NHS
Lancashire and South Cumbria
Integrated Care Board

Long Term Conditions LES Specification for 2026-27

1. Introduction:

The LSC LTC LES for 2026-27 will be an evolution of the work undertaken in 2025-26.

The fundamental approach and framework will remain the same – a focus on identifying individuals within our practices with significant health or care needs and taking steps to remedy this using a holistic and integrated approach.

The intentions remain the same as well, balancing the overlapping needs of:

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

And combining this with a developing focus on inclusion health principles to ensure that those individuals whose needs are greatest are proactively given the opportunity of access to health services to support their needs.

At the time of writing we are currently on target to complete over 76 000 assessments in 2025-26 and we are beginning to see reductions in non-elective admissions for those patients who have had a Holistic Health Assessment in 2025-26.

We aim to continue and grow this approach for 2026-27.

2. Key changes for 2026-27:

Following the implementation year of 25-26, the updated LTC LES specification will see a change in the balance of resourcing to focus more on MDT development and delivery in 2026-27. This results in a change in the proportion of funding allocated to each domain:

Domain	2025-26	2026-27	Rationale
Implementation	35%	20%	Move to business-as-usual activity
Delivery of Assessments	53%	55%	Increased to support an increase in assessment activity
MDT Approach	12%	25%	Focus for development and delivery

The second key change will be in the potential assessment cohorts:

Clinical Segment	Minimal % of total activity	Clinical Rationale
Population Health Management	10%	Ongoing focus on individuals at greatest risk of harm
Cardiovascular Disease	10%	Clinical priority area across the ICB
Respiratory	10%	Clinical priority area across the ICB
Severe Mental Illness	3% (reduced from 5% in 25/26)	Individuals at risk of holistic health needs
Place based choice of: **1. Diabetes** **2. Frailty**	10%	**Provides each place the ability to localise to meet the needs of their individual populations**

This means the retirement of the Clinical Case Finding aspect of the LTC LES and enables greater resources to be focused on those individuals with known and existing needs. It will also streamline the delivery and development of patient cohorts from 26-27.

The main risk we have identified is that of re-assessing the same patients for two consecutive years and this may compromise the value of these assessments. There is limited evidence available, but two factors have been considered:

1. The population health management cohort will likely have changed significantly as this has a significant recent hospital attendance component.
2. Patients with complex needs are likely to accrue ‘new’ unmet needs over a twelve-month period and a reassessment is a valid exercise.

The clinical areas where each place has discretion of choice may choose to focus on a different patient cohort for 2026-27 to ensure maximum reach of support to these individuals. Given some of the uncertainties about the acceptability of repeat assessments of these cohorts we will endeavour to monitor this in the first half of the financial year.

The Implementation Domain will also focus on the development and review of internal practice systems and processes and external peer practice discussions for specified Long Terms Conditions.

The MDT domain will grow to support continued the Holistic MDTs already developed and delivering with additional development of a local clinical MDT.

3. Overview of LTC LES 2026-27:

The Long-Term Condition LES is structured in an identical structure to the previous year with adjustments to the emphasis of delivery to ensure greater focus on the development and delivery of an MDT approach to care of individuals with complex needs.

<table>
<tr><th colspan="2">Resource %</th><th colspan="5">Activity Expectation</th><th>Outcome/monitoring</th></tr>
<tr><td>20%</td><td>Domain 1</td><td colspan="5">Implementation

Administration & support to care coordinator/navigation support
Case finding and risk stratification work
Monitoring of outcomes and reporting
Develop internal practice systems and cycles to effectively improve quality for specified Long Term Conditions
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">55%</td><td rowspan="3">Domain 2</td><td>Segment 1
10%</td><td>Segment 2
10%</td><td>Segment 3
10%</td><td>Segment 4
10%</td><td>Segment 5
3%</td><td rowspan="3">Assessment number based on weight population

Practice to deliver at least 10% of total activity from each segment excluding SMI which is a minimum of 3%

Generic template to be provided with codes and holistic health needs relevant to all LTCs, prevention and population health.</td></tr>
<tr><td>Population Health Management</td><td>Cardiovascular Disease</td><td>Respiratory</td><td><u>Place based choice</u> of:
Diabetes
Frailty</td><td>Severe Mental Illness</td></tr>
<tr><td>Ongoing focus on individuals at greatest risk of harm</td><td>Clinical priority area across the ICB</td><td>Clinical priority area across the ICB priority</td><td>Individuals at risk of holistic health needs</td><td>Provides each place the ability to localise to meet the needs of their individual populations</td></tr>
<tr><td>25%</td><td>Domain 3</td><td colspan="5">MDT approach

Development and delivery of practice/PCN/neighbourhood MDT approach covering but holistic care needs and specific clinical challenges.

