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Post COVID-19 Recovery

Support for Transformation in Long Term Condition Management

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“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

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- 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.
- And as a result of the dramatic changes in the way we deliver primary care to our patients we need to create **new ways of working** that help patients and clinicians adapt to the new world.
- UCLPartners has developed a **Long-Term Condition Framework** and comprehensive support package for stratifying patients and developing new models of care that mobilise the wider primary care workforce and support self management at scale.

Managing Long Term Conditions post COVID-19 Framework for Primary Care

Core principles

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

The UCLP Long-Term Conditions Framework

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Principles:

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

Identify
Search for risk groups via health records

Stratify
Low risk
Medium risk
High risk

Communicate
Text/letter/ call to let patient know they will hear from practice

Management
Match risk/need to professional role

High Risk
GP/specialist nurse/clinical pharmacist

Medium Risk
Nurse/clinical pharmacist

Low Risk
HCAs, nursing associates and others

Resources: comprehensive search tools, protocols, scripts for HCAs, training, education, digital tools, project management, communities of practice uclpartners.com/work/support-for-long-term-conditions-during-the-covid-19-pandemic/

Patient and Public Insight

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UCLPartners tested the Primary Care LTC framework with patient and public representatives via a virtual engagement session. Themes that emerged:

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

Long-Term Condition Framework

Asthma

COPD

Type 2 Diabetes

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

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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
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

COPD

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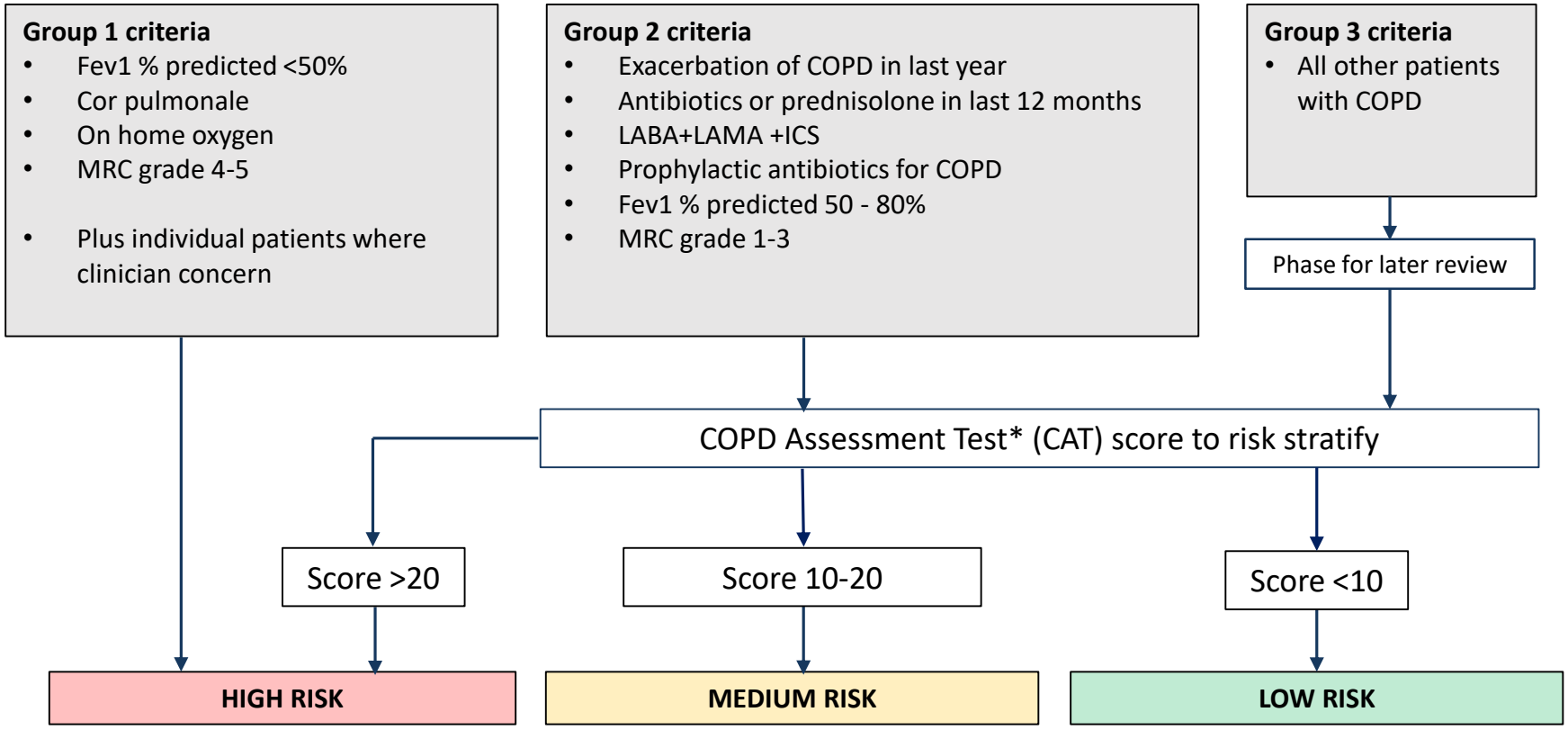
1 Identify & 2 Stratify

