

**LONG TERM CONDITIONS:  
Managing co-morbidities and identifying risk  
groups**

**LOCALLY COMMISSIONED SERVICE  
1<sup>st</sup> April 2022 – 31<sup>st</sup> March 2023**

**APPENDICES**

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# Appendix 1: Background and Rationale for the LTC LCS

## **Background**

A 2011 survey<sup>1</sup> reviewing 1.75 million people showed that the majority of people over 65 have two or more long term conditions (LTC), the majority over 75 have three or more and more people have two or more conditions than one. Indeed in Islington, the Public Health profile on older people shows that 14,600 over 65s have one LTC and 62% of these have 2 or more (equating to >9,000 people). There is predicted to be a 252% rise in people with multiple long term conditions by 2050 and the associated costs of treating patients with LTC are projected to rise to £26 billion by 2050. The burden of ill health is particularly affected by deprivation and the fact that people now are living longer with greater health care needs.

Islington is the 24<sup>th</sup> most deprived borough in England. We know that in Islington, health inequality (the gap between the health experienced by the richest and the poorest) is largely driven by long term conditions such as cardiovascular and respiratory disease. Earlier identification and management of people with LTCs will help tackle health inequality. However LTCs are not just about physical health. There are around 38,000 people in Islington who have one or more LTC and it is estimated that most of these patients will also experience mental health problems at some point in their lives as a direct result of their LTC.

In the past, Islington CCG (previously operating as Islington PCT and as NHS Islington) in collaboration with the Public Health team (now London Boroughs of Camden and Islington Joint Department of Public Health) has commissioned enhanced services with the intention of better preventing and managing LTCs by providing enhanced primary care services for patients with diabetes and COPD; it has commissioned services which attempt to close the prevalence gap (diabetes, COPD, CKD, hypertension) and it has also commissioned services to support last years of life care. GPs in Islington have provided these enhanced services, however at times the large number has felt unwieldy.

In recognition of the increasing number of patients who have more than one LTC and the desire to treat the whole patient with a more holistic approach, in 2014 it was decided to develop a service that sought to address the issue of co-morbidities, so that patients receive their care as efficiently as possible.

## **Rationale for developing an LTC Locally Commissioned Service**

In 2014 the decision was made to streamline the following Locally Commissioned Services (LCS) – Closing the Prevalence Gap, Diabetes, COPD and Over 75s Health Checks - by creating a single Long Term Condition LCS. The infrastructure for these enhanced services was well established, which was the rationale for banding together these services, along with some small additions. It also complemented the NHS Health Checks LCS commissioned by Public Health.

The current combined service seeks to provide better care for the patient by treating all conditions at the same time, with patient need being the driver rather than individual conditions. Patients are now covered by the same LCS from the moment of being flagged for risk of developing an LTC through diagnosis, treatment and long term management.

The holistic LTC approach also reduces the consultation time burden for GPs and should ultimately result in fewer appointments. The aim is to pay a flat rate per patient based on the number of LTCs they have.

This LCS is in place for up to five years (3 + 2) to allow practices the time to build on and develop the initiatives which have been implemented in the previous contract in order to

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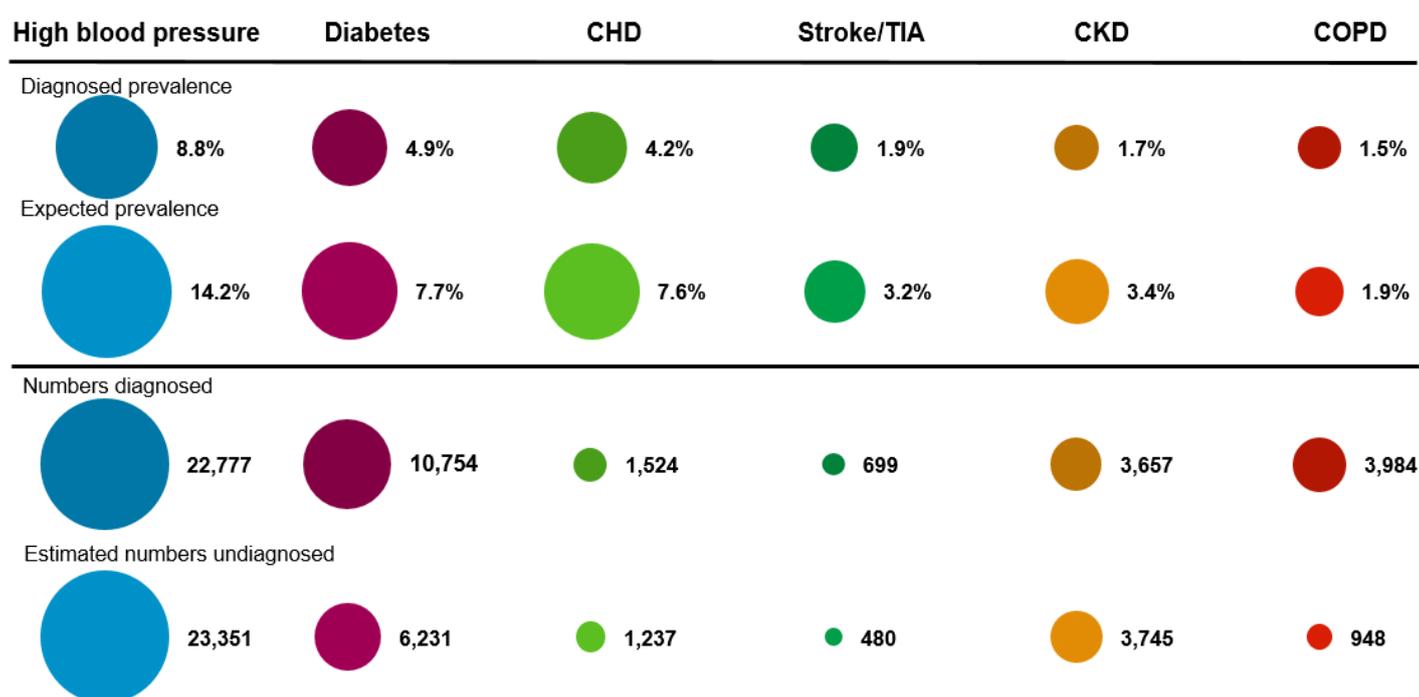
<sup>1</sup> The Scottish School of Primary Care's Multimorbidity Research programme, 2011

