Written evidence submitted by UCL Partners Academic Health Science Network (FGP0393)

1. I am Dr Matt Kearney. I am a GP of over 30 years' experience. I was the National Clinical Director for Cardiovascular Disease (CVD) Prevention in NHS England 2016-2019. In this role, I led development of the CVD prevention programme in the NHS Long-Term Plan with its central ambition to prevent 150,000 heart attacks, strokes and cases of dementia by optimising the detection and management of atrial fibrillation, high blood pressure and high cholesterol in primary care. I led development of *CVDprevent*, the new national primary care audit that has been taken up by 95% of practices in England. Since 2019 I have been Programme Director at UCLPartners Academic Health Science Network where we have developed the UCLP Proactive Care Frameworks to support primary care recovery and transformation as we emerge from the pandemic.

Introduction

2. General practice in the UK has many strengths, but it is a system under huge strain. COVID-19 has added substantially to that strain with widespread disruption to routine patient care. But as we emerge from the pandemic, we have a unique opportunity to consider how we might do things differently, to build a general practice for the future that is more suited to our patients' needs and our capacity. The UCLPartners Proactive Care Frameworks are now being adopted by Integrated Care Systems (ICSs) and Primary Care Networks (PCNs) across the country as a model to support transformation in the management of long-term conditions.

The Long-Term Condition Challenge

3. Long term condition management accounts for a substantial proportion of our work in primary care. For people with conditions such as hypertension, high cholesterol, type 2 diabetes, Chronic Pulmonary Obstructive Disease (COPD) and asthma, most care is provided by GPs and their teams. Management of these conditions is underpinned by NICE guidance with clear evidence-based recommendations on how to diagnose, investigate and treat. In all of these conditions there is robust evidence that optimal treatment prevents complications and exacerbations, admissions and premature death from heart attack, stroke and respiratory disease. The Quality and Outcomes Framework (QOF) was introduced to support General Practice to deliver optimal management and improve outcomes in these conditions. QOF resources have been used by practices to improve the organisation of care for patients, with increased multidisciplinary care using nurses, pharmacists, healthcare assistants and others.

4. Despite the improvements in care resulting from QOF, suboptimal treatment and late diagnosis remain common, with substantial variation between practices. For example, despite the extensive evidence that blood pressure treatment prevents heart attacks, around 30% of people with hypertension are undiagnosed and so are unaware of their heightened risk and the need for treatment. And once diagnosed, even before the pandemic around a third of people with hypertension were not treated to target, with substantial variation across the country. Indeed, the management of hypertension has made limited progress over the last 30 years with optimal treatment rates rising from 50% (the so-called 'rule of halves' I was taught in medical school) to just 70% (QOF 2019-20). Similar substantial undertreatment and variation is seen in other high impact and highly modifiable conditions such as high cholesterol, diabetes, asthma, COPD and chronic kidney disease.

5. Why does this sub optimal care persist despite QOF, NICE guidance, benchmarking data, local incentive and quality improvement schemes, professional development support, GP appraisals and Care Quality Commission inspections? To understand this it is critical to acknowledge that even with simple sounding interventions (check the blood pressure, do the blood test, prescribe a statin) management of

long-term conditions in real world primary care is difficult. GP consultations are time-pressured and complex. It is the norm for patients to have multiple conditions and a list of their own priorities to address. It is seldom realistic to do all that we need to do in 10 minutes. And patients with conditions such as high blood pressure, high cholesterol and chronic kidney disease usually have no symptoms to alert them that there is a problem.

The impact of COVID-19

6. Added to these historic challenges, the COVID-19 pandemic has considerably worsened care for patients, with severe disruption to routine care in long term conditions, with patients missing out on the regular assessment, testing and adjustments to treatment that keep them well and minimise exacerbations and complications. As an example, QOF data for 2020-21 shows that during the preceding year the percentage of patients on GP hypertension registers whose blood pressure was treated to target fell from 70% to 49%. If this is not addressed, modelling suggests that this will result in over 27,000 additional heart attacks and strokes in 3 years.
7. The imperative to restore routine primary care is very clear. But as we emerge from the pandemic, we also have the opportunity to rethink and transform the way we do things in primary care to address the historic challenges to delivering high quality care to our patients with long term conditions.

