NHS RightCare - Delivering Optimal Healthcare in England

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National Director, NHS RightCare
What is NHS RightCare?

RightCare is a methodological approach to reducing unwarranted variation that provides local health economies in the NHS with:

- a robust starting point - indicative data
- an effective system of engagement for all stakeholders
- a means of encouraging and focussing clinical leadership
- a step-by-step business process to build the case for change
- a clear prioritisation and decision making process
- clinical pathway redesign tools
- enhanced implementation capability
- substantially improved health outcomes, value and financial sustainability
What are we trying to achieve?
Reduce the range of variation, Improve the mean
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
NHS RightCare’s essentials of population healthcare

<table>
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<tr>
<th>Objective</th>
<th>Maximise Value</th>
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<td>Principles</td>
<td>Get everyone talking about same stuff</td>
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<th>Phases</th>
<th>Where to Look</th>
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<td>1</td>
<td>Clinical leadership</td>
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<td>2</td>
<td>Indicative data</td>
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<td>3</td>
<td>Engagement</td>
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<td>Evidential data</td>
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<td>5</td>
<td>Effective processes</td>
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The 1st principle of population healthcare improvement

Awareness is the first step towards improvement –

If the existence of clinical and financial variation is unknown, the debate about whether it is unwarranted cannot take place.
Diabetes in Slough

Outcomes Versus Expenditure (DOVE) Tool - Diabetes quadrant chart 2013/14

Data:
Total spend on diabetes prescribing compared to people with diabetes with a HbA1c of 59mmol/mol or less in the TVSCN area
Diabetes in Slough

- Higher numbers of non-elective admissions associated with diabetes and spent more on prescribing for conditions resulting from complications in poorly controlled cases of diabetes
- Spent less on prescribing anti-diabetic items
- Control of diabetes was less effective in terms of HbA1c, blood glucose, blood pressure and cholesterol levels
- Worst in England for supported self-care
- Following primary care pathway reform –
  - Of known patients with pre-diabetes, 100% saw a reduction in their HbA1c levels
  - Of the patients with type 2 diabetes, 89% saw a reduction in their HbA1c levels
  - Significant increase in the number of patients whose diabetes was controlled
  - Increase from 72.25% to 80.06% of known patients whose blood pressure was <140/80
  - Now the best in England for supported self-care (15 months)
GP Chair, Slough Local Health Economy

• “It was NHS RightCare that gave us the impetus to make the commitment to deliver that performance. It had the data, it had the process to tell us how to achieve this, and the method that appealed to the GPs”
Examined causes of non-elective admissions, A&E attends and costs.

Identified unique cohorts of patients as highest risk of emergency admission:

- CHF & CRF
- CHF & COPD
- Diabetes, CHF & CRF
- Diabetes, IHD & CRF

Commissioned additional regular primary care contacts for at risk population and, via system-wide MDTs, developed care plans with the patient

- 28% reduction in targeted non-elective admissions (34% reduction in spend)
- 28% reduction in targeted A&E attends (31% reduction in spend)
- Now being spread across East Berkshire CCGs and wider STP footprint
So what did Slough do that we should all do?

- When faced with variation data, don’t ask:
  - How can I justify or explain away this variation?

- Instead, ask:
  - Does this variation present an opportunity to improve?
Heart disease pathway of a page – Why Bradford chose CVD

= 95% confidence intervals

% difference from Similar 10 CCGs

CHD prevalence
Hypertension prevalence
Patients with CHD as % of estimated prevalence
Patients with hypertension as % of estimated prevalence
% patients with CHD whose blood pressure is 150/90 or less
% patients with CHD whose cholesterol is 5 mmol/l or less
% patients with hypertension whose blood pressure is 150/90 or less
Prescribing spend
Elective spend
Non-elective spend
<75 Mortality from CHD
<75 Mortality from acute MI

