



Post COVID-19 Recovery: Primary Care Support for Long Term Condition management

UCLPartners
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1. Overview

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.

“LTC management is at risk of neglect during national emergencies”



But **Recovery** also offers major opportunity:

- To do things differently in primary care for the benefit of patients and clinicians
- To build capacity in the primary care workforce
- To support patients in self management
- To reduce variation in quality of care

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

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



Principles:

- Virtual first
- Wider 1^o 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/ spec nurse/ spec pharmacist

Med Risk – phased review

Nurse/ pharmacist

Low Risk – holistic proactive care
(Education, self management, behaviour change support etc)

Eg HCA, nursing associate, social prescriber

Conditions included:

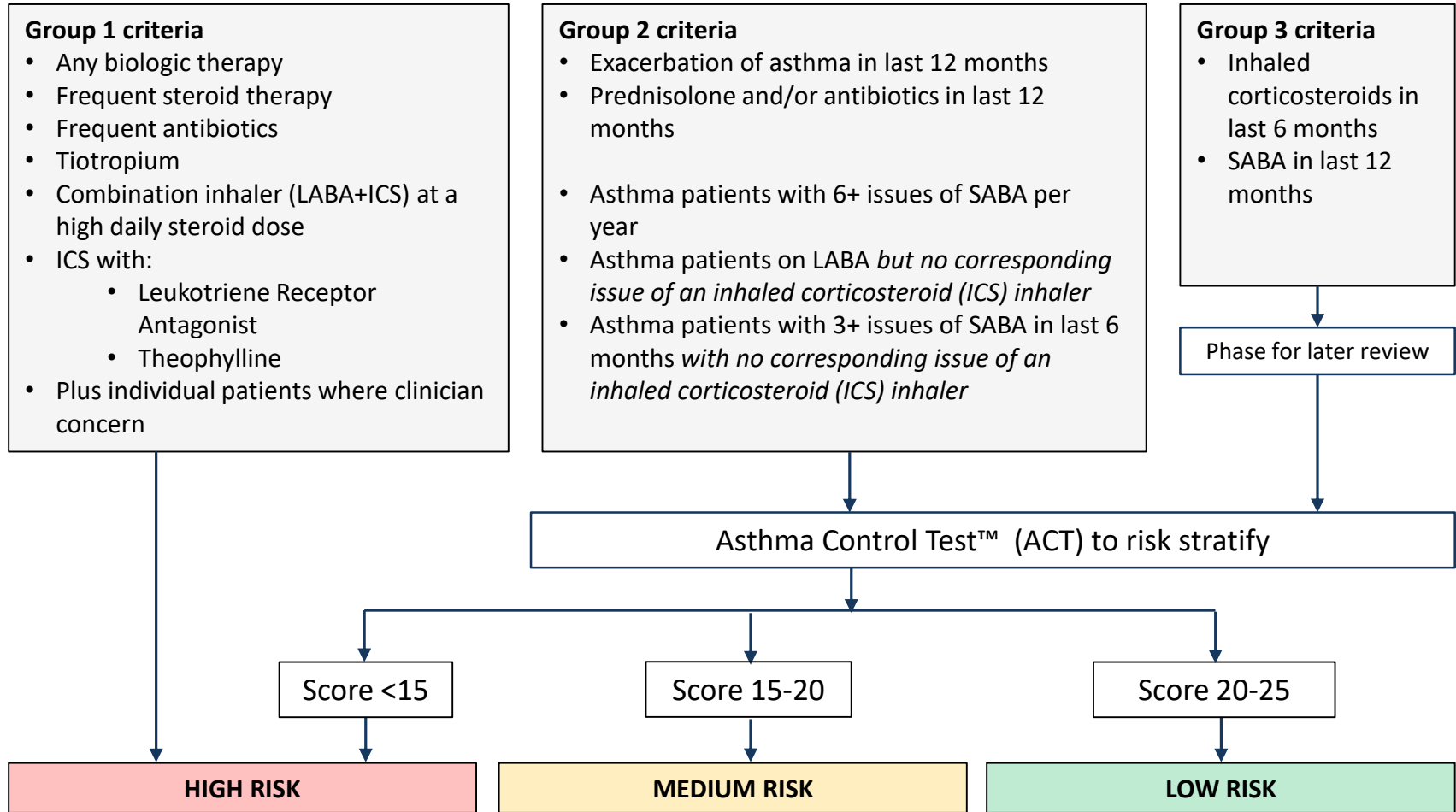
- Asthma
- COPD
- Diabetes Type 2
- Cardiovascular Disease (in development):
 - Hypertension and Heart Failure, AF and high cholesterol

