

### 419 - Care pathway governance guides for boards: asking the right questions Clinical Board Assurance Prompts

**What is diabetes?**  
Affecting around two million people in the UK, diabetes is a condition which results in people having too much glucose in their blood. Type 1 diabetes (insulin dependent diabetes) is caused 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 or total deficiency of insulin, to many cases it is linked to obesity. 90% of people with diabetes have type 2 diabetes. Linked to high blood pressure, adverse lifestyle of circulating blood lipids and accelerated narrowing of major blood vessels it 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 vascular damage leading to heart disease, strokes, visual impairment, kidney failure and can compromise lower limb function in a variety of ways. Effective management of diabetes involves targeting blood glucose and blood lipids, weight and blood pressure.

**What are the benefits of improving the reliability of care for diabetes?**

- Enable people with diabetes to take control of their lives, adopt healthy behaviours and add life to years, years to life
- Reduce unnecessary early disability and death
- Reduce unnecessary admissions
- Reduce the risk of dangerous co-morbidities

**Avoiding diabetes, and living with diabetes**  
There is no such thing as an 'ideal' diabetes-free life. All patients in hospitals have diabetes. More than half the cases of type 2 diabetes are potentially preventable. 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 application of non-pharmaceutical measures to increase effective monitoring of those at risk and living with diabetes is key to maintaining good health.

**The need of the guide**  
Below 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. Check it is a guide to the stages in a Diabetes care/OSA care the diabetes world class commissioning maturity matrix

Key Questions	Possible answers	Unacceptable answers
1. What plans are in place to raise awareness with risk and diabetic people within our local population, and to raise awareness of the local population?	We have a series of primary care based screening programmes targeting at risk groups. We have set local targets and are achieving them.	Nothing is being done to raise the local self-awareness of people at risk of diabetes. The current awareness climate makes it unlikely for anyone to be screened.
2. For patients with an HbA1c of greater than 9.0 within our local population, do we have a comprehensive programme of intensive insulin treatment (tight control), including target HbA1c, target blood pressure, cholesterol, weight, lifestyle and patient education programmes?	Target HbA1c of patients will not exceed agreed targets for patients at risk, our primary aim is to reduce a population at risk on the basis of strong evidence and a sustained reduction of HbA1c targets, and other markers of risk.	Our aim is to reduce our HbA1c target to 8.5% for all patients with diabetes. We do not have a comprehensive programme for all our diabetes in being implemented, but we are doing it in a limited number of patients with long term conditions. This includes patient education.
3. Do we have clinical and commissioning care for our patients between our local primary care services and our specialist clinical services?	We have a multi-specialist local diabetes system, supported by clinical and non-clinical staff in primary care, the HCP and local specialist providers. We share expertise from the services.	We have a clinical team for diabetes who is based in the specialist services. The diabetes team for diabetes is developing a care pathway document.

Developed by the Good Governance Institute with input from NHS colleagues and an educational grant from BMS - vascular overall

### The diabetes career - PYRAMID

**The general population**

- Education and awareness raising
- Central Government - health policy
- Local Government - parks, sports, town planning, public transport

**People with HbA1c 5.6 & over with cardiovascular risk**

- Targeting of risk groups (genotypes and phenotypes) including South Asians, people with severe and enduring mental illness, those with a family history of diabetes
- Advice and screening services

**Pre-diabetes, defined on the basis of a fasting blood glucose level of 6.1 - 6.9. Elevated CVD risk including blood pressure, lipids & reactive protein**

- Enhanced GGP
- Lifestyle advice
- Medicines
- Annual monitoring
- Aggressive targeting of cardiovascular risk factors

**Newly diagnosed type 2 diabetes**

- Social issues considerations start to be relevant
- Psychological and family support
- Medicines to address employment issues

**Long term conditions management including type 1 insulin dependent diabetes**

- Epidemic problems which require specialist clinical input
- Other specialist clinicians
- Annual screen of eyes, feet, ADHD
- Addressing microvascular risk