provide better patient care. It also supports the recruitment planning for any extra staff which might be needed to support this work-stream.

## Appendix 2: Earlier Diagnosis of Long Term Conditions - rationale

Life expectancy in Islington remains significantly below the England average. Vascular diseases are a key contributor to the gap in life expectancy between Islington and England. Whilst action to address risk factors for vascular disease within the population (primary prevention) will yield improvements in population health and reduced disease incidence in the medium to short term, vital to improving population health outcomes including life expectancy in the short to medium term is the identification and management of vascular long term conditions. Local analysis presented in the Islington Annual Public Health report 2019 showed that there are large numbers of people living with undiagnosed long term conditions in the borough. The expected prevalence is markedly higher than the diagnosed prevalence for hypertension, diabetes, coronary heart disease, chronic kidney disease, and stroke/TIA.

**Figure: Prevalence gaps for long term conditions, Islington, 2019**



**Note.** The expected prevalence for diabetes is an estimation for 2019 based on the Health Survey for England (2012-2014) and ONS population projections. Also, the actual and expected prevalence for CHD and stroke are based on individuals aged 55-79 years.

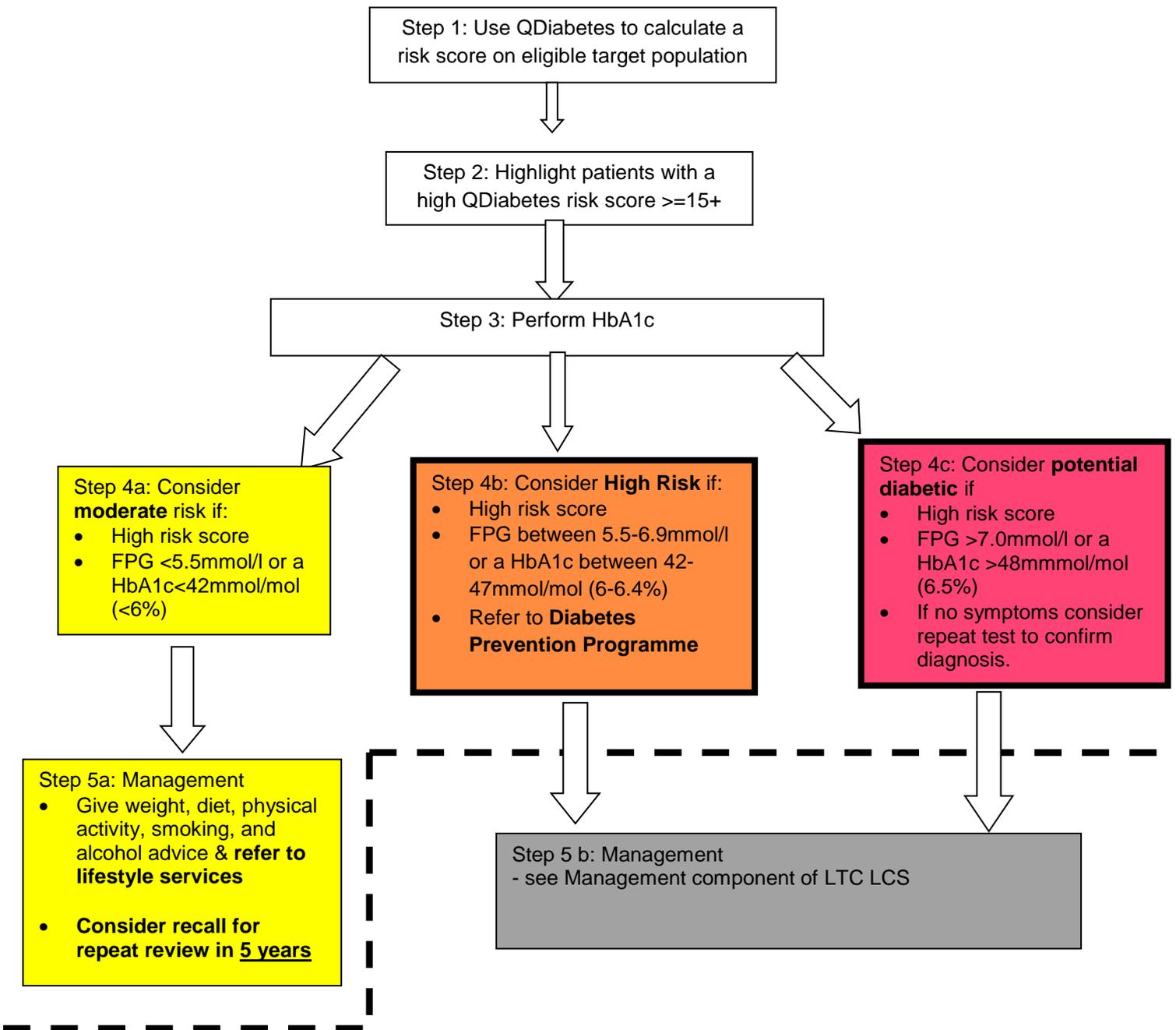
**Sources:** Quality and Outcomes Framework (QoF, 2018/19), PHE Fingertips Estimated Prevalences (2015), PHE CKD Prevalence Model (2015), PHE Diabetes Prevalence Model (2015), PHE Hypertension Prevalence Model (2016).

