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

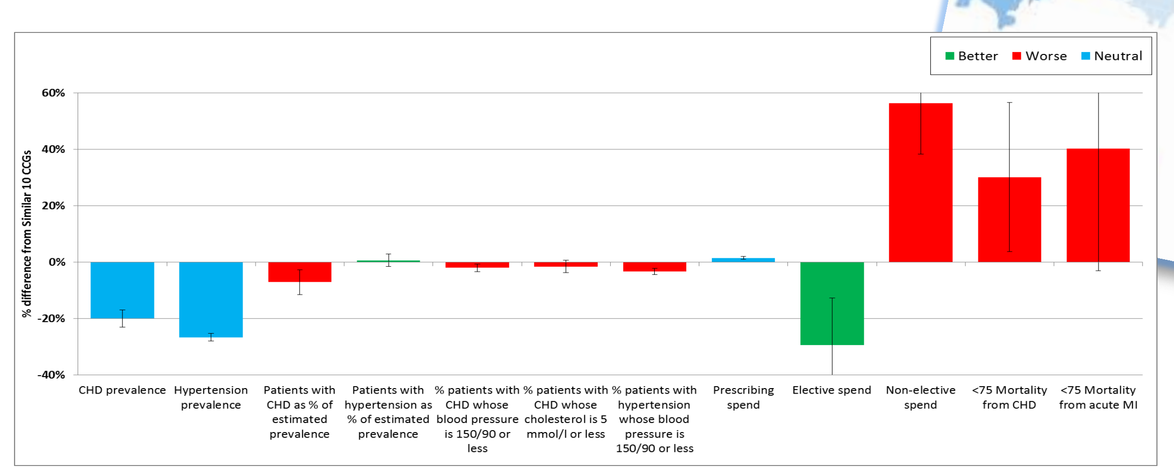
NHS

November 2011

The NHS Atlas of Variation in Healthcare

Reducing unwarranted variation to increase value and improve quality

www.rightcare.nhs.uk



NHS RightCare's essentials of population healthcare

Objective	Maximise Value			
Principles	Get everyone talking about same stuff	Talk about fix and future	Demonstrate viability	Isolate reasons for non-delivery

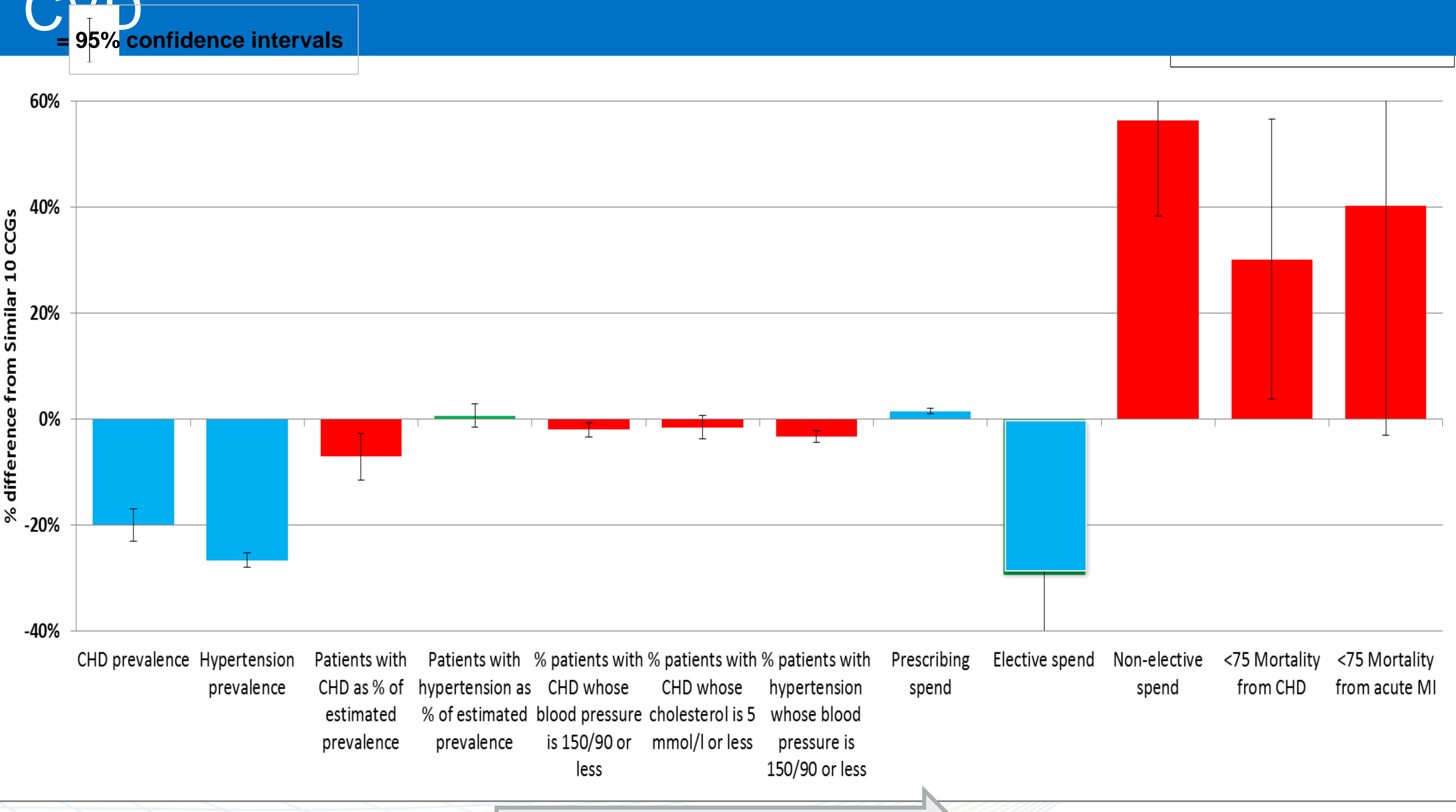
Phases	Where to Look	What to Change	How to Change

Ingredients	1 Clinical leadership	2 Indicative data	3 Engagement	4 Evidential data	5 Effective processes

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 trough 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 £2million – prototype for replication across systems

Heart disease pathway of a page – Why Bradford chose CVD



NHS Bradford City CCG

Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

The Interventions	High BP detection and treatment	AF detection & anticoagulation	Detection, CVD risk assessment, treatment	Type 2 Diabetes preventive intervention	Diabetes detection and treatment	CKD detection and management
Cross Cutting:	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					
The Opportunities	5 million un-diagnosed. 40% poorly controlled	30% undiagnosed. Over half untreated or poorly controlled	85% of FH undiagnosed. Most people at high CVD risk don't receive statins	5 million with NDH. Most do not receive intervention	940k undiagnosed. 40% do not receive all 8 care processes	1.2m undiagnosed. Many have poor BP & proteinuria control
The Evidence	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%	Control of BP, HbA1c and lipids improves CVD outcomes	Control of BP, CVD risk and proteinuria improves outcomes
The Risk Condition	Blood Pressure	Atrial Fibrillation	High CVD risk & Familial H/ cholesterol	Non Diabetic Hyperglycemia ('pre-diabetes')	Type 1 and 2 Diabetes	Chronic Kidney Disease

Detection and 2°/3° Prevention

The Outcomes	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

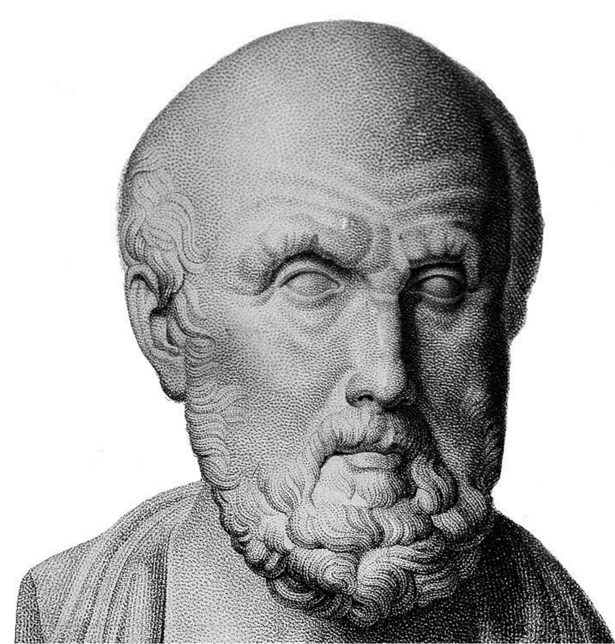
- 95% of people with elective stents think they reduce risk of heart attack
  - They don't (most informed people don't want one)

- 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)

140
120
100
80
60
40
20
0

MSK
Respiratory
Circulation Problems
Neurological
_ndocrine, Nutritional & Metabolic Problems
Gastro-intestinal
Cancers & Tumours
Trauma and Injuries
Cross Cutting
Complex Patients
Mental Health
Genitourinary conditions
Gastroenterological conditions
Maternity and Early Years
CHC
Problems of the Skin
Genitourinary conditions
Maternity & Reproductive Health

- 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

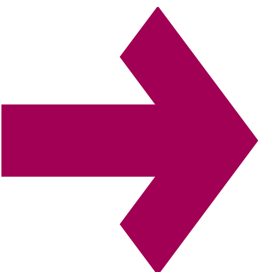
Linking Right Care and Self Care

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

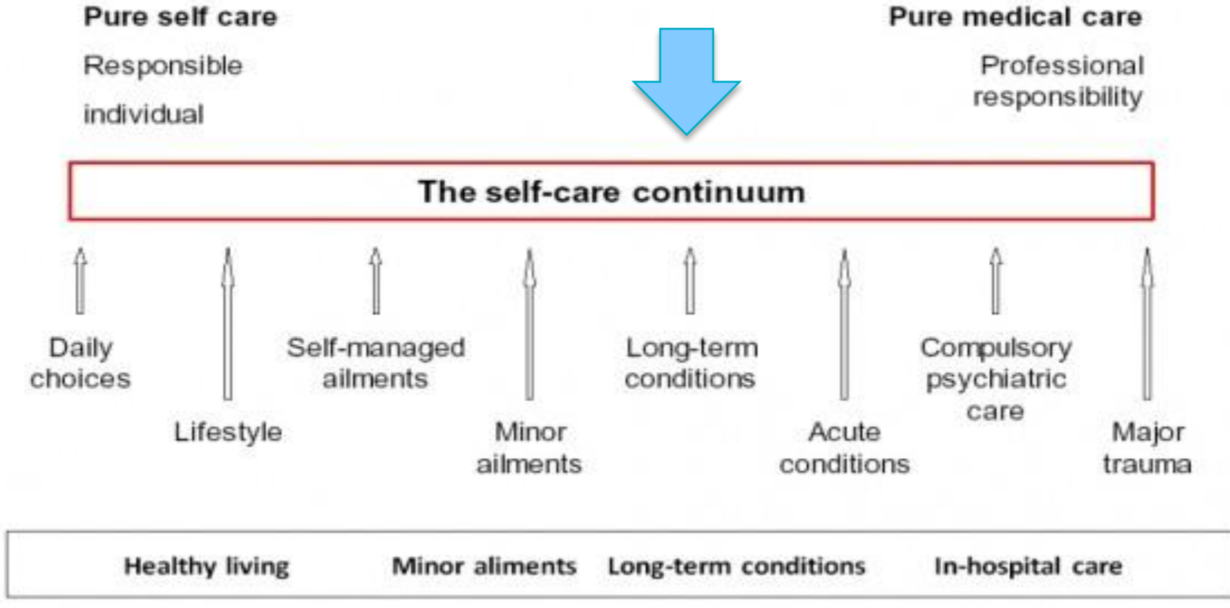
SC Conference. September 26th 2017

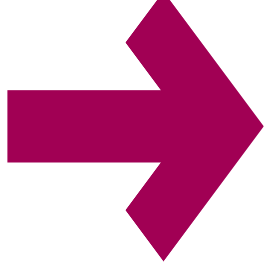
The system faces multiple overlapping challenges

- 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





Multimorbidity is the norm

Patients with one and multiple ETGs

	single	plus 1	plus 2	plus 3 or more
Hypertension (17,777)	4955	5116	3659	4047
Asthma (12,769)	6209	3215	1665	1680
Anxiety (7,962)	2627	2362	1451	1522
Cancer (5,932)	1078	1620	1409	1825
IBS (5,688)	1865	1700	1073	1050
Diabetes (5,676)	829	1559	1362	1926
Skin infections (5,086)	1945	1294	772	1075
CAD (4,695)	706	1084	1001	1904
Hypothyroidism (4,275)	981	1179	954	1161
Skin trauma (3,611)	1334	873	584	820
Stroke (2,665)	269	595	641	1160
Tendinitis (2,578)	739	742	512	585
Gastr signs symptoms (2,144)	724	548	378	494
COPD (1,989)	206	450	432	901
Breast disorders (1,951)	259	565	491	636
Fractures (1,546)	511	382	273	380

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Percentage and number of patients

Number of LTCs *(and impact)* drives cost

Average costs for patients with diabetes by setting and number of other ETGs

Diabetes: N= 829
plus 1: N=1,529
plus 2: N=1,362
plus 3: N= 898
plus 4: N= 527
plus 5: N= 279
plus 6 or more: N= 222

Average cost per patient (£)

£12,000
£11,000
£10,000
£9,000
£8,000
£7,000
£6,000
£5,000
£4,000
£3,000
£2,000
£1,000
£0

diabetes
plus 1
plus 2
plus 3
plus 4
plus 5
plus 6 or more

Number of ETGs

cc
sc
cm
mh
ae
op
ip
pc

40% of people with LTCs have low / no confidence to manage their health and wellbeing

25% of population

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

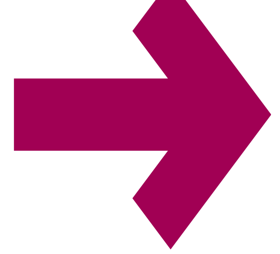
Maintaining Behaviors & Techniques to Prevent Remission

- 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 unwarrented utilization of services



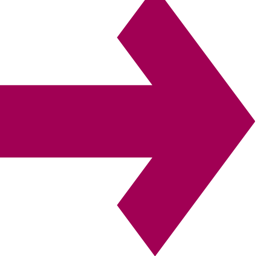
If you live with LTCs, managing health and wellbeing is *work/burden*

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



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FRUSTRATION IDENTITY STIGMA fear loneliness HOPE LOSS GRIEF guilt self

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2017 We have reached the limits of the biomedical model.

Reassurance

Referral

Prescription

DOCTOR

Undifferentiated need

Person- and community- centred approaches

Hospital

GP

Social prescribing

Formal health and care setting

Shared decision making

Care and support planning

Health coaching

Health centre

Self management support

Peer support

Community Centre

Group-based activities

Care Home

Volunteer health roles

Bridging roles

Timebanking

Community

Personal budgets

Home

Community hubs

Asset-based approaches

An all age, whole population approach to personalised care and support

Target populations and outcomes

Primary interventions

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

5%
~3m

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

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

30%
~16m

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)

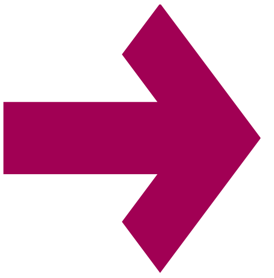
Whole population
Universal approaches to supporting people to stay well and building community resilience, enabling people to make informed decisions when their health changes.

100%
~54m

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

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Self Care. 26th September 2017