NHS RightCare
Achieving The Right Approach

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12th July 2018

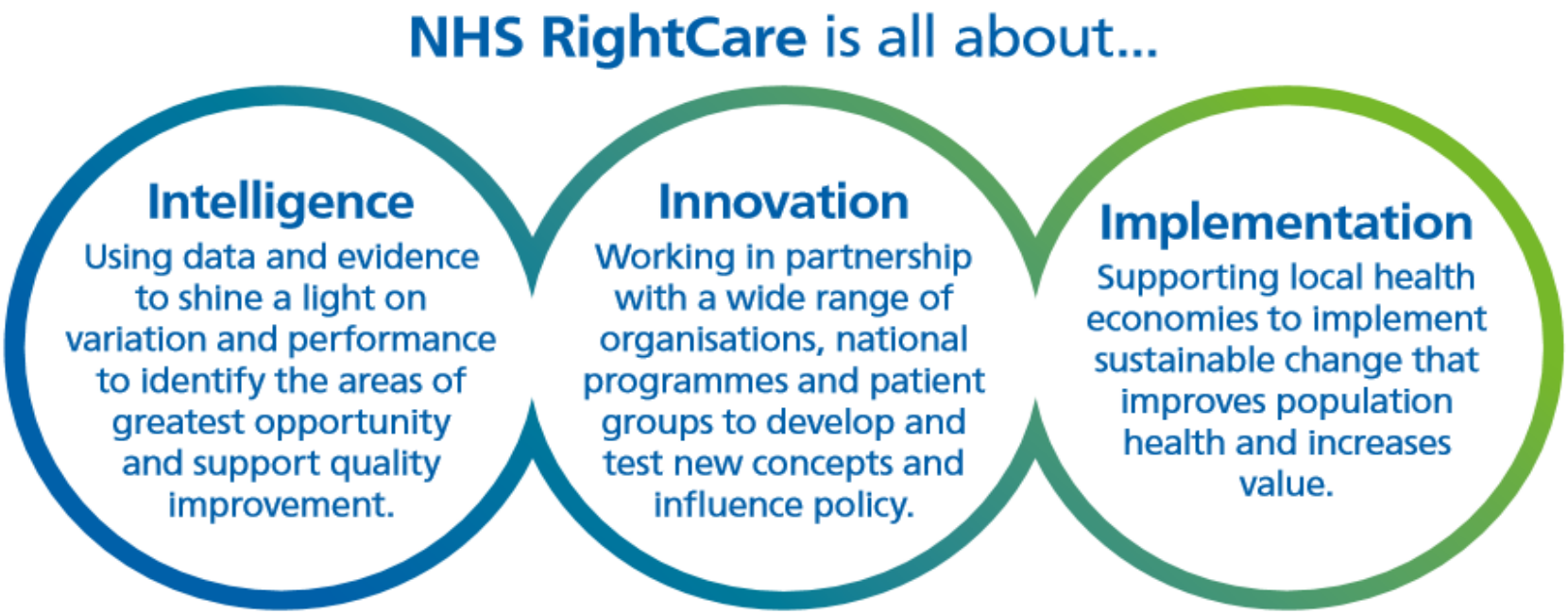
What is NHS RightCare?

NHS RightCare is a programme committed to reducing unwarranted variation to improve people's health and outcomes. It ensures that the **right person** has the **right care**, in the **right place**, at the **right time**, making the best use of available resources.