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

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

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
Intervention	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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/

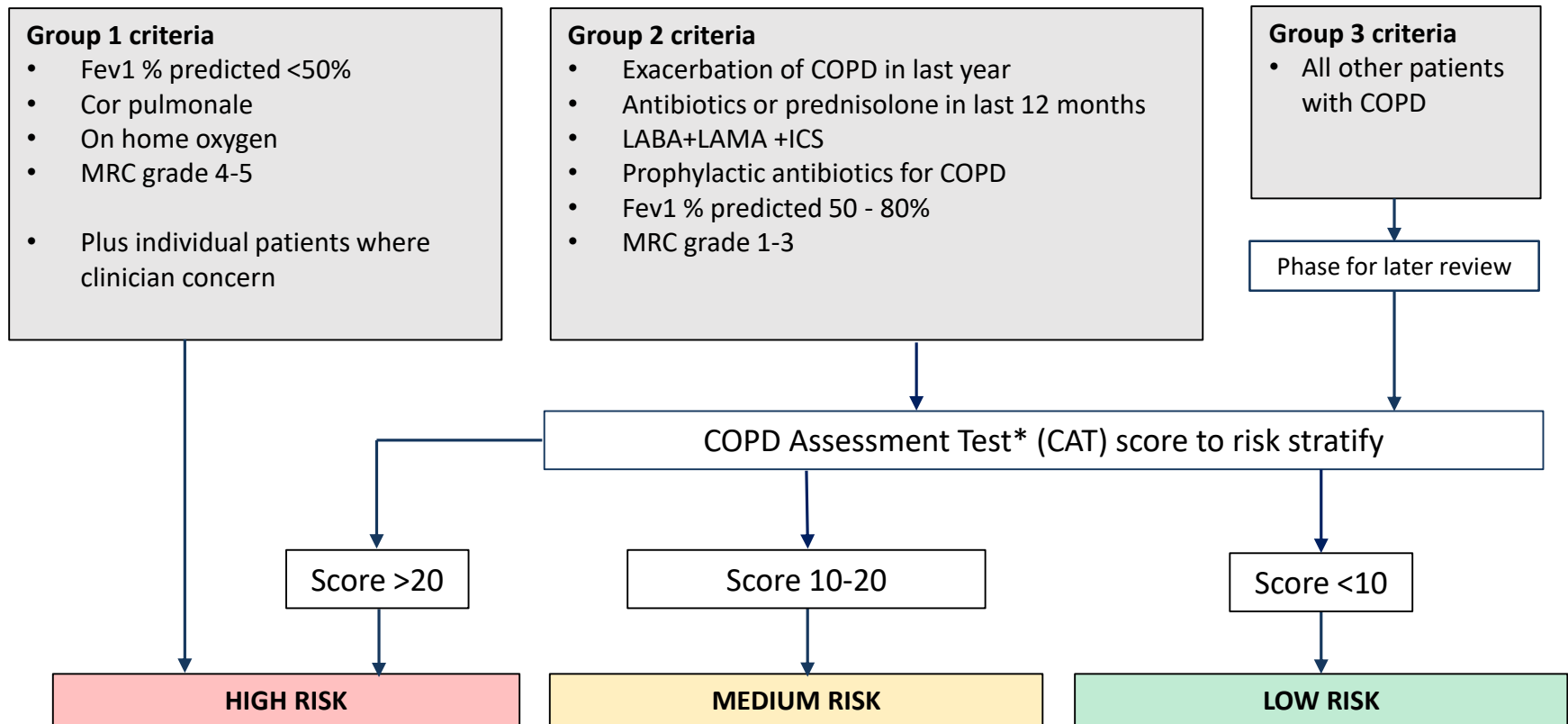
General Health Advice www.asthma.org.uk/advice/manage-your-asthma/adults/

