

## Making Change

A building block to support delivery of multiple long-term condition (mLTC) care

### Key messages

- **Moving from single condition care to mLTC involves change**
- **Quality improvement methods can help this transition**
- **Innovation is key to developing systems that best meet our patients' needs**

This resource includes tools to help make change and innovations that can support mLTC care delivery

Always work within your knowledge and competency

# CESEL MULTIPLE LONG-TERM (mLTC) CONDITION RESOURCE PACK FOR INTEGRATED NEIGHBOURHOOD TEAMS (INT)

## The Building Blocks for mLTC Care

RESOURCE SECTIONS	WHATS INCLUDED?	WHO THIS IS FOR?																																
<p><b>1. <u>Clinical mLTC care</u></b></p>	<p>Clustered condition care: cardiorenal metabolic conditions: prompts for clinical care</p> <ul style="list-style-type: none"> <li>• T2DM + CKD +/- hypertension</li> <li>• Hypertension + T2DM</li> <li>• Hypertension + CKD</li> </ul>	<p>Clinicians delivering cardiorenal metabolic reviews</p>																																
<p><b>2. <u>Getting the basics right</u></b></p>	<p>Page number</p> <p>Single condition care</p> <p>Call and recall systems</p>	<p>Practice, PCN, INT leadership and management teams</p>																																
<p><b>3. <u>Know your population</u></b></p>	<p>Multimorbidity in SEL Your population data 3+LTC SEL Data Ardens Resources</p>	<p>Practice, PCN, INT leadership and management teams</p>																																
<p><b>4. <u>Make the best of the team</u></b></p>	<p>Building effective teams INT to support mLTC care Match team members to risk/need</p>	<p>Practice, PCN, INT leadership and management teams</p>																																
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# Making change

Making change can be challenging but is fundamental to delivering the best value health and care for our communities.

## Invest time

- Improvement work requires time and resources.
- It's a team effort, most effective when led by those closest to the work e.g. reception teams leading changes in reception.

## Start small

- Small projects that deliver manageable improvements build team confidence and create momentum for larger changes.

## Have a plan

- Quality Improvement (QI) Methods will help structure and plan your changes effectively.

## Be proportionate

- Apply QI methods appropriately—simple changes may not require a full QI approach.

## Use data

- Data is key to delivering effective change and sharing our learning

## Involve the whole team

- Engage the full team
- Foster collaboration across teams
- Co-create solutions with patients and communities

# Innovation

A new way of working, or innovation, is most effective if the following apply<sup>1</sup>:

*'Only innovation can enable modern health and social care organisations and systems to meet radically changing needs and expectations of the communities they serve.'*

Michael West<sup>2</sup>

Professor of Work and Organisational Psychology at Lancaster University, King's Fund Fellow

Relative advantage over status quo

Not too complex

Fits with how we work already

We can see and measure the benefits

Can be tested small and scaled up if effective









Can be adapted to different teams and situations

Is relatively easy to do

# Quality Improvement Methods

Tools to help deliver improvement projects

“While all changes do not lead to improvement, all improvement requires change. The ability to develop, test, and implement change is essential for any individual group, or organisation that wants to continuously improve.” Institute for Healthcare Improvement<sup>1</sup>

