

Paul Adams Scenario

The story of Paul's experience of a diabetes care pathway, and how it could be so much better

In this scenario we examine a typical long term condition pathway, comparing a sub-optimal but typical scenario against an ideal pathway. At each stage we have modelled the costs of care, both financial to the commissioner but also the impact and cost on the patient, family and their contribution to society.

We show how the Right Care methodology can help clinicians and commissioners to improve the value of the care pathway.

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Introduction

More than 3 million people in the UK are currently diagnosed with type 2 diabetes and the prevalence is increasing. Type 2 diabetes is associated with significant clinical and social consequences.

Type 2 diabetes has a long pre-clinical phase, with the condition remaining undiagnosed for many years in a significant number of cases (Woolthius et al 2007). A group of conditions defined by blood glucose level that fall between normal and those defining type 2 diabetes are typically known as Impaired Fasting Glucose (IFG) and Impaired Glucose tolerance (IGT) or collectively as pre-diabetes – a risk factor for developing type 2 diabetes¹.

The York Health Economic Consortium estimated in 2012 that the direct costs of treatment for type 2 diabetes was £8.8 billion, which includes treatment, intervention and complications. The indirect costs, such as those related to increased death and illness, work loss and the need for informal care, were estimated at £13.9 billion. Complications accounted for 79% of the NHS spend on type 2 diabetes²

Introducing Paul Adams

Paul Adams is a 45 year old bricklayer working for a local employer. Like many of his peers, he smokes 10 cigarettes per day and drinks 4 pints a day. He is overweight, with a BMI of 31.

Paul is married to Wendy, 42, who works as a Barmaid and he has a 16 year old son, David, at secondary school.

Paul lives in a council house in a small village which is 17 miles from the nearest District Hospital.

The village has only one shop with limited food options.



¹ Woolthuis EPK., de Grauw WJC., van Gerwen WHEM., van den Hoogen HJM., van de Lisdonk EH., Metsemakers JFM., van Weel C. Identifying people at risk for undiagnosed type 2 diabetes using the GP's electronic medical record. *Family Practice* June 14, 2007

² Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Hex et al, *Journal of Diabetic Medicine*, April 2012. http://www.thechip.org.uk/images/uploads/j.1464-5491_.2012_.03698_.x_.pdf

Paul is not untypical of a white, working class male and many GPs will recognise the stereotype. In the UK it is estimated that there may be 2 million Paul's who may be on the way to developing Type 2 Diabetes because of their lifestyle.

Paul's Journey

Paul's journey starts, as with many men, when his wife nags him to go to see the GP having had for two years symptoms of increased urinary frequency, getting up at night to have a wee. He has also been feeling a bit listless and finding it hard to cope at work. His GP does the tests and confirms what was suspected, which was that Paul has diabetes.

The initial management is support within the GP practice. He is offered diet and exercise but very rapidly he goes onto pills because diet and exercise alone are not doing it for him. Paul is offered six visits per year to the practice nurse, which is how this practice manages patient education, with the practice incurring the cost. He doesn't actually attend all of them, he only attends four of them. In the course of his interactions with the GP and the practice nurse, six lab tests are requested for him per year in his early years to check on his lipids and his renal function, as well as his day to day diabetic care.

Also of wider interest is that this GP practice has not been on the CCG's performance, medicines or demand management radar or the PCT's, before that because they are lower than average prescribers and lower than average referrers – which has generally been seen to be a good thing hitherto, although without any assessment of outcomes or other measures to support this assumption. In this context the practice is generally thought to be safe and performing.

