Manchester City Council  
Report for Resolution

Report to: Health Scrutiny Committee – 18 October 2012  
Subject: Diabetes Services for People in Manchester  
Report of: Director of Public Health and Chief Officers of the Manchester Clinical Commissioning Groups

Summary

This overview report has been requested following the publication of a report by the National Audit Office into the management of adult diabetes services in the NHS. This report provides background information on diabetes risk and prevalence in Manchester. It describes in detail the areas of Primary Prevention, Primary care, Screening, Services to promote self-care, Community-based Services, Secondary Care (Hospital) Services, Social care and Support Services; identifying where and how provision of services differs between North, Central and South Manchester. The purpose of the report is to assist the Committee in reviewing if there are service areas that are not meeting the needs of patients and the impact of this on the services received by patients.

Recommendations

The Committee is asked to;

1. Note the report

2. Highlight areas for further scrutiny and future reports

Wards Affected:

All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

National Audit Office; Department of Health; The management of adult diabetes services in the NHS; May 2012

NICE Quality Standard QS6 – Diabetes in Adults  
(http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13827)

National Service Framework for Diabetes; UK Department of Health Dec 2001
1. Introduction

1.1. In May 2012, the National Audit Office reported on the management of adult diabetes services in the NHS. The report highlighted variable provision of and access to services for people with diabetes at a national level.

1.2. Diabetes is a significant and growing challenge for the NHS. There is a range Department of Health policy and guidance, which specifies the standards of diabetic care which must be met across England, and how to improve existing services. In 2001, the Department of Health produced the National Service Framework (NSF) for Diabetes. In March 2011, the National Institute for Health and Clinical Excellence (NICE) brought all relevant policy and guidance together in a single quality standard (Quality Standard 6- Diabetes in Adults) to provide patients and the public, health and social care professionals, commissioners and service providers with definitions of high-quality care.

1.3. The National Audit Office report examined whether the NHS in England is meeting the standards of care for diabetes as set out in 2001. It found that, although there are clear standards to describe good diabetic care, only half of people with diabetes receive care in accordance with these standards. Less than one in five people with diabetes are achieving recommended treatment standards.

1.4. The report also found significant variation in the quality of care across the NHS. Current payment mechanisms are failing to ensure sustained improvements in outcomes, with many people with diabetes experiencing poor levels of care in primary and secondary settings. It also highlighted that access to education and support for people with diabetes is known to be effective, yet nationally, too few people are offered this.

1.5. The authors conclude that the NHS does not understand the cost of diabetes at local level and lacks clarity about the most effective way to deliver local services. They correctly identify that better understanding and management of diabetes will save money and lives.

1.6. This report to the Health Scrutiny Committee has been compiled by Public Health Manchester. It brings together information from the Clinical Commissioning Groups (CCGs) in North, Central and South Manchester; the Hospital Trusts of Pennine Acute, Central Manchester and South Manchester; Manchester Mental Health and Social Care Trust; NHS Manchester and Manchester City Council Adult Social Care. It examines services along the whole patient pathway; from prevention to hospital care; identifying where possible, the differing service models and provision for residents of North, Central and South Manchester.

2.0 Background

2.1 There are two main types of diabetes. Type 1 and Type 2. Age, deprivation, obesity and ethnic origin are keys factors in deciding who will develop diabetes and which type.
2.2 Type 1 diabetes occurs when the body produces no insulin. People with type 1 diabetes need daily injections of insulin to survive. This type of diabetes usually develops in early life, particularly adolescence.

2.3 Type 2 diabetes occurs when not enough insulin is produced by the body for it to function properly. People with type 2 diabetes need to adjust their diet and lifestyle and may need to take tablets or insulin to control their blood glucose level. The prevalence (how often it occurs) of type 2 diabetes increases steadily after the age of 45 years. Type 2 diabetes is more common in people of South Asian, African-Caribbean or Middle Eastern origin. It is also strongly linked to obesity and strongly associated with social deprivation.

2.4 Manchester has (a) high levels of deprivation (b) a high proportion of people aged 40 years and older who are from high risk ethnic groups and (c) high estimated levels of adult obesity. These factors all increase the risk of diabetes in the population.

