior to the surgery. His knee pain was significantly affecting his quality of life, he found exercising difficult and had to take early retirement as he felt he could not continue working.

The wait to see cardiology was 4 months. The Complex Long Term Conditions team liaised directly with the cardiology and orthopaedics teams, to arrange a myocardial perfusion scan followed by a coronary angiogram. His medications were optimised pre-operatively. He was also contacted by the clinical coordinator and offered a referral to local weight loss services and smoking cessation support, to further improve his cardiovascular risk factors, and enable him to proceed with *the planned surgery. Expediting the necessary diagnostic tests enabled him to progress to surgery 3 months earlier than planned, so that the knee pain that was severely affecting his quality of life could be addressed, also saving an outpatient cardiology appointment.*

Spotlight: Engaging with patients and members of the public

Communication between NHS departments

Poor communication between NHS departments was the most frequently raised issue. Interviewees described how repeated explanations, missing information, and lack of coordination added unnecessary work and frustration for carers, patients, and professionals. Better collaboration and information sharing are essential to improving efficiency and patient outcomes.

Patient-centred care and individual needs

Participants stressed that care must reflect individual needs rather than treating patients as one group. Access to information and personalised support were seen as key to delivering effective, compassionate care, especially for those who are often overlooked.

Carer involvement and support

Carers face heavy demands and said that disconnected healthcare systems increase their burden. They valued being included in programmes and decisions, which helped them feel supported and reduced pressure. Involving carers improves both their experience and the overall coordination of care.

Access to and management of appointments

Delayed or cancelled appointments, long waiting lists, and lack of follow-up were common concerns. Interviewees saw early referrals and better scheduling as essential for avoiding emergencies and improving patient care. Effective appointment management is vital to achieving timely and equitable treatment.

Transparency and oversight in patient diagnosis and records

Gaps in assessments and communication created doubts and reduced patient confidence in diagnoses but coordinated access to records helped improve understanding. Greater transparency and oversight can build trust and ensure patients feel informed and supported in their **care.**

Evaluation design

The evaluation used a mixed methods approach, with quantitative and qualitative data collected and analysed to address the evaluation objectives. The data collection and analyses are specified in the following sub-sections.

Qualitative data collection and analysis

Learning log

To support capturing and sharing formative insights arising from programme meetings, we created a Learning Log, an online tool accessible to all members of the team. The learning log is a live, accessible document enabling stakeholders to track, reflect and act on findings. Notes and insights arising from programme meetings and other engagements, such as the learning event, were thematically analysed and updated on the learning log on a monthly basis from January 2025 to July 2025. These insights were utilised in the qualitative analysis, forming a starting point to determine areas of interest.

Pathway mapping

We worked in partnership with the Innovation Unit to create a pathway map illustrating each step in the CLTCS service, as well as challenges, opportunities and case studies. A series of 1:1 interviews with staff members supporting the programme was carried out, to create a draft pathway map.

The draft map and the data on which it was based were shared back in a second round of 1:1 staff interviews, to check for accuracy. Finally, the changes were incorporated to create a final version of the CLTCS pathway. As the pilot continues to change and evolve, we decided to time stamp the pathway map to make it clear that it refers to the state as of April/May 2025. Any further changes that have been made to the pathway during the evaluation period have been noted in the Findings section of this report where relevant.

Stakeholder interviews

A total of 21 semi-structured interviews were conducted with staff members supporting the CLTCS programme and those across NCL who either expressed interest in the programme or are indirectly involved in the programme. An initial list of key stakeholders for interview was shared by the core CLTCS team. Taking this as a starting point, a snowball sampling technique was applied to identify additional stakeholder interviewees. Interviews were held on MS Teams, and transcriptions were analysed thematically using the NVivo qualitative data analysis software.

Observational work was not undertaken within MDT discussions where identifiable patient information was being considered, as the evaluation team was not involved in direct patient care and this would not have been appropriate from an information governance and confidentiality perspective.

Quantitative data collection and analysis

Data on the activity of the service was collected by CLTCS team as a part of their regular programme monitoring. This included data on patients who are eligible for inclusion, their activity, and outcomes of their MDT review as a part of the programme. Their coordinators and NCLHA team created a number of spreadsheets to track patients through the system. They then shared this data with us for evaluation.

Data structuring, cleaning and analysis was performed in Excel, R[3], and Tableau. Data was shared by the NCL HA team in an Excel file for each PCN. Data was merged and cleaned in Excel before analysis following the stages set out below.

Analysis stages

Stage 1: Understanding characteristics of eligible population and their flow through the new service

Stage 1 of data analysis focused on answering following questions:

1. What is the total population in pilot PCN sites that has been reviewed for the CLTCS?
2. What are their key characteristics?
3. Why have patients not been taken forward to MDT reviews?
4. How has CLTCS changed the patient pathway?
    a. Which appointments were deemed inappropriate?
    b. What additional services have been consulted or booked?
    c. How has patient treatment changed?

Stage 2: Understanding how MDT actions translate to changes in patient care

Stage 2 of data analysis focused on answering the following questions:

1. Have all MDT requests for changes in patient care been actioned by responsible party?
2. Have patients attended new appointments where appropriate?
    a. How have patients interacted with new services? What do we know about stages of patient initiation into new service? i.e.:
        i. GP informed
        ii. Patient informed
        iii. Patient referred
        iv. Patient attended new appt/service
        v. Patient completed new appt/service (i.e. weight management)
3. Have clinicians made the changes to prescriptions where appropriate?
4. Have patients accepted new interventions?

Stage 3: Understanding if changes in patient care resulted in better health outcomes and a decrease in health system utilization

3A: within cohort health outcomes analysis

Stage 3A of data analysis will focus on answering the following questions:

1. Has there been a change in clinical outcomes for patients who have accepted new interventions?
    a. This could capture, but not limited to weight management, smoking cessation programme, clinical QOF T2T measures

As advised by the CLTCS clinical team, with the current NHS waiting times for programmes and procedures, it is unlikely that this can be explored in the first 6 months of the pilot programme. The analysis therefore aims to understand as much as possible and set out the plan for further analysis of the patient journey after the MDT.

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[3] R Core Team (2025). _R: A Language and Environment for Statistical Computing_. R Foundation for Statistical Computing, Vienna, Austria.

[3] Wickham et al. (2019). Welcome to the tidyverse. Journal of Open Source Software, 4(43), 1686.

3B: cost-consequence analysis

Stage 3B of data analysis is designed to use the insights gathered through pathway mapping and engagement with stakeholders to understand the delivery cost of the new pathway in relation to perceived benefits. However, whilst we have undertaken some costing analysis of the early iterations of the service, the data available for this report is not representative of the more established service. As a result, a cost-consequence analysis is not included in this report but is available on request.

Findings

This section combines the findings from all of the data gathering methods described in the previous section. These findings relate to the results of the analysis of evidence gathered up to July 2025. As a developing service, the CLTCS has sought to identify problems and issues and address them as the service progresses.

Overview of the service

Population
The CLTCS is being piloted at four PCN sites in North Central London, capturing patients registered at 23 GP practices (Figure 2).

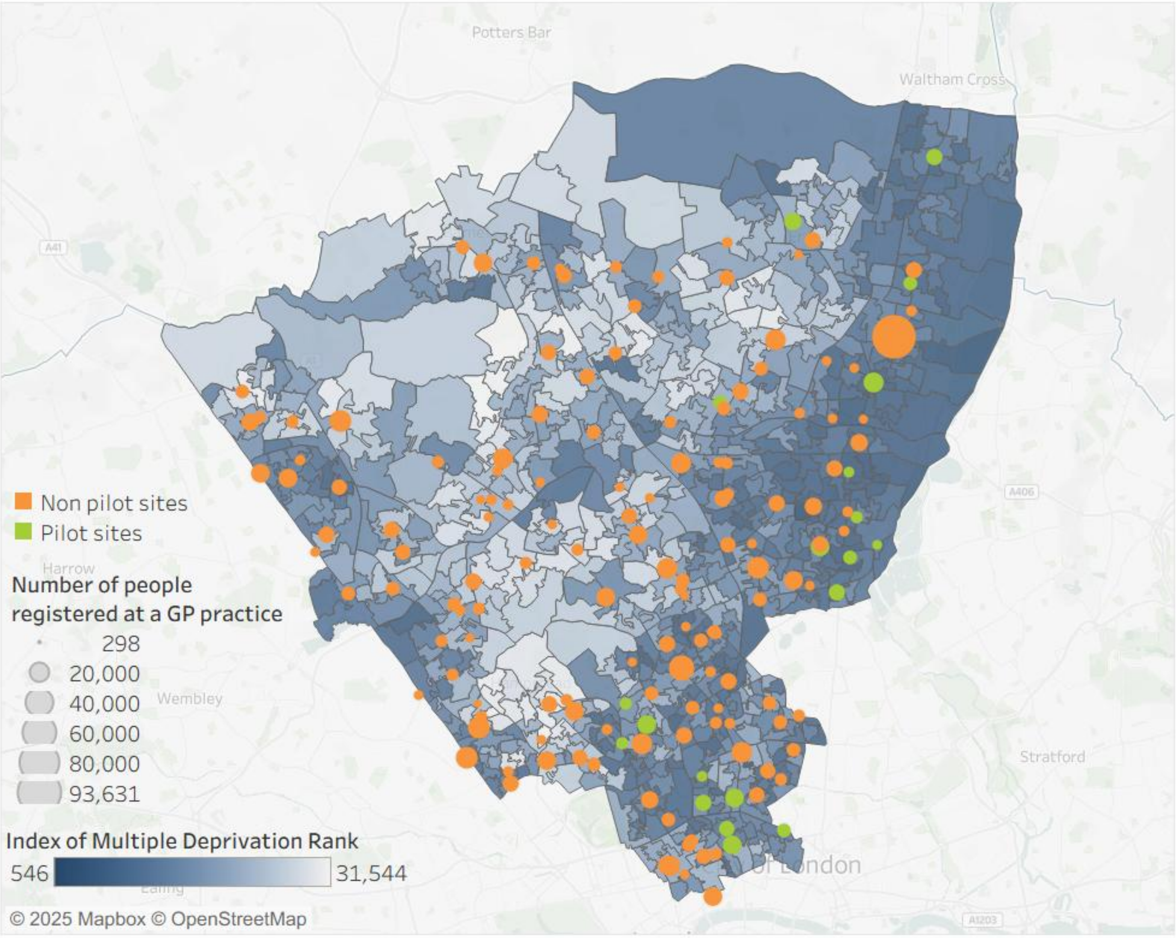
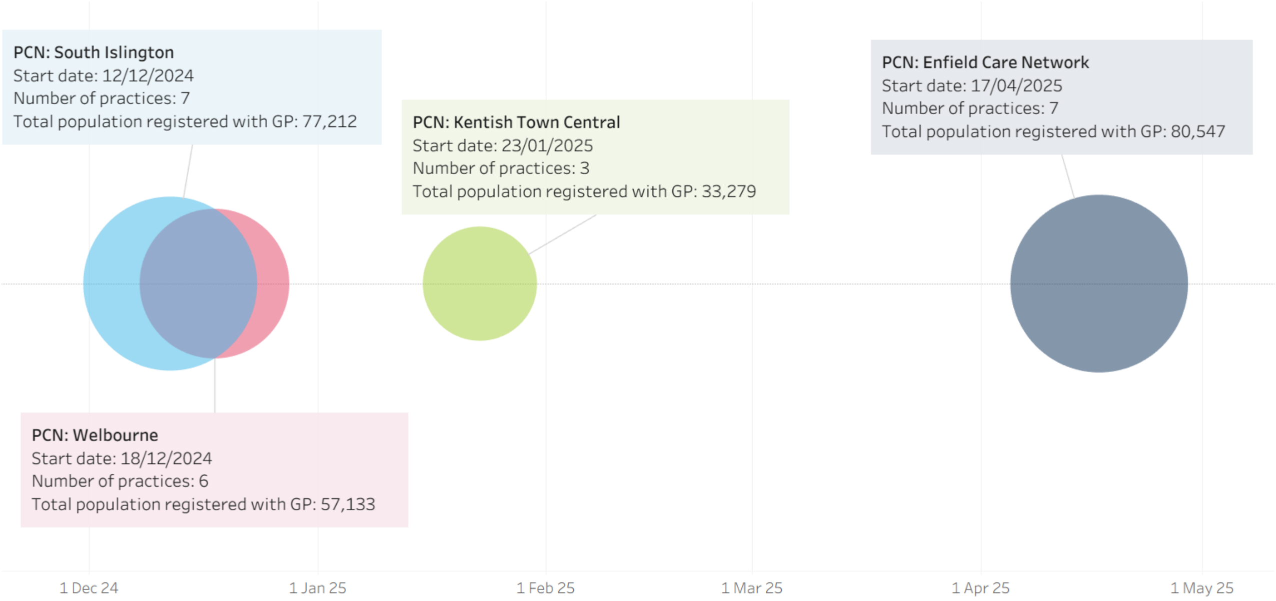