Details and guidance about formation and delivery of MDT laid out in this specification.</td><td>High level practice plan of delivery

Activity monitoring undertaken, no specific target to be given.</td></tr>
</table>

4.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.

<table>
<tr><th colspan="3">PRACTICE EXAMPLE</th></tr>
<tr><th colspan="3">Domains</th></tr>
<tr><td>Domain 1 - Implementation</td><td colspan="2">20% of total achievable payment</td></tr>
<tr><td rowspan="9">Domain 2 – Assessments</td><td colspan="2">55% of total achievable payment -</td></tr>
<tr><td>Total activity target:</td><td>100</td></tr>
<tr><td>Segment 1 – Population Health Management - (10% minimum of total activity)</td><td>10</td></tr>
<tr><td>Segment 2 – Cardiovascular Disease - (10% minimum of total activity)</td><td>10</td></tr>
<tr><td>Segment 3 - Respiratory (10% minimum of total activity)</td><td>10</td></tr>
<tr><td><u>Place based choice</u> of: Diabetes OR Frailty.
(10% minimum of total activity)</td><td>10</td></tr>
<tr><td>Segment 5 - Severe Mental Illness – (3% minimum of total activity)</td><td>3</td></tr>
<tr><td>Total for all 5 segments</td><td>43</td></tr>
<tr><td>Remaining assessments out of the total 1000 activity Target:
These can be allocated across any of the five segments at the practice's discretion.</td><td>57</td></tr>
<tr><td>Domain 3 – MDT Approach</td><td colspan="2">25% of total achievable payment</td></tr>
<tr><td colspan="3">Indicative numbers will be provided to each practice ahead of contract renewal.</td></tr>
</table>

5. Funding for the 2026/27 LTC LES -

Practices will receive 80% of their annual contract value in advance, paid in monthly instalments from April 2026 to March 2027.

The remaining 20% of the contract value will be paid as a reconciliation payment in June 2027, 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 2027 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 2027 payment run.

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

Whereas for 2025-26 there was a 'run-in' period during April to the contract, for 2026-27 the expectation is that due to minimal changes to the structure and processes the delivery of the contract will continue without pause.

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

Area	Total proposed LTC LES £PWH (2026/27)
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

6. Domain 1 Guidance: Implementation (20%)

The intention of this domain is to give practices an understanding of the principles and outcomes expected of the LTC LES covering LSC ICB and starting in April 2026. It is to provide guidance for usage of the 20% total practice resource allocated.

Due to the minimal changes for 2026-27 and the simplification of the process the amount of resource available has been reduced to reflect these changes. The focus of this domain begins to move away from the development of tools to deliver the Holistic Health Assessments (Business as Usual) and into developing internal systems and cycles to manage the named Long-Term Conditions.

This process will be assessed in a formative manner similar to 2025/26 with practices submitting a brief report on approaches taken to:

- Development of internal processes to support improvement in quality of delivery of defined Long-Term Condition.
- Development of local peer practice (either via PCN or neighbourhood) review of specified Long Term Condition data and sharing/adoption of helpful approaches.

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 20% 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):

Business as Usual:

Delivery needs:

- At the beginning of the contract period, using the pre-set filter provided through the LSC Population Segmentation tool (Aristotle) 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 of Holistic Health Assessments.
- 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.