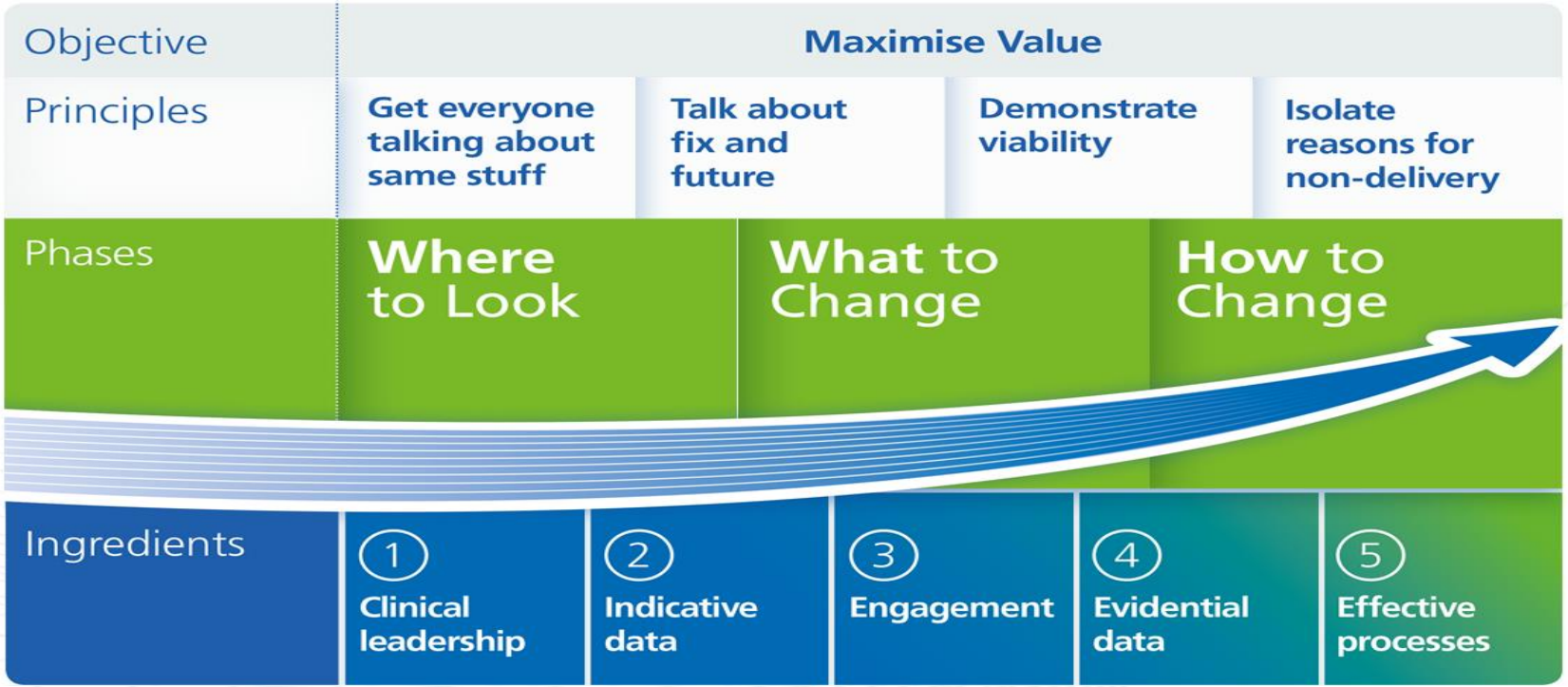
NHS RightCare ensures local health economies

- **make the best use of resources** to give better value for patients, the population and the tax payer.
- **understand how they are doing** – by identifying variation with demographically similar populations
- **get talking about the same stuff** - about population healthcare rather than organisations
- **focus on the areas of greatest opportunity** by identifying priority programmes which offer the best opportunities to improve healthcare for populations
- **use tried and tested processes** to make sustainable change to care pathways to reduce unwarranted variation

