Covid-19
Guidance for practices

Date: 07.04.2020

Please be aware that this is a rapidly evolving situation.

Management of long-term conditions during and post-Covid-19

Key messages

1. Identification and stratification of patients into higher and lower risk groups, prioritising highest risk individuals for ongoing, proactive management.
2. Clinical management according to clinical need with care by the most appropriate team member.
3. Remote assessment to be utilised wherever possible and appropriate.
4. Supported self-management using validated resources including digital tools where appropriate.

Principles

- Long-term conditions (LTCs) cause considerable co-morbidities and the management of these has mostly been contractualised through QOF.
- The BMA and NHS England have produced updated guidance on QOF requirements for 21/22. While there were some income-protected indicators for 20/21, there has been no indication that this is the case for 21/22.
- The oscillating demands of Covid-19 related emergency care and workforce impact during the pandemic will result in variable levels of capacity that can be directed to proactive care therefore the principle of patient prioritisation is key.
- Given the risks of coronavirus transmission, it is vital that care is delivered remotely wherever possible. However, essential face to face care must continue.

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Delivery of care

- All consultations should be remote in first instance, with face to face only if required and ideally in the context of a 'one-stop-shop' appointment if possible.
- Practices support multidisciplinary team working including utilising nursing staff, healthcare support workers and practice pharmacists to help manage LTCs.
- Consider all options for patient self-monitoring at home, supporting autonomy and empowerment through online resources. For example, this may involve supporting individuals to take their own blood pressure, oxygen saturations or peak flow.

Patient cohort stratification and prioritisation

- Searches of patient records will enable identification of patients with highest clinical risk or potential for risk factor modification. This may be due to uncontrolled risk factor parameters, or potentially suboptimal prevention medication.
- Consideration should also be given to BAME patients who may be at higher risk of adverse clinical outcomes, as well as those in deprived populations.
- Some prioritisation tools have been facilitated through AHSN, with the UCLP tool being widely adopted.
- Reviewing identified notes can help refine the prioritisation, this can be carried out by clinical staff from home if required.

UCL Partners long term condition tool

- UCLP have created this set of tools to support long term conditions in the context of Covid. They are referenced in the table below and has helpful information regarding identification, risk stratification and clinical management for the Asthma, COPD, hypertension and type 2 diabetes. To apply for use of the search tool, please visit this page.
- We have linked to the appropriate sections of the resources for the four conditions below, as well as additional guidance for managing other LTCs. This is a guide and practices are advised to use this flexibly according to their needs

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Please note: We acknowledge every practice team is different, with variable access to nursing staff, heathcare assistants, clinical pharmacists and social prescribing link workers especially as some members of staff are required to self-isolate. The suggested clinical management is team-dependent and can be delivered by an alternative appropriate member of the primary care team.

Long-term condition	Stratification of higher risk patients	Clinical management	Self-management tools
All	• Poor compliance with medication/ interventions • Socially vulnerable	Initial assessment: appropriate team member undertakes initial contact for all patients with long term conditions using template tools or texts.	• NHS personal quit plan • NHS Smokefree help and advice • NHS One You lifestyle advice

Type 2 diabetes	• See UCLP tool.
	
	High risk patients:
	HbA1c >90 OR
	HbA1c with any one of the following:
	  • BAME
	  • Social complexity
	  • Severe frailty
	  • Insulin or other injectables
	  • Heart failure
		Initial assessment: appropriate team member undertakes initial contact for all risk groups to provide; check HBA1C up to date, provide information on risk factors, eg smoking cessation, diet and exercise, waist circumference.
		• Protocol for Low Risk Type 2 diabetes
		• Protocol for Medium and High Risk Diabetes
		
		Requires annual vaccinations and blood tests where indicated*.
			• NICE approved face to face programme, offering education, diet & exercise advice
			• Diabetes UK advice
			• NHS My Diabetes, My Way app
			• Digital tools for managing Type 2 diabetes

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Long-term condition	Stratification of higher risk patients	Clinical management	Self-management tools
COPD	See UCLP tool. High risk patients: • Fev1 • % predicted - <50% • Cor pulmonale • On home oxygen • MRC grade 4-5 • Plus individual patients where clinician concern • Plus patients identified as high risk using symptom tools.	Initial assessment: appropriate team member undertakes initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources. • Protocol for Low Risk COPD • Protocol for Medium and High Risk COPD Requires annual vaccinations*	• MyCOPD app offering patient information & education, inhaler technique, online pulmonary rehab classes, smoking cessation support, self-management plan. • Overview of COPD – diagnosis, treatment, and managing flare ups. • Step-by-step guidance on physical activity.

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Asthma	See UCLP tool.
	
	High risk patients:
	• Any biologic therapy.
	• Frequent steroid therapy
	• Frequent antibiotics
	• Tiotropium
	• Combination inhaler (LABA+ICS) at a high daily steroid dose
	• ICS with:
	  ○ Leukotriene Receptor Antagonist
	  ○ Theophylline
	• Plus individual patients where clinician concern
	• Plus patients identified as high risk using symptom tools.
		Initial assessment: appropriate team member undertakes initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources.
		• Protocol for Low Risk Asthma.
		• Protocol for Medium and High Risk Asthma
		
		Requires annual vaccinations*
			• Inhaler technique by Asthma UK and Right Breathe.
			• Asthma deterioration
			• General Health Advice

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Long-term condition	Stratification of higher risk patients	Clinical management	Self-management tools
Depression and anxiety	High risk: • Suicidal ideation • Previous history self-harm • Unstable condition	Initial assessment: appropriate team member undertakes initial contact to discuss lifestyle interventions and assess PHQ9/ GAD-7 score where indicated. Medication reviews and compliance assessed where appropriate. GP escalation: Identified high risk patients prioritised for telephone/ video assessment with GP.	• Mental health digital resources for Londoners. • 24 hour crisis text service • Mental health resources for depression and anxiety
Hypertension	High risk: • Clinic BP > 180/120	Initial assessment: appropriate team member undertakes initial contact to check regarding medication compliance, lifestyle factors and most recent BP reading. • Protocol for low risk hypertension • Protocol for medium or high risk hypertension May require blood tests*	• Patient resources for hypertension • Validated blood pressure monitors for home monitoring

Long-term condition	Stratification of higher risk patients	Clinical management	Self-management tools
Atrial fibrillation	Identify those not on treatment • Assessment using CHA2DS2VASC score. • Consider ATRIA or HASBLED score for those who have treatment indicated.	Initial assessment: appropriate team member undertakes initial contact to check regarding medication compliance. • INR monitoring for patients on warfarin must continue*. GP escalation: • For patients not on treatment with qualifying CHA2DS2VASC score to arrange GP telephone/ video consultation. • Consider switching appropriate patients to DOACs via telephone/ video consultation.	• Living with atrial fibrillation

*Requires face-to-face assessment in the most appropriate setting. For further information regarding face-to-face assessment, see our safe practice guidance.