NHS RightCare

NHS RightCare – improving population healthcare through better patient outcomes

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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 and Patient harm (even when the quality of care is high)

Underuse – leading to

- Failure to prevent disease and Inequity

Evolution of NHS RightCare

- Atlases of Variation & Health Improvement Packs
- **Clinical Engagement**

- Improvement processing

- **Clinical leadership**
- Evidential and Indicative data - Triangulation of variation – Where to Look
- Intelligence packs

- Knowledge transfer and shared learning
- National mandate and industrialisation

NHS RightCare's essentials of population healthcare

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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

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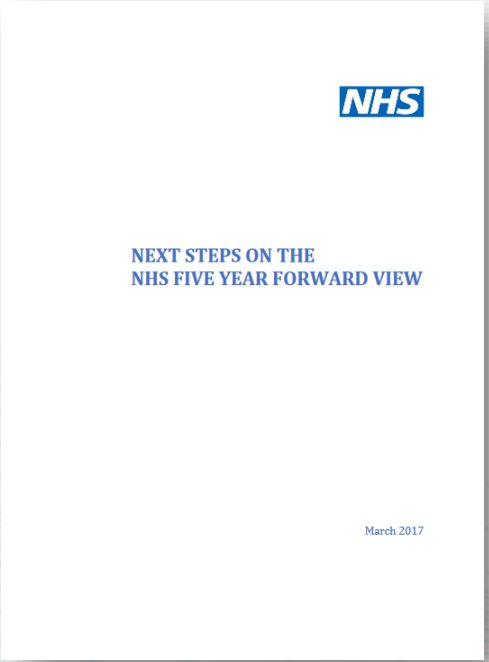
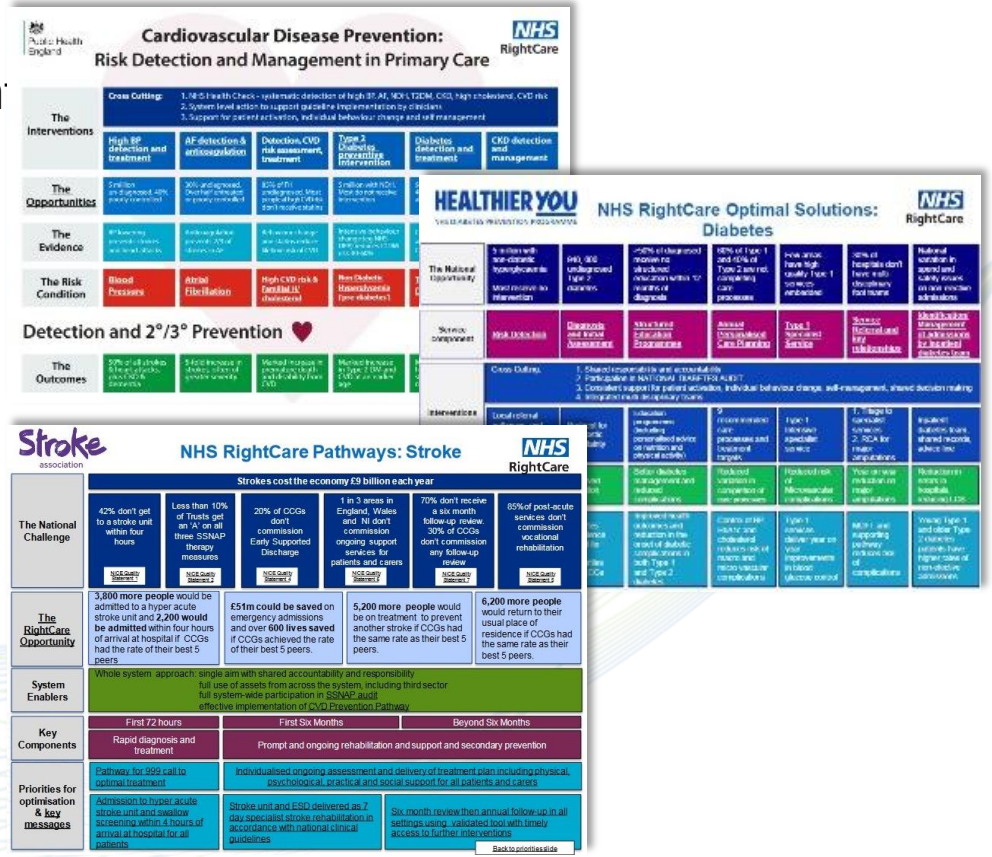
Acceleration plan 2020/21



