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Proactive Care Frameworks

All six conditions
February 2021

Supporting Primary Care to Restore and Improve Proactive Care

- COVID-19 has placed unprecedented pressure on our health system. This brings an added risk to people with long term conditions who need ongoing proactive care to stay well and avoid deterioration. Disruption to routine care may worsen outcomes for patients, increase their COVID risk and result in exacerbations that further increase pressure on the NHS – driving demand for unscheduled care in GP practices and hospitals.

- As primary care transforms its models of care in response to the pandemic, UCLPartners has developed real world frameworks to support proactive care in long term conditions. The frameworks include pathways for remote care, support for virtual consultations and more personalised care, and optimal use of the wider primary care team, e.g. Healthcare Assistants, Link Workers and Pharmacists.

- Additionally, the frameworks include a selection of appraised digital tools, training and other resources to support patient activation and self-management in the home setting.

- This work has been led by primary care clinicians and informed by patient and public feedback.

- The UCLPartners frameworks and support package will help Primary Care Networks and practices to prioritise in this challenging time and to focus resources on optimising care in patients at highest risk. It will support use of the wider workforce to deliver high quality proactive care and improved support for personalised care. And it will help release GP time in this period of unprecedented demand.

UCLPartners has developed a series of frameworks for local adaptation to support proactive management of long-term conditions in post-COVID primary care.

- Led by clinical team of GPs and pharmacists
- Supported by patient and public insight
- Working with local clinicians and training hubs to adapt and deliver

Core principles:

1. Virtual by default
2. Mobilising and supporting the wider workforce (including pharmacists, HCAs, other clinical and non-clinical staff)
3. Step change in support for self-management
4. Digital innovation including apps for self management and technology for remote monitoring

UCLPartners Proactive Care Frameworks for Local Adaptation

Principles:

- Virtual first
- Wider 1º care workforce
- Step change in self management
- Digital technologies

Stratify (clinical, ethnicity, social factors)

Low priority
Medium priority
High priority

1. **Begin with highest priority**
2. **Use wider workforce to share delivery of care**
3. **Innovation to support remote care and self care**

High priority – early review
Prescribing clinician

Medium priority – phased review
Prescribing clinician

Low priority – holistic proactive care
Eg HCA, nursing associate, link worker etc

HCA/other roles
Structured support for education, self management and lifestyle change.

Arrange bloods, collate data to inform risk assessment

The Frameworks

1. Comprehensive **search tools** to risk stratify patients – built for EMIS and SystmOne
2. **Pathways** that prioritise patients for follow up, support remote delivery of care, and identify what elements of LTC care can be delivered by staff such as Health Care Assistants and link workers.
3. **Scripts and protocols** to guide Health Care Assistants and others in their consultations.
4. **Training** for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing.
5. **Digital and other resources** that support remote management and self-management.

Contents

Cardiovascular risk conditions

- Atrial fibrillation
- Hypertension
- Lipid management
- Type 2 diabetes

Respiratory conditions

- Asthma
- Chronic obstructive pulmonary disorder

NB full slide packs available for each condition:

https://uclpartners.com/proactive-care/

Contents

Atrial fibrillation: stratification and management of stroke risk

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Healthcare assistants/other appropriately trained staff

Gather information	Up to date bloods, BP, weight, smoking status, run CHA_2DS_2VASc, HASBLED, QRISK score
Self management	Education (AF/stroke risk, bleeding risk, CVD risk reduction), signpost to shared decision making resources.
Behaviour change	Brief interventions and signposting e.g., smoking, weight, diet, exercise, alcohol

Stratification

Priority One	Priority Two	Priority Three	Priority Four	Priority Five
Not on anticoagulant	On anticoagulant & antiplatelet/s	On Warfarin (or other Vitamin K antagonists)	On DOAC Renal function >12m ago	On DOAC Renal function <12m ago
Offer anticoagulant if indicated*	Review need for antiplatelets*	Check TTR for optimal control*	Check CrCl and review dosage*	Routine annual review*

Prescribing clinician

Optimise anticoagulation therapy and CVD risk reduction

1. Review: blood results, risk scores & symptoms
2. Initiate or optimise anticoagulant
3. Consider switch to DOAC if poor control on warfarin
4. Check adherence and review any side effects
5. Review and mitigate bleeding risk: BP control, medication, alcohol, PPI
6. Optimise BP and lipid management to reduce cardiovascular risk
7. Address rate and rhythm control as needed