Closing this 'prevalence gap' for these conditions and diagnosing disease earlier will help to reduce premature mortality, prevent disease progression and avoid disease complications.

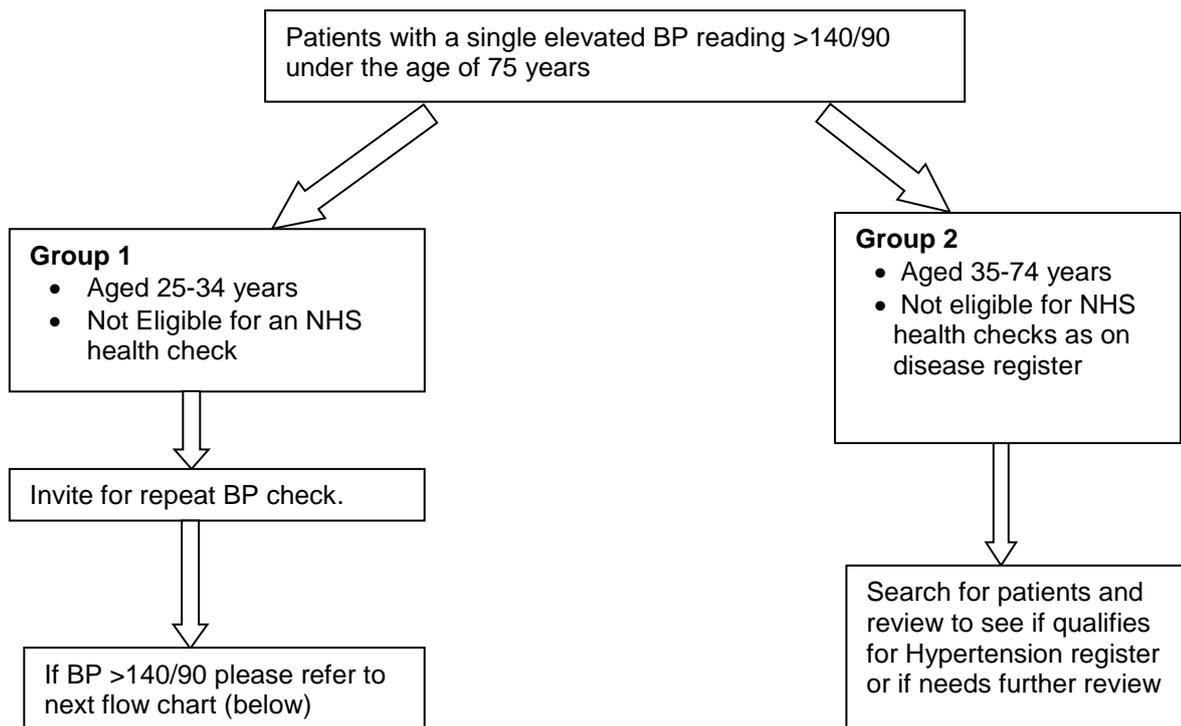
The Case Finding component of the LTC LCS aims to identify patients with undiagnosed long term conditions. It builds on and complements the NHS Health Checks programme and the work previously undertaken through the COPD LES, and aims to capture patients who are ineligible for NHS Health Checks, including patients on other vascular disease registers and those aged 34 years and below. Patients on vascular disease registers who are ineligible for NHS Health Checks have a limited range of investigations performed as part of their annual QoF check, and may represent a large number of patients who have undiagnosed co-existing conditions.

