# Know your population

A building block for multiple long-term condition care (mLTC)

Key messages:

- Data combined with patient and community feedback is vital to understand your population and design services that best meet their needs

This resource supports service planning at practice, PCN and INT level and outlines data sources and how data can be used to support delivery of mLTC care.



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

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

## The Building Blocks for mLTC Care

| RESOURCE SECTIONS | WHATS INCLUDED? | WHO THIS IS FOR? |
|---|---|---|
| 1. Clinical mLTC care | Clustered condition care: cardiorenal metabolic conditions: prompts for clinical care<br>• T2DM + CKD +/- hypertension<br>• Hypertension + T2DM<br>• Hypertension + CKD | Clinicians delivering cardiorenal metabolic reviews |
| 2. Getting the basics right | Page number<br>Single condition care<br>Call and recall systems | Practice, PCN, INT leadership and management teams |
| 3. Know your population | Page<br>Multimorbidity in SEL 3<br>Your population data 4<br>3+LTC SEL Data 5<br>Ardens Resources 6-8<br>Other data sources 9 | Practice, PCN, INT leadership and management teams |
| 4. Make the best of the team | Building effective teams<br>INT to support mLTC care<br>Match team members to risk/need | Practice, PCN, INT leadership and management teams |
| 5. Making Change | Making change and innovation<br>Moving from single to mLTC care<br>Whole person annual review<br>Quality Improvement methods<br>SEL System Level Support<br><br>Try new things<br>• Patient activation<br>• UCLP Proactive Care Framework<br>• Group Consultations<br>• Point of Care Testing<br>• Community of Practice | All those interested in delivering improvements<br>Practice, PCN, INT leadership and management teams<br>Clinical and non-clinical teams |

# Why is it important to know about your population?

- **Population Health Management (PHM)** uses data alongside patient and community feedback to build a comprehensive understanding of population needs and to design and deliver services accordingly.
- Population health data can identify the most common long-term conditions (LTC) among people living with multimorbidity, enabling targeted preventative interventions where they are likely to have the greatest impact (1).
- For example, multimorbidity tends to occur around a decade earlier in more deprived communities than in affluent ones (2). This highlights a significant opportunity to improve outcomes by focusing preventative and proactive care on younger populations in areas of greater deprivation.

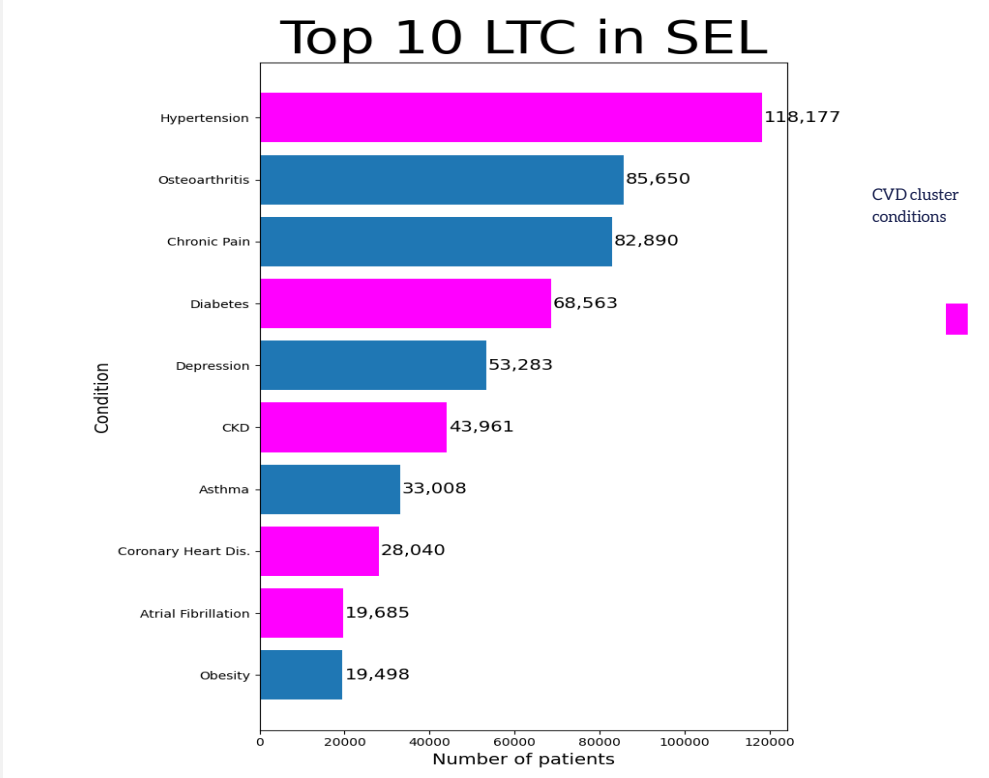
| | |
|---|---|
| Know | Use data and patient and community insights to understand your population health and care needs. |
| Connect | Collaborate across the system to deliver integrated health and care services. |
| Prevent | Shift from reactive to proactive care, preventing illness, illness progression and ill-health. |