Figure 2: Map of participating GP practices in NCL

Figure 3 shows the time line of the onboarding for the four participating PCNs, between December 2024 and April 2025:



PCN: South Islington
Start date: 12/12/2024
Number of practices: 7
Total population registered with GP: 77,212

PCN: Kentish Town Central
Start date: 23/01/2025
Number of practices: 3
Total population registered with GP: 33,279

PCN: Enfield Care Network
Start date: 17/04/2025
Number of practices: 7
Total population registered with GP: 80,547

PCN: Welbourne
Start date: 18/12/2024
Number of practices: 6
Total population registered with GP: 57,133

Figure 3: Timeline of onboarding PCNs to the CLTCS programme

As of 1st February 2025, the total population registered with a GP in the pilot practices was 247,999 people. This represents 13.5% of the population registered with a GP across NCL (1,839,069 people). The age and sex distributions of patients registered with a pilot practice and those registered with a non pilot practice in NCL are statistically significantly different. However, the difference appears to be minor in absolute terms and the age distribution follows a similar pattern in both pilot and non-pilot populations. The overall difference between pilot and non-pilot PCNs in the age profile of patients is spread across most of the age groups, with the smallest difference observed in 40-49 age group (Figure 4, Figure 5).

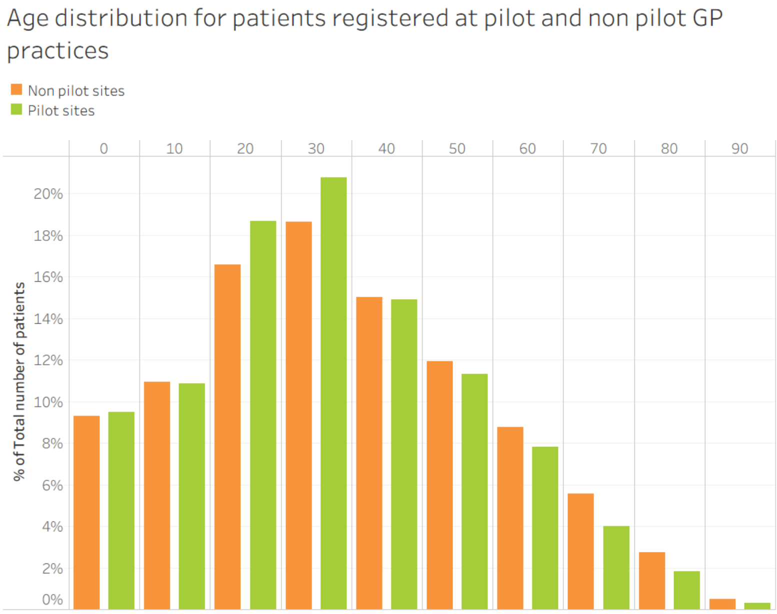


Figure 4: Age distribution for patients registered with a GP at pilot and non-pilot sites (February 2025)

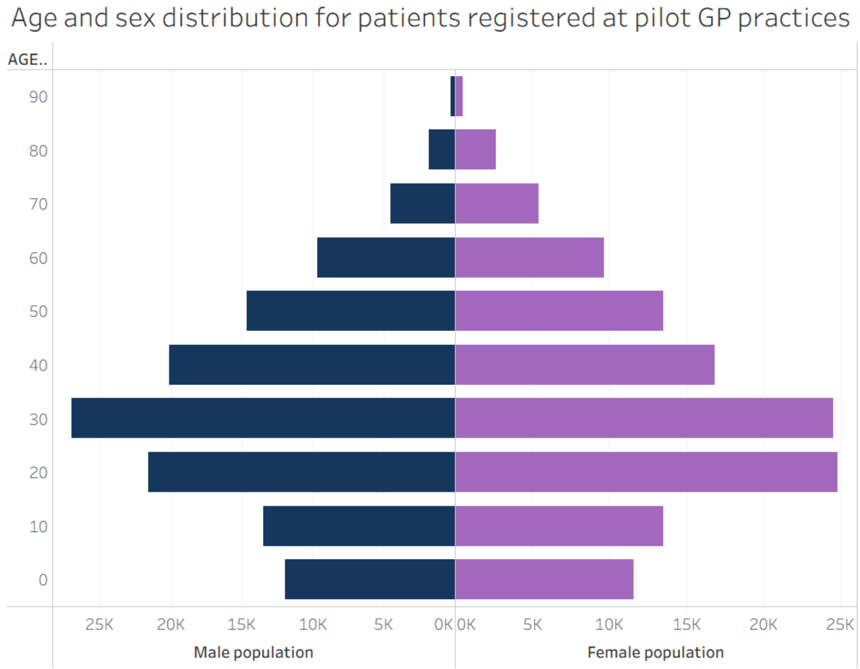


Figure 5: Age and sex distribution for patients registered with a GP at pilot practices (February 2025)

Patient Pathway

In the identification phase, in preparation for an MDT, a Coordinator completes a desktop review of all eligible patients looking at their health information, upcoming appointments, and medications to decide if they would benefit from an MDT review. More details including the patient journey and staff roles and responsibilities against each phase can be found on the pathway map below (Figure 6).

Spotlight: Pathway map

As part of CLTCS evaluation, the Innovation Unit mapped the pathway to help assess its success and future viability. This map documents the core process as described by staff in April-May 2025.

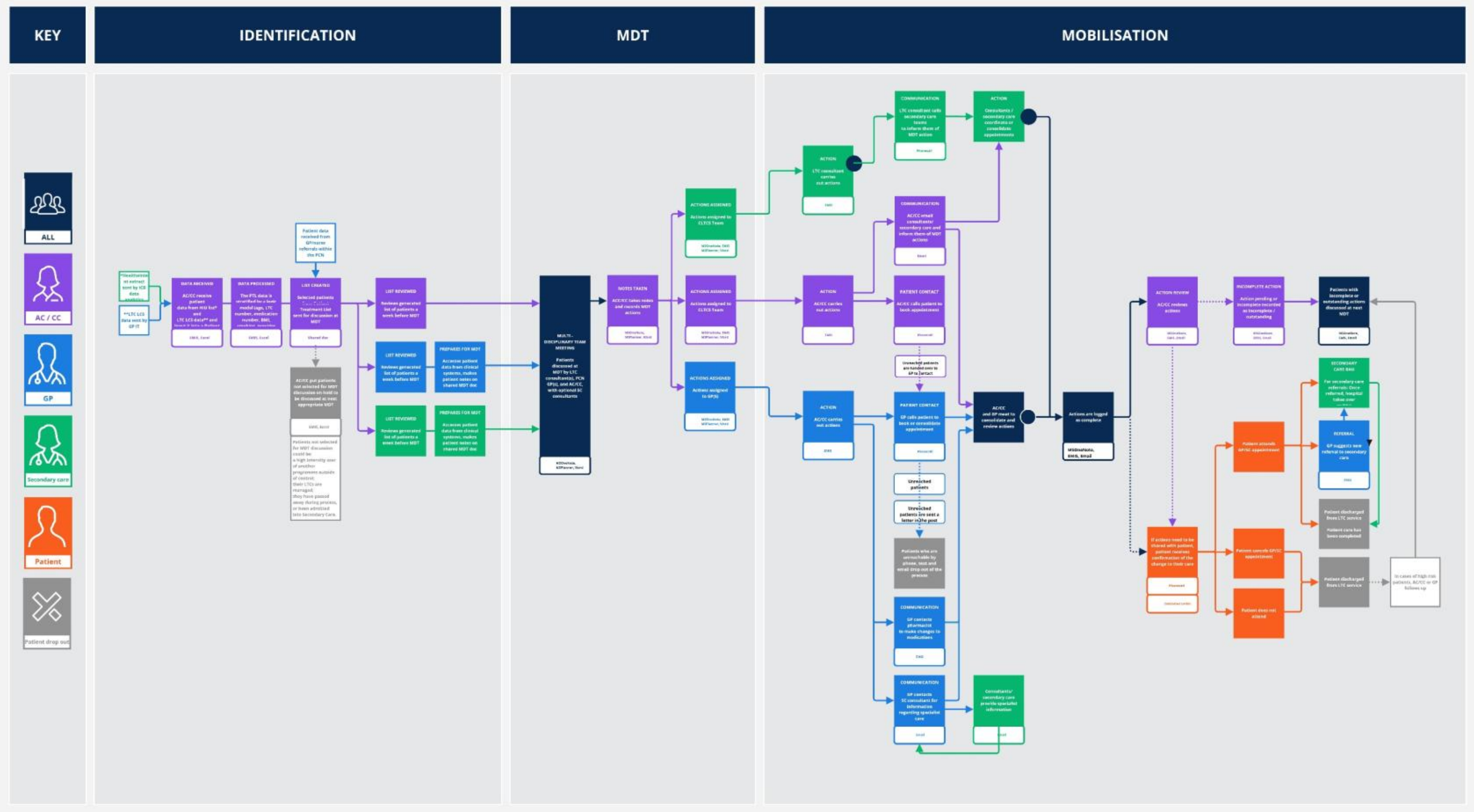


Figure 6: Pathway map illustrating key steps in the patient journey for CLTCS (full version available **[here](#)**)

Patient characteristics

During the data collection period for this evaluation (from 12/12/2024 to 26/06/2025), a total of 318 patients were identified for desktop review across four pilot PCNs. Two data sources were utilised to identify patients who were likely to have uncontrolled complex long-term conditions: the LTC LCS and an extract from HealtheIntent[4], which flags patients with high healthcare utilisation. A small number of patients were referred into the service by their GP or secondary care services.

A Patient Target List (PTL) for each PCN was used to complete the desktop reviews; South Islington completed the most desktop reviews (115 patients), followed by Kentish Town (111 patients), Welbourne (74 patients), and Enfield (18 patients). The difference in number of patient reviews completed is driven by programme start date and evaluation timeline, as each PCN was onboarded at a different time (see Figure 3).

Out of 318 eligible patients, 57 were not selected for MDT (17.9%, Figure 7). The main reason for a patient not being selected was that all of their appointments were appropriate (51 patients), therefore there would be minimal benefit from an MDT where the main goal was to cancel/coordinate outpatient appointments. The 261 patients taken forward for discussion at MDT were representative in terms of demographics compared to the wider cohort who were reviewed.

