Programme Closure Report: Complex Long-Term Conditions

NCL Health Alliance | March 2026

Summary

One of the Government's core goals for neighbourhood health is to improve diagnosis and treatment for people with long term conditions. Neighbourhood working is seen as a way to reduce variation in access to elective care for people with cardiovascular disease (CVD) diabetes, COPD and mental health conditions.

People living in disadvantaged areas experience poorer health outcomes and the incidence of individuals having multiple-Long Term Conditions is increasing. By 2035, approximately 17% of the UK population is projected to have four or more chronic conditions, almost double the current prevalence[i].

UCLPartners, working with the North Central London health system, explored a practical approach aimed to offer proactive and joined up care for people with multiple long-term conditions. Between December 2024 and April 2026, the test and learn explored how hospital-based specialists could collaborate across specialties working together with primary care to support patients with complex multi-morbidity pro-actively. The programme aimed to challenge the traditional dependency on a hospital visit as the only way to get specialist input and to provide opportunities to test out a neighbourhood-based approach particularly including deprived populations.

This brief report highlights key insights to inform any future application of similar models of care. It is relevant to organisations involved in neighbourhood care seeking to improve clinical outcomes and better coordinate support for people with long term conditions, particularly those with complex multi-morbidity.

Aims

The programme explored whether pro-active identification and case-management for people with multiple Long Term Conditions in high areas of deprivation could both:

1. Improve disease management across multiple conditions (with better treatment to target) and evaluate the potential impact from this.
2. Better coordinate care relating to hospital-based outpatient care and evaluate return on investment from this.

Through the test-and-learn we evaluated how patients with health complexity could be supported through an integrated approach between primary and secondary care; drawing out learning for Integrated Neighbourhood Team development and for acute Trusts thinking about the role of specialists within the left-shift.

Key features of the programme

- **Case finding:** In order to offer pro-active, preventative care accurate risk stratification and case finding of patients likely to have high future healthcare needs is needed. This methodology requires development and testing and at present case finding can be complex and manual. Evidence suggests that identification of high-risk individuals does not necessarily translate into improvements in service delivery or morbidity.[1] We also know it can be difficult to identify people who are 'under the radar' and struggling to access care who therefore have a lack of presence in data sets. Through the programmes test-and-learn a methodology was developed and refined for case finding of individuals who were assessed as being impactable from the intervention offered. A risk score was developed based on LTCs not being treated to target, obesity, smoking status, medication, outpatient use and age (prioritising younger age).

  This case finding process is now being automated by West and North London ICB, drawing on linked data from the London Data Service to surface a patient's whole journey across different providers. Ongoing testing and refinement of the case finding approach will be possible through use and iteration of this tool. For the purpose of the test-and-learn it was possible to measure whether case finding, when combined with a targeted clinical intervention, offered benefit. It yielded promising, though small-scale results. Automation of case finding will allow wider and longer term testing and evaluation to better understand the translation of case finding into improved disease management.

- **Coordination:** A group of 7 hospital-based consultants from a range of LTC specialities were recruited for 1 session/week. Each consultant was linked into a PCN but took responsibility for linking into other specialities where needed. PCNs were largely represented by a single GP or primary care lead with clinical time funded equally between consultant and primary care clinicians. The PCN consultant and primary care lead(s) met on a two-weekly basis to plan and coordinate care for the patients identified with multi-morbidity. The primary care lead and the consultant lead acted as the bridges, the primary care lead working across the PCN and the consultant working across specialties and across Trusts. A methodology was developed for asynchronous communication and updates between consultants, the primary care leads and coordinators who were often linking into community services and voluntary care.

[1] Oddy C, Zhang J, Morley J, et al. Promising algorithms to perilous applications: a systematic review of risk stratification tools for predicting healthcare utilisation. BMJ Health Care Inform 2024;31:e101065. doi:10.1136/ bmjhci-2024-101065

- **Case management:** Dedicated case managers 'coordinators' were appointed - two clinical and two administrative coordinators. Coordinators worked into each PCN, carrying out case-finding; compiling in-depth summaries of patients identified through case finding to smooth MDT case discussion. They worked with the patient in questions over the course of several weeks if needed to support delivery of the agreed action plan. They ensured that actions were followed up and communicated back into patient records (both primary care, community and acute providers).