Context – un-explained variation

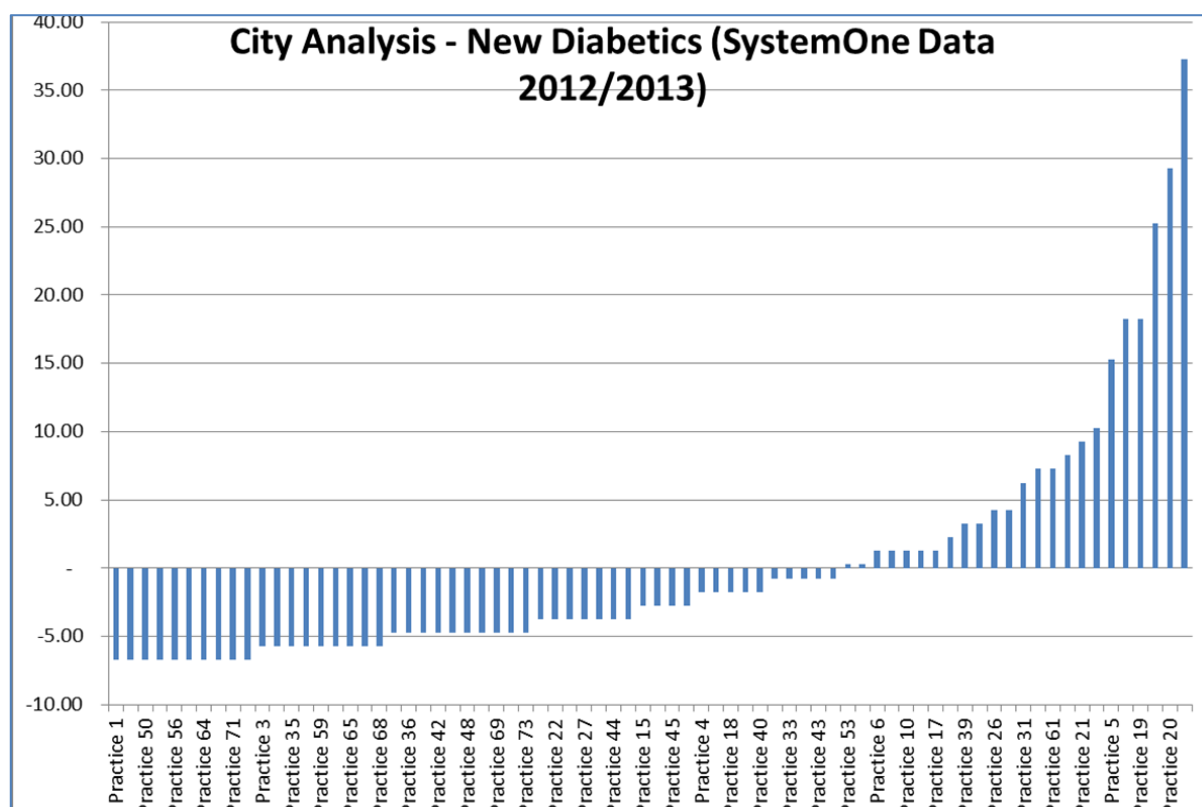


Figure 1: New Diabetics

Figure 1 shows real data taken from GP Systems from a group of practices in a northern city. The figure shows an un-explained variation in diagnosis of diabetes from 1 patient a year to 45 patients a year depending on practice. Taken on their own, the data does not explain this variation as we do not know what is going on in each practice. However, the scope of variation and the long tail nature suggest that some variation is un-warranted. Given the importance of early diagnosis and prevention in terms of both cost and health outcomes in type 2 diabetes, this merits investigation.

GP practices do vary in their inputs, outputs and outcomes. The role of Clinical Commissioning Group is to help their local communities to look at variation, understand it and use that knowledge to commission care differently in the future.

Turning to management of diabetes, **Figure 2** below shows the rate of patients in the same group of practices, who have achieved an HbA1c level of 7 or less within the previous 15 months.

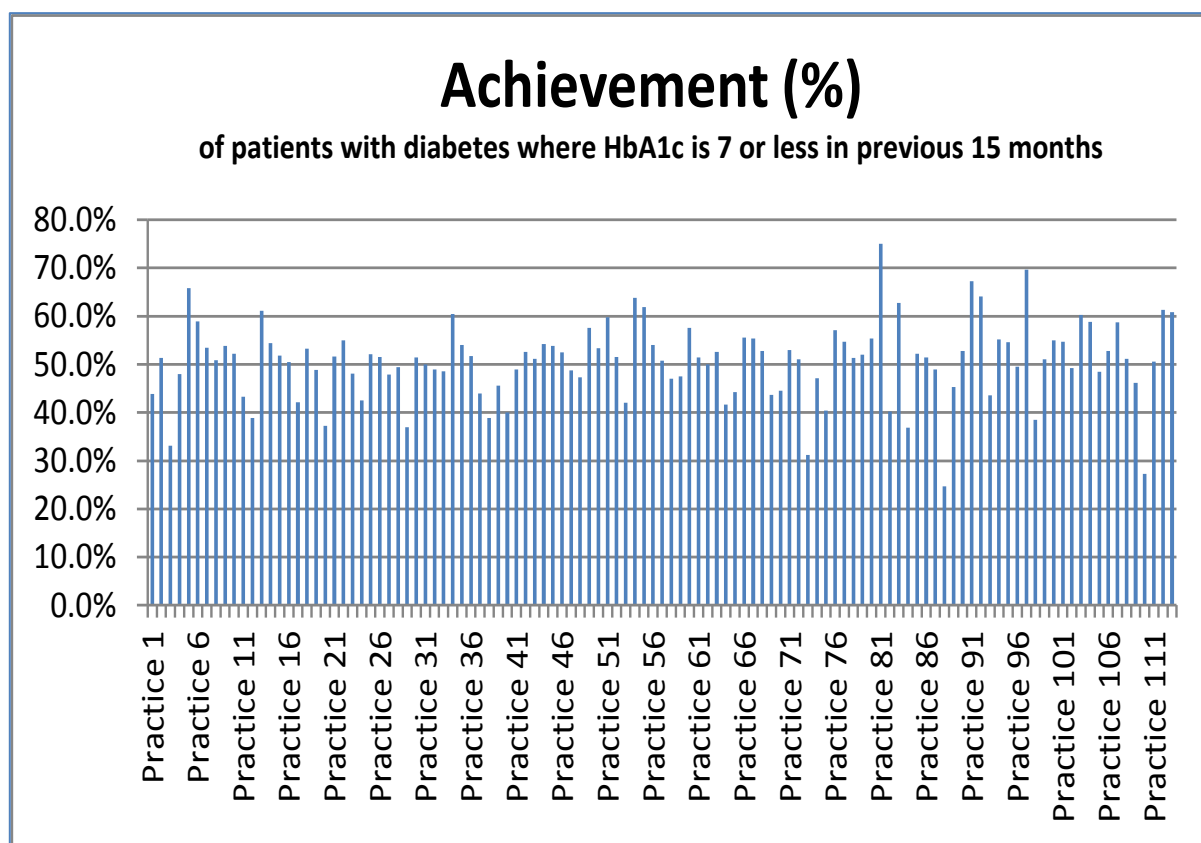


Figure 2: Achievement against target

The data shows a variation between practices from 25% to over 70%, a near three fold difference. Perhaps most significantly, the average is only 50.4% - indicating that the need to manage diabetes better.

The NHS Atlas of Variation in Healthcare for People with Diabetes showed that across PCTs in England there was a 10 fold variation in the percentage of patients receiving all nine NICE recommended key care processes. Further, the Atlas showed no significant correlation with deprivation at the health economy (PCT) level ³.

