Diabetes Services
In Northern Ireland
REGIONAL SUMMARY

Health Services Audit

Department of Health, Social Services and Public Safety
An Roíonn Sláinte, Seirbhísí Soisialta agus Sábhailteachta Poiblí
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INTRODUCTION

Background

Diabetes is one of the most common chronic diseases for all age groups. It affects 2% - 4% of the population and its prevalence is increasing.

In 1989 the St Vincent Declaration aimed to raise the profile of diabetes and set standards to improve the quality of care and outcomes. Since then, there have been major changes in the provision of services for people with diabetes, including:

- more diabetes centres, in hospitals and in the community;
- an increasing number of, and expanding role for, diabetes specialist nurses; and
- a higher level of involvement of GPs and practice nurses in the care of people with diabetes.

Despite these developments, the debate continues over the best way of providing services, especially in relation to:

- the relative roles of primary and secondary care;
- skill-mix; and
- the most effective way of achieving lifestyle changes for patients.

The Directorate of Health Services Audit within the Department of Health, Social Services and Public Safety commissioned the auditors appointed to the HSS to carry out a Value for Money study of diabetes services at seventeen trusts in 2000/2001.

This Northern Ireland Regional Summary sets out:

- the main findings arising from the study;
- the key recommendations; and
- the way forward.
INTRODUCTION

Methodology

The methodology for the study was based on the Audit Commission's guidance, issued as a result of its report "Testing Times", which reviewed acute diabetes services in England and Wales. The methodology was extended in Northern Ireland to include a review of diabetes services provided by community trusts.

The study focused on:

- the structure of service provision;
- the standards of patient care, measured against good practice;
- the interface between primary and secondary care services.
STRUCTURE OF THE DIABETES SERVICE

This section of the study looked at:

- staffing;
- facilities and equipment; and
- access.

Staffing

Key members of the adult diabetes team include diabetologists, or physicians with an interest in diabetes, diabetes specialist nurses (DSNs), dietitians, podiatrists and psychologists.

Consultants

Chart 1 indicates the number of outpatient consultations in 1999, per weekly consultant sessions by trust site. Seven of the twelve trusts that provide an acute diabetes service were unable to provide the relevant data for this chart.

Chart 1: Outpatient consultations per weekly consultant session

![Chart showing number of consultations per week by trust site.]


The chart shows considerable variation among the trusts reviewed. It should be acknowledged that this methodology does not take into account the input of non-consultant medical staff.

Diabetes Specialist Nurses (DSNs)

DSNs are unique in that they are often the only staff dedicated to diabetes services at trusts. All but one of the seventeen trusts reviewed employed a nurse or health visitor dedicated to diabetes. Table 1 shows the number of whole time equivalent (WTE) DSNs employed in the four HSS Board areas.
STRUCTURE OF THE DIABETES SERVICE

Table 1: DSN staffing

<table>
<thead>
<tr>
<th></th>
<th>EHSSB</th>
<th>WHSSB</th>
<th>NHSSB</th>
<th>SHSSB</th>
<th>N.I. total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of WTE DSNs</td>
<td>9</td>
<td>3.8</td>
<td>4.5</td>
<td>4</td>
<td>21.3</td>
</tr>
</tbody>
</table>

Diabetes UK recommends that there should be 4 WTE DSNs per 250,000 population. Based on a Northern Ireland population of 1.7 million, the number of DSNs recommended by Diabetes UK is 27.2 WTEs.

Comparisons of DSN staffing levels need to be considered in the context of the different functions that DSNs typically perform. The auditors' work highlighted that the roles undertaken by DSNs varied considerably and not just between those employed by acute and community trusts. For example, some acute DSNs did not work outside the hospital setting, while other acute DSNs spent a large proportion of their time visiting people with diabetes in their own homes and liaising with primary care.