The case-finding component of the LTC LCS specifically aims to identify patients with hypertension, diabetes and COPD.

### Appendix 3: Diabetes pathway

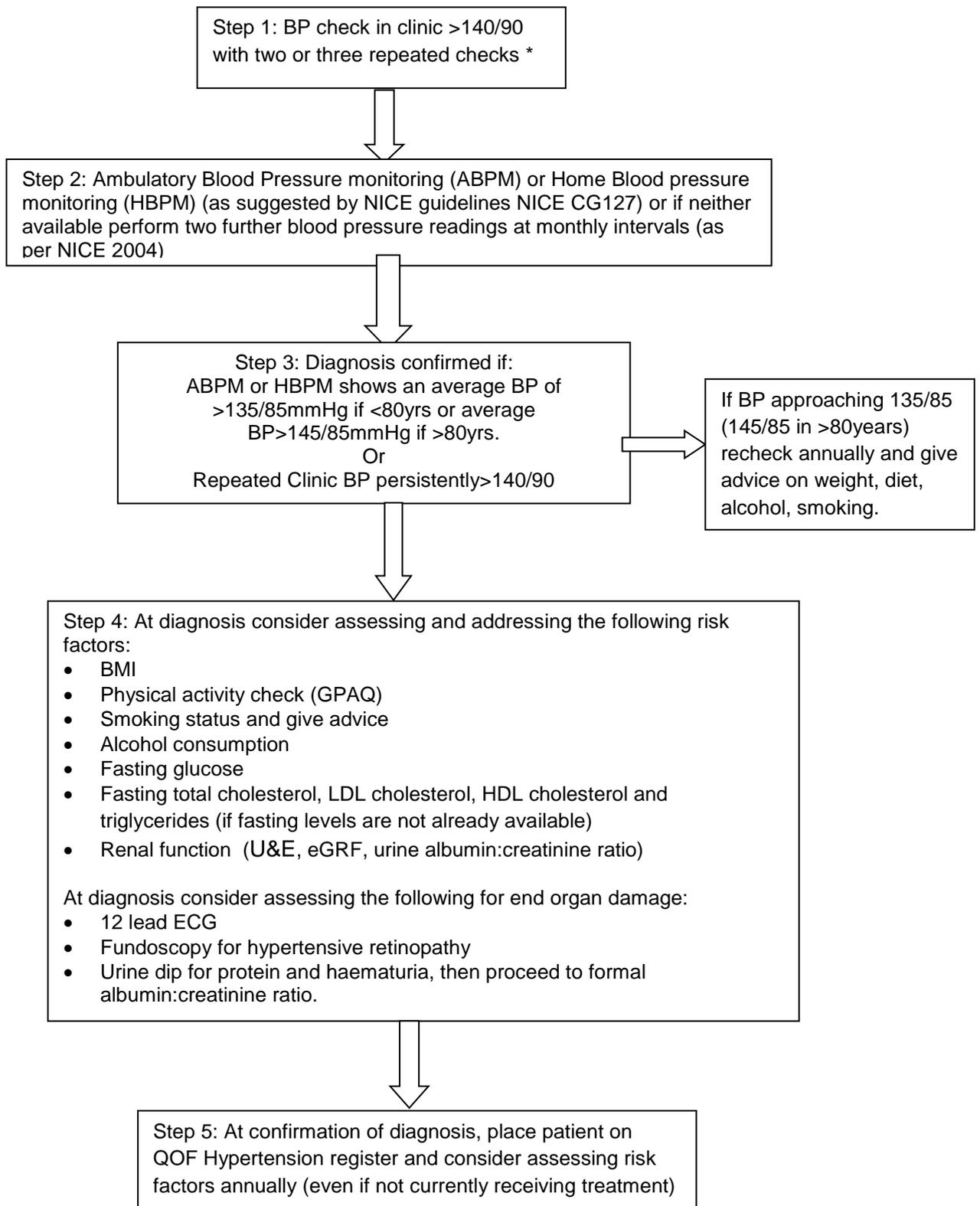


## Appendix 4: Hypertension Pathway



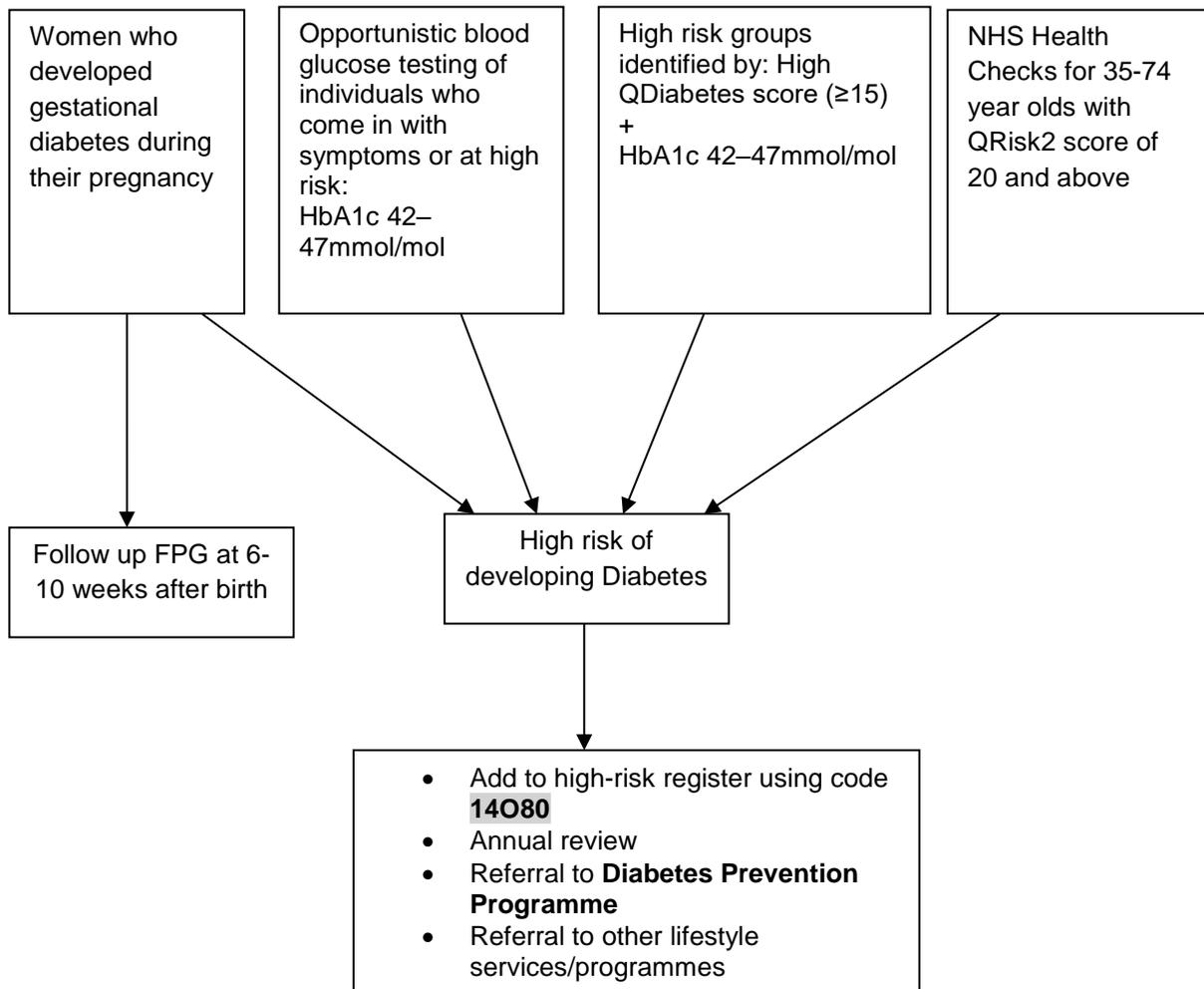
Islington CCG suggests that the blood pressure checks could be done by a health care assistant.

## Hypertension diagnosis and intervention pathway



\*N/B If clinician is highly suspicious that patient will need hypertensive therapy, consider performing cardiovascular risk assessment and management of risk factors prior to confirmation of diagnosis (i.e. refer to step 4).

## Appendix 5: High Risk of Diabetes



## Appendix 6: Collaborative Care & Support Planning – example of adapted practice processes

### Feedback from Newcastle and Gateshead David Paynton – National RCGP Clinical Lead for CC&SP

Two surgeries in the more socially disadvantaged parts of the City.

Training and project mapping exercise at the start. Training done by “Year of Care”.

Three to five year journey but took 9-12 months to get a routine established.

Key role for administration and HCA with good standardised operational processes.

Starting with a known cohort (usually diabetes and COPD) but one practice starting to pilot C&SP with people with a predominately MSK problem. 8-10% of practice population now supported by C&SP.

Role of social prescribing in the area with Ways to Wellness <http://waystowellness.org.uk/> a social enterprise funded via social impact bonds (seven year outcome based contracts). Link worker in each surgery facilitates referral to Ways to Wellness. In Gateshead the link worker is a surgery administrator who also doubles up to support the C&SP systems in the surgery and is seen as a critical success factor.

Many of the C&SP consultations undertaken by Advanced Nurse Practitioners.