³ <http://www.rightcare.nhs.uk/index.php/atlas/diabetes> - Map 2: pp30-31

Map 2: Percentage of people in the National Diabetes Audit (NDA) with Type 2 diabetes receiving all nine key care processes by PCT

1 January 2009 to 31 March 2010

Domain 2: Enhancing quality of life for people with long-term conditions

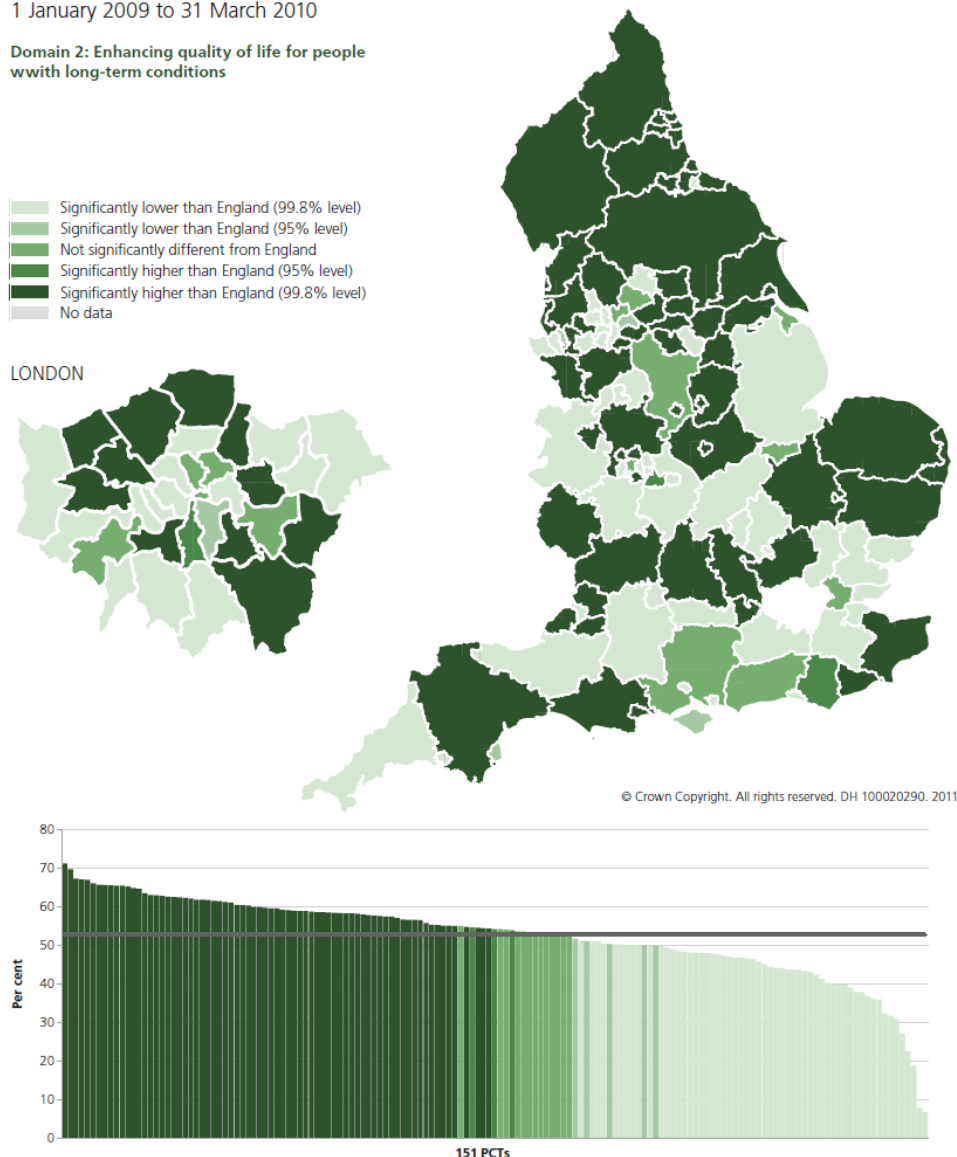


Figure 3: Atlas of Variation

Questions for GPs and Commissioners

At the CCG population level, there are likely to be several hundred thousand people with type 2 diabetes, which will represent a spend on diabetes of circa £20 million. CCGs and GPs are responsible for identifying and investigating patients, preventing or treating the disease and generating good health outcomes for their populations.

All of these parts of the pathway can now be mapped using various tools. These data sets are a challenge to clinicians and commissioners to explain variation. They also represent an opportunity to improve value as, in considering the appropriateness of variation, there is a recognition and determination to tackle it where the variation is deemed inappropriate.

CCGs are now responsible for the spend on diabetes and need to consider the value both the patient gets from the healthcare provided, and also the value to the population for which the CCG is responsible. This latter is particularly the case in the context of achieving the optimal value allocation of resources across the whole system of healthcare for a local population.

Questions for Commissioners

In the local population, who has overall responsibility for:

- ✧ Preventing diabetes?
- ✧ Raising awareness and screening for diabetes?
- ✧ Quality assurance of diabetes care?
- ✧ Getting best value for money from the investment by caring agencies in diabetes?

The above questions are vital in understanding who manages what components of a whole system. Most importantly, it is impossible to effect optimal improvement if the system is not even aware of the answers.

Paul, Five Years On

Not smoking but still drinking and has not lost weight; his recreation is watching football and pub

Has been on insulin for a year

Left leg hurts (vascular problem)

Not walking far, not driving, missing work days

Referred to hospital diabetes service and vascular surgeon – OPD at hospital

Wendy, his wife, drives him and has to take time off work to do so

David is at university



Paul has now been managed for five years in a relatively small GP practice some way from the main local hospital. He has been through a smoking cessation programme and succeeded in stopping smoking.

However, he is still drinking and has failed to lose weight. His main recreation is the pub and watching football. In the last of these five years, Paul has moved onto Insulin, and he is beginning to experience ischaemic pain in his left leg. That means he's not walking so far and it's getting even harder to hold down his job, he's been missing some work.

