Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 15 January 2015

Subject: Improving Diabetes Care

Report of: Nick Gomm**,** North, Central, and South Manchester Clinical Commissioning Groups

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Summary

This report provides Members of the Committee with an overview of the ongoing work to improve diabetes care in the community.

Recommendations

The Health Scrutiny Committee are asked to note the contents of this report.

Wards Affected: All

Contact Officers:

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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.
None

1. Introduction

1.1 In January 2014, the Committee received a paper on diabetes services in Manchester and it was agreed that the Committee would receive a follow up paper a year later. The following paper provides an update on diabetes services in each of the three Clinical Commissioning Groups in Manchester.

2. North Manchester

2.1. Self Care

North Manchester CCG has continued to invest in Self Care though initiatives such as North Manchester Integrated Neighbourhood Care (NMINC) teams, an innovative way of bringing together health and social care around patients at risk of admission to hospital to develop co-ordinated care. Patients in this cohort largely have multiple long term conditions, often including diabetes. One of the three key aims of the service is enabling and empowering patients to self-care though referrals to healthy life style interventions and access to Telehealth.

By popular demand the CCG updated and reprinted the North Manchester patient information booklet in 2014. The information packs were originally commissioned in 2012, and distributed by GP practices and Diabetes Specialist Nurses to existing and newly diagnosed patients.

The book is intended to help address patient feedback about a lack of information provided at diagnosis, and also to make patients more informed about what to expect from their GP and support services, in particular the 9 key care processes for diabetes. The booklet also provides lifestyle advice and sign posting to local services. The CCG have also been working with Diabetes UK to address the availability of diabetes information in different languages.

North Manchester CCG commissioned a Diabetes Ramadan campaign which ran over the summer leading up to Ramadan to raise awareness of safe fasting and promoting healthy lifestyle in Muslim population in North Manchester. The campaign worked with local voluntary groups, faith leaders and community groups through various community events and media campaigns.

2.2. Community Based Care

North Manchester CCG continues to commission a Community Diabetes Specialist Nursing service from Pennine Acute Hospital to provide care for patients with uncontrolled diabetes and support General Practice. The service, alongside the community Nutrition Team have also been commissioned to deliver structured diabetes education called DESMOND. This is a 6 hour course which teaches people the facts about diabetes and how to manage it safely. They are currently running two sessions per month in the community.

North Manchester CCG has a very diverse patient population, and is aware that Type 2 diabetes is around three times more common in people of African and African-Caribbean origin and six times more common among those of South Asian descent.

Their associated morbidity and mortality from diabetes is also considerably higher than those of white, European origin. Whilst the evidence supporting structured education is based on white European groups, a recent Health Technology Assessment concluded that it is also likely to be effective in ethnic minority populations; if adapted appropriately.

In response to this NMCCG have worked with and commissioned Al-Hilal -a voluntary organisation based in Cheetham Hill to develop and deliver a culturally specific structured diabetes education Pilot in a range of languages to the population of North Manchester. These sessions were launched in May 2014, and 9 sessions have been held to date. A review of the pilot will be taken this year to inform future commissioning intensions.

2.3. Primary Care

The prevalence of diabetes which indicates identification and recoding of patients with Diabetes in General Practice has increased according to QOF (Quality and Outcomes Framework) from 6.15 in 2013 to 6.37 % in 2014. This demonstrates practices actively identifying and monitoring patients with diabetes. 100% of the practices have also taken part in the National Diabetes Audit that presents key findings on key care processes and treatment target achievement rates from 2012-2013 in all age groups in England and Wales. Further improvement work is needed in this area and a programme of work in primary care is in development, starting with identifying patients with Pre diabetes and supporting them to make changes which will either halt or slow the development of diabetes.

In 2013 the CCG had identified care home residents as one potentially disadvantaged group with disproportionately high levels of admissions to hospital relating to poor diabetes management. As a result, the CCG commissioned an independent review of diabetes care in care homes to audit care, to identify any shortcomings or opportunities, and to make recommendations for the future. In response to this audit the CCG has been working with practices to identify and ‘flag’ Diabetic nursing home patients on Practice registers, and highlighting the need for comprehensive care plans and good communication to help support continuing care in nursing homes.

The CCG in conjunction with Diabetes UK delivered one full day education to nursing homes to educate them on the management of diabetes and good nutrition. North Manchester CCG intends to re run this course in 2015.

2.4. Acute Care

North Manchester CCG has the second highest spend per 1000 patients on all secondary care admissions for Endocrine, Nutritional and Metabolic Problems in which Diabetes falls. To address this the above mentioned community and primary care measures have been put in place.

In 2014, practices have been provided with prescribing data at their patch meetings which correlates practice spend on diabetic drugs and hospital admissions due to diabetes, compared to their patch peers. The provision of this data is intended to

stimulate discussion regarding practice variation and prescribing between peers and with the Medicines Management Team.

Work is also underway this year to identify patients with diabetes related secondary care admissions, to review this by practices to see if good standards of care were provided and if admissions could have been prevented.

A service review will be undertaken this year of the Community Diabetes Nursing Services to see what opportunities there are to provide more holistic care for patients with diabetes.

3. Central Manchester

3.1. Self Care

Self care and self management are high on Central Manchester CCG's agenda. The CCG have participated in a number of initiatives to support patients with long term conditions improve their self care. Central Manchester have also been working with Public Health Manchester and North and South Manchester CCG's to centralise the targeted working and ensure a smart and targeted work approach to maximise outcomes.