#### Process

- Administrator (also can double up as Link Worker to Ways to Wellness) pulls out name based on birthday and sends out invitation for initial information gathering appointment with HCA.
- HCA does relevant tests and tasks according to medical conditions (e.g. bloods, BP, weight etc.) and explains the next steps
- GP and ANP look at results/ records and decide conversation appointment length and who should undertake it (GP/ANP/PN). (This may vary)
- Administration sends out results in the post in a simple person centred template, which also asks the person about what they think is important to them.
- This letter also has suggested appointment time for care and support planning conversation
- Conversation between ANP/GP (20-60 minutes).
- ANP and GP will require some training to support an asset based conversation
- Task can be sent to link to help with social prescribing if required.

#### Keys to success

A program plan over at least three years.

Whole surgery support especially management together with CCG system support (Ways to Wellness contract and training within a strategic plan.)

Social prescribing supported internally by link worker as part of surgery team.

A formal standard operational plan built into the working week.

Initial training and system support.

## Appendix 7: UCLP Long-Term Condition Risk Stratification Search Guides

### Asthma



#### UCLPartners/CEG Risk Stratification Tool June 2020 – Asthma

This search will identify patients with asthma who are potentially at higher risk of exacerbation. All patients with an asthma diagnosis who have had asthma treatment in the previous 12 months will be included. There are separate searches for patients aged 12-16 year olds and patients aged over 17. The UCLP/CEG search results differ from QOF searches because the UCLP/CEG search includes only those patients registered on the day of the search. QOF 'rules' on age-group and exclusions also differ from UCLP/CEG groupings

These patients will then be stratified into 3 groups.

- Group 1 are at greatest risk of exacerbation, and they will fall automatically into the high risk cohort
- Group 2 meet criteria that suggest they may be at higher risk of stratification. They will be stratified further using the ACT Test into high, medium and low risk cohorts.
- Group 3 includes patients who are on ICS or SABA alone with no other risk factors for exacerbation. This group can be phased for later review and risk stratification using the ACT Test.

	Risk Factor	Search period	Comment
<b>Group1</b>	Biologic therapies	Any prescribed in 12m	Omalizumab, mepolizumab, reslizumab, and benralizumab.
	Tiotropium	Any prescribed in 6m	
	Prednisolone	3 or more prescribed in 12m	
	Antibiotics	3 or more prescribed in 12m	Amoxicillin, doxycycline, erythromycin, clarithromycin,
	High dose ICS in LABA/ICS combination	Any prescribed in 6m	
	Montelukast	Any prescribed in 12m	
	Theophylline	Any prescribed in 12m	
<b>Group2</b>	Exacerbation asthma	Acute exacerbation in 12m	
	Prednisolone	Prescribed in 12m	
	Antibiotic	2 or more prescribed in 12m	Amoxicillin, doxycycline, erythromycin, clarithromycin,
	6+ SABA	Prescribed in 12m	
	LABA but no ICS	Any prescribed in 6m	
	3 SABA no ICS	Prescribed in 6m	
<b>Group 3</b>	ICS	Any prescribed in 6m	
	SABA alone	Any prescribed in 12m	

### UCLPartners/CEG Risk Stratification Tool June 2020 – COPD

This search will identify patients with COPD who are potentially at higher risk of exacerbation. Search results may differ from QOF searches because it includes only those patients registered on the day of the search.

These patients will then be stratified into 3 groups.

- Group 1 are at greatest risk of exacerbation, and they will fall automatically into the high risk cohort
- Group 2 meet criteria that suggest they may be at higher risk of stratification. They will be stratified further using the CAT Test into high, medium and low risk cohorts
- Group 3 patients meet none of the criteria in groups 1 and 2 and are likely to be at lowest risk of exacerbation. This group can be phased for later review and risk stratification using the CAT Test

Using the UCLPartners pathway patients in each cohort can then be phased for review over time by respiratory nurse/clinical pharmacist or GP (high risk), generalist nurse/clinical pharmacist with appropriate training medium risk), or HCAs and other staff (low risk).

	Risk Factor	Search Period	Comment
Group 1	FEV1 <50%	Most recent ever	
	Cor pulmonale	In last 5 years	
	Oxygen prescription	In last 12m	
	MRC4-5	In last 5 years	
Group 2	COPD Exacerbation	In last 12m	
	Antibiotics	2 or more prescribed in 12m	Amoxicillin, co-amoxiclav, doxycycline, erythromycin, clarithromycin,
	Triple Therapy	Any prescribed in 6m	LABA + LAMA+ICS
	Prednisolone	Any prescribed in 12m	
	Prophylactic antibiotics	Any prescribed in 12m	Azithromycin
	FEV1 50-80	Most recent ever	
	MRC 1-3	Latest in 5 years	
Group 3	All other patients		

# Hypertension



## UCLPartners/CEG Risk Stratification Tool September 2020 – Hypertension

This search identifies all patients with Hypertension. These patients are then stratified into priority groups based on last recorded blood pressure as well comorbidities and ethnicity.