Paul is now in the care of the hospital diabetes service and has been seen by the vascular surgeon at the District General Hospital. Paul is beginning to clock up some hospital outpatient visits and because the pain in his leg is stopping him from driving, his wife Wendy has to transport him. As a result Wendy is starting to lose work as well. His son David is now away at University.

The cost of his care is going up in terms of treatment because his underlying risk factors are still there.

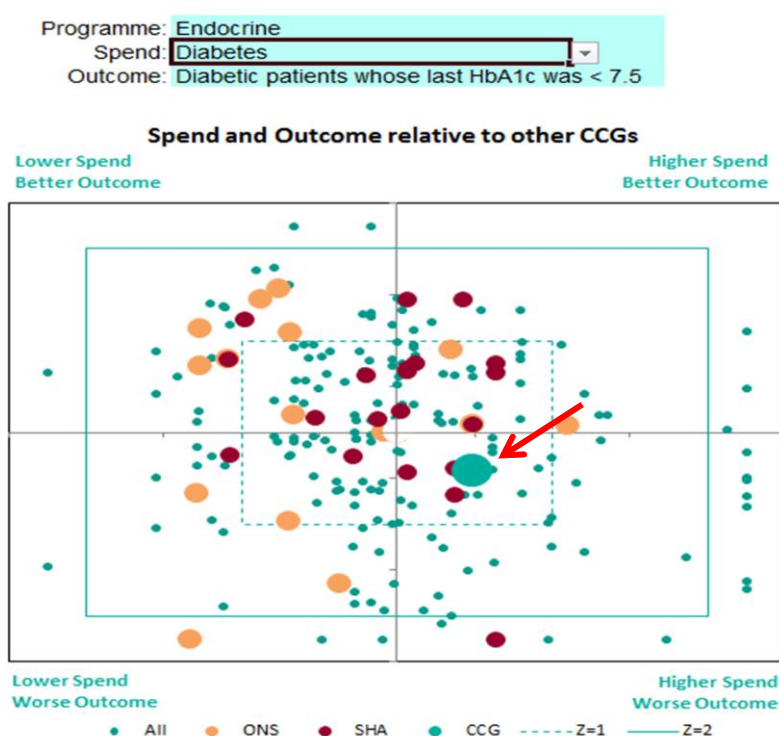
It is worth reflecting on an aspect of our scenario and its relevance to prevention of disease. The scenario is not unusual and if the catchment population are down the pub or they are at the football ground, then that is where the prevention and detection services have to go if they want to get messages about prevention and early detection to the target population. The Pauls of this world are not going to be at the GP surgery for health promotion and prevention; it took his wife two years to persuade him to go for an initial investigation.

There are examples of initiatives which address this issue. For example, Leeds United Football Club has a big outreach programme going on in the community to encourage people to have a healthier lifestyle using the football club's nutritionist and using the football club's coaches to get people more active and able to manage obesity.

Spend and Outcome

We now return to the context of variation – this time examining outcomes in general practice but relating it to spending.

Figure 3: Spend and Outcome tool



This particular group of practices are spending quite a lot on diabetes but they're not generating the best outcomes [red arrow]. They have a challenge trip to go and they have some distance to go.

On the chart, every dot represents a PCT in England. The red dots show this CCG SHA cluster allowing comparison with immediate geographical neighbours. More important are the yellow dots which show CCGs with a similar demography - a much better comparator than immediate neighbours.

Figure 3 is a spend and outcome map for diabetes in the same cluster of GP practices referred to in Figures 1 and 2 above, taken from the Spend and Outcome factsheet and Tool (SPOT) available on the Public Health England website.⁴

Programme budgeting is a well-established allocative value technique for assessing investment in programmes of care rather than services. All local health economies in England have submitted an annual programme budgeting return since 2003/4. The tool and factsheets use this Programme Budgeting data and available indicators of health outcome by programme (where available) to present at PCTs and CCGs level an analysis of the impact of their expenditure. This allows easy identification of those areas that require priority attention, where relative potential shifts in investment opportunities will optimise local health gains and increase quality.

The SPOT quadrant graph above shows increasing spend along the x-axis and improving outcome up the y-axis. The naughty corner, if you like, is the bottom right corner. CCGs in this quadrant are spending too much and getting too little for that money ('high spend, low outcome').

Generally speaking CCGs will want to move up and left. On occasion a CCG may need to move from poor outcome to better outcome by spending more. The yellow dots are the key comparator. These show the position of demographically similar health economies to your CCG. Any of these that are above and/ or left of your CCG are achieving better value healthcare for a demographically similar population, thereby indicating the possible value achievable for you.

If you study **figure 3** you will spot [sic] that some CCGs are getting a similar outcome level than our group of GPs here but are able to do so for much less spend, many are getting a much better outcome for the same spend. Better still, there are CCGs that are able to deliver better outcome for less spend.

The power of this tool is that it lets you identify which of your democratic peers are already delivering value for commissioners, their populations and their individual patients [you identify the name of CCGs by hovering your mouse over the live version on the website. The obvious next act is to give them a ring to ask "how do you do that? – is it an artefact of the data or is it something real that we can learn from?" If the latter, would the same or similar work for your local characteristics?

Back to Paul and his story

Paul is now two years further on and he's now in serious trouble. His leg has gone white and painful and has eventually had to be amputated. Because of his vascular problems, his heart is now causing him serious problems and he has renal complications. These problems have kicked in before they might have otherwise done because of the gaps in his care hitherto. Further, the arteries to the eyes are beginning to cause him problems and his vision is deteriorating and consequently he's been picked up by the retinopathy screening programme. Because of these problems he has now lost his job and he's too old and deskilled to really have a chance to re-train and he is not an attractive prospect to a new employer.

