UCLPartners

UCLP Proactive Care Frameworks

Restoring and improving long term condition management post COVID-19

Proactive Care in the pandemic

COVID-19 impact in primary care

- Disruption of routine, proactive care
- Disruption to relationship based care
- Risk of deterioration/exacerbations with poor outcomes in people with LTCs
- Risk of further waves of demand for urgent care in Long Term Conditions – eg CVD, hypertension, diabetes, COPD

UCLPartners Proactive Care Frameworks

- Real world frameworks to support proactive care in long term conditions
- Led by GPs and pharmacists
- Supported by patient and public insight
- Used as enablers of other resources and QI tools

UCLPartners Proactive Care Frameworks

UCLPartners has developed a series of real world frameworks 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 where appropriate and face to face where needed
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

High Impact Conditions

CVD prevention

1. Atrial Fibrillation
2. Blood pressure
3. Cholesterol
4. Type 2 Diabetes

Respiratory

5. Asthma
6. COPD

In development

7. Heart Failure
8. SMI

Principles

- Primary care led with PPI support
- Improve clinical care and self-care
- Mobilise wider workforce to support patient care and release capacity

Population Health Management Approach

- Risk stratification based on NICE guidance
- Prioritisation to optimise treatment early in those with greatest need
- Structured support for self-management and personalization

CVD High Risk Conditions – Stratification and Management Overview

UCLPartners

Healthcare Assistants/other trained staff

Gather information e.g.	Up to date bloods, BP, weight, smoking status, run risk scores: QRISK, ChadsVasc, HASBLED
Self management e.g.	Education (condition specific, CVD risk reduction), self care (eg red flags, BP measurement, foot checks), signpost shared decision making
Behaviour change e.g.	Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Risk Stratification & Prioritisation

- **Atrial Fibrillation**
- **Blood Pressure**
- **Cholesterol**
- **Diabetes**

Prescribing Clinician

Optimise therapy and mitigate risk
Review blood results, risk scores & symptoms
Initiate or optimise therapy
Check adherence and adverse effects
Review complications and co-morbidities
CVD risk – BP, cholesterol, pre-diabetes, smoking, obesity

Asthma and COPD – Stratification and Management Overview

Healthcare Assistants/other trained staff

Gather information e.g.	Up to spirometry, weight, smoking status, RCP questions, ACT/CAT scores
Self management e.g.	Education (condition specific, exacerbation advice), self care (eg inhaler and spacer technique)
Behaviour change e.g.	Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Risk Stratification & Prioritisation

Asthma

COPD

Prescribing Clinician

Optimise therapy and mitigate risk
Review symptoms, exacerbations, severity
Optimise inhaler therapy, oral therapy and pulmonary rehab
Check adherence and adverse effects
Safety netting and rescue meds
Review co-morbidities
Smoking cessation support

Systematic support for primary care to restore and improve proactive

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.

Hypertension

UCLPartners

High Blood Pressure Stratification and Management

UCLPartners

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** if under 80 years
OR Clinic BP ≥150/90mmHg** if 80 years and over

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

Review results and CVD risk
- Investigations as needed: Renal, lipids, ACR, ECG
- If existing CVD or QRisk > 10% support behaviour change and optimise lipid lowering therapy

