Background
Following COVID-19, primary care and the wider healthcare system have already started to tackle the challenge of recovering routine care for patients. Key national data from England has shown significant impact of the pandemic on many long-term conditions. For example

- Nearly 2 million fewer people with hypertension were recorded as being treated to target compared with the previous year (Quality and Outcomes Framework 20/21).
- Fewer patients with diabetes are recorded as receiving all eight care processes, with relative decreases of 35% for type 1 diabetes and 37% for type 2 diabetes when comparing 20/21 to 19/20.
- Rates of diagnosis for chronic obstructive pulmonary disease and asthma have been lower than before the pandemic.
- At the end of December 2021, 70% of people with severe mental illness had not received a physical health check.

Whilst we expect these figures to improve over the coming year as business-as-usual progresses, it provides an opportunity to consider how we can ensure those who are most at need of review could be seen first. Further to our previous guidance to support workload prioritisation (December 2021), this document aims to help general practice teams over the next six months and as we move through the next phases of the pandemic. In it we highlight that those who have not had a review for over 12 months or are most at risk of complications from their long-term condition, could, where appropriate and safe, be considered for review before those who are more stable.
Development
This guidance has been developed by the RCGP with input from NHSE/I, for clinicians working in general practice and is based on data for England from NHSE/I. It replaces prior RCGP guidance on workload prioritisation developed during COVID-19 (December 2021).

A flexible response is required
There is no single 'one size fits all' blueprint for how practices and systems should operate, or what measures should be taken to manage the backlog of long-term condition care. GPs and their teams must be given 'permission' to provide care that best serves the needs of their patient population, in a way that adds most clinical value. Importantly, a whole system approach to recovery of routine care is important and this document includes suggestions that could be considered across both primary care and the wider system.

Recommendations
This guidance sets out suggested actions that can be considered to support long-term condition management over the coming year, aiming to reduce health inequalities, recognising that in many instances, annual reviews were not possible during the pandemic. This document contains examples only and in no way suggests these are the only conditions that are important. Local systems will need to determine priorities themselves, based on their own population. The aim is to ensure, where possible and safe to do so, that those who need care most and are at highest risk are seen first, rather than default to standard arrangements such as birthdays to determine when patients are called for review across the year.

Importantly, people with multiple long-term conditions are likely to benefit from a holistic review and therefore aiming for review of all conditions and prescribed medications at one point in time should be considered where possible.

Disclaimers:
- This document should be read alongside local and national guidance, from NHS and government bodies and is not a substitute for clinical judgement.
- Included below is a list of resources for consideration to support long term conditions management recovery in primary care. The RCGP does not specifically endorse these resources as some are still awaiting evidence of effectiveness.
## Long Term Condition Management Recovery in Primary Care 2022-2023

### Cardiovascular disease (hypertension or heart failure patients)

From July – December 2021, ONS data shows deaths relating to heart conditions and diabetes were among the main causes of excess mortality – conditions which can become fatal if not treated in time - above five-year average levels.

Consider, all patients on the hypertension register with one or more of the following:
- Not reviewed for >12 months
- Last recorded BP ≥160mmHg systolic AND/OR 100mmHg diastolic (unless already on a treatment pathway)
- Last recorded BP ≥140/90mmHg and comorbidities (CVD, DM, obesity) unless already on a treatment pathway.

Heart failure patients face a poor prognosis where 9% of heart failure patients die in hospital; almost one quarter of patients are readmitted within 30 days of discharge and overall mortality is 46% at 5 years.

Consider all patients on the heart failure register not reviewed for >12 months to optimise risk factors and medication.

All patients coded with prior heart attack or stroke should have CVD risk factors (HT, cholesterol) optimised to ensure secondary prevention treatment.

### Diabetes

The pandemic has seen fewer patients with diabetes receiving all eight care processes, with relative decreases of 35% for type 1 diabetes and 37% for type 2 diabetes when comparing 20/21 to 19/20.

Consider all patients not reviewed for >12 months, further prioritising those with clinical factors suggesting higher risk of adverse outcomes including:

- Last HbA1c >58 mmol/mol
- Last BP >140/90 mmHg
- Known complications of diabetes
- Other comorbidities or clinical factors associated with increased risk of adverse outcomes, e.g. CKD, CVD, Serious Mental Illness, cognitive impairments/dementia.

### COPD and asthma

Lack of an early and accurate diagnosis prevents optimal disease management. It is presumed that the incidence of new cases has not fallen and that people will still be prescribed symptomatic treatment, primarily a short acting beta agonist (SABA) indicating poor asthma control.

Consider all high-risk patients with COPD/asthma not reviewed for >12 months and prescribed either:

- 3 or more SABA in the last 12 months, age 5 and over AND NOT on the asthma or COPD register
- 2 or more courses of oral steroids in 12 months AND ON the asthma or COPD register.

### People with serious mental illness and/or a learning disability

People with serious mental illness (SMI) are 4.9 times more likely to die prematurely than those without SMI. People with a learning disability were disproportionately affected by COVID-19, exacerbating existing co-morbidities.

Consider those who have not received a health-check in the past 12 months OR with one or more of the following:

- Those with a comorbidity (e.g. epilepsy, obesity, diabetes, dementia), and those with an ethnicity other than white British.

### Cancer treatment gap

Urgent 2 WW referrals to continue for all patients who meet NICE NG12 guidelines. Be aware of the treatment cancer gap with 34,000 fewer new cancers diagnosed, especially Prostate, Bladder and Lung cancers.

Consider the following to increase diagnosis

**Prostate cancer:**
- Black men aged over 45
- Men with a family history of prostate cancer aged over 45
- Men aged over 55
- Familial history of BRCA positivity.