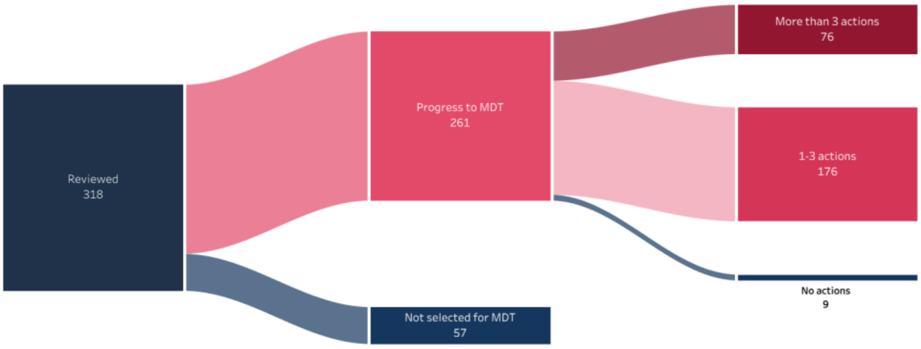


Figure 7: A Sankey diagram showing the total number of patients across all steps of the CLTCS journey

Overall, 167 of the eligible patients were female (52.5%) and 151 were male (47.5%). A majority of patients were aged between 50 and 69 years old (71%) with only 13 patients aged 70 or over (4%). Most patients lived in Camden (33%), Islington (31.4%), or Haringey (22.6%). 141 patients were current smokers (44.3%) and 195 were obese or severely obese (61.3%). 66 patients had known mental health issues (20.8%).

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[4] HealtheIntent is a system that was used in NCL at the time of the CLTCS set-up. It links elements of health and care information from different sources, with the purpose of enabling clinicians to manage and plan care for individuals and groups of residents in relation to health or social care.

The majority of patients identified their ethnicity as white, accounting for 58.5% (186 patients). Black patients represented the second largest group at 16.7% (53 patients), and 36 patients (11.3%) were recorded as unknown. There were no significant differences in the demographics of patients who received a desktop review and those who were taken forward for discussion at MDT (a detailed breakdown can be seen in Table 1).

Table 1: Comparison of key demographics between MDT cohort and Desktop review cohort

	MDT cohort		**Desktop review**		Difference
	Count	%	Count	%	%
Gender					
Female	136	52.1%	167	52.5%	-0.4%
Male	125	47.9%	151	47.5%	0.4%
Age					
Under 30	11	4.2%	17	5.3%	-1.1%
30-49	48	18.4%	62	19.5%	-1.1%
50-69	190	72.8%	226	71.1%	1.7%
Over 70	12	4.6%	13	4.1%	0.5%
Borough					
Camden	85	32.6%	105	33.0%	-0.4%
Islington	78	29.9%	100	31.4%	-1.5%
Haringey	63	24.1%	72	22.6%	1.5%
Enfield	18	6.9%	18	5.7%	1.2%
Unknown	11	4.2%	15	4.7%	-0.5%
Other	6	2.3%	8	2.7%	-0.4%
Ethnicity					
White	153	58.6%	186	58.5%	0.1%
Black	46	17.6%	53	16.7%	1.0%
Asian	19	7.3%	22	6.9%	0.4%
Other ethnic group - Any other ethnic group	11	4.2%	14	4.4%	-0.2%
Mixed	5	1.9%	7	2.2%	-0.3%
Unknown	27	10.3%	36	11.3%	-1.0%
BMI risk category					
Severely Obese	41	15.7%	42	13.2%	2.5%
Obese	130	49.8%	153	48.1%	1.7%
Overweight	45	17.2%	60	18.9%	-1.7%
Normal	38	14.6%	52	16.4%	-1.8%
Underweight	6	2.3%	9	2.8%	-0.5%
Unknown	1	0.4%	2	0.6%	-0.2%
Other demographics					
Homeless	4	2%	5	2%	0.0%
Current Smoker	126	48%	141	44%	4.0%
Alcohol use	76	29%	92	29%	0.2%
Alcohol abuse	16	6%	19	6%	0.2%
Known mental health issues	57	21.8%	66	20.8%	1.0%

Patients had an average of 14 prescribed medications and 3.3 long-term conditions. The three most common long-term conditions were Hypertension, Diabetes, and Depression (Figure 8), with 289 patients having at least one of these conditions (90.9%).

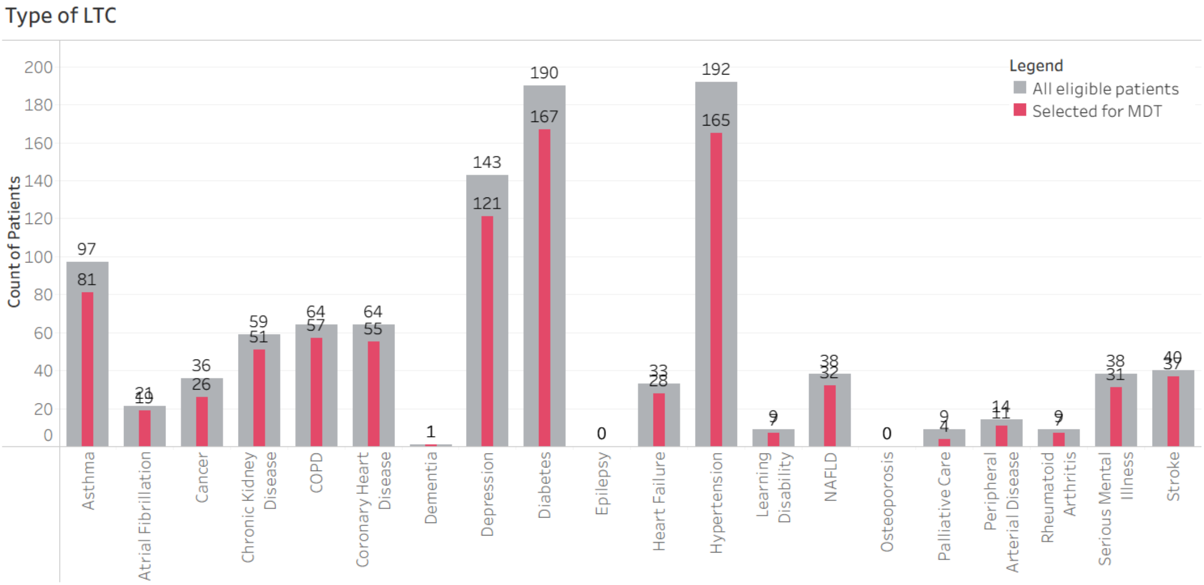

Figure 8: Prevalence of long-term conditions among all eligible patients (318 patients) and the cohort of patients selected for MDT (261 patients)

The presence of multiple conditions with overlapping symptoms is one of the main challenges for optimising treatment for patients with long-term conditions. Out of 192 patients with hypertension, 131 of them also had diabetes (68.2%). Chronic kidney disease (CKD) also commonly occurs in conjunction with hypertension and diabetes: out of 59 patients with CKD, 53 had hypertension (89.8%) and 47 had diabetes (79.6%).

Patients with hypertension (n = 192) had, on average, more long-term conditions (mean 3.94) compared to those without hypertension (n = 126, mean 2.42). The difference of about 1.5 conditions was statistically significant (p < 0.001, 95% CI 1.23–1.82), indicating a higher comorbidity burden among patients with hypertension.

Setting up the service

Primary and secondary care colleagues reflected a keen interest to join the pilot phase of the programme, as a result of the aim of promoting cross-organisation working to support a cohort of complex patients. Specifically for primary care, joining a programme like this offered an opportunity to receive additional support and resources to support the delivery of the best possible patient care.

Along with this service, primary care colleagues can also receive support through Consultant Connect Advice and Guidance[5] or by contacting hospital departments directly. These options usually focus on one question or issue, and the time to receive a response varies, with staff members reporting real improvements and speedy resolutions over the last few years. Along with these options, some PCNs employ specialist nurses who can provide support for the care of

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[5] Advice & Guidance service gives clinicians access to relevant advice and tools that help improve patient care via phone or messaging. [Consultant Connect advice & guidance - NCL ICB General Practice Website]

more complex patients. The CLTCS programme, however, provides an opportunity for a holistic overview of patient care, not limited to one LTC.

> *I feel like all of these pieces of advice [Consultant connect, Advice and Guidance] are a GP asking a very specific question rather than the programme [which is] very different. It's supposed to do a bird's eye view of the patient's health across all sectors and gives you the time and space to do that. So there are other avenues to get advice, but it has to be a GP asking a specific question.*
>
> *Staff member*

Colleagues have emphasised the importance of exploring pockets of deprivation across a local authority, and ensuring there is equality of access to innovation across the area.

> *There's obviously the areas that need it more, but then inequality in innovation is what I'm trying to get across. They [patients in less deprived areas] don't get to experience any new ways of working.*
>
> *Staff member*

The original funding allocation for pilot PCNs was based on an expected weekly sessional commitment from primary care. Staff members requested that the funding allocation be regularly reviewed in light of any future changes to the scale or scope of the programme. Reflecting on the process of applying for funding, staff members highlighted the short turnaround time required for the application, and unclear criteria for success. Finding the time to complete the application in an already busy environment was challenging.

Once the pilot started, staff members reflected on fast implementation and changing processes, that responded reactively to the different needs of the team. The roles and responsibilities were defined at the beginning of the programme, but they have changed as the programme develops. Time commitments were challenging, especially for those colleagues also involved in programme development, including coordinators, GPs, and consultants, and staff have reported feeling overwhelmed by the amount of tasks that needed doing. As of the end of the evaluation period, staff have reported feeling more settled in their roles and having clearer roles and responsibilities.

The visibility of the programme amongst primary and secondary care colleagues not participating in the programme was low. Increasing the engagement, promoting the service and sharing expectations with the wider system was suggested as a way of supporting the actions and outcomes of this programme.

> *[What we need is] More visibility for secondary care saying: 'you may receive emails from this service about management plans for patients. We are doing this because*

we are trying to improve patient care but also trying to reduce the amount of hospital appointments they need to attend. (…) So if you do receive emails about these patients, we'd be really grateful if you could reply or give some feedback'.

Staff member

Identifying patients

In this early phase, the processing of data required to identify patients and create patient lists has been done manually, using the EMIS information system and MS Excel. Once a patient list has been created, and patients have been chosen to proceed to MDT, it is communicated with MDT staff via a shared document. This manual process is time consuming and reducing the burden of identifying patients not suitable for a discussion has been shared as a priority action to support the team with patient identification.

It can sometimes take 10-15 minutes of searching before I realise that someone's not suitable for discussion. It takes a fair amount of digging until you can find out enough about the patient to make it clear why things are going wrong and it might mean that you have to read five or six different clinic letters until you get the sense of who this person is.

Staff member

During the pilot phase, this step in the pathway was supported by consultants, the administrative coordinator and the clinical coordinator. The programme began with two coordinators from inception until June 2025. Then a further two coordinators were recruited from July 2025.

Part of the role of the programme is to test methodologies for identifying patients who would benefit from care coordination and optimisation. The NCL HA team are reviewing potential options to support, optimise and automate this process for the future.

Primary care colleagues have shared that there were no surprises for them regarding the cohort of patients who were eligible for this service, as the majority of patients with complex needs are known to primary care due to either having multiple long term conditions or being high users of primary care services. Along with reviewing patients already known to the system through either the high intensity user list or the LTC LCS list, primary care colleagues suggested implementing and sustaining the option of GPs being able to directly refer into the service. This is on the basis that there may be patients with complex needs that are known to primary care, and would benefit from this intervention, but who would not be selected under the current patient identification process.

Bringing patients that you say 'these meet our criteria, these are very high users' I think is probably pragmatically better but with allowing for this person here who

> *might be really, really beneficial or suitable. That's my view. I don't think there's a right answer necessarily.*
>
> *Staff member*

After identifying the eligible patients, team members review the patient lists and prioritise by age in the first instance, with younger patients prioritised. This was seen as a positive approach by the wider programme staff members. When selecting patients for a review, along with the current practice, staff members suggested reviewing patients who are consistently high intensity users, not only within the last 12 months. This would include reviewing the last four or five years of appointments in primary care, and selecting patients who consistently have the highest number of appointments over that time period. It is worth noting that under the data protection rules, the CLTCS team is not allowed to access all patient information, but is limited to the previous 12 months.