Dietitians

In 1994 the Clinical Standards Advisory Group recommended that a senior dietitian with a special interest in diabetes should take responsibility for dietetic services within diabetes care. Only two of the seventeen trusts reviewed had specialist dietitians, one employing 1 WTE, the other 0.5 WTEs. None of the trusts outside the Belfast area employed specialist dietitians.

Podiatrists

Podiatrists have a key role in providing education on foot-care and assessing and treating foot problems. However, none of the trusts reviewed had sufficient resources to meet the 1998 CREST guidelines for management of the diabetic foot.

Psychologists

There is an absence of psychological support to people with diabetes, either directly or through the diabetes team, with the exception of one trust that had two psychology sessions dedicated to diabetes. A number of professionals working in diabetes care highlighted the poor accessibility to psychology services as a significant issue for people with diabetes.
STRUCTURE OF THE DIABETES SERVICE

Access to a multidisciplinary team

Trusts with diabetes outpatient clinics were reviewed to determine if people with diabetes had access to a multidisciplinary team. For this purpose, a clinic was considered to be multidisciplinary if a consultant, specialist nurse, dietitian and podiatrist were in attendance. Ten of the twelve acute or combined trusts were found to have at least one multidisciplinary diabetes clinic. Regarding the other two:

- one does not employ a DSN. However, two outpatient nurses have been assigned the role of diabetes nurses at diabetes clinics; and
- one holds DSN clinics separately from the consultant-led clinics.

A number of trusts also have peripheral clinics to ease access for the local diabetic population. Four of these clinics were found to be non-multidisciplinary, commonly lacking podiatry or dietetic input. One peripheral clinic was staffed only by a consultant physician and a non-diabetes specialist outpatient nurse.

Facilities and equipment

Diabetes centres, which are dedicated to diabetes clinics and education sessions, are becoming more common. Many trusts hold diabetes clinics in general outpatient departments, if dedicated diabetes centres are not available.

Eleven of the twelve acute or combined trusts hold diabetes clinics in general outpatient departments. The remaining trust has accommodation dedicated to diabetes but insufficient space to host both diabetes and foot clinics. Patient education conducted outside clinic times is often held in the DSN office accommodation, although two trusts have dedicated education centres where patient education and staff training can take place.

Good Practice Example

At two trusts, patients are able to call at the education centres at any time during normal working hours for advice on their diabetes control. The centres also facilitate structured one-to-one and group support.
STRUCTURE OF THE DIABETES SERVICE

Diabetes outpatient clinics

A clinic quality survey was carried out at nine of the twelve trusts that hold diabetes outpatient clinics. The results are summarised in chart 2.

Chart 2: Clinic quality survey


Most respondents to the survey had a high degree of satisfaction with the diabetes clinics they attended. Overall, 94% of respondents indicated that they consider staff to be caring and supportive. However, 33% of respondents considered that they do not get enough information about new developments in the treatment of diabetes, while 29% did not feel that they see the doctor or nurse within 30 minutes of their appointment time. These issues were also of concern in England and Wales.

Access

Access to diabetes services was reviewed in terms of the timeliness of initial outpatient appointments following a GP referral, and the extent of access to advice and support for people with diabetes outside normal working hours.

Speed of access

As part of the audit, a sample of casenotes was reviewed at eleven acute trusts to identify the length of time from GP referral letter to the first offered appointment. Average results at each trust are shown in chart 3.
The average length of wait for an outpatient appointment was 35 days, with a range of 20 to 70 days. The trust with the longest waiting time has attempted to address this issue by ensuring that newly referred patients have access to a DSN and dietitian prior to the initial outpatient consultation.

**Immediate access to advice**

Self-management is crucial for people with diabetes. Immediate access to support and advice is an important factor in maintaining good diabetes control.

The majority of Northern Ireland trusts are able to provide formal access to advice during working hours. However, additional support is variable. Some trusts advise patients to telephone the medical or diabetes wards outside normal working hours, while the availability of advice at other trusts is often dependent on the goodwill and dedication of DSNs.