Long Term Condition Implementation:

Internal Practice Development

- Each practice to review and assess their own internal processes to effectively manage their defined long-term condition.
- This should take into account clinical and managerial leadership, operational and delivery components, and relevant clinical pathways/processes.
- It could consider elements of care and organisation in the practice – including data entry and quality, cohort, and prevalence reviews, ensuring suitable access to services for specified patient groups, suitable planning of care provision.
- Review against relevant national activity and outcome data, assess any additional internal development that is required.
- Highlight any challenges to effective delivery of LTC care.

Peer Practice Development:

- Identify local practices (either through PCN or neighbourhood) to contact and approach regarding a shared review of processes, activity, and outcome data against national and local standards.
- Completion of a minuted meeting across these practices to record:
    - Shared learning about any variation identified (and potential drivers)
    - Defined actions for the peer practices.
    - Common challenges (internal to practices and system based)
- The intention is the meeting should be self-facilitated and supportive in nature.

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 by specified dates.

The focus of the return for this domain 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.

7. Delivery of LTC LES - Holistic Health Assessments (55%):

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

	Population health management	**Cardiovascular Disease**	**Respiratory Disease**	**Long term condition**	**Severe Mental Illness**
Choice of one from each column				Diabetes or Frailty	
Number of patient Holistic Health Assessments planned	Minimum 10%	Minimum 10%	Minimum 10%	Minimum 10%	Minimum 3%

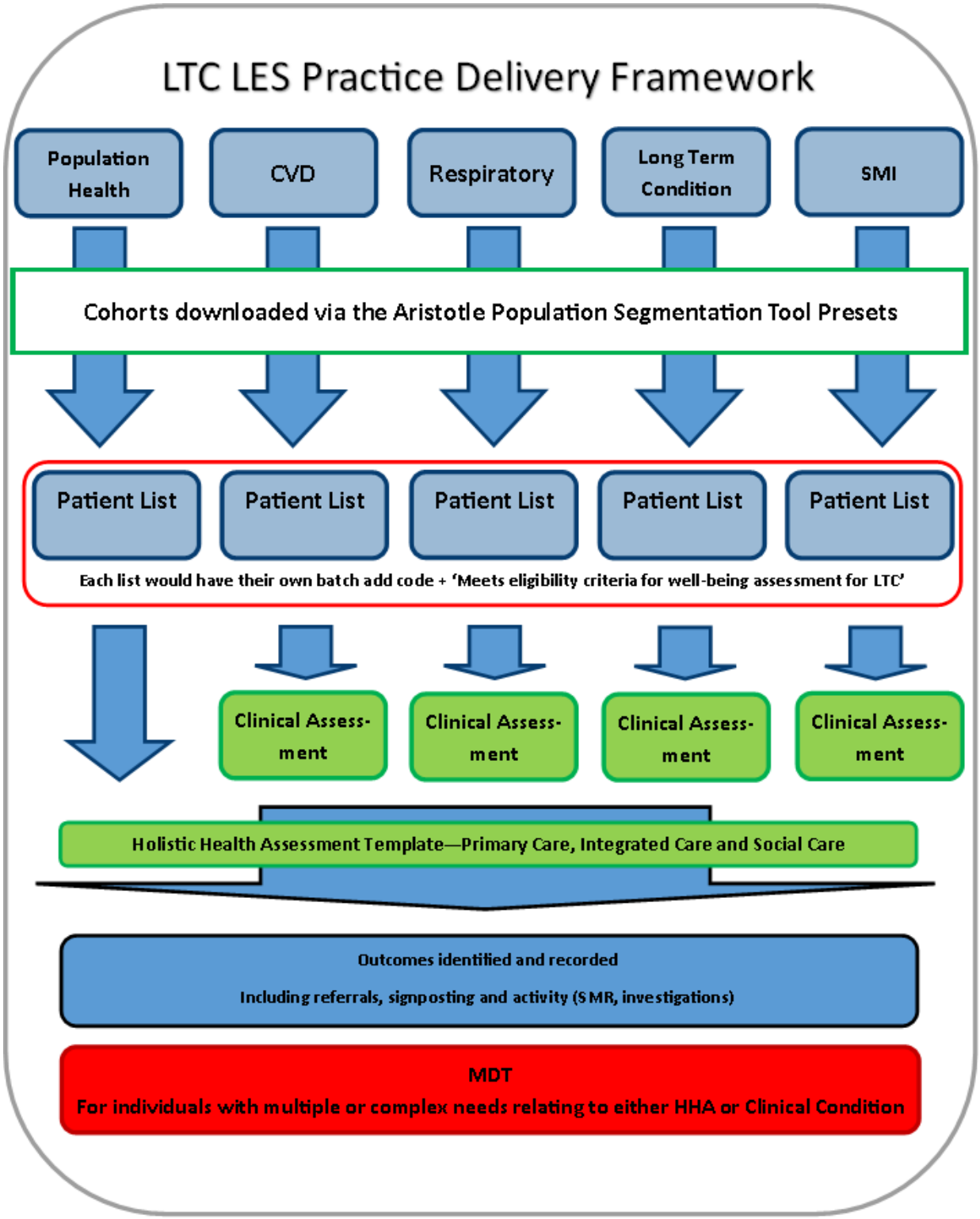
Each practice will be expected to balance activity across each segment to ensure that delivery reaches all clinical cohorts in proportion.