Smoking Cessation: www.nhs.uk/oneyou/for-your-body/quit-smoking/personal-quit-plan/ www.nhs.uk/smokefree/help-and-advice

COPD

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/

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
Intervention	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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>

Type 2 Diabetes

1 Identify & stratify

Search tool identifies patients with Diabetes and stratifies them into high, medium and low risk depending on clinical characteristics.

High risk

- HbA1c > 7.5
- eGFR < 45
- Insulin or other injectables
- Severe frailty
- History of foot ulcer in last 3 years
- Heart failure
- MI or stroke/TIA in last 12 months
- Metabolic syndrome
- Social complexity
 - LD, SMI
 - housebound, homeless,
 - alcohol or substance misuse
- Under c/o community diabetes team

Medium risk

- HbA1c 5.8 - 7.5
- BMI > 35
- BP > 140/90
- eGFR 45-60
- mild-mod frailty
- Previous coronary heart disease or cerebrovascular disease
- ED ever
- Foot disease risk (PAD or neuropathy)
- Proteinuria (includes ACR > 3)
- Retinopathy

Low risk

- HbA1c < 5.8
- BMI < 35
- Hypertension with BP < 140/80
- No other features in high or medium risk groups

2 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
Intervention	<ul style="list-style-type: none"> • Medication: <ul style="list-style-type: none"> • Adherence • Titrate as appropriate • Monitoring <ul style="list-style-type: none"> • Blood sugar control • Lipids/lipid lowering therapy • BP and proteinuria • Education (inc online tools) <ul style="list-style-type: none"> • Sick day rules • DVLA guidance • Review & Discuss Red flags <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Medication: <ul style="list-style-type: none"> • Adherence • Titrate as appropriate • Monitoring <ul style="list-style-type: none"> • Blood sugar control • Lipids/lipid lowering therapy • BP and proteinuria • Education <ul style="list-style-type: none"> • Sick day rules • Signpost online resources • DVLA guidance • Review & Discuss Red flags <ul style="list-style-type: none"> • Vision: floaters/flashing lights • Feet/skin: pressure areas; virtual skin integrity check • Blood sugar control: hypos • Infections • Signposting and Escalation • Recall & Code 	<ul style="list-style-type: none"> • Medication: <ul style="list-style-type: none"> • Adherence • Explore/ check understanding • Confirm supply and delivery • Education <ul style="list-style-type: none"> • Signpost online resources • Risk factors – diet/lifestyle/smoking cessation • DVLA guidance • Review & Discuss Red flags <ul style="list-style-type: none"> • Vision: floaters/flashing lights • Feet/skin: pressure areas; virtual skin integrity check • Blood sugar control • Infections • Signposting and Escalation • Recall & Code



Digital Support Tools to support patient self-management

NICE approved face to face programme, offering education, diet & exercise advice: www.mydesmond.com/home/
 General info & advice: www.diabetes.org.uk/diabetes-and-me www.nhs.uk/apps-library/my-diabetes-my-way/

3. Expert input

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

Aiysha Saleemi, Pharmacist Advisor

Dr Deep Shah, GP

Helen Williams, Consultant Pharmacist

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

Mandeep Butt, Clinical Medicines Optimisation Lead, UCLPartners

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Dr Sarujan Ranjan, GP and Health Tech Advisor

Dr Stephanie Peate, GP

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

4. Training package & support available

Implementation Support is Critical

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
- **Practical support:** e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc
- **Health coaching:** How to have productive, adult to adult conversations
- **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

Thank you

For more information please contact:

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www.uclpartners.com
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