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

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

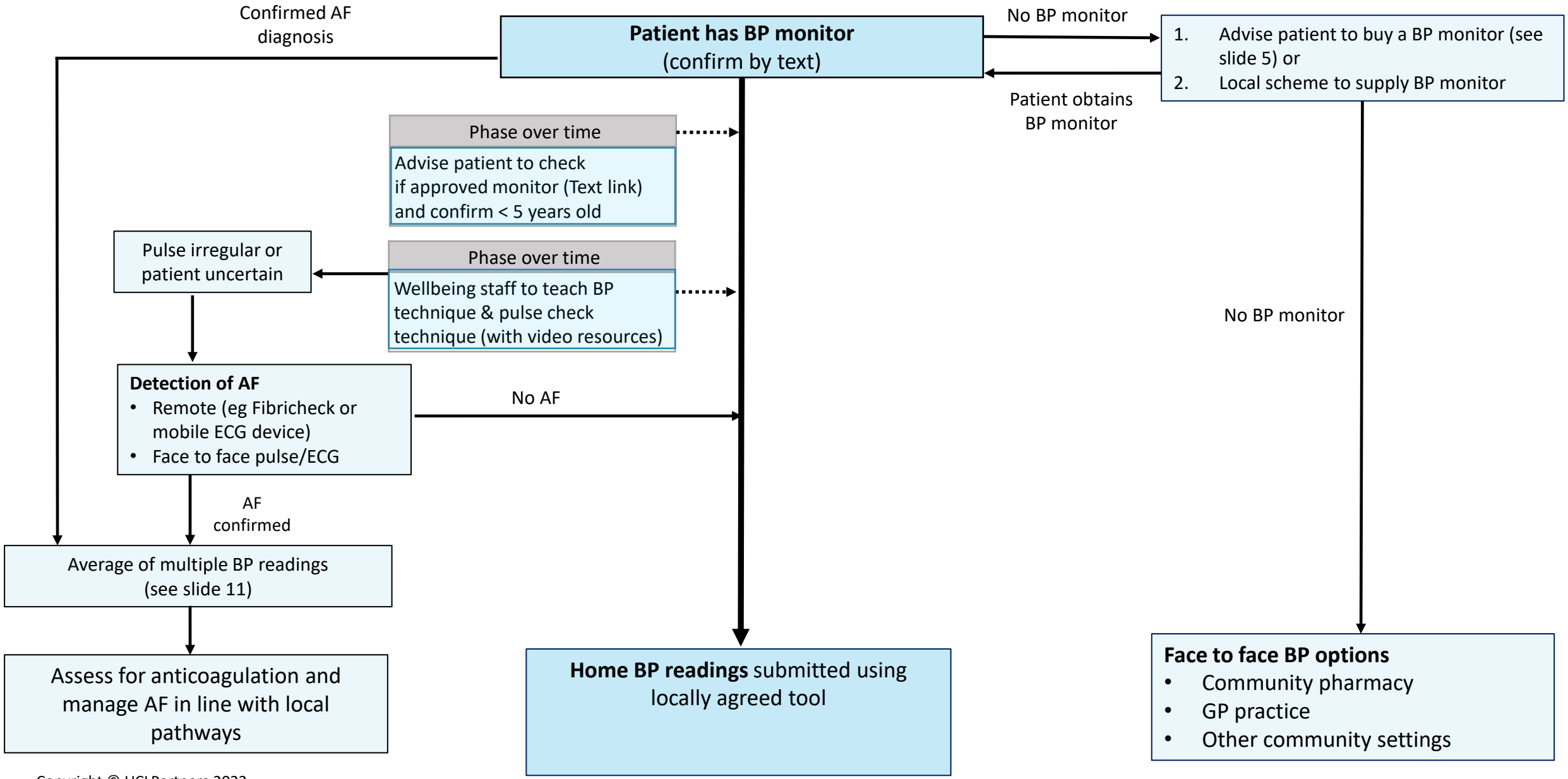
Advise
- When to submit BP readings (e.g. every 3 months)
- When to seek help based on BP readings

Referral
- Refer to GP if any red flags identified
- **If existing CVD or QRIsk > 10% and no statin – refer to prescribing clinician**

Recall and code

* / ** see slide 9

Home Blood Pressure Monitoring Pathway



Atrial Fibrillation

UCLPartners

Atrial Fibrillation: Stratification and Management of Stroke Risk

UCLPartners

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

Prescribing clinician

Optimise anticoagulation therapy and CVD risk reduction

1. Review: blood results, risk scores & symptoms.
2. Initiate or optimise anticoagulant.
3. For patients on warfarin consider switch to DOAC at next routine review.
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.

Type 2 Diabetes

UCLPartners

Type 2 Diabetes stratification and management

UCLPartners

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		Medium risk		Low 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)	**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)	**Priority Five** **All others** (Except patients included in Priority 1-4 groups)

Type 2 Diabetes stratification and management

UCLPartners

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 to contact	**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 plus personal targets • Set HBA1C targets • Lipids/lipid lowering therapy • BP and proteinuria **Education (inc online tools)** • Sick day rules • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Feet/skin : pressure areas; virtual skin integrity check • 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 **Education** • Sick day rules • Signpost online resources • DVLA guidance • Flu jab **Review & Discuss Red flags** • Vision: floaters/flashing lights • Feet/skin: pressure areas; virtual skin integrity check • 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 **Review & Discuss Red flags** • Vision: floaters/flashing lights • Feet/skin: pressure areas; virtual skin integrity check • Blood sugar control • Infections • Signposting and Escalation **Recall & Code**

Cholesterol

UCLPartners

Cholesterol – Secondary Prevention (pre-existing CVD)

UCLPartners

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)