Initial contact to end of treatment

NHS Bradford City CCG
Bradford Healthy Hearts

- Variation - 7\textsuperscript{th} worst mortality rate for CVD <75 years old
- 28\% of all deaths amongst <75 year olds
- Programme overview - Statin Switches, Hypertension, Stroke prevention
  - Over 6000 on simvastatin with total cholesterol >4 mmol/l or LDL >2 mmol/l (no direct comparison of simvastatin vs atorvastatin)
  - Converted to only two doses of statin (40mg and 80mg atorvastatin) as per ACC guide (greater benefits since NNT=62 for moderate/high intensity cholesterol management vs. NNT=156 for low intensity)
- Switched 6,000 patients (completed in 3 months)
- Improved mortality – including 210 less deaths last year (£1.6M)
- 17,000 people helped, either better or for the first time
- 32,000 people monitoring BP remotely
**Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care**

### The Interventions

| 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 |

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<td><strong>High BP detection and treatment</strong></td>
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<td><strong>AF detection &amp; anticoagulation</strong></td>
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<td><strong>Detection, CVD risk assessment, treatment</strong></td>
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<td><strong>Type 2 Diabetes preventive intervention</strong></td>
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<tr>
<td><strong>Diabetes detection and treatment</strong></td>
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<td><strong>CKD detection and management</strong></td>
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### The Opportunities

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<td>5 million un-diagnosed. 40% poorly controlled</td>
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<td>30% undiagnosed. Over half untreated or poorly controlled</td>
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<tr>
<td>85% of FH undiagnosed. Most people at high CVD risk don't receive statins</td>
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<td>5 million with NDH. Most do not receive intervention</td>
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<td>940k undiagnosed. 40% do not receive all 8 care processes</td>
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<td>1.2m undiagnosed. Many have poor BP &amp; proteinuria control</td>
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### The Evidence

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<td>BP lowering prevents strokes and heart attacks</td>
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<td>Anticoagulation prevents 2/3 of strokes in AF</td>
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<td>Behaviour change and statins reduce lifetime risk of CVD</td>
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<td>Intensive behaviour change (eg NHS DPP) reduces T2DM risk 30-60%</td>
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<td>Control of BP, HbA1c and lipids improves CVD outcomes</td>
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<tr>
<td>Control of BP, CVD risk and proteinuria improves outcomes</td>
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### The Risk Condition

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<td><strong>Blood Pressure</strong></td>
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<td><strong>Atrial Fibrillation</strong></td>
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<td><strong>High CVD risk &amp; Familial H/cholesterol</strong></td>
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<td><strong>Non Diabetic Hyperglycaemia ('pre-diabetes')</strong></td>
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<td><strong>Type 1 and 2 Diabetes</strong></td>
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<td><strong>Chronic Kidney Disease</strong></td>
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### Detection and 2°/3° Prevention

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<td>50% of all strokes &amp; heart attacks, plus CKD &amp; dementia</td>
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<td>5-fold increase in strokes, often of greater severity</td>
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<td>Marked increase in premature death and disability from CVD</td>
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<td>Marked increase in Type 2 DM and CVD at an earlier age</td>
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<td>Marked increase in heart attack, stroke, kidney, eye, nerve damage</td>
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<td>Increase in CVD, acute kidney injury &amp; renal replacement</td>
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**NHS RightCare**
Spreading the impact

- West Hampshire estimate 52 strokes averted though systematic support to improve GP management of AF.
- In Lambeth and Southwark (in London), pharmacist management in blood pressure and AF has improved control and contributed to averting 45 strokes.
- Medway in Kent are re-designing the entire CVD secondary prevention system to mirror this NHS RightCare Optimal Solution.
- The hypertension and atrial fibrillation components will be copied in every part of the NHS in England in 2017, via the NHS RightCare approach.
- “This is a game changer” – British Health Foundation.
Helps to tick lots of boxes within same effort – Blackpool & Fylde CCGs

• Advanced paramedic project significantly reduced frequent calling and delivered –

