NHS
Lancashire and South Cumbria
Integrated Care Board

FAQs for Long Term Conditions LES

Q: Why do I need to use Aristotle when I can look at my own system?
A: The Aristotle dashboards have been created to mirror specific measurement criteria, and may appear differently to other dashboards, such as the QOF indicators. The cohort generated by the segmentation tool will have been filtered to identify individuals at most risk of harm. They are also there to benchmark starting points for diagnosis, treatment and management at practice, PCN and place level.
Q: What are the UCLPartners reports available on EMIS?
A: These are reports that were created to support the BP@Home programme, which can be utilised across your patient system, to risk stratify patients into groups that require similar input/management. It is not necessary to use these tools to complete the processes required in the LTC LES.
Q: How can pharmacy first support us in this?
A: Using the 'send to Pharmacy' functionality that already exists in EMIS, will start the process of sending specific patients to pharmacy for care such as ABPM.
Q: Why are tobacco, weight management and physical exercise risk factors singled out?
A: These three areas have received funding in the past, to ensure that programmes are available to refer into. Whilst the offer may vary in different localities, there are options available to support patients with stopping smoking, losing weight and becoming more active.
Q: Are we being asked to switch all patients to DOACs from warfarin?
A: No, only when decided by clinical judgement that they can/should be. L&SC are an outlier for higher-than-average patients being treated with warfarin, therefore we are hoping to bring this down by switching patients that can be, and not starting patients on warfarin unless that is the only suitable option.
Q: How do we identify our patient cohort?
A: This should be the cohort identified by the Aristotle Population Segmentation tool. Preset filters will be available for each of the LTC LES cohorts.
Q: Do we have to use the MLCSU template or can we use our own template or Ardens template
A: For the LTC LES it is essential that the Holistic Health Assessment is completed for each assessment to ensure consistency of coding. This would be in additional to your practices own template for the clinical aspect of the review (diabetes, asthma etc.)
Q: Is there any help available to contact patients and encourage attendance?
A: The process required is similar to the Frailty module within 24/25's GPQC. The learning from this process (and LMC guidance) will be applicable for LTC LES.
Q: Is there a document we can use for a combined Physical and Mental Health care plan?
A: For the holistic health assessments within the LTC LES it is not mandatory to produce an hard copy agreed care plan. The main aim is to identify and address any unmet needs an individual patient may have.

Q: We understand from the engagement sessions and the document the Why, who and what, however we are struggling to understand from a practice implementation and operational point of view the How and the When. The document is very detailed in its intentions however just reading through rather than being walked through it is difficult to clarify expectations.
A: Following feedback, we are looking to add an extra Webinar session for this. We will look at an example case study and walk through this with practices. We anticipate this will be held in mid-February.
Q: Will the ICB link with the other statutory agencies to encourage attendance at PCN level MDT's
A: From February local Place support will be stood up to provide support in developing local MDTs. The design of the MDT structure means that if this is not possible practices will be able to undertake their own internal MDT.
Q: There's already an established MDT set-up in BwD. Is engaging with that sufficient for this piece of work, or is there an expectation that we should run our own and invite other providers? Do MDT/INT partners know of the ICB's intentions in this work for increased MDT referrals and do they have capacity?
A: Depending on the local MDT set-up it may be appropriate to feed patients identified into this space. The local support team will be able to advise on this.
Q: Respiratory - recall patients "who have suffered an exacerbation" - what's the scope?
A: The intention for patients at risk who have been identified as being at risk would be prioritised for post exacerbation review – following a course of antibiotics or steroids.
Q: Frailty - why do the reviews need to be Face-to-Face reviews? This should be flexible approach based on the needs and wants of the patient? i.e. follow up phone call for frailty part of review?
A: All reviews are expected to be face-to-face where possible and have been costed as such.
Q: SMI patients - two reviews - already difficult to get these patients to attend one review, never mind two. This very much feels like a backward step for this patient cohort. A targeted care coordinator approach, whereby a positive and trusting relationship can be built, is a far better approach and will help to achieve the required outcome. There needs to be a flexible approach (not prescriptive attendance at two appointments) with this cohort the most - telephone SMRs, personalised approach to appointments etc
A: All specifications are clinical, and require at least one clinical review, and therefore cannot be carried out by care coordinators. Although it may be appropriate for a care coordinator to undertake the Holistic Health Assessment with the patient, with a following clinical appointment.
Q: If patients are in more than one cohort i.e. PHM and LTC will an enhanced review count towards both targets as these are the patients being asked to be prioritised
A: There is an expectation that there is likely to be a significant overlap of cohorts. In this instance it would be appropriate to prioritise these individuals. The assessment will only count towards one target cohort. The cohorts have been designed to ensure that even with significant overlap there will be enough patient availability.
Q: Is the expectation just to ensure patients are reviewed or are there any other targets that practices need to work towards?
A: The expectation for each patient is to ensure there is a completed Holistic Health Assessment (HHA) AND relevant clinical review. Some of the data items in the HHA will be monitored to ensure quality of reviews is maintained.