*** Support/how to can be found in the full slide set: https://uclpartners.com/proactive-care/**

Contents

High Blood Pressure Stratification and Management

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PRIORITY ONE:
Clinic BP ≥ 180/120mmHg**

PRIORITY TWO:
- Clinic BP ≥ 160/100mmHg**
- Clinic BP ≥ 140/90mmHg** if BAME AND relevant co-morbidity/risk factor*
- No BP reading in 18 months

PRIORITY THREE:
Clinic BP ≥ 140/90mmHg**

PRIORITY FOUR:

Under 80 years
Clinic BP < 140/90mmHg**

80 years and over
Clinic BP < 150/90mmHg**

Ask patient for up-to-date home BP if available: adjust priority group if needed (as above)

Review by Prescribing Clinician

Monitor
- Investigations, as needed: Renal, lipids, ACR, ECG
- If no pre-existing CVD - assess QRisk score and consider lipid lowering therapy if >10% and not on statin

Review medication:
- Identify and address adherence issues – refer to practice pharmacist if additional support required
- Optimise medications, in line with NICE guidance (see slide 8)

Seek specialist advise
- If BP uncontrolled on four antihypertensives and no adherence issues identified
- Multiple drug intolerances
- Hypertension in young person requiring investigation of secondary causes

Advise
- When to check BP and submit readings (e.g, monthly until controlled, then every 3 months)
- When to seek help based on BP readings

Book follow up and code

Review by HCA or other staff role

Support for self management and behaviour change
- Check BP taking technique
- Check if existing CVD or QRisk >10% and not on statin (refer to prescribing clinician)
- Share resources to help understanding of high blood pressure, CVD risk and treatment
- CVD prevention brief interventions – diet / exercise / smoking / weight / alcohol
- Signpost tools and resources

Review by HCA or other staff role

Self management and behaviour change support
- Check BP taking technique
- Share resources to help understanding of high blood pressure, CVD risk and treatment
- CVD prevention brief interventions – diet / exercise / smoking / weight / alcohol
- Signpost tools and resources

Medication:
- Check if any issues / concerns regarding medicines – refer to practice pharmacist for meds review / adherence support, if needed
- Confirm supply / delivery

Advise
- When to submit BP readings (e.g. every 3 months)
- When to seek help based on BP readings

Referral
- **R**efer to GP if any red flags identified
- If QRISK > 10% and no statin – refer to prescribing clinician

Recall and code

* / ** see slide 5 of full condition pack

Contents

Cholesterol – Secondary Prevention (pre-existing CVD)

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Healthcare assistants/other appropriately trained staff

Gather information e.g. Up to date bloods, BP, weight, smoking status

Self-management e.g. Education (cholesterol, CVD risk), BP monitors (what to buy, how to use), signpost to shared decision making resources

Behaviour change e.g. Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Stratification

Priority One	Priority Two (A)	Priority Two (B)	Priority Three – routine follow up
Not on statin therapy	On suboptimal intensity statin*	On suboptimal statin dose**	Sub-optimal non-HDL (>2.5mmol/l) levels despite maximal statin therapy

Prescribing clinician

Optimise lipid modification therapy and CVD risk reduction

1. Review CVD risk factors, lipid results and liver function tests
2. Initiate or optimise statin to high intensity – e.g. atorvastatin 80mg
3. Titrate therapy against reduction in LDLc/non-HDLc (statin>ezetimibe>PCSK9i)
4. Optimise BP and other comorbidities
5. Use intolerance pathway and shared decision-making tools to support adherence
6. Arrange follow-up bloods and review if needed

* E.g simvastatin
** E.g atorvastatin 40mg

Cholesterol – Primary Prevention (no pre-existing CVD)

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Healthcare assistants/other appropriately trained staff

Gather information: E.g. up to date bloods, BP, weight, smoking status, run QRisk score.*

Self-management: Education (cholesterol, CVD risk), BP monitors (what to buy, how to use), signpost to shared decision making resources

Behaviour change: Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Stratification