2.5 According to data from the Public Health Observatory, in 2010/11 there were 23534 people aged 17 years and older diagnosed with diabetes in NHS Manchester. There was also an estimated 3577 adults with undiagnosed diabetes. This gives a prevalence of diagnosed disease of 5.4% (e.g. 5.4% of the adult population of Manchester is known to have either type 1 or type 2 diabetes). The estimated actual prevalence of 6% (e.g. it is estimated that a further 0.6% of the adult population has unidentified diabetes). This gap between observed and expected prevalence suggests that not all adults with diabetes are (a) correctly diagnosed or (b) correctly recorded as such on patient data systems.

2.6 NHS Programme budgeting data and prescribing data have enabled the comparison of cost and outcomes within Primary care Trusts (PCTs). NHS Manchester is classified as having higher than average expenditure on diabetes services with lower than average outcomes.

Diabetes Services in Manchester

The following sections describe the range of NHS and social care services that are offered to people with diabetes. The sections are:

- Primary prevention
- Primary care
- Screening
- Self-care
- Community-based services
- Secondary care (hospital) services
- Social Care and support services

3.0 Primary Prevention

3.1 The national NHS Health Checks programme targets adults aged 40-74 years. It focuses primarily on risk of developing cardiovascular disease and includes
an assessment of risk of diabetes. There is no single accepted way of identifying people who are at risk of diabetes or who have existing undiagnosed diabetes, and discussions are ongoing internationally. Therefore the Manchester model describes two main approaches, using weight (by calculating a person’s Body Mass Index - BMI) and blood pressure to identify people at high risk. Using these factors as a filter, it is then possible to identify who may be at high risk and should go on to receive a blood glucose test. These people then receive a blood test to establish how best they can be managed.

3.2 The Manchester Physical Activity on Referral Service (PARS) offers a service for all patients with controlled diabetes. This includes those with Type I and Type II. The referral form asks Health professionals to refer patients with either type of Diabetes. Patients who have diabetes and who are referred to PARS are seen in clinic for pre-activity screening and are then included in classes which are delivered in line with national standards. Patients are followed up at twelve weeks/ six months and twelve months during which time they are referred onto either gym or other activity sessions. A project is in development whereby PARS will work with a GP Practice to look at the impact of early referral to PARS for patients with newly diagnosed Type 2 diabetes.

3.3 The Community Health Trainer Programme in Manchester is available to people at risk of developing diabetes. This service offers individual support to increase levels of physical activity and adopt healthier lifestyles.

3.4 Healthy Living networks in North and South Manchester are commissioned to develop community capacity to increase choices and opportunities to improve health and well-being.

3.5 Manchester Stop Smoking services are open to people who live, work or are registered with a GP in Manchester and are a valuable component of a citywide healthy living service.

4.0 Primary Care

4.1 All GP practices in Manchester are contracted to provide services for patients with diabetes. Each of the Clinical Commissioning Groups (CCGs) is currently developing ways in which they can monitor outcomes for patients at GP practice level. Computer-based information systems, known as clinical dashboards, are being used to support practices in the management of patients with diabetes and to monitor variation in care and outcomes across GP practices, particularly around complications that are secondary to diabetes. Each CCG is taking a slightly different approach, but with broadly similar aims. As an example, the work currently being undertaken in North Manchester is described below. It differs slightly from the work in Central and South Manchester CCGs, but is representative of work taking place across the city.
4.2 In North Manchester, the timely diagnosis and effective management of diabetes in primary care is a key priority. The local approach aims to be patient focused, with an emphasis on ensuring that all diabetic patients

- have access to structured education programmes
- understand the level of care to expect for their level of need
- are supported to self manage their condition
- receive care in line with NICE guidelines

The CCG provides a structured programme of professional education to practices to ensure they have the skills and knowledge to provide an agreed minimum standard of diabetes care, with further support available to practices wishing to provide an enhanced level of care. Until 2009, a community diabetes team existed in North Manchester. During re-organisation, specialist posts were lost. North Manchester Clinical Commissioning Group (NMCCG) has now redeveloped a local community diabetes team, with a revised remit to provide an intermediate level of care, as well as providing support and mentoring to North Manchester practices.