UCLPartners

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

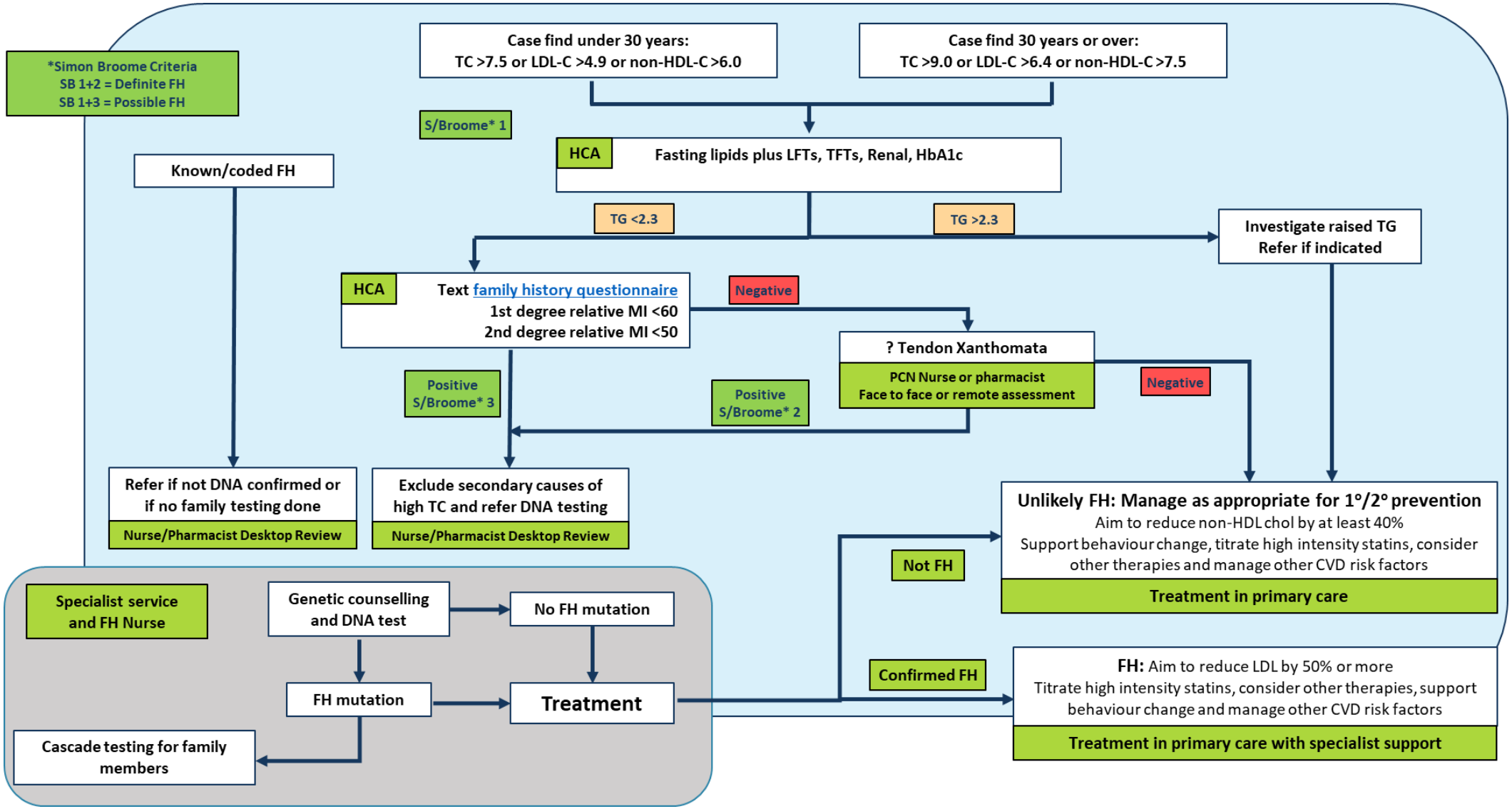
Prescribing clinician

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

Familial Hypercholesterolaemia Pathway



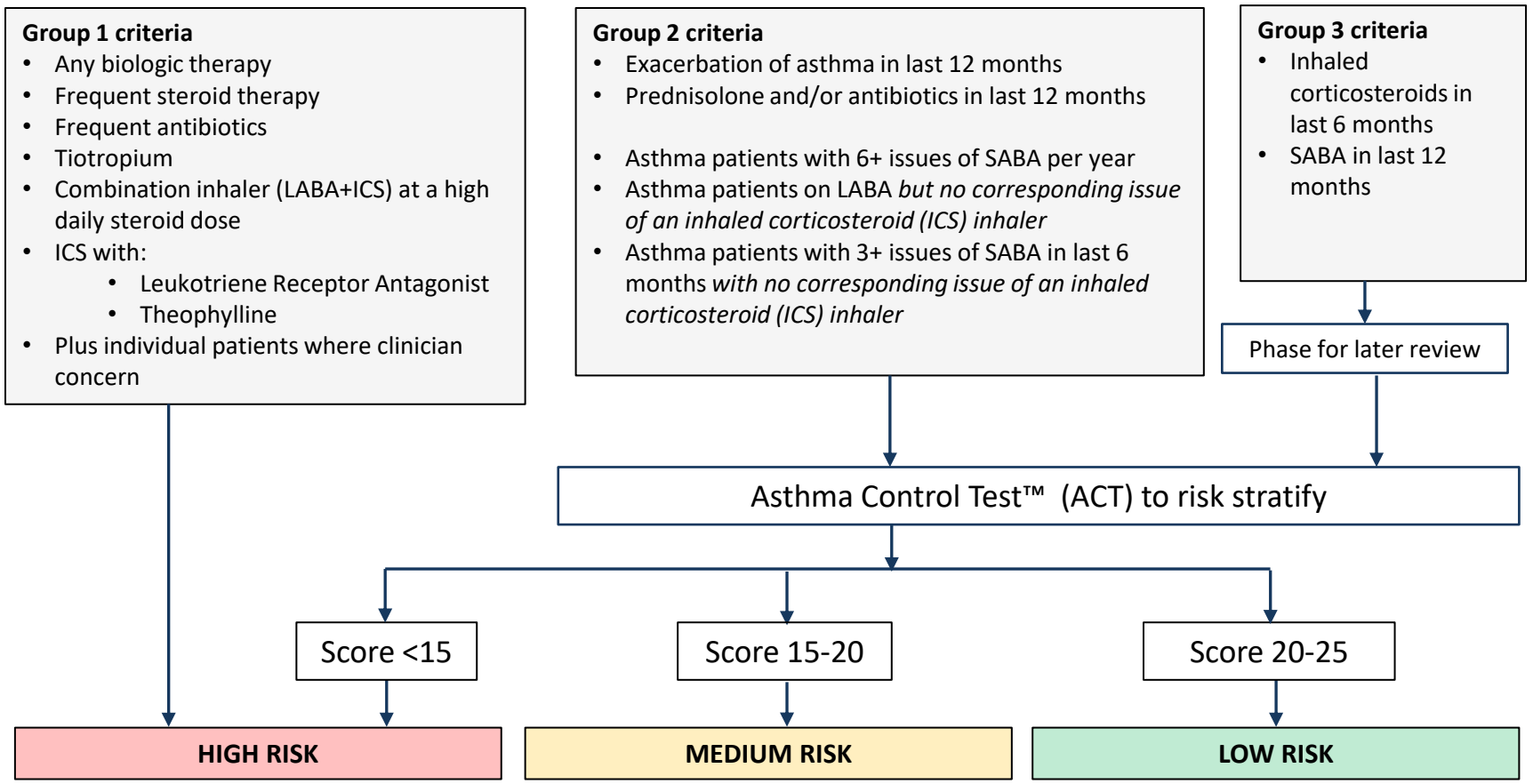
Asthma

UCLPartners

Long Term Condition Pathway: Asthma

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

Long Term Condition Pathway: Asthma

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
GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant/ other appropriately trained staff
• 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