Priority One

One of:
- QRisk ≥20%
- CKD
- Type 1 Diabetes

AND
- Not on statin

Priority Two
- QRisk 15-19%

AND
- Not on statin

Priority Three
- QRisk 10-14%

AND
- Not on statin

Priority Four
- On statin for primary prevention but not high intensity

Prescribing clinician

Optimise lipid modification therapy and CVD risk reduction

1. Review QRisk score, lipid results and LFTs
2. Initiate or optimise statin to high intensity – eg atorvastatin 20mg
3. Titrate therapy against reduction in LDLc/non-HDLc (statin>ezetimibe)
4. Optimise BP and other comorbidities
5. Use intolerance pathway and shared decision-making tools to support adherence
6. Arrange follow-up bloods and review if needed

*Qrisk 3 score is recommended to assess CV risk for patients with Severe Mental Illness, Rheumatoid Arthritis , Systemic Lupus Erythematosus, those taking antipsychotics or oral steroids

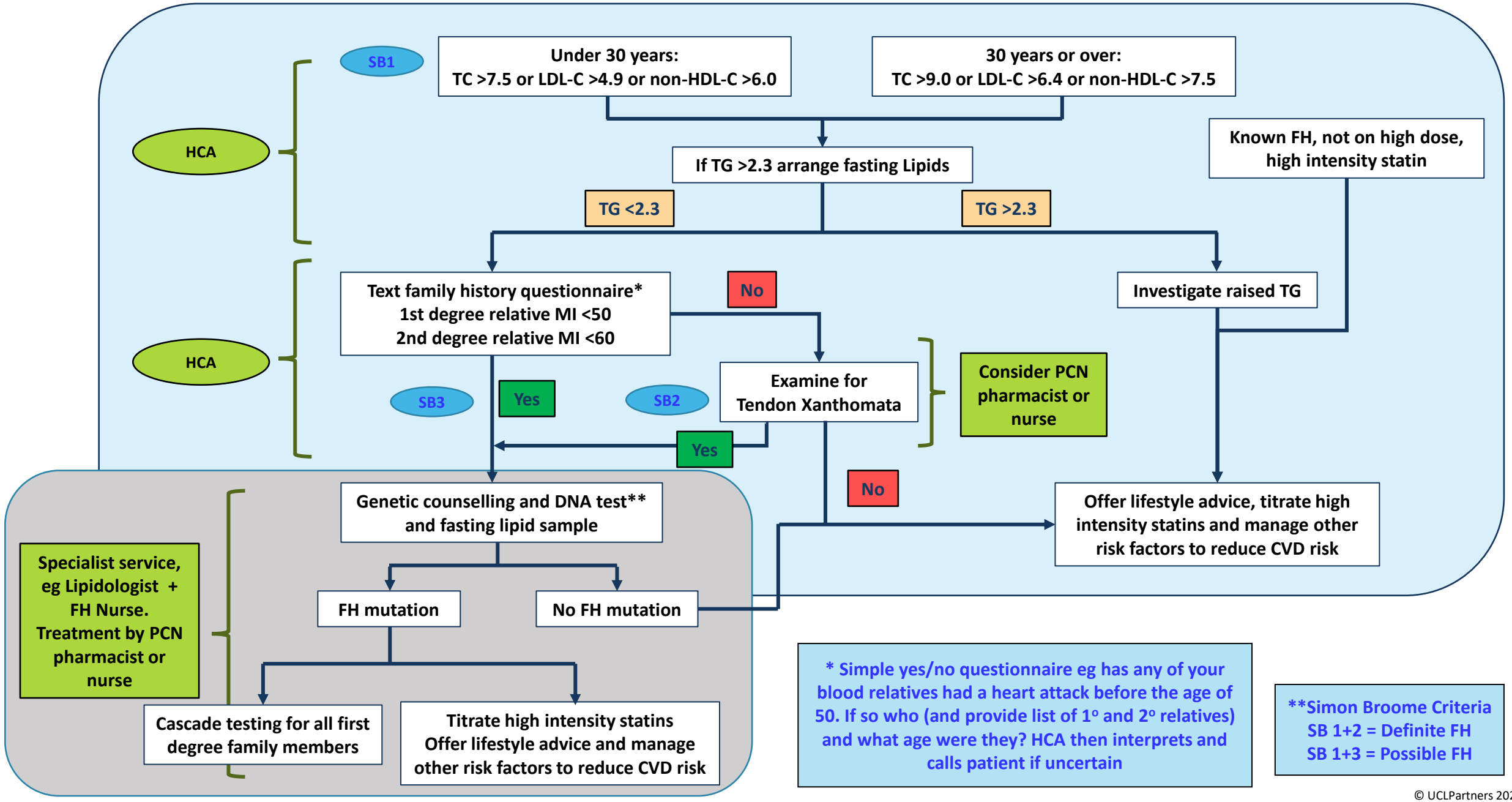
The FH pathway will help improve identification and management of patients with possible undiagnosed Familial Hypercholesterolaemia (FH).