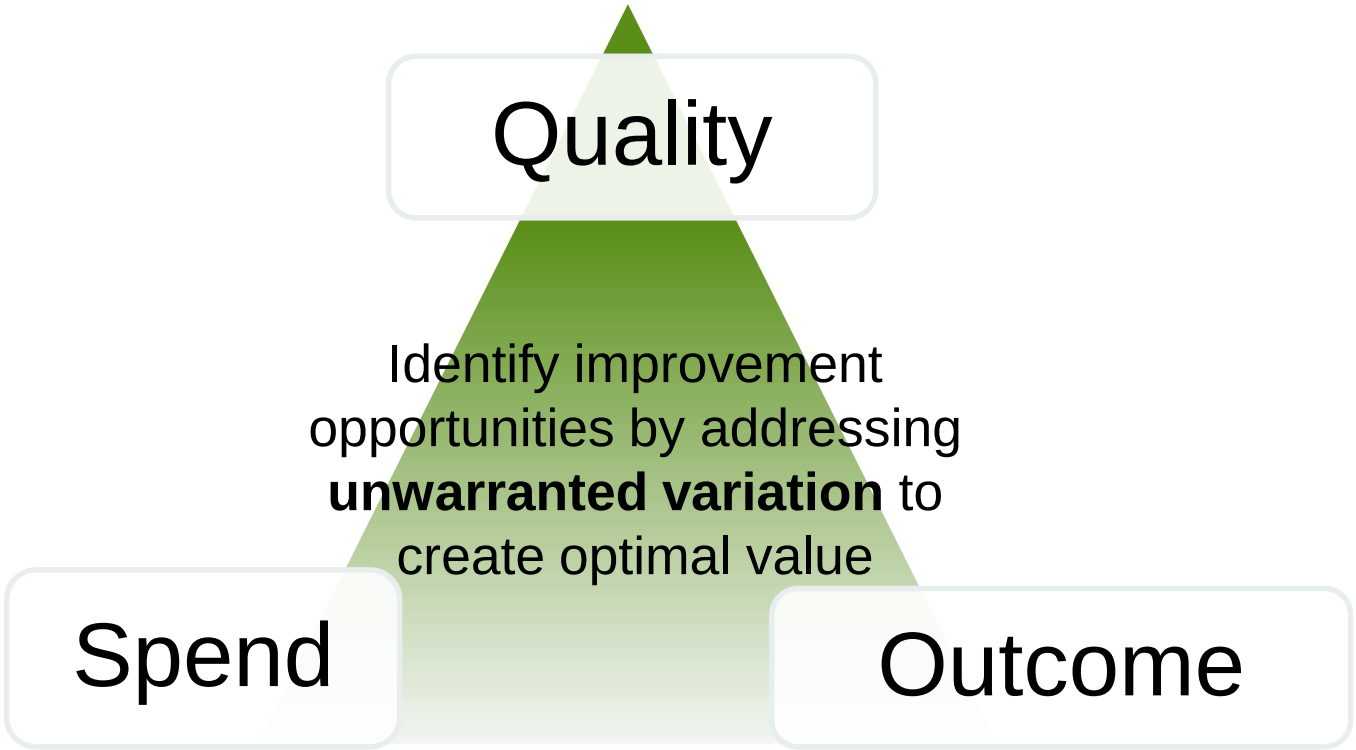
The three pillars of NHS RightCare



NHS RightCare - Approach



At the heart of RightCare methodology is the triangulation of indicators



Principles of value based optimal design

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Population focus

- Focus on people and the population not the organisations.
- Focus on those we don't know as well as those we do

System thinking

- Shared, common aim
- Shared involvement in defining optimal and how best to use assets from across the system to achieve the aim

Value based

Think of value in two ways:

1. Allocative/Technical/Personal
   - Allocative – doing the right things
   - Technical – doing them right
   - Personal – decisions based on best current evidence, individuals values
2. Overuse/underuse
   - Overuse of lower value interventions
   - Underuse of higher value interventions

A pathway approach to identify variation and ensure a whole systems approach to improve quality, spend and outcomes

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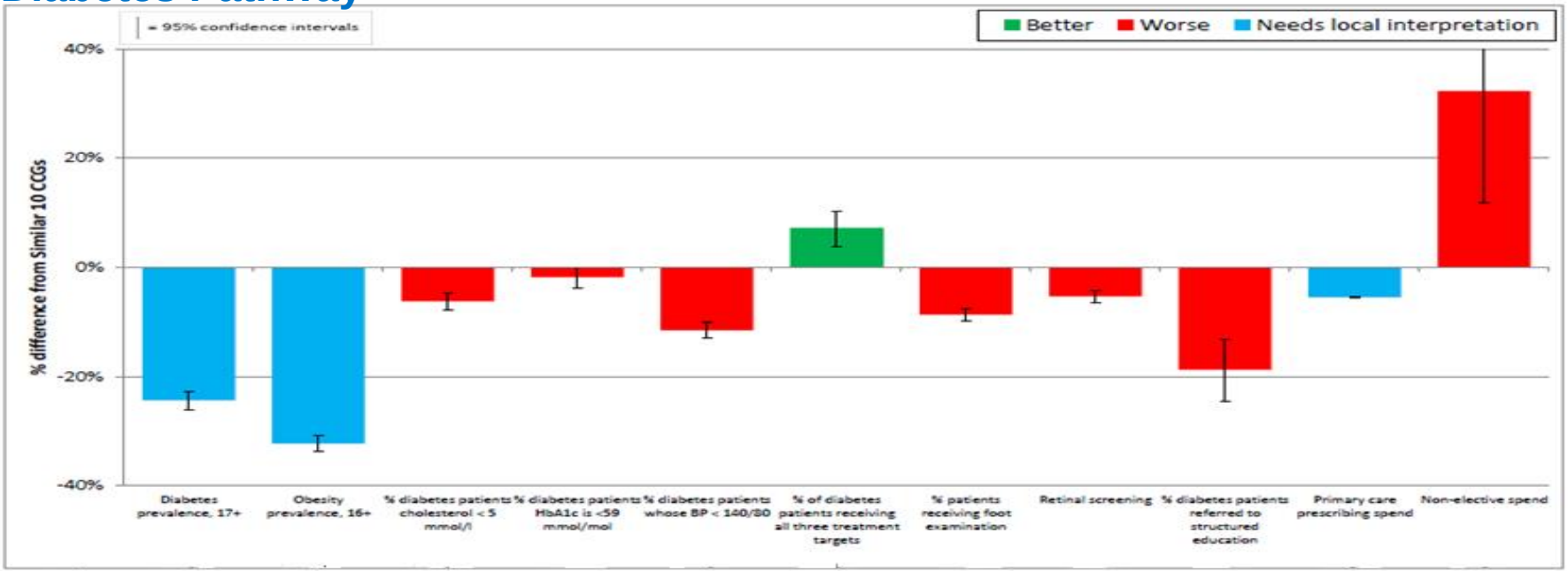
Diabetes Pathway



