# GP Delivery Improvement Framework 2025/26

# Long Term Condition Locally Enhanced Service

## 1st April 2025 – 31st March 2026

**Lancashire and South Cumbria ICB**

**Introduction:**

Welcome to the Long-Term Condition LES Specification for 2025-26.

Over the past 12 months we have taken learning from the GP Quality Contract changes and used this to identify an approach that will provide meaning and support for patients, a simplified approach for practices to deliver and a mechanism to reduce pressure within the system by a Holistic Health Assessment approach.

The delivery is intended to be flexible for each practice but with a simplified approach. Further documentation will be produced over the coming weeks to include activity and practice resource packs for each practice as well as the formal contract offer.

Supporting tools - including coding guidance, data searches and clinical templates - will also be published in a timely manner.

Alongside this will be a programme of implementation support to ensure that each practice has equal opportunity to deliver successfully.

This is intended to be the first year of a multi-year contract and opportunities to provide feedback will be regularly presented in order to continue to grow and evolve this core part of the ICB commitment to General Practice and our wider populations.

Many thanks

**Peter Tinson, Lindsey Dickinson and Peter Gregory**

February 2025

**Table of Contents –**



*CTRL + click to link to the specification's individual contents page*

**Intentions of LTC LES Specification:**

The overarching aim of the LTC LES is to identify individuals with significant health or care needs registered with each practice, identify their unmet needs and provide relevant support.

The design and delivery of the LTC LES aims to balance the overlapping needs of:

- The unmet needs of the individual patient
- The needs of system by reducing pressure on the Urgent Care sector through proactive assessment
- Effectively resourcing GP practices to provide sustainability in delivery and expectation of transformation.

Underpinning these is an intention to develop an inclusion health approach to ensure that those individuals whose needs are greatest are proactively given the opportunity of access to health services to support their needs.

## Overview:

Following a review of the General Practice Quality Contract in Autumn 2024 the LTC LES has been designed with more flexibility for delivery and consideration around delivery support. An overview is presented on the following page and split into 3 domain areas which provides a split of the payment and contractual proportionality. The main area of the contract is split into 5 segment areas;

1. Clinical case finding
2. Population health management
3. Severe mental illness
4. Long term condition 1
5. Long term condition 2

<table>
<tr><th colspan="2">Resource %</th><th colspan="5">Activity Expectation</th><th>Outcome/monitoring</th></tr>
<tr><td>35%</td><td>Domain 1</td><td colspan="5">Implementation<br><br>Administration & support to care coordinator/navigation support<br>Case finding and risk stratification work<br>Monitoring of outcomes and reporting<br>Training needs assessment and meeting training requirements to deliver this LES<br>Building relationships across practices and partners and ‘headspace’ for leadership and transformation activity</td><td>High level practice plan of delivery</td></tr>
<tr><td rowspan="3">53%</td><td rowspan="3">Domain 2</td><td>Segment 1</td><td>Segment 2</td><td>Segment 3</td><td>Segment 4</td><td>Segment 5</td><td rowspan="3">Assessment number based on weight population<br><br>Practice to deliver at least 10% of total activity from each segment excluding SMI which is a minimum of 5%<br><br>Generic template to be provided with codes and holistic health needs relevant to all LTCs, prevention and population health.</td></tr>
<tr><td>Clinical Case Finding</td><td>Population health Management</td><td>Long Term Condition 1</td><td>Long term condition 2</td><td>Severe Mental Illness</td></tr>
<tr><td>Case finding chosen according to variance from expected population prevalence</td><td>Use risk stratification and Inclusion Health knowledge to identify cohort.</td><td>Place based decision based on pop health and Place based knowledge</td><td>Place based decision based on pop health and Place based knowledge</td><td>Universal focus on individuals with SMI, undergoing stratification of health inclusion risk</td></tr>
<tr><td>12%</td><td>Domain 3</td><td colspan="5">MDT approach<br><br>Practice level MDT, PCN level or collective MDT based on historic multi-practice working.<br><br>Details and guidance about formation and delivery of MDT laid out in this specification. (page 35)</td><td>High level practice plan of delivery<br><br>Activity monitoring undertaken, no specific target to be given.</td></tr>
</table>

## Activity & Payments Overview

The example below illustrates how a specific practice's payments and activities are calculated. The total achievable payment is based on the practice's weighted population and the payment per weighted head (PWH). Each domain contributes a certain percentage to the total achievable payment, and additional payments are determined by the units of activity performed.

| PRACTICE EXAMPLE | | |
|---|---|---|
| **Domains** | | |
| **Domain 1 - Implementation** | 35% of total achievable payment | |
| **Domain 2 – Assessments** | 53% of total achievable payment **-** | |
| | **Total activity target:** | **100** |
| | **Segment 1 - Clinical Case Finding** (10% minimum of total activity) | **10** |
| | **Segment 2 - Population health Management** (10% minimum of total activity**)** | **10** |
| | **Segment 3 - Long Term Condition 1** (10% minimum of total activity) | **10** |
| | **Segment 4 - Long Term Condition 2** (10% minimum of total activity) | **10** |
| | **Segment 5 - Severe Mental Illness** (5% minimum of total activity) | **5** |
| | **Total for all 5 segments** | **45** |
| | **Remaining assessments out of the total 1000 activity Target:**<br>These can be allocated across any of the five segments at the practice's discretion. | **55** |
| **Domain 3 – MDT Approach** | 12% of total achievable payment | |
| Indicative numbers will be provided to each practice ahead of contract implementation. | | |

## The proposed funding for the 2025/26 LTC LES -

Practices will receive 80% of their annual contract value in advance, paid in monthly instalments. This will begin with a two-month upfront payment in mid-April, covering both April and May 2025. Payments will be paid on separate invoice refs, not a combined payment value – i.e. one will ref P1 & one will ref P2. Thereafter, payments will continue monthly in advance – for example, June's payment will be made in May, July's in June, and so on. The final monthly payment will be made in February 2026, covering March 2026. As a result, there will be no payment made in March 2026.

The remaining 20% of the contract value will be paid as a reconciliation payment in June 2026, subject to performance.

Reconciliation will be based on performance against the agreed LTC LES targets.

1. Underachievement (<80%): If your practice does not achieve 80% of the targets by the end of the year, any overpayment made during the upfront instalments will be recouped in the June 2026 payment run.

2. Achievement (80%–100%): Practices achieving between 80% and 100% of their targets will receive the calculated balance of their payment (up to the 20% remaining) in the June 2026 payment run.

3. Overachievement (>100%): Practices delivering activity beyond the capped 100% targets will not receive additional payments for exceeding these targets.

To support early implementation, practices will receive their first two monthly payments (April and May) as a combined payment in April 2025.

April is recognised as a planning month to support implementation for practices. However, any LTC activity already undertaken in April will be captured and counted towards the 2025/26 delivery.

The ICB have agreed an increased investment in general practice and commissioning all LES activity on a consistent and sustainable basis from 2025/26 onwards.

Specific funding details for each area are provided in the table below –

| Area | Total proposed LTC LES £PWH (2025/26) |
|---|---|
| Blackburn with Darwen | £8.40 |
| East Lancashire | £8.40 |
| Morecambe Bay | £8.40 |
| Fylde & Wyre | £8.40 |
| Blackpool | £8.40 |
| Greater Preston | £8.40 |
| Chorley & South Ribble | £8.40 |
| West Lancashire | £8.40 |

**About Inclusion Health:**

Inclusion health is an umbrella term used to describe people who are socially disadvantaged and/or excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma (these are the groups referred to as the ‘Core20plus’ in the national Core20plus5 frameworks).

People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

Inclusion health groups are a relatively small but significant population with high needs for healthcare. Whilst numbers may be small, the cost is high to individuals and systems.

## Domain 1 Guidance: Implementation (35%)

The intention of this item is to give practices an understanding of the principles and outcomes expected of the LTC LES covering LSC ICB and starting in April 2025. It is to provide a guidance for usage of the 35% total practice resource allocated.

As part of the redesign of the GP Quality Contract 24/25 into the LTC LES there is an acknowledgement that practices will require resource to change to new operational approaches. Some of this resource should be directed to the practical delivery of the specification domains, and some should be directed towards practice development.