Access to advice outside normal working hours was one of the issues addressed in a patient postal questionnaire carried out at sixteen trusts in Northern Ireland. The results are shown in chart 4.
STRUCTURE OF THE DIABETES SERVICE

Chart 4: Access to advice at night or at weekends

Although the views of respondents may have been influenced by the provision of diabetes support by healthcare professionals outside the trust setting, such as GPs and practice nurses, chart 4 highlights that an average of only 48% knew of a doctor or nurse they could contact concerning their diabetes outside normal working hours.

PATIENT CARE

Key findings from the audit work on patient care are presented under the following headings:

- patient education;
- structured reviews;
- complications;
- pregnant women with diabetes; and
- children and young people with diabetes.

Patient education

High quality patient education is important if people with diabetes are to be successful in controlling their own condition. As part of a review of DSN roles in Northern Ireland, auditors found that patient education is often the principal function of the DSN.

To ascertain the extent of patient knowledge of issues relevant to their diabetes, the postal questionnaire asked respondents to indicate how much they understood about various aspects of diabetes control. The results are shown in chart 5.

Chart 5: Patient knowledge of diabetes education issues
Percentage stating they understand enough or a lot about...

PATIENT CARE

Chart 5 shows a high degree of patient knowledge of issues relevant to diabetes control, with an average of over 90% indicating satisfactory knowledge in most areas. However, the questionnaire results suggest that, in particular, knowledge relating to the effects of being ill on diabetes control could be improved.

Structured reviews

Good practice states that a person with diabetes should be screened for diabetes control and early complications at least once a year.
As part of the sample casenote review at eleven trusts, the extent to which different tests or examinations were recorded in patient notes was determined. The results are shown in table 2.

Table 2: Record of clinical review in patient notes

<table>
<thead>
<tr>
<th>Test/examination</th>
<th>Percentage of casenotes recording a test or examination result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NI trust average</td>
</tr>
<tr>
<td>Weight</td>
<td>98%</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>96%</td>
</tr>
<tr>
<td>HbA1c</td>
<td>97%</td>
</tr>
<tr>
<td>Urine albumin / creatinine</td>
<td>79%</td>
</tr>
<tr>
<td>Visual acuity</td>
<td>62%</td>
</tr>
<tr>
<td>Fundi examination through dilated pupils</td>
<td>74%</td>
</tr>
<tr>
<td>Foot examination - pulses</td>
<td>87%</td>
</tr>
</tbody>
</table>

None of the eleven trusts reviewed scored over 90% in all tests or examinations. The exercise showed considerable variation in the extent to which certain tests or examinations were being recorded at trusts, as indicated by the range of results. In addition, significant variations were found at trusts carrying out diabetes care on multiple sites.
PATIENT CARE

Complications

Two diabetic complications were reviewed as part of the methodology for this study:

- complications of the feet; and

- diabetic retinopathy.

Complications of the feet

Table 3 highlights some of the areas considered as part of a review of foot services.

Table 3: Review of the diabetic foot service at eleven trusts

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are referred guidelines agreed with general practice staff?</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Is there audit of general foot and foot pulse examinations in the &quot;annual review&quot;?</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>
| Is an orthotist available at clinics?                                    |  1  | 10*
| Does the vascular team work as an integral part of the foot service (rapid open access to vascular services)? |  5  |  6 |

* At one of these trusts an orthotist attends one of the trust's six diabetes clinic sites. At another trust, although the orthotist is not routinely in attendance at clinics, he may be requested to attend.

The table highlights the variation in the extent to which the diabetic foot service has developed in Northern Ireland. One trust has only recently begun to carry out annual podiatry reviews in line with CREST guidelines, while another, although unable to comply fully with CREST, has implemented open access to specialist foot clinics and a regular programme of audit.