4.3 The aim of the local programme is to improve diabetes management in primary care - specifically:

- Increase confidence of primary care health professionals to manage diabetes
- Enhance ability of primary and community care to manage diabetic patients
- Reduce referrals to secondary care outpatient diabetes clinics
- Reduce non-elective attendances and admissions related to diabetic complications
- Improve the outcomes for patient with diabetes, and their ability to self-manage.
- Increase discharge from secondary care outpatient clinics for ongoing management by GP
- Achieve optimal drug regimen for patients
- Reduce exception reporting in the Quality and Outcomes Framework (QOF). This refers to the number of patients who are excluded from performance reporting due to a variety of reasons.

By focusing diabetes care on pro active, planned management the CCG aims to reduce the number of diabetes patients needing urgent care services, in particular reducing urgent care attendances and admissions.

4.4 Activity and clinical effectiveness in General Practice are measured against the 14 Quality and Outcomes Framework (QOF) indicators for diabetes. These indicators measure the quality of care provided to diabetic patients by their General Practice Team. QOF has operated in the NHS since 2004/05 as a voluntary incentivised programme where GPs are rewarded for identifying and managing patients with long term conditions across a range of 86 clinical treatment and measurement indicators. There are currently 22 disease registers within QOF, including adult diabetes. (QOF applies only to diabetic
patients aged 17 years or older. Those below this age group continue to receive the majority of their treatment in secondary care). 14 clinical indicators in QOF apply to the diabetes register and cover the following areas:

- BMI measurement
- Blood Glucose levels
- Retinal screening
- Foot examination risk classification
- Foot neuropathy testing
- Blood pressure control
- Kidney function testing and monitoring
- Cholesterol levels
- Influenza immunisation

These areas are referred to in the report of the National Audit Office as the “nine basic care processes for people with diabetes to be delivered annually”.

One outcome of the QOF process is that approximately 90% of type 2 diabetes care is now provided in general practice compared to 20 years ago. There are currently (2012) 24,772 patients registered in Manchester on the QOF diabetes registers.

4.5 In terms of income from QOF, practices need to reach a minimum number of points before they become eligible for payment and once at a maximum threshold e.g. 90% of total eligible patients, they then receive the maximum payment per indicator. Perversely, the principle of entitling full payment to a below 100% threshold means there are practices which may cease targeting eligible patients once they reach the maximum threshold and there are therefore patients not reached. For 2011/12, the NHS Manchester QOF spend on diabetes was £1.09 million (15.35% of the total for QOF) across 102 practices.

4.6 In 2011/12 the total achievement for practices across Manchester reached the maximum set thresholds apart from for the following indicators where the 90% threshold was not met:

- Maintenance of adequately controlled blood glucose level (only 85.67% met)
- Retinal screening (88.66% met)
- Foot examination risk classification (87.28% met)
- Foot neuropathy testing (88.69% met)
- Record of micro-albuminuria (kidney function) testing (86.66% met)

4.7 There is concern nationally that QOF reduces diabetic care to a list of unrelated tasks that may not be meaningful for patients. For 2013/14, national changes are proposed to QOF in relation to diabetes. Rather than rewarding practices for completing a number of tasks, consideration has been given to having a composite indicator that would constitute a diabetic review and measuring achievement on ‘an all or nothing’ basis. This approach is not supported by the National General Practitioners Committee, on the basis that
patients may not wish to undertake a whole suite of indicators at the same time and therefore may refuse to be reached for future assessment.

5.0 Screening

5.1 The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss among people with diabetes by the early detection and treatment, if needed, of sight-threatening retinopathy. The Manchester Programme is delivered by local optometrists. People with positive test results attend a treatment centre at Manchester Royal Infirmary. The most recent figure for the uptake of diabetic eye screening in Manchester is 73% of the eligible population screened. This is lower than in surrounding areas, but in line with similar sized cities with corresponding levels of deprivation.