Currently 92% of people with the condition are undiagnosed. The pathway automates and simplifies this process and offers pragmatic solution to case-finding.

The Simon Broome (SB) criteria can be used to determine if a patient with high cholesterol needs genetic testing.

1. Searches identify patients with a high cholesterol above the threshold.
2. For patients with a raised triglyceride level, an HCA or other team member then arranges a fasting sample to verify the triglyceride result.
3. If the triglycerides are normal, a simplified family history questionnaire can be texted to the patient. If family history is positive, the Simon Broome criteria for genetic testing are met and local testing or referral to a lipid specialist is required.
4. If family history is negative, the patient should be examined for tendon xanthomata (TX). This service could be provided across a PCN or CCG by a trained pharmacist or nurse. If TX are present, the Simon Broome criteria for genetic testing are met, and local testing or referral to a lipid specialist is required.

Familial Hypercholesterolaemia Pathway



* Simple yes/no questionnaire eg has any of your blood relatives had a heart attack before the age of 50. If so who (and provide list of 1º and 2º relatives) and what age were they? HCA then interprets and calls patient if uncertain

**Simon Broome Criteria
SB 1+2 = Definite FH
SB 1+3 = Possible FH

Contents

Type 2 Diabetes stratification and management

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1 Identify & 2 Stratify

This search identifies all patients with T2 Diabetes. These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors and ethnicity

High risk

Priority One

Hba1c >90 OR

Hba1c >75 WITH any of the following:

- BAME
- Social complexity**
- Severe frailty
- Insulin or other injectables
- Heart failure

** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse

Priority Two

Hba1c >75 OR

Any HbA1c WITH any of the following:

- Foot ulcer in last 3 years
- MI or stroke/TIA in last 12 months
- Community diabetes team codes
- eGFR < 45
- Metabolic syndrome

(Except patients included in Priority 1 group)

Medium risk

Priority Three

Hba1c 58-75 WITH any of the following:

- BAME
- Mild to moderate frailty
- Previous coronary heart disease or stroke/TIA >12 months previously
- BP≥140/90
- Proteinuria or Albuminuria

(Except patients included in Priority 1 and 2 groups)

Priority Four

Hba1c 58-75 OR

Any HbA1c WITH any of the following:

- eGFR 45-60
- BP≥140/90
- Higher risk foot disease or PAD or neuropathy
- Erectile Dysfunction
- Diabetic retinopathy
- BMI >35
- Social complexity
- Severe frailty
- insulin or other injectables
- Heart failure

(Except patients included in Priority 1, 2 or 3 groups)

Low risk

Priority Five

All others

(Except patients included in Priority 1-4 groups)