Diabetic retinopathy

People with diabetes who attend hospital outpatient clinics should be screened regularly for diabetic eye disease by means of visual acuity tests and fundi examinations through dilated pupils. However, a comprehensive eye screening programme would extend beyond the hospital setting and reach the entire diabetic population.
In Northern Ireland there is a regional eye screening programme with a mobile unit serving the population within the Northern, Southern and Eastern HSS Board areas. The mobile unit is limited in that:

- only a small percentage of the diabetic population is reached by the screening service;
- there is no register of patients who have been screened; and
- there are no protocols, standards or guidelines on screening.

From a trust perspective, the extent to which the local population has been screened by the mobile service is unknown and results of eye screening are not available to trust staff.

An alternative system is in place in the Western HSS Board. Local optometrists, who have been trained by ophthalmologists, carry out diabetic eye screening. A list of trained optometrists is available to local healthcare professionals and a screening form has been developed. A copy of each form is sent to a consultant ophthalmologist based at one of the local acute trusts, who monitors and evaluates the Board-wide service.

**Pregnant women with diabetes**

The health of pregnant women with diabetes is susceptible to increased risks of diabetic and pregnancy related complications. In addition perinatal mortality is considerably higher than for non-diabetic pregnancies.

Since this review, CREST has issued extensive guidelines for the care of **pregnant women with diabetes in Northern Ireland**. Key areas for improving outcomes in diabetic pregnancy include the structure of diabetes/antenatal care and the availability of staff who are appropriately experienced in managing diabetic pregnancies.

Six trusts in Northern Ireland provide a service to pregnant women with diabetes. Four of these hold joint diabetes/antenatal clinics where a physician and obstetrician are in attendance.

One of the six trusts has established a programme of audit for pregnant women with diabetes, and another has developed an audit form for future use. It is acknowledged that where the number of pregnant women with diabetes is small, joint audit with other sites should be considered.

1. CREST, Management of Diabetes in Pregnancy, September 2001; CREST, Management of Diabetes in Pregnancy, Primary Care Summary, September 2001
Children and young people with diabetes

Eight trusts provide acute diabetes services to children and young people with diabetes. Key areas reviewed as part of this study include the:

- extent of multidisciplinary staffing at paediatric diabetes clinics;
- length of inpatient stay when children are newly diagnosed; and
- transition from paediatric to adult services.

**Multidisciplinary staffing**

Four of the eight trusts reviewed had paediatric diabetes clinics which were staffed by a multidisciplinary team, consisting of a consultant paediatrician, a dietician and a DSN or paediatric DSN. Trust clinics which were not considered to be multidisciplinary, fell short of this standard for the following reasons:

- two had no diabetes specialist nursing input;
- one did not have a dietician in attendance at the clinic; and
- one was staffed by a physician with an interest in diabetes, rather than a consultant paediatrician.

**Average length of inpatient stay on diagnosis**

The UK St Vincent group recommends that:

"where the child is admitted to hospital this should be for the shortest time."

As part of this study, the lead consultants in diabetes for children and young people were asked to estimate the average length of inpatient stay following the initial diagnosis of diabetes in children. The results are shown in table 4.

**Table 4: Approximate inpatient stay following diagnosis of diabetes in children**

<table>
<thead>
<tr>
<th>Trust</th>
<th>Audit Commission range (9 study sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>7-10 3-5 4 2 3-5 4-5 3 3-5 1.5-4</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>
PATIENT CARE

The length of inpatient stay is closely related to the availability of resources for support of children and their families in the community. The trust with the longest initial inpatient stay in Northern Ireland has no arrangements for home visits, while the majority of the other trusts have limited resources for DSN or paediatric DSN home visits.

Good Practice Example

The trust with the shortest inpatient stay has achieved a Charter Mark for its paediatric diabetes service. Features of the service include:

- DSN home visiting to reinforce treatment and education, particularly following initial diagnosis;

- liaison with schools by means of a DSN school visit each time a newly diagnosed child attends the diabetes clinic; and

- regular evaluation of the service including bench-marking against other trusts.