Each indicator is shown as the percentage difference from the average of the 10 CCGs most similar to CCG X

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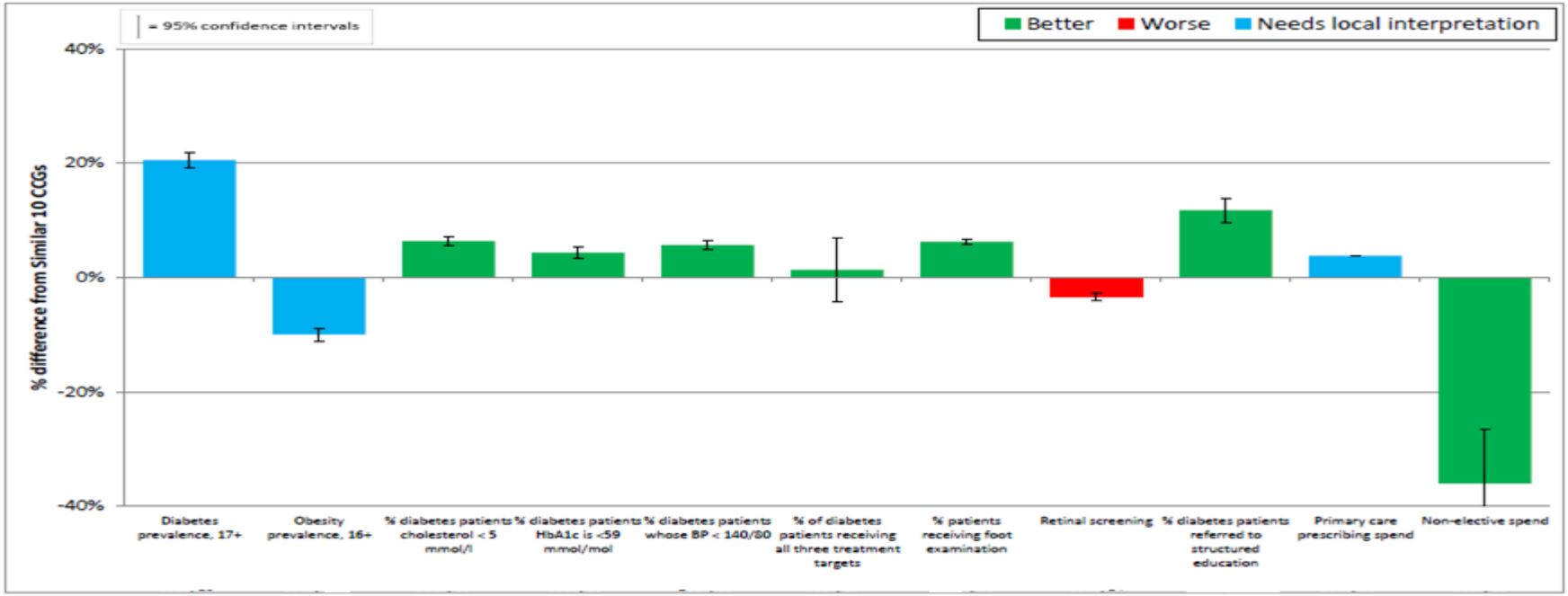

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STP Diabetes Pathway
System wide opportunities to improve at scale