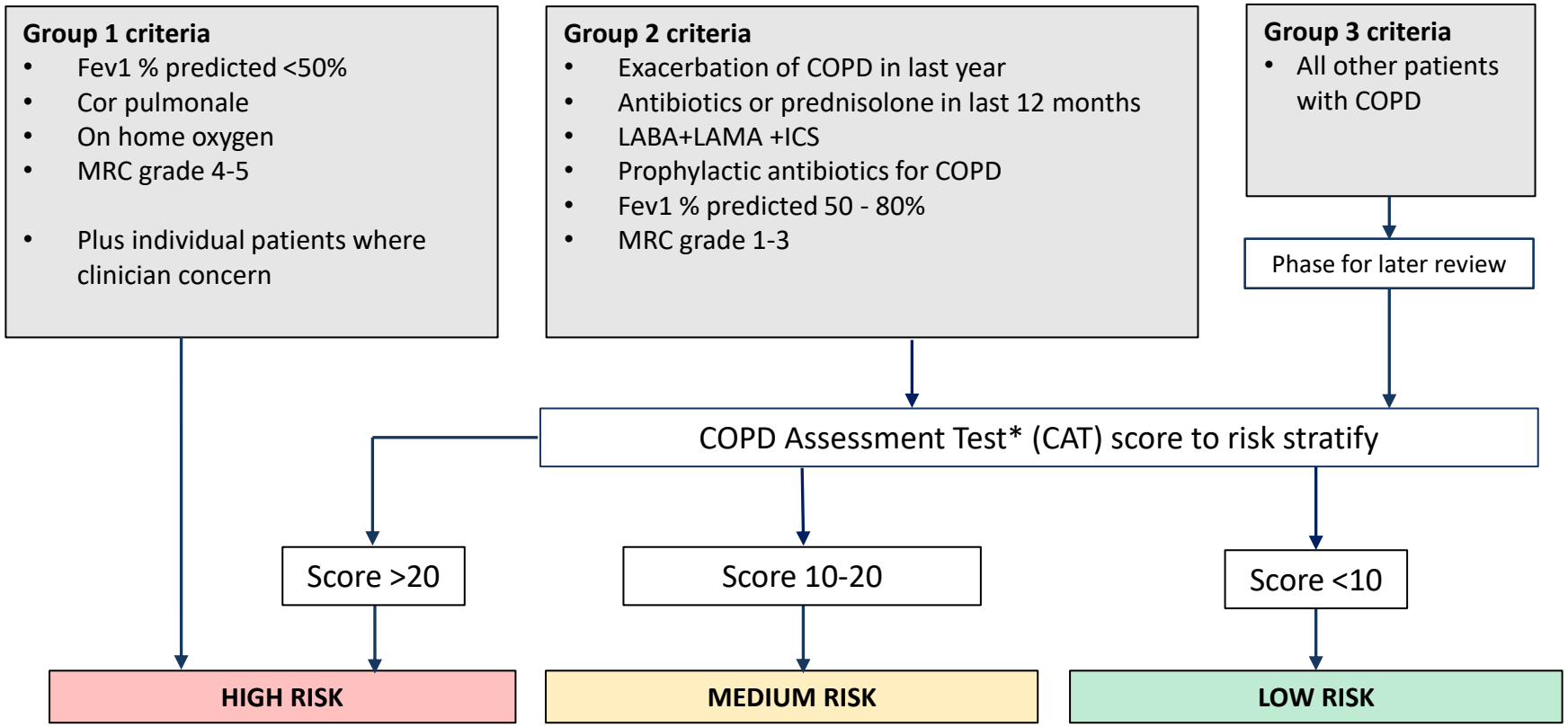
COPD

UCLPartners

Long Term Condition Pathway: COPD

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/

Long Term Condition Pathway: COPD

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
GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant/ other appropriately trained staff
• 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: https://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

Patient and Public Insight

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 consider 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

"If I'd had this document 20 years ago, I would probably not suffer from some of the conditions I now have".
Public representative feedback

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 and Programme Director UCLPartners AHSN

Dr Mohammed Khanji, Consultant Cardiologist, Barts Health NHS Trust

Professor Mike Roberts, Consultant Respiratory Physician and Managing Director UCLPartners

Dr Morounkeji Ogunrinde, GP SPIN

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

Implementation Support

UCLPartners

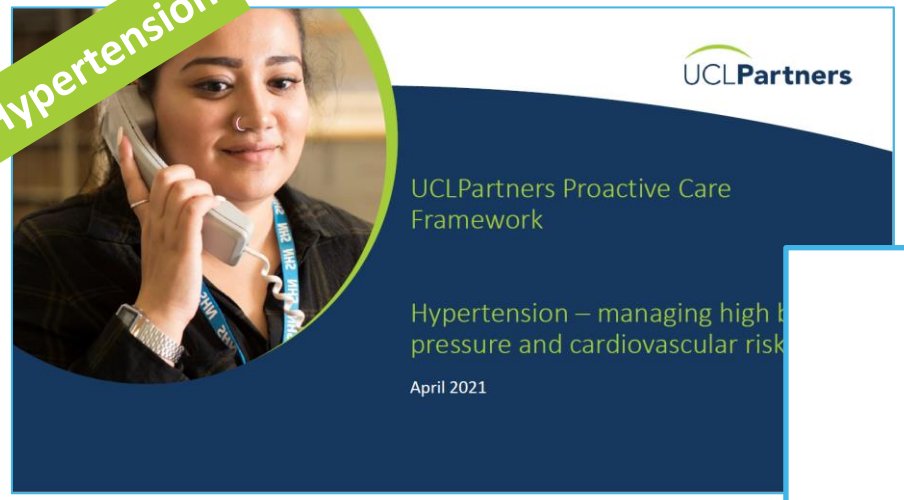
Implementation support is critical