The intention is for each practice to undertake a minimum activity of 10% of their total allocated activity in each segment – except for SMI which will require only 3%. 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 population health management and each of the three LTC domains: 30 for the SMI domain. Further allocation of activity is at the discretion of the practice.

For the 2026/27 the primary activity target will be the overall number of assessments undertaken. It is critical that this is spread across all five of the clinical domains and the minimum percentages should be used to guide this.

The choice of which of the two LTC (Frailty or Diabetes only) to be undertaken will be delegated to each Place to decide, via a single meeting which has the same membership as last years ‘Team of Team’ meeting which includes practices, population health, LMC/Federations and Place Integration Leads etc. This is to ensure that there are local discussion and agreement of the 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. *This is one off meeting and will be co-ordinated by the primary care teams per place.*

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


LTC LES Practice Delivery Framework
Population Health
CVD
Respiratory
Long Term Condition
SMI
Cohorts downloaded via the Aristotle Population Segmentation Tool Presets
Patient List
Patient List
Patient List
Patient List
Patient List
Each list would have their own batch add code + 'Meets eligibility criteria for well-being assessment for LTC'
Clinical Assess-ment
Clinical Assess-ment
Clinical Assess-ment
Clinical Assess-ment
Holistic Health Assessment Template—Primary Care, Integrated Care and Social Care
Outcomes identified and recorded
Including referrals, signposting and activity (SMR, investigations)
MDT
For individuals with multiple or complex needs relating to either HHA or Clinical Condition

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 be more complex and significant. The EMIS search will be provided by the ML CSU Data Quality Team.

Holistic Health Assessments and Outcome Recording:

Holistic Health Assessments will be recorded on provided templates from the ML CSU 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 CSU 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 Long Term Condition LES 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.

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.

Clinical Domain Guidance

The guidance that follows covers the approach to be taken for any of the clinical domains that form part of the LTC LES (CVD/Respiratory/SMI/Diabetes/Frailty).

If a patient also falls under the Population Health Cohort, then it would expected that the clinical guidance also applies.

The underlying principle of the LTC LES is to identify the significant clinical or care needs of each individual and to meet those needs (or put in place a plan to have them met).

The Holistic Health Assessment is designed to meet the non-medical needs whereas the specific clinical assessment should focus on their specific clinical condition.

In practice, it is not possible to specify the exact clinical needs of each patient. The expectation is that the assessment and treatment would be aligned with:

a) The identified and elicited clinical need for that individual (taking into account non-clinical factors and patient wishes)
b) Providing care to the highest appropriate quality and ensuring adherence to all relevant local and national best practice.

The following paragraphs are intended to provide guidance and reference for each of the specified clinical conditions and illustrate the outcomes the LTC LES intends to aim for. They are not intended to be a comprehensive set of instructions but a set of areas that would be suitable for practices to consider when undertaking the Domain 1 for their populations.

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Cardiovascular Disease

Hypertension, AF, and CKD:

To develop proactive detection and structured management of high-impact cardiovascular risk factors—AF, hypertension, and CKD—to reduce strokes, myocardial infarctions, renal decline, and premature mortality, through early identification, prevention and optimisation of treatment and integrated pathways. This will involve a coordinated, system-wide approach to reduce the morbidity, mortality, and health inequalities from CVD through early identification, prevention, optimisation of treatment and integrated care pathways for these conditions.