Q: If someone if flagged up as being eligible and I review their notes, and they e.g. don't have angina on the CHD LT condition tab or they have depression and are on a mood stabiliser and don't have schizophrenia/bipolar etc on the SMI tab is there an exemption code we add to show we have reviewed the notes? Or are you saying that anyone flagged up will have been flagged up for more than one reason so even if they are not added to a specific LT conditions register, they should still have a holistic assessment?
A:The intention is that these individuals (even if they demonstrably haven't a specified condition on notes review) may still benefit from a holistic health assessment so would be eligible for assessment. An example would be an individual on antipsychotic medication is at risk of additional health or care needs. The assessment will be item of service that counts towards target. The review of notes would be an activity that falls within the Implementation funding.
Q: Also is there a code if the patient declines or repeatedly DNA's given that there is the intention to claw back funding, we do need to be able to evidence work we have done that may adversely affect our target?
A: The assessment once undertaken will count towards target. The administration costs associated with booking appointments including patient declines and DNA's are covered by the implementation portion of funding. The cohorts of patients identified through the population segmentation tool have a significant margin to incorporate significant DNA rates without exhausting the cohort.
Q: I previously asked about HI budget and was assured that it was not absorbed into this. Please can you confirm?
A: It's a different funding route, so the HI budget hasn't been subsumed into this work - some of the learning has - we're awaiting decisions on the funding
Q: We used to have a practice CSU DQ person who would attend on a frequent basis and help do a lot of this work - and extractions. Do we have any similar support?
A: You do still have access to a CSU DQ person to help just I am afraid not physically in person but certainly via teams
Q: I continually raise the point that to the best of my knowledge that Aristotle is very poor at identifying frailty as it uses eFI rather than Rockwood (unless this has now changed). Is eFI still used?
A: The accuracy of Aristotle has improved over the past year with the additional assessments undertaken through the GPQC. So, it demonstrates two separate items: 1. eFI – universal coding now of population over the age of 50 from 2024 – illustrates risk of frailty. 2. Rockwood scoring – demonstrates diagnosis of frailty. And although this doesn't give an exact method of identifying individuals with moderate or severe frailty the accuracy has increased significantly in the past 12 months.
Q: Re case finding there is no clinical oversight around the 'bulk coding process' and errors may result in clinical risk – please could we have your thoughts?
A: The batch adding of codes only applies to administrative codes - 'meets eligibility criteria for well-being assessment for LTCs' applies to individuals with an existing LTC and does not have a clinical or QOF meaning.