- 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
- Vale of York CCG – Musculoskeletal pathway ensuring patients are referred for appropriate lifestyle interventions and provision of support for GPs to improve their knowledge and skills. This has resulted in savings of £1.3m in 2016/17 and estimated savings of £1.1m in the first quarter of 2017/18.
- 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

NHS RightCare Pathways

- Cardiovascular disease preven
- Diabetes
- Stroke
- Falls & Fragility Fractures



ACS example: Musculoskeletal Triage

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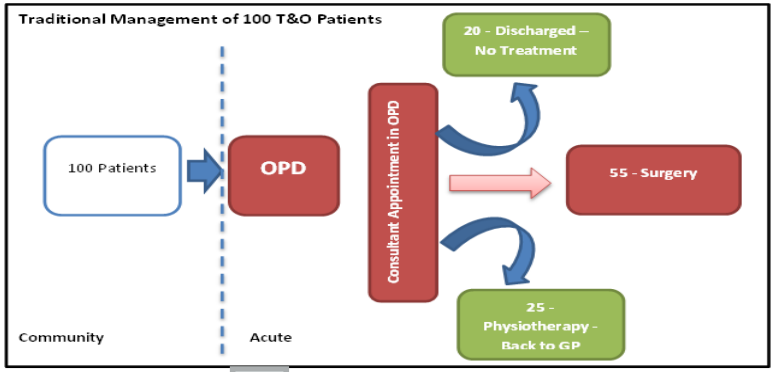
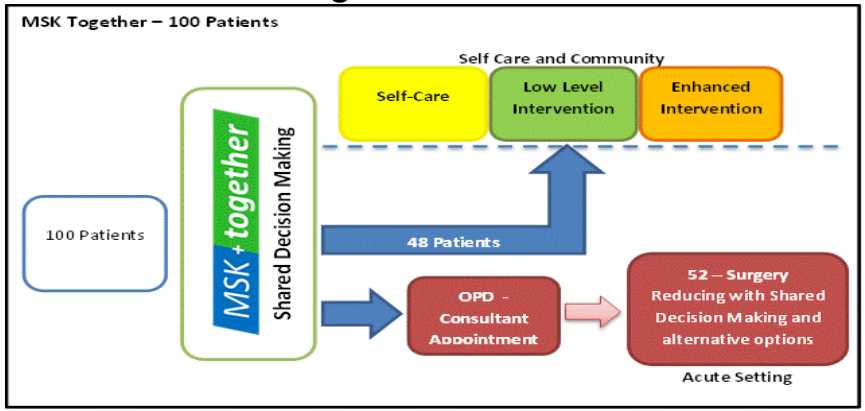


- South Yorkshire & Bassetlaw (SYB) implementation of an Musculoskeletal (MSK) triage service.
- MSK Together programme
  - triage mechanism keeps patients out of hospital who don't need to be there
  - better value than traditional models of care
- Savings across the footprint by 2019/20 will be £5m+ on this pathway alone, by supporting patients better and making decisions with them



CROC

There are c. 12,400 beds in use at any point in time, containing people that appear at the unwarranted end of the variation range.

Note – this is only vs 75th %ile, the no. is much higher vs optimal

There are also 1,000,000+ people undetected with at least one of CHD, AF, COPD, CKD or hypertension.

It would be very surprising if there is no correlation. And the money available to fund better detection and subsequent secondary prevention is tied up paying for the activity in those 12,400 beds

What are the principles?

Archie Cochrane –

Cochrane was a PoW in WWII and was made to be the camp doctor. One night he treated a Russian pilot who was dying. The pilot was screaming and Cochrane misdiagnosed that he needed morphine. He had none and had to innovate. With little equipment he finally took the dying man in his arms to comfort him. The pilot immediately stopped screaming and died peacefully a few hours later.

Cochrane realised that clinicians often make wrong decisions, based on the availability of and access to equipment, drugs and capacity. In short, if the system supplies, clinicians will use, whether the optimal treatment option or not. **This is supply-driven demand** and was the catalyst for Cochrane's life's work.

Our aim, and a key purpose of CROC, is to supply the clinical community with the optimal equipment and re-allocate the sub-optimal to do so.