The MDT meetings among the four PCNs are held either online or in person. There was strong feedback about the benefits of holding the MDTs in person, where the ease of accessing systems, forming good relationships and learning from each other were all highlighted as enablers. Getting the timing right between MDTs is crucial – if too frequent, they can cause unmanageable workloads and bottlenecked actions.

Staff members have highlighted the importance of good MDT scheduling, not only to ensure that the workload can be managed, but also to allow time to do effective follow-up in the mobilisation phase. Staff members also shared that preparing desktop reviews and lists a few weeks prior to the MDT gives the wider team enough time to undertake pre-MDT actions, whilst reducing the post-MDT workload.

> *At the moment there's not enough time built in the programme to ensure the outcomes are done, and that's the bit I'm a bit worried about because I just feel (...) there's no time here to really ensure that the actions have been done.*
>
> *Staff member*

Learning acquired in the first three months of the programme enabled the programme team to gather information, address these concerns and plan the workload effectively to ensure sufficient time is protected for follow-up.

Conditions for implementation

Enablers of scaling up the service

Coordination support

The work of the coordinators was considered crucial for the delivery of this service, supporting the team with data preparation, desktop reviews, leading MDTs, following up on actions and directly contacting patients. The quality and amount of preparatory work done by coordinators prior to an MDT was highlighted as a key enabler, and staff members shared how impressed they were with it. Having support to capture MDT minutes and following up on administrative tasks was seen as critical to delivery of this programme.

The support provided by coordinators extended to the wider NCL HA team, who all played a role in programme delivery and development. To successfully continue the programme, it was considered that coordinator support would need to be sustained with more time built into the programme for actions and follow-up post MDT meetings. Some PCNs might employ a PCN care coordinator, whose workload and support can be complimentary to this programme.

> *The big part of general practice that's a problem is that I will do three clinics and I'll create one clinic's worth of work so I can only [see patients] at 75% of my available time. I can't see patients for the other 25%, and the more work you do, the more patients you see, the more stuff you generate and the less time you have to deal with it, which is the big problem.*
>
> *Staff member*

Two-way conversations

Ensuring the programme engages both primary and secondary care is a crucial enabler for delivery. Engaging in two-way conversations, facilitating both sides to input, based on their knowledge and experience, will support further scale and implementation of the programme across NCL.

Effective data capture

Capturing actions and outcomes in EMIS is essential, as is updating other EPRs, as this enables clinicians to understand the suggested actions from the MDTs and follow-up effectively when needed. Continuing to accurately capture the data enables any future follow-up that may be required in primary care.

> *I think that [the action] needs to be fed back on the EMIS record. Otherwise that GP in a few months is going to be starting that whole thing again. And then it seems a complete waste of time.*
>
> *Staff member*

Barriers to scaling up the service

IT access

Staff members expressed concerns about the amount of time and permissions it takes to set up access to different EPR systems. As different information about patients' care is held in different systems, multiple accesses are needed to enable informed MDT discussions. Once access was set-up, staff had to log into multiple systems to fully understand patients' care. It was frequently reported that this took a significant proportion out of their allocated CLTCS time. The amount of work involved, and the time it takes to complete, were seen as a major barrier to successful scale-up of the service.

> *I realised I was doing half an hour of free work where I like logged on to everything, it does take a long time to get on to all of the different platforms.*
>
> *Staff member*

Staff members mentioned that the implementation of the One London Record could serve as a facilitator of this process if all adequate permissions are in place. Once in place, staff members emphasised that ease of access and availability of all relevant data will be key. During the pilot phase, the access to EPR systems did not include being able to see future appointments for patients, which is not always available.

Actions and follow-up

Contacting patients was a barrier for coordinators who took on follow-ups and actions. As the programme developed, the team found a solution to this by enabling coordinators to text patients and work is in progress to organise technological support for this process.

Aligning actions with usual practices in primary care when it comes to blood tests in particular was challenging. Staff have reflected that the difference between offering blood tests in the GP practice and receiving a blood form from the hospital has an impact on patient uptake. Coupled with early blood pick-up times in primary care, this caused issues when trying to follow-up on actions. This isn't unique to the CLTCS programme, as it reflects the usual arrangements in primary care.

Perception of additional work

The time commitment required to deliver this programme was considered to be significant. Staff members shared that the perception of additional work will continue to be one of the most important barriers for implementation. Defining and sharing the ways of working, time commitments and practical examples might help to support this.

> *It is tricky and I think that is going to be a big barrier to scaling things up in, in the future. If it does need to scale up, it's just finding people who have capacity to do this work and want to do it.*
>
> *Staff member*

One suggested option for removing this barrier for primary care is to offer specific MDT slots for clinical teams to join. For example, a GP would only join the MDT for a 15-minute slot in which their patient is being discussed. Some of the additional work would be business as usual for different partners. Highlighting these opportunities and sharing them with participating PCNs would support further implementation.

Another option might be to review the staff members that support the programme from primary care. Staff members reflected that different PCNs took on a different approach – including which staff member will be a PCN representative: a GP, pharmacist or practice nurse. The variation in approach could have an impact on the perception of additional work, identified as a main barrier to implementation. However, when making this decision, it is important to consider the requirements of the programme and appropriateness of different staff members supporting it.

> *It clearly didn't have to be a GP. I think that GPs have very little capacity day in, day out. To do this work, I, as I said, I don't have any dedicated time to do this work. And so it's kind of above and beyond what I'm already doing.*
>
> *Staff member*

Funding

The way of working in the CLTCS initiated a series of changes in primary and secondary care. Scheduling meetings, providing access to different systems, learning from each other and making changes to patient care, although usual tasks for both primary and secondary care colleagues, were done in a slightly different way here.

The main concern raised about the future of the service was financial sustainability: understanding what is possible and who is responsible for finding, holding and distributing the funding post pilot phase. Staff members have reflected on the perception that many pilot programmes across the NHS, where significant effort has been put in to make it work, unfortunately are not sustained after the pilot phase.

Staff acceptability

Ways of working

Scope of the service

Staff members reflected on the high needs of this population, where any additional input and resource to help manage patients, and support with care coordination and needs, would be welcome. The initial perception of the service was largely that the CLTCS takes over the care of the patient, coordinating actions and next steps, without major implications to business as usual.

However, staff members have questioned the model of delivery, including the frequency of the MDT meetings, which affects the ability to effectively support patients at the right time. As the programme is developing, the CLTCS team have implemented changes to enable tracking and reviewing the actions and outcomes for each patient, in order to enable reflection and onward planning.

> *MDTs are just the buzzword. We've been having MDTs for years because we obviously have clinical meetings with various different people. But they don't fix everything because they're every four weeks, maybe every two months. You might actually have a patient that can't wait for four weeks. So what do you do then? It's ticking off the buzzword list, but is it actually fulfilling the needs from primary care?*
>
> *Staff member*

The majority of actions arising from MDT meetings included coordination and organisation, which is where staff members have seen the most benefit. MDT members reflect that the anticipated need for consulting additional services wasn’t as high as expected, although the data shows there were 175 instances of advice and liaison with other services. Most commonly this was ‘other’ secondary care liaisons (32%) followed by liaisons with secondary care diabetes (15%) and mental health (13%) teams. In total, liaisons with community services (diabetes, respiratory, community therapies, and other) accounted for 20% of all liaisons (

Table 2). It is worth noting that, in usual care, the approach to managing queries of this type would be through either advice and guidance services, or direct service referral; as such, instances of advice and liaison represent an improvement, at least in terms of service utilisation, compared to usual care.

Table 2: List of liaisons with other service

Action	Count	%
Other secondary care liaison	56	32%
Liaise with secondary care diabetes	26	15%
Liaise with Mental Health	23	13%
Liaise with secondary care respiratory	21	12%
Liaise with community diabetes	17	10%
Liaise with community respiratory	10	6%
Liaise with secondary care cardio	7	4%
Other	15	8%
Total	**175**	**100%**

Workforce model

The current model of CLTCS service is supported by GPs, coordinators, mental health clinicians and consultants. There was significant variation in the acceptability of this way of working among staff, in relation to both secondary care input and primary care support. In terms of secondary care input, the consultants are specialists in their area, however in the context of this service, they operate as a 'specialist generalist'.

This fact gave rise to concerns amongst primary care colleagues who have questioned what additional value a secondary care clinician specialising in another area represents, when compared to a GP. Secondary care clinicians also shared this concern at the beginning of the programme, however the nature of actions that were taken and the focus on coordination provided reassurance.

> *It is reassuring that this role does not require an awful lot of specialty specific knowledge, and it's largely just about sensible accumulation of information about what's happening to a patient and then decision making about what looks like ought to happen.*
>
> *Staff member*

Primary care colleagues reflected that there was no negative impact on their workload as a result of actions arising from the MDT. However, it was recognised that there is limited capacity for any additional follow-up that will be needed for this complex cohort of patients, which caused anxiety amongst care providers. The key issues were identified as accurately capturing outcomes of MDTs, finding an effective way to share these with the wider primary care system, following up on any outstanding actions, and accurately coding the data in primary care systems. A number of challenges identified with working in this way, including version control of actions documents, increased email traffic, poor understanding of progress, unclear follow-up, and limited capacity to follow-up

More exposure and additional information will be necessary as the programme scales up across NCL. Some staff members expressed concerns about managing risks and fully understanding the information shared in clinic letters, if they are acting as a ‘specialist generalist’. Learning from each other and consistently reviewing patient information through desktop reviews and MDT discussions could support the change in the ways of working, with consistent review of risk and staff acceptability.

> *Throw me in the world of kidney and I would not have the abbreviations they use. You can have all the access you want, but what does that mean in English? And does that mean they're going to die or that means they're going to recover? We all have our own little lexicon of language and what that means and how we understand that in terms of risk.*
>
> *Staff member*

During the pilot, some PCNs decided to nominate one PCN representative who would join the MDTs on behalf of all GP practices within that PCN. Others have decided to work on a practice-by-practice basis, with one representative from each of the GP practices in the PCN. Both staff members participating in the pilot and those interviewees who had just expressed interest in the programme shared mixed views on this way of working.

In cases where one GP represents the whole PCN, key challenges that were identified included joining an MDT and discussing a patient that they don’t know very well, and needing to spend additional time reviewing the information and getting familiar with a patient’s case. The use of shared information systems, particularly EMIS across a PCN, will play a key role as an enabler of working in this way, helping MDT members to get ‘up to speed’. At the same time, working in this way supported MDT scheduling, as it was easier to find a time convenient for all, which was identified as a main barrier for delivery of this programme.

Additionally, staff members recognised a need to clearly define who can represent a GP practice or a PCN. This is important to avoid variation and potential negative impacts on ways of working and equity of service provision. As each GP practice chose whom to put forward as a practice or PCN representative – which could be a GP, a pharmacist, or a practitioner – some staff members shared a concern about unintended impacts on the equity of care of having such varied professional groups.

> *That [working on a GP level] makes it quite a disjointed service I think. It's not easy for the acute providers to meet with different people all of the time. There's not a lot of equity in the sense that one practice might put forward a GP and other practices might put forward a pharmacist and other practise might put forward an advanced practitioner.*
>
> *Staff member*

On the other hand, working on a practice-by-practice basis enabled GPs to discuss patients that are under their care, potentially reducing the amount of preparatory work required. Resolving actions when working on this basis was identified as a benefit, with staff members recognising that it is easier to complete actions and get information back to care teams and patients.