The UCLPartners Proactive Care Frameworks

8. UCLPartners is one of 15 Academic Health Science Networks (AHSN) in England. A key role of the AHSNs is to accelerate the translation of research evidence into practice and to support the adoption and spread of innovation in the NHS. To help address some of the historic challenges in primary care and to support transformation as we emerge from the pandemic, UCLPartners has developed a series of proactive care frameworks for the management of long-term conditions. The frameworks have been built by primary care clinicians with patient and public support. They focus on how to do things differently at scale to deliver quality care in real world primary care. The frameworks cover six conditions (atrial fibrillation, high blood pressure, high cholesterol, type 2 diabetes, asthma and COPD), with two more in development (heart failure and physical health in severe mental illness). All of the framework resources are free and easy to access.
9. The UCLP Proactive Care Frameworks take a population health management approach – with risk stratification, prioritisation and targeting of interventions, and support for the wider primary care workforce to personalise and optimise care:
    - Stratification and prioritisation based on clinical criteria, age, ethnicity and other factors: comprehensive search tools built for EMIS and SystmOne that allow GPs to identify patients in need of treatment optimisation and to safely prioritise clinical care.
    - Pathways (for local adaptation) and a range of resources that support pharmacists and nurses to manage long term conditions and optimise treatment and prevention.
    - Deployment of the wider workforce (for example healthcare assistants, wellbeing coaches and social prescribing link workers) to systematically support remote care and self-care, with delivery of structured interventions for education, self-management and lifestyle change. These are all elements of long-term condition management that impact on patient outcomes that historically we have struggled to do well in time-limited GP consultations. The frameworks include guides/protocols, training and a range of practical resources and digital tools for staff and patients.

Using the proactive care frameworks to do things differently in general practice

10. If we take hypertension as an example, a practice or PCN runs the automated searches in EMIS or SystmOne and this provides lists of patients in four priority groups. In a typical GP population, over half of patients on the hypertension register have a latest blood pressure (BP) that it is normal and GPs can be reassured that they do not need to see a clinician urgently. Around 18% have significantly high blood pressure and so need an urgent review, while a further 15% are not treated to target but are not in the urgent range and so their review can safely be phased over a realistic time. The stratification also identifies patients without a recent blood pressure reading so that a healthcare assistant or non-clinical staff member can contact them to obtain up to date readings.
11. In addition to the clinician review, the health care assistant or similar role provides a holistic proactive care consultation that can be phased over time. This includes using the framework resources to consult with the patient by text, video and face-to-face as needed, help to access BP testing at the surgery, support where wanted to buy a validated and affordable blood pressure monitor, help to understand their condition by signposting to education and shared decision-making information on the British Heart Foundation and HeartUK websites, sharing a video on how to use the BP monitor correctly, and delivering brief interventions and signposting for smoking cessation, physical activity and diet. Taking a holistic approach, the health care assistant can also refer to the social prescribing link worker or care coordinator where appropriate to help meet the patient's wider health and social needs.
12. This framework approach, with stratification, prioritisation and mobilisation of the wider workforce helps practices to safely manage demand and free up GP capacity, and it provides reassurance to clinicians that they are reaching the patients who need treatment optimisation while providing a more personalised approach to all patients with systematic support for self-management.

Adoption and spread

13. The UCLP Proactive Care Frameworks have been widely welcomed by GPs and their teams around the country. They are seen as grounded in real world primary care with a focus on 'how-to-do' rather than a reiteration of what-to-do guidance. In general, they are viewed by GPs not as a new ask but as a pragmatic support to restore business-as-usual primary care post COVID – in a way that improves care, helps meet QOF and other targets and frees up capacity.
14. There has been significant national uptake, with over 7,000 downloads of the search and stratification tools by practices across the country. NHS England has adopted the frameworks into a new national programme (Proactive Care @home) to support long term condition recovery and transformation, initially funding implementation in four pilot ICSs (North East London, North Central London, Cheshire and Merseyside and Leicester, Leicestershire and Rutland). A further 9 ICSs have now been recruited in wave 2 and will begin implementation as soon as the demand from Omicron and the vaccination programme settles. In addition, the national AHSN Network has been commissioned to deliver a new blood pressure optimisation programme across all ICSs, supporting local systems to transform management of hypertension, and prevent heart attacks and strokes at scale, by implementing the proactive care framework.
15. In supporting adoption and spread of innovation, it is critical to recognise that provision of frameworks and resources is not enough to transform care. Systematic support for implementation is essential if we are to avoid just creating more pockets of good practice and worsening the inverse care law. In deploying the Proactive Care Frameworks, ICSs and PCNs are drawing on implementation support from local AHSNs and NHS England working in partnership with UCLPartners. Learning from the pilots shows that critical elements of this support include building local clinical leadership to adapt, own and champion the frameworks; engagement with teams on the ground who will be working in new ways; workforce mapping and training; local operational support and project management; and system

engagement to align with workforce/primary care transformation strategies and local incentive schemes.

Summary

16. The UCLPartners Proactive Care Frameworks are a major innovation to help practices/PCNs to transform management of long-term conditions to prevent premature death and disability: risk stratifying to prioritise and target treatment optimisation; mobilising the wider workforce to deliver more personalised care and support for self-management; and freeing up GP capacity. The frameworks are achieving significant traction in primary care across the country as a new way of delivering care – not as an additional ask when GPs are overwhelmed, but as a solution to the problems of capacity and suboptimal care, not as a reiteration of what needs to be done, but as a framework for doing things differently and sustainably in real world primary care.

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