This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. It also helps match patient care to the workforce. Patients with suboptimal blood pressure will need to be seen by a prescribing clinician in order to optimise their treatment.

Patients whose blood pressure is well controlled may not need clinical input, but they will need support for self-management, education about their condition and support for lifestyle change. This care can be delivered by staff such as health care assistants, link workers and other non-clinical roles with appropriate training.

Note search results may differ from QOF searches because it includes only those patients registered on the day of the search.

Priority 1	Clinic BP $\geq$ 180/120mmHg
Priority 2	Clinic BP $\geq$ 160/100mmHg Clinic BP $\geq$ 140/90mmHg if BAME with CVD, CKD, diabetes, or BMI >35 No BP reading in 18 months
Priority 3	Clinic BP $\geq$ 140/90mmHg
Priority 4	Clinic BP < 140/90mmHg (under 80 years) Clinic BP < 150/90mmHg (80 years and over)

Clinic BP reading	Equivalent Home BP
BP = 180/120mmHg	BP = 170/115mmHg
BP = 160/100mmHg	BP = 150/95mmHg
BP = 150/90mmHg	BP = 145/85mmHg
BP = 140/90mmHg	BP = 135/85mmHg

# Diabetes



## UCLPartners/CEG Risk Stratification Tool September 2020 – Type 2 Diabetes

This search identifies all patients with Type 2 Diabetes. These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors, and ethnicity.

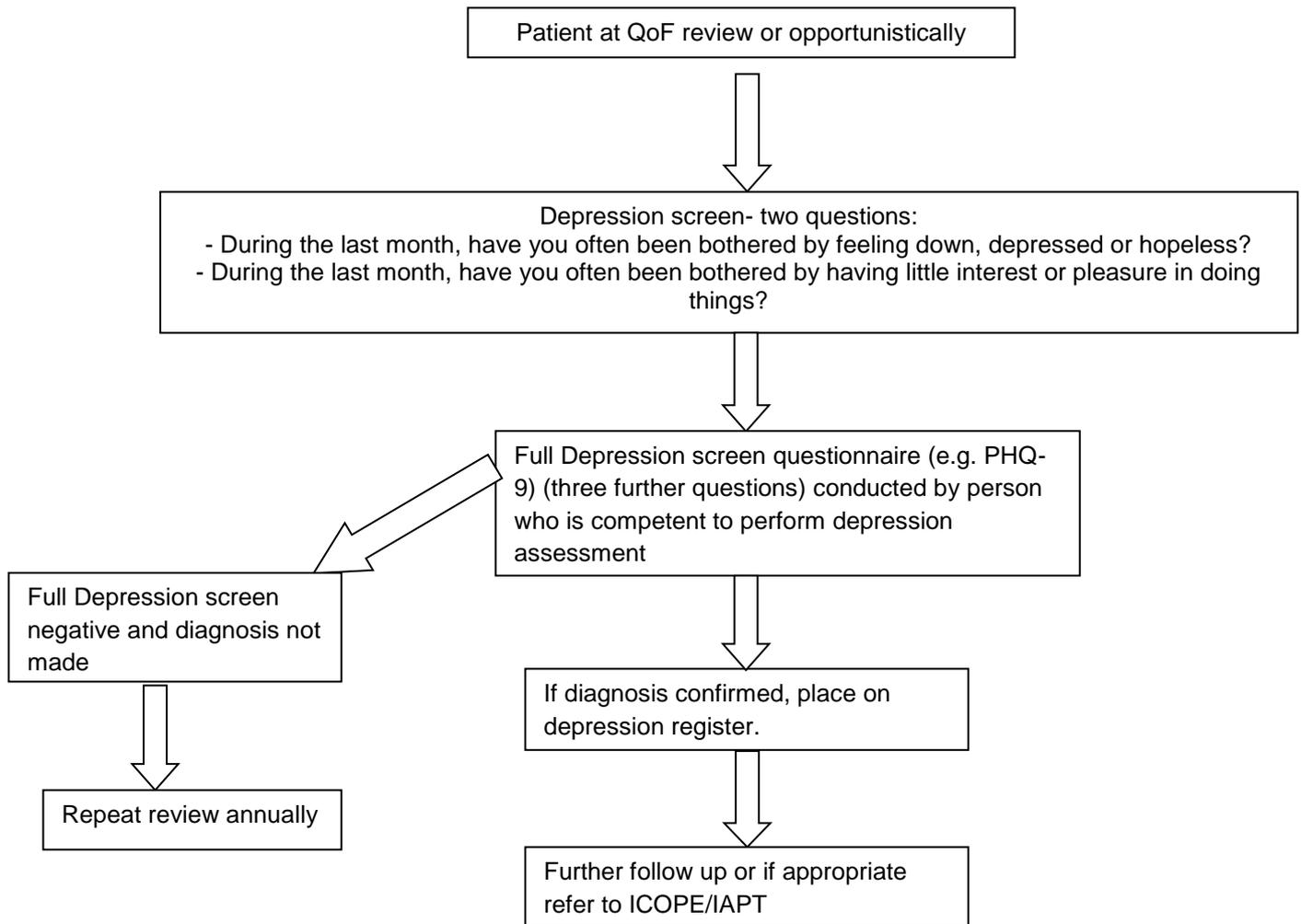
This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. It also helps match patient care to the workforce. Patients in the high risk groups have greater degrees of complexity and are at higher risk of deterioration. In general, they will require review by a specialist diabetes nurse or pharmacist or a GP.

