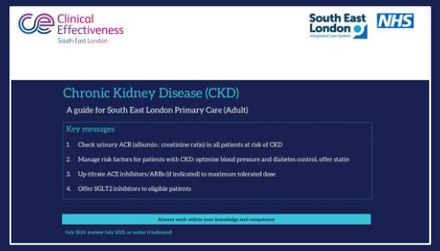
Clinical multiple Long-Term Condition (mLTC) Care

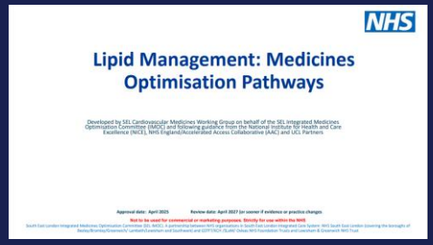
Supporting delivery of mLTC care across South East London

Key message:

- Shifting from single-condition to mLTC care requires changing how we work

This resource pack includes prompt sheets to support clinicians delivering cardiorenal metabolic (CRM) reviews and is a synthesis of the CESEL Hypertension (HTN), Type 2 Diabetes (T2DM), Chronic Kidney Disease (CKD) and SEL Lipid Management Pathways





Always work within your knowledge and competency

April 2026 – due review in November 2027– sooner if new changes

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

The Building Blocks for mLTC Care

RESOURCE SECTIONS	WHAT'S INCLUDED?	WHO IS THIS FOR?
1. Clinical mLTC care	T2DM + CKD +/- HTN — Page 3 T2DM + HTN — Page 4 CKD + HTN — Page 5 Patient Resources — Page 6	Clinicians delivering cardiorenal metabolic reviews
2. Getting the basics right	Single condition care Call and recall systems	Practice, PCN, INT leadership and management teams
3. Know your population	Multimorbidity in SEL Your population data 3+LTC SEL Data Ardens Resources	Practice, PCN, INT leadership and management teams
4. Make the best of the team	Building effective teams INT to support mLTC care Match team members to risk/need	Practice, PCN, INT leadership and management teams
5. Making Change	Making change and innovation Quality Improvement methods Try new things: The Bristol Model Patient activation UCLP Proactive Care Framework Innovation and risk groups Group Consultations Point of Care Testing Community of Practice Action Learning Sets Lifestyle Medicine Group Education Community of Practice SEL System Level Support	All those interested in delivering improvements General Practice, PCN, INT leadership and management teams Clinical and non-clinical teams

This page is a prompt sheet and assumes a good understanding of the individual condition management.
Use Ardens multimorbidity template to ensure correct coding.

Your patient has: Type 2 Diabetes + Chronic Kidney Disease +/- Hypertension

PRE REVIEW

WHO?
Non clinician e.g. Health Care Assistant/Care Coordinator
Information gathering
Accurx messaging or phone call

'What matters to you?': discover issues of importance to individual to be discussed in review appointment

Arrange investigations: BP, BMI, renal function, lipid profile, HbA1c, TFT, urine ACR, foot check, retinopathy screening in place

Consider

Vital 5 Check


Healthy Blood Pressure


Stop Smoking


Safe Drinking


Healthy Mind


Healthy Weight

T2DM + CKD +/- HTN

REVIEW APPOINTMENT

WHO?
Appropriately trained clinician
Review and explain results
Document agreed personalised goals/targets (QOF and NICE)
Individualise targets especially in those with personal risks e.g. falls & frailty
Screen for AF
Give tailored lifestyle advice

BP Target

Clinic BP: 5mmHg lower for ABPM and home readings

ACR/frailty	Systolic	Diastolic
ACR <70	120-139	<90
ACR ≥70	120-129	<80
Frail	Individualise	

HbA1c Target

NICE	≤48mmol/mol - unless taking drug that causes hypos
	≤53mmol/mol - on a drug that causes hypos
	Relax targets for frail/older patients.
QOF	≤58mmol/mol – without moderate or severe frailty
	≤75mmol/mol – with moderate or severe frailty

Aim for especially tight control in younger people < 40 years

Lipid Target

No CVD – primary prevention
40% reduction in baseline non-HDL cholesterol.
Established CVD – secondary prevention
LDL-C ≤ 2mmol/L or non-HDL ≤ 2.6mmol/L

BMI Target: NICE

If overweight, weight loss target of 5–10% of body weight.