Q: Could May be an additional planning month?
A: Due to the delays with LTC LES sign off we have introduced April as a dedicated planning month with activity modelled to take place over the following eleven months. Each practice will be able to phase that activity in a way that works for their own capacity and capability.
Q: Please could we have a single spreadsheet showing the activity requested of all practices in the LTC LES (i.e. an aggregate of the information that went out to each practice) - This will enable us to see, if all practices undertook for example frailty, how many minimum units of activity there would be and the associated payments.
A: The practice should have received a breakdown of their individual expected resource availability and assessment targets. The minimum units of activity will not change with chosen LTC 1&2.
Q: Is there any further information that we could have at PCN or District level around health need/prevalence (PH Leads will hopefully have some)
A: The local team of teams is undertaking the exercise to bring together prevalence and morbidity data at a place level with local plans to decide on LTC 1 & 2
Q: Page 30 of the LTC LES says practice template for planning by 1st April- can that be changed please. We cannot have a planning month of April but the plan in on the 1st.
A: Apologies. This is an error, and will be amended. The date is 30th of May for submission of plan for Domain 1 (Implementation).
Q: The prevalence work suggests just to upload codes giving people a chronic disease from coding work- no clinical input. I have already complained to the LMC that this is unsafe. Please can this be looked at - as clinical time has not been considered in costing. Impact of complaints via bulk coding chronic diseases as well- did we learn nothing from frailty?
A: The batch added code after the searches have been run is not a clinical code and does not confer diagnosis. It is an administrative code that is intended to support invitation and recall of the specified cohort. Appropriate diagnosis and clinical coding should only be made following appropriate assessment. The clinical time is factored into the assessment costs.
Q: Can you clarify from the assessments- if for instance we have someone who hits our LTC 1 and LTC 2 - eg if we get frailty and respiratory and its a frail asthmatic- does that count under each as an assessment- or are the number of assessments counted even if people fall under multiple areas.
A: Each assessment will only count once towards the target. Individuals on multiple registers are likely to have greater unmet need and would be appropriate to prioritise. It would be up to the practice to decide if it counts towards frailty or respiratory minimum targets in this example.
Q: If we do any reviews in April on the LTC LES, will these numbers be 'counted' or is it just from May onwards that the numbers will be counted?
A: For the LTC LES, data is collected from 1 Apr.
Q: If we undertake activity for LTC LES in April will it be counted?
A: Yes. It will count towards 25/26 target.
Q: Can the ICB please confirm that we will be paid for activity done through April re the LTC LES?
A: Yes, this will be paid

Q: When will the templates for next year/codes be confirmed to ensure we are able to evidence work correctly?
A: LTC LES searches and codes have been sent to practices and have been added to the Intranet in the Technical guidance documents.
Q: Starts 1st April but we don't have the templates etc - so can't start yet - also the Aristotle reports and training that is mentioned. Thats not happened. What's the ETA please?
A: All the templates and searches etc for LTC LES will be on the intranet today and have been emailed to practices today (27th March)
Q: When will the holistic health assessment template be available?
A: This is on the intranet
Q: On the long term LES disease area it says CVD, but the Aristotle pre-set filters have CHD. Is that the correct data to pull for that area?
A: The CHD filter in Aristotle is the correct one to use. The narrower filter (rather than all CVD) changed throughout the cohort definition process and hasn't been updated within the specification to reflect this. This is based on cohort numbers available, overlap of cohorts and simplicity of clinical care delivery factors.
Q: Can you clarify whether the holistic assessment has to be done the same day as the review? We were told no, but the searches still look for the codes the same day
A: Yes. That is correct - they are part of the same process but can be undertaken by different professionals at different times to ensure efficient delivery.
Q: When will the delivery plan templates be shared?
A: These are already available on the intranet in the resources section
Q: is there a search that will identify patients identified in more than one identified group?
A: There is currently not a search for this, but we are looking at adding one for the May update.
Q: Does the LTC LES review need to be face to face?
A: Yes - assessing the needs of an individual patient will require a face to face component. But some of the data gathering can be undertaken remotely ahead of assessment.
Q: Do we know what searches we are working on for clinical case findings or do we choose?
A: The searches are available through the EMIS LTC LES search package. You can choose which of the case finding searches you work on.
Q: Can the LTC Review be done on same day as holistic health assessment?
A: Yes. The LES has been designed with flexibility to work with whatever suits practices and patients best. In some instances a review may take place in a single time and place, with others splitting the HHA and clinical components may be more effective (e.g with diabetic patients having an HCA appointment for bloods and HHA at one appointment, Practice Nurse clinical review to results and plan care). It should all form part of a single planned process though.
Q: The 5 LTC LES search groups in Domain 2 are for people who may have an undiagnosed LTC, or who may be at risk of developing one. Under the LES we wouldn't be inviting them in for a standard LTC review (although they may have other diagnosed LTCs). Is this correct?