Transition to adult services

Trusts were found to have varying systems in place to ensure the smooth transfer of diabetic young people to adult diabetes services. In four trusts, the paediatric DSN or adult services DSN provides the link from one service to the other. Two of the six trusts ensure that young people are seen by an adult physician prior to transfer, in an attempt to ease transition to the adult service.

Good Practice Example

One trust has carried out an audit to identify the problems associated with transition to adult diabetes services. As a result of the audit an adolescent clinic has been established. Nurses have established an out of hours adolescent group to encourage attendance at the adolescent clinic. A diabetologist from the adult service reviews young people on a monthly basis and organises visits to the adult unit prior to transfer.
As part of the study, the extent of interaction between the acute hospital team and providers of care within the community was assessed.

The main findings are presented under the following headings:

- information and planning;
- Local Diabetes Service Advisory Groups (LDSAGs);
- links between acute and community trusts;
- links with general practitioners; and
- patient perceptions.

**Information and planning**

A comprehensive information base is required to enable trusts and boards to plan diabetes services and monitor outcomes.

The diabetes information systems in operation at the twelve acute or combined trusts, which provide diabetes services in Northern Ireland, were reviewed:

- three had implemented or were in the process of implementing an advanced clinical information system;
- two had manual recording systems, with no computerised register; and
- seven had computerised systems, which were limited either by poor access to information, or in terms of outputs available.

None of the five community trusts audited had a comprehensive information system providing data on people with diabetes. Usually, data was held separately by each professional staff group, and to varying levels of detail.

There is no regional register of people with diabetes. However, one clinical information system is at varying stages of implementation at three trust sites, and, if extended, it may have the capability to form a regional register of people with diabetes in Northern Ireland. The system may also have the potential to be integrated with management systems currently in use within general practice.
Good Practice Example

One trust has obtained the co-operation of a local general practice and the podiatry department of a neighbouring community trust, to pilot its clinical information system in the primary care setting.

Local Diabetes Service Advisory Groups (LDSAGs)

LDSAGs have been established in many areas to raise the profile of diabetes and to help shape service developments. These groups normally report to health commissioners, and members comprise both health professionals and people with diabetes.

Fifteen of the seventeen trusts, which provide a diabetes service, have representation on LDSAGs. The remaining two trusts do not have an operational LDSAG in their area. However, representatives from these trusts are involved in a diabetes shared care group. This group has been active in developing guidelines on diabetes care for local use.

Links between acute and community trusts

Good communication between diabetes healthcare professionals is essential if diabetes services are to operate as effectively as possible.

Good Practice Example

One acute trust holds monthly diabetes meetings that are attended by the acute diabetes team and DSNs from the neighbouring community trust.

Many community healthcare professionals working in the area of diabetes in Northern Ireland also have an integral role as part of the ‘acute’ diabetes team. Examples include:

- community DSNs who often attend either all, or part, of hospital diabetes clinics to enable more efficient follow up of people with diabetes in the community; and

- community podiatrists, some of whom undertake the role of diabetes podiatrists at hospital clinics.

However, this is not the case for dietitians who tend to work either wholly in a hospital or community setting.

The organisation of diabetes care between community and acute services shows considerable variation throughout Northern Ireland. Services have developed
mainly on an ad hoc basis, in line with individual trust initiatives. None of the four HSS Boards has an up-to-date formal diabetes strategy, although two Boards stated that they were in the process of developing or updating strategies for diabetes care.

Links with general practitioners

As part of this review, a survey of general practitioners was undertaken throughout Northern Ireland. Responses were received from 238 GPs and analysed by HSS Board area. Chart 6 shows the number of GPs who hold diabetes clinics in their practice, and the percentage they form within their boards.