Pulse check for AF

Check pulse and if irregular follow CESEL AF guide


Vaccination advice: Flu, Pneumococcal (5 yearly)


Sick day rules


Avoid nephrotoxic drugs including over the counter NSAIDs


Dietary advice including reduce salt to <6g a day
Avoid low protein diets


Address mental health needs, vital to engage in LTC care


Aim for >150mins of moderate intensity exercise/week


Offer nicotine dependence advice. Major addictive CVD risk factor

Optimise medication

Assess adherence and medicine management
See individual guides for medication details
Consider signposting to Community Pharmacy (CP) New Medicines Service

ACE/ARB – 1st line ramipril/lisinopril or losartan
Titrate to maximum tolerated dose (reduce other antihypertensives if needed).
If not meeting BP target add calcium channel blocker (CCB) **or** thiazide-like diuretic **or** both if needed.
1st line amlodipine or indapamide.
Check individual drug license for low eGFR.

+

Metformin
Use only if eGFR >30 – lower dose if eGFR 30-45
Maximum tolerated dose: 1g twice daily
Offer slow release if GI side effects.

Once ACE/ARB at maximum tolerated dose and stable on metformin offer SGLT2i

SGLT2i
If not already on SGLT2i, offer generic dapagliflozin.
If on SGLT2i continue generic dapagliflozin, for other SGLT2is consider switch to generic dapagliflozin.
When initiating SGLT2i consider reducing the dose of concomitant glucose-lowering agents that increase the risk of hypoglycemia in patients with good glycaemic control, consider risks of DKA.
Counsel re possible side effects and sick day rules. Share information.

+

Lipid lowering therapy

No CVD
Atorvastatin 20mg (or rosuvastatin 10mg) titrate to maximum tolerated dose to achieve target.
If not achieving target on maximum tolerated statin dose, consider adding ezetimibe.
If statin intolerant– offer ezetimibe, if not reaching target consider switching to bempedoic acid with ezetimibe.

Established CVD
Atorvastatin 80mg (rosuvastatin 20mg)
If statin intolerant– offer ezetimibe 10mg and if not achieving target consider bempedoic acid + ezetimibe tablets, assess for eligibility for injectables.

See SEL IMOC Lipid Management Pathway for more information

Not achieving target?

Refer to individual condition guides

Hypertension | **Type 2 Diabetes** Includes weight management | **Lipids** | **Chronic Kidney Disease**

Agree a personalised care plan and arrange appropriate follow up

Create a personalised care plan with the patient based on their priorities, including when to seek help and the next review date.
Share relevant health information/leaflets and signpost to community support.

POST REVIEW - if needed

WHO?
Multidisciplinary team
Not achieving target?
Seek advice/support

MDT meeting: Explore barriers to managing condition? Focus on what matters to the patient. Use the whole team e.g. Social Prescribing Link Worker, Mental Health Practitioner, voluntary sector

Seek advice: via Advice and Guidance/Consultant Connect or specialist within PCN/INT, consider mental health team for patients with mental health diagnosis

Explored all options? On maximum treatment, assessed adherence, asked advice – then consider referral to secondary care – pathways in individual condition guides

This page is a prompt sheet and assumes a good understanding of the individual condition management.
Use Ardens multimorbidity template to ensure correct coding..

Your patient has: Type 2 Diabetes + Hypertension

PRE REVIEW

WHO?
Non clinician e.g. Health Care Assistant/Care Coordinator
Information gathering
Accurx messaging or phone call

'What matters to you?': discover issues of importance to individual to be discussed in review appointment

Arrange investigations: BP, BMI, renal function, lipid profile, HbA1c, TFT, urine ACR, foot check, retinopathy screening in place

Consider Vital 5 Check — Healthy Blood Pressure — Stop Smoking — Safe Drinking — Healthy Mind — Healthy Weight

