Good Governance Institute

Institute of Healthcare Management

Good Governance Institute and Institute of Healthcare Management

Pathway Governance Guides No 2: Diabetes care

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What is this guide? Who is it for?
This guide is targeted at NHS Board members and those planning health care improvement. It is intended to support debate around service development in a precise and informed manner.

What is diabetes?
Affecting around two million people in the UK, diabetes is a condition that results in people having too much glucose in their blood. Type 1 diabetes (insulin dependent diabetes) is cause by the body's failure to produce insulin, a hormone which controls blood sugar levels. Onset is predominantly at a younger age. Type 2 diabetes occurs when there is a relative, not total, deficiency of insulin in hand with resistance of the body to insulin. In many cases it is linked to obesity. 90% of people with diabetes have type 2 diabetes. Linked to high blood pressure, adverse levels of circulating blood fats and accelerated narrowing of major blood vessels diabetes can cause premature death. Diabetes is a long-term condition. If not properly controlled it can have devastating effects such as large or small vessel damage leading to heart disease, strokes, visual impairment, kidney failure and can compromise lower limb function. Effective management of diabetes involves targeting blood glucose, blood cholesterol levels, weight and blood pressure.

What are the benefits of improving the quality of care for diabetes?

1. Enable people with diabetes to have a greater confidence in their lives, self manage their condition, adopt healthy behaviours and live longer.
2. Reduce unnecessary early disability and deaths.
3. Reduce unnecessary use of unscheduled care (e.g. unscheduled GP appointments or hospital admissions).
4. Reduce the risk of dangerous co-morbidities.

Avoiding diabetes and living with diabetes
There is no such thing as 'mild diabetes'. It is currently estimated that 10% of all patients in hospitals have diabetes. Many of the cases of type 2 diabetes are potentially preventable or can be delayed. By adopting healthy living strategies, those at risk of diabetes can significantly reduce their risk of developing the condition. Those with diabetes can control their health through lifestyle and drug-based therapies. As the disease progresses the intensity and sophistication of interventions needs to increase. Effective monitoring of those at risk and living with diabetes is key to maintaining good health.

The rest of the guide:
Overleaf is a series of questions that Board members might ask to ensure that they are adopting strategies that will improve the reliability of care for people with diabetes, and that plans are in place to support members of the population at risk. We also include a guide to the stages in a 'diabetes career' and a diabetes world class commissioning maturity matrix on the back cover.

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KEY QUESTIONS	PLAUSIBLE ANSWERS	UNACCEPTABLE ANSWERS
1. What steps are we taking to raise awareness with at risk pre-diabetic groups within our local population, and to steer them towards lifestyle control programmes?	We have systematic primary care based screening programmes targeting at risk groups. Our strategy includes the use of demographic profiling to identify individuals at elevated cardio metabolic risk. We have set local targets and are achieving them.	We use existing diabetes registers and these programmes are best left to primary care to decide. The current economic climate makes it sensible not to unearth unmet need.
2. Is there an integrated quality and financial plan for delivery of care for type 2 diabetes in our area?	We have an integrated quality and financial plan for type 2 diabetes that takes into account the quality of clinical care, long term cost effectiveness and patient priorities. The required outcomes for this plan have been agreed in advance and use a combination of clinical indicators, cost savings and patient reported outcomes to measure success. There are short, medium and long term parts to this plan and programmes of work in place to achieve the agreed outcomes. There is a system in place to measure the agreed outcomes and agreement of how to maintain clinical quality should budgets need to be reduced. This plan has been developed with clinical input from all stakeholders within our area and is aligned with the medicines management strategy for our PCT.	We have integrated plans, but no way of measuring progress in terms of costs savings and clinical quality. or We have integrated plans, but these have been developed at the PCT with no clinical input. or We have integrated plans, but they do not include long term cost effectiveness in diabetes including savings due to reductions in diabetes related complications. or We have integrated plans, but no plan for maintaining clinical quality if budgets need to be reduced.
3. Have we got a comprehensively structured programme of care for people with diabetes, supported by clinical engagement and education, to ensure that patients receive properly tailored packages of care as they progress through the various stages of diabetic disease and does this allow for clinician and patient choice?	Quality is monitored regularly against agreed key performance indicators. Regular audits compare practice with NICE guidelines, and this has identified service gaps which our multi-disciplinary team for diabetes is addressing with the commissioner. A structured education programme for all local clinicians is being implemented, and we are rolling out a shared care record for patients with long term conditions. This includes patient education and internet based applications.	We have a clinical lead for diabetes and a team of specialist nurses. The diabetes lead for diabetes is developing a care pathway document.
4. For people with diabetes and individuals at high risk of diabetes within our local population do we have a comprehensive programme to continuously monitor relevant clinical markers, including sugar levels, blood pressure, cholesterol, weight, lifestyle habits and potential for vascular damage?	Though a proportion of people with diabetes and individuals at high risk of diabetes will not achieve agreed targets for parameters of risk, our priority is to achieve a reduction in the number of people at risk, especially those at dangerous risk. Year on year audits of strategy demonstrate a sustained reduction of HbA1c levels, blood pressure and other markers of risk and we have strategies in place to continually improve these measures.	QOF and enhanced QOF are sufficiently robust targets and ensure we identify the patients we need to. Additionally, the dietetic service manages healthy lifestyle programmes. We are target driven and achieve our QOF targets in diabetes.
5. Do we ensure continuity and consistency of care for our patients between our local primary care services and our specialist diabetic services?	We have a well-supported local diabetes network attended by clinical and managerial staff from primary care, the PCT and local hospital providers. We follow up patients lost to the service. The care pathway and medicines management protocols are agreed across all places where care is delivered to prevent inconsistency.	This issue is addressed by the agreed local formulary.