- **Early Detection & Diagnosis**
- **Optimised Management Pathways**
- **Shared-Care Clinics**
- **Digital Decision Support & Recall**
- **Workforce Capability**
- **Raise awareness and understanding within the population**

Expected Outcomes:

- Improved diagnosis and management of hypertension, AF, and hypercholesterolaemia.
- Reduction in strokes, heart attacks, and preventable renal decline.
- Consistent delivery of evidence-based pharmacological treatment.
- Decreased variation in CVD-related outcomes across the ICB.

Heart Failure

To develop a system-wide heart failure model that enables early diagnosis, evidence-based therapy, coordinated post-discharge care, and integrated community-based support, reducing unplanned hospital admissions, mortality, and unwarranted variation in care.

- **Enable NT-pro BNP testing in primary care**
- **Ensure timely access to echocardiography and ECG**
- **Embed post-discharge reviews**
- **Align protocols with NICE/ESC guidelines**
- **Expand virtual ward and remote monitoring models**
- **Mandate annual personalised care reviews**
- **Address inequities**

Expected Outcomes:

- Increased early and accurate diagnosis of HF
- Greater uptake of guideline-directed medical therapy
- Reduced HF-related hospital admissions and readmissions
- Improved patient quality of life and functional status
- Narrowing of equity gaps in HF outcomes and access to services

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Respiratory Disease

COPD

Purpose:

To develop a proactive, equitable, and tiered care model for COPD that reduces morbidity, mortality, and unplanned care through early diagnosis, personalised support, and rehabilitation.

- **Smoking Cessation & Early Detection**
- **Proactive Management**
- **Risk Stratification**
- **Pulmonary Rehabilitation**
- **Virtual Respiratory MDTs**
- **Community Crisis Response**
- **Integration with UCR/Virtual Wards**

Expected Outcomes:

- Reduction in ED attendance and readmission rates for COPD.
- Increased uptake of pulmonary rehab within 28 days of discharge.
- Improved inhaler technique and self-management outcomes.
- Consistent delivery of smoking cessation interventions.

Asthma

Purpose:

To develop a standardised, stratified, and person-centred asthma care model that minimises exacerbations, improves disease control, and reduces health inequalities.

- **Diagnosis & Stratification**
- **Routine Control Management**
- **Stratified Escalation Protocols**
- **PAAP Provision**
- **High-Risk Patient Flagging**
- **Severe Asthma Referral Pathway**
- **Digital Tools & Remote Monitoring**

Expected Outcomes:

- 60% reduction in preventable asthma admissions.
- Increased ICS adherence and reduced SABA overuse.
- Improved ACT control scores and equity in access to PAAPs.
- Reduced variation in reviews and severe exacerbations.

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Severe Mental Illness

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. 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.

The key objectives of the Long-Term Condition LES's are 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.

Frailty

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 if appropriate.

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

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Diabetes

Purpose:

To develop a whole-system, life-course approach to improve outcomes and reduce health inequalities for people living with Type 1 and Type 2 diabetes. This includes prevention, early detection, structured management, and complication prevention across all ages—ensuring equitable access to modern technologies, age-appropriate services, and coordinated multidisciplinary care.

- **Prevention & Early Detection:**
- **Structured Education:**
- **Personalised Care Planning:**
- **Technology Access & Optimisation:**
- **Complication Surveillance & Reduction:**
- **Integrated MDT Review:**
- **Children & Young People / Transition Pathway:**

Expected Outcomes:

- Increased proportion of patients achieving three treatment targets (HbA1c, BP, cholesterol).
- Reduced variation in access to structured education and diabetes technologies.
- Decrease in emergency admissions and diabetes-related amputations.
- Improved experience of care and self-management, particularly during transition and in deprived areas.