6.0 Self-care; the Expert Patient Programme

6.1 Any adult with diabetes in Manchester is able to access a Chronic Disease Self Management Expert Patients Programme (EPP). The programme targets people who live with (or care for) any long term health conditions and is offered to patients who are resident/GP registered in Manchester at 13 venues across the city. Referrals are accepted from patients themselves and any other health/non-health professionals. The EPP has been proven to reduce health care costs and improve patient experience. Since 01/04/2011 the Manchester programme has received 96 referrals where diabetes is recorded as a condition, with 16 completing it so far. The EPP team also signposts people to diabetes-specific services. Under Transforming Community Services the EPP service was transferred to University Hospital of South Manchester NHS Foundation Trust in April 2011 as a citywide service but has been advised that the service will be reviewed/restructured by the end of 2012.

7.0 Community-based services; North Manchester

7.1 NHS Diabetes is a national agency; providing the link between strategy and frontline services. In 2009/10, using guidance from NHS Diabetes, North Manchester Clinical Commissioning Group (NMCCG) undertook a diabetes health needs assessment to review each aspect of diabetes care and understand whether services were in line with NICE guidance; identifying areas for development. During this assessment, NMCCG developed and published a patient questionnaire to gain views from local patients about their diabetic care. This was intended to assist in identifying the particular areas of diabetic care which patients indicated needed to improve. The findings suggested that NMCCG needed to focus on patient education, and the diagnosis and treatment of diabetes in primary care.

7.2 As a result, Professor Dang, the local Consultant Diabetologist, based in North Manchester general Hospital, worked with the CCG to develop a programme of diabetes education and training for local GPs and practice nurses to improve their level of diabetes care. This has been delivered over the last 18 months, with the final session in July 2012. In 2012, NMCCG also commenced a specific programme of education and training for practice nurses. Over the
next 12 months this will focus on pre-insulin diabetic management, insulin initiation for type 2 patients and insulin optimisation.

7.3 NMCCG commissions a community diabetes team, including two diabetic specialist nurses, to provide a service which bridges the gap between primary care, or the GP practice, and secondary care, or hospital care. These nurses are already in post and are working with local community services, including district nurses, to ensure that patients who are housebound or in residential care receive optimal diabetic care.

7.4 For Type 1 patients, the Dose Adjustment for Normal Eating (DAfNE) course is available locally, delivered by Diabetic Specialist Nurses.

7.5 Until recently, patients with Type 2 could not access accredited education, a critical service to enable patients to manage their diabetes. Following research and consultation with Diabetes UK (the UK’s leading diabetes charity) and the local diabetes team, NMCCG commissioned the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) education programme for Type 2 Diabetic patients. DESMOND meets NICE requirements for patient education.

7.6 Adults with diabetes in North Manchester have access to specialist dietetic support via the North Manchester Nutrition Service. The service is compliant with national standards and provides dietary education to those newly diagnosed and established diabetics. People are triaged depending on the most recent blood glucose readings and level of medication required. Those at highest risk are offered appointments with a highly specialist diabetes dietician; those at moderate and low risk are managed by a community Specialist Dietician appointment. Depending on the assessment completed by the registered dietician, the patient is either provided with dietary education within a group or a clinic appointment. The service is structured around developing a greater understanding of “What is Diabetes?” and “Managing Diabetes through a Healthy Lifestyle.” In the future, the dietetic staff aim to provide a training programme to increase the knowledge around diabetes and dietary control of diabetes. They have identified the Care Home and Residential Home setting to be the primary focus for this training programme, which will then hopefully be extended to Practice Nurses and Community Nurses.

7.7 The North Manchester Community Nutrition Service is also developing a project to train Food and Nutrition Champions within Care Homes and Residential Homes, with diabetes included in the programme.

7.8 Adults with diabetes in North Manchester are able to access local podiatry (foot health) services in community clinics. For patients who develop more advanced problems, North Manchester CCG commissions a ‘High Risk Foot Multi-Disciplinary Team’ in line with national standards. Where diabetic patients are diagnosed by either their GP or general podiatry as being at increased risk of foot ulceration, they are seen the high risk foot team to
ensure their condition is managed in line with the best clinical practice, preventing further degeneration.