# Knowing the SEL population (3)

- South East London (SEL) has a population of approximately 2.1 million people, around 10% of whom are living with three or more LTC (3+ LTCs).
- Within this group, 17% have experienced high levels of urgent care use, defined as either two or more unplanned hospital admissions or three or more A&E attendances in the past 12–18 months.
- The prevalence of 3+ LTCs rises from the age of 50, is higher among women than men, and is greatest in both the most and least deprived areas.

# Key themes in multimorbidity in SEL (3)

- Hypertension is the most prevalent individual long-term condition.
- 90% of people living with 3+ LTCs have at least one condition within the cardiorenal metabolic (CRM) disease cluster, and five of the ten most prevalent conditions fall within the CRM cluster (see below).
- Depression and chronic pain together account for 67% of all conditions among people with 3+ LTCs.
- Taken together, these findings suggest that prioritising CRM conditions, multisystem disease, and mental health is likely to deliver the greatest overall benefit. However, the prevalence of individual conditions varies by locality, highlighting the need for service priorities to be tailored to local population needs.




*SELICB 3+LTC Dashboard accessed January 2026 (3)*

# Your population data

This table captures information needed to plan and deliver mLTC care and where to source the data. Ask your CESEL facilitator to help you with the data relevant to your team.

| | Questions to ask | Why ask the question? | Data Source to find the answer |
|---|---|---|---|
| 1 | **WHERE AM I NOW?** | Who are the people in my population with mLTCs and how well are they managed? | email bi@selondonics.nhs.uk for access to their dashboards- available to all SEL practices, PCN and ICB team. |
| | Prevalent LTCs | Identify conditions of high prevalence in your population to focus on. | • 3 Plus Long Term Conditions Report (BIU dashboard)<br>• Ardens Clinical case finder searches - Bespoke practice/PCN searches<br>• Ardens Manager |
| | Individual LTC prevalence | If prevalence for a particular condition is lower than expected – i.e. compared to SEL average or comparable population, consider case-finding to improve your prevalence. | • 3 Plus Long Term Conditions Report (BIU dashboard)<br>• BIU hypertension dashboard<br>• Ardens Clinical and Ardens Manager |
| | LTC management | **What data shows our achievements in single LTCs?** Because cross-condition performance data for people with mLTCs is limited, we need to identify and agree on condition-specific metrics that best reflect how effectively we are delivering care. Regular data check points supports proactive planning and progress toward key targets, including achievement of the Quality and Outcomes Framework (QOF) | • Emis Clinical QOF searches (practice level)<br>• Ardens Clinical and Ardens Manager<br>• SEL BIU dashboards for individual conditions e.g. hypertension, diabetes, CESEL CKD dashboard. Performance over time and compared to peers. Updated monthly.<br>• QOF national datasets<br>• CVD Prevent -National CVD dashboard, updated every 3-6 months<br>• Open Prescribing – National Prescribing Data at ICB and practice level |
| | Patient and community feedback | How acceptable is the care we deliver and where are improvements needed? | • Patient Participation Group, Friends and Family Test, complaints<br>• Patient Survey - Annual survey. Compare your practice results with your peers.<br>• Healthwatch reports |
| 2 | **HOW AM I DOING OVER TIME?** | Knowing where our improvement is dipping can help us decide where to focus or efforts, particularly in relation to key targets e.g. QOF. | • SEL BIU dashboards for individual conditions e.g. hypertension, diabetes, CESEL CKD dashboard<br>• Ardens Manager |
| 3 | **HOW AM I DOING COMPARED TO MY PEERS?** | Comparing our performance with teams serving similar populations highlights strengths and areas for improvement.<br>Sharing data and learning from high performers helps improve outcomes at practice, PCN, borough, ICB, regional, or international level | • Within SEL: Ardens Manager and ICB Dashboards – see above<br>• Beyond SEL:<br>  • CVD Prevent -National CVD dashboard, updated every 3-6 months<br>  • Open Prescribing – National Prescribing Data at ICB and practice level |
| 4 | **WHERE IS MY VARIATION?** | Understanding variation in people with mLTCs helps target improvement efforts. Differences can occur across demographics (age, ethnicity, sex, deprivation), circumstances (homeless, housebound, unemployed), or co-morbidities (learning disability, serious mental illness, depression). For example, CVD Prevent data show younger Black patients with hypertension have poorer control than older patients or those of other ethnicities, | • 3 Plus Long Term Conditions Report (BIU dashboard)<br>• Ardens Manager<br>• CVD Prevent<br>Additional data sources available on page 9 |