8. Multidisciplinary Team (MDT) Meeting Guidance for LTC LES

Introduction:

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

The intention for 2026-27 is for each practice either alone or as part of a local network or neighbourhood to develop and consolidate MDT groups for:

a) Holistic needs (integrated care and community focus) – continuation of 2025-26

AND

b) Identification of clinical MDT development area based on practice/neighbourhood/PCN development needs/plan

The resource (25% 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 five clinical segments. The resource is intended to be used to support the practice portion of the MDT development.

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.

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 or neighbourhood 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 (the template is available on GP intranet):

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:

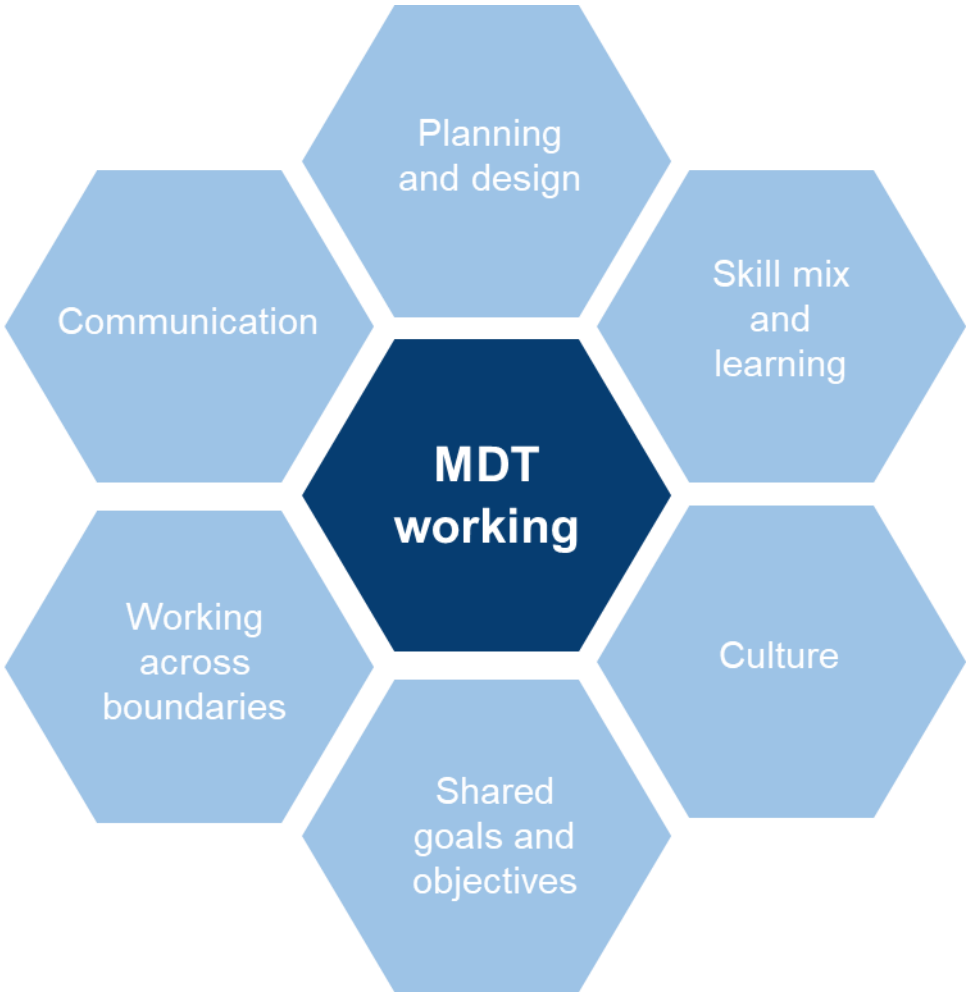
The guidelines below are intended to provide guidance and support in the implementation of practice MDTs.

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

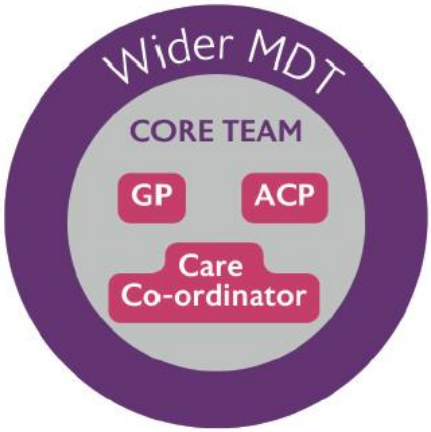
Holistic MDT

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*

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.