The expectation is that each practice will assess their own needs and act to use the resource wisely in support of the delivery of the LTC LES and related practice development.

**Expected Resource Utilisation:**

The LTC LES consists of the five deliverable segments and one MDT domain. The 35% resource allocated to a practice to support with practice development and delivery would be expected to cover additional costs incurred by activity in support of the successful delivery. The expectation is that this will include (but not limited to):

**Delivery needs:**

- At the beginning of the contract period, using the pre-set filter provided through the LSC Population Segmentation tool (Aristotle) or Case finding searches (EMIS Web) will be utilised to identify specific cohorts for intervention.
- All associated administration to ensure successful patient invitation, structure of assessment sessions and necessary referral/signposting activity required.
- Necessary planning and ‘headspace’ time to ensure successful planning of LTC LES delivery. Also to ensure timely identification of potential enabling needs that may require additional support to be met.
- Identify specific training and education of relevant clinical, direct patient care or administrative staff.

**Development needs:**

- Resource use to support practice leadership development and attendance at meetings to ensure successful delivery.
- To support practices to continue and evolve local integration conversations with local relevant services.
- Support development of a practice-based inclusion health approach with relevant support and training.

**Activity Monitoring:**

Due to the likely diverse needs of individual practices the assurance monitoring will be high level and focus on activity undertaken. Implementation documents and returns will be provided by the ICB for completion.

The focus of the return will be to identify delivery actions planned/undertaken or development needs planned/undertake. The high level delivery plan templates for the Implementation and MDT monitoring are available on the GP intranet under the resources section.

This will enable the ICB to identify common activity themes and use these to support future development of the LTC LES as well as providing assurance of responsible resource utilisation.

**Delivery of LTC LES - Holistic Health Assessments:**

The delivery activity of the LTC LES is split across five domains, each practice will have to undertake activity in each segment:

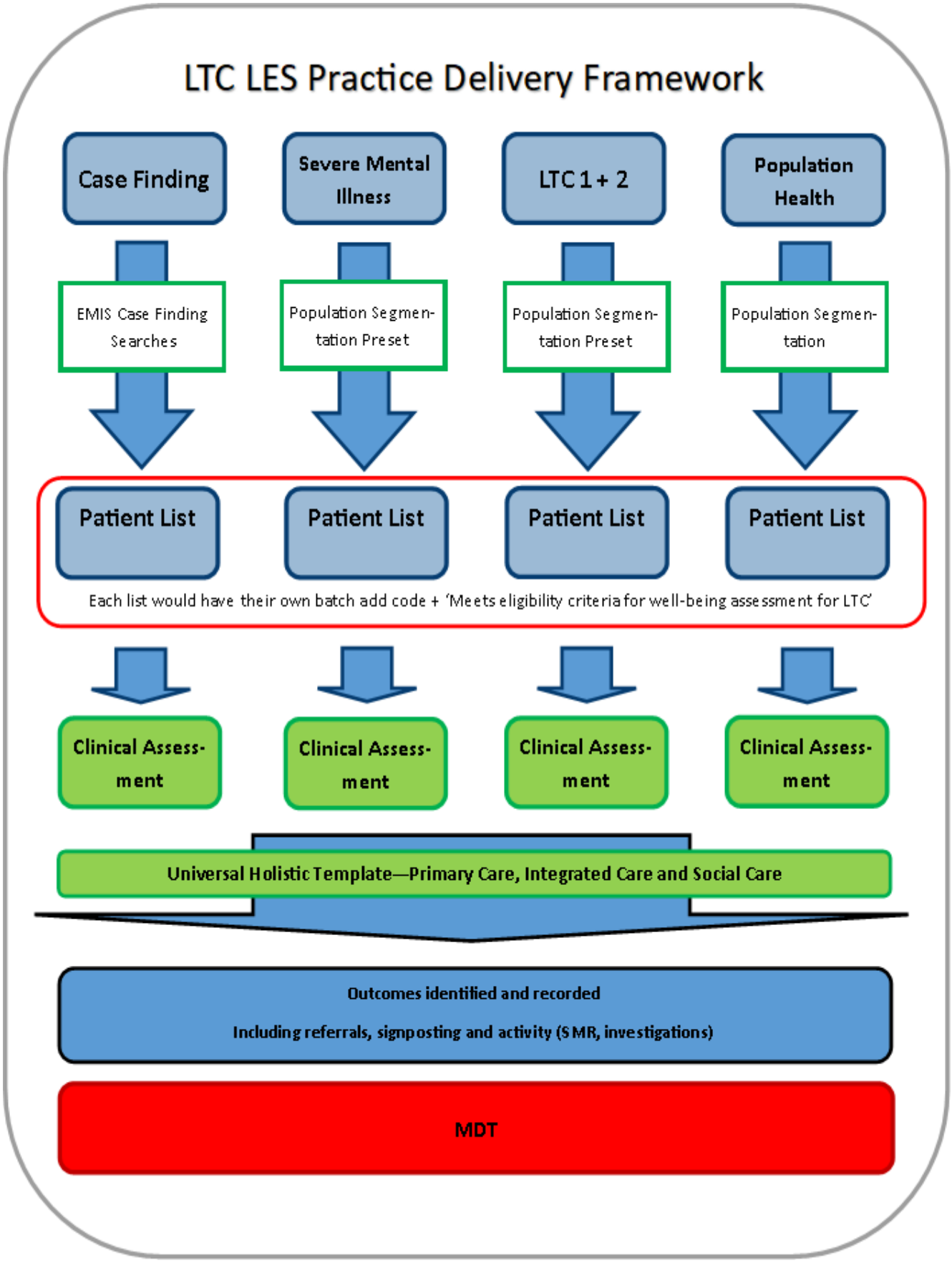
| | **Clinical Case Finding project** | **Population health management project** | **Long term condition 1** | **Long term condition 2** | **Severe Mental Illness** |
|---|---|---|---|---|---|
| **Choice of one from each column** | | | CHD<br>Diabetes<br>Respiratory<br>Frailty | CHD<br>Diabetes<br>Respiratory<br>Frailty | |
| **Number of patient Holistic Health Assessments planned** | Minimum 10% | Minimum 10% | Minimum 10% | Minimum 10% | Minimum 5% |

Each practice will need to undertake a minimum activity of 10% of their total allocated activity in each segment – except for SMI which will require only 5%. The total allocated activity may exceed the minimum percentage target under each segment and therefore practices should pick which segment they will undertake the additional activity to meet their full annual target. For example, a practice with an allocated activity of 1000 would be required to undertake at least 100 Holistic Health Assessment in case finding, population health management and each of the two LTC domains; 50 for the SMI domain. Further allocation of activity is at the discretion of the practice.

The choice of which of the LTC to undertake will be delegated to each Place to decide, via a time limited meetings called ‘Team of Team’ which includes practices, population health, LMC/Federations and Place Integration Leads etc. This is to ensure that there is local

consistency of delivery to best meet the needs of the local population. The decision-making process should consider local unmet need, local relevant resources and best fit with existing locally agreed plans.

The schematic overleaf provides an ‘at a glance’ outline of the delivery process.




**Cohort Overlap:**

As part of the cohort identification, it is expected that individual patients will frequently fall in more than one cohort (either PHM or clinical LTC). This will be identified through an additional EMIS search and those individuals should be prioritised for care as their needs will likely be more complex and significant. The EMIS search will be provided by the ML Data Quality Team.

The exception is the Clinical Case Finding segment as these will exclude patients with any pre-existing LTC within the domains listed above.

**Holistic Health Assessments and Outcome Recording:**

Holistic Health Assessments will be recorded on provided templates from the ML Data Quality team. These will (where relevant)

The holistic health assessments are built around identifying and assessing unmet needs. They focus on social care needs, integrated or nursing care needs and primary health care needs. Additional relevant clinical information to the Holistic Health Assessments should be recorded.

Outcomes should be recorded and acted upon where appropriate.