8.0 Community-based services; Central Manchester

8.1 Central Manchester Clinical Commissioning Group (CMCCG) has a Diabetes Local Enhanced Service (LES) to which 18 GP Practices have signed up to provide additional community-based care for their patients. Of these, 4 have become ‘Beacon’ Practices and will see patients from those Practices in Central Manchester which do not deliver the enhanced service. This will ensure that all Diabetic patients in Central Manchester have access to this community service. Clinicians in the LES Practices will initiate injectable treatments to those patients that require it in order to improve their Glycaemia (blood glucose) control. Practices have been offered a comprehensive educational programme to gain accreditation to deliver this more advanced level of care. The service will be fully operational from December 2012.

8.2 The X-pert patient programme course is run over six weekly, three hour sessions designed to increase the skills, knowledge and confidence of patients to manage their diabetes. The programme can improve diabetes control, increase self-management skills and improve lifestyle and quality of life. Patient and professional education is offered through the nationally accredited X-pert patient education programme and Dose Adjustment for Normal Eating (DAfNE). CMCCG is now also in the process of commissioning a Structured Education programme for our Type 2 Diabetics.

8.3 CMCCG has just developed a project to improve the identification, prompt early diagnosis and effective management of five Long Terms Conditions, of which diabetes will be one. Diabetes Specialist Nurses from the Manchester Royal Infirmary Diabetes Centre will work with a number of local Practices to (a) support them in identifying diabetic patients by screening those at the highest risk and (b) optimising the care of diabetic patients. They will also support Practices to develop their skills and knowledge.

8.4 CMCCG has identified further areas where development would improve local diabetes services and which will form the basis of future work, including:

- A structured education programme for primary care clinicians
- Funding for advanced education courses such as the Warwick course
- Variability in the standard of care delivered in primary care, specifically QoF and patient outcomes
- Proactive screening for diabetes, particularly in high risk populations, to support secondary prevention is not carried out routinely
- There is a need to improve awareness amongst high risk black and minority ethnic groups of the prevalence of diabetes and measures that can be taken to reduce the likelihood of the development of type 2 diabetes
- Sharing of patient records across organisations
- Increased uptake of Diabetic Retinal Screening.
8.5 Finally, CMCCG has recently appointed an Ophthalmology Clinical Lead who will work with the CCG to understand and review the local Retinal Screening service.

9.0 Community-based services; South Manchester

9.1 Patient education is offered via a number of sources. These include the Xpert patient education programme (http://www.xperthealth.org.uk/), newly diagnosed diabetes educational sessions, Dose Adjustment for Normal Eating (DAfNE - http://www.dafne.uk.com/) and the Warwick Certificate in Diabetes Care (one of a number of courses provided by Warwick Medical School). The Warwick course has a very good reputation for providing the practical knowledge and skills necessary for healthcare professionals to deliver an effective and efficient service for people with diabetes. The course content and materials are evidence based and incorporate national and local guidelines.

9.2 The DAfNE course is delivered locally in conjunction with UHSM who deliver six courses a year for up to eight patients per course. The course is Diabetic Specialist Nurse (DSN) and dietician led, and overseen by a Consultant. Refresher courses are held for patients who have previously completed the course.

9.3 South Manchester Clinical Commissioning Group (SMCCG) commissions a Tier 2 Diabetes Intervention Clinic. This multidisciplinary specialist diabetes service provides intensive, holistic management of people with type 2 diabetes and associated cardiovascular risk factors. It offers an intermediate level of care between that provided by primary and secondary care to patients with diabetes who have complex needs, facilitating the delivery of high quality diabetes care in a community setting.

9.4 The team comprises a GP with Special Interest (GPwSI), Assistant Practitioner, an Advanced Nurse Practitioner and Diabetic Specialist Nurses. The team also has podiatry and dietetics support. They have strong links with SMCCG GP practices and offer regular clinics to individual practices with Advanced Nurse practitioners and Diabetic Specialist Nurses each affiliated to a number of practices. In addition to seeing patients with diabetes, the team also offer advice to primary care in response to GP/practice nurse queries. In addition, the team hold a regular complex foot clinic for patients with diabetes, the aim of which is to deliver a multidisciplinary approach to the management of foot ulcers and offer a wide range of interventions aimed at assessing and healing foot pathology.

