Care for people with Long Term Conditions during the pandemic – contacting patients

For information and action

The management of chronic disease and acute illness must continue, albeit in a modified form, to reduce the collateral health damage from the understandable change in focus of health services during the initial stages of the pandemic. To help keep these patients healthy, City and Hackney has developed a suggested approach to managing high risk LTC patients to:

- Reduce progression of disease which could lead to hospital attendances
- Reduce greater complexity to be dealt with post COVID
- Reduce workload in primary care and utilise support of the wider workforce including community teams
- Address a range of patient needs with a holistic approach (clinical, mental, social etc.)

Our proposal is that we begin in phases by initially addressing those with poorly controlled diabetes, respiratory and cardiac conditions. Not only in an effort to diminish the morbidity and mortality associated with these conditions but many of these patients (often with multi-morbidities) should they become ill with Covid-19 will do very badly.

The high risk, clinically vulnerable cohorts will be patients with:

- Poorly controlled diabetes (last HbA1c was ≥9.5%)
- Severe COPD (MRC Step 3 or above)
- Severe asthma (BTS Step 3 or above)
- Hypertension (BP>150/90)
- Heart failure (NYHA III+ who have not had a review in the last 6 months or with a HF related admission in the last 6 months)

CEG have put together searches to support practices in identifying the above cohorts.

The expectation is that supporting these patients will be mostly done by the practices themselves (via telephone/video and, if necessary, F2F consultations) with help from the extended team, for example DSNs for diabetes and ACERS for COPD/Asthma/HF. Physical health reviews including BP checks and phlebotomy should be done in a way that safe and minimises risk of exposure.

So that practices know who is actively being managed by community teams, Homerton will share these lists of patients with practices (to generic practice email addresses; see below), a process which may be repeated on a regular basis if needed. Practices should contact Homerton teams via standard methods, to let them of patients that will no longer need their input (for example if they have passed away).

For all cohorts, GPs to consider whether referral to IAPT would be of benefit to patients: https://talkchangesforhealth.org.uk/ (GP referral or self-referral).

Requirement of primary care

Diabetes:

(I) Practices should have shared the list of patients with poorly controlled diabetes (identified via CEG search: last HbA1c ≥9.5%) with their diabetes specialist nurse (DSN).

(II) DSNs are/will be working with the Homerton diabetes team to establish who within the cohort will be managed by the DSNs and who will need to be managed by general

practice. DSN will reply to the person who sent the list with which patients are under the active care of the diabetes team.

(III) Practice to follow up any that are not being managed by diabetes team – using attached pathway.

(IV) If practices have any questions, please contact: Lauraelwood@nhs.net or Louis.Bolter@nhs.net

COPD and asthma:

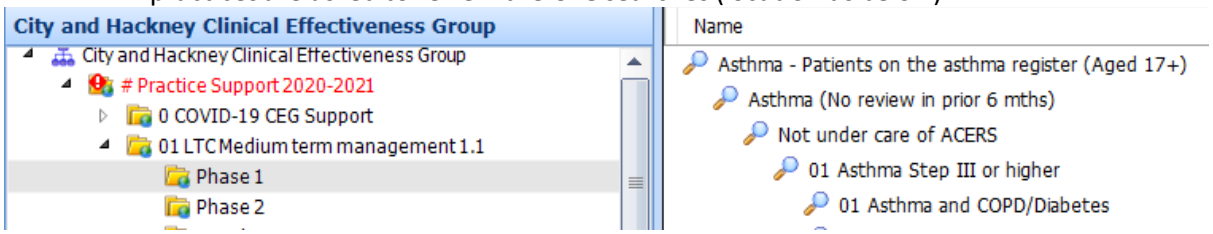
(I) Homerton will send each practice the list of patients who have been identified by the ACERS Respiratory team as being vulnerable and are therefore regularly receiving contact from the ACERS team to check on their well-being during the COVID-19 pandemic.

(II) The list will be sent from Homerton Information Team to the practice generic email address and should be received by practices on or before 27th May

(III) On receipt of the lists GP practices should code all patients on the list received from Homerton as: 'Under care of community respiratory team'

Under care of community respiratory team	247691000000100	405401000000110

(IV) To identify patients with severe COPD/asthma and not being managed by ACERS, practices are asked to review the CEG searches (location as below)



(V) Practices to follow up any patients that are not being managed by ACERS – using attached pathway

Heart failure:

(I) Homerton will send each practice the list of patients who have been identified by the Heart Failure Team as being vulnerable and are therefore regularly receiving contact from the HF Team to check on their well-being during the COVID-19 Pandemic.

(II) The list will be sent from Homerton Information Team to the practice generic email address and should be received by practices on or before 27th May.

(III) On receipt of the lists GP practices should code all patients on the list received from Homerton as: 'Seen by community heart failure nurse'

Seen by community heart failure nurse	417359009	2548316014

(IV) To identify patients with heart failure not being managed by ACERS, practices are asked to review the CEG searches (location above)

(V) Practice to follow up any that are not being managed by ACERS – using attached pathway

Hypertension

(I) Practice to review CEG search to identify uncontrolled hypertension

(II) Practice to follow up patients – using attached pathway