

**CREST**  
CLINICAL RESOURCE EFFICIENCY SUPPORT TEAM

**DIABETES CARE  
IN  
NORTHERN IRELAND**



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This booklet has been produced by CREST (the Clinical Resource Efficiency Support Team) which is a small team of doctors, established under the auspices of the Central Medical Advisory Committee, to promote clinical efficiency in the Health Service in Northern Ireland while ensuring the highest possible standard of clinical practice is maintained.

CREST wish to thank all those who provided comments on the reports produced by the Specialty Advisory Sub-Groups of the UK Task Force. Special thanks are due to Dr Brid Farrell who made a major contribution to the production of this booklet.

## Contents

	Page
INTRODUCTION	<a href="#">3</a>
NORTHERN IRELAND PRIORITIES	
A. Local Strategies	<a href="#">5</a>
B. Diabetes Registers	<a href="#">6</a>
C. Local Guidelines	<a href="#">7</a>
(1) Renal Disease	<a href="#">7</a>
(2) Foot Complication	<a href="#">8</a>
(3) Coronary Disease	<a href="#">9</a>
(4) Complications of Pregnancy	<a href="#">10</a>
(5) Children and Young People	<a href="#">11</a>
D. Retinopathy	<a href="#">13</a>
E. Research and Development	<a href="#">14</a>
F. Education and Training	<a href="#">14</a>
THE WAY FORWARD	<a href="#">15</a>
APPENDICES	
1. Membership of the Northern Ireland Task Force	<a href="#">17</a>
2. Experts consulted in Northern Ireland	<a href="#">18</a>



# **Report of the St. Vincent Joint Task Force for Diabetes**

## **1. INTRODUCTION**

- 1.1 The St Vincent Joint Task Force on diabetes was established in 1992 jointly by the Department of Health (London) and the British Diabetic Association (BDA) to advise on the implementation of the St Vincent Declaration. The Declaration was the outcome of a meeting which was sponsored by the European office of the World Health Organisation and the European region of the International Diabetes Federation held in St Vincent in Northern Italy In October 1989. The meeting was attended by representatives of the health professions, of European Government health departments and of people with diabetes. It formulated a series of recommendations which embodied both general goals and specific targets for the improvement In the health and betterment of the lives of those with diabetes, and it urged the commitment of European nations to their fulfilment.
- 1.2 The Task Force identified seven immediate priority areas and sought agreement for the establishment of Specialist Advisory Subgroups to carry forward the detailed work in each. It forecast the need to establish further Subgroups as the work of the Task Force progressed.
- 1.3 Observers from Scotland, Wales and Northern Ireland were co-opted on to the Task Force to facilitate the co-ordination of plans for the implementation of the St Vincent Declaration throughout the United Kingdom.

- 1.4 In response to the establishment of the UK Task Force CREST organised a major conference on diabetes in May 1994. The Chairman of the UK Task Force, Professor David Shaw and three of the Task Force members, Professor Harry Keen, Professor Rhys Williams and Mrs Mary McKinnon took part in the conference. On the advice of the conference CREST established a Northern Ireland Task Force on Diabetes the membership of which is given in [Appendix 1](#). During the course of its deliberations the Northern Ireland Task Force considered the second draft report of the UK Task Force. In this process CREST sought the advice of specialty experts in Northern Ireland on the reports produced by the Specialty Advisory Subgroups of the UK Task Force. The experts consulted in Northern Ireland are listed in [Appendix 2](#). As a result of these discussions and consultations CREST decided that the second UK Task Force report should be widely circulated in Northern Ireland with a covering CREST paper highlighting the areas of the report which were of particular relevance to Northern Ireland.
- 1.5 CREST would strongly commend and support the general thrust of the UK Task Force's second report. The main recommendations and targets in the report should be addressed by commissioners, purchasers and providers in order to ensure high quality care for people with diabetes in Northern Ireland. In addition to an overall endorsement of the Task Force report the CREST Task Force would wish to specifically underline the following issues in relation to diabetes care in Northern Ireland.

## 2. NORTHERN IRELAND PRIORITIES FOR DIABETES CARE

### A. *Commissioners should develop local strategies and comprehensive purchasing plans for diabetes care in consultation with health professionals and people with diabetes to ensure a co-ordinated approach to diabetes care.*

A.1 Local strategies for diabetes care should be developed by Local Diabetes Services Advisory Groups, (LDSAGs). Such strategies should reflect advice from people with diabetes and from health professionals from hospital and primary care sectors involved in the care of patients with diabetes; key professionals should include diabetes specialist doctors, nurses, dietitians, chiropodists and clinical psychologists. Guidance on LDSAGs produced by the British Diabetic Association is being circulated with this report. The following paragraphs include the main components of diabetes care packages.

A.2 ***For all patients:*** information, education, self management skills, 'empowerment', social and emotional support, nutritional advice, regular clinical surveillance for monitoring control and for detecting and correcting risk factors and early complications.

A.3 ***For many patients:*** regular skilled foot care, control of hypertension, cessation of smoking, correction of blood lