NHS RightCare – getting our priorities right

Professor Matthew Cripps, National Director
First Do No Harm

The first Atlas of Variation (2009) – destabilised complacency by highlighting huge and unwarranted variation in:

- Access
- Quality
- Outcome
- Value

Also revealed two other problems:

Overuse – leading to
- Waste
- Patient harm (even when the quality of care is high)

Underuse – leading to
- Failure to prevent disease
- Inequity
Awareness is the 1st step to population healthcare improvement

If the existence of clinical and financial variation is unknown, the debate about whether it is unwarranted cannot take place.
# NHS RightCare’s essentials of population healthcare

<table>
<thead>
<tr>
<th>Objective</th>
<th>Maximise Value</th>
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<tbody>
<tr>
<td>Principles</td>
<td>Get everyone talking about same stuff</td>
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<table>
<thead>
<tr>
<th>Phases</th>
<th>Where to Look</th>
<th>What to Change</th>
<th>How to Change</th>
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<table>
<thead>
<tr>
<th>Ingredients</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Clinical leadership</td>
<td>Indicative data</td>
<td>Engagement</td>
<td>Evidential data</td>
<td>Effective processes</td>
</tr>
</tbody>
</table>
Acceleration plan 2020/21

- Bradford CCG – Cardiovascular campaign resulting in saving of £1.6 million; 210 fewer deaths from stroke, 38,000 new people self-caring to manage hypertension – prototype for NHS RightCare CVD optimal pathway

- Ashford CCG – 30% reduction to acute MSK demand; 7% reductions in MSK spend through introduction of triage service – prototype for replication across other systems

- Slough CCG – new complex care case management service; 24% reduction in A&E demand; 17% reductions in non-elective admissions.

- Blackpool CCG – reduced demand from frequent callers by 89% (999 calls), 93% A&E attends, 82% admissions; saving £2 million – prototype for replication across systems
Heart disease pathway of a page – Why Bradford chose CVD

CVD = 95% confidence intervals

Initial contact to end of treatment

NHS Bradford City CCG
## Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

### The Interventions

<table>
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<tr>
<th>Cross Cutting</th>
<th>The Opportunities</th>
<th>The Evidence</th>
<th>The Risk Condition</th>
<th>Detection and 2°/3° Prevention</th>
</tr>
</thead>
</table>
| 1. NHS Health Check - systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk  
2. System level action to support guideline implementation by clinicians  
3. Support for patient activation, individual behaviour change and self management | 5 million undiagnosed. 40% poorly controlled  
30% undiagnosed. Over half untreated or poorly controlled | BP lowering prevents strokes and heart attacks  
Anticoagulation prevents 2/3 of strokes in AF  
Behaviour change and statins reduce lifetime risk of CVD  
Intensive behaviour change (eg NHS DPP) reduces T2DM risk 30-60% | Blood Pressure  
Atrial Fibrillation  
High CVD risk & Familial H/ cholesterol  
Non Diabetic Hyperglycaemia ('pre-diabetes')  
Type 1 and 2 Diabetes  
Chronic Kidney Disease | 50% of all strokes & heart attacks, plus CKD & dementia  
5-fold increase in strokes, often of greater severity  
Marked increase in premature death and disability from CVD  
Marked increase in Type 2 DM and CVD at an earlier age  
Marked increase in heart attack, stroke, kidney, eye, nerve damage  
Increase in CVD, acute kidney injury & renal replacement |
Spreading the impact

- West Hants CCG estimate 52 strokes averted though systematic support to improve GP management of AF.
- In Lambeth and Southwark pharmacist management in blood pressure and AF has improved control and contributed to averting 45 strokes
- Medway are re-designing entire CVD secondary prevention system to mirror the RightCare Optimal Pathway

- “This is a game changer” – BHF

- Atrial Fibrillation and Hypertension components converted into High Impact Interventions for all health economies
Closing the perception gap – Shared Decision Making and Health Literacy

• 70% of breast surgeons believe a primary concern of women with breast cancer is to keep their breast
  • The real number is 7% of informed women

• 95% of people with elective stents think they reduce risk of heart attack
  • They don’t (most informed people don’t want one)

• Vast majority of medics believe the primary concern for those with colorectal cancer is to get rid of the cancer
  • In reality, for many it is to maintain bowel function
  • How many? We don’t know! Why not? Because we haven’t sought either to inform the patients or to understand their preferences

• BHF study found that heart disease patients, with the lowest health literacy scores, die sooner

• US study shows that heart attack victims with lower health literacy are more likely to be readmitted within 30 days
Closing the perception gap

“It is far more important to understand the person who has the disease than it is to know what disease the person has”
Summary of RightCare programmes of care (count, from 207 CCGs)

- 799 programmes of care being transformed under the programme
- Actively supported by 20 Delivery Partners (soon to be 30) aligned to regions and a core national team
Further Information

www.england.nhs.uk/rightcare

@NHSRightCare

@Matthew_Cripps1
Linking Right Care and Self Care

Prof Alf Collins
Clinical Director,
Personalised Care Group,
NHS England

SC Conference. September 26th 2017
The system faces multiple overlapping challenges

- Over 50% of our population lives with a long term condition (LTC)
- 66% of people who are aged 65+ live with 2 or more conditions
- 70%+ of NHS spend is on treating people with LTC
The self care continuum

The self-care continuum

Pure self care
Responsible individual

Pure medical care
Professional responsibility

The self-care continuum

Daily choices
Lifestyle
Self-managed ailments
Minor ailments
Long-term conditions
Acute conditions
Compulsory psychiatric care
Major trauma

Healthy living
Minor ailments
Long-term conditions
In-hospital care

www.england.nhs.uk
Multimorbidity is the norm

<table>
<thead>
<tr>
<th>Condition</th>
<th>Single</th>
<th>Plus 1</th>
<th>Plus 2</th>
<th>Plus 3 or more</th>
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<tbody>
<tr>
<td>Hypertension (17,777)</td>
<td>4955</td>
<td>5116</td>
<td>3659</td>
<td>4047</td>
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<tr>
<td>Asthma (12,769)</td>
<td>2627</td>
<td>3215</td>
<td>1665</td>
<td>1680</td>
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<tr>
<td>Anxiety (7,962)</td>
<td>1078</td>
<td>1451</td>
<td>1522</td>
<td></td>
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<tr>
<td>Cancer (5,932)</td>
<td>1865</td>
<td>1700</td>
<td>1825</td>
<td></td>
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<tr>
<td>IBS (5,688)</td>
<td>1865</td>
<td>1700</td>
<td>1825</td>
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<tr>
<td>Diabetes (5,676)</td>
<td>829</td>
<td>1362</td>
<td>1926</td>
<td></td>
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<tr>
<td>Skin infections (5,086)</td>
<td>1945</td>
<td>1294</td>
<td>772</td>
<td>1075</td>
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<tr>
<td>CAD (4,695)</td>
<td>1084</td>
<td>1001</td>
<td>1904</td>
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<tr>
<td>Hypothyroidism (4,275)</td>
<td>981</td>
<td>1179</td>
<td>954</td>
<td>1161</td>
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<tr>
<td>Skin trauma (3,611)</td>
<td>1334</td>
<td>873</td>
<td>584</td>
<td>820</td>
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<tr>
<td>Stroke (2,665)</td>
<td>1334</td>
<td>873</td>
<td>584</td>
<td>820</td>
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<tr>
<td>Tendinitis (2,578)</td>
<td>739</td>
<td>742</td>
<td>512</td>
<td>585</td>
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<tr>
<td>Gastr signs symptoms (2,144)</td>
<td>724</td>
<td>548</td>
<td>378</td>
<td>494</td>
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<tr>
<td>COPD (1,989)</td>
<td>206</td>
<td>432</td>
<td>901</td>
<td></td>
</tr>
<tr>
<td>Breast disorders (1,951)</td>
<td>259</td>
<td>491</td>
<td>636</td>
<td></td>
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<tr>
<td>Fractures (1,546)</td>
<td>511</td>
<td>382</td>
<td>273</td>
<td>380</td>
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</table>
Number of LTCs *(and impact)* drives cost
40% of people with LTCs have low/no confidence to manage their health and wellbeing

15% of population

Level 1

Build Knowledge Base, Self-Awareness & Initial Confidence
- Understand condition and/or disease prevention basics and their role
- Become aware of own behaviors and symptoms
- Pursue small steps to build confidence

Level 2

Increase in Knowledge, Initial Skills Development
- Close any knowledge gaps
- Clearly understand the role they must play
- Focus on clinically meaningful behavior change through small steps
- Most behaviors will not yet achieve guideline level

Level 3

Skills Development, Gains in Knowledge
- Strive for behavior development consistent with guidelines
- Be self-aware and good at monitoring one's health and responding to changes
- Lifestyle behaviors come into stronger focus

Level 4

Maintaining Behaviors & Techniques to Prevent Remission
- Achieve guideline behaviors
- Maintain behaviors and learn to anticipate difficult situations
- Develop bounce back strategies
- Focus on closing gaps around nutrition, activity, and coping with emotions

Improved health

Increased self-management ability

Reductions in unwarranted utilization of services
If you live with LTCs, managing health and wellbeing is work/burden

The work of
• **Changing** lifestyle (to manage condition and prevent disease progression)
• **Adhering** to medication
• **Attending** medical appointments and co-ordinating care

Managing my condition(s)

Managing the **impact** of my conditions on my psychosocial wellbeing

The work of
• **Adjusting to** and **developing control** over changing identity and social role
2017 We have reached the limits of the biomedical model.

Undifferentiated need

Referral → Reassurance → Prescrioption
Person- and community-centred approaches

- Hospital
- Formal health and care setting
- Shared decision making
- Health centre
- GP
- Social prescribing
- Care and support planning
- Health coaching
- Self management support
- Volunteering health roles
- Bridging roles
- Timebanking
- Community Centre
- Personal budgets
- Community hubs
- Asset-based approaches
- Community
- Home
- Peer support
- Group-based activities

www.england.nhs.uk
An all age, whole population approach to personalised care and support

Target populations and outcomes

5%
~3m

People with complex needs
Intensive approaches to empowering people, integrating care and reducing unplanned service use

30%
~16m

People with long term physical and mental health conditions
Proactive approaches to supporting people to build knowledge, skills and confidence and to better manage their health conditions

100%
~54m

Whole population
Universal approaches to supporting people to stay well and building community resilience, enabling people to make informed decisions when their health changes.

Primary interventions

Specialist (Universal and targeted interventions plus):
Integrated personal commissioning including, proactive case finding and personalised care and support planning through Multi-Disciplinary Teams, Personal health budgets & integrated personal budgets

Targeted (Universal interventions plus):
Proactive case finding and personalised care and support planning through General Practice
Self-care support (including health coaching, self-management education and use of tools such as the Patient Activation Measure)

Universal
Shared Decision Making
Social prescribing and community connecting roles
Community capacity building

Increasing complexity
An integrated system that adds value to individuals lives. And creates value for the taxpayer
Thank you

Alf.collins@nhs.net
Self Care. 26th September 2017