QUALITY IMPROVEMENT (QI) METHOD	WHAT IT IS?	WHEN IT'S USEFUL?	PRACTICAL APPLICATION AREAS	LINK TO MORE INFO ABOUT THE QI
<b>SMART aims</b> 	<b>Specific, Measurable, Achievable, Relevant, Time-bound</b>	Use at the outset of all QI projects to clarify <i>what you're trying to improve</i> and <i>by when</i> . Powerful used in combination with PDSA.	<b>Setting a quality improvement goal.</b> <ul style="list-style-type: none"> <li>• <a href="#">Single condition care</a></li> <li>• <a href="#">Try new things - pages 5-9</a></li> <li>• <a href="#">Matching team to patient need</a></li> </ul>	<a href="#">SMART aims explained   Quality Improvement video</a>
<b>Plan, Do, Study, Act (PDSA) cycles</b> 	Tests impact of changes on a small scale before wider implementation	Any new idea or change to a process or system.	<b>Try new things</b> <ul style="list-style-type: none"> <li>• <a href="#">Group consultations</a></li> <li>• <a href="#">Matching team to patient need</a></li> <li>• <a href="#">Clustered conditions</a></li> </ul>	<a href="#">First steps towards quality improvement: A simple guide to improving services</a> See chapter 9
<b>Process mapping</b> 	Visually represents how a process works, showing all the steps, decisions, roles, and functions involved	Understanding a complete process from the beginning to end. Helps clarify process flows, team roles, can help identify problems, delays, bottlenecks and duplication and areas of error and confusion as well as steps that add value. This will be helpful as INTs come together to agree pathways of care and everybody's role and to have a basis to communicate planned changes.	<b>Understanding the steps in a process to make improvements</b> <ul style="list-style-type: none"> <li>• <a href="#">Try new things - pages 5-9</a></li> <li>• <a href="#">Point of care testing</a></li> <li>• <a href="#">Make the best of your team/s</a></li> <li>• <a href="#">Call and recall</a></li> </ul>	<a href="#">First steps towards quality improvement: A simple guide to improving services</a> See chapter 8
<b>Audit</b> 	A <b>clinical audit</b> checks whether patient care meets agreed standards and helps improve the quality and safety of care.	Checking how you are doing against with guidelines, policies, or best practices. Useful as part of a QI project to assess baseline and improvement.	<b>Comparing current practice with guidelines or best practice</b> <ul style="list-style-type: none"> <li>• <a href="#">mLTC clustered care</a></li> </ul>	<a href="#">UHB Clinical Audit - How To Guides</a>
<b>Lean methodology</b> 	Improves processes by reducing waste, increasing efficiency, and focusing on what adds value for patients.	When introducing a new process or pathway, to limit duplication, fragmentation and waste.	<b>Removing inefficiencies in a process</b> <ul style="list-style-type: none"> <li>• <a href="#">Getting the basics right</a></li> <li>• <a href="#">Make best of team/s</a></li> <li>• <a href="#">mLTC clustered care</a></li> </ul>	<a href="#">Institute for Innovation and Improvement - Going lean in the NHS</a>
<b>Fishbone (Cause and effect/Ishikawa)</b> 	A diagram that aids the identification of factors that contribute to an outcome or result and therefore highlight potential causes of a problem	Useful to identify and analyse multiple potential causes of a problem. Can complement other QI tools such as Process Mapping and Lean when considering solutions.	<b>Identifying causes of a problem</b> <ul style="list-style-type: none"> <li>• <a href="#">Getting basic right</a></li> <li>• <a href="#">Make best of team/s</a></li> <li>• <a href="#">Know your population</a></li> </ul>	<a href="#">Online library of Quality, Service Improvement and Redesign tools - Cause and effect (bone)</a>
<b>Driver diagrams</b> 	Helps identify the root causes of a problem by visually mapping possible contributing factors.	When you are looking to change a system in response to feedback.	<b>Planning and implementing a change</b> <ul style="list-style-type: none"> <li>• <a href="#">Getting basics right</a></li> <li>• <a href="#">Try new things - pages 5-9</a></li> </ul>	<a href="#">Online library of Quality, Service Improvement and Redesign tools - Driver diagrams</a>
<b>Appreciative Inquiry</b> 	Focuses on strengths and what's working well and building on it	When a pathway is working well, how can the learning be used in other areas. Good for a positive team activity.	<b>Building on what is already working well</b> <ul style="list-style-type: none"> <li>• <a href="#">Getting the basics right</a></li> <li>• <a href="#">Make best of team/s</a></li> <li>• <a href="#">Know your population</a></li> </ul>	<a href="#">NHS Health Education England - Module: Start with what's working - An Introduction to Appreciative Inquiry</a>

## Whole-Person: Annual Review - The Bristol Model<sup>1</sup>

An alternative to or next step on from clustered condition care is a single review appointment that covers a wider range of conditions in one review. This includes conditions in the CRM cluster described in the [CESEL Clinical mLTC Resource](#) and respiratory, mental health and musculoskeletal conditions.

This approach has been developed and evaluated in Bristol and shown to be valued by patients and an efficient use of practice staff but requires a skilled/trained workforce. This slides captures the Bristol approach and signposts to resources they have developed.

University of Bristol and NIHR Applied Research Collaboration West (ARC West) resources with links to a range of tools to help plan and conduct a successful annual review covering a wide range of conditions.