9.5 There are also monthly Diabetic Specialist Nurse drop-in clinics held in all GP practices in south Manchester for the general review and management of patients with diabetes and weight management clinics, delivered by community dieticians, offering lifestyle advice etc. Referral to these clinics, and the Tier 2 clinics, is via GPs, practice nurses or Diabetic Specialist Nurses. (Tier 2 services are provided in community settings and treat people who have conditions that are more complex than would usually be managed by their GP,
but do not require hospital care). Diabetes care is also delivered to patients in nursing homes and residential care.

9.6 Community-based services for people with diabetes in South Manchester are currently being redesigned. SMCCG is about to implement an integrated diabetes service across seven practices in south Manchester to improve the management, outcomes and experience of people with diabetes, and adopt an integrated approach to care delivery. The service will be delivered initially as a six-month pilot, with the potential to be rolled out across all 25 GP practices in SMCCG in the future.

9.7 The service will be delivered by a multidisciplinary team comprising a Consultant Endocrinologist (a specialist in disorders of hormones and glands), DSN, dietician and podiatrist who will develop formal links with the practices and deliver services from a primary care location.

Service delivery will comprise the following:

- A weekly Multi-disciplinary team (MDT) clinic for patients with complex and/or poorly controlled diabetes. Specialist telephone advice will be offered to primary care clinicians at the beginning of each session.
- Weekly drop-in clinics, delivered by a DSN and dietician, for follow-up of patients seen at the MDT clinic and those already on the DSN caseload.
- A monthly case notes review of clinical queries for specific patients, e.g. treatment, medication, complications.
- Bi-monthly specialist education sessions for primary care clinicians. Suggested topics for discussion include; new treatment, the importance of peri-conception care, foot disease and problems with managing adolescents with diabetes.
- A drive for patients to attend an educational programme; X-pert patients or DAfNE as appropriate.

Patient feedback will be sought throughout the pilot through the use of a questionnaire as patients enter and leave the service, and the opportunity to complete patient/carer diaries. This will inform planning around future service delivery.

10.0 Secondary Care Services

10.1 Whilst over 90% of adults with diabetes are treated successfully in community settings, secondary Care services are commissioned for those who have unstable conditions or complex needs.

10.2 North Manchester / Pennine Acute Hospitals Trust

NMCCG aims to focus on the diabetes pathway over the coming year. Patient feedback on current services highlighted a need to focus on several key areas from diagnosis to continuing care including foot care and patient education. NMCCG and Pennine Acute NHS Hospitals Trust have agreed to work on a model of diabetes care which is underpinned by an agreed ‘levels of care’. The levels of care will define three or four levels of diabetes care, level one
being the minimum standard to be provided by practices, level four being specialist diabetes provision at a secondary care level.

10.3 **Central Manchester Hospitals Foundation Trust (CMFT)**

The existing adult diabetes service at the Diabetes Centre at the Manchester Royal Infirmary has a dedicated team of Diabetes Consultants, diabetes specialist nurses (DSNs), podiatrists and dieticians. The Royal Manchester Children’s Hospital also offers a comprehensive paediatric diabetes service. Both teams are responsible for the care of inpatients and outpatients with complex diabetes needs and cover the following:

- Outpatient services with DSN, dietetic and podiatry input for complex Type 1 and Type 2 patients (new/review)
- Specialist foot clinic
- Erectile dysfunction clinic
- Specialist podiatry clinic
- Specialist renal clinic
- Antenatal clinic
- Young person’s transitional clinic (age 16 to 24)
- Specialist education and start-up clinics for patients who require insulin pumps and complex glucose monitoring devices (CGMS)
- Patient education including dose adjustment for normal eating (DAfNE)
- Telephone support
- Education and support for our Primary Care staff
- Telephone and email advice lines for our Primary Care staff