> *You really know the patient and you don't need to spend ages looking through their history because you know what, you've met them, you actually know what they're like in real life. It's not just an EMIS record.*
>
> *Staff member*

Finding the time to schedule MDTs that were convenient for all people involved was challenging. During the early phase, it contributed to a significant variation in the number of MDTs held over time.

Along with the key MDT personnel, the programme also receives input from mental health clinicians. Mental health colleagues don't join all MDTs, but provide information as and when needed. For both mental health clinicians and MDT team this was reported to work really well. Staff members have recognised the high mental health needs of this cohort, and the advice from mental health clinicians on what interventions could work was valuable. Increasing this support, and further integrating mental health specialists into core MDT roles would be beneficial for scaling up and sustainability of the service.

> *I'd like more mental health. It feels very physical health. We know that a large part of this is a net psychological distress, mental health problems. This physical/mental health divide again doesn't really work. And actually, if you could bring in a psychiatric psychological component to this to augment the physical stuff.*
>
> *Staff member*

Regardless of the way of working across a PCN, staff members highlighted the importance of focusing on staff wellbeing and embedding a process of checking-in with MDT staff, to provide learning opportunities, and an active feedback system. In the early phase there was no system for checking if MDT actions were correctly suggested. In addition, staff members expressed concerns about fatigue, caused by long, intense MDT meetings, which could impact on their decision-making. It is worth noting that the CLTCS team have acted on this feedback after the data collection period for this evaluation, and a process is now in place to support capturing actions and progress.

Working with patients

Staff members have reflected that contact with patients was not problematic when done via a GP, as it is perceived as a usual GP surgery call. However, coordinators faced issues with contacting patients as they are calling from an unknown number, with patients often not responding to a call or it being difficult to explain why they are being called.

As the programme developed, this was mitigated by sending text messages to patients, and is being resolved further by aiming to use technologies already available in GP systems (such as the Accurx messaging system). GPs reported that, once patients have been contacted, their feedback has been good and the proposed next steps by the CLTCS team have been well received. Working within this service has enabled GPs to have extended discussions with patients, which would not necessarily happen in usual care.

> *For example, last week one of the outcomes was for me to call the patient and discuss a lot of the outcomes that come on each of their different long term conditions. And I had a chat for an hour with the patient, which would never ever happen on my normal clinic at 10-15 minutes.*
>
> *And the patient was so grateful, and I felt like we could sort out so much. (...) Actually a few of the times I've called the patients and explained why I'm calling (...) and they're like, oh someone's looking at me or thinking about me. I think the patient feedback I've had has been really good.*
>
> *Staff member*

Unfortunately, this was not the case for all patients who have been reviewed as a part of this service. Staff members noted a low success rate within this programme for those patients who have not engaged with their GP, or attended appointments or tests. Staff reflected that neither primary care nor secondary care systems hold information to fully understand why a patient chooses to not to attend an appointment, and further engagement is needed to understand this.

As noted in the introduction to this report, patients living with LTCs across NCL were invited to join the Advisory Group to work together with the programme team. This was helpful for programme delivery and for understanding the issues patients face when accessing care. Continuing this engagement could support further understanding on barriers to receiving care for this cohort of patients.

> *Some of these patients that we're finding that have been difficult to engage (...) they're not going to suddenly engage if we kind of call them out the blue. I don't think we've been particularly successful in getting them to engage.*
>
> *Staff member*

To support working with patients more directly, staff members suggested different possibilities, such as including patients in MDT meetings. This way their voice would be heard and would be a part of the decision-making process, rather than them being informed of the outcome at the end.

> *I do think it's valuable and I do think it's useful, but I worry slightly in our MDTs that we're not quite getting the patient voice into that discussion because we are a group of clinicians talking about our opinion about what we think's best for the patient and any discussion with the patient happens afterwards. That just worries me slightly, is this the best way of doing this for this patient group?*
>
> *Staff member*

Integration

Ownership of care

Actions resulting from the MDT are assigned to either the CLTCS team or the patient's GP. Actions assigned to GPs are defined as anything that takes additional GP time outside of the MDT. More actions were assigned to the CLTCS team compared to the GP (69% and 31% respectively). There were significantly more actions assigned to GPs at each MDT in South Islington (11.6 average) compared to the other PCNs (Figure 9).

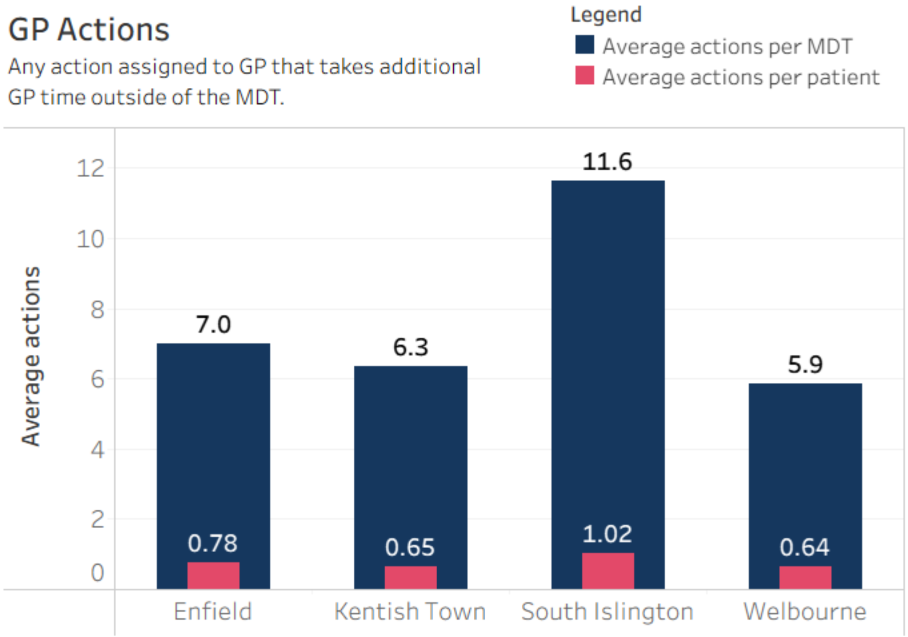


Figure 9: Average number of actions per MDT/Patient assigned to GPs broken down by PCN

During the evaluation period, the teams used a combination of OneNote, Excel and email to keep track of actions and to feed back. The intervention was seen as a one-off coordination effort with limited capacity and opportunity to follow-up and monitor patients whose care has changed. The ongoing management of care is critical, especially for those patients who needed test results prior to decision making, or a new referral to prevention programmes, and the absence of a pathway to follow-up on their care was commented on.

> *I've had one MDT where I've discussed 12 patients. Not even the tip of the iceberg, it's a snowflake. I took some actions away, but I certainly haven't had the capacity to go and have a look and see how those people are doing subsequently. And I've got no idea if anyone else is bothered to look after them from a complex care perspective. (...) [It is] not a team doing the work for a dedicated caseload of people. You've literally come in and started something, but then left it, who knows if actually that's had an impact. These are people who need almost probably weekly sort of follow up until you begin to get them sorted.*
>
> *Staff member*

Additionally, it was unclear who holds the responsibility and care for patients beyond actions arising from the MDT. This was raised in particular for cases where actions included arranging tests, initial hospital appointments, and suggested onward referrals. In some cases, coordinators can support the patient cohort who are not attending the appointments as planned. However, with the programme expanding and with more patients being reviewed, there will not be sufficient capacity to do this.

> *I don't actually know if we're ever going to get that plan from that consultant or from that specialty. My worry is that GP having full faith that this MDT is going to sort out this very complex issue or this complex question. And if we're not going to get an answer, then who's whose responsibility is sorting that bit out?*
>
> *Staff member*

Additionally, staff members recognised the impact of skill set variation in primary care when it comes to follow-up appointments, if primary care is to be responsible for onward care. This could present a challenge when trying to effectively manage patient care post MDT reviews.

IT interoperability (non-clinical systems)

Setting up relevant IT access and permissions during the initiation period for each PCN was challenging. The programme team worked on processes and systems that will support patient review, capturing the outcomes of the review and the outcomes of the MDT. There have been significant changes in the way of working with IT systems during the evaluation period, with some being more successful than others.

Staff members have commented on the processes of using multiple spreadsheets, MS Teams folders, planners and emails to capture their activities and share actions, as well as accessing multiple patient information systems to understand their clinical needs. In order to support service delivery, coordinators have also established catch-up meetings with primary care and secondary care colleagues to discuss actions and capture progress. Although this has supported service delivery so far, it is not felt to be a sustainable method of capturing actions and tracking progress.

> *One of the biggest barriers is the diversity and complexity of information systems in which information about our patient is kept and the fact that there is nowhere where it's all kept.*
>
> *Staff member*

Data availability

Data availability can present a significant barrier to this programme. One important example is the fact that current systems do not allow the team to see future planned outpatient appointments. During the evaluation period, staff members had to read clinic letters to understand if there is a planned follow-up or new outpatient appointments for each patient. This process is resource intensive and required significant time investment during the patient review and MDT preparation phase.

> *At present if we want to find out if somebody has upcoming appointments, we have to log on to every single different system from all the different trusts to find out where their appointments are, which is incredibly time consuming and very frustrating because they're all just as clunky as each other and they all take an average of 5 minutes to load.*
>
> *Staff member*

Defining the benefits of the service

During the evaluation period, we have identified potential benefits of CLTCS through a logic model exercise and 1:1 staff interviews. As the pilot programme timeline did not allow for quantitative exploration of these benefits, we have asked staff members to identify which benefits they think should be explored, and when. These findings take into account clinical knowledge and experience, typical patient journeys and an understanding of the CLTCS pathway.

Reduced administrative burden on primary care

Staff members recognised the potential of this programme to reduce the administrative burden on primary care by finding blockers in the patient pathway and resolving them. This should enable patients to receive test results, understand their appointment schedules and potential waiting times.

> *About 40% of our workload is problems with the interface, patients calling up because they don't know when their appointment is, they don't know that they haven't got their test results or they chase. So if you've got someone that's working on that interface for these patients, that takes a lot of our workload.*
>
> *Staff member*

Introducing expert opinion in patient care management

Although it was recognised that there are complex patients who will require more care, and where actions might not be straightforward, streamlining patient care by reviewing relevant investigations with a clinician who is an expert in their field was seen as beneficial.

Moving to holistic care

The move to reviewing patients more holistically was seen as a very positive and a necessary change in the way that this cohort of patients is managed. This service did not appear to conflict with the already existing mechanisms of working between primary and secondary care, but has offered an opportunity to review a patient in a more general way, not limited to one speciality or one LTC. A key enabler that was proposed for working in this way, along with additional capacity provided by both primary and secondary care, will be a change in process in the mobilisation phase, to support generalist follow-up after the initial MDT meeting.

> *Patients who've got multi morbidity are inevitably going to have focus placed on one of their conditions and probably less on the other, and I feel even more frustrated when I'm at the point of discharging somebody that I have nowhere to follow them up from a generalist point of view. (...) Sometimes they're already being seen by different specialists in different hospitals and the patient experience we know is poor because they have different follow-ups and different hospitals with different doctors who have no way of communicating with each other.*
>
> *Staff member*

Actively finding patients who 'fall through the cracks'

The CLTCS pathway currently involves a full review of patient information, appointments and health needs as well as a review of clinic letters. It also involves contacting specialists, if necessary, prior to an MDT discussion. On some occasions these initial discussions resulted in benefits prior to an MDT discussion, with patients being booked in for relevant appointments that will support their care. One such example is detailed in the case study below.