Data will be extracted via the ML Data Quality Team/PRIMIS Cumbria, on behalf of the practices, using EMIS searches and analysed by Business Intelligence. A data dashboard similar to this year's GP Quality Contract will be produced so that practices can track progress in relation to the activity target in each segment. EMIS searches will be made available to practices so that they can look at their activity and identify patients who have not yet had the assessment.

## Clinical Case Finding Segment

### Condition overview:

Clinical Case Finding can be defined as:

"A systematic or opportunistic process that identifies individuals (e.g., people with COPD) from a larger population"

Within General Practice there is significant variation in apparent prevalence of long-term conditions between practices and areas. Much of this variation will reflect variation of the true prevalence, but some will be linked to 'missing' or undiagnosed patients on a registered list.

An undiagnosed individual will not access the relevant care required and as such be more at risk of negative outcomes linked to the condition/s.

This domain within the LTC LES will promote a systematic case finding approach to identify individuals with one or more of the following conditions:

- Hypertension
- Heart Failure
- Asthma
- COPD
- Severe Mental Illness

The ICB has undertaken some prior work to estimate the size of the gap – within Lancashire and South Cumbria for example, there are potentially 461,000 patients undiagnosed with hypertension.

The approach will be to case find from a series of EMISWeb clinical code searches and to assess those at greatest risk of each clinical condition. The search strategies are listed below:

| **Clinical Domain** | **Likely number undiagnosed** | **Examples of search strategy – <u>to be finalised</u>** |
|---|---|---|
| Hypertension | Large | Identify patients over 40 with a latest BP greater than 140/90. Further stratification by Townsend score, never COVID-19 vaccination and smoking. |
| Heart Failure | Small | Identify patient with and without CVD with a significantly raised BNP and no existing diagnosis of heart failure |
| Asthma | Moderate | Individuals with two or more issues of SABA prescriptions in past 5 years.<br><br>Individuals with previous asthma diagnosis i.e. those with old child diagnosis and new symptoms. |

| | | |
|---|---|---|
| COPD | Small | History of current smoking and episode of bronchitis/prescription for SABA/prednisolone in past 3 years. |
| SMI | Small | Individuals on regular antipsychotic or mood stabiliser (lithium) with no diagnosis of SMI |

Each of these searches will be provided through the CSU Data Quality Team for running within each practice. Each practice would identify which searches to run and how to stratify further risk within each identified cohort (i.e. use inclusion health approaches).

**Practice activities:**

To achieve for this segment of the LTC LES each practice would need to undertake:

*Planning activities:*

- Assess practice prevalence of key diseases listed against local and national prevalence (e.g. using Fingertips PHE tools, Fingertips | Department of Health and Social Care ).
- Identification of patient cohorts using clinical case finding searches.
- Attach relevant SNOMED CT code to patient cohort for identification which will include a batch add. Guidance will be produced and provided by the ML Data Quality Team.
- Plan a Holistic Health Assessments approach for practice over the period of the LTC LES, incorporating inclusion health principles where appropriate.
- Develop a practice pathway to invite patients to attend relevant diagnostic tests and complete the holistic health assessment.

*Direct Patient Care Activities:*

- Undertake appropriate clinical assessment to diagnosis/rule out specified clinical condition.
- Undertake templated holistic health check/enhanced review to meet any unmet medical, nursing, social or primary care needs.
- Record and action appropriate outcomes including signposting and referrals.
- Identify individuals with multiple or significant unmet needs and refer to local LTC LES MDT.

*Multidisciplinary team activities:*

- For appropriate individuals ensure referral and presentation to local LTC LES MDT meeting as created in specified part of LTC LES (see MDT section for MDT structures permissible).
- Ensure actions are fed back to individual patient.

**Population Health Management**

Across Lancashire and South Cumbria, the health needs of many in our population has increased in complexity over recent years, resulting in:

- Increased acute exacerbations and higher rates of urgent and emergency service usage.
- Higher need for planned secondary care interventions and longer waiting times.
- Increased complexity of needs adding more need for community and social care and increasing pressure on primary care.
- Increased risk of poor health outcomes for many in our population with wide reaching impact on mental health, ability to work etc and ultimately increasing risk of premature deaths.

People from lower socio-economic groups and those in inclusion groups (as described in the national Core20plus5 frameworks) are disproportionally affected with significantly higher risk of experiencing ill health and barriers to accessing services.

The need to get further upstream and take more preventative action is clear, with every service having a role to play. Using a population health management approach, we can identify patients within the practice register who are at increased risk of adverse events and plan more beneficial and cost-effective interventions that seek to reduce the risk and ultimately to support patients to take better control of their own health and wellbeing.

**Aim**

The aim of this contract is to promote a population health management approach using existing tools and data to identify and target segments or individuals within the registered population who are at higher risk of adverse health events and to offer person-centred interventions which:

- address the short and medium-term clinical risk.
- work towards improving the health and wellbeing of the individual longer term by offering holistic, multi-disciplinary support to achieving agreed health goals, based on what matters to the individual.

The approach set out in this specification targets rising clinical need for people with multi-morbidities and considers the wider determinants of health such as levels of deprivation and other socio-demographics using the Acorn Wellbeing scores. Practices should consider the population health management approach to support the improvement of access for inclusion groups and to develop a broader approach to identifying and reducing barriers to ill health in their communities.

**Contract summary and description:**

Risk stratification is a method of assessing the potential scale of future adverse events among patients at high, medium, and low risk. By identifying these groups, health planning may be adapted to meet their needs by providing interventions to avoid these adverse events happening.

The two main forms of risk stratification are clinical judgement and predictive modelling. The sole use of clinical judgement limits the impact of risk stratification beyond the individual patient. This approach is strengthened with statistical analysis that draws on multiple past characteristics of a group of patients and applies individual risk scores.

In this specification we are asking practices to risk stratify patients based on an existing diagnosis of 2 or more long term physical conditions OR 1 or more long term physical conditions AND a diagnosis of depression or severe mental illness as well as using the Acorn Sociodemographic Wellbeing Groups a) Health Challenges and b) At Risk. By doing this, practices will call forward a small cohort of patients with some of the most complex needs where there is a good opportunity to improve their outcomes and prevent avoidable exacerbation of their conditions.

**Practice activities**

1. Generate a patient list utilising the pre-set filters (this will be included as a separate guide in the practice resource pack) in Aristotle which will help to identify the various groups of patients in Aristotle using the following filters:
    a. Existence of 3 or more physical long-term conditions using QOF registers (practices may choose which LTCs to include), OR
    b. Existence of 2 or more physical long-term conditions and 1 or more of the following diagnosis of depression or severe mental illness
    c. Risk Stratification Tool score of 50+ OR more than 2 Non-Elective (NEL) admissions within last 12 months*
2. Upload and process the patient list in EMIS, batch code the patient list – guide will be produced by ML Data Quality Team.
3. Identify the clinical and administrative team to support the cohort, and:
    a. identify any training needs and how these will be met
    b. develop a robust call/recall process
    c. identify appropriate clinic slots (consider length of slot and times of day offered as well as communication needs etc)
4. Undertake the Holistic health assessment and deliver the required interventions (relevant to their conditions and health goals) including referral to social prescribing or health and wellbeing coaches as appropriate.

*Expected outputs*

- A targeted patient list aimed at those with highest need regarding long term physical and mental health with consideration to other risks such as deprivation, housing issues etc
- A robust call/recall process to invite patients in, with consideration for flexible appointment times, and other reasonable adjustments (translation, extended appointments etc)
- Increased take up of vaccinations, medication reviews and other clinical support – e.g. inhaler techniques, asthma clinics etc as relevant to the conditions
- Referrals to social prescribing or other social support (housing teams potentially, respiratory health and wellbeing coaches where these exist)

*Expected outcomes*

- Better management of clinical risk factors and LTCs amongst a cohort more likely to be higher users of unplanned care or to become higher users soon.
- Better patient outcomes and reduction in avoidable use of urgent and emergency care or excessive pressure on primary care during winter.
- Targeted call/recall for patients who need more support to access services – improving access, building connections etc
- Increased understanding of population health – including risk stratification, population health management and health inequity and inclusive approaches to health

## LTC Domain: Respiratory

Reduction of chronic respiratory disease is one of the ‘plus 5’ priorities of the Core20PLUS work that is a priority for LSC ICB.