The diabetes career: stages of diabetes and key local actions

The general population

- Education and awareness raising
- Central Government - health policy
- Local Government – parks, sports, town planning, public transport, involve food retailers and restaurants in healthy eating initiatives
- Locally defined screening policy and protocol for the general population
- High risk groups (including South Asians, people with severe mental illness or those with a family history of diabetes) require targeted and intensive advice and more comprehensive screening.

Pre-diabetes, with or without presence of elevated cardiovascular risk factors including blood pressure and lipids

- Structured and ongoing patient education
- Lifestyle advice
- Annual monitoring
- Aggressive targeting of elevated cardiovascular risk factors
- Enhanced QOF

Newly diagnosed diabetes*

- Self management support
- Structured and ongoing patient education
- Psychological and family support
- Need to address potential employment issues
- Small vessel complications start to be relevant

Diabetes care (long term conditions management*)

- Personalised care planning
- Self management support
- Structured and ongoing patient education
- Episodic troubleshooting of problems which require specialist physician input
- Multidisciplinary cross-boundary team with other specialist clinicians
- Annual screen of eyes, feet, kidneys
- Addressing long-term macrovascular risk
- Ensure consistency of care wherever delivered
- Patient empowerment strategies such as expert patient programmes

Patients with more complex needs (e.g. multiple complications of diabetes or unstable type 1 diabetes*)

- Self management support
- Structured and ongoing education programmes for clinicians & patients
- Where appropriate easy access to specialist care
- Virtual consultations
- Episode based trouble shooting interventions when necessary in secondary or tertiary care

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* Those with type 1 diabetes should always have access to specialist care

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Diabetes Care and World Class Commissioning: Maturity Matrix

To use the matrix: Statements are incremental. Meeting stage 2 implies also meeting stage 1, and so on. To understand your own service identify with a circle the level you believe your organisation has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months.

PROGRESS LEVELS: / KEY ELEMENTS:	0: NO	1: BASIC LEVEL - PRINCIPLE ACCEPTED AND COMMITMENT TO ACTION	2: EARLY PROGRESS IN DEVELOPMENT	3: RESULTS BEING ACHIEVED	4: MATURITY - COMPREHENSIVE ASSURANCE IN PLACE	5: EXEMPLARY
OUTCOMES	NO	We understand which of our selected outcomes relate to diabetes care and understand where our population is in relation to national norms. We have linked this to our strategy and commissioning plans	We have good local systems in place for measuring key processes that have a proven link to better outcomes for people with diabetes, including patient reported outcomes	We have worked out our trajectory for outcome improvements as they relate to diabetes and diabetes risk factors and are receiving reports which indicate that we are making progress according to plan	Gap analysis has enabled us to use our system of outcome monitoring to make improvements to plans and commissioning developments	We are in the upper quartile for those of our outcomes which relate to the care of people with diabetes, and the reduction of risk behaviour. We benchmark ourselves internationally with similar populations to determine we provide efficient and effective care
COMPETENCIES	NO	Our current PCT competencies can be explained in terms of how we commission services for diabetes	Our competencies assessment tells us that our commissioning of diabetes care is not below the standard of any other significant care group	Developments in diabetes care demonstrate an improvement in our WCC competencies	Our competencies can demonstrate that in diabetes care we are commissioning strategically	Our PCT has achieved level 4 in all WCC competencies and actively promotes better commissioning to other organisations
GOVERNANCE	NO	Our Board understands the process by which diabetes care is commissioned, and receives periodic assurances that plans are being successfully put into action	Our corporate dashboard includes information directly relevant to the commissioning of diabetes care and risk behaviours	Our Board can demonstrate that it is constructively challenging plans and strategies which effect the care of patients with diabetes and has active assurance that these represent better practice and consistency of care	The Board Assurance Framework can demonstrate that we have successfully controlled the risks to achieve our strategic aims for people with diabetes and the reduction of risk behaviour in the population	Board members are knowledgeable about local diabetes services, and have assurance that local services continuously meet better national practice. Outcomes are in the upper quartile nationally
STRATEGY	NO	Our strategy explains how we are addressing the needs of people with diabetes and working with our local population to reduce the factors which cause diabetes	Our plans for diabetes services have been agreed with all relevant partner organisations, and have involved clinicians and patients in their development. The Board Assurance Framework includes reference to diabetes related issues	The WCC process is supported by evidence that elements of our plans to improve diabetes care are being delivered. The commissioning strategy is refreshed to take note of any emerging better practice in relation to diabetes care	Our plans ensure that while maintaining the duty of financial balance we are not compromising long term benefits through failing to commission strategically. We are investing in healthcare interventions with longer term outcome benefits	Delivering our strategy has led to improved health of our local population, with a lower incidence of diabetic illness in our population than the expected norm
ORGANISATIONAL DEVELOPMENT	NO	Our organisational development plan has in place measures which will ensure that the PCT has the right skills and capacity to commission diabetes care	Our organisational development activity includes input from local clinicians from all the required specialities and specifically covers knowledge management to promote good diabetes care	Primary care services are successfully being developed to enable the safe and effective care of patients with diabetes in the community. Individual care plans and care records systems are in place utilising current IT solutions.	We have successfully developed the capacity and capability of our PCT to commission better diabetes services and have promoted developments to ensure clinician development. Outcome for patient groups is audited through our patient data management system.	As an acknowledged beacon of better practice in diabetes care, we are actively promoting improvement in colleague organisations

Developed under license from the Benchmarking Institute - 'Good is only good until you find better'.
For more information and for further copies of this matrix see www.good-governance.org.uk