> *What needed to happen was that the patient needed to not have an [extremely high] BMI. If we could address his weight, then everything else would be sorted out. But these specialists were continuing to see him and continuing to say I'll see him again for his breathing. I'll see him again for his kidneys. When I dug back down, he had been seen by a bariatric surgeon. But the bariatric surgeon had asked [for a psychiatric opinion]. No one had chased it up and nothing had happened.*
>
> *I emailed the psychiatrist and copied in the bariatric surgeon and the bariatric team, and the GP. The psychiatrist wrote back within about 15 minutes saying 'I absolutely support it' and they actually had written a letter, but it hadn't got to the right places. 15 minutes after that there was an appointment for bariatric surgery. It was a real moment of 'This is what that guy needed was someone just to have a step back and to look at the whole thing'.*

Impact on appointments, health and wellbeing

At the beginning of the pilot programme, staff members expected that cancelation of appointments would be the main outcome of this programme, and would represent a majority of their actions. However, only a small proportion of appointments were cancelled (see Figure 11, below), compared to the number of appointments that were coordinated. ‘Coordination’ included changing the order of appointments, ensuring patient transport is booked, calling the patient to confirm the appointment, and scheduling tests that are necessary prior to an appointment.

> *Most of the decision making we're doing is about identifying gaps in care, duplications in care, and things that are poorly coordinated rather than making an awful lot of direct clinical decisions.*
>
> *Staff member*

Although not many appointments were cancelled, staff members reflected on the benefits of coordinated appointments, and a more streamlined patient journey, on patient experience. This could potentially impact the DNA rates in hospitals and the stress/anxiety levels for those patients who have a high number of different hospital appointments for different LTCs.

For patients with complex needs, where clinical decisions are less straightforward, having their investigations reviewed by a specialist clinician was viewed as helpful for ensuring high-quality care. However, most patients seen during the pilot phase of the programme primarily required better coordination of appointments rather than clinical decision-making, and staff questioned whether consultant-level input was necessary for this type of administrative support.

> *It feels like a very not particularly good use of my time or expertise to be pointing that stuff out.*
>
> *Staff member*

When it comes to understanding the impact of this programme and identifying key benefits and measures, a fundamental issue is defining what to measure, and when. Patient and clinician satisfaction rates and perceptions of the service were suggested as measures of the experience of service delivery on an ongoing basis.

Staff members shared that they are not expecting to see this service impacting specific clinical indicators measuring disease progression, such as HbA1C, blood pressure, and cholesterol levels, or changing morbidity and mortality within the timescale of this initial phase, as this cohort of patients is very complex. Similarly, the impact on hospital admissions and associated cost was not seen as a likely impact area for this programme over this initial development phase. Focusing actions to impact on care management and coordination was suggested as a an initial priority for ongoing measurement for the programme, indicating the high importance of streamlining care for this patient cohort. For clarity, the primary purpose of the programme in the longer term included impact on the above mentioned biomarkers and hospital activity but this would *not* be expected to be seen, at least at statistically significant levels, in the timeline covered by this formative report.

> *These are going to be high users of services, right? They're sick people with multiple multi morbidity, they're using the healthcare services somewhere and I guess the answer is can they get the best use of the system in the most efficient way. So that is planned care. That's continuity of care. That's not hospital admissions and A&E admissions and unplanned attendances.*
>
> *Staff member*

Working across sectors

A key benefit identified in 1:1 staff interviews was an improvement in working across sectors. Increased understanding of processes, opportunities and ways of working, as well as upskilling and learning from each other, had an impact on staff satisfaction on this programme (see more in the sub-section ‘Collaboration between sectors’).

> *I think the learning between the GPs and the consultants [has worked really well].*
>
> *Staff member*

Service impact

In total 261 patients had their care reviewed at 26 MDTs held between 12/12/2024 and 26/06/2025. This relatively small number of patients have had a disproportionate impact on the health service in the previous 18 months, with a large number of appointments, prescribed medications, emergency department visits, and inpatient stays (Figure 10).

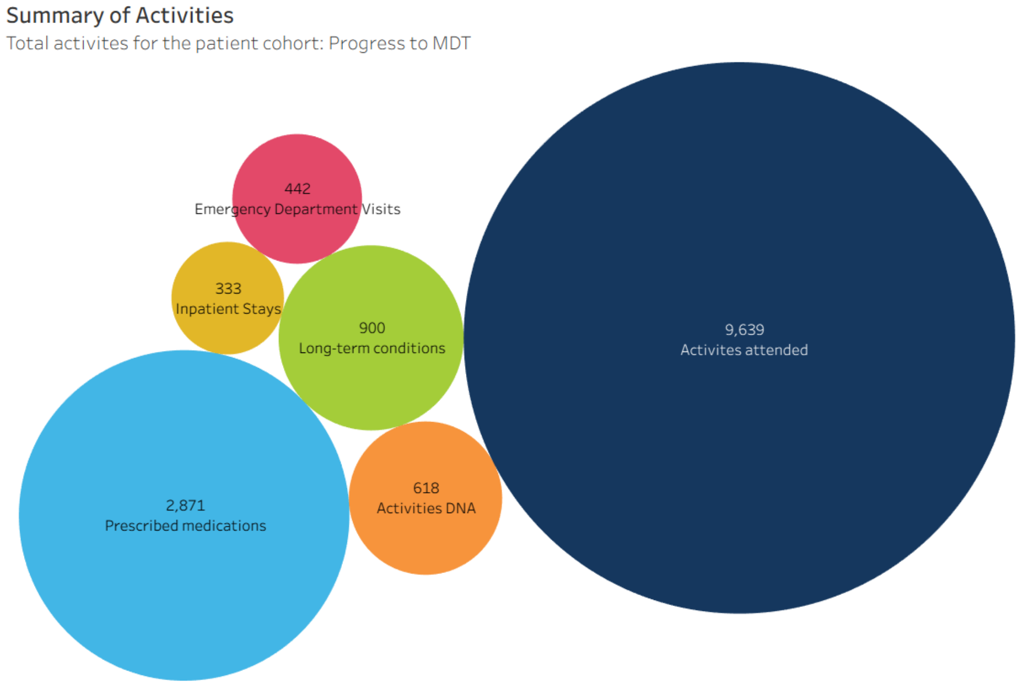
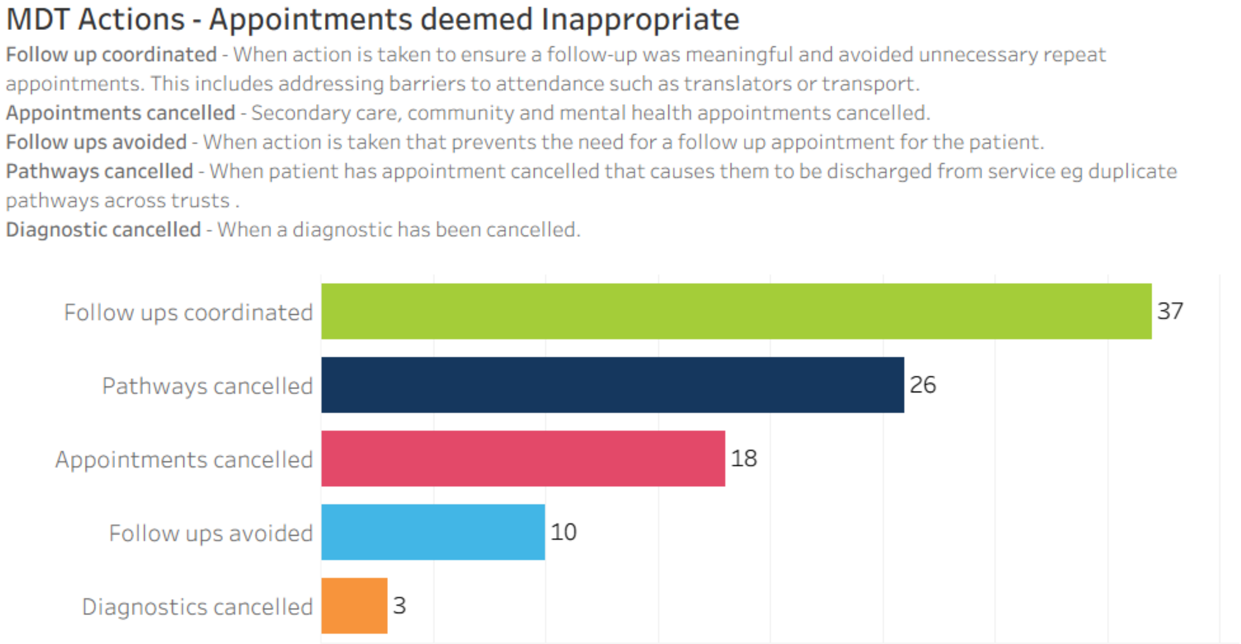


Figure 10: Combined total activity from the last 18 months for the patients taken forward for MDT following a desktop review (261 patients)

On average, 12 patients were reviewed at each MDT (min=8, max=19), with an average of 2.7 actions identified per patient. Each MDT resulted in an average of 28 actions (min=12, max=47). The most common actions resulting from MDTs were appointment cancellations, changes to medications, liaisons with other services, and new referrals.

MDT outcomes

Overall, 82 patients had an appointment deemed inappropriate recorded (31%) (Figure 11). 44 patients had an appointment, pathway or diagnostic cancelled (17%), and 43 had a follow up appointment avoided or coordinated (16%). Appointment coordination includes actions taken to ensure an appointment was meaningful and avoid unnecessary repeat appointments (e.g. changing the order of appointments, or addressing barriers to attendance such as transport or translators). In total, 72 patients had one appointment deemed inappropriate, nine patients had two appointments deemed inappropriate, and one patient had four appointments deemed inappropriate.



MDT Actions - Appointments deemed Inappropriate

Follow up coordinated - When action is taken to ensure a follow-up was meaningful and avoided unnecessary repeat appointments. This includes addressing barriers to attendance such as translators or transport.

Appointments cancelled - Secondary care, community and mental health appointments cancelled.

Follow ups avoided - When action is taken that prevents the need for a follow up appointment for the patient.

Pathways cancelled - When patient has appointment cancelled that causes them to be discharged from service eg duplicate pathways across trusts .

Diagnostic cancelled - When a diagnostic has been cancelled.

Figure 11: Breakdown of appointments deemed inappropriate

Patients identified via the HealtheIntent data source were more likely to have an appointment cancelled or follow up avoided (35/142, 24.6%) compared to those identified via the LTC LCS data source (14/105, 13.3%). The difference in proportions was statistically significant (χ^2, (1, N = 247) = 4.17, p = .041).

Additional needs

Other significant changes to patient care included a total of 101 patients having their medication changed. This included new prescriptions, stopping a medication, or changes to dosage. 130 patients were referred to at least one new service (50%) with 31 patients being referred to two or more services, primarily different community services. Out of all referrals, 77 were to weight management (46%) and 54 to smoking cessation advice (32%).

Another key benefit of the service was having access to specialist advice and liaising with other services, as these interactions provided specialist input when necessary, without requiring a secondary care referral. There were 143 patients where liaisons with other services were made (55%), most often with other secondary care services (32% of liaisons). Specialist advice was sought for 103 patients (39%); this included core consultants and a specialist advisory network (91% and 9% respectively).

There were nine patients who were discussed at an MDT for whom no actions were made as a result.

Understanding impact

Measuring the impact of the new CLTCs pathway is challenging due to the long wait lists for some services like weight management, and new referrals. The data used for this evaluation captures the intent for patients to attend these new services, but whether they engaged with the service or not is out of scope.

At this stage of the pilot no follow up data has been collected, so assessing the impact of the CLTCS is limited. An impact score was introduced by the clinical team to give an objective indication of how much each patient's care has been impacted by the CLTCS process. A high impact score indicates significant changes to a patient's care such as an appointment cancellation or more than three actions as a result of the MDT (see Appendix 3: Impact score definition for scoring criteria).