| CRM cluster | Suggested metrics |
|---|---|
| Diabetes | HbA1c, BP and lipid control measures. 8 care processes |
| Hypertension | BP control in <80<br>BP control in ≥ 80<br>Urine ACR |
| Atrial Fibrillation | CHADSVASC score<br>Anticoagulation |
| Lipids | Lipid lowering treatment to target |
| Chronic Kidney Disease | BP control, lipid lowering treatment, SGLT2iuse, urine ACR |

# SEL 3+ LTC Data (1)

SEL has agreed a common definition of conditions to include in the SEL 3+LTC cohort with associated vulnerabilities and exclusions, this is reflected in the SEL 3 Plus Longterm Conditions Dashboard.

## LTC in SEL
Comon definition of 3+LTC

- Atrial Fibrillation
- Chronic pain
- Stroke and TIA
- Osteoporosis
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Heart Disease
- Heart Failure
- Dementia
- Depression
- Diabetes Mellitus
- Epilepsy
- Hypertension
- Peripheral Arterial Disease
- Bronchiectasis
- Rheumatoid Arthritis
- Asthma
- Osteoarthritis
- Parkinson's Disease
- Sickle Cell Disease
- Cystic Fibrosis
- Inflammatory Bowel Disease
- Sarcoidosis
- Systemic Lupus Erythematosus
- Cirrhosis of Liver
- Obesity BMI>40
- Multiple sclerosis
- SLE

## Vulnerabilities
supporting risk identification SEL definition

- Alcohol and substance misuse
- Deprivation
- Disability
- Has carer/care package
- Language difficulties
- Refugee/Asylum seeker
- Safeguarding/neglect/Abuse concern
- Socially marginalised e.g. homeless, probation
- Violence/criminal exploitation concern

## 3+LTC Reviews

If offering reviews for patient with 3+ LTC from the above list consider:

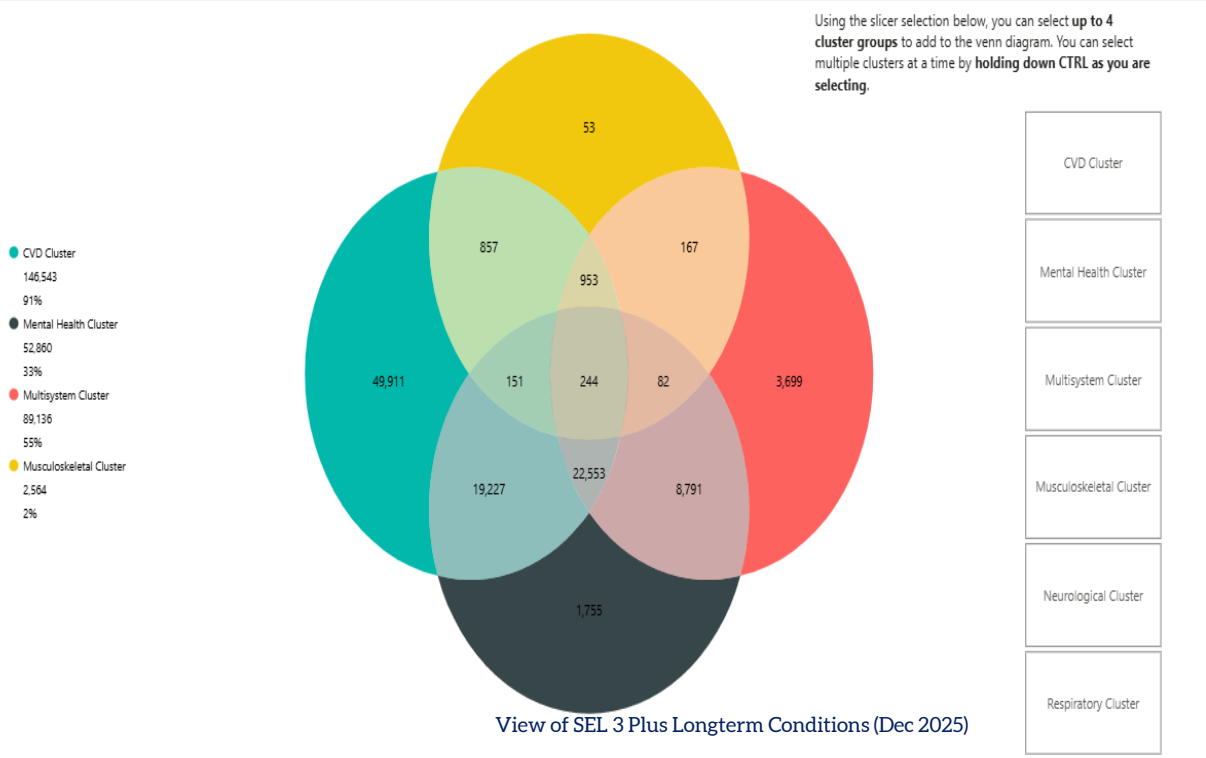
- **Clustered condition reviews** – as described in Resource Section 1 for CRM conditions (Type 2 Diabetes, Hypertension, Chronic Kidney Disease )
- **Single review of all conditions** –. if a clinician is less confident in a particular condition e.g. Parkinson's Disease, it may be adequate to ensure
  - Specialist care is in place
  - Medications are reviewed and prescribed safely
  - Polypharmacy is addressed
  - A personalised care approach is taken, ensuring the patient understands their condition and knows when and where to seek help

Ensure patient conditions not included in the above list are also reviewed in 'all condition' reviews

See **Clinical mLTC Care and Whole-Person: Annual Review - The Bristol Model**

## SELBI 3+ Longterm conditions dashboard

Useful for modelling at INT/PCN/Place level, identifying need and planning services accordingly.
The dashboard has clustered conditions into clinical groups.



View of SEL 3 Plus Longterm Conditions (Dec 2025)

**CVD Cluster:** AF, CKD, CHD, DM, HF, HT, Obesity, PAD, CVA and TIA

**Respiratory cluster**: asthma, bronchiectasis, COPD, Cystic Fibrosis

**Neurological cluster:** dementia, epilepsy, multiple sclerosis, Parkinson's Disease

**Mental Health**: depression

**Multisystem:** chronic liver disease, chronic pain, inflammatory bowel disease, rheumatoid arthritis, sarcoidosis, sickle cell disease, systemic lupus erythematosus

**Musculoskeletal:** osteoarthritis, osteoporosis

**Patient identification**
Work is underway to enable patients identification from the SEL+LTC Dashboard.



Know your population: SEL 3+LTC Data

# Ardens Resources

- Ardens provides EMIS integrated digital tools to support general practice teams to deliver, record, monitor and improve patient care
- **Ardens Clinical templates** support correct coding
- **Ardens Clinical** includes quality assured searches to help monitor performance
- **Ardens Manager** is a series of dashboards built from EMIS data and includes clinical and administrative performance

