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# Post COVID-19 recovery:

# Primary care support for long-term condition management

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September 2020

# 1. Overview

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# Primary Care during & post COVID-19…and as we transition to the new normal

- COVID-19 has placed unprecedented pressure on our health system. Immediate focus has understandably been on supporting patients with, or at risk of the virus.
- However, there is a large cohort of people living with long term conditions that need **ongoing, proactive management** to prevent a wave of exacerbations in the months ahead.
- To help us adapt our care for people with long term conditions in the new world of primary care post COVID-19, UCLPartners has developed a **support package** based on new pathway development, virtual consultations, digital solutions and optimal use of the wider primary care team, e.g. **Healthcare Assistants, nursing associates and Pharmacists.**
- Additionally the package includes a selection of appraised **digital tools** 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**.
- This support package is designed to help primary care teams deliver quality care to patients and meet QOF and other contractual requirements while releasing GP time at this time of unprecedented demand.

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# 2. The Framework – to be adapted for use in local systems

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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 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 Long Term Condition Frameworks for Local Adaptation

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**Principles**:

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

**Stratify** (clinical, ethnicity, social factors)

**Low risk**
**Medium risk**
**High risk**

1. **Prioritise – highest risk first**
2. **Use wider workforce to share delivery of care**
3. **Innovation to support remote care and self care**

**High Risk –early specialist review**
GP/ specialist nurse/ specialist pharmacist

**Med Risk – phased review**
e.g. Nurse/ clinical pharmacist

**Low Risk – holistic proactive care**
(Education, self management, behaviour change support etc)
E.g. HCA, nursing associate, social prescriber

# Conditions included:

- Asthma
- COPD
- Diabetes Type 2
- Cardiovascular Disease:
  - Hypertension
  - In development: AF and high cholesterol

The following slides show indicative frameworks for stratification and management that can be adapted for local use depending on existing activity, workforce and pathways

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# Asthma

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# 1. Long Term Condition Pathway: Asthma

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## 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.**

**Group 1 criteria**
- Any biologic therapy
- Frequent steroid therapy
- Frequent antibiotics
- Tiotropium
- Combination inhaler (LABA+ICS) at a high daily steroid dose
- ICS with:
  - Leukotriene Receptor Antagonist
  - Theophylline
- Plus individual patients where clinician concern

**Group 2 criteria**
- Exacerbation of asthma in last 12 months
- Prednisolone and/or antibiotics in last 12 months
- Asthma patients with 6+ issues of SABA per year
- Asthma patients on LABA *but no corresponding issue of an inhaled corticosteroid (ICS) inhaler*
- Asthma patients with 3+ issues of SABA in last 6 months *with no corresponding issue of an inhaled corticosteroid (ICS) inhaler*

**Group 3 criteria**
- Inhaled corticosteroids in last 6 months
- SABA in last 12 months

Phase for later review

Asthma Control Test™ (ACT) to risk stratify

Score <15 → **HIGH RISK**

Score 15-20 → **MEDIUM RISK**

Score 20-25 → **LOW RISK**

*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

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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 to contact** | GP/ Nurse specialist/ Specialist Respiratory Pharmacist | Clinical Pharmacist/ Practice nurse/ physician associate | Health Care Assistant/ other appropriately trained staff |
| **Intervention** | • Titrate therapy, if appropriate<br>• Ensure action plan in place<br>• Check adherence, inhaler technique (video) , spacer advice<br>• Rescue packs prescribed if necessary<br>• Review of triggers, e.g. hay fever<br>• Exacerbation safety netting<br>• Follow up and referral as indicated | • Check optimal therapy; Titrate, if appropriate<br>• Review triggers, e.g. hayfever<br>• Check adherence, inhaler technique (video), spacer advice<br>• Exacerbation management advice<br>• **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<br>• Exacerbation management advice inc. mild hayfever symptoms<br>• Signpost to appropriate information for: Lifestyle information/management of stress<br>• Smoking cessation support<br>• Exercise<br>• 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

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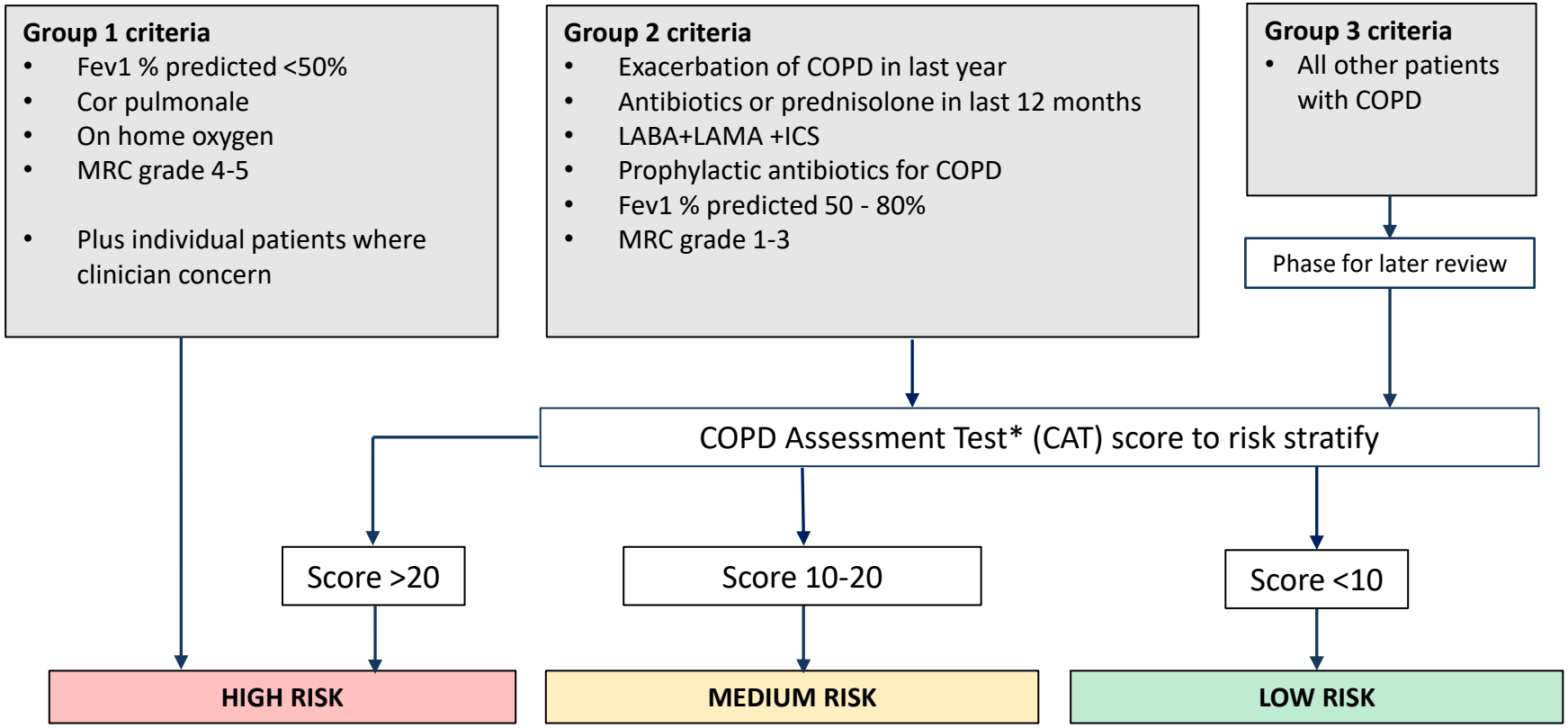
# 1 Identify & 2 Stratify

**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 to contact** | GP/ Nurse Specialist/ Specialist Respiratory Pharmacist | Nurse/ Clinical Pharmacist/ Physician Associate | Health Care Assistant/ other appropriately trained staff |
| **Intervention** | • Titrate therapy if appropriate<br>• Ensure action plan in place<br>• Check adherence & inhaler technique<br>• Spacer advice<br>• Rescue packs – prescribe if needed<br>• Exacerbation safety netting<br>• If MRC 4/5 - offer Pulmonary Rehab via video consultation /My COPD App | • Check optimal therapy; titrate if appropriate<br>• Check adherence & inhaler technique (video)<br>• Spacer advice<br>• Exacerbation management advice<br>• 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)<br>• Spacer advice<br>• Lifestyle info/ stress management/ exercise<br>• Smoking Cessation advice<br>• Exacerbation management advice<br>• 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

# Type 2 Diabetes

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# 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)

# 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:**<br>  • Adherence<br>  • Titrate as appropriate<br>• **Monitoring**<br>  • Blood sugar control<br>  • Lipids/lipid lowering therapy<br>  • BP and proteinuria<br>• **Education (inc online tools)**<br>  • Sick day rules<br>  • DVLA guidance<br>• **Review & Discuss Red flags**<br>  • Vision: floaters/flashing lights<br>  • Feet/skin : pressure areas; virtual skin integrity check<br>  • Blood sugar control: hypos<br>  • Infections<br>  • Signposting and Escalation<br>  • Diabetes community +- secondary care team/advice<br>  • Recall & Code | • **Medication:**<br>  • Adherence<br>  • Titrate as appropriate<br>• **Monitoring**<br>  • Blood sugar control<br>  • Lipids/lipid lowering therapy<br>  • BP and proteinuria<br>• **Education**<br>  • Sick day rules<br>  • Signpost online resources<br>  • DVLA guidance<br>• **Review & Discuss Red flags**<br>  • Vision: floaters/flashing lights<br>  • Feet/skin: pressure areas; virtual skin integrity check<br>  • Blood sugar control: hypos<br>  • Infections<br>  • Signposting and Escalation<br>  • Recall & Code | • **Medication:**<br>  • Adherence<br>  • Explore/ check understanding<br>  • Confirm supply and delivery<br>• **Education**<br>  • Signpost online resources<br>  • Risk factors – diet/lifestyle/smoking cessation<br>  • DVLA guidance<br>• **Review & Discuss Red flags**<br>  • Vision: floaters/flashing lights<br>  • Feet/skin: pressure areas; virtual skin integrity check<br>  • Blood sugar control<br>  • Infections<br>  • Signposting and Escalation<br>  • Recall & Code |

**Digital Support Tools to support patient self-management [full list included in diabetes slide pack)**
General info & advice: www.diabetes.org.uk/diabetes-and-me www.nhs.uk/apps-library/my-diabetes-my-way/

# Hypertension

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# 1 Identify, 2 Stratify 3 Manage