Clinician value is the perceived value of the service on patient outcome; a more subjective score which captures the importance of valuable conversations and the joining up of patient care. The two scores were correlated, with a statistically significant association (Spearman's $\rho(N = 261) = 0.42$, S = 1,704,799, $p < .001$). Overall, clinician value tends to rate the impact more highly than the impact score. This suggests that higher patient impact scores were moderately associated with higher clinician value scores, although there are exceptions to this where a high impact score was perceived to be low value by the clinicians (Figure 12).

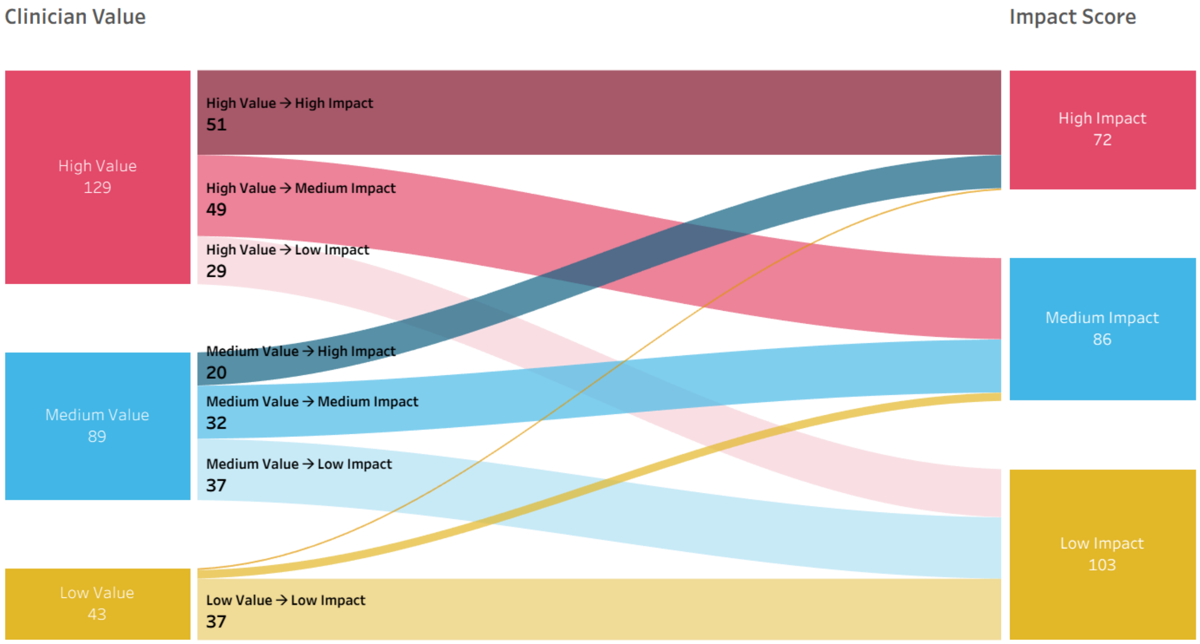


Figure 12 Sankey chart showing the similarities and differences between clinician value and impact score

Patients in the obese or severely obese BMI group were significantly more likely to have a high or medium impact score (124/171, 72.5%) compared to patients in the normal, underweight, or overweight categories (34/89, 38.2%). The difference in proportions was statistically significant (χ^2, (1, N = 260) = 27.49, $p < .001$).

This suggests that patients who are obese or severely obese could be more likely to benefit from the CLTCS pathway as they are more likely to see a high impact change to their care compared to those who are not obese (Figure 13). A similar pattern is observed with smoking status but to a lesser extent (65.9% of current smokers are rated as high or medium impact).

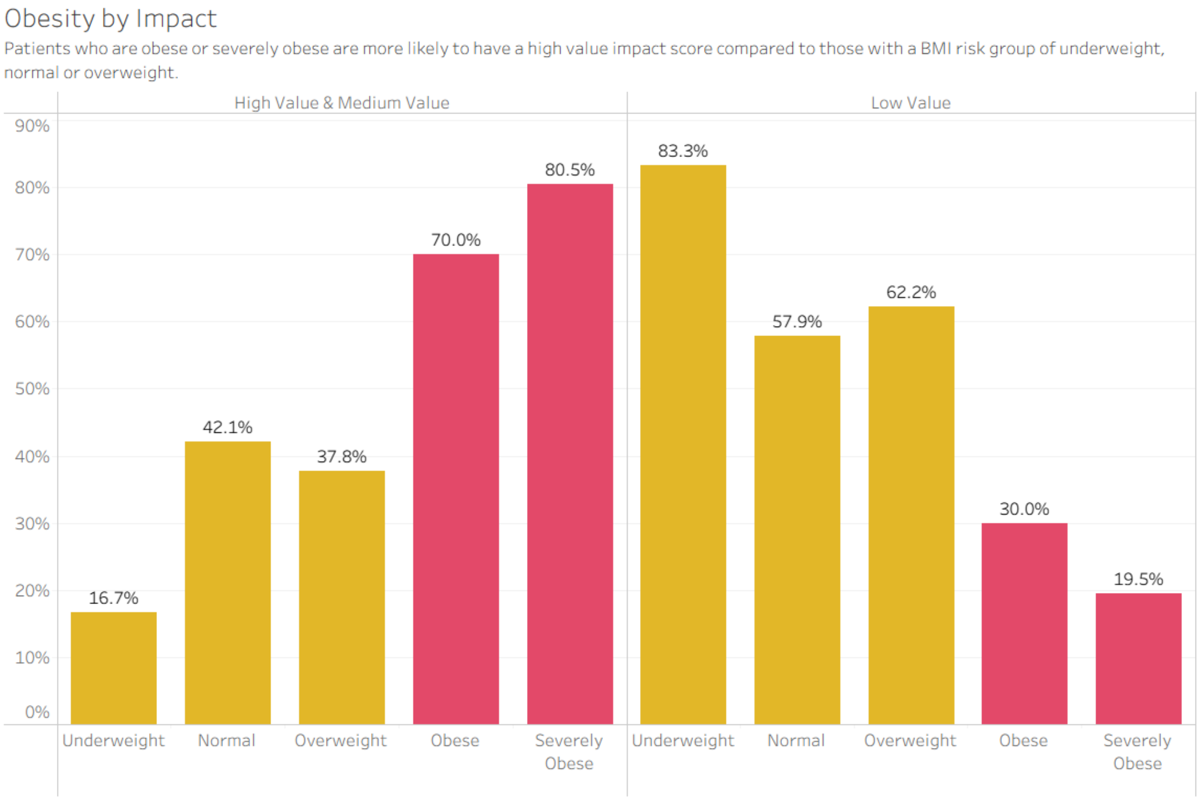


Figure 13: Percentage of patients in each BMI risk group by impact score (high & medium vs low)

Patients identified via the HealtheIntent data source were more likely to have a high or medium impact score (96/142, 67.6%) compared to those identified via the LTC LCS data source (54/105, 51.4%). The difference in proportions was statistically significant ($\chi^2(1, N = 247) = 5.96, p = .015$).

Collaboration between sectors

Effective teamwork and communication in the project were seen as extremely positive. Staff members reflected on a good skill mix within the project team, supporting not only the tasks arising from MDTs, but cross-sector learning, dealing with issues, and further developing the digital side of this programme. This way of working enabled cross-sector learning, with all staff members reflecting on how many opportunities they've had to learn from and further understand each other's way of working.

Holding MDTs in person was seen as an enabler of cross-sector learning and forming effective relationships. For example, Kentish Town PCN conduct MDTs in person, rotating between three GP practices. As reported by staff members, this approach results in stronger connections between primary and secondary care, as secondary care colleagues see first hand how the GP practice works. The MDT team also reported having a stronger connection to patients, by being in their setting and talking to the people who know them best.

Clinicians supporting the service from primary care highlighted the importance of visibility for this programme among other primary care colleagues, who are not participating in the programme. This can be achieved by inviting colleagues to MDTs, particularly when their patients are being discussed. This was also reciprocated in secondary care, with colleagues reporting the importance of sharing the visibility of the programme across different Trusts, which is a key enabler for successfully completing actions and scaling up the programme.

It's also been quite enjoyable to work with clinicians from other services and other specialties. I think that's one of the big values in this - working more collaboratively, particularly with colleagues in primary care. We are hopelessly divided in our services and just thinking in a slightly different way is, I think, valuable.

Staff member

I think it has been a bit of a learning and education thing for them [secondary care] as well. We do different jobs like I don't sit in a in a consultant's office. I don't do Ward rounds on a on a ward. I don't know what their pressures are. It's good to actually get that sort of two way communication about it.

Staff member

Future of the service

Staff members highlighted the importance of clarifying the remit of each role in the programme and the ownership of care. Providing additional clarity, and sharing the details and experiences of people who are already supporting the programme, could support with recruitment and onboarding of new staff members. The review of recommendations from behaviour change work delivered during the pilot phase will further support the team in identifying necessary changes.

> *In future, being clear of the kind of remit of the role. If I was explaining to someone what it involves, I would say it does not involve an awful lot of subject specific knowledge. It's about someone who's got a level of clinical experience that allows them to understand what a patient might need, but you don't necessarily need to have the answers to all of that, because if there are specialty specific questions, you can take them to a specialist and say what do we do here?*
>
> *Staff member*

Through the pilot phase considerable time was spent ensuring that there was clarity on the ownership of care, including following up on actions and making clinical decisions post MDT, would be beneficial. These decisions needed to take into account who was best placed to support the patient and any existing knowledge and relationships with local services, where appropriate.

In terms of the economic impact of the service, we have undertaken some costing analysis of the early iterations of the service, but this is not representative of the more established service and, as a result, is not included here. Further cost analysis should incorporate changes to the way of working since the set-up phase, and assessment of equity benefits or improvements in health and wellbeing.

Sustaining the coordinator support is considered crucial for the ongoing success of the programme, as their input to the pre-MDT identification and post-MDT mobilisation phases constitutes a significant proportion of work required for this programme. Along with sustaining coordinator support, it was posited that mental health clinicians should be integrated to each MDT team, although this may not be the best model to maximise used of mental health clinician time.

As issues with IT and data negatively impacted the time requirements for delivering this pathway, it would be beneficial to explore platform options that would enable communication between staff members, provide access to patient information, enable recording and following up on actions. Staff members envisage this working as a dashboard, giving them one source to check the status of each action post MDT, and to prepare for upcoming MDTs. This could reduce workload, minimise the risk of duplicating work and avoid errors in data capture.

Following up on patients' care, and understanding the impact of decisions made by the MDT, beyond the early indications of the impact of appointment coordination, should be prioritised for the future. At the time of the evaluation, some staff members shared concerns about the sufficiency of time for further follow-up and planning. The concerns shared included ownership of care (further discussed in Integration), understanding impact of the intervention, increased workload back in primary care, and the importance of ongoing care management for this cohort of patients.

Developing and maintaining relationships with patients was also seen as important. To enable this, staff have suggested holding ownership of their care by working as an integrated neighbourhood team that carries a caseload, as is indeed planned with the CLTCS being incorporated as part of the wider Integrated Neighbourhood Team service offer. The team would not be responsible for registering patients with a GP, but would provide care and regular support to patients to help them move along in their care journey. Dedicated resource would support more effective and joined up care for the most complex patients.

> *Continuity of care has proven to improve longevity, hospital admissions, survival courses and it’s dose dependent. So the longer you have it, the better you do. And I think it would be like having a regular structured thing that proactively manages these people who are very complicated, high risk, need a lot of input to try and manage them as best you can in the community in a comprehensive way. Just accept that they don't fit into the normal box, or the normal boxes that we have. They need to be under this specialist service, not ten different referrals to 10 different people.*
>
> *Staff member*

Finally, staff members indicated that there needs to be a change in general culture of referring in the NHS. They wondered whether this service could support the change by being embedded and continuing with reviews of upcoming appointments.