Click here to see how Ardens Clinical can be used for mLTC management

Click here to see how Ardens Manager can be used for mLTC management

| | **Ardens Clinical** - *Supporting Direct Patient Care* Click here | | **Ardens Manager** – *Enabling Population-Level Oversight* Click here |
|---|---|---|---|
| | • Integrated within EMIS<br>• Supports coding, templates, and assessments<br>• Guides completion of required care actions | **EMIS/Ardens Clinical → Data Extract → Ardens Manager**<br>*Data entered through Ardens Clinical informs reporting and improvement via Ardens Manager* | • Analyses clinical data for reporting and improvement<br>• Identifies gaps in care or incomplete activity<br>• Tracks progress over time via dashboards and metrics<br>• Tracks performance against national and local incentives |
| Purpose | Supports delivery of direct patient care within the clinical system through templates, searches, and coding tools | **What?** | Provides population-level insight through dashboards and reports that monitor clinical activity and outcomes. |
| System | Integrated within EMIS | **Where?** | Web-based platform accessed through browser login |
| Focus | Individual patients and care delivery | **Who?** | Groups of patients, population data, trends, and performance metrics |
| Core functions | • Clinical templates for condition reviews and care actions<br>• Searches to identify patients due for follow-up<br>• Standardised data entry and coding to improve record quality | **Tools** | • Case finders to identify specific patient cohorts<br>• Performance indicators to track care completion<br>• Dashboards to visualise progress and variation |
| Users | Clinicians, nurses, pharmacists, and allied health professionals. | **Users** | Practice managers, PCN leads, data quality staff, ICB and neighbourhood teams |
| Benefits | • Promotes consistent, evidence-based care delivery<br>• Improves data quality and coding accuracy<br>• Helps teams manage individual patient needs effectively | **How?** | • Identifies gaps or inequalities in care.<br>• Supports improvement initiatives and audits<br>• Enables proactive, population-based planning |

Practice teams across SEL have access to both Ardens Clinical and Ardens Manager – ask your Practice Manager for your team access
For support in use see resource section or reach out to CESEL, Digital or Medicines Management Teams

# Ardens Clinical

**Ardens Clinical (AC)** provides searches, templates, and protocols aligned with national and local guidance to support consistent, high-quality care.
It helps teams identify, assess, and manage patients efficiently within defined clinical areas.

**Typical functions include:**
- Creating registers and case finders for long-term conditions
- Supporting structured clinical reviews
- Tracking completion of key care elements e.g. medicines reviews, assessments, care plans
- Flagging patients where activity is overdue

## Identify the mLTC Population

**Practices can:**
→ Identify who has multiple LTCs
→ Understand their risk level and care needs
→ Target interventions efficiently

AC comes with **QOF and LTC searches**, which identify patients on registers for conditions like:
- Diabetes
- Hypertension
- CHD
- COPD
- Asthma
- CKD
- Heart failure
- Depression
- Atrial fibrillation, etc.

Using AC search functionality, you can **combine multiple condition registers** to generate:
Patients with ≥2 LTCs
Patients with ≥3 LTCs
Patients with specific combinations e.g. diabetes + CKD


*Screenshot of AC view*

## Segment by Risk or Complexity

Practices can:
- Identify patients at **highest risk of deterioration or hospitalisation** – RAG rating Prioritise **resources and interventions** efficiently.
- Tailor **personalised care plans** and MDT support.
- Monitor **outcomes and performance** for IIF, QOF, and PHM.

Standard segmentation considers:
- **Number** and **type** of LTCs
- **Disease control** e.g., HbA1c, BP, lung function
- **Frailty** score or **functional** status
- Recent **hospital admissions** or **A&E** attendance
- **Social** factors (deprivation, care home residence)

Example of AC searches; complexity

| Complexity | Criteria / Indicators | Typical Intervention |
|---|---|---|
| **Low Complexity** | Stable LTCs, controlled metrics, low frailty | Routine review, prevention |
| **Medium Complexity** | Multiple LTCs, moderate risk, occasional admissions | Proactive monitoring, personalised care plan |
| **High Complexity** | ≥3 LTCs, uncontrolled disease, high frailty, recent admissions | MDT review, care coordinator, community or social care involvement |
| **Very High / Frail** | Advanced frailty, polypharmacy, end-of-life needs | Intensive case management, palliative care planning |

Example of Ardens Clinical Searches: UCLP Proactive Care


*Screenshot of AC view*

CVD prioritisation according to risk

## Ardens Templates for Consistent Coding

Navigate to:
*Population Reporting → Ardens Searches → 4.11 Conditions – Management (and Identification)*

Use templates e.g. **" Review"** to add codes, assessments, and management actions.

**Performance Indicators folder**: track specific care elements that have not been completed.
In the patient record:
- **Home Tab**: key info such as care home status, care team, record sharing consents.
- **Review Tab**: especially for severely frail patients; lists required items (meds review, falls, etc.) with visual markers (blue stars for national requirements, yellow for local codes).

Includes reports for the CVD prevention QOF indicators:


*Screenshot of AC view*

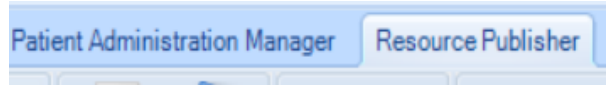
## Continuity of Care – RAG Status (optional)

**Purpose:** Divides patients by need to guide care and reduce hospital admissions (based on Foundry model).

**Ardens resources:**
- **Data Entry Template:** view/update patient RAG status.
- **Protocol:** triggers on record save/update to assign RAG status.
- **QOF Alert:** shows current RAG status; double-click to launch template.