There is also a growing adverse economic impact on the family. They are now applying for a different council house and they are becoming known to Social Services and Social Care. Wendy has now had to give up her job because there is so much ferrying around to do and consequently the family is making significant demands on the welfare state to keep them going. David has decided to take a year off university and just help his dad out with some of the driving, daily care support and to help them move house and to make sure they are settled before he goes back to university.

The stresses and strains of their new lifestyle has begun to impact on their general happiness and mental health. Wendy is very tired all of the time and has been prescribed anti-depressants. Paul has stopped socialising with his friends and leaves the house only to attend healthcare appointments.

⁴ <http://www.yhpho.org.uk/resource/view.aspx?RID=49488>

At this time, Paul is only 52 and would have expected at least another 13 or more years of productive contributory work.

The bill

What is the cost of Paul's journey to the NHS and the wider social and economic impacts?

To build up a picture of the NHS and social costs of Paul's journey, we have looked across an 11 year pathway, split into distinct stages:

- Pre-primary case review
- Paul at 45 – early intervention
- Paul at 50 – complications emerging
- Paul 52 – severe complications

Next, we analysed the pen portrait above to identify the likely cost drivers that would be incurred in primary care and hospital care. We have included the wider social impacts and economic impacts but we have not attempted to include social care costs. **Table 1** below summarises these costs and economic impacts.

In the first two years of early symptoms Paul suffered in silence – no NHS costs arise but Paul experienced impact on the quality of his life: increased urinary frequency, issues around thirst and excessive tiredness. Strategically, these years were two of the most damaging to Paul's long-term care. If preventative care had begun to impact here, then the later complications would have been far less likely.

In years 3-7 Primary care starts to get involved. Some resource is put into self-management education, diet and exercise support but the bulk of costs at this stage, 80%-plus, are on lab tests and medication.

The next phase years 8 and 9 is when Paul's health starts to deteriorate more seriously. It will be no surprise that as this journey progresses costs go up from an NHS perspective but a detailed analysis of cost drivers shows a marked increase in the spend on Paul's care.

The same is true of the personal and emotional costs: the leg pain, the missing work, stopping driving, Wendy having to take time off work.

When we get to the final stage, years 10 and 11, 85% of the costs of the whole journey are incurred and these are heavily weighted towards the treatment costs in secondary care, a total just short of £50,000 for the whole 11 year journey. The obvious question to be answered is whether this provided the optimal value for the health service, for Paul and his family or the wider population?

Journey 1 - (less than perfect)

		Paul 45					Paul 50		Paul 52			
Pre Primary Care Review		Phase 1 Activity & Treatment					Phase 2 Activity & Treatment		Phase 3 Activity & Treatment			
Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11		
Personal & Emotional Costs	Increased urinary frequency	Excessive drinking (reduced)	Excessive drinking				Excessive drinking	Excessive drinking				
	Issues around Thirst	Obese (but improved)	Obese				Obese	Obese				
	Excessively Tired	Smoking (reduced)					Left leg pain	Left leg - white & very painful (then amputated)				
	Excessive drinking					Missing work days	Loses job					
	Obese					Stopped exercising	Cant exercise					
	Smoking					Stopped driving	Cant drive					
					Wendy taking half days off to drive to treatments /	Wendy taking more time off as carer						
					Economic situation of the family becoming tough	Economic situation of the family is now extreme						
					Paul's quality of life now very poor							
					Both Paul & Wendy depressed							
				David takes time out of University to assist the family								
				Council contacted - alternative housing - rent not affordable								
				Forced to sell car - so Wendy also less mobile								
Economic Costs	-	-	1,360	576	576	576	576	1,762	1,953	8,948	32,757	49,084

Table 1: Journey 1 costs and economic impacts

It is not possible to include the detailed breakdown of all cost assumptions in **Table 1**, but **Table 2** below shows a sample of the type costs we have included for three of the eleven years of this journey. The full analysis spreadsheet is available for download online⁵

Phase 1 - Yr 3			Phase 2 - Yr 8 (Paul at 50)			Phase 3 - Yr 10 (Paul at 52)		
Activity	Costs		Activity	Costs		Activity	Costs	
GP Visit	4	30.66	GP Visit	3	23.00	GP Visit	3	23.00
Diet advice	1	17.39	GP Care plan review	1	11.50	GP Care plan review	1	11.50
Exercise advice	1	17.39	Prescription Drugs	1	370.52	Prescription Drugs	1	370.52
Prescription Drugs	1	370.52	Testing Strips	1	9.89	Testing Strips	1	9.89
Testing Strips	1	9.89	Lab Tests	2	252.00	Lab Tests	3	378.00
Lab Tests	6	756.00	Practice Nurse	6	34.78	Practice Nurse	6	34.78
Practice Nurse	6	34.78	Daily insulin injections (Levemir)	1	715.00	Daily insulin injections (Levemir)	1	715.00
District Nurse Visit	0	-	Diabetology clinic	1	50.00	Diabetology clinic	1	50.00
Care Plan developed	1	23.00	Diabetes specialist nurse	1	7.73	Diabetes specialist nurse	1	7.73
Retinopathy screening	1	100.00	Referred to vascular clinic (Registrar)	1	235.00	Treatment - Heart disease (investigative procedure)	1	210.00
			Retinopathy screening follow up	1	53.00	Treatment - Renal Impairment (initial dialysis - monthly)	1	3,012.00
						Treatment - Eye disease (glasses)	1	50.00
						Anti depressants prescribed	2	107.76
						NHS Transport (Ambulance)	4	854.00
						Leg ulcer treatment (septicaemia)	1	3,114.00

Table 2: Detail breakdown of cost drivers

⁵ http://www.rightcare.nhs.uk/paul_adams

The complete list of interventions and activities is not intended to be exhaustive. However, in discussion with clinicians to identify the probable activity which will contribute most to care costs.