The Lancashire and South Cumbria ICB has a strategic aim to improve both diagnosis and management of these conditions. Last year the Quality Contract supported the training and quality assurance process to enable primary care-based spirometry and FeNO delivery which will be funded through a separate diagnostic LES from April 2025 onwards. This specification compliments these schemes and supports an enhanced delivery of management for Asthma and Chronic Obstructive Pulmonary Disease (COPD).

### Aim

The aim is to ensure that those patients with an existing diagnosis of COPD and asthma who are at highest risk of worsening respiratory health and most likely to exacerbate are identified and offered Holistic Health Assessment to ensure their respiratory care is optimal and additional unknown health needs are identified and met.

The key objectives are to reduce exacerbation rates in known COPD and Asthma sufferers, to utilise a multidisciplinary team approach where this is helpful and increase pulmonary rehabilitation referral rates.

**Service Specification**

**Condition overview:**

General Practice is often the initial point of contact for patients experiencing an exacerbation of their respiratory illness and requiring access to same day or urgent care. Most patients with a long-term respiratory illness will be managed entirely within primary care, supporting patients to manage their condition and recognise when they have an exacerbation.

The primary care approach which is being advocated is to contribute to the improvement of care and outcomes for people with respiratory diseases, by supporting them with the right level of access to diagnostics and care plans, to offer an inclusive approach on the best way to manage their condition successfully in the community.

The main clinical focus will be patients with confirmed or suspected Asthma and Chronic Obstructive Pulmonary Disease.

| | |
|---|---|
| **Practice activities**<br>• Identify a practice Lead Clinician who will familiarise themselves with current NICE guidance on management of COPD and Asthma.<br>• Establish how the practice intends to access quality assured pulmonary function testing, building on the work of the GP quality contract 2024/5, including:<br>  ○ Spirometry + Bronchodilator Responsiveness Testing<br>  ○ FENO<br>• Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle and batch add.<br>• Establish a process using the invite/decline codes for recalling patients who have suffered an exacerbation for an enhanced review.<br>• Undertake the enhanced reviews including any additional unknown health needs are identified and met. | |
| **Holistic Health Assessment**<br><br>Undertake a Holistic Health Assessment by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician.<br>• Address unmet medical needs and agree a care plan with the patient to meet ongoing care needs.<br>• Undertake a Structured Medication Review (SMR) or appropriate medication review where indicated.<br>• Ensure key care processes and QOF targets are met where appropriate utilising the appropriate templates.<br>• Review holistic health and wellbeing needs, identifying and addressing unmet need and refer on where appropriate.<br>• Ensure that a diagnostic spirometry or FeNO has been undertaken where diagnosis has not been confirmed. | |
| **Enhanced care plan**<br>Mutually agree with the patient the clear next steps for care, considering:<br>• Medical needs.<br>• Health and wellbeing needs. | |

| | |
|---|---|
| • MDT referral where appropriate.<br>• Referrals and signposting to other services. | |
| **Interventions**<br>• Clinical review.<br>• Address medical needs and agree appropriate follow up including post-exacerbation reviews.<br>• MDT approach at practice or PCN level where needed.<br>• Referral to pulmonary rehab or smoking cessation services. | |

## MONITORING, REPORTING AND RESOURCE LIBRARY

| | |
|---|---|
| **ACTIVITY MONITORING & REPORTING REQUIREMENTS**<br><br>Use the standard code for Holistic Health Assessment (this is the same for ALL long-term condition, prevention and population health contract areas)<br><br>Practice high level delivery plan templates to be completed for all practice areas and submitted to your local area team email by:<br><br>30th May 2025 – Implementation high level delivery plan<br>1st October 2025 and 31st March 2026 – 2 x submissions of the MDT high level delivery plan on the above dates.<br><br>Templates are available in Resource section on GP Intranet. | Reporting deadlines:<br><br>Data will be extracted monthly |
| **RESOURCES**<br><br>Overview \| Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) \| Guidance \| NICE<br><br>Overview \| Chronic obstructive pulmonary disease in over 16s: diagnosis and management \| Guidance \| NICE | |

## LTC Domain: Diabetes

### Rationale

Diabetes is a national, regional, and local clinical priority. It is associated with significant morbidity and early mortality, with associated complications including cardiovascular disease, stroke, blindness, renal failure, and lower limb amputation. Diabetes is a major chronic disease which has significant impact on mortality, morbidity, and health costs in the UK.

### Aim

The aim of the contract is to identify those patients with diabetes who have the highest risk of diabetes related complications, have comorbidities, and where diabetes is most likely to be impacting their health and wellbeing. Once identified to undertake a holistic enhanced review of their care and meets the needs of the patients.

The key objectives of the contract:

- Reduce the burden of diabetes and its complications and improve quality of life.
- Improving management of diabetes in Primary Care
- Ensuring patients have better quality of life, improved outcomes, and positive patient experiences
- Empowering patients to self-manage their care and access the most appropriate support and services to meet their needs
- Improve the three key treatment targets: HbA1c (blood sugar), lipid management and blood pressure.
- Increase referrals to appropriate local diabetes education (DESMOND).
- Increase the number of patients accessing all 9 key care processes and manage the clinical needs of the patient.

**Service Specification**:

**Condition overview:**

Diabetes is one of the common endocrine diseases affecting all age groups with approximately 3.5 million people in the England having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetes, particularly type 2 diabetes, is undertaken by GP practices and members of the primary care team. Within Lancashire and South Cumbria there are more than 121,000 people living with diabetes.
Diabetes is a growing problem for our health services. Over 90% of people with diabetes have type 2 diabetes which can result in severe complications, affecting the eyes, the nervous system, and the kidneys.

**Practice activities**

- Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle, batch guidance and batch add coding.
- Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.
- Undertake the enhanced reviews

**Holistic Health Assessment**

- Undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician
- Address unmet medical needs and agree a care plan with the patient to meet ongoing care needs aiming to achieve the 3 key care targets for diabetes to reduce the risk of future complications
    - BP control
    - HbA1c control
    - Lipid management
- Undertake an SMR or appropriate medication review where indicated, considering:
    - Titration of medication
    - DVLA guidance on safe medication management
- Ensure key care processes and QOF targets are met where appropriate
    - The 9 key diabetes processes for care are:
        1. Weight and BMI
        2. Blood pressure
        3. HbA1c
        4. Foot risk stratification
        5. Urinary albumin test
        6. Serum creatinine
        7. Smoking status
        8. Cholesterol level
        9. Retinopathy screening
- Review holistic health and wellbeing needs, identifying and addressing unmet need

**Enhanced care plan**

Mutually agree with the patient the clear next steps for care, considering:

- Medical needs and personalised goals for the 3 key care targets, BP, HbA1c and lipids, considering medication risks (hypoglycaemia), frailty and comorbidity

| | |
|---|---|
| • Health and wellbeing needs and psychological support for long term conditions<br>• MDT referral where appropriate, at practice level or collaborative MDT<br>• Referrals and signposting to other services, including diabetes UK | |
| **Interventions**<br>• Clinical review<br>• Address medical needs and agree appropriate follow up as per practices own recall system.<br>• MDT approach at practice or PCN level where needed<br>• Referral to appropriate services for holistic health and wellbeing needs | |

## MONITORING, REPORTING AND RESOURCE LIBRARY

| | |
|---|---|
| **ACTIVITY MONITORING & REPORTING REQUIREMENTS**<br><br>Use the standard code for enhanced review TBC (this is the same for ALL long-term condition, prevention and population health contract areas)<br><br>Practice high level delivery plan templates to be completed for all practice areas and submitted to your local area team email by:<br><br>30th May 2025 – Implementation high level delivery plan<br>1st October 2025 and 31st March 2026 – 2 x submissions of the MDT high level delivery plan on the above dates.<br><br>Templates available in resources section of GP intranet. | Reporting deadlines:<br><br>Data will be extracted quarterly |
| **RESOURCES**<br><br>Lancashire and South Cumbria Medicines Management Group: Guideline for antihyperglycemic management in type 2 diabetes: Algorithm type II DM<br><br>National Institute for Health and Care Excellence (2015) Type 2 diabetes in adults: management NICE guideline (NG28)<br><br>National Institute for Health and Care Excellence (2015) Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guideline (NG5)<br><br>Diabetes UK website | |

**LTC Domain: Frailty**

Individuals living with Frailty remain one of the most significant challenges for any Health and Care system. The person specific needs of each individual and the high level of integration required to meet those needs leads to many patients not receiving the care required to maintain their independence and health.