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What are the principles?

- It is NOT just about closing beds – hence Re-allocating Capacity, not Closing Capacity
- It is about surrounding our clinicians with the equipment and resources they need to deliver optimal healthcare for the population
- And when the starting position includes equipment and resources that are sub-optimal, moving from one to the other requires a coordinated system-wide approach
- This is CROC

CROC Opportunity – Northumberland Tyne and Wear, North Durham STP

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CCG Name	Bed Days Opportunity	Beds		CHD Detection Opportunity	Hypertension Detection Opportunity	COPD Detection Opportunity	CKD Detection Opportunity	Atrial Fibrillation Detection Opportunity	Total Detection opportunity
NHS NORTH DURHAM CCG	25,261	69						469	469
NHS NORTHUMBERLAND CCG	62,063	170							-
NHS SOUTH TYNESIDE CCG	40,806	112			1,517	216	2,231	260	4,224
NHS SUNDERLAND CCG	19,383	53				1,042		296	1,338
NHS NEWCASTLE GATESHEAD CCG	89,091	244		4,006	7,283	3,964		850	16,103
NHS NORTH TYNESIDE CCG	27,041	74			1,938	2,168		323	4,429
STP total	**263,645**	**722**		**4,006**	**10,738**	**7,390**	**2,231**	**2,198**	**26,563**

Detection opportunity is included to highlight the likely correlation between detection, and subsequent secondary prevention support, and overuse of bed days in secondary care.

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Why STPs?

Programme of care	Bed days opportunity	Beds	Beds by CCG programme of care					
Northumberland, Tyne and Wear STP			**NEWCASTLE GATESHEAD**	**NORTH DURHAM**	**NORTH TYNESIDE**	**NORTH-UMBERLAND**	**SOUTH TYNESIDE**	**SUNDERLAND**
Cancer and Tumours	48,292	132	28	10	25	31	12	27
Circulation	24,125	66	18	13	10	17	8	0
Endocrine	7,391	20	6	3	1	2	5	4
Gastro	25,845	71	28	10	3	13	14	2
Genitourinary	30,891	85	33	2	10	15	17	7
MSK	16,368	45	21	8	2	8	4	3
Neurological	25,009	69	34	2	3	22	8	0
Respiratory	46,881	128	45	12	12	20	29	10
Trauma and injuries	38,841	106	31	9	8	42	15	0
	263,643	**722**	**244**	**69**	**74**	**170**	**112**	**53**

North Tyneside's share = 74 beds. Of which 3 are in Gastro.

Acute providers will say they can't easily remove just 3 beds without working across the system. However, when looked at across the STP, it is 71 beds or 3 wards.

And re-allocating that capacity and funding becomes far more feasible.

Articulating the Impact of Change - Logic Models

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Activity and Finance impact analysis forces you to define the miracle

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Knowledge Transfer

- GIRFT
- Academia
  - Warwick Business School
  - Salford University
  - Oxford University
  - LSE
  - Manchester Met Business School
- Clinical Colleges and national charities (best practice)
- Manchester Airport
- McLaren F1
- CIPFA, CIMA, HFMA (financial sustainability)
- Euler Hermes
- Pfizer

DIY Knowledge Transfer - LTCs

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Multi-Pathways on a page

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	Prevention & Public Health	Estimated Prevalence	Detection	Primary Care Management	Self Care	Prescribing	Elective	Non-Elective	Step-up/ Step-down	Rehab	Outcome	End of Life
Breast Cancer						▲	▲					
Lower GI Cancer							▲					
Lung Cancer							▲					
Neurological						▲	▲					
Serious Mental Illness						▲						
Common mental health disorders						▲						
Dementia						▲						
CHD						▲	▲					
Stroke						▲	▲					
Diabetes						▼						
Renal						▲	▲					
COPD						▲						
Asthma						▲						
Musculoskeletal			▲			▲	▲					
Frailty			▲									
Multiple Conditions												

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Knowledge Transfer – a lesson from history:

What happens when you don’t use NHS RightCare?