10.4 **University Hospital South Manchester Foundation Trust (UHSM)**

The existing adult diabetes service at the University Hospital of South Manchester (UHSM) includes four whole-time equivalent (WTE) Consultants (with only a proportion of their time dedicated to diabetes care), a small team of diabetes specialist nurses (DSNs) with support from dietetics and podiatry. In addition there is a small team who provide paediatric diabetes care. The team are responsible for the care of inpatients and outpatients with complex diabetes needs and cover the following:

- Outpatient services with DSN, dietetic and podiatry input for complex cases e.g. complex Type 1 diabetes (new/review)
- Specialist foot clinic (delivered jointly with orthopaedic consultant)
- Erectile dysfunction clinic
- Specialist podiatry clinic
- Specialist renal clinic
- Antenatal clinic
- Complex review clinic
- Young person’s transitional clinic (age 16 to 24)
- Specialist services for patients with Cystic Fibrosis
- Specialist education and start-up clinics for patients who require insulin pumps and complex monitoring devices (CGMS)
- Patient education including dose adjustment for normal eating (DAfNE)
The team also provide secondary care drop-in clinics at UHSM and Withington Community Hospital for all patients with diabetes. Patients who are registered with a south Manchester GP and are under the care of secondary care diabetes services can self-refer into the clinics for support with insulin starts, insulin titration and other general support for their diabetes. The DSNs also provide telephone advice to patients and clinicians.

11.0 Social Care and Support Services

11.1 The provision of social care and support for adults with diabetes or any other medical condition depends upon assessment of eligible need. A diagnosis of diabetes will not necessarily equate to a need for social care or support. However the relationship between diabetes and other factors such as older age, deprivation and obesity means that people who have diabetes are more likely than people who are medically fit to require help and support at some stage to meet their social needs. Where individuals with diabetes are assessed as eligible for social care and support they have choice and control over how their needs are met. Social care and support is arranged to complement medical treatment to help people to remain as well, healthy and independent as possible.

11.2 A specific diabetes service is provided by a diabetes worker within the African Caribbean Care Group, in Central Manchester. This group is based around a lunch cub, seeing between 80 and 120 customers per month.

11.3 The Sugar Group, at the Kath Locke Centre, provides group support for adults with diabetes.

11.4 The Chinese Health information Centre provides a diabetes information service, funded by voluntary contributions.

11.5 Within the last few months, an organisation known as the Manchester City Wide Diabetes Support Network has been created. This is a registered charity led by individuals who have previously been involved in diabetes work within the city. The reported aim is to develop a structure of support groups, run by volunteers from local communities and supported by voluntary co-ordinators. Members of the network have met with a number of elected members of Manchester City Council to discuss how they may support further developments. Links to local CCGs are not yet been established.

12.0 Conclusion

12.1 The provision of diabetes services across Manchester is complex. In common with the findings of the National Audit Office, the current design of some local services is as a result of historic practice and does not always reflect local need. However, each of the CCGs is currently undertaking significant work to review and redesign local services that deliver improved outcomes and meet the needs of local people.
12.2 Local education programmes adults with diabetes are delivered in accordance with national standards. The programmes are well received by those people who access them and are proven to have a positive impact on health and wellbeing. However, access to this service is not consistent across the city. Not all adults with diabetes are referred to an education programme by their GP and not all of those referred choose to attend. The current capacity to provide diabetes education is insufficient to meet demand, if all eligible adults were to attend.

12.3 The provision of community and voluntary sector support groups for people with diabetes is patchy. The established support groups identified target people from black and minority ethnic populations.

12.4 There is potential for the complexity of local services to be improved by current projects in each CCG / locality aimed at greater integration of NHS and Social Care.

12.5 A key priority is the early detection and effective management in primary care of people with diabetes. The quality of care provided by General Practice (as measured by QOF and levels of exceptions to achievement of clinical indicators) is variable; a matter which has been identified by all three CCGs and is a priority for each for the future.

13.0 **Recommendations**

The Committee is asked to;

a. Note the report
b. Highlight areas for further scrutiny and future reports