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
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

Type 2 Diabetes

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3. Long Term Condition Pathway: Type 2 Diabetes

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1 Identify & stratify

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

High risk	Medium risk	Low risk
High Risk • HBA1c>75 • eGFR <45 • Insulin or other injectables • Severe frailty • History of foot ulcer • Heart failure • MI or stroke/TIA in last 12 months • Metabolic syndrome • Social complexity — LD, SMI, housebound, homeless, alcohol or drug misuse • Under c/o community diabetes team • ?TBC Multimorbidity measure	**Moderate Risk** • HbA1c 58 -75 • BMI >35 • BP >140/90 • eGFR 45-60 • mild-mod frailty • Previous coronary heart disease or cerebrovascular disease or ED • Foot disease risk (PAD or • neuropathy) • Albuminuria • Retinopathy • >3 oral hypoglycaemics • ? TBC Multimorbidity measure	**Lower Risk** • HbAIC <58 • BMI <35 • Hypertension with BP <140/80 • No other features in high or mod risk groups

3. Long Term Condition Pathway: Type 2 Diabetes

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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	• **Medication:**
	  • Adherence
	  • Titrate as appropriate
	• **Monitoring**
	  • Blood sugar control
	  • Lipids/lipid lowering therapy
	  • BP and proteinuria
	• **Education (inc online tools)**
	  • Sick day rules
	  • DVLA guidance
	• **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
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		  • 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
			• **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

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/

Implementation Support

Key to achieving local ownership, scale & sustainability

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Implementation tools

Comprehensive search tools to identify and stratify patients with LTCs

Frameworks for local adaptation – risk stratification and interventions tailored to staff roles

Protocols and scripts to guide HCAs and other staff in consultations

Digital resources for patients and clinicians

Training and education to support the workforce to deliver this approach

UCLPartners implementation resources

- **Clinical team** including GPs, pharmacists
- **Project management**
- **Quality & capability and education expertise**
- **Commercial and innovation team** support for innovation implementation

Four principles:

Virtual by default	Mobilise the wider workforce	Step change in self management	Digital innovation

Illustrative Local Implementation Outline

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Local Kick-off Meeting

- Overview of framework with key stakeholders from across the local health system
- Agree adaptations to fit with local pathways, workforce and context
- Agree phasing of support package for high, medium, low risk patients
- Identify training needs and innovation support needs

Searches

Training to run the searches
Deployment – searches deployed and plan phasing for patient cohorts

Workforce Training & Support

Healthcare assistants/ staff to contact low risk patients

- How to use the protocols/scripts
- Practical support: teaching inhaler technique/ peak flow etc, using digital innovations
- Motivational interviewing and health coaching

Clinical Pharmacists

- Introduction to pathway/ approach
- Specialist training on specific conditions, e.g. asthma, COPD, diabetes

GP/ other specialist clinician

- Introduction to the approach as required
- Mobilising local education-appropriate sessions with e.g. local Training Hub, specialist clinicians

Communities of practice – to support learning, sharing, professional development (eg pharmacists, nurses, HCAs)

Learn and Evaluate

Work with local systems to learn from and adapt implementation of the framework

Work with partners to evaluate impact on care, self care and outcomes

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Thank you

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