	Diabetes prevalence, 17+	Obesity prevalence, 16+	% diabetes patients cholesterol < 5 mmol/l	% diabetes patients HbA1c is <59 mmol/mol	% diabetes patients whose BP < 140/80	% of diabetes patients receiving all three treatment targets	% patients receiving foot examination	Retinal screening	% diabetes patients attending structured education	Primary care prescribing spend	Non-elective spend
STP opportunity (to Best 6)			2,712 Pats.	2,260 Pats.	4,016 Pats.	1,946 Pats.	2,446 Pats.	4,448 Pats.	661 Pats.		£286K
CCG	△	▽					▽		△	▽	
CCG	▲	▽				△	△			▽	▽
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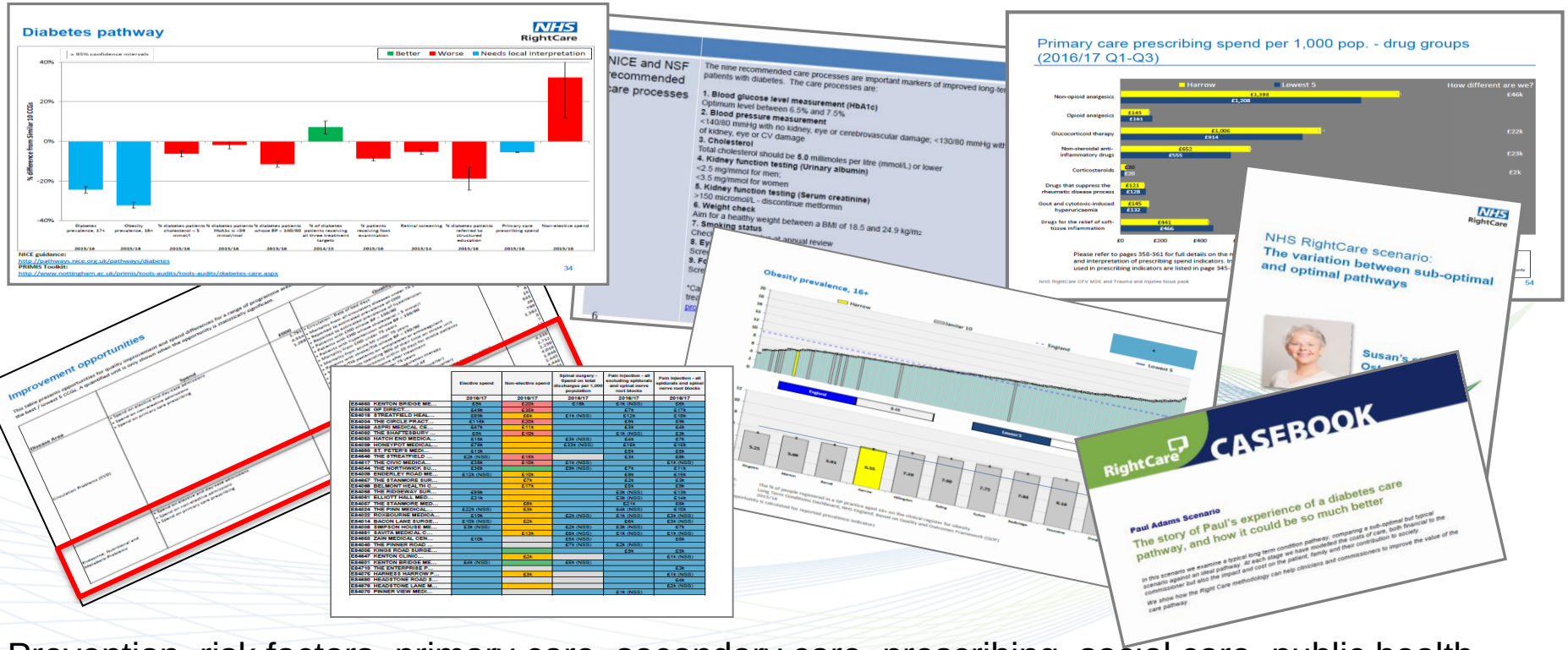
Diabetes pathway and indicators shown for each CCG within the STP to identify system wide improvement opportunities

Suite of Intelligence products to build storyboards, explore the drivers of variation and join the dots in the system



Prevention, risk factors, primary care, secondary care, prescribing, social care, public health, outcomes, other co-morbidities and patient journey