In contrast, the low risk patients in priority group 5 are likely to be at lowest risk of deterioration. Most of their care (eg support for self-management, education and support for lifestyle change) can be delivered by staff such as health care assistants, link workers and other non-clinical roles with appropriate training.

Note search results may differ from QOF searches because it includes only those patients registered on the day of the search.

High risk		Medium risk		Low risk
<b>Priority One</b> <b>Hba1c &gt;90 OR</b>  <b>Hba1c &gt;75 WITH any of the following:</b> <ul style="list-style-type: none"> <li>• BAME</li> <li>• Social complexity**</li> <li>• Severe frailty</li> <li>• Insulin or other injectables</li> <li>• Heart failure</li> </ul>	<b>Priority Two</b> <b>Hba1c &gt;75 OR</b>  <b>Any Hba1c WITH any of the following:</b> <ul style="list-style-type: none"> <li>• Foot ulcer in last 3 years</li> <li>• MI or stroke/TIA in last 12 months</li> <li>• Community diabetes team codes</li> <li>• eGFR &lt; 45</li> <li>• Metabolic syndrome</li> </ul>	<b>Priority Three</b> <b>Hba1c 58-75 WITH any of the following:</b> <ul style="list-style-type: none"> <li>• BAME</li> <li>• Mild to moderate frailty</li> <li>• Previous coronary heart disease or stroke/TIA &gt;12 months previously</li> <li>• BP≥140/90</li> <li>• Proteinuria or Albuminuria</li> </ul>	<b>Priority Four</b> <b>Hba1c 58-75 OR</b>  <b>Any Hba1c WITH any of the following:</b> <ul style="list-style-type: none"> <li>• eGFR 45-60</li> <li>• BP≥140/90</li> <li>• Higher risk foot disease or PAD or neuropathy</li> <li>• Erectile Dysfunction</li> <li>• Diabetic retinopathy</li> <li>• BMI &gt;35</li> <li>• Social complexity</li> <li>• Severe frailty</li> <li>• insulin or other injectables</li> <li>• Heart failure</li> </ul>	<b>Priority Five</b> <b>All others</b>
<small>** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse</small>		<small>(Except patients included in Priority 1 and 2 groups)</small>		<small>(Except patients included in Priority 1-4 groups)</small>

## Appendix 8: Diagnosing Depression



## Appendix 9: Very Severe COPD

### MANAGING PATIENTS WITH VERY SEVERE COPD (FEV<sub>1</sub> <30% predicted) WHO HAVE NOT BEEN ADMITTED TO HOSPITAL

#### Process

Practices should ensure that all patients with very severe COPD (FEV<sub>1</sub> <30% predicted) are reviewed every six months and receive the following assessments, as a minimum:

- Spirometry
- Review of medications
- Oxygen saturation (SaO<sub>2</sub>) - patients with SaO<sub>2</sub> < 92%, when stable, should be referred to secondary care for arterial blood gases and assessment for Long Term Oxygen Treatment.

In addition, practices may wish to consider undertaking the following assessments, if appropriate:

- If on Long Term Oxygen treatment, record last assessment.
- If on Non Invasive Ventilation, record last assessment and refer to dietician if appropriate.
- Health education on diet (measure BMI if appropriate)
- Asking the question “*Are you breathless when you eat?*”
- Smoking cessation intervention for patients who are still smoking.
- Need for social services and occupational therapy input, and referral to SHINE.
- Need for referral to community respiratory team.
- Advanced Care Planning discussion: if a patient’s wishes are not known (including CPR, Non Invasive Ventilation and preferred place of death) record on the supportive/palliative care (GSF) register, if appropriate.
- Screening for anxiety and/ or depression.
- Documentation of co-morbidities e.g. heart failure
- Whether the patient is at risk of osteoporosis and/or Vitamin D deficiency<sup>2</sup>.
- Flu vaccination
- Usually, people with very severe COPD should be added to “*Coordinate My Care*” system (CMC) using the appropriate template. Practices are to note that whilst they are not paid under this LCS for specifically adding COPD patients to the CMC system, these patients are picked up and paid through the Last Years of Life LCS.

**NICE recommends that patients with COPD who have attended A&E or who have had a non-elective admission should be followed up within 48 hours of receipt of discharge letter. This process is recommended as good practice.**

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<sup>1</sup>The prevalence of osteoporosis is high in COPD patients.