**Activation:**
Go to *Resource Publisher/Template Manager → Shared Folders → Ardens Content → Other Protocols → Continuity of Care.*
Right-click **protocol** and **template**, select **Activate**.

**Reporting:**
*Ardens Searches → 1.37 Administration – Foundry RAG (Ardens)* to view patients by RAG status or identify those without one.




*Screenshot of AC view*

*For further support and guidance on Ardens tools, visit https://support.ardens.org.uk/support/solutions/31000074522*
Contact the team training@ardens.org.uk for bespoke training requests

# Ardens Manager

**Ardens Manager (AM)** provides practice-level dashboards covering both clinical and administrative activity. It can generate patient lists to support note reviews and patient follow-up and enables comparison and shared learning across SEL GP teams through standardized data collection.

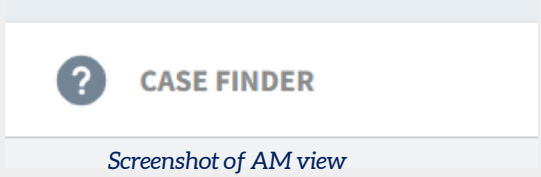
**Functions include:**
- Dashboards showing completion of key care elements
- Case finders to identify specific patient groups
- Performance indicators to track achievement rates
- Benchmarking to highlight variation and best practice
- QOF financial achievement – income prediction

**Using Ardens Manager**
- Clinical leads can i**dentify, validate and confirm** patient diagnosis
- Care Coordinators & Pharmacists can **plan reviews**
- Administrators can **track coding & recall processes**

## Detection – Case Finders

🔍 **Run predefined searches** to identify patients with risk factors or missing diagnoses e.g. high HbA1c but not coded for diabetes, or repeated asthma meds but no diagnosis.
•**Highlight patients at risk** of developing a condition — e.g. those with raised BP readings not on the hypertension register.
•**Support proactive review** lists e.g. frailty, COPD heart failure, for clinical validation.
• ✅ *Example:*
*Run the "Prevalence and Case Finding" suite → identify patients with possible COPD based on symptoms or spirometry but no current diagnosis code.*

📋 **Cross-reference condition registers** to find patients appearing on 2 or more LTC lists e.g. diabetes + CHD + CKD.
•**Generate multimorbidity cohort lists** for personalised care planning or Structured Medication Reviews (SMRs).
•**Support workload planning** by stratifying patients by number and severity of conditions.
•**Identify data quality gaps**, ensuring correct coding so patients are accurately included in registers.
• ✅ *Example:*
*Run the "Multi-Morbidity" report → produces a list of patients on ≥2 LTC registers (useful for IIF targets or personalised care planning).*




*Screenshot of AM view*

## Management – Performance Indicators

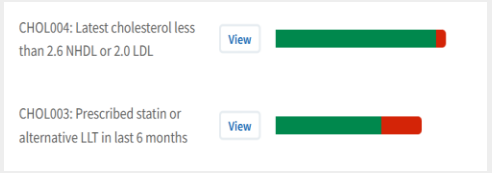
• 📈 The **Trend / Overview** tab (if enabled) shows:
- •Change in **register size** (how many 3+LTC patients over time)
- •Progress in **annual reviews completed**
- •Improvement in **indicator achievement** e.g. BP control, HbA1c, COPD review
- •Comparison with PCN averages (if aggregated)

• ➡️ This can be can exported into **Excel or Power BI** for deeper analysis or PCN reporting.

🖥️ **.Accessing the Multi-Morbidity Dashboard**
•I → **Long-Term Conditions → Multi-Morbidity**, you'll find a dashboard or search suite titled something like:
•**"Patients on multiple LTC registers"**
**or**
**"Multi-morbidity cohort"**
•This dashboard pulls data from all your LTC disease registers (Diabetes, CHD, CKD, COPD, Asthma, etc.) and groups patients based on how many registers are on.