Key findings[2]

Finding	Comment
Patients reviewed and discussed	1,149 patients had desktop reviews of their care records. 922 patients were case managed between specialists and GPs across 98 MDT meetings.
Scope for better coordination	46% of patients had scope for improved secondary care coordination (the remainder did not have planned future LTC outpatient appointments). 50% of this group had a coordination opportunity relating to future appointments, such as reduction in any duplicate or unnecessary pathways, flagging any risk of non-attendance or ensuring necessary diagnostics were completed in time.
Not treated to target	85% of patients reviewed were not treated to target for one or more LTCS. In just over 50% of cases, medications were changed; and over 50% had weight management, smoking cessation or smoking support initiation or proposed with enhanced support to take up such offers.
Barriers to health	49% had identified barriers to prioritising their health. Connections were made with voluntary sector, mental health and community services. Referral costs are included in ROI calculation. Further development of local care networks at neighbourhood level would enrich this offer.
Cost and return on investment	Cost per case was £153 per patient. The gross projected saving was £193k for 1000 patients and the return on investment of 0.07. The additional net cost benefit associated with treatment optimisation is estimated to be £678k for 1000 patients. Additional savings to primary care time or reductions in referrals made were not calculated in this phase of the project but would be of interest to consider.

[2] Percentages here based on detailed clinical audit of 437patients from Islington, Camden and Haringey MDTs

What we did

NCL Providers allocated funding for clinical time (primary and secondary care), coordinator roles, and non- pay costs (IT licences, PPIE sessions).

Eight PCNs were identified as host sits – one per borough, with Camden and Haringey each hosting additional PCNs to support Neighbourhood footprint working.

Patient cohorts were built at a PCN level using the primary care register of patients with one or more long term condition coupled with historic secondary care utilisation data. This allowed clinicians to view demographic data alongside morbidity, biomarkers, medication information and the multi-trust planned care activity.

Cohorts were refined and prioritised using a case finding risk score. The co-ordinators working with the link consultants undertook a 'desktop' review of the high priority patients drawing on both primary care and hospital records to build a comprehensive clinical picture of the patient problems and the interventions to date.

Patient summaries were prepared to focus MDT discussion. GP/primary care nurse and/or pharmacist reviewed cases with link consultant and coordination team.

Actions were identified and tracked on an action tracker, followed up by coordinator with review meetings held every 3-4 weeks to ensure actions being completed.

Patient outcomes and actions were recorded in EMIS and all relevant EPRs for each patient.

Case Studies

AG - 63-year-old man living in supported accommodation. He has serious mental illness, and had been previously diagnosed with COPD. Over the past year, he has needed to go to the emergency department several times because of breathlessness, including one hospital admission in December 2025.	Mr AG had been relying on steroid rescue medication for flare ups of his COPD, even sometimes coming to the GP surgery for a nebuliser, but was unwilling to go to hospital, even when his oxygen levels were low. The team identified that he needed a clearer, safer plan that worked better for him. The team reviewed spirometry results from 2023 which indicated asthma in addition to COPD. Once this was recognised, his medical records were corrected and important changes made to his inhaled medication which would reduce the risk of future flare ups and better treat his condition. To help reduce the risk of future emergencies, he was booked to see a practice nurse to check his inhaler technique and support him with managing his condition day to day. The team also re-connected him with the community respiratory team so he could start pulmonary rehabilitation and support for flare-ups if needed. He was referred for additional input and prescribed treatment to help him quit smoking. An unnecessary hospital follow-up for a lung nodule was cancelled because a scan had previously shown this nodule had resolved. This case review corrected a missed diagnosis, improved his treatment and clarified his risk of dropping oxygen levels when unwell. His universal care plan was changed to reflect this.

Case Study 2

MK - 34-year-old woman living with her partner and two children Severe obesity, diabetes, high blood pressure, breathlessness and asthma. She has struggled with	MK was discussed in the complex LTC MDT. The clinical coordinator spoke to her ahead of the meeting and she shared that her weight gain was her greatest concern and that she was feeling very anxious about her health. At the time of review her diabetes control was poor and she was only on one medication for treatment. Addition diabetes medication was started which included GLP-1 treatment as this would also support weight reduction which was key for better management of her multiple conditions. The team also planned discussions about weight loss surgery for her. Referrals were made to the diabetes self-management programme and for her to have retinal screening which she had missed. Her blood pressure was still high despite taking three medicines and she

mental health difficulties.	had struggled to attend for hospital tests to consider causes of high blood pressure. The team liaised with the hospital team to make sure the right tests were done. Finally she also had symptoms of sleep-related breathing problems and indicated the need for sleep study. The review was valuable because it brought together care that had become fragmented, making sure that important tests and referrals were not missed, treatment was optimised and she was linked in with the right support both for her diabetes and weight-related health problems.

Learning points and recommendations

For integrators and partners working on INT development

- **Review how preventative services are provided:** In the test and learn phase, 85% of patients identified through case finding and reviewed by GPs and specialists were not treated to target. Of these, 61% needed lifestyle or behavioural support (e.g. weight loss, smoking cessation, or drugs and alcohol services).