Adapting to your local context	• **Programme and project management** to adapt and embed the frameworks in Primary Care Networks • Support for **local clinical engagement and leadership** • Adaption of the frameworks to **reflect local pathways** • Facilitated **Community of Practice/shared learning forums** to enable peer support across local systems
Workforce training and support	• Support to **identify training needs** • Training **tailored to each staff grouping** (e.g. HCA/ pharmacist etc) and level of experience • **Communications training and support** – encompassing motivational interviewing and health coaching principles to support the primary workforce to deliver the protocol • **Best practice in virtual consultations** – practical training and support to deliver high quality remote consultations • **Condition-specific training** – we are working with local Training Hubs to provide training on each of the conditions covered by the frameworks
Data and evaluation	• Support to use **search tools** • Support with **coding and data collection approaches** to enable implementation
Digital Support Tools	• Sign-posting to **digital resources** to support remote management and self management FOR each condition • **Digital implementation** support: how to get patients set up with the appropriate digital tools

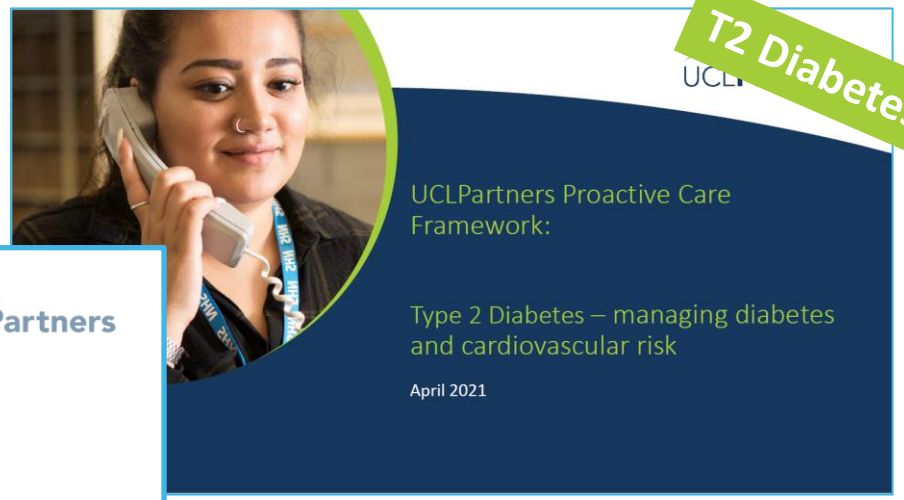
Resources for clinical management – including co-morbidity