[Video](#)

[Guidance](#)

### How to do it: 9 steps

1. Create a planning group

2. Identify a template

3. Identify patients

4. Training

5. Process Mapping

6. Make a plan

7. Start small and build up

8. Monitor and audit

9. Community of practice

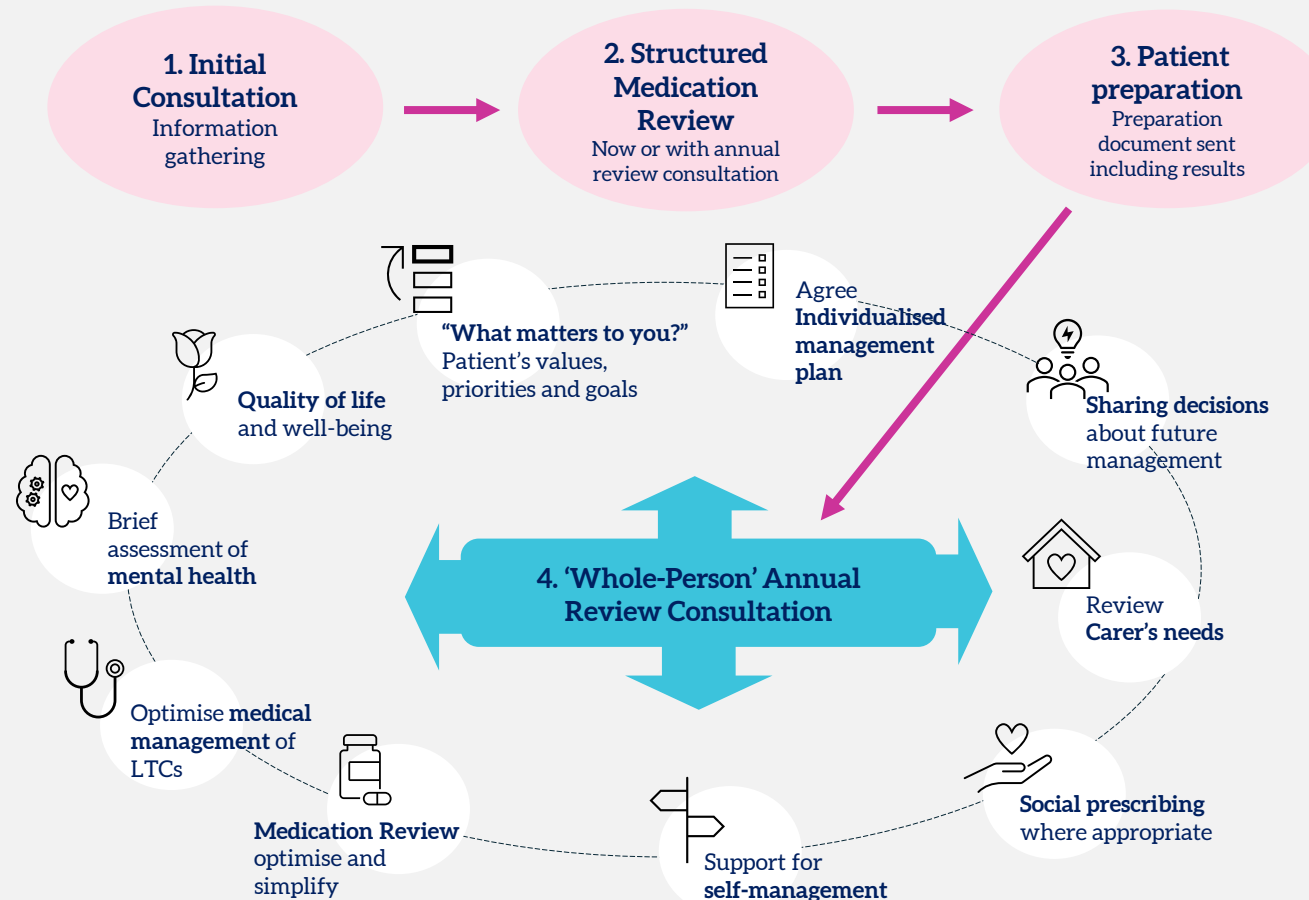
### Underlying principles:

A 'whole-person' annual review is more effective and improves staff and patient experience. The annual review will involve more than one consultation. Focus on patients with 3 or more types of conditions. Staff need to be competent to perform a review of all long-term conditions.