T2DM + HTN

REVIEW APPOINTMENT

WHO?
Appropriately trained clinician
Review and explain results
Document agreed personalised goals/targets (QOF and NICE)
Individualise targets especially in those with personal risks e.g. falls & frailty
Screen for AF
Give tailored lifestyle advice

BP Target

Clinic BP: 5mmHg lower for ABPM and home readings

ACR/frailty	Systolic	Diastolic
ACR <70	120-139	<90
ACR ≥70	120-129	<80
Frail	Individualise	

HbA1c Target

NICE	≤48mmol/mol - unless taking drug that causes hypos
	≤53mmol/mol - on a drug that causes hypos
	Relax targets for frail/older patients.
QOF	≤58mmol/mol – without moderate or severe frailty
	≤75mmol/mol – with moderate or severe frailty

Aim for especially tight control in younger people < 40 years

Lipid Target

No CVD – primary prevention
40% reduction in baseline non-HDL cholesterol.

Established CVD – secondary prevention
LDL-C ≤ 2mmol/L or non-HDL ≤ 2.6mmol/L

BMI Target: NICE

If overweight, weight loss target of 5–10% of body weight.

Pulse check for AF

Check pulse and if irregular follow CESEL AF guide

Vaccination advice: Flu, Pneumococcal (5 yearly) — Sick day rules — Avoid nephrotoxic drugs including over the counter NSAIDs — Dietary advice including reduce salt to <6g a day Avoid low protein diets — Address mental health needs, vital to engage in LTC care — Aim for >150mins of moderate intensity exercise/week — Offer nicotine dependence advice. Major addictive CVD risk factor

ACE/ARB - 1st line ramipril/lisinopril or losartan

Titrate to maximum tolerated dose (reduce other antihypertensives if needed).
If not meeting BP target add CCB **or** thiazide-like diuretic **or** both if needed.
1st line amlodipine or indapamide.
Check individual drug license for low eGFR.

Metformin

Use only if eGFR >30 – lower dose if eGFR 30-45

Maximum tolerated dose: 1g twice daily
Offer slow release if GI side effects.

Qrisk ≥10%: Once ACE-I/ARB at maximum tolerated dose and stable on metformin consider SGLT2i

SGLT2i

If not already on SGLT2i, offer generic dapagliflozin. .
If on SGLT2i continue generic dapagliflozin, for other SGLT2is consider switch to generic dapagliflozin.
When initiating SGLT2i consider reducing the dose of concomitant glucose-lowering agents that increase the risk of hypoglycaemia in patients with good glycaemic control, consider risks of DKA.
Counsel re possible side effects and sick day rules. Share information.

Lipid lowering therapy

Qrisk<10%: Lifestyle advice

Qrisk ≥10%: Atorvastatin 20mg (or rosuvastatin 10mg) titrate to maximum tolerated dose to achieve target.
If not achieving target on maximum tolerate statin dose, consider adding ezetimibe.
If statin intolerant– offer ezetimibe, if not reaching target consider switching to bempedoic acid with ezetimibe.

Established CVD
Atorvastatin 80mg (rosuvastatin 20mg)
If statin intolerant– offer ezetimibe 10mg and if not achieving target consider bempedoic acid + ezetimibe tablets, assess for eligibility for injectables.

See SEL IMOC Lipid Management Pathway for more information

Optimise medication

Assess adherence and medicine management
See individual guides for medication details
Consider signposting to Community Pharmacy (CP) New Medicines Service

Not achieving target?

Refer to individual condition guides

Hypertension | **Type 2 Diabetes** Includes weight management | **Lipids**

Agree a personalised care plan and appropriate follow up

Create a personalised care plan with the patient based on their priorities, including when to seek help and the next review date.
Share relevant health information/leaflets and signpost to community support.

POST REVIEW - if needed

WHO?
Multidisciplinary team
Not achieving target?
Seek advice/support

MDT meeting: Explore barriers to managing condition? Focus on what matters to the patient. Use the whole team e.g. Social Prescribing Link Worker, Mental Health Practitioner, voluntary sector

Seek advice: via Advice and Guidance/Consultant Connect or specialist within PCN/INT, consider mental health team for patients with mental health diagnosis

Explored all options? On maximum treatment, assessed adherence, asked advice – then consider referral to secondary care – pathways in individual condition guides

This page is a prompt sheet and assumes a good understanding of the individual condition management.
Use Ardens multimorbidity template to ensure correct coding.