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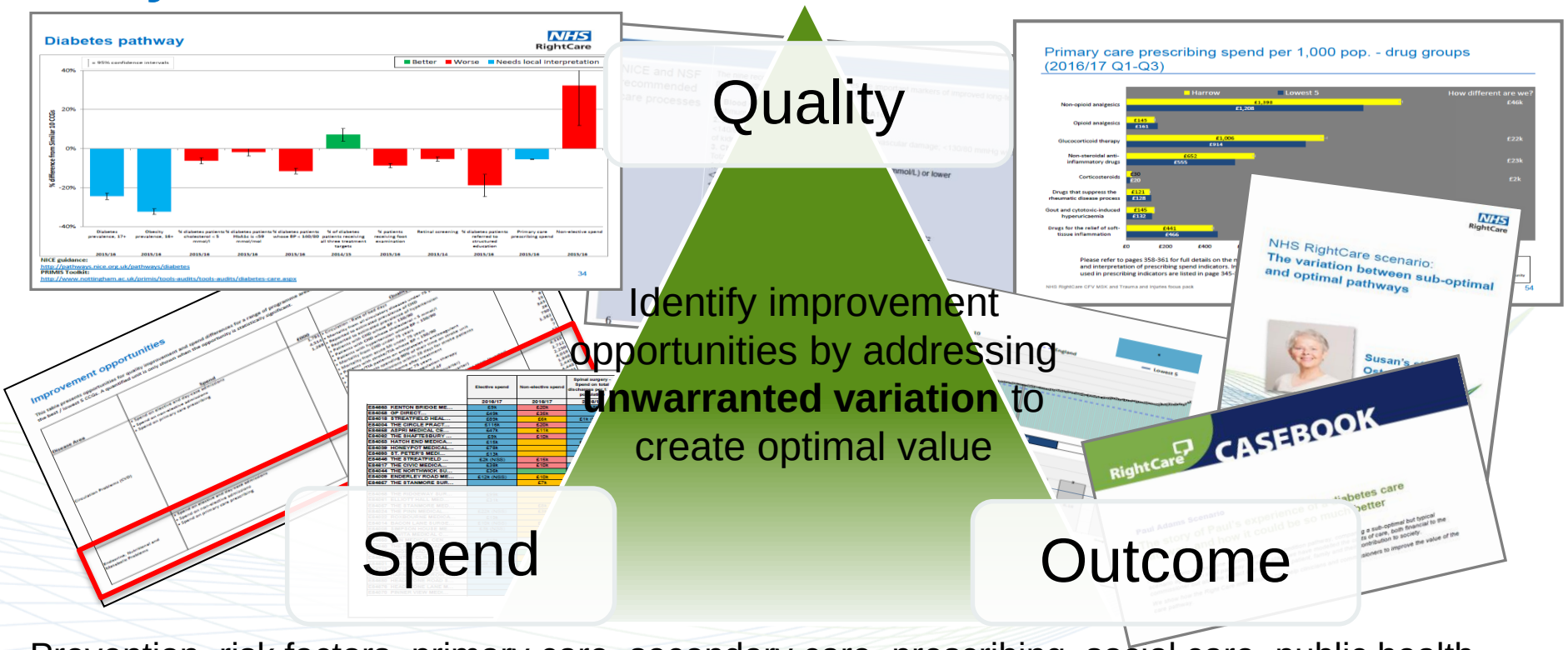

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HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

NHS RightCare Pathway: Diabetes

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The National Opportunity	5 million with non-diabetic hyperglycaemia Most receive no intervention	940, 000 undiagnosed Type 2 diabetes	>50% of diagnosed receive no structured education within 12 months of diagnosis	60% of Type 1 and 40% of Type 2 are not completing care processes	Few areas have high quality Type 1 services embedded	30% of hospitals don't have multi-disciplinary foot teams	National variation in spend and safety issues on non-elective admissions
Service component	**Risk Detection**	**Diagnosis and Initial Assessment**	**Structured Education Programmes**	**Annual Personalised Care Planning**	**Type 1 Specialist Service**	**Service Referral and key relationships**	**Identification/ Management of admissions by Inpatient diabetes team**
Interventions	Cross Cutting: 1. Shared responsibility and accountability 2. Participation in NATIONAL DIABETES AUDIT 3. Consistent support for patient activation, individual behaviour change, self-management, shared decision making 4. Integrated multi-disciplinary teams						
	Local referral pathways and provision of lifestyle change programmes	Protocol for diagnostic uncertainty	Education programmes (including personalised advice on nutrition and physical activity)	9 recommended care processes and treatment targets	Type 1 Intensive specialist service	1. Triage to specialist services 2. RCA for major amputations	Inpatient diabetes team, shared records, advice line
Target outcomes	Decreased incidence of Type 2 diabetes	Improved detection	Better diabetes management and reduced complications	Reduced variation in completion of care processes	Reduced risk of Microvascular complications	Year on year reduction on major amputations	Reduction in errors in hospitals, reducing LOS
The evidence	Intensive behaviour change can on average, reduce incidence of Type 2 diabetes by an average of 26%	Diabetes prevalence model for local authorities and CCGs	Improved health outcomes and reduction in the onset of diabetic complications in both Type 1 and Type 2 diabetes	Control of BP, HbA1c and cholesterol reduces risk of macro and micro vascular complications	Type 1 services deliver year on year improvements in blood glucose control	MDFT and supporting pathway reduces risk of complications	Young Type 1 and older Type 2 diabetes patients have higher rates of non-elective admissions

Working with expert partners: National charities, NCDs, NDPP, clinical colleges, Public Health England, NICE, academia, patient groups

Risk

Risk Detection (T1DM and T2DM)

