The King's Fund | Policy brief

Improving clinical co-ordination for people with multiple long-term conditions

What's the issue?

Increasingly, people are living with multiple long-term conditions – defined as having two or more chronic health conditions. These might be conditions that are likely to show up together (such as chronic kidney disease, diabetes and heart disease, or COPD and heart disease), or more unrelated (such as bipolar disorder, Crohn's disease and polycystic ovary syndrome). In the UK, between 20–40% of the population are estimated to live with multiple long-term conditions, and the numbers are only likely to increase. This presents a significant challenge for a health care system that was designed around single conditions, as people with multiple long-term conditions often have to navigate multiple pathways and interactions with clinicians from multiple specialties, resulting in fragmented, ineffective and inefficient care. The government's proposed three shifts for the health and care system – from analogue to digital, hospital to community, and from sickness to prevention – all reflect the need to respond to this change.

Why is clinical co-ordination important?

As the NHS wrestles with existential crises, getting the right support for people with multiple long-term conditions is key to ensuring its future. But this is not about creating a new pathway for the care of multiple long-term conditions to sit alongside other condition-specific pathways. Rather, it is about making room for flexibility and co-ordination within the health and care system to ensure people receive holistic care and are supported to manage their conditions, whichever service or clinician they encounter.

What did we find?

In this work we have focused on the clinical co-ordination of care for people with multiple long-term conditions as part of a wider holistic approach. There are steps clinicians and commissioners can take to co-ordinate care in a way that reduces the burden on people with multiple long-term conditions and ensures they can be a valued part of the decision-making process. But policy-makers and system leaders need to play a crucial role in driving the systemic changes needed to improve clinical co-ordination for people with multiple long-term conditions.

Actions policy-makers and system leaders need to take to promote effective clinical co-ordination

For clinicians

1. **Create a culture that prioritises a holistic approach to care**: clinical care needs to intrinsically consider that an individual is likely to have multiple long-term conditions. The current single specialty and sub-specialty-based models of care, particularly in secondary care settings, mean that people with multiple long-term conditions are treated separately for each specific, discrete diagnosis, which oversimplifies their health needs. Without a clear understanding of where accountability for managing people with multiple long-term conditions sits within the system, patients and carers are often left to do the entire work of managing care across complex organisations and structures.
2. **Change training pathways and curricula**: changing the approach to clinical co-ordination for people with multiple long-term conditions requires system leaders to make changes to clinical training and continuing professional education. Training should prioritise the management of multiple

long-term conditions and a whole-person approach to care, ensuring that clinicians have the skills to understand, work and collaborate across specialties.

3. **Ensure clarity of roles and responsibilities**: clinicians need to know what their role is. Additional roles to support care co-ordination, such as care navigators and co-ordinators, can provide significant benefit to patients and clinicians alike. Policy-makers and system leaders should ensure that roles and responsibilities are clearly defined, whether new roles or roles within multidisciplinary teams.
4. **Improve IT capacity and digital infrastructure to enable clinical co-ordination**: the digital infrastructure of the health and care system must be able to support care across multiple pathways. System leaders and policy-makers will need to invest in up-to-date information systems and hardware, and ensure interoperability of systems within and between organisations. This also requires the development of effective information governance frameworks that enable shared use of patient records. Training on how to use new systems effectively also needs to be carefully planned and funded.

For commissioners

5. **Design financial and clinical systems around multiple long-term conditions**: current financial operating systems can limit care delivery to functional silos, making it more difficult for clinicians to provide holistic care. Policy-makers and system leaders need to develop financial systems that support whole-person care and allow funding to follow patients across settings. Clinical pathways, protocols and job plans need flexibility to enable work within and across organisations and settings.
6. **Enable locally driven and co-produced service and pathway design**: services and clinical pathways must be co-produced, drawing on deep local population knowledge and stakeholder perspectives. Patients and carers of people with multiple long-term conditions should be at the heart of service and pathway design, and cross-sector relationships will be particularly important for considering and addressing wider needs beyond health care.
7. **Develop and implement outcome-focused metrics**: effective delivery of clinical co-ordination for people with multiple long-term conditions requires policy-makers to develop metrics that measure outcomes rather than processes, focusing on the effectiveness of care co-ordination.

By promoting holistic care, supporting financial and systemic reforms, and fostering collaboration across sectors, policy-makers can help create a health and care system that manages the complexities of multiple long-term conditions effectively, ultimately improving both patient experience and outcomes, and system efficiency.

Further reading

Fenney D, Gowar C, Baird B, Scott S (2025) *Improving clinical co-ordination of care for people with multiple long-term conditions: the art of the possible*. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/improving-clinical-coordination-multiple-long-term-conditions

The way forward: realising the vision of care closer to home. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/projects/way-forward-vision-care-closer-home

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Morris L, Livesey K, Naylor C (2024) *The role of integrated care systems in improving dementia diagnosis*. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/role-integrated-care-systems-improving-dementia-diagnosis

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