CKD + HTN

PRE REVIEW

WHO?
Non clinician e.g. Health Care Assistant/Care Coordinator

Information gathering
Accurx messaging or phone call

'What matters to you?': discover issues of importance to individual to be discussed in review appointment

Arrange investigations: BP, BMI, renal function, lipid profile, HbA1c, TFT, urine ACR,

Consider Vital 5 Check — Healthy Blood Pressure; Stop Smoking; Safe Drinking; Healthy Mind; Healthy Weight

REVIEW APPOINTMENT

WHO?
Appropriately trained clinician

Review and explain results
Document agreed personalised goals/targets (QOF and NICE)
Individualise targets especially in those with personal risks e.g. falls & frailty
Screen for AF
Give tailored lifestyle advice

BP TARGET

Clinic BP: 5mmHg lower for ABPM and home readings

ACR/frailty	Systolic	Diastolic
ACR <70	120-139	<90
ACR ≥70	120-129	<80
Frail	Individualise	

Lipids

No CVD – primary prevention
40% reduction in baseline non-HDL cholesterol.
Established CVD – secondary prevention
LDL-C ≤ 2mmol/L or non-HDL ≤ 2.6mmol/L

BMI Target: NICE
If overweight, weight loss target of 5–10% of body weight.

Pulse check for AF
Check pulse and if irregular follow CESEL AF guide

Vaccination advice: Flu, Pneumococcal (5 yearly)
Sick day rules
Avoid nephrotoxic drugs including over the counter NSAIDs
Dietary advice including reduce salt to <6g a day Avoid low protein diets
Address mental health needs, vital to engage in LTC care
Aim for >150mins of moderate intensity exercise/week
Offer nicotine dependence advice. Major addictive CVD risk factor

Optimise medication

Assess adherence and medicine management
See individual guides for medication details
Consider signposting to Community Pharmacy (CP) New Medicines Service

eGFR 20-45

eGFR 45-90
ACR <22.6 | ACR ≥22.6

BP control as per CESEL Hypertension Guide

Offer ACE/ARB 1st line ramipril/lisinopril or losartan
Titrate to maximum tolerated dose (reduce other antihypertensives if needed).
If not meeting BP target add calcium channel blocker (CCB) **or** thiazide-like diuretic **or** both if needed.
1st line amlodipine or indapamide.
Check individual drug license for low eGFR.

Once ACE-I/ARB at maximum tolerated dose

SGLT2i
If not already on SGLT2i, offer generic dapagliflozin.
If on SGLT2i continue generic dapagliflozin, for other SGLT2is consider switch to generic dapagliflozin.
Counsel re possible side effects and sick day rules. Share information.

Lipid lowering therapy

No CVD
Start atorvastatin 20mg (or rosuvastatin 10mg) titrate to maximum tolerated dose to achieve target.
If not achieving target on maximum tolerate statin dose, consider adding ezetimibe 10mg.
If statin intolerant– offer ezetimibe 10mg, if not reaching target consider switching to bempedoic acid with ezetimibe.
Established CVD
Atorvastatin 80mg (rosuvastatin 20mg)
If statin intolerant– offer ezetimibe 10mg and if not achieving target consider bempedoic acid + ezetimibe tablets, assess for eligibility for injectables.

See SEL IMOC Lipid Management Pathway for more information

Not achieving target?

Refer to individual condition guides

Hypertension | Lipids | Chronic Kidney Disease

Agree a personalised care plan and appropriate follow up

Create a personalised care plan with the patient based on their priorities, including when to seek help and the next review date.
Share relevant health information/leaflets and signpost to community support.