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3 Manage

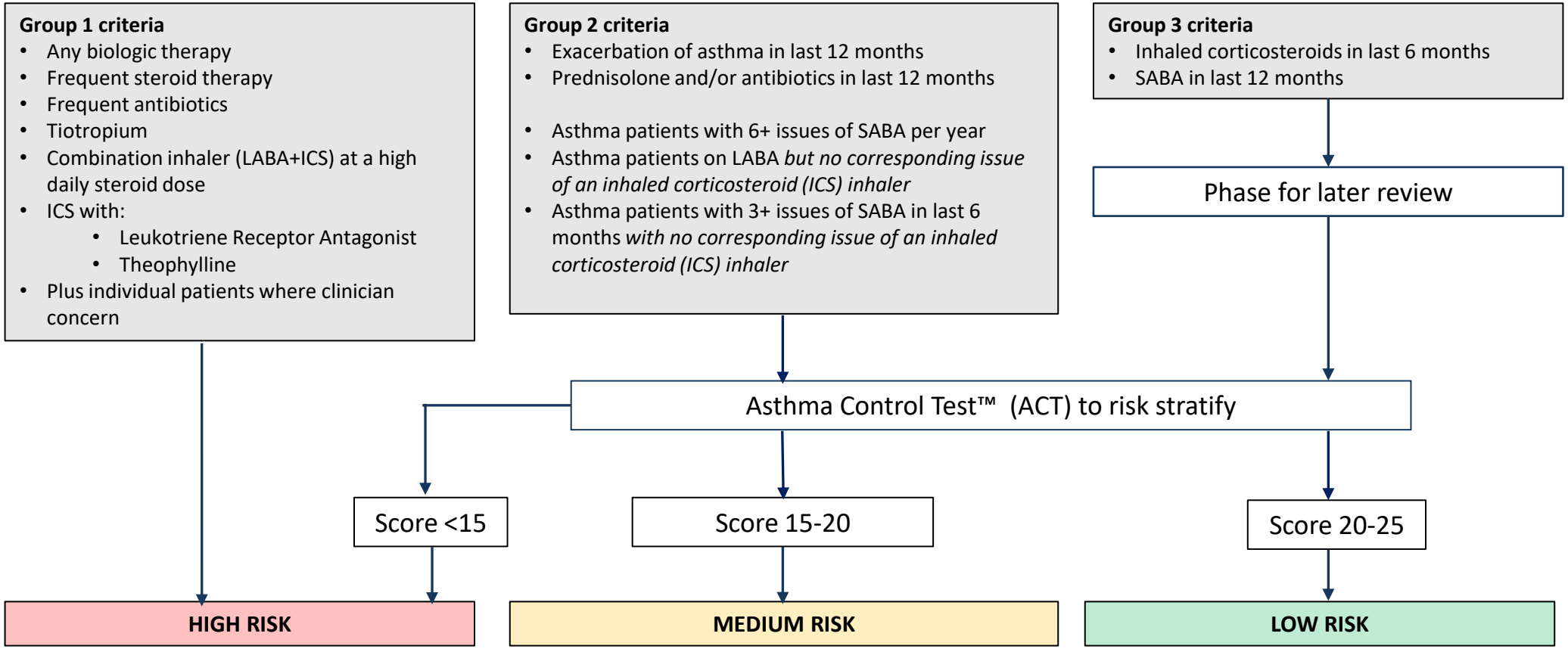
Healthcare Assistants undertake initial contact for all risk groups to provide; check HBA1C up to date, provide information on risk factors, eg smoking cessation, diet and exercise, waist circumference

	High risk	Medium risk	Low risk
Staff type	**GP/Diabetes Specialist/ Nurse**	**Clinical pharmacist/ Nurse/ Physician Associate**	**Healthcare Assistant/ other appropriately trained staff**
Intervention	**Medication:** • Adherence • Titration & intensification as appropriate **Monitoring** • Blood sugar control & personal targets • Agree HBA1C targets • Lipids/lipid lowering therapy • BP optimisaion • Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease **Education (inc online tools)** • Sick day rules • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control: hypos • Infections • Signposting and Escalation • Diabetes community +- secondary care team/advice **Recall & Code**	**Medication:** • Adherence • Titrate as appropriate **Monitoring** • Blood sugar control • Lipids/lipid lowering therapy • BP and proteinuria • Screen and manage Diabetic Foot Disease and Diabetic Kidney Disease **Education** • Sick day rules • Signpost online resources • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control: hypos • Infections • Signposting and Escalation **Recall & Code**	**Medication:** • Adherence • Explore/ check understanding • Confirm supply and delivery **Education** • Signpost online resources • Risk factors – diet/lifestyle/smoking cessation • DVLA guidance • Flu jab • Advise and signpost re Diabetic Foot Disease **Review & Discuss Red flags** • Vision: floaters/flashing lights • Blood sugar control • Infections • Signposting and Escalation **Recall & Code**

Contents

1 Identify & 2 Stratify

Search tool identifies patients with asthma. These patients are stratified into 3 groups depending on clinical characteristics, and then further stratified into high, medium and low risk using the Asthma Control Test™ score.