  While most had already been offered some form of support, there was a mismatch between what was offered and what was accessed and utilised. Neighbourhoods could support significant health benefits by assessing the accessibility and effectiveness of preventative services to help people who are facing barriers to prioritising their health and ensure these services maximally meet residents needs.

- **Support primary care to develop partnerships:** Delivering neighbourhood-wide proactive care requires agreement across practices on how input will be provided for cohorts such as frail or multi-morbid patients. The *Single Neighbourhood Provider Contract* will seek to formalise this approach. However, readiness for this model varies.

  Clinicians and practices need support to plan how primary care can provide input for a cohort of patients that are being supported within a neighbourhood-based team and how the liaison and communication with home practices is maintained.

- **Invest in case management and coordination:** Effective case management is essential for preparing, connecting with, and following up patients. Clinical coordinators, often from a range of professional backgrounds, quickly developed the skills to produce cross-condition summaries covering treatment history, goals, and

barriers. Clinicians found these summaries valuable and time-saving, suggesting opportunities to automate parts of the process in future.

More work is needed to establish effective digital platforms for this case management that are accessible to all required parties across health and social care.

- **Involving Patients in Care Planning**
  Proactive case identification from datasets and remote case reviews are becoming standard practice in population health. In the CLTC model, recommended actions were always discussed with patients, with follow-up letters sent when direct contact was not possible. Scaling up this approach would require clear standards for public communication, transparency, and patient engagement.

For Acute Hospitals

- **Consultant Involvement in Proactive Care**
  Consultants found cross-specialty, primary care-aligned work highly rewarding and impactful. It allowed them to intervene with support earlier in disease trajectory, more comprehensively across conditions and to impact on a larger cohort that would be possible in a traditional outpatient model for the same sessional time. Consultant involvement supported risk sharing of complex cases and the cross-speciality element reduced requirement for limiting inclusion or exclusion criteria for the intervention.

  For this approach to be sustainable, Trusts must job-plan proactive care sessions as part of outpatient work provided. This may therefore require a focus on patients who would otherwise be referred or who are already on multiple waiting lists. Mapping consultant input to neighbourhood-based MDTs is likely to be cost saving and support improved outcomes and consultants can provide input to several neighbourhoods.

For ICBs

- **Prioritise effective community provision and holistic support**: Current variation in delivery models risks exacerbating the impact of demographic inequalities.
  Where boroughs were providing sufficient quality of prevention services (e.g. a strong smoking cessation service) and sufficient capacity in community LTC services, fewer patients were flagged for needing review by the C-LTC service.

  Where community capacity was limited, proactive care coordination proved particularly high value. Closer connection between community LTC services and neighbourhood level INTs would bring benefits and ways to better share live information between primary and community service EPRs and the LCR are needed.

- **The ICB should plan on the basis that INTs include specialist consultant input for common LTC areas.** This test and learn has demonstrated how that is possible to provide this input across multiple- LTCs rather than running separate siloed pathways. This will support proactive best management of LTCs and ensure case referral through to secondary care occurs at the optimum moment.

  For those people who have multiple Long-Term Conditions, direct case discussion is likely to be more impactful than separate asynchronous advice and guidance. Shared case management supports rapid skills transference across all parties which support smoother pathway development and delivery. The test and learn showed that primary care should be supported to provide the medical leadership of neighbourhood INTs as they are best placed to hold the core care of the person with consultants deployed across one or more neighbourhood working as part of a team.

Key Learning for Implementation

Theme	What this means in practice
Proactive Case finding	Can be automated, but requires local refinement and clinical validation looking across provider healthcare records.
Digital infrastructure	A shared digital workspace for multi-agency care plan documentation and an action tracker to manage actions across the team is needed. No single EPR was able to provide the level of access required or task management functionality.
Review cadence	Action review meetings every few weeks are required to update and formally close cases. An appropriate caseload for team capacity needs to be defined.
Consultant model	Consultants benefit from being embedded in a specific locality but also in being part of a wider consultant team working in the same way - building shared momentum and cross-specialty capability.
Primary care capability	Primary care clinicians need to be able to manage caseloads beyond their PCN on behalf of their colleagues if they are to be a core part of the INT unit.
Person centred care	Establishing the way to bring the patient/ resident voice into INT case management is needed. This is particularly important

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	where they are identified remotely from datasets for review, so as to hear their priorities and preferences re being offered additional input.
Evaluation	Automation of outcomes and evaluation of impact is needed to further improve case selection approaches and confirm appropriate resource allocation in future models. Evaluation of staff and resident/ patient experience is key.

[i] Kingston, A; Robinson, L; Booth, H et al. Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model in Age Ageing. 2018; 47:374-380