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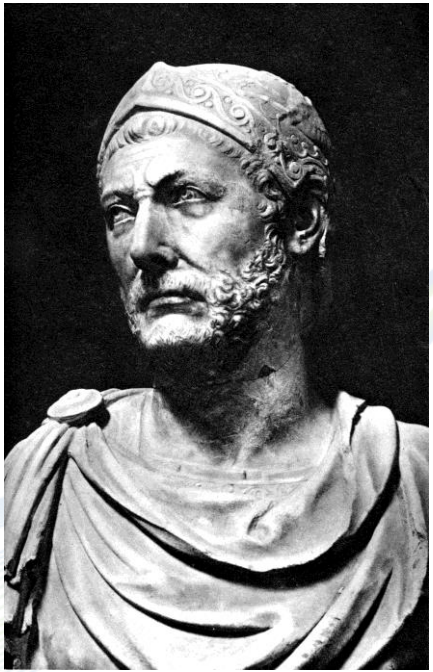
What can Hannibal’s elephants and the Carthaginians teach us about healthcare improvement?

Quite a surprising amount

<u>Positive</u>

Improvement agenda – Imagine, Design, Build

- Creative optimal design – let's defeat the Romans with elephants!
- Innovative problem solving – e.g. how do we get the elephants across the rivers Rhone and Rubicon? Answer = elephant rafts!



<u>Negative</u>

- But more importantly for our population healthcare agenda – what happens if you have unwarranted variation in:

  Detection – Primary prevention – Secondary prevention

The Second Punic War (218 – 201BCE)

The Carthaginians (modern day Tunisia) were the power in the Mediterranean basin

<u>IDENTIFICATION OF RISK-FACTOR AND SECONDARY PREVENTION</u>

- Young upstart building a power base
- Needed putting in their place –
  - Rome…

- Pretence for war
  - Carthage accused Rome of unwarranted variation in their trading
  - Gave an impossible ultimatum
  - Declared war when Rome refused

- General Hannibal was given whatever he wanted to attack Rome -
  - Carthage were willing to pump prime secondary prevention to avoid future acute exacerbation….

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He wanted elephants…

Primary prevention

- But before Hannibal, let's do a lessons learned review to see if Carthage missed any detection and primary prevention opportunities…

- By about 800BCE, Carthage had been founded by Queen Dido

- Meanwhile, over in modern day Turkey –
  - Trojan War ending: Prince Aeneas was leading an escape from Troy
  - These Trojan refugees landed in Carthage and were taken in by Dido

Then ensued Purcell's opera – Dido and Aeneas

Lessons learned review - Detection and Primary Prevention

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RISK FACTOR & DETECTION OPPORTUNITY

Whilst he was there, the gods warned Dido that Aeneas's descendants would found Rome and Rome would destroy Carthage

PRIMARY PREVENTION FAILURE

Blinded by love, she let Aeneas and his refugees go and killed herself from sorrow at his departure

Had she paid attention to the gods, she could have prevented Rome ever happening

Back to Hannibal & Secondary Prevention

The war is going well for Carthage – until immediately after…**THE BATTLE OF CANNAE (2 August 216BCE)**

Still studied at Sandhurst as an example of missing the perfect opportunity, and the consequences that can follow.

It also shows that the only thing we learn from history is that we don't learn from history - the Allied forces repeated the exact same mistake on D-Day

At Cannae –

- All available Roman soldiers had been sent
- The Carthaginians annihilated the Roman army
- This meant no soldiers in Rome and none between the Carthiginians and the city.

- There wouldn't be another opportunity to march on a defenceless Rome and destroy it for another 636 years when the Visigoths managed it.

So, what did Hannibal do?

He just sat still and did nothing.

Why?

Fear? Disbelief that it could be this easy? Crisis of confidence?

Lack of a robust programme plan? Inflexible strategy? Had to propose it through three committees and then the Board before he could act?

No one knows for sure.

But we do know what happened next….

Secondary prevention failure – acute exacerbation

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- Hannibal finally marched on Rome but
  - The Roman armies stationed elsewhere had rushed home and the city was defended again.

What was the long-tem consequence that occurred due to this lack of secondary prevention?

ACUTE EXACERBATION – negative population health impact

- Carthage eventually lost the war
- Rome invaded Carthage, destroyed the city and enslaved the population.
- It was the end of Carthage and Rome dominated for 600 years.

Moral of the story

If we miss our detection, primary and secondary prevention opportunities then far more acute and costly things happen that might have been avoided… and that might be the end of us….

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For more information and support about how to use the NHS RightCare approach to get best value for your population, go to www.england.nhs.uk/rightcare or email us at rightcare@nhs.net

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