*The Asthma Control Test™ provides a snapshot as to how well a person's asthma has been controlled over the last four weeks and is applicable to ages 12 years or older. Available here: www.asthma.com/additional-resources/asthma-control-test.html

3 Manage

Healthcare Assistants/ other appropriate staff undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

	High risk	Medium risk	Low risk
Staff type	GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant/ other appropriately trained staff
Intervention	• Titrate therapy, if appropriate • Ensure action plan in place • Check adherence, inhaler technique (video) , spacer advice • Rescue packs prescribed if necessary • Review of triggers, e.g. hay fever • Exacerbation safety netting • Follow up and referral as indicated	• Check optimal therapy; Titrate, if appropriate • Review triggers, e.g. hayfever • Check adherence, inhaler technique (video), spacer advice • Exacerbation management advice • **Repeat ACT as per recommendation from ACT test result and escalate to GP/Nurse if red or amber**	• Check inhaler usage & technique; signpost to education; spacer advice • Exacerbation management advice inc. mild hayfever symptoms • Signpost to appropriate information for: Lifestyle information/management of stress • Smoking cessation support • Exercise • Appropriate resources

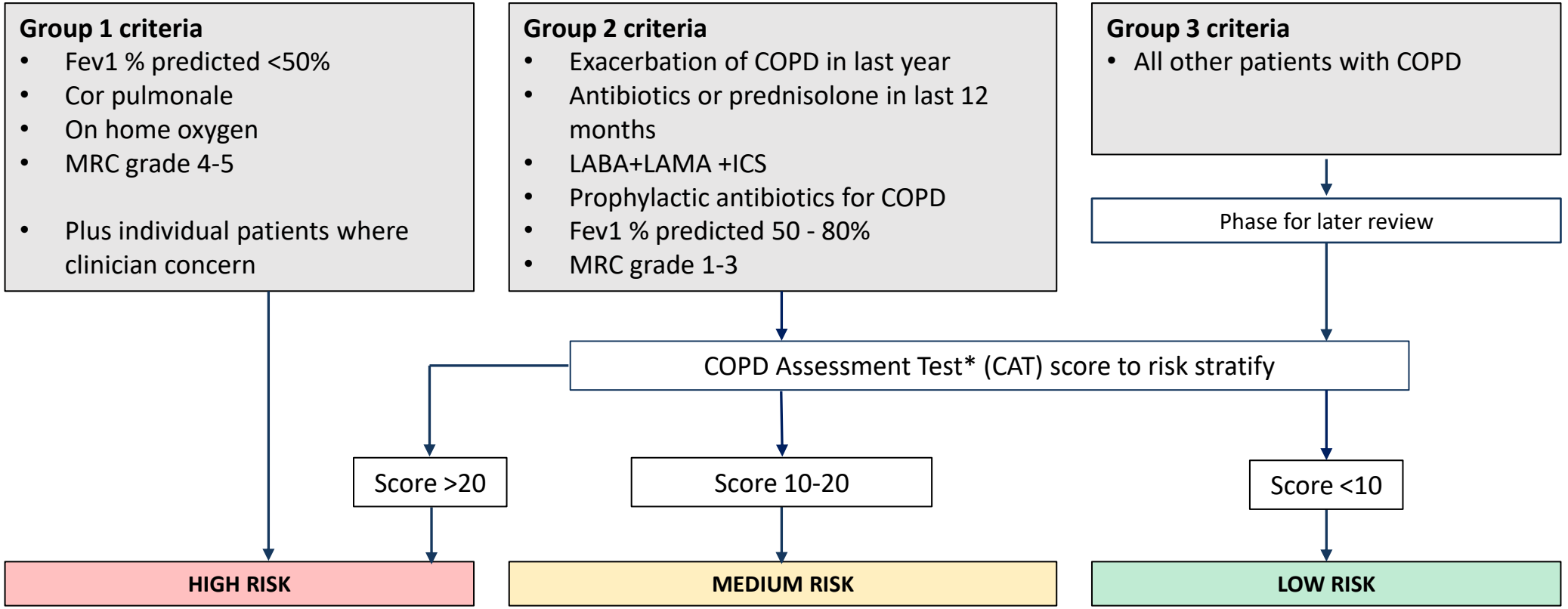
Digital Support Tools to support patient self-management