> *In an ideal world, we'd want to think of the way where you don't need to cancel somebody's five appointments. Those five appointments were never made.*
>
> *Staff member*

Recommendations

These recommendations have been structured into key themes and should be reviewed together with the sections on local context. Since the end of the data collection phase for the evaluation, these recommendations have been reviewed and considered for incorporation into the further development of the CLTCS service.

The way of working

The evaluation findings suggest that effective follow-up of patients who have been reviewed is essential, in order to achieve the identified benefits. To support this, the CLTCS team should explore the option of working across a neighbourhood as a service that carries a caseload, to facilitate effective patient follow-up and equitable care across NCL. Depending on programme progress, the following steps should be reviewed in the order considered most beneficial.

1. Continue to explore technologies that could support the excess workload arising after MDT reviews.
2. Test out working across a neighbourhood, carrying a caseload. This test should include clear definitions of the scope and ownership of care, as well as processes of communication with patients' GPs.
3. Given that the most common referrals are for weight management and smoking cessation, the service should consider a design that supports and sustains patient motivation in these areas.
4. Explore the need for focused MDT sessions for patients with hypertension and other specific clinical areas, such as asthma, diabetes, or chronic kidney disease.
5. Explore options for GPs to be able to refer patients directly into the service to improve access and coordination.
6. Opportunities to link with existing PCN structures, such as care coordinators, should be reviewed to strengthen continuity of care and reduce duplication.

Workforce

1. Conduct a workforce review, with the aim of understanding whether the current staffing mix is supportive and necessary, based on the type of patients that are being reviewed.
2. Once the workforce model is confirmed, create case studies, gather examples of contributions and staff reflections to add into a new PCN onboarding pack.
3. Invest in and integrate mental health clinician and pharmacists support to core MDT staff, in order to fully support patients with complex long-term conditions.
4. Sustain coordinator support and review their interactions and commitments for programme development. Coordinators will provide key information on the programme and should have a consistent feedback loop to the programme team, however, their time should be protected to avoid burnout.
5. Prioritise staff wellbeing, by actively checking in with programme staff and implement clear processes for escalation of issues. As part of this, consider implementing a buddy programme for spot checking and support when necessary.
6. Actively share expectations for and limitations of the service with primary and secondary care colleagues, particularly in relation to the proportion of eligible patients that can be reviewed as a part of this service, due to capacity constraints.

Patient and public involvement and engagement

Engagement with patients and the public will enable an increased understanding of barriers to care and what matters to patients.

1. The Advisory Board, created at initiation of this programme, should be sustained or an equivalent created at borough level, with continued engagement being a fundamental element of the programme.
2. There should be co-design and discussion of options for patient involvement in the MDT with the advisory group. This should include exploration of options for informing patients of the review process prior to an MDT and inviting them to join the discussion.
3. Continue to learn about the barriers for accessing care for this cohort of patients.
4. Implement a feedback mechanism for patients to review and feed back on their experience of this way of working.

Data and outcome tracking

A significant amount of work has been carried out to support data collection, establish EMIS templates, and find the most efficient way of working across the team. To enable effective cross-sector working, the following recommendations should be considered:

1. Assess the options for recording follow up data for patients who have been discussed at an MDT. This should include different options for data storage and sharing with relevant partners, as well as options for capturing the nuances of each action (for example, if a patient dropped out of the weight management service but has joined a gym and as a result still lost weight).
2. Agree standardised time frames for follow-up of each patient or LTC, taking into account when the potential effects of the intervention might be realised. For example, for patients that are referred to weight management services, should their follow-up be at the end of the programme, or at 6 or 12 months post MDT?
3. Implement a process for collecting patient and staff satisfaction data at regular intervals.
4. Record cancelled appointments with a breakdown by service (e.g., outpatient, community, etc.).
5. Conduct a detailed health economics analysis to understand the impact of implementing and scaling up the CLTCS service.

Onboarding and programme visibility

1. Create an onboarding pack for new PCNs or neighbourhoods that includes examples of support, staff reflections and time estimates for each action, to address the perceived barriers to engagement from the staff perspective.
2. For each new PCN or neighbourhood that is being onboarded, work in partnership with staff to understand if any work will be duplicated by implementing this programme, and to maximise connections with existing work.
3. Review funding allocations in light of changes to the way patients are identified, to ensure the service is adequately resourced and sustainable.
4. Communication with other trusts should be increased to promote visibility, raise awareness of the service, and encourage broader system engagement.

Appendix

Appendix 1: Actions breakdown

Action	Count
Count of specialist advice given (core consultants only)	107
Medications changed	101
Weight management	77
Other secondary care liaison	56
Smoking cessation advice	54
Count of follow ups coordinated	37
Count of pathways cancelled	26
Liaise with secondary care diabetes	26
Liaise with Mental Health	23
Liaise with secondary care respiratory	21
Count of appts cancelled	18
Liaise with community diabetes	17
Count of advice from specialist advisory network	11
Number of follow ups avoided	10
Liaise with community respiratory	10
Referral to Secondary Care	9
Referral to Community Service	8
Alcohol related advice	8
Liaise with secondary care cardio	7
Referral to Social Prescriber	5
Liaise with community therapies	4
Referral to Mental Health	4
Liaise- ClinPharm	4
Liaise with community - other	4
Drug abuse advice	3
Count of diagnostics cancelled	3
Liaise with Social Services	2
Liaise with social prescribing	1
Referral to ASC (Adult social care)	1
Total	**657**

Appendix 2: Patient comorbidities

	Asthma	Atrial Fibrillation	Cancer	Chronic Kidney Disease	COPD	Coronary Heart Disease	Depression	Diabetes	Heart Failure	Hypertension	NAFLD	Peripheral Arterial Disease	Serious Mental Illness	Stroke
Asthma	97	5	12	14	24	19	54	51	3	55	12	1	8	10
Atrial Fibrillation	5	21	3	7	3	6	7	13	11	13	1	2	2	7
Cancer	12	3	36	6	10	10	19	13	6	24	2	2	1	2
Chronic Kidney Disease	14	7	6	59	7	12	20	47	15	53	6	2	6	13
COPD	24	3	10	7	64	15	40	21	5	35	8	3	8	9
Coronary Heart Disease	19	6	10	12	15	64	30	43	18	42	7	5	3	11
Depression	54	7	19	20	40	30	143	76	9	88	10	7	22	14
Diabetes	51	13	13	47	21	43	76	190	24	131	29	9	20	27
Heart Failure	3	11	6	15	5	18	9	24	33	25	3	2	7	8
Hypertension	55	13	24	53	35	42	88	131	25	192	24	10	22	28
NAFLD	12	1	2	6	8	7	10	29	3	24	38	2	2	1
Peripheral Arterial Disease	1	2	2	2	3	5	7	9	2	10	2	14		3
Serious Mental Illness	8	2	1	6	8	3	22	20	7	22	2		38	8
Stroke	10	7	2	13	9	11	14	27	8	28	1	3	8	40

Hypertension by LTC count

	Count of long-term conditions					
	1	2	3	4	5+	Mean average
Hypertension	6	28	34	60	64	3.94
No hypertension	33	38	28	20	5	2.41

Appendix 3: Impact score definition

Impact score:

After each patient is discussed, stratify whether each case discussion was of high, medium or low impact based on the following:
- Any cancellations are automatically high impact (pathway, appointment or diagnostic)
- Any follow-ups avoided are automatically high impact
- At least one appointment planned to be coordinated
- At least one planned medication change (incl. new medication prescribed)
- At least one prevention priority planned to be supported (e.g. Smoking cessation offered, commence GLP-1 for weight management etc.)
- At least one referral made
- At least one diagnosis made or existing diagnosis planned to be changed

One criterion met = low impact
Two criteria met = medium impact
Three or more criteria met = high impact

Appendix 4: PPIE engagement

This appendix presents a collation of the feedback from the PPIE activity undertaken in the development of the CLTCS service.

Communication between NHS departments

All four interviewees raised concerns about poor communication across NHS departments. They noted that patient information is often not shared effectively, leading to repeated explanations, confusion, and extra work. For example, one carer highlighted how lack of inter-department communication creates more work for both them and the patient. Another interviewee mentioned that their primary care provider often lacks information about recent hospital visits.

Another two interviewees hoped for better joined-up working to reduce frustration and repetition. This theme was the most common issue discussed and seen as critical for improving patient experience and care efficiency. Ineffective communication and poor coordination of patient information create extra work for not only carers and patients, but also healthcare professionals. As one interviewee put it, “help us help you,” highlighting the need for better collaboration to improve outcomes and reduce avoidable burdens.

Key takeaway: poor communication between NHS departments was the most frequently raised issue. Interviewees described how repeated explanations, missing information, and lack of coordination added unnecessary work and frustration for carers, patients, and professionals. Better collaboration and information sharing are essential to improving efficiency and patient outcomes

Patient-centred care and individual needs

Three participants emphasised the need for personalised care that acknowledges individual differences. One interviewee said, “I liked the fact that people who fall through the cracks will get some attention and some help,” highlighting the importance of reaching those who are often overlooked. In the same vein, another interviewee pointed out that patients are often treated as a general group, but each has unique needs, some being less visible like sensory impairments.

Others highlighted the importance of care coordinators having access to patient information to tailor care. Recognising and responding to these individual needs is essential to delivering effective and compassionate care, ensuring patients don’t have to repeat themselves and receive the targeted support they deserve.

Key takeaway: participants stressed that care must reflect individual needs rather than treating patients as one group. Access to information and personalised support were seen as key to delivering effective, compassionate care, especially for those who are often overlooked

Carer involvement and support

Two of the interviewees were carers and when asked about the management of caring for someone, they described the heavy demands of managing multiple appointments, household tasks, and caregiving duties, with one especially saying “if the healthcare [transfer of information between appointments] is not seamless, it makes life very, very hard”, adding extra work on top of the many responsibilities they already manage as a carer. They valued being consulted and involved in programmes.

One of the carers stressed that if healthcare services are not seamless, it adds to carers' burden and makes fitting in appointments difficult. The other appreciated the programme, allowing him to be able to express frustrations and receive constructive feedback. They both emphasised that being involved and heard not only eases their burden but also helps create a more coordinated and supportive healthcare experience for everyone involved.

Key takeaway: carers face heavy demands and said that disconnected healthcare systems increase their burden. They valued being included in programmes and decisions, which helped them feel supported and reduced pressure. Involving carers improves both their experience and the overall coordination of care

Access to and management of appointments

One interviewee raised issues with appointment delays and cancellations, claiming to have been "seen more often in hospitals before the lockdown" but since has had no recent hospital appointments but remains on several waiting lists. Another hoped that better coordination would reduce emergency visits by addressing problems early. A third saw value in early referrals and timely appointments for people who often get overlooked. Improving appointment management was seen as vital to better patient outcomes.

Key takeaway: delayed or cancelled appointments, long waiting lists, and lack of follow-up were common concerns. Interviewees saw early referrals and better scheduling as essential for avoiding emergencies and improving patient care. Effective appointment management is vital to achieving timely and equitable treatment.

Transparency and oversight in patient diagnosis and records

Two participants expressed concerns about diagnosis and access to records. One doubted their diagnosis due to lack of clinical assessments and wished for a consultant to review their case. The same participant was comfortable with coordinators having access to patient information to provide accurate updates, which highlights the need for transparency and oversight to build patient trust, ensure clarity in their care, and improve communication between patients and healthcare teams. Coordinators play a key role in bridging gaps and helping patients feel more confident about their diagnosis and treatment plan.

Key takeaway: gaps in assessments and communication created doubts and reduced patient confidence in diagnoses but coordinated access to records helped improve understanding. Greater transparency and oversight can build trust and ensure patients feel informed and supported in their care.