**Bladder cancer:**
- Active or ex-smokers
- Obesity
- Occupational exposure
- Family history of an affected first degree relative
- Radiation exposure e.g. pelvic radiation
- Check macroscopic haematuria thought to be secondary to a benign condition resolves post treatment

**Lung cancer**
- Active smoker, ex-smoker, or passive smoking
- Consider referral/ A&G when high clinical suspicion of lung cancer, despite a negative chest X-ray
- Occupational exposure
- Radon exposure
For CVD consider:
- Empowering patients through BP @home and Managing Heart Failure @home where clinically appropriate.
- Using the UCLPartners search tools to identify and prioritise patients who have not been reviewed or whose BP is poorly controlled*
- Using the UCLPartners Proactive Care framework resources to optimise clinical care and self-management for patients with AF, high BP and high cholesterol*
- Signposting patients to the wider system to support blood pressure checks e.g. Community Pharmacy Blood Pressure Check Service (includes Ambulatory Blood Pressure Monitoring).
- Referral to cardiac rehabilitation services and the NHS Digital weight management programme.
- Identifying opportunities to optimise heart failure management and secondary prevention ahead of autumn and winter.
- Using local data and population management to inform activities including data for individual GP practices on managing high blood pressure, CVD Prevent Audit, OHID Fingertips Public health data for Cardiovascular Disease and the Model Health System.

For DM consider:
- Parameters associated with increased risk are described in resources such as those from the Primary Care Diabetes Society or the East of England Diabetes Clinical Network.
- Accessing the National Diabetes Programme Diabetes Data Hub recovery dashboard.
- Support self-management, including through promoting access to structured education programmes, Healthy Living for people with Type 2 diabetes and MyType1Diabetes are available for self-referral.
- Use of National Diabetes Programme ICS level funding to support care process recovery.
- Support referrals to the NHS Digital Weight Management Programme.

For COPD and Asthma consider:
- In addition to LTC management reviews and adding patients to the asthma or COPD register, continue ongoing referral to pulmonary rehabilitation (National COPD Audit) AND to consider:
  - Using the UCLPartners search tools to identify and prioritise patients who have not been reviewed, who are at higher risk of exacerbation, or who may have undiagnosed asthma or COPD*
  - Using the UCLPartners Proactive Care framework resources to optimise clinical care and self-management for patients with asthma and COPD*

For people with serious mental illness and/or a learning disability consider:
- Ensuring the QOF GP Serious Mental Illness Register and GP Learning Disability Register is reviewed, updated and validated as per DES requirements.
- Using the UCLPartners Proactive Care framework (including search tools) for people with severe mental illness to stratify patients on basis of risk factors for cardiovascular and other conditions in order to optimise clinical care and self-management.*
- Referral to existing guidance to support general practice to identify people with a learning disability.
- Supporting people with serious mental illness, and people with a learning disability to access physical health interventions, additional LTC reviews, immunisations, medication reviews and cancer screening as appropriate.
- Use local data to inform activities, such as the OHID Fingertips Public health data for Severe Mental Illness and Learning Disability Profiles.

For Cancer consider:
- To narrow the treatment gap systems should consider awareness raising with at risk groups for the three cancer sites and use local data to inform activities, such as the OHID Fingertips Public health data for Cancer Services.
- The Updated Early Cancer Diagnosis service requirements of the PCN DES 2022/23 also outlines specific actions around early cancer diagnosis.

*Note: evidence of effectiveness of these frameworks is awaited.
Educational packages

- RCGP e learning packages
- Heart Failure and Heart Valve Disease e-learning (e-LfH)
- Hypertension e-learning (e-LfH)
- Gateway C eLearning Modules and webinars
- Population health management tools and Pharmacy Education Packages
- CPPE e-learning, health inequalities
- How to deliver culturally competent healthcare for communities and people with an ethnic minority background

Guidance

- Quality on Outcomes Framework (QOF) changes for 2022/23 and QOF guidance
- Letter: General practice contract arrangements in 2022/23 - 16 March 2022
- Network Contract Directed Enhanced Service – Investment and Impact Fund 2022/23 summary
- Network Contract Directed Enhanced Service guidance
- 2022/23 priorities and operational planning guidance
- Making Every Contact Count (MECC): Consensus statement
- Core20PLUS5 tool To help improve health inequalities
- Health Inequalities Improvement Dashboard (Link to the Neighbourhood Emergency Admissions dashboard which shows at locality level ambulatory care sensitive conditions (typically LTCs) driving un-scheduled hospital admissions)
- Anticipatory care and multimorbidity for 2023/24. For individuals who are also eligible for anticipatory care (AC), there is an opportunity to share holistic assessments done as part of the LTC management recovery work with local AC teams who can assess whether a proactive AC offer in 23/24 should be prioritised. More information will be available in the coming months.
- The Additional Roles Reimbursement Scheme (ARRS) provides support to Primary Care Network to develop bespoke multi-disciplinary teams.

Resources

- NHS @ home
- UCLPartners Proactive Care Frameworks including search and stratification tools
- Community Diagnostic Centres for spirometry
- Targeted lung health checks (TLHC) programme to improve earlier diagnosis of lung cancer.
- Macmillan Rapid NG12 Referral guideline
- The Learning Disability and autistic people Research (LeDeR) Report 2020

Data Tools

- Office for Health Improvement and Disparity (OHID) Excess Mortality in English Regions tool which includes regional data on excess mortality and national disaggregated data on deprivation, ethnicity and cause of death.
- Office for Health Improvement and Disparity (OHID) Excess Mortality in England which includes data on excess mortality and national disaggregated data on deprivation, ethnicity and cause of death.