Chart 6: GPs who hold diabetes clinics in their practice

<table>
<thead>
<tr>
<th>NHSSB</th>
<th>SHSSB</th>
<th>EHSSB</th>
<th>WHSSB</th>
<th>All Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Chart 6 shows that approximately 70% of GPs have dedicated time for diabetes clinics in their practice. A greater involvement of GPs and practice nurses in the care of people with diabetes increases their need for appropriate training and education.

Northern Ireland trusts are responding to the training needs of GPs to varying degrees. Some diabetes teams have been proactive in holding GP training initiatives while others do not consider that they have the resources to extend their expertise outside their immediate care setting.
**PRIMARY CARE INTERFACE**

*Good Practice Example*

Comprehensive ‘diabetes shared care guidelines’ have been compiled by representatives from an acute trust, its neighbouring community trust, the local HSS Board, local GPs and other stakeholders. The guidelines include referral criteria to the hospital service and detailed guidelines for diabetes management in the primary care setting. The guidelines were distributed to all GPs within the trusts’ catchment area.

The key areas which GPs consider would help to improve practice-based diabetes clinics are shown in chart 7.

**Chart 7: Improvements to diabetes clinics: GP views**

The two main areas identified for improvement are the provision of dietitians and podiatrists at clinics.

**Patient perceptions**

Patient surveys and questionnaires were used to gain users’ views of local diabetes services. The majority of respondents praised the dedication of their diabetes team, although some provided examples of occasions when they were unhappy with the quality of care available. Two comments received as part of the patient postal questionnaire illustrate this point:
"My diabetes care from both hospital staff and GP staff has been excellent. I can also say that any time I have needed help or asked for advice about my diabetes, I was given excellent care and helpful advice."

"Due to my condition, I am nervous and unsure as to what to do; I live alone with my dependent husband and feel isolated and not heard about my condition. I believe that I need more time to receive education, assurance and advice."

KEY RECOMMENDATIONS

A) Structure of the diabetes service

Trusts should:

- review the adequacy of current staffing resources and liaise with their commissioners to address any identified shortfalls;

- ensure that each person with diabetes who attends an outpatient clinic has access to a multidisciplinary diabetes team;

- review the appropriateness of existing accommodation for diabetes outpatient clinics and educational sessions;

- monitor the speed of access to the diabetes service of new referrals, and consider whether action is required to increase accessibility; and

- ensure that people with diabetes have adequate access to support and advice, both during and outside normal working hours.

B) Patient care

Trusts should:

- provide high quality education programmes to encourage people with diabetes to manage their condition effectively;

- monitor the extent to which people with diabetes are receiving a comprehensive structured diabetes review on an ongoing basis;

- review the adequacy of the diabetic foot service, in line with good practice;

- consider the adequacy of services for pregnant women with diabetes, particularly in the context of the CREST guidelines;

- ensure that each child or young person with diabetes has access to a multidisciplinary paediatric diabetes team; and

- ensure that processes are in place to ease the transition from paediatric to adult diabetes services.
KEY RECOMMENDATIONS

C) Primary care interface

Trusts should:

• work with their commissioners to develop a comprehensive register of people with diabetes;

• attempt to improve communication and working practices with primary care professionals; and

• take an active part in local diabetes service developments, through LDSAGs or other groups.
THE WAY FORWARD

This review has shown that services for people with diabetes in Northern Ireland are already under strain, a situation that is likely to deteriorate further in light of the increasing prevalence of diabetes.

Consequently HSS trusts and boards should consider:

- the development of a comprehensive register of people with diabetes in Northern Ireland, to aid the planning and evaluation of services and the monitoring of structured reviews and clinical outcomes;

- the production and implementation of strategic plans to address the needs of the current and projected local diabetic population, particularly in terms of service organisation between primary and secondary care;

- the future roles of key staff involved in diabetes care and the inadequacy of current psychology input;

- the development of a comprehensive eye screening programme for the local diabetic population; and

- the educational needs of people with diabetes, in terms of providing high quality education programmes and immediate access to advice both during and outside normal working hours.