POST REVIEW - if needed

WHO?
Multidisciplinary team

Not achieving target?
Seek advice/support

MDT meeting: Explore barriers to managing condition? Focus on what matters to the patient. Use the whole team e.g. Social Prescribing Link Worker, Mental Health Practitioner, voluntary sector

Seek advice: via Advice and Guidance/Consultant Connect or specialist within PCN/INT, consider mental health team for patients with mental health diagnosis

Explored all options? On maximum treatment, assessed adherence, asked advice – then consider referral to secondary care – pathways in individual condition guides

Your patient has: Chronic Kidney Disease + Hypertension

Patient Rresources

Healthy Lifestyle

- The Eatwell Guide - NHS
- 8 tips for healthy eating
- DASH diet
- Healthy living – BHF
- African & Caribbean Eatwell Guide
- Carbs & Cals resources for patients
- Physical activity infographic for patients.
- Physical Activity resources from Make Every Contact Count
- Vital 5 patient website
- NHS Better Health free tools and support to kickstart your health (weight, smoking, activity, alcohol)

Type 2 Diabetes

- NHS Healthy Living Programme
- SEL Diabetes Education.
- Diabetes UK
- Health and Care patient information videos on range of diabetes topics
- Diabetes UK Patient information leaflets in different languages
- Diabetes Peer support
- Ramadan & Diabetes
- 10 tips for healthy eating with diabetes | Diabetes UK
- SEL Sick day guidance for patients
- TREND: What to do when you are ill, patient information

CKD

- Think Kidneys - range of PILS such as explanation of CKD and at risk of AKI (including sick day rules)
- Kidney Care UK – range of PILS with information on medication, grants, travel, dialysis and more
- Patient.info – PILS on your kidneys
- Living with CKD (nhs.uk)
- Kidney Care UK's National Advocacy Service 01420 541 424 or online community
- National Kidney Federation offer a Free National Kidney Patient's Helpline 0800 169 09 36
- Patient information for SGLT2is

Hypertension

- Check your BP reading Understanding your BP
- Home BP measurements: British Heart Foundation
- How to reduce your blood pressure 6 top tips
- BP Patient information leaflets in different languages
- Online programme about hypertension for patients

Community Pharmacy BP Check Service
Patients over the age of 40 may qualify for a free BP check at a local pharmacy without a GP referral.
Find a pharmacy that offers free blood pressure checks – NHS

Lipids

- BHF information on statins
- Heart UK: Information on statins
- NICE shared decision-making guide
- NHS Statins - side effects

Medicines Adherence

- NICE Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence
- Specialist Pharmacy Service: Defining and understanding medication adherence

Abbreviations

ACE	Angiotensin-converting enzyme inhibitors
ACR	Albumin creatinine ratio
AF	Atrial fibrillation
ARB	Angiotensin II receptor blockers
BHF	British Health Foundation
BMI	Body mass index
BP	Blood pressure
CCB	Calcium channel blocker
CESEL	Clinical Effectiveness South East London
CKD	Chronic kidney disease
CP	Community pharmacy
CRM	Cardiorenal metabolic
CVD	Cariovascular disease
DASH	Dietary approaches to stop hypertension
DKA	Diabetic Ketoacidosis
eGFR	Estimated glomerular filtration rate
HbA1c	Glycosylated haemoglobin
HTN	Hypertension
INT	Integrated neighbourhood team
LTC	Long-term condition
MDT	Multi-disciplinary team
mLTC	Multiple long-term conditions
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSAID	Non-steroidal anti-inflammatory drug
PCN	Primary care network
QOF	Quality and Outcomes Framework
Qrisk	Cardiovascular risk tool
SEL	South East London
SELIMOC	South East London Integrated Medicines Optimisation Committee
SGLT2i	Sodium-glucose co-transporter-2 inhibitor
T2DM	Type 2 Diabetes
UCLP	University College London Partners

Acknowledgements: CESEL guides and resources are co-developed by SEL primary care clinicians and SEL experts. The guides go through a formal approval process including SEL Integrated Medicines Optimisation Committee (IMOC) for the medicines content and Southeast London Long-Term Conditions Steering Group.
CESEL would like to thank all our colleagues who participated and fed-back during the guide development and consultation process.
SEL Approval: April 2026.
Visit **Clinical Effectiveness (CESEL) - NHS South East London** for details of the CESEL support offer.

Clinical Effectiveness
South East London

Making the right thing to do the easy thing to do.