A: For the clinical case finding cohort there's still the need to undertake the:

1. Holistic Health Assessment
2. Clinical assessment to ascertain if has specified (or alternative diagnosis)

It is at the discretion of the practice to identify which clinician is most appropriate to review the patient.

Q: Please could you clarify how payments will be split for the LTC LES?

A: Practices will receive 80% of their annual contract value in advance, paid in monthly instalments. This will begin with a two-month upfront payment in mid-April, covering both April and May 2025. Payments will be paid on separate invoice refs, not a combined payment value – i.e. one will ref P1 & one will ref P2. Thereafter, payments will continue monthly in advance – for example, June's payment will be made in May, July's in June, and so on. The final monthly payment will be made in February 2026, covering March 2026. As a result, there will be no payment made in March 2026. The remaining 20% of the contract value will be paid as a reconciliation payment in June 2026, subject to performance.

Q: A practice has reported that although this search is looking for pts on MH drugs but not MH register they have a patient who is coming up on this list of patients but they are on the MH QOF register the drug they are finding is Aripiprazole and they are on the MH1 register with the catatonic schizo diagnosis?

A: The text below was taken from the original LSC SMI LTC LES spec:

- People who are in remission will remain on the SMI register in case they relapse but should not be invited for an annual physical health check. A remission code (under the SNOMED cluster MHREM_COD) should only be applied if the patient has had none of the following for at least 5 years:
- record of antipsychotic or mood stabiliser medication
- mental health inpatient episode
- secondary or community care mental health follow-up.

....so if the patient is still on meds they probably need a non-remission code adding after the remission code to take them out of our search and make them eligible for an annual review again.

Q: I am confused, I understand that in EL we are working on Respiratory and Diabetes do we still need to download all the lists from Aristotle and import?

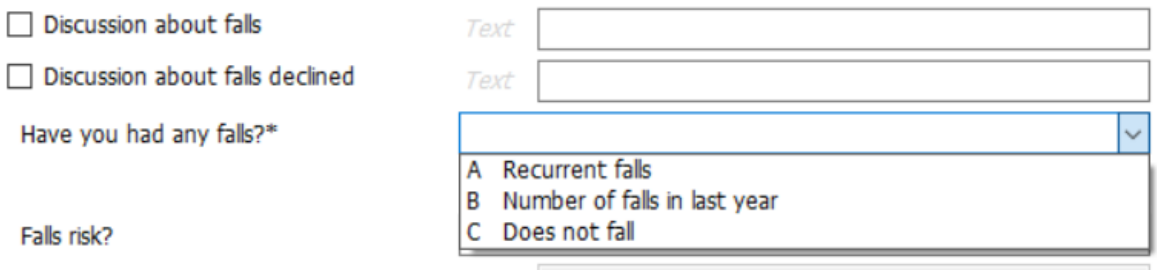
A: You only have 2 LTC specified by the local ICB you only need to download the 2 LTC and import in EMIS as a patient list. You also need to download the lists for Population Health Management, and SMI (as these are separate sections in the LTC LES). Case finding is obtained from the EMIS Searches.

Q: Which search related to population health?

A: You can find this in Aristotle to download (Aristotle looks at other areas for this group of patients deprivation, ethnicity etc)

Q: Regarding the Holistic Assessment template our clinicians want to know if all the questions must be answered or if it is differing per patient. I think this has been raised because on other templates the "key questions" have a * next to them which must be answered to be completed.