Inhaler Technique: www.asthma.org.uk/advice/inhaler-videos/ www.rightbreathe.com
Asthma deterioration: www.asthma.org.uk/advice/manage-your-asthma/getting-worse/
General Health Advice www.asthma.org.uk/advice/manage-your-asthma/adults/
Smoking Cessation: www.nhs.uk/oneyou/for-your-body/quit-smoking/personal-quit-plan/ www.nhs.uk/smokefree/help-and-advice

Contents

1 Identify & 2 Stratify

Search tool identifies patients with COPD. These patients are stratified into 3 groups depending on clinical characteristics, and then further stratified into high, medium and low risk using the COPD Assessment Test score.



*The COPD Assessment Test (CAT) is a questionnaire for people with COPD. It is designed to measure the impact of COPD on a person's life, and how this changes over time. Available here www.catestonline.org/

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3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

	High risk	Medium risk	Low risk
Staff type	GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant/ other appropriately trained staff
Intervention	• Titrate therapy if appropriate • Ensure action plan in place • Check adherence & inhaler technique • Spacer advice • Rescue packs – prescribe if needed • Exacerbation safety netting • If MRC 4/5 - offer Pulmonary Rehab via video consultation /My COPD App	• Check optimal therapy; titrate if appropriate • Check adherence & inhaler technique (video) • Spacer advice • Exacerbation management advice • Repeat CAT test at 4 weeks and escalate to GP/Nurse if red or amber	• Check medication compliance - regular inhaler usage. Signpost to education (video) • Spacer advice • Lifestyle info/ stress management/ exercise • Smoking Cessation advice • Exacerbation management advice • Signpost to British Lung Foundation and other resources

Digital Support Tools to support patient self-management

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: www.blf.org.uk/support-for-you/copd

Step-by-step guidance on physical activity : https://movingmedicine.ac.uk/disease/copd/#start

Expert input

UCLPartners

UCLPartners tested the Primary Care support package with patient and public representatives via a virtual engagement session. Key themes included:

Communication	Patients were concerned about not having regular communication with their usual GP but would be happy to hear from someone who was confident and consistent in their messaging & who had access to their existing health information
Holistic approach	Support offered needs to consider more than just the specific condition the individual is calling about but take into account and be responsive to the person's wider mental and physical wellbeing.
Trust	Patients raised concerns of fraud or breach of confidentiality when being contacted. They also wanted to have a single number/ named person to call if they needed support urgently

Clinical Advisory Group

Aiysha Saleemi, Pharmacist Advisor

Dr Deep Shah, GP SPIN

Helen Williams, Consultant Pharmacist

Dr John Robson, Reader in Primary Health care; Clinical Lead Clinical Effectiveness Group

Mandeep Butt, Clinical Medicines Optimisation Lead, UCLPartners

Dr Matt Kearney, GP, Programme Director UCLPartners AHSN

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Dr Nausheen Hameed, GP SPIN

Dr Sarujan Ranjan, GP and Health Tech Advisor

Sotiris Antoniou, Lead Pharmacist, UCLPartners

Dr Stephanie Peate, GP

Dr Zenobia Sheikh, GP & Primary Care Clinical Lead, UCLPartners

Proactive Care Frameworks: implementation & support package

Implementation Support is critical to enable sustainable and consistent spread.
UCLPartners has developed a support package covering the following components:

Search and stratify

Comprehensive search tools for EMIS and SystmOne to stratify patients
- Pre-recorded webinar as to how to use the searches
- Online Q&A to troubleshoot challenges with delivery of the search tools

Workforce training and support

Training tailored to each staff grouping (e.g. HCA/ pharmacist etc) and level of experience
- **Delivery:** Protocols and scripts provided/ training on how to use these underpinned with motivational interviewing/ health coaching training to enable adult-to-adult conversations
- **Practical support**: e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc
- **Digital implementation** support: how to get patients set up with appropriate digital
- **Education** sessions on conditions
- **Communities of Practice**

Digital support tools

Digital resources to support remote management and self-management in each condition
Implementation toolkits available where required, e.g. MyCOPD
Support available from UCLP's commercial and innovation team for implementation

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Thank you

For more information please contact:

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