### Tools

An outline structure for a review  
How to plan for change  
An EMIS template  
An EMIS search

Guidance for staff training  
An audit search  
Common issues and how to overcome them



### Conditions included in Bristol mLTC search

- Chronic kidney disease
- Heart failure
- Hypertension
- Coronary heart disease
- Peripheral arterial disease
- Atrial fibrillation
- Stroke
- Diabetes
- Epilepsy
- Severe mental health
- Current depression
- Dementia
- Learning disabilities
- Rheumatoid arthritis
- Asthma
- COPD

## Patient Activation

Assess your patients' readiness to manage their own condition/s

### What is patient activation?

Patients who are better able to manage their health conditions have fewer GP appointments and hospital admissions than those who struggle with self-management. Supporting patients to develop the knowledge, skills, and confidence to manage their conditions can improve health outcomes and reduce reliance on healthcare services<sup>1</sup>.

Patient activation measure can be included in a pre-review questionnaire e.g. on an [Accurx Questionnaire](#) or in a review appointment e.g. for patients with poor control. It could also be used across a group of patients to stratify and plan service delivery e.g. text to all patients with cardiorenal metabolic conditions to plan tailored review appointment times.

### How to measure patient activation?

The **PAM® (Patient Activation Measure)**<sup>2</sup> licensed by the US company *Insignia Health LLC*, is a validated 13-question survey that assesses a patient's level of activation. Use of the tool requires a paid license.

### Develop your own activation measure

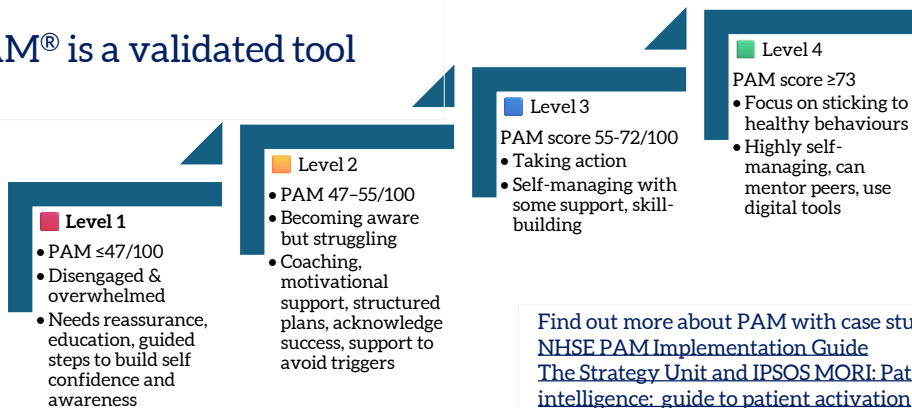
As an alternative to the PAM®, you could develop and agree on a small set of simple questions. For example:

**How well do you understand your condition and how confident do you feel in managing most aspects of it?**

- I feel very confident managing my condition and usually don't need any extra support.
- I feel confident managing my condition but sometimes need a bit of support.
- I don't feel very confident managing my condition and often need support.
- I don't feel confident managing my condition and need support most of the time

Responses can then be used to tailor support to each patients' needs. Developing the right questions and agreeing on appropriate levels of support could be a collaborative project involving both staff and patients. See also [Match team members to risk/need](#).

## PAM® is a validated tool



## UCLP Proactive Care Framework

An approach to stratification

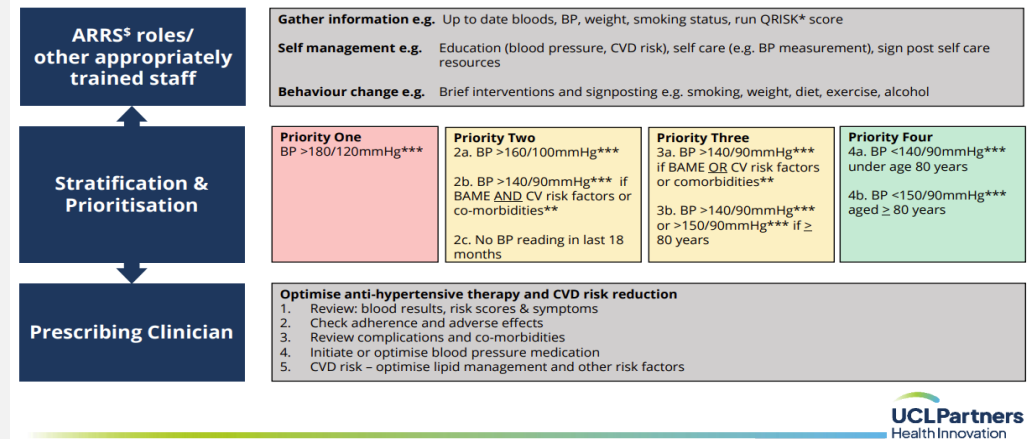
University College London Partners (UCLP) have developed a suite of searches which include clinical risk and ethnicity for risk stratification the following conditions