  • Quick win (98% reduction in targeted 999s)
  • Immediate saving (£2.7m FYE)

• Parity of Esteem & patient empowerment
• Integrated Care/ multi-agency working
• Care planning & Long Term Conditions management & care closer to home
• Demand management
• Reduced pressure on urgent and OOH social care

• 36 LHEs actively seeking to replicate (and growing)
More to come from NHS RightCare

- NHS RightCare wave 1 roll out commenced February 2016
  - 65 CCGs, 10 Delivery Partners (now >200 improvement programmes active)
- Wave 2 (the rest of England) now active

- Now a further expansion to increase focus and pace, including
  - RightCare Optimal Solutions
  - High impact quick wins
  - Hot-house replication
  - Improvement processing expertise and support
  - Partnerships – social care, charities, clinical colleges
  - Knowledge transfer
Knowledge Transfer

- Academia
  - Warwick Business School
  - Oxford University
  - Salford University
  - London School of Economics
  - Manchester Met Business School
- Manchester Airport
- McLaren Formula 1
- CIPFA, CIMA, HFMA (finance management)
- Clinical Colleges (best practice)
- Euler Hermes
- Pfizer
And why does it matter?
Population healthcare: The variation between standard and optimal pathways

Janet’s story: Frailty
Janet’s story: Journey 1

- Janet is 84 - a retired teacher living with her 85 year-old husband Arthur
- On a Friday evening, Janet falls. Arthur calls 999. Janet is taken to A&E
- She is given a hip x-ray. There is no fracture but blood and urine tests show UTI and dehydration, so she is admitted to an acute medical ward
- The next day (Saturday) she is moved to a general medical ward
- After the weekend, Janet is assessed as having postural hypotension
- In 2014/15 there were 2,154 serious falls (per 100k population) in the average CCG
- Due to a lack of available beds in the community, Janet is moved to a winter escalation ward in the hospital. She falls again in the ward. As a result she is no longer fit for rehabilitation and requires a care package
- This is put in place almost three weeks after admittance and she is finally discharged.
- 10 days in a hospital bed leads to the equivalent of 10 years of ageing in the muscles for people over 80
- Seven months later, Janet falls again and, after discharge from hospital, goes into a care home. After rapid deterioration and another fall, she returns to acute care and after 10 days on the intensive care ward, she passes away aged 85.

This version of Janet’s journey costs £35k at 2015/16 prices
Janet’s story: Journey 2

• Janet’s journey begins four years earlier when, aged 80, she and Arthur are visited by the Fire Service. As well as helping with fire prevention, they conduct a gait speed test on Janet and Arthur and deem Janet to show early signs of frailty. They provide her with the Practical Guide to Healthy Ageing and put her in contact with a local charity that runs exercise classes for the over 80s which Janet enjoys.

• Five years on she remains well and engaged in the local community but is beginning to feel frail. She visits her GP who diagnoses moderate frailty and refers the system-wide multi-disciplinary team to her. The team assess her needs, make her home ‘frailty-friendly’, optimise her medication and engage her in the local Memory Service. This culminates in a jointly agreed personalised frailty and dementia care plan.

• Two years later, aged 87, Janet falls. The out of hours GP visits, armed with her care plan and aware of her personal preferences. Via discussion with Janet, Arthur and – by phone – the on-call case management team leader, they agree how to manage the situation, without recourse to A&E or a hospital bed. Instead the new Community Geriatric Rapid Access Clinic is used.

• A year later, Janet falls again and this time does have a hospital stay but returns home quickly, with a support package. 11 months on, aged 89, Janet passes away.

Journey 1 cost £35k
Journey 2 cares for Janet much better and costs only £19k
For further information -

- Email RightCare
- rightcare@nhs.net

- Twitter:
  - @nhsrightcare
  - @matthew_cripps1

- Visit RightCare:
  - http://www.england.nhs.uk/rightcare/