The proactive GPQC work throughout 24/25 has led to the number of individuals identified over 65 with frailty or potential frailty increasing from 27 634 last year to 136 083 by the end of October 2024. For those individuals with mild or moderate Frailty the number with a care plan has increased from 890 to 17 153 over the same period.

This still leaves a significant number of individuals without a care plan or needs Holistic Health Assessment. NHSE and the British Geriatrics Society have reiterated and emphasised at proactive care approach (with additional supporting evidence).

**Holistic Health Assessment:**

Practices will invite patients for an enhanced review appointment to undertake a brief-CGA type assessment. This face-to-face Holistic Health Assessment should cover the individual's unmet health and care needs.

The template approach will be similar to 24-25 and cover falls risk, mobility, medication and care needs. An appropriate SMR should also be undertaken and brief care planning undertaken using 'I' statements.

Any unmet needs identified should result in an action, signpost or referral where appropriate and recorded in the record.

Individuals with multiple, significant or complex needs should be offered review by local Frailty MDT group.

**Interventions:**

Due to the individual and unique nature of frailty reviews it is difficult to identify all potential outcomes of the Holistic Health Assessment/review. The responsibility of referring or signposting would be with the contracting practice to undertake this is a timely manner.

Significant actions such as referral to secondary care, social prescribing link works, other primary care providers or health and wellbeing workers should be coded.

Referral to local MDT should also be recorded.

A record of the proactive care plan 'I' statements should be made available to the individual patient.

**MDT structure:**

It is expected that the Frailty MDT would consist of a core team including a care coordinator role (e.g. health and wellbeing worker), Advanced Care Practitioner or practice nurse and GP.

The intention is that the MDT would eventually expand to include:


Notes and outcomes from the MDT would be expected to be kept within a suitable electronic health care record.

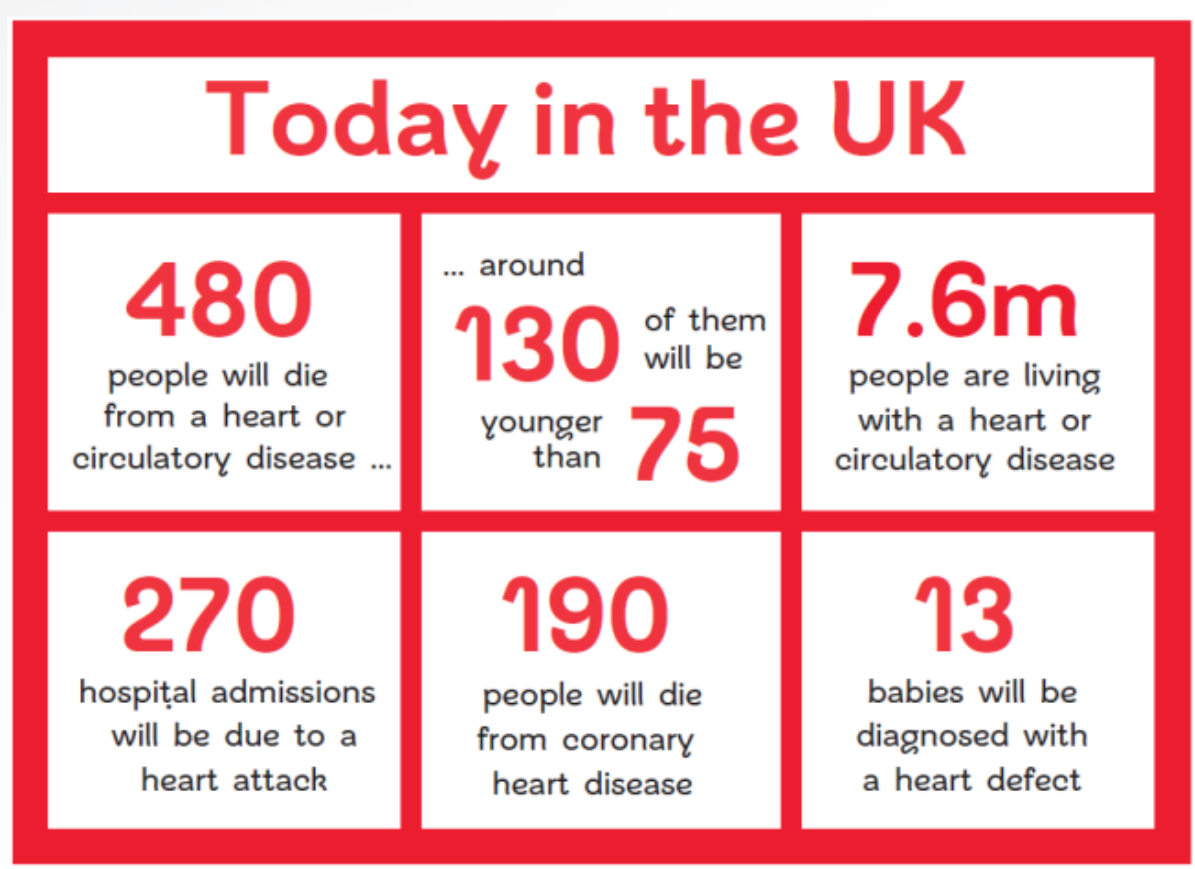
| **ACTIVITY MONITORING & REPORTING REQUIREMENTS** | Reporting deadlines: |
|---|---|
| Use the standard code for enhanced review TBC (this is the same for ALL long-term condition, prevention and population health contract areas) | Data will be extracted quarterly |
| Practice high level delivery plan templates to be completed for all practice areas and submitted to your local area team email by:<br><br>30th May 2025 – Implementation high level delivery plan<br>1st October 2025 and 31st March 2026 – 2 x submissions of the MDT high level delivery plan on the above dates. | |
| Templates are available in Resource section on GP Intranet. | |

**RESOURCES**

Insert details on any local or national resources for practices to utilise or to be referenced.


**LTC Domain: Cardiovascular Disease**

**Rationale**




3

Cardiovascular disease (CVD) is well known to be one of the biggest causes of ill health and premature mortality across our population, as outlined within the current NHS Long Term Plan[1] With the new government will come a new plan, with the initial concepts being a clear fit to preventing, diagnosing and treating cardiovascular disease; -

- shifting from acute to community
- sickness to prevention
- analogue to digital

The British Heart Foundation, Britain's leading charity for heart related illness, describes cardiovascular disease (CVD) as an umbrella name for conditions that affect your heart or circulation (also known as heart and circulatory disease). It can lead to heart attack, angina and some strokes. Heart disease also covers conditions that affect your hearts muscle, valves or cause abnormal rhythms (arrhythmias)[2]

With CVD there are several risk factors; some genetic, some related to lifestyle or environment and modifiable, and some classed as illnesses in themselves, such as Hypertension, Atrial Fibrillation and Hypercholesterolemia, that can be managed through medication.

In Lancashire & South Cumbria, our data tells us that there are thousands of patients on the relevant disease registers that have increased CVD risk; -

- Almost 48,000 patients are diagnosed with AF, with AF being a contributing factor to one in every five strokes[3].
- Over 315,000 people have diagnosed hypertension, which nationally, is associated with around 50% of all heart attacks and strokes[3]
- Almost 64,000 patients are on lipid lowering therapies to bring cholesterol levels down.
- Over 71,000 patients are diagnosed with chronic kidney disease (CKD), which high blood pressure can often be an initial indicator of.

The BHF also tell us that 80 percent of people living with heart & circulatory diseases, have at least one other health condition[3] therefore, some people may be on all the above registers, increasing their risk of CVD, heart attack and/or stroke and premature mortality.