Targeted Diabetes self care programmes have been developed in coordination with the Diabetes Centre at CMFT through structured education sessions. The patient and carer education support attendees recently diagnosed with Diabetes understand the condition and how to manage different elements of daily life to include food, travel, insurance among many other practical aspects. A significant proportion of patients are referred to this programme, however, uptake is low.

Central Manchester are aware that more work can be undertaken to support self management, this includes the provision of further training aimed at both type 1 and 2 patients and clinicians. The implementation of this programme will be reviewed under the development of the new delivery care model; which aims to restructure and improve the delivery of diabetes care to all CMCCG patients.

3.2. Community Based Care

Central Manchester CCG has no targeted community based care for Diabetes patients. This will be reviewed and developed as part of the Diabetes working group that was set up in collaboration between the CCG, primary and secondary care.

CMCCG are aware of the importance of utilising community based services within the current financial climate. This will not only alleviate financial pressures, but also reduce demand on primary and secondary care services, whilst also providing specialist high level care.

3.3. Primary Care

Central Manchester remains to have a poor uptake of QOF indicators (88%) compared to the England average, with a large variance between practice achievement.

In a bid to support the greater understanding of primary care achievements relating to the national recommendations of the 9 process of care, a local audit was completed with 100% uptake by practices. The audit was similar to that as the National Diabetes audit. Results were informative in that they identified and provided evidence to gaps of care within the system.

CMCCG has continued with the provision of initiation of injectable insulin for patients registered at accredited practices through the locally commissioned service. No new practices have been accredited to deliver this service within this year.

Central Manchester is aware of the inequality of care this currently poses for the population; thus has developed a working group which includes members of primary, secondary and community care to support the development of a model of which will ensure all patients are cared in the most appropriate manner.

Central Manchester has also identified to work around the prescribing of medication in line with the Greater Manchester Medicines Formulary to support the improved optimisation and prescribing costs of patients. This programme is currently under development.

3.4. Acute Care

Central Manchester is mainly served through CMFT. Data shows Central Manchester patients have a high level of first to follow up ratio of secondary care appointments. A review of this has indicated there is much room for patient care to be transferred from secondary care to the community.

CMFT are working with CMCCG to improve the delivery of care and promote out of hospital care for patients were safe and appropriate to do so.

4. South Manchester

4.1. Self-care

The National Diabetes Audit for 2013 highlighted poor completion of the 9 Key Care Processes for both Type1 and Type2 diabetes. The North West Clinical Network for Diabetes has been working with Diabetes UK in engaging with patients to highlight the importance of the 9 Care Processes. The audit also demonstrated poor uptake of structured educational programmes, although referral rates were high.

During 2014-15 we will aim to focus on prevention, with the support of the public health. We held a ‘Diabetes Listening Event’ in August 2014 which was led by Dr Naresh Kanumilli, the NW Clinical Network Lead for Diabetes, and the Senior Engagement Manager for the 3 CCGs. The event was an opportunity for patients with Type 1 and Type 2 diabetes to share their experience of diabetes care in south Manchester, with the aim of improving the quality of care and support patients

receive as a direct result of their feedback. We also continue to liaise with local support groups.

In his role as Clinical Network Lead, Dr Kanumilli is also working with Public Health to develop the health checks programme, with a specific focus on obesity as a pre-cursor to diabetes and other conditions of pre-diabetes. Information will be provided to patients and clinicians to improve knowledge and understating and encourage healthier lifestyle choices in order to prevent conversion to diabetes. In addition, and in recognition of the fact that the NW has the highest rate of amputations in the country, the NW Clinical Network is working with Diabetes UK on a campaign to promote foot checks and ensure these are done annually for patients with diabetes to prevent complications.

4.2. Community Based Care

Integration remains high on the agenda for SMCCG and discussions are currently underway with the local acute provider to look at integrated models of care and enabling an environment where people with diabetes are at the centre of the care pathway and services are structured around them.

4.3. Primary Care

Diabetes prevalence increased slightly in 2013-14, compared against 2012-13 QOF results. In 12-13, the prevalence rate for adult diabetes (17+) was 5.6%, with an increase to 5.7% in 13-14. This is lower than the England average of 6.2%, but prevalence varies greatly across the patch with one practice having the lowest observed prevalence for the CCG (1.65%), and another practice the highest (9.9 3%). Of a total number of 25 practices, 16 have prevalence of 6% or above. This is largely due to the mix within practice demographics; some practices have a significantly younger population and some have a large South Asian population where diabetes is more prevalent.

We continue to have Diabetes Specialist Nurses affiliated to, and delivering clinics within, a number of practices in SMCCG. Dr Kanumilli is keen to develop this further, and is particularly enthusiastic to ensure patients are involved in service redesign; previous patient feedback has indicated a high regard for a coordinated approach to care where services are delivered from easily accessible community locations.

4.4. Acute Care

Between January and March 2014, we undertook a comprehensive review of a number of our community services, including diabetes. As a result of the review, we have written a revised service specification for community nursing services which brings together all services under one team; the Integrated Community Care Team. The team includes diabetes specialist nurses, who operate as part of the wider team of generalist and specialist nurses, providing expertise where it is needed through involvement in community based, multi-disciplinary meetings with health, social care and mental health practitioners, and inputting to the personalised care planning process for patients.

5. Recommendations

5.1 The Committee is asked to note the report.