Editorials

Learning from long COVID:

integrated care for multiple long-term conditions

INTRODUCTION

Long COVID is a multisystem condition requiring a range of medical, therapeutic, and psychological inputs. Given the complexity of the illness affecting multiple organ systems, often impacting physical and mental health, individuals can be heavy healthcare users across primary, secondary, and emergency services.

The long COVID clinics commissioned in England[1] have provided an opportunity to innovate within a complex care pathway, bringing multiple providers together to meet needs broader than has been historically possible for many other complex conditions. Designing these new services from a blank page has enabled teams to co-create services with patient groups and work more effectively in an integrated way. Significant benefits have been seen, including skills transference between professions.

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CRITICAL EVALUATION OF LONG COVID CLINICS

Long COVID services have enabled closer working between primary and specialist care by working across boundaries, and they have helped a broader multidisciplinary team (MDT) to be involved in complex care decision making to meet therapeutic needs. There is a need for a critical evaluation of long COVID clinics to determine how these improve outcomes and meet patient needs, including a critical analysis of patient outcomes, the availability of services, and the economic costs of MDT services, such as long COVID clinics themselves. This is ongoing in the context of the STIMULATE-ICP-Delphi study,[2] and the following relevant factors have been identified:

- accessing a range of specialist input through an often virtual MDT, without needing onward separate referrals, has improved the 'one team' approach. It has maximised learning, improved primary and specialist care integration, and reduced single-specialty referrals;
- integrating psychological and psychiatric treatment into standard practice has been embedded by delivering physical and mental health-focused treatment strategies alongside each other; and
- the use of vocational rehabilitation – supporting those of working age back into work – has shown promising outcomes where this offer is robust.

The experience of both clinicians and patients has been positive; therefore, we must learn from this novel approach to care and embed holistic and multi-professional integrated care practice across the NHS, not just for those with long COVID, but also for persons with a long-term condition, especially where more than one specialty is involved, or there are multiple long-term conditions.

What we have learned from long COVID, we believe, can bring benefits for the whole NHS by applying the innovative approach to all conditions where more than one specialty is involved in the patient pathway, including those with multiple long-term conditions or with diseases at the interface of physical and mental health. Standard care in the NHS currently means patients are treated within primary care, where the whole person and their physical and mental health needs are considered together. However, this approach then changes when specialist care is required. Once a referral is made to seek specialist advice, patients are usually reflected within healthcare systems as a single organ or disease – a heart, a lung, or cancer. Either is a physical or mental health problem, but rarely both together. Even our standard approach to rehabilitation is often siloed between separate organ systems, such as pulmonary rehabilitation for the lung, but a separate service for recovery post-heart attack or a broken leg.

People, however, are not individual organs and increasingly do not have single diseases. Care within the NHS and worldwide has been designed on organ-based specialists and single-disease programmes. Our national guidelines are disease specific in general, rarely considering the impact of more than one condition at a time. Where guidelines do exist that consider the whole person, they are often not cross-referenced within the disease-specific guidance. For example, the National Institute for Health and Care Excellence guideline on multimorbidity[3] recommends holistic care.[4] If the approach within this guidance could be applied to all new clinical guidelines, ensuring the whole person (including the somatic and psychiatric domain) were considered, it would empower clinicians seeing patients to work in this way, improving the horizontal integration of clinical care. While the guidelines deliver essential benefits in the relevant specialist areas, patients with multiple long-term conditions or complex healthcare needs must juggle investigations, advice, treatment, and medication from siloed specialist thinking with their primary care team. As the number of people with multiple long-term conditions increases, there is an urgent need to steer health care towards the 'complexity-multisystem model' exemplified by long COVID. Experiences from pain clinics, which usually don't run as a single organ or disease service, and input into conditions such as fibromyalgia and chronic pain, including both somatic and psychiatric aspects, might be relevant here as well.

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The Department of Health and Social Care has announced a Major Conditions Strategy calling for change in how the NHS approaches care.[5] Tackling the five major long-term conditions that account for around 60% of total disability adjusted life years in England is quoted as being critical to achieving the government manifesto commitment of gaining 5 extra years of healthy life expectancy by 2035, and for the levelling up mission to narrow the gap in healthy life expectancy by 2030.

What we have learned from organising care for long COVID provides us with answers that, if applied to the whole of the NHS, could have a considerable impact. Changing how care is delivered by redesigning services to consider clusters of diseases will improve the integration between primary and specialist care. Using virtual MDTs will increase shared professional learning and reduce individual outpatient referrals. Expanding the standard offer and embedding integrated psychiatric and vocational rehabilitation into care pathways places the range of a person's needs at the heart of their care in a single pathway. Given the current limitations in resource and workforce, these will need to be balanced against the other competing issues, costs, and workforce demands in secondary and primary care in enactment from a policy and funding perspective. How this can be done is a focus of the STIMULATE-ICP-Delphi study, which is aiming to inform policymakers after a process of surveys and expert meetings.[2]

CONCLUSIONS AND RECOMMENDATIONS

From our experiences caring for those with long COVID, we recommend implementing the following three changes as a priority to begin the journey towards truly integrated care for all:

1. A national clinical lead for multiple long-term conditions and integrated care with physical and mental health expertise should be appointed to lead the change within the NHS.
2. Every region (integrated care system, health board, or cluster) should identify a 'multiple long-term condition' lead with physical and mental health expertise to enable our regional system leaders to understand the need to put the whole person at the heart of their healthcare pathway.
3. Using the virtual MDT, the number of specialist integrated care pathways should be expanded beyond long COVID to broaden the reach to community-managed patients without needing multiple outpatient referrals. Such integrated care pathways must be resourced appropriately for all clinicians involved in the pathway. This should be detailed in job plans for secondary care colleagues, with resources transferred to primary care for any additional workload moved from secondary care into the community.

By learning from the complexity of long COVID and the opportunity given to us to design services from scratch for this condition, we can make a difference to everyone who has complex medical needs or multiple long-term conditions, aiming to prevent people from being placed on single-organ pathways and redefining integrated medical care throughout the NHS.

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