UCLPartners

Hypertension

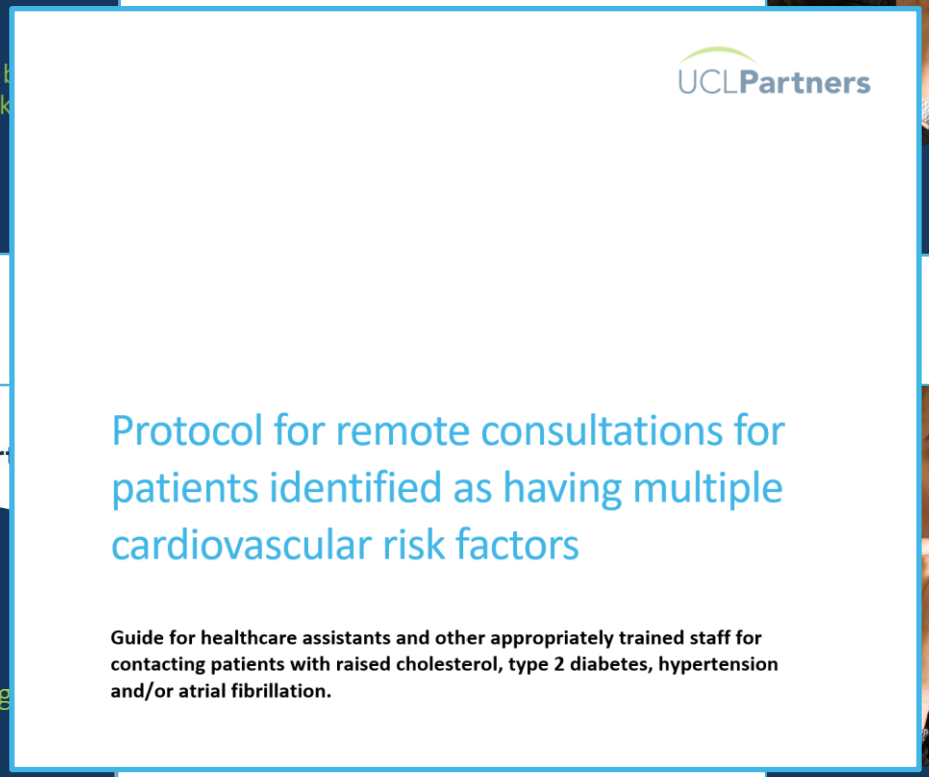


T2 Diabetes

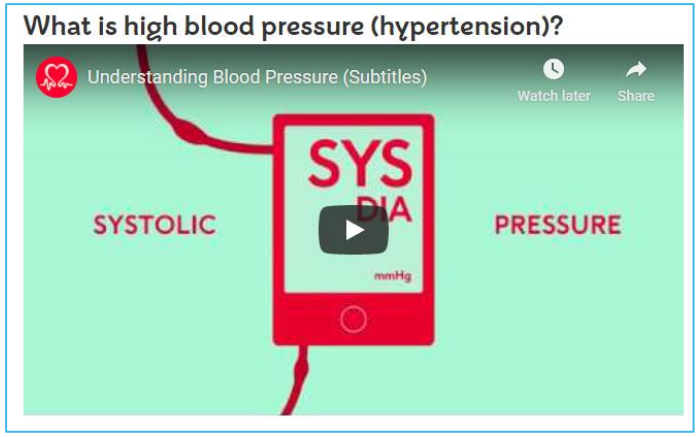


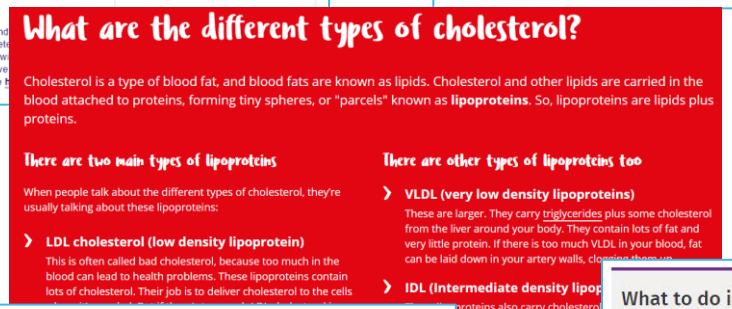
Atrial Fibrillation

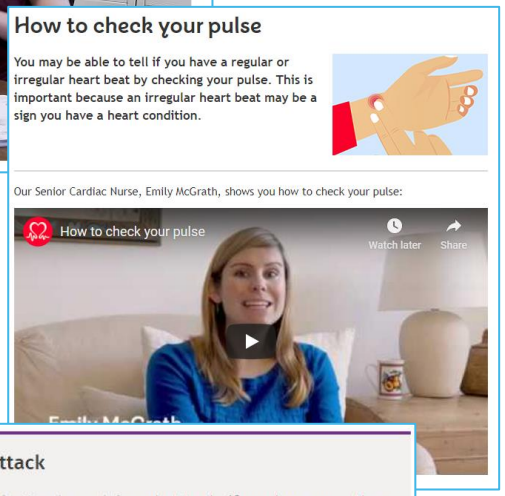
Cholesterol

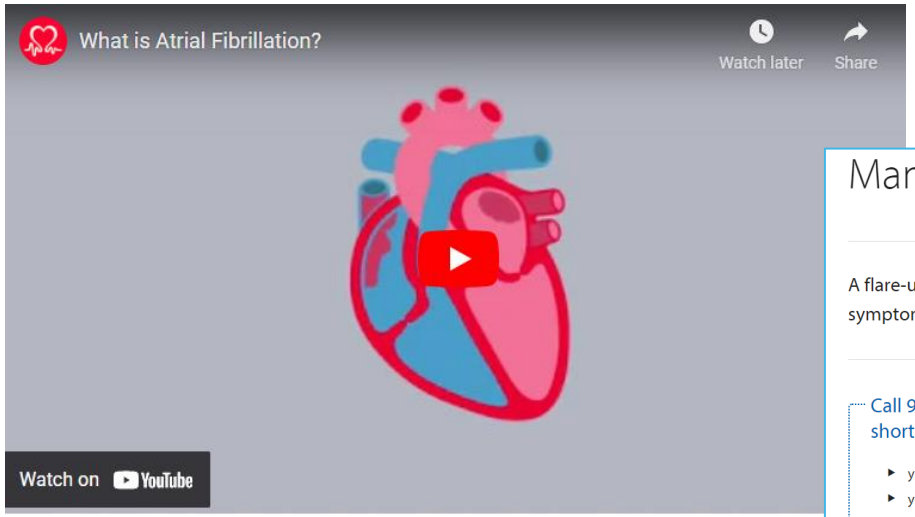


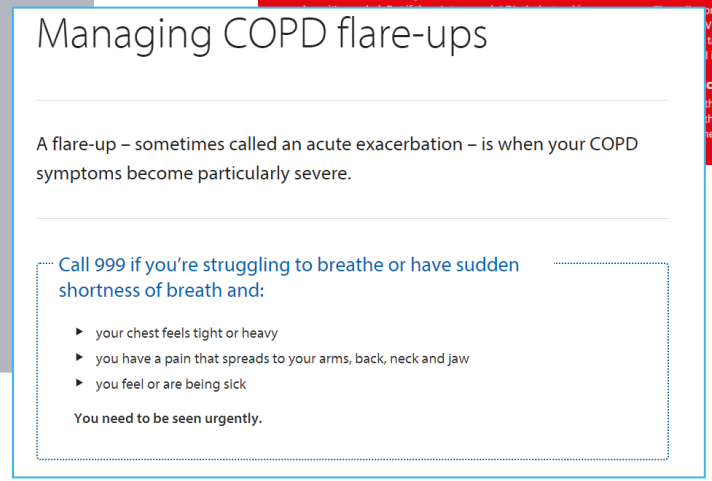
Resources for patients – supporting education and self management











Resources for patients – Supporting behaviour change

Quit smoking

Stopping smoking is one of the best things you will ever do for your health.

When you stop, you give your lungs the chance to repair and you will be able to breathe easier. There are lots of other benefits too – and they start almost immediately.

It's never too late to quit. Let's do this!

Lose weight

If you're overweight, losing weight has many health benefits. Making small, simple changes to what and how much you are eating and drinking can really help you lose the pounds.

Get active

No matter how much you do, physical activity is good for your body and mind. Adults should aim to be active every day. Some is good – more is better still.

A daily brisk walk can boost your energy, lift your mood and make everyday activities easier.

Try these tools, tips and special offers to move more every day.