**National challenges:**
As with many conditions, cardiovascular disease risk increases with age, and as our aging population increases, there are many differing projections of what the CVD burden will be by 2040. The one thing that they all have in common, is that the number of patients living with CVD is increasing, the cost to the healthcare system and economy are both increasing by billions, and the gap in health inequalities is widening.

The majority of diagnosis, treatment and management of CVD falls into Primary Care within the current healthcare models, and whilst some fantastic strides have been made across the country (NHS Health checks outlined in the recent NAO report[5]), with high blood pressure being largely symptomless, a large number of people are not being picked up early and are presenting at emergency departments with life threatening issues such as heart attacks and strokes.

**Aim**

**The aim of the contract is** to improve the detection, diagnosis and treatment of the ABC[2] of Cardiovascular Disease to reduce CVD impact within our populations.

**The key objectives of the contract are –**

- a focus on Secondary prevention through data and risk stratification.
- improve the management of disease by increasing Treatment to Target across ABC[2]
- begin to reduce health inequalities at practice level.

**Service Specification**:

**Condition overview:**

Within this specification we aim to encourage to work on treating the above risk areas for each patient via a holistic approach, understanding that these can often indicate risk factors for many other long-term conditions. Working across the wider patient practice register, as well as focusing in on any specific cohorts of patients with the greatest needs, based around system knowledge, local knowledge, understanding and data available.

- 80 percent of people living with heart & circulatory diseases, have at least one other health condition

| | |
|---|---|
| • is associated with around 50% of all heart attacks and strokes | |
| **Practice activities**<br>• Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle.<br>• Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.<br>• Consider the use of pharmacy first and other community based services that could support patient care, e.g.. pharmacy hypertension service | |
| **Holistic Health Assessment**<br>• Invite patient into surgery to undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician.<br>○ Address unmet medical needs in all 4 of the CVD umbrella illnesses (AF, Hypertension, Hypercholesterolaemia and CKD) and agree a care plan with the patient to meet ongoing care needs<br>○ Undertake an SMR or appropriate medication review where indicated<br>○ Ensure key care processes and QOF targets are met where appropriate<br>○ Provide lifestyle advice and referral to supporting services (tobacco, weight, exercise) to reduce CVD risk, using resources below in resource section<br>○ Review holistic health and wellbeing needs, identifying and addressing unmet need | |
| **Enhanced care plan**<br>• Mutually agree and record with the patient the clear next steps for care, considering:<br>○ Medical needs<br>○ Health and wellbeing needs<br>○ MDT referral where appropriate<br>○ Referrals and signposting to other services | |
| **Interventions**<br>• Clinical review<br>• Address medical needs and agree appropriate follow up<br>• MDT approach at practice or PCN level where needed<br>• Referral to appropriate services for holistic health and wellbeing needs | |

## MONITORING, REPORTING AND RESOURCE LIBRARY

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| **ACTIVITY MONITORING & REPORTING REQUIREMENTS**<br><br>Use the standard code for enhanced review TBC (this is the same for ALL long-term condition, prevention and population health contract areas)<br><br>Practice high level delivery plan templates to be completed for all practice areas and submitted to your local area team email by:<br><br>30th May 2025 – Implementation high level delivery plan<br>1st October 2025 and 31st March 2026 – 2 x submissions of the MDT high level delivery plan on the above dates.<br><br>Templates are available in Resource section on GP Intranet. | Reporting deadlines:<br><br>Data will be extracted quarterly |
| **RESOURCES**<br><br>• CVD support pack (currently under construction)<br>• Hypertension pathway<br>• NICE patient decision aid – blood pressure<br>• Blood pressure leaflet<br>• Blood pressure monitoring diary<br>• Lipids prevention pathway (primary prevention)<br>• Lipids prevention pathway (secondary prevention)<br>• NICE patient decision aid – statin<br>• CKS primary care medication aid<br>• AF pathway<br>• Tobacco service for LSC<br>• Weight management services for LSC<br>• Physical Exercise services for LSC | |

**LTC Domain : Severe Mental Illness**

**Rationale**

Adults living with SMI have an almost five times increased risk of dying prematurely compared to those living without SMI, and premature deaths of people living with SMI are increasing. An estimated 50% of deaths in people living with SMI are attributable to smoking[1].

People living with SMI have:

- 6.6 times increased risk of respiratory disease
- 6.5 times increased risk of liver disease
- 4.1 times increased risk of cardiovascular disease
- 2.3 times increased risk of cancer
- are 3 times more likely to lose their natural teeth

Annual physical health checks are recommended for people of all ages, with SMI. The use of anti-psychotic or mood stabilising medication increases the risk of physical health problems like obesity, diabetes, and heart disease. People with an SMI are also more likely to smoke and drink alcohol more heavily than the general population, affecting their health and life expectancy. They may also be more likely to have a history of past or current substance misuse.

People with SMI may find access to health improvement services more challenging and may face barriers in accessing national screening programmes. A physical health check can be an important opportunity to identify physical health problems and offer support.

The National QOF framework requires 6 pieces of data to be collected.

- **National and local context, data and statistics**

In England there are 551,000 patients on SMI registers and for Lancashire and South Cumbria there are 20,426 Patients on SMI registers. For Lancashire and South Cumbria ICB this equates to 1.13% of the population.

**As these numbers are very small in comparison to other LTCs all practices/ PCNs are expected to assessment these patients as a separate cohort.**

The current national target (linked to QOF) is for 60% of SMI patients to have received a check and had all the 6 core items recorded.

- National/local guidance and links to other contracts e.g. LES/community/acute contracts

While QOF SMI checks are limited to patients with Psychoses, National Guidance[1] encourages clinicians to consider the physical health needs of all people severely affected by their mental illness, in line with community mental health transformation commitments. This includes, but is not limited to, those with a diagnosis of personality disorder, eating disorder or severe depression, and people with mental health rehabilitation needs – some of whom may have co-existing conditions, for example, frailty, cognitive impairment, neurodevelopmental conditions or substance misuse.

Practices may therefore wish to offer the Enhanced SMI checks to patients covered by this recommendation at their clinical discretion and risk stratifications.

**Aims**

- Provide high quality physical health checks via an enhanced review for SMI patients in primary care.
- Improve uptake of physical health checks for those eligible on the GP SMI register in line with national expectations.
- Measure and monitor the physical health of SMI patients, enabling early identification and intervention.
- Provide follow up health interventions and relevant advice, in line with NICE guidelines, that support and educate patients with SMI to make informed, healthy choices and positive lifestyle changes
- Initiate personalised care planning in partnership with the patient that encourages active participation and ownership.
- Support the system wide objectives to make every contact count for our patients and reduce health inequalities.

The key objectives of the Long-Term Condition LES's is to deliver an enhanced review to provide more in-depth care planning, risk stratification and patient management. As well as expanding the data collection with additional fields as recommended by National guidance[1] and includes an enhanced health check via a second appointment where results are discussed, and a Health Action Plan is agreed.

**Service Specification**:

**Condition overview:**

The term SMI (Severe Mental Illness) refers to individuals, who have received a diagnosis of schizophrenia, other psychosis, bipolar affective disorder, and all patients on lithium. The Quality and Outcomes Framework (QOF) Register should consist of all the people who have a recorded diagnosis or other long-term psychotic illness. Use of antipsychotic or mood stabilising medication including lithium may help to identify this population.