## Management – Incentive income

Ardens Manager includes details of
- national and local incentives
- Achievement to date
- Missed income
- Income per patient to achieve target




*Screenshot of AC view*

*This is particularly helpful towards the end of the financial year to decide where to focus attention to maximize QOF income*

INEQUALITIES

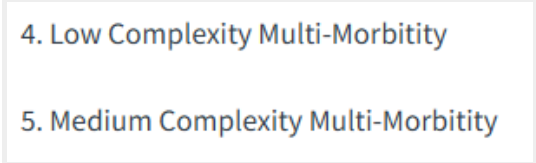
## Demographics and Health inequality

For **multi-morbidity and LTCs**, AM helps practices and PCNs to:
- Understand **who their** multimorbid patients are (by age, sex, deprivation, ethnicity, etc.)
- Identify **where inequalities exist** in disease burden, access, or outcomes
- Target **resources and interventions** to reduce those gaps

## Continuity of Care – Ardens RAG status

**Based on the Foundry Model**

| | |
|---|---|
| Green | General health good<br>Continuity of care **less important** |
| Amber | Chronic long term disease management required<br>Continuity of care **important** |
| Red | Chronic long term disease management required: complex needs<br>Continuity of care **paramount** |




*Screenshot of AC view*

## Bridges to Health

Bridges to Health

Bridges to Health links directly with:
- Multi-Morbidity Dashboard → shows condition overlaps by segment.

The Bridges to Health module in Arden's Manager segments the entire registered population into clinically meaningful groups. It helps practices and PCNs identify, stratify, and proactively manage multimorbid and high-need patients, while tracking performance and outcomes over time.

Know your population
Ardens Manager

| OTHER SUGGESTED DATA SOURCES | |
|---|---|
| PHE Fingertips | Public Health Data Base, to regional level, includes health inequalities dashboards. |
| Joint Strategic Needs Assessment | overview of health needs in your borough<br>Southwark Lambeth<br>Lewisham Greenwich<br>Bexley Bromley |
| Chief Medical Officer Annual Reports | Summarised health and care national trends with supporting data and narrative |
| NHS Race and Health Observatory | Data and research to support addressing inequalities in health and care |
| Global Burden of Disease | Study that demonstrates the conditions that contribute to ill health and early death globally |
| Community Pharmacy (CP) Data | NHSBSA dispensing data<br>Clinical Services Statistics<br>CP data can improve risk stratification and identify underserved cohorts engaging primarily with pharmacy. |
| Open Prescribing | Useful for trends across prescribing data |

# References


| Page | Ref | Reference with link and access date |
|---|---|---|
| 3 | 1 | Making sense of the evidence: Multiple long-term conditions (multimorbidity) - NIHR Evidence Accessed March 2026 |
| | 2 | Understanding the health care needs of people with multiple health conditions \| Health Foundation Accessed March 2026 |
| | 3 | 3 Plus Long Term Conditions Report Accessed March 2026 |
| 5 | 1 | 3 Plus Long Term Conditions Report Accessed March 2026 |


# Abbreviations

| | |
|---|---|
| 3+LTC | 3 or More Long Term Conditions |
| ACR | Albumin Creatinine Ratio |
| AF | Atrial Fibrillation |
| BIU | Business Intelligence Unit |
| BMI | Body Mass Index |
| BP | Blood Pressure |
| CESEL | Clinical Effectiveness South East London |
| CHADS VASC | Clinical prediction tool used to estimate the annual risk of stroke in patients with AF |
| CHD | Coronary Heart Disease |
| CKD | Chronic Kidney Disease |
| COPD | Chronic Obstructive Pulmonary Disease |
| CRM | Cardiorenal Metabolic |
| CVA | Cerebrovascular Accident |
| CVD | Cardiovascular Disease |
| HbA1c | Glycated Haemoglobin expressed as percentage |
| HF | Heart Failure |
| HTN | Hypertension |
| ICB | Integrated Care Board |
| IIF | Investment and Impact Fund |
| INT | Integrated Neighbourhood Team |
| LTC | Long Term Condition |
| MDT | Multidisciplinary Team |
| mLTC | Multiple Long-term Condition |
| PAD | Peripheral Arterial Disease |
| PCN | Primary Care Network |
| PHM | Population Health Management |
| QOF | Quality and Outcomes Framework |
| RAG | Red, Amber, Green |
| SEL | South East London |
| SGLT2i | Sodium Glucose Co-transporter 2 inhibitor |
| SMR | Structured Medication Reviews |
| T2DM | Type 2 Diabetes Mellitus |
| TIA | Transient Ischaemic Attack |
| 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.