Take care of your mind

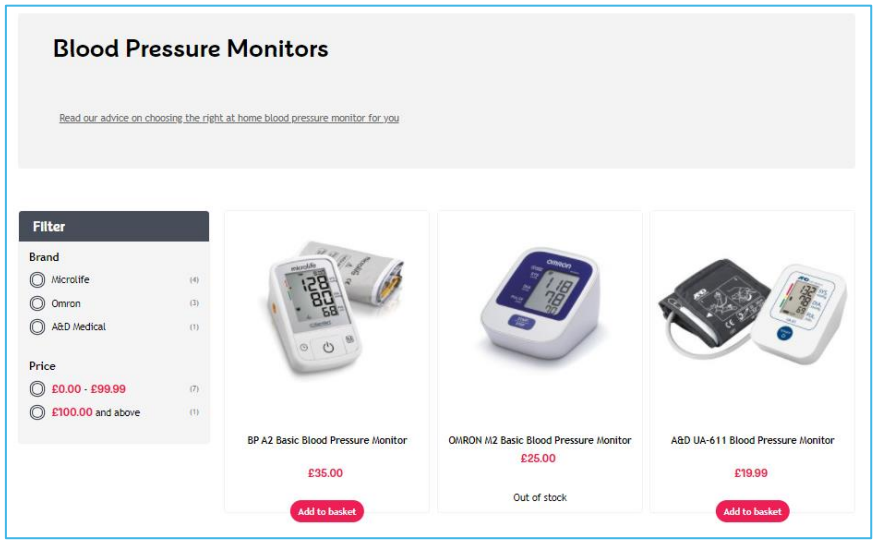
Looking after your mind is just as important as looking after your body, but it can be easily overlooked.

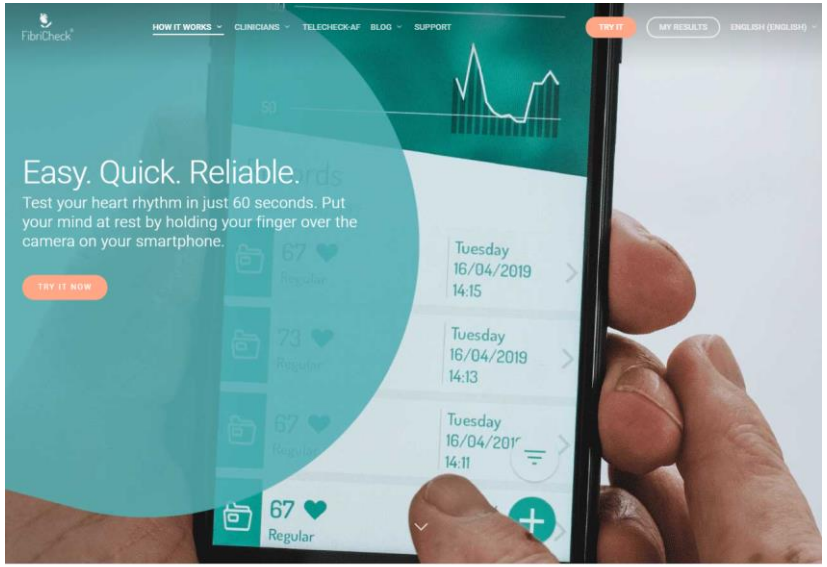
Every Mind Matters has lots of expert advice and practical tips to help you stay on top of your mental wellbeing.

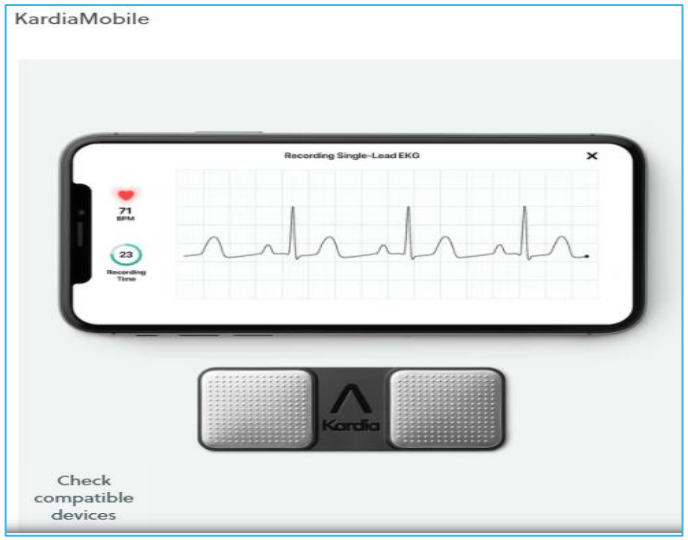
Visit Every Mind Matters

https://www.nhs.uk/better-health/

Resources to support remote management







National uptake of the UCLP Proactive Care Frameworks

- Wide traction and growing uptake in primary care across England:
  - Widely welcomed by GPs and primary care teams
    - Improving care for people
    - Releasing GP capacity
    - Meeting QOF and other targets
  - Over 7,000 downloads of the search tools

- NHSE/I has adopted the UCLP frameworks into new national programme (*NHSE/I Proactive Care @Home Programme)* with initial 4 funded pilot implementation ICS sites from January 2021 and further 9 ICSs from autumn 2021

Free Resources – uclpartners.com/proactive-care/

UCLPartners

UCLPartners

Thank you

For more information please contact:

primarycare@uclpartners.com

www.uclpartners.com
@uclpartners

Version tracker

Version	Edition	Changes Made	Date amended	Review due
2	2.0	• Principles and population health management approach information added to slide 4 (UCLP proactive care frameworks) • 'One You' website information amended to better health (slide 33) • National uptake of UCLP Proactive Care Frameworks updated (slide 35)	28th January 2022	July 2022