| | |
|---|---|
| **Practice activities**<br>• Identifying patients with SMI using the Aristotle Population Segmentation preset.<br>• Utilise the ICBs "**Practical Guide to SMI Physical Health checks**" (appendix 1) to aid prioritising and undertaking checks.<br>• Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.<br>• Undertake the Holistic Health Assessment and clinical reviews. | |
| **Holistic Health Assessment and Clinical Review**<br>• Undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician. Data should be recorded and coded on EMIS using either the template provide by MLCSU<br>○ Would be expected to be a multi-stage process. The first appointment would usually be undertaken by an HCA to undertake 6 QOF items - blood tests, measure BP, weight and collect the other data items. | |

| | |
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| ○ The 2nd appointment would be undertaken by a Nurse, Pharmacist or Doctor and would include a review of the results, the Additional Questions (as outlined below) and agreement of the Holistic Health Assessment<br>○ Importantly, all patients taking antipsychotics or mood stabiliser should have medication reviews and their physical health monitored in line with summary of product characteristics (SmPC) and/or British National Formulary guidelines on:<br>○ antipsychotics (includes those prescribed antipsychotics without a mental health diagnosis, such as people with a learning disability whose behaviour challenges)<br>○ lithium<br>○ sodium valproate (should not be used in women/girls of childbearing potential unless conditions of the Pregnancy Prevention Programme are met; MHRA drug safety update April 2018).<br>○ Ensure that PREVENT paperwork is complete and where it is not refer to MH provider for this to be undertaken<br>○ Cardiovascular risk should be assessed using Qrisk3 in this population and the Lester Tool[2] gives further guidance.<br>6 QOF items:<br>▪ alcohol consumption status<br>▪ blood glucose or HbA1c test<br>▪ blood pressure<br>▪ body mass index<br>▪ lipid profile<br>▪ smoking status | |
| **Holistic Health**<br>• Mutually agree with the patient the clear next steps for care, considering:<br>○ Medical needs<br>○ Health and wellbeing needs<br>○ MDT referral where appropriate<br>○ Referrals and signposting to other services<br>○ Agree a written Health Action Plan on measures to be taken to improve physical health<br>○ A document will be provided via CSU that incorporates a Physical health action plan with a Psychiatry Care Plan (required for QOF) in 1 document. | |
| **Interventions**<br>• Clinical review<br>• Address medical needs and agree appropriate follow up<br>• MDT approach at practice or PCN or Locality level where needed<br>• Referral to appropriate services for holistic health and wellbeing needs | |

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|---|---|
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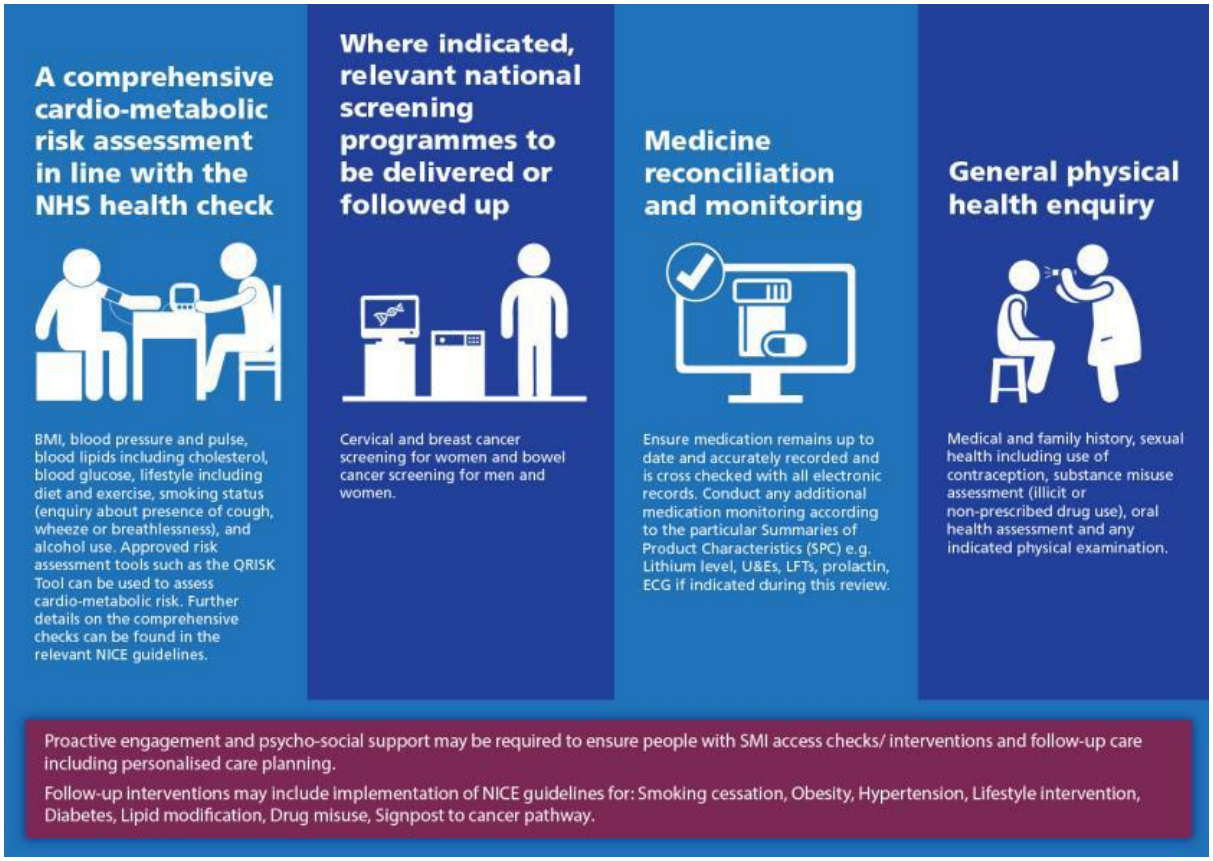
| **RESOURCES**<br><br>EMIS template and Care Plan document will be provided by MLSCU into EMIS.<br><br>References<br>1. https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/#purpose-of-this-guidance<br>2. Lester Tool ncap-lester-tool-intervention-framework.pdf | A Practical Guide to SMI Health checks<br><br>- see appendix 1 |




**Appendix 1 -** A Practical Guide to SMI Health checks
A Practical Guide to SMI Physical Health Checks Final Version - JHcomments.docx

**Holistic Multidisciplinary Team (MDT) Meeting Guidance for LTC LES**

**Introduction:**

The MDT segment of the LTC LES builds on and learns from the work undertaken as part of the 2024/25 GPQC (Frailty). The intention is to ensure that individuals identified with a significant number or severity of unmet needs will be reviewed by a relevant local holistic MDT.

Although there is significant variation in each of the LTC LES domains the intention is for the MDT to focus on any holistic needs identified. Any unmet medical needs (including multimorbidity) should be addressed but the primary function of the MDT is not to provide specialist medical input.

The resource (12% of total practice resource available for LTC LES) is intended to support the set up and delivery of MDT care for patients assessed through any one of the four domains.

**LTC LES MDT Expectations:**

The expectation is that as a minimum each practice would:

1. Set up a working core team MDT according to the principles laid out below. This set up should cover inclusion criteria, exclusion criteria, referral and action processes and record keeping.
2. Actively review/signpost/refer patients with multiple unmet needs identified and/or significant/complex need identified that may require multidisciplinary input.
3. Record activity numbers through designated SNOMED CT codes.

Throughout the 12 months span of the 25/26 LTC LES there is the intention to move beyond the core MDT set up and towards an extended or integrated MDT structure. The leadership/integration/population development resource outlined within the LTC LES implementation document should be used to further evolve the MDT structure locally.

The intention is that the MDT and LTC LES be deliverable by individual practices, there is the opportunity, where appropriate, for practices to work together (e.g. PCN footprint) to deliver this portion of the LTC LES for reasons of scale and local service engagement.

**MDT Activity Monitoring:**

Coded activity will be monitored on a quarterly basis, using specified SNOMED CT code terms.
A brief self- reporting high level delivery plan template will need to be completed at six months and year end basis on the following format:

| | |
|---|---|
| **MDT Participants (list):** | e.g. GP, Practice Nurse or ANP etc. |
| **Development narrative** | e.g. How the group was formed (brief) |
| **Development benefits** | e.g. beneficial impact to patients/practice |
| **Development challenges** | e.g. finding difficult to expand because etc. |

The high level delivery plan template is available on the GP intranet under the resource section.