What it means for commissioners	• All Commissioners (CCGs) should be aware of the prevalence of diabetes and local participation rates in the National Diabetes Audit (NDA) • Identify where there is low CCG participation in the NDA , reasons and agree actions. Most recently published (2015/16) data shows low levels of NDA participation in some CCG areas. • CCGs, with their STPs should consider diabetes prevalence across their STP area and where some aspects of service should be strategically developed across the STP. The 'Diabetes STP Aide Memoire' sets out further details. • Commissioners work with their local practices to develop a local process to establish the number of people with T1DM and T2DM • Commissioners should consider ensuring that upon diagnosis, patients are assigned to a care team for their ongoing care needs across a STP area (whether practice or community based). • Commissioners could consider identifying a core team (i.e. Commission Specialist Lead, a Strategic Clinical Lead and System Leader) with dedicated time to redesign services and achieving better clinical and patient reported outcomes • **For Type 1 diabetes**, Commissioners should ensure: - Everyone with T1DM should have access to specialist services throughout their life time, when they feel appropriate and at least annually. - Local arrangements for a structured programme for initiating insulin immediately on diagnosis and managing insulin or insulin pump therapy including training and support for the healthcare professionals and the patients (QS 6, 2011) This will include having access to the CGM NICE Guidelines.
Useful links	• Diagnostic criteria for diabetes: Diabetes UK • Type 1 diabetes in adults: diagnosis and management • Prevalence estimates of diabetes in local authorities and CCGs
NICE Quality Standard	NICE QS 125 -Diabetes in children and young people

Nine Care Processes

Diagnosis and Initial assessment (continued)

NICE and NSF recommended care processes	The nine recommended care processes are important markers of improved long-term care of patients with diabetes. The care processes are: **1. Blood glucose level measurement (HbA1c)** Optimum level between 6.5% and 7.5% **2. Blood pressure measurement** <140/80 mmHg with no kidney, eye or cerebrovascular damage; <130/80 mmHg with evidence of kidney, eye or CV damage **3. Cholesterol** Total cholesterol should be **5.0** millimoles per litre (mmol/L) or lower **4. Kidney function testing (Urinary albumin)** <2.5 mg/mmol for men; <3.5 mg/mmol for women **5. Kidney function testing (Serum creatinine)** >150 micromol/L - discontinue metformin **6. Weight check** Aim for a healthy weight between a BMI of 18.5 and 24.9 kg/m2 **7. Smoking status** Check smoking status at annual review **8. Eye examinations** Screening at least annually **9. Foot examinations** Screening at least annually *Care processes 1-3 are part of the CCG Improvement Assessment Framework (CCG IAF) treatment targets for diabetes. Ensuring the effective management and monitoring of care processes can potentially reduce the risk of future complications.

Diabetic Complications

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Identification and management of complications

Key criteria	Microvascular complications are the major risk in type 1 diabetes, while macrovascular complications are the major cause of morbidity and mortality in type 2 diabetes. Control of hyperglycaemia and hypertension may prevent microvascular complications in both types of diabetes; a multifactorial approach, including behaviour modification and pharmacological therapy for all risk factors, may reduce the development of micro and macrovascular complications in type 2 diabetes.
NICE guidance	• Diagnosis and management of type 1 diabetes in children, young people and adults • Type 2 diabetes: The management of type 2 diabetes
What this means for commissioners	Diabetic complications are common, costly and have a major impact on length and quality of life. There is good evidence that they can be delayed or even prevented in type 1 and type 2 diabetes by achievement of normoglycaemia, achievement of 3 treatment targets, control of other risk factors, regular review and early treatment. Commissioners should ensure: • Regular reviews and assessment of individuals with diabetes. The frequency will vary with the duration of the condition and individual needs • The 9 recommended care processes should be undertaken as part of regular reviews and assessments as they are important markers of improved long-term care and management of patients with diabetes • % achieving 3 treatment targets
Useful links	• Cardiovascular disease profiles allow you to compare complication rates in your CCG with England, your STP and similar CCGs (with respect to age, deprivation and ethnicity) • Diabetes Footcare profiles

Good Practice Examples

- “Bradford Beating Diabetes” NHS Bradford City CCG – Improving detection and prevention of T2D through a 3-phase campaign
- North West London Diabetes Transformation – improving patient pathways, digital, dashboards to drive improvement
- Effective models of working between primary and secondary care to support reduced unnecessary referrals and improved outcomes for patients
- Joint management plans held between the consultant and GP
- Access to the clinical record, shared between the consultant and GP
- Virtual clinics
- Integrated IT

The Super Six model of care: Portsmouth

ISSUE: The model of care for diabetes has traditionally been delivered in a specialist setting due to the perceived requirements of a complex multi-system condition. However, in the modern climate, the financial and workforce demands faced by the NHS has shifted the focus of diabetes management to primary care and required primary, community and specialist care to find collaborative and innovative ways to meet the needs of people with diabetes.