- AF
- Cholesterol
- COPD
- Diabetes
- Heart Failure
- Hypertension
- Serious Mental Illness

available within both Ardens Manager and Ardens Clinical.

The framework includes tools to support risk groups seeing the right person in the team.

### Hypertension- Stratification and Management



### View of the UCLP Hypertension searches on [Ardens Manager](#)

Ardens Manager is updated daily allowing you to quickly see the impact of improvement work with the movement of patients between risk groups.

Risk Stratification	UCLP   Priority
	UCLP   Priority 1
	UCLP   Priority 2a
	UCLP   Priority 2b
	UCLP   Priority 3a
	UCLP   Priority 3b
	UCLP   Priority 4a
	UCLP   Priority 4b

## Test innovations across stratified risk groups

([link to team members to match risk page](#))

### Outreach service for high-risk, vulnerable groups:

Proactive outreach service.

[Clinical and admin teams with CC support.](#)  
[Community teams.](#)

### Micro-teams for continuity<sup>1</sup>

Provide continuity with a group rather than a single individual

[Reception, ARRS and GP roles.](#)

### Group consultations

Group consultations for those who may benefit from collective approach and mutual support/connections.

[Clinical and admin teams with CC support.](#)

### Peer to Peer Support<sup>2</sup>

Signpost to local peer support groups, particularly for those with mental health conditions

[SPLW](#)

### Rapid optimisation pathway

Intensive support to achieve optimal control for patients with a new or poorly controlled condition.

[Clinical and admin teams with CC support.](#)

### Digital Tools

Digital LTC support for patients with high activation measures e.g. lifestyle apps

[Admin and CC teams](#)



## Group consultations

### What are Group Consultations?

- 8-12 patients with the same condition/s are seen together
- Combine clinical review, education, and peer discussion to strengthen confidence and self-management
- Typically facilitated by a clinician with a health coach and/or pharmacist including community pharmacist

### What can group consultations add?

- Improve activation, engagement, and improved clinical outcomes e.g. HbA1c, BP
- Enhance peer learning, reduce isolation, and increase motivation
- Promote efficient use of clinician time and better patient experience

### How can group consultations be used?

- Common for primary care LTC reviews (diabetes, asthma/COPD, hypertension, mental health)
- Combine individual results review with shared learning and goal-setting
- Can work well with personalised care and proactive LTC pathways

### Implementation essentials

- Identify target patient groups and align scheduling with capacity
- Provide staff training in facilitation and confidentiality
- Integrate with existing care planning templates and [patient activation assessment](#)
- Evaluate outcomes and share learning across teams
- Ensure patients happy/consent to be part of a shared, group approach – group consultations not right for everybody and should be an **option** for care

### References & Resources

- [NHS England - Group Consultations: Together, Patients Are Stronger](#)
- [Southeast London ICS - "Me, My Health, My Choice" Personalised Care page](#)
- [Practice Guide for Group Consultations - "Harnessing Group Consultations in Primary Care"](#)
- [Lunch and learn webinars - ELC Programme](#)

## Point of care testing (POCT)

### What is Point of Care testing?

- Analytic test done outside of the laboratory
- Undertaken by a healthcare professional e.g. in GP practice or Community Pharmacy
- Provides immediate result as part of a care pathway
- Growing use across general practice, community pharmacy and other community sites
- Has been evaluated for renal function in SEL General Practice in CKD management pathway and found to be acceptable by staff and valued by patients.