**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

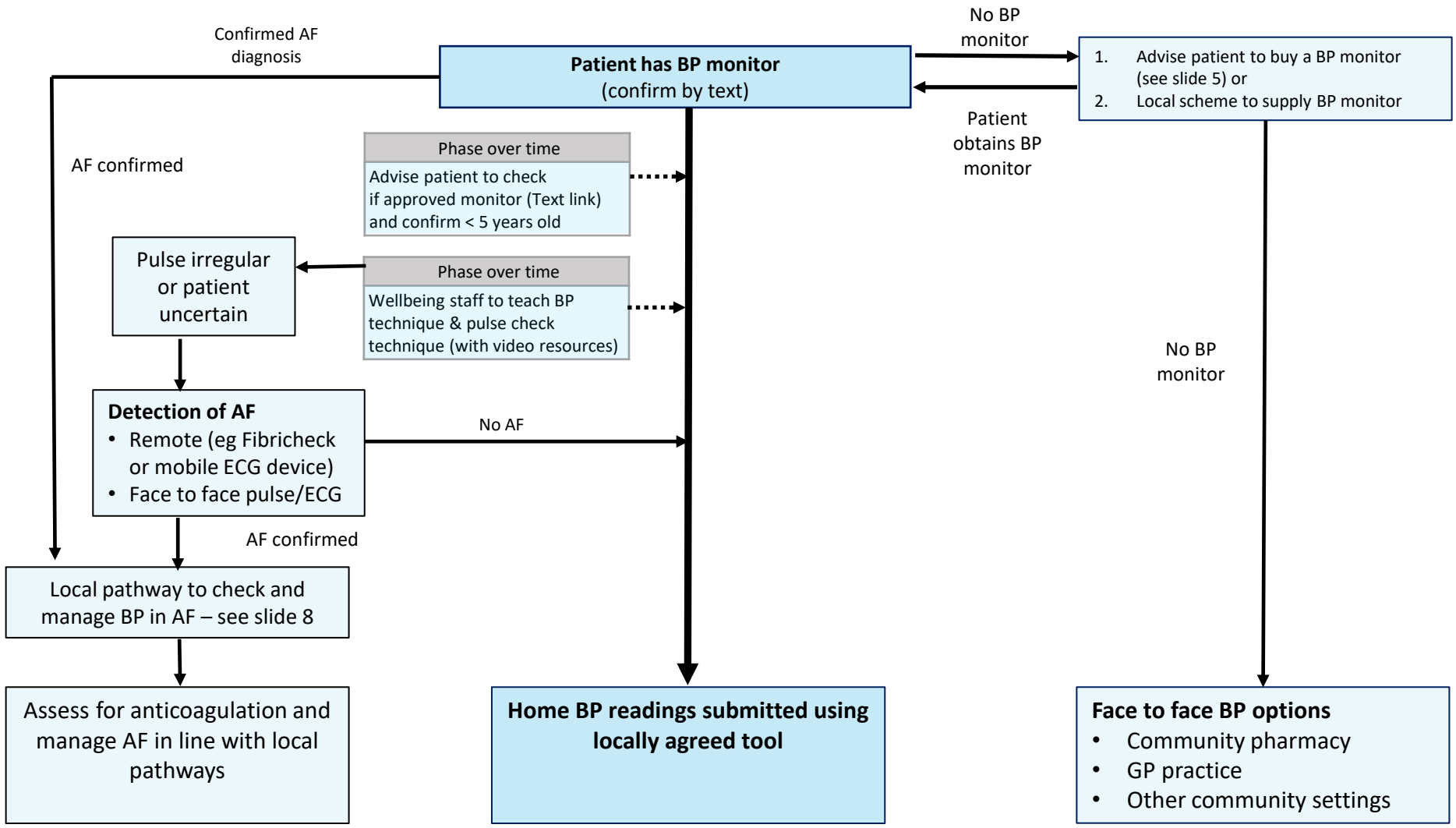
**Advise**
- When to submit BP readings (e.g. every 3 months)
- When to seek help based on BP readings

**Referral**
- Refer 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 hypertenstion slide pack

# Home blood pressure monitoring – suggested pathway



# 3. Expert input

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**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

Professor Mike Roberts, 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 & Primary Care Clinical Lead, UCLPartners

# 4. Training package & support available

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# Long term condition management: implementation support offer

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UCLPartners is working with local systems to offer the following support to ensure sustainable and consistent spread:

| | |
|---|---|
| **Search/ stratification** | Tools to identify and stratify patients available. These can be downloaded from: https://uclpartners.com/long-term-condition-support/ |
| **Training & education** | **Workforce training includes:**<br>• **Virtual training** in how to use the protocols, support patient self management and covering motivational interviewing developed by UCLP in partnership with Care City<br>• **Practical training**: Video training links, e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc<br>• **Specialist briefings** on the long term conditions |
| **Digital tools** | **Digital Support Tools:** identified innovations to support patient self management that can be embedded into these pathways |
| **Evaluation** | Via a partnership with City University to evaluate the acceptability and feasibility of this framework and the impact it has on raising workforce competence and confidence |

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# Thank you

For more information please contact:

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