**Patients with more complex needs, unstable type 2 diabetes**

- Specialist support to primary care team
- Virtual consultation

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### Clinical Board Assurance Commissioning Maturity Matrix

Diabetes Care and World Class Commissioning: Maturity Matrix

To use the matrix, Statements are incremental. Moving stage 2 implies also meeting stage 1, and so on. Do not understand your own score or identify with a circle that does not indicate your own organisation has reached or is on its way to achieve it. Use the right to the level you intend to reach in the next 12 months. **Green**

Progress levels	1	2	3	4	5
<b>Key Elements</b>	1. Basic level: Prioritise urgent and essential activities	2. Start progress in development	3. Establishing a solid base	4. Monthly comprehensive reviews in place	5. Exemplar
<b>Outcomes</b>	No. The operational status of the clinical commissioning unit is stable and effective. The clinical commissioning unit is effective in meeting the needs of the population it serves. The clinical commissioning unit is effective in meeting the needs of the population it serves.	No. We have identified systems in place for meeting the needs of the population it serves. We have identified systems in place for meeting the needs of the population it serves.	No. We have established our regularity for meeting the needs of the population it serves. We have established our regularity for meeting the needs of the population it serves.	No. Our needs are met through the use of specialist commissioning programmes. We have established our regularity for meeting the needs of the population it serves.	No. We have the agreement of the board of the population it serves. We have established our regularity for meeting the needs of the population it serves.
<b>Competencies</b>	No. The clinical commissioning unit is effective in meeting the needs of the population it serves. The clinical commissioning unit is effective in meeting the needs of the population it serves.	No. We have identified systems in place for meeting the needs of the population it serves. We have identified systems in place for meeting the needs of the population it serves.	No. We have established our regularity for meeting the needs of the population it serves. We have established our regularity for meeting the needs of the population it serves.	No. Our needs are met through the use of specialist commissioning programmes. We have established our regularity for meeting the needs of the population it serves.	No. We have the agreement of the board of the population it serves. We have established our regularity for meeting the needs of the population it serves.
<b>Governance</b>	No. The clinical commissioning unit is effective in meeting the needs of the population it serves. The clinical commissioning unit is effective in meeting the needs of the population it serves.	No. We have identified systems in place for meeting the needs of the population it serves. We have identified systems in place for meeting the needs of the population it serves.	No. We have established our regularity for meeting the needs of the population it serves. We have established our regularity for meeting the needs of the population it serves.	No. Our needs are met through the use of specialist commissioning programmes. We have established our regularity for meeting the needs of the population it serves.	No. We have the agreement of the board of the population it serves. We have established our regularity for meeting the needs of the population it serves.
<b>Strategy</b>	No. The clinical commissioning unit is effective in meeting the needs of the population it serves. The clinical commissioning unit is effective in meeting the needs of the population it serves.	No. We have identified systems in place for meeting the needs of the population it serves. We have identified systems in place for meeting the needs of the population it serves.	No. We have established our regularity for meeting the needs of the population it serves. We have established our regularity for meeting the needs of the population it serves.	No. Our needs are met through the use of specialist commissioning programmes. We have established our regularity for meeting the needs of the population it serves.	No. We have the agreement of the board of the population it serves. We have established our regularity for meeting the needs of the population it serves.
<b>Organisational development</b>	No. The clinical commissioning unit is effective in meeting the needs of the population it serves. The clinical commissioning unit is effective in meeting the needs of the population it serves.	No. We have identified systems in place for meeting the needs of the population it serves. We have identified systems in place for meeting the needs of the population it serves.	No. We have established our regularity for meeting the needs of the population it serves. We have established our regularity for meeting the needs of the population it serves.	No. Our needs are met through the use of specialist commissioning programmes. We have established our regularity for meeting the needs of the population it serves.	No. We have the agreement of the board of the population it serves. We have established our regularity for meeting the needs of the population it serves.

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

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