We have also factored in direct labour costs. We have not included indirect costs such as premises and administration.

It is, therefore likely that this calculation of total cost is conservative.

Commissioning for Value

How does our Anytown CCG improve the care that Paul receives? Could care, costs and overall value have been significantly different if the CCG had employed an alternative approach to commissioning and managing the local health system?

In NHS Right Care we use a focus on value to build a route and a case for change that engages the whole health system, including patients.

By value, we mean the value that the patient receives from their care and the value that the whole population receives from the spend on their healthcare, note the focus on the whole population, not just those patients that appear in clinic.

Value, is define by Mike Porter:

“value is built around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is.. the patient health outcomes relative to the total cost (inputs). Efficiency, then, is subsumed in the concept of value”⁶

Right Care’s **Commissioning for Value** mantra can be summarised as:

One objective – to maximise value for patients and populations

Achieved by **Three key phases** – Where to look, What to change, How to change

And optimised by **Five essential ingredients** – clinical leadership, indicative data, clinical engagement, evidential data and effective improvement processes.

In October 2013, Right Care with NHS England and Public Health England delivered bespoke Commissioning for Value Insights packs to all 211 CCGs⁷. Those packs used data on spend at the programme budget level (Diabetes, CVD, Respiratory et al) and population health outcomes, together with variation against comparable peers, to identify the prime value opportunities for each CCG – the “where to look” phase. Without this data, we might ask how is Anytown CCG prioritising its improvement effort? Does it even know it is different from its peers and does it know why?

⁶ Source: Porter ME. (2008) *What is Value in Health Care?* Harvard Business School. Institute for Strategy and Competitiveness. White Paper.

⁷ <http://www.rightcare.nhs.uk/index.php/commissioning-for-value/>

Let us imagine that the CfV insight pack has landed well with our CCG, that they have discussed it at their Board and with their Health and Wellbeing Board and there is a strong commitment to tackle their Diabetes 2 pathway.

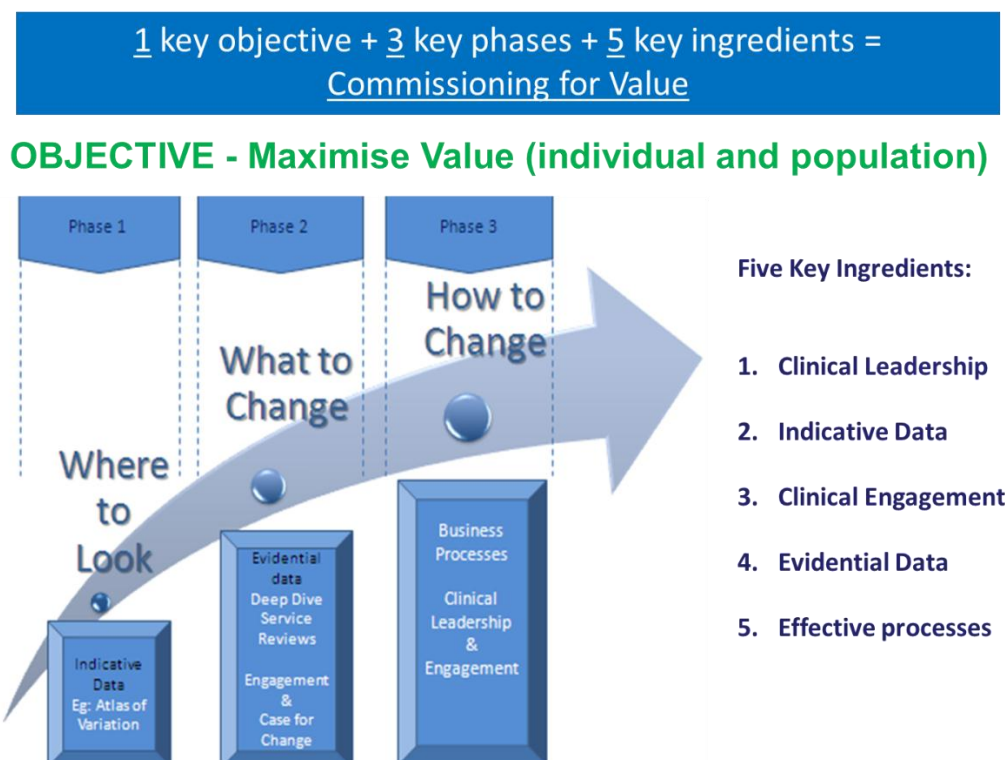


Figure 4: The Right Care approach

Their next stage would be “where to change”. A first step may be to commissioning a Commissioning for Value “focus” pack or “Deep Dive” from their local commissioning support service. This would look in greater detail at indicators across the whole pathway, focussing attention on the parts of the diabetes service most in need of reform and improvement. This might, for example, show that they are an outlier compared to demographically similar CCGs in there expected to registered prevalence, indicating that earlier diagnosis should be an area for redesign and/ or renewed effort.

The CCG implements a Service Review, working closely with clinicians, to design an improved pathway. This phase also needs to build the evidence base for change and consider the impact of the change on the overall economy; this is the case for change.

Let us also imagine that our Anytown CCG has engaged with their NHS England Area Team, who have identified four other CCGs with the same issues, together with engagement with their Health and Wellbeing Board. Working with these four will help to resolve wider system improvement issues. It is very important though, that Anytown CCG do not allow slower progress or the lower prioritisation of diabetes improvement by partners to slow their own improvement efforts. NHS Right Care encourage use of the change partnership principle of “keep up or catch up” in this regard.

The next phase is implementation – “How to change”. This employs Business Process Engineering processes to ensure that change actually happens on the ground. A key ingredient in “what to change” and “how to change” is clinical leadership and engagement. With clinical leadership from the outset, improvement ideas land with credibility and ownership. A lack of clinical engagement is a major reason why improvement projects fail.

Let’s assume our CCG has taken the difficult decisions and driven through change, even if doing so has made them un-popular with their providers. In this reformed, improved and (closer to) optimal pathway, what does Paul’s journey now look like? What does Paul’s journey look like now?

Business Process Engineering is a term used to describe the systems, techniques and tools employed to coordinate and direct the management structure of an organisation to deliver its core purpose. When designed and operated effectively, it ensures:

- A focus of management and supporting resources on the objectives of the organisation
- Delivery of prioritised outcomes, in an environment of expenditure reductions
- Development of proposals in a way that ensures appropriate decision-making;
- Decisions at optimal points in the process to drive delivery
- Actual and timely implementation of decisions made, and
- Minimal use of resource activities that are not viable or capable of implementation

The approach drives the use of the optimal lever to implement individual changes, for example contract management, clinical leadership, policy development or procurement.

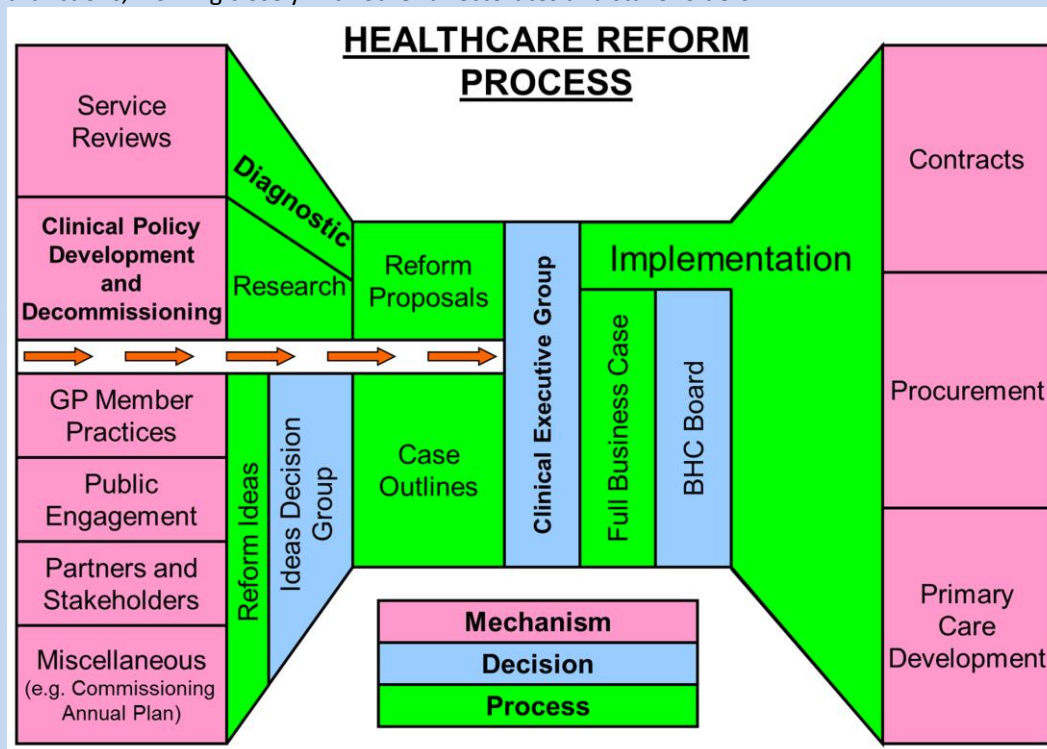
The **Healthcare Reform Process** takes reform, innovation and efficiency proposals from initiation, through case for change development to delivery. The key components of the system are:

- A Service Review
- A policy development process to ensure the continuing sustainability of the health economy
- A programme approach to delivery, and
- The business delivery process itself

The **Service Review Programme** reviews all service areas currently provided within the economy to determine their worth and the opportunities for efficiencies and improvements.

The clinically-led **policy development process** ensures the right level of appropriate treatments are provided within the economy, accounting for the benefit to patients and the wider population and for the level of available resource.

The **business delivery process** takes the findings from both of the above, plus innovative proposals for reform from other sources, adds detailed option appraisals, service specifications, costing models and impact assessments as appropriate, and processes them through clinical and corporate decision filters (such as the CCG's Finance and Performance committee). Implementation of approved proposals is then delivered by the contracts, procurement and primary care development functions, working closely with other directorates and stakeholders.



Paul Adams Re-booted

Paul has been called in for a routine health check and this means that his Type 2 Diabetes is detected a year earlier than in our previous scenario. There is a more pro-active and assertive management of his diabetes in the early days. Instead of using the practice nurse, specialist clinics for advice on diet and exercise are provided. He has a care plan which he has collaborated on developing, there are regular medication reviews, the retinopathy screening kicks in early, so that problems across his whole care needs are picked up at the earlier remedial stage. He's encouraged into a self-management programme (Desmond Programme) and comes in to a diabetes social support group which has been set up locally. He does so because he is able to see the benefits to him of doing so, partly because the health system has engaged him directly in his care decisions and explained to him the options, benefits and consequences of different approaches to his care. The revised journey looks like this:

The costs associated with this new, improved journey are shown in **Table 3** below.

Journey 2 - (Improved Pathway - Revised Focus)

Pre Primary		Phase 1 Activity & Treatment					Phase 2 Activity & Treatment		Phase 3 Activity & Treatment	
Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11

Personal & Emotional Costs	Increased urinary frequency	Excessive drinking (reduced)	Support working - Eating well, Exercising, & Drinking Controlled. Keeping work and social life healthy, no depression, no serious interventions: focus is on Support, Education & Medication.							
	Issues around Thirst	Obese (but improved)								
	Excessively Tired	Smoking (reduced)	Initial pathway = sub-optimal quality, cost £49k, low value Post-improvement = optimal quality, cost £9k, high value							
	Excessive drinking									
	Obese									
	Smoking									

Economic Costs	23	1,153	607	958	587	958	710	1,084	736	1,210	909	8,936
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Table 3: Cost and economic impacts for an improved pathway

The first phase, the pre-diagnostic phase, is now only one year, so there has been less impact in terms of Paul's own personal adverse impact.