### Why it matters?

- POCT reduces need for separate phlebotomy and results review appointments, speeding up mLTC optimisation and improving convenience for patients

### How it can be used for LTC care

- As part of a care pathway with agreed management steps depending on result e.g. Red/Amber/Green
- Renal function testing useful for up titrating ACE and ARB

### Implementation essentials

- Buy it right - get the right equipment for the task
- Use it right - provide staff training on equipment use
- Keep it right - store appropriately and regular checks

### References & Resources

- [Bringing diagnosis closer to patients](#)
- [NHS England » Point of care testing in community pharmacy](#)
- [Video showing POC testing in SEL CKD project](#)
- [POC testing Case example from Lewisham Pharmacies celebrated at Independent Pharmacy Awards in the House of Commons](#)

## Community of Practice (COP)

### What is a community of practice?

- A network of professional working to achieve the same aim
- A forum to share ideas, learning, how to overcome challenges and what has worked well

### Key Characteristics

- **Domain** - the shared area of interest to underpin the COP
- **Community** - relationship and connection between team members that generates trust to underpins shared learning
- **Practice** - how the COP works, the shared knowledge and examples of work that supports the collective expertise of the group.

### Implementation essential

- **Discovery:** where are you now and where do you want to be, agree how a COP can help?
- **Design:** agree how the COP of practice will work, remote or in person, how long, when, who set the agenda and who will be invited, how to ensure commitment from members?
- **Delivery:** promote engagement with colleagues, agree purpose and goals, share ideas, experiences and knowledge
- **Data: check** evaluate how it is working, refine with feedback from members

### References & Resources

[Communities of Practice: Definition, characteristics, and distinction from networks Learning-handbook-communities-of-practice.pdf](#)

## Action Learning Sets

- Teams coming together to solve workplace problems
- Ideally supported by a facilitator
- More information can be found [here](#)

## Lifestyle Medicine

### What is Lifestyle Medicine?

- Evidence-based care that supports lifestyle change to improve health
- Involves clinical care and policy and public health action
- Lifestyle medicine support for patients includes approach structured support to make lifestyle changes in e.g. diet, exercise, sleep to optimise their LTC outcomes.

### Why it matters

Lifestyle medicine addresses the upstream determinants of health, the commercial, social, economic and environmental determinates of health to help enable people live healthy lives.

### Implementation essentials

1. Acknowledge the need for action on socioeconomic determinants of health
2. Proven techniques to sustain lifestyle changes
3. Knowledge of the six pillars of lifestyle medicine.

### How it can be used for LTC care: support improvements in

- Adoption of a nutrient-dense whole food plant predominant diet
- Incorporating exercise and movement
- Restorative sleep
- Avoiding substance abuse
- Meditation and stress management
- Healthy social relationships

### Find out more

[British Association of lifestyle medicine: What is Lifestyle Medicine?](#)  
[RCGP: Lifestyle medicine in general practice](#)

## Group Education/Supported Self Management

### What is Group Education /Supported Self Management?

Education for people with LTCs to help them develop the capability and motivation to effectively manage their health or the health of somebody they care for.

### Benefits of self-management education

- Demonstrated to be a cost-effective intervention for many LTCs
- Improves health outcomes and reduces unwarranted service use
- Improves patient's knowledge of their condition and how best to manage

### How to deliver Group Education /Supported Self Management?

This can vary depending on resource, need, and team skills. Consider

- Condition specific education sessions
- Linked to Lifestyle Medicine Education, [Patient activation measures](#), [Group consultations](#)
- Single session or multiple sessions/course
- Small group or large group
- Stand alone sessions or session as part of wider health improvement initiatives e.g. [community blood pressure testing](#)
- Ingle condition sessions or session across conditions e.g. CRM

Work with your patient participation group and or local community groups to determine what is right for your population.

SEL offer groups support and patient education for specific, single conditions including [pre-diabetes](#), [diabetes](#) and [healthy weight programmes](#)

### References & Resources

[NHS England » Supported self-management education guide](#)  
[What Is Supported Self-management?](#)

## **Ardens**

- Clinical decision and population health management tools

Resources available here: [Ardens academy platform](#)

Contact the team [training@ardens.org.uk](mailto:training@ardens.org.uk) for team training requests

## **Digital team**

- Support teams in best use of clinical systems, coding and digital tools
- Offer annual digital health checks for GP teams
- Contact your digital team facilitator for support [primary care IT facilitators](#)

## **Pathology**

- **Synnovis Primary Care Information Centre**
- Email [LetsTalk@synnovis.co.uk](mailto:LetsTalk@synnovis.co.uk) to receive Synnovis Primary Care newsletter  
This email can also be used for enquiries and to provide feedback on Synnovis communications.