A: The extent of what is completed on the template will differ from Patient to Patient. The Key items for the HHA are consent, ethnicity and Falls. Ensuring that the Actions section at the bottom of each page is also completed (where there are actions to be taken).
Q: Is there a standard invite we need to send out to the patients or do we just create this ourselves?
A: No this is up to practices to devise an invite which could go along with the QOF annual review.
Q: Are the completed assessments auto extracted for payment or do we have to submit figures?
A: You do not have to submit any figures this will be auto extracted so ensure you have batch added the correct codes for and ticked the Holistic Health review for payment purposes.
Q: When will the searches and templates for the care home LES be released?
A: There is already a template on RP and the searches are the PCN searches as in previous years
Q: Looking at the invite search it will invite all case finding patients, even if they haven't been confirmed as having a LTC. Is this correct? Should these patients be called in?
A: Yes, this is correct. Case finding searches are to look at patients who may need to go on your register or not. Even if you find they do not need to be added the register, they are still eligible for the HHA.
Q: I presume the clinical case finding is like a validation exercise?
A: Clinical case finding is looking at patients who have coding in their record suggesting that they may potentially need to be added to a chronic disease register. Case finding can also increase your prevalence of a chronic disease which in turn can increase your points value.
Q: Is there a clinical case findings search for frailty?
A: No, although use of the eFI score can help to identify patients who may require a clinical review to assess their level of frailty.
Q: for the CCF HYP report - do we need to only work on the CCF HYP2a filter to increase inclusion health factors ?
A: Yes you only need to work on the filtered searches – HYP1a and HYP2a
Q: If we only had to do the case findings for the conditions we have been given, what would hypertension come under?
A: The case finding is completely separate to the 2 LTCs that have been selected at a place level. You can choose which of the case finding searches you wish to work on and these do not necessarily need to reflect your 2 LTCs.
Q: Who can do the holistic reviews, do they have to be face to face?
A: Following a discussion with the ICB, it is expected that there should be an element of Information can be sent to the patients before or some elements can be carried out via a questionnaire, however the ICB do expect the patient to have had some sort of F2F appointment.
Q: What about GP assistants doing the HHA's?
A: Yes this is down to the practice and would be for the practice to decide on who is suitable to do these assessments.

Q: Just looking at the template what is there is no issue with falls etc what do you put in signposting ? referrals? Do you just leave blank.
A: You could tick the box discussion about falls. There is also an option to state does not fall. 
Q: What's happening with MDTs this year - do we have targets, is there going to be set criteria (i.e. last year was briefly 3 unmet needs), etc.?
A: No there are no targets, as yet, for MDTs this year.
Q: Would you suggest using the words Holistic Health Review in the invites?
A: It would be up to the practice but it would be a good idea to use this then you would know what the patient is coming in for.
Q: Going back to MDTs - the LES presentation mentioned core and extended MDTs. Do we have to do so many of each (i.e., last year was 25% MDT target), who goes to what MDT, and are we going to start MDTs only when the ICB decide what qualifies for an MDT (unless serious concerns)?
A: As far as we are aware, there are no targets for MDTs and it would be down to the practice to decide who would benefit from an MDT.
Q: Where do I find the technical guidance to confirm the codes to batch add
A: You can find this on the GP Intranet, under other resources: LES 2025/26 – Lancashire and South Cumbria Primary Care Intranet
Q: We don't keep drugs for patients on testosterone / Denosumab / zoladex etc on repeat prescribing here - we keep them on acute so that we make sure that the monitoring has taken place before they are administered. In some cases, this can result in the drug having expired in EMIS and dropped into the past before it is re-started and re-issued when needed. I notice that the searches only look for current prescribing so I don't know if this will affect any reconciliations for us. We have our own recall system so we will be picking these patients up as usual but they haven't all appeared on your register searches and I think this might be why. Do you think this might cause any problems?
A: In terms of recalls, that is absolutely fine that you have your own system and you can continue to do this. You do not need to use the invites searches provided. As long as you add the 'claim code' to the patients who have received an injection, it will ensure that those patients are all being counted. We are waiting for EMIS to release a better code for Testosterone which is coming out in MKB222, as we are not currently happy with the coding available. This would be the same for any of the injections.
Q: The total number of patients from our Aristotle lists for CVD, Diabetes, SMI and PHM total 1027 but when I run the invites search it shows 746 patients to be invited. All batch add codes have been added so not sure of the reason for the discrepancy.
A: This could be because the patient is appearing in more that one search i.e., they may have CHD, Diabetes and PHM, but you would only invite them in once for the HHA.

Q: Who should we contact with any support or queries relating to Aristotle?
A: For Aristotle support and queries: mlcsu.aristotlesupport@nhs.net