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.

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.

Clinical MDT Guidance

Using the principles and tools used to develop and deliver the holistic MDT approach it will be expected that each practice in 2026-27 works towards the development of a local clinical MDT pathway.

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 or neighbourhood footprint) to deliver this portion of the LTC LES for reasons of scale and local service engagement. This is especially relevant for the clinical MDT approach where practices may need to work together to ensure local clinical input and expertise.

The development of the Clinical MDT will necessarily be variable across practices and dependent on existing MDT facilities, local expertise and integration development. As such it is impossible to specify a comprehensive set of actions and outcomes but would be expected to include:

a) Assessment of local clinical needs in one of the LTC LES clinical areas the practice is delivering.
b) Identification of internal and local resources that may form part of any local clinical MDT (practice clinical leads, pre-linked community, or secondary care services, local VCSFE organisations with specified interest in clinical area).
c) Local discussion through PCN or neighbourhood communications to assess ability of practices to work collaboratively on clinical MDT development.
d) Development of MDT structure based on the model and guidance used for the Holistic MDTs.
e) Delivery of MDT work in Q3/4

APPENDIX 1 – LTC LES DATA QUALITY GUIDANCE

CLAIM CODE

Code	Description
756261000000100	Well-being assessment for long term conditions reviewed

BATCH ADD CODES

Main Category – All Patients

Patient Group	Code	Description
All Patients	756161000000107	Meets eligibility criteria for well-being assessment for long term conditions

Sub Category – Based on Aristotle Lists

Patient Group	Code	Description
Population Health	716081000000105	Social circumstances
CVD	417206009	Cardiovascular disease monitoring
Respiratory	268511007	Respiratory disease monitoring
SMI	713761000000107	Mental health monitoring administration

Sub Category – Place Based Choice from Aristotle Lists

Patient Group	Code	Description
Diabetes	713671000000109	Diabetes monitoring administration
Frailty	894301000000105	Frailty needs assessment planned

GUIDES AVAILABLE

Guides for the following can be found on the GP Intranet/Learning Academy/DQ Specialist:

- For Aristotle: LTC LES Patient List User Guide
- For Batch Adding and Searches: ML DQ LTC LES Guide
- For activating the template launcher and alert: LSC ICB LES Protocol Guide

TEMPLATES

The template for the LTC LES is available through your shared folder in Resource Publisher and is titled **ML DQ ICB Holistic Health Assessment**. Emails will be sent whenever the template is updated. Please ensure that you keep Resource Publisher refreshed to ensure that you are using the most up to date template.

Any chronic diseases specific annual reviews should be carried out using the template that you would normally use in practice. **Please note** – the LTC reviews do not need to be completed on the same day as the Holistic Health Assessment.

To help identify patients who have been coded as eligible for a review, practices can activate **protocols** that generate on-screen messages or alerts.

A template picker is also available to support the selection of the appropriate template. Instructions on how to enable these protocols are provided in the guide referenced above.

SEARCHES

All searches for the LTC LES are available through Enterprise Searches & Reports, the CCG tab at the bottom of Population Reporting. Searches are managed by the Data Quality Team and emails will be sent from the Data Quality Team regarding the location and also when any searches have been updated. Any updated searches will be available in the same place. Searches need to be copied and pasted into your practices folder to be able to use them.

DATA EXTRACTS

All data is extracted based on left/deceased patients and the code above being added to the patients record once within the specified timeframe.

DATA QUALITY CONTACT DETAILS

All requests for support or query resolution should be logged on the Self-Service Portal at: https://sunrise-saas.com/mlcsu/SContacts/

For any urgent queries please ring: **0300 555 0212**

Fraud Policy

In the event of suspected fraud or other illegality being uncovered at any stage the ICB will implement the ICB Fraud Policy and will investigate.

Information supporting reported activity and monitoring information must be made available to the ICB or its representatives upon request. Failure to provide this information, or the provision of incomplete or inaccurate information, may result in suspension of payments or clawback, as well as further investigation by the ICB and its representatives.