## **SELNET**

SELnet is a central resource for primary care in South East London with a range of information, useful resources, updates and tools. It available to all GPs and others working in primary care with an nhs.net email address. Access via your desktop at the practice or [SELnet – Home](#) or from an ICB Sharepoint.

## **SE London Workforce Development Hub (SELWDH)**

- Education, training and workforce planning across the six SEL boroughs.

More information, including forthcoming training can be accessed [here](#).

General enquiries: [info@seltraininghub.co.uk](mailto:info@seltraininghub.co.uk)

Phone support: 07386469528 (Monday to Friday, 8am-4pm)

## **Clinical Effectiveness SE London (CESEL)**

- Develop guides, resource packs (like this one), education, data and facilitation support for teams for LTC care and improvement projects
- CESEL resources available [here](#)
- For a CESEL visit contact to your team contact [clinicaleffectiveness@selondonics.nhs.uk](mailto:clinicaleffectiveness@selondonics.nhs.uk)

## **Medicines Optimisation Team**

- Advise on the prescribing of medicines and work closely with GP practices, hospitals, community pharmacies, and voluntary sector organisations.
- More information, including local medicines guidance and pathways, available [here](#).
- Contact [medicines@selondonics.nhs.uk](mailto:medicines@selondonics.nhs.uk)

## **Community Pharmacy Leadership Programme**

Support for community pharmacists to become Community Pharmacy Neighbourhood Leads

## **Newsletters**

Sign up to

- South East London news and updates across the Integrated Care System - available at [News - NHS South East London](#)
- South East London General Practice updates available on SELNET
- Guys and St Thomas' news update for GPs and primary care colleagues: email [GPLiaison@gstt.nhs.uk](mailto:GPLiaison@gstt.nhs.uk)
- [Kings Health Partners](#) news email [kingshealthpartners@kcl.ac.uk](mailto:kingshealthpartners@kcl.ac.uk).
- NHS England Primary care bulletin [NHS England » Primary Care bulletin](#)

## References

Page	Ref		Accessed
3	1	Adapted from: Innovation, Intellectual Property, and Economic Growth – 5 Feb. 2010 Rogers and Greenhalgh	
3	2	<a href="#">Caring to change. How compassionate leadership can stimulate innovation in health care. King's Fund publication. Michael West, Regina Eckert, Ben Collins, Rachna Chowla. May 2017</a>	April 2026
4	1	<a href="#">Model for Improvement: Selecting Changes. Institute for Healthcare Improvement.</a>	April 2026
5		<a href="#">New guidance to help clinicians improve care for people with multiple long-term conditions. University of Bristol</a>	April 2026
6	1	<a href="#">Supported self-management: the evidence base. NHSE</a>	April 2026
	2	<a href="#">NHSE PAM@ implementation – quick guide</a>	April 2026
7	1	<a href="#">Are microteams the key to primary care continuity?   NHS Confederation</a>	April 2026
	2	<a href="#">NHS England » Supported self-management: peer support guide</a>	April 2026

## Abbreviations

Making the right thing to do the easy thing to do

AF	Atrial fibrillation	HTN	Hypertension
ARC	Applied Research Collaborative	INT	Integrated neighbourhood team
ARRS	Additional roles reimbursement scheme	IT	Information technology
BAME	Black, Asian and Minority Ethnic	LTC	Long term condition/s
BP	Blood pressure	mLTC	Multiple long term condition/s
CC	Care coordinator	PAM	Patient activation measure
CKD	Chronic kidney disease	PCN	Primary care network
COPD	Chronic obstructive pulmonary disease	QI	Quality improvement
CRM	Cardiorenal metabolic	QRISK	Cardiovascular risk score
CVD	Cardiovascular disease	SEL	South East London
EMIS	General Practice IT system	SPLW	Social Prescribing link worker
GP	General practice/practitioner	T2DM	Type 2 diabetes
HbA1c	Glycosylated haemoglobin	UCLP	University College London Partners

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SEL Approval: April 2026.

Visit [Clinical Effectiveness \(CESEL\) - NHS South East London](#) for details of the CESEL support offer.