Then over the next phase, now extended to six years, in which a number of costs that were not in the initial pathway are come in, including the additional costs to the patient education and support lines.

In phases 2 & 3 - further complications down the pathway have been deferred or averted completely, avoiding the need for managing and treating complications, avoiding amputation and preventing entirely his cardiac event and his renal failure.

It is not always possible in real life to completely avoid some of these complications with diabetes but we can certainly postpone them for two, four, ten, even fifteen years. That provides a huge payback for Paul, his family, societal costs and NHS treatment costs.

As a result of this improved pathway value is improved for both the patient and the population. In the first scenario treatment costs are nearly £50,000, in this more idealised pathway of care, the cost is nearer £9,000. This would allow the CCG to put four or five people through the programme for the same amount of

money. Assuming those four or five people would also have suffered greater complications requiring more costly interventions, each of these also creates a resource saving whilst receiving better care. This virtuous circle of improvement directly supports the transformation of Anytown CCG's healthcare economy into a financially sustainable one.

Take home messages

Famously, "there is no more money" and the NHS is facing a funding shortfall in the coming years- which could grow to £30bn between 2013/14 to 2020/21. But the NHS is not yet using the money it does have to best effect, as implied by this scenario.

Although this scenario is theoretical, CCGs who have been using the Right Care approach have demonstrated increased value as shown below:

CCGs can and are using the "Right Care approach" to shift spend	<ul style="list-style-type: none"> Achieved Turnaround (Warrington CCG - Winner of HSJ Commissioning Organisation of the Year 2012) Financial sustainability (West Cheshire CCG - Winner of HSJ Commissioning Organisation of the Year 2010) Clinically led annual QIPP planning and delivery (Borough of Wigan) Clinical Leaders driving change (Vale of York CCG) Galvanising commissioners in a growing number of health economies (20+ CCGs and growing) 	
Achieving financial stability in West Cheshire	Year 1 – "Came from behind" - Implemented system mid year Year 2 – "Delivered as went along" - Began at year start, achieved by end Year 3 – "Planned ahead" - Began before year start, over-achieved Year 4 – "Ahead of the curve" - 20% of QIPP delivered by start Year 5 – Increased focus on Quality!	
It's not just about money - developing the Right Care model in West Cheshire led to real quality improvements in just one annual cycle:	<ul style="list-style-type: none"> A&E attends & admissions, Elective & Non-elective activity, OP Firsts and Follow-ups – all decreased Outcomes & Quality – improved Integration occurred across health sectors and with social care 	Enabled by, for example - <ul style="list-style-type: none"> Medicines administration training to care homes Personalised care plans (LTC) Community endoscopy, optometry, ophthalmology, neurology & pain management pathways MRI Scanner Direct Access

The approach has been shown to be replicable across a number of CCGs and you can find a set of Casebooks on how CCGs are using Commissioning for Value on the Right Care website⁸.

Some final thoughts

Type 2 diabetes, like so many other conditions, is largely man-made, caused by lifestyle. Type 2 diabetes is theoretically entirely preventable, even in susceptible individuals. To achieve the improvements in our scenario will require both "vertical" and "horizontal" integration. Vertical integration of the whole patient pathway and horizontal integration meaning integration of the agencies and professions involved in the care pathway. A manifestation of this will be the list of those present at the care planning stage – if this includes all of the partners required to support Paul and his family on their self and case management journey then integration is achieved.

If it does not, then –whilst improved – Paul's pathway has not been optimised. In order to support the delivery of this, the optimal pathway needs to be specified, including which agencies need to be involved, at

⁸ <http://www.rightcare.nhs.uk/index.php/resourcecentre/commissioning-for-value-best-practice-casebooks/>

what stage and how. These agencies then need to be held to account for delivery of their component of the specification. This is one of the key roles that the 'healthcare system manager', that is the CCG, is itself accountable for.

One way in which this might be achieved – but by no means the only way - might be to commission for an entire programme of care from the secondary care provider and to enable and incentivise the diabetes consultant to be responsible for the diabetic health of the entire population. Not just to react to those patients who happen to be lucky to be referred to his/her service. This may involve coming out of the hospital to work with GPs and other agencies on the causes and solutions to variations in detection, diagnostics, medicines and hospital referrals.

In this approach, the focus of change is on clinical systems and at a programme budget level and not on changes in organisational structures or contracts, although this may well follow in pursuit of a collective aim to optimise healthcare and outcomes for the population and individual patients within it.

Using the NHS Right Care tools, Atlases of Variation and Commissioning for Value packs helps to create a narrative which engages all stakeholders and will help mobilise their efforts to improve the health of the population, not only those patients known to the service.

Finally, some questions to reflect on

For your population...

- *Do you know the number of diabetics?*
- *Do you know how much you are spending on diabetes?*
- *Do you know how you compare on spend and outcome for your peers?*
- *Did you know you were different?*
- *Are you comfortable being different?*

Right Care Resource Centre

Right Care has a new resource centre where CCGs can find supporting materials describing the Commissioning for Value approach:

- Online learning videos
- "how to" guides
- Theme based Webinars
- Casebooks showing learning from early adopters
- Essential reading lists and glossary
- Tried and tested process templates to support taking the approach forward
- Access to a Practitioner Network

www.rightcare.nhs.uk/resourcecentre