AIM: The “Super Six” model was established in Portsmouth Hospitals NHS Trust to streamline care across the Clinical Commissioning Groups in its catchment area with the aim to improve health outcomes of people with diabetes.

It has been in place for over 5 years with the aim of improving diabetes care in the Portsmouth area by creating uniformity across primary care trusts and providing support for the majority of diabetes management to be in primary care.

The defined areas of specialist diabetes care in the Super Six model

1. Inpatient diabetes
2. Antenatal diabetes
3. Diabetic foot care
4. Diabetic nephropathy (individuals on dialysis or with progressive decline of renal function)
5. Insulin pumps
6. Type 1 diabetes (individuals with poor control or young people)

OUTCOMES: The Super Six model has allowed the specialist team to deliver timely, high-quality care in areas where their expertise is better suited within acute trusts, such as concentrating on supporting individuals who fall into the Super Six remit and providing a 7-day diabetes service. There have been improvements to the care of young people with type 1 diabetes, with sessions on alcohol and drugs delivered in university campuses, patient engagement, innovations to improve inpatient foot care, including an ongoing joint vascular and diabetes inpatient audit investigating the development of diabetic foot disease and the possibilities for earlier intervention. The “Hypoglycaemia Hotline” has been a major contributing factor in reducing admissions secondary to hypoglycaemic events. When people with diabetes require paramedic assistance for hypoglycaemia, the diabetes specialist team is informed by the paramedic, allowing direct follow-up by the specialist team (by telephone initially) within one working day

KEY LEARNING POINTS: The reported achievements of the Super Six model have relied on the strong relationships that have been built across primary and secondary care. The basis for success in Portsmouth has been in redefining the role of the consultant to that of a specialist who is also capable as an educator to provide a support framework for primary care.

...Super Six model of care has been recognised in The King’s Fund ...out-of-hospital settings 2015” (Robertson et al, ...example of integration of

NWL Diabetes Transformation - 8 CCGs in NWL selected diabetes as RightCare Priority with Improvement opportunities. There have been improvements in patient pathway and reduction in emergency spend.

AIM:
1. Increase attendance at Structured Education
2. Reduce variation in 3 Treatment Targets [3TTs] of HbA1c ≤ 58, BP ≤ 140/80, Cholesterol ≤ 5
3. Redesign Diabetes Foot pathway across NW London
4. Prevention of Type 2 diabetes

Impact: Improvements in key parameters

Impact: Dashboards effectively driving change

January 2015 | June 2016 | February 2018

Impact: significant improvements in diabetes care

- 24,843 more receiving 9 key care processes
- 4,254 more with HbA1c ≤ 58 since 1/15
- 3,039 more achieving NICE 3TT targets since 6/16
- 5,315 more on NICE recommended statin
- > 52,000 more with collaborative care plan
- 11,161 have accepted referral to NDPP

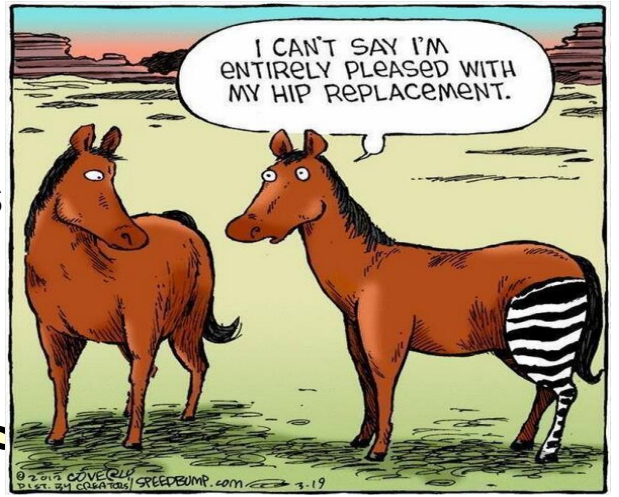
Opportunity to create a paradigm shift

- Bringing together pieces of the puzzle to reduce unwarranted variation, create optimal care pathways and systems, with patients at the centre

- Adopting population health based approach from wellbeing and prevention through to end of life - shift activity towards prevention

- Working closely with Partners – Getting It Right First Time (GIRFT), Elective Care Transformation Programme (ECTP), Diabetes UK Public Health, National Programmes, Clinical Colleges Social Care to align priorities, strengthen and support a co-ordinated approach for system wide improvements

- Advocacy role – spreading RightCare concepts and principles across other workstreams in NHS: Integrated care, supported self-care and shared making



Thank you

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