**Further Guidance:**

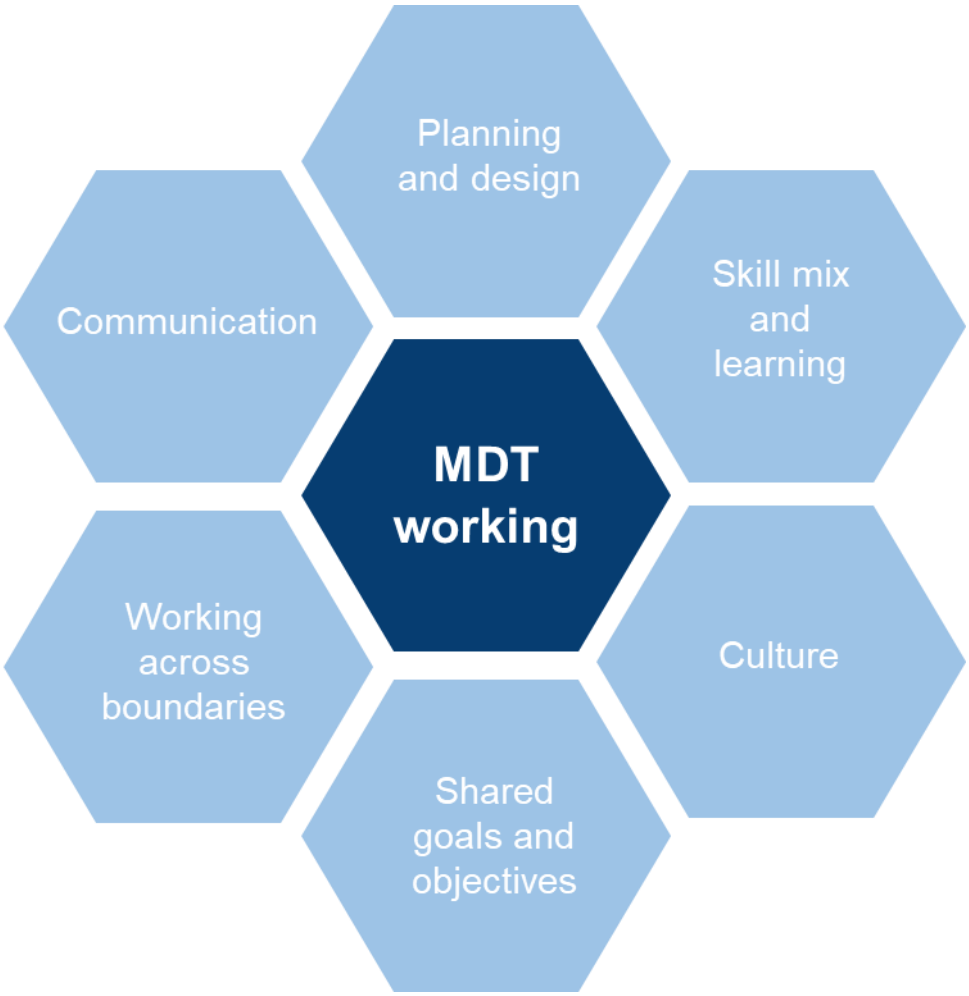
The attached guidance below is intended to provide guidance and support in the implementation of practice MDTs.

What is an MDT and how can it support Proactive Care?

- A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations
- A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings.
- MDTs are teams consisting of individuals drawn from different disciplines who come together to achieve a common goal(s)

Hence, there is no pre-defined structure but to be successful we would wish for each practice to focus on the ***function*** of their own MDT to meet the requisite quality needed to successfully achieve within the LTC LES framework.

This is outlined by the NHSE MDT toolkit:



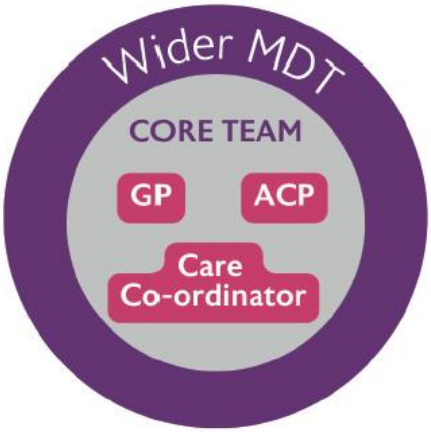

| Domain: | Example: |
|---|---|
| **Communication** | Open and transparent with partners, engaging effectively |
| **Working across Boundaries** | Leadership and ownership clearly defined. Enabled by technology |
| **Shared Goals** | Shared decision making, governance and accountability |
| **Culture** | Consider inter-professional training and education |
| **Skill mix** | Ensure correct skills and membership |
| **Planning & Design** | Design based on population need |

As acknowledged each place will likely have a different make up to the MDT. Further detailed guidance about how to set up and MDT is found below, using the example of frailty.

**From *Be proactive: Delivering proactive care for older people with frailty***

1. Agree proactive care team membership for service Core team membership

At a minimum, the core proactive care team should consist of a GP with an interest in frailty, an Advanced Clinical Practitioner, and a Care Co-ordinator. If the resource is available, a gold standard core team can include professionals from mental health services, pharmacy, social care, therapy and geriatric medicine. Core team membership will vary depending on whether there are funded roles available, if there is protected time for existing staff, the size and demographic of the population, funding, and local resources.





*Advanced Clinical Practitioners*

The core team should include highly trained professionals who are able to manage a complex caseload, such as ACPs from either nursing or allied health professions. It is more important that they have the right mindset rather than belonging to a specific profession as generic skills for managing people with frailty can be acquired. Availability of highly trained experienced staff is limited so staff should be offered training and support on the job if needed.

*Care Co-ordinators*

Care Co-ordinators are non-clinical staff who help to Coordinate and navigate care across the health and care system. They are vital members of the core team, providing support to reduce the fragmentation between health and social care. A key part of the role is forming relationships with patients, carers and families to help improve the continuity of care by acting as a connector between health and care teams. They are often the main link in the MDT to social care services, local authority services, and voluntary organisations. They can provide skilled administrative support for the core team by reviewing day to day referrals and hospital discharges and flagging up patients suitable for the proactive care service. In some teams, the Care Co-ordinators help to identify cases by reviewing lists of people identified

via data reports and phoning patients at home to assess their degree of frailty. They can also help to promote the proactive care service to external organisations.

*GPs*

GPs are crucial members of the core proactive care service team, contributing medical knowledge and acting as a link between general practice and other services. Some GPs are employed by community services and acute trusts to work in proactive care, while others are employed directly by PCNs/PCCs or equivalents and general practices. In some smaller proactive care services, GPs are given dedicated protected time within their existing role to work for the proactive care service. Funding is often a barrier for GPs wishing to work in proactive care.

*Administrative services*

Administrative support can release clinical time and is often overlooked. Larger services require in-house administrative support while smaller services may need to rely on administrative support from the community services, PCNs/PCCs and GP practices where they work.
Agree the infrastructure required for the proactive care service

*Employment*

The service can function as one team, the employing organisation is not important. Where line management arrangements are outside the core team, it is important that the line manager understands frailty and the aims of the proactive care team.

*Core team location*

It is important that all core team members have a shared base where they can meet up daily. It is helpful if the core team is co-located with the community teams, allowing collective responsibility, open conversations, reflection and debriefing. It also makes it easier for MDT members, such as geriatricians, who may only be available once a week to be part of the team. However, although helpful, co-location with community services is not essential. Some PCN/PCCs and practice led services are co-located in GP surgeries allowing close communication with other practice based multidisciplinary team members.

1. Set up regular MDT meetings at practice or PCN/PCC or equivalent level

Regular multidisciplinary meetings are key to ensuring that the necessary multidisciplinary interventions are delivered. They provide dedicated time to review patients as a team, have case discussions, establish clear and simple referral pathways, and help members to get to know each other. MDT meetings can be face-to-face or virtual or a combination of both. Virtual meetings help some members to attend but may impede team building, informal information sharing and learning. A stable team with regular attendance by the same people helps to establish and maintain effective team working.

MDT meetings could be set up for each PCN/PCC, as well as at practice level as well if preferred. As well as the core team, MDT meetings could evolve to include a community matron, community nurse, a social worker, a mental health professional, a PCN/practice pharmacist and a medical consultant (if available) as a minimum. Other services attending MDT meetings can include intermediate care and community rehabilitation teams.

2. Ensure the proactive care team has access to shared care records

Information sharing is vital for proactive care services as it requires multidisciplinary interventions across a range of health and care organisations. If possible, ensure that core team members have access to all electronic patient records, including general practice, community services, hospitals and social care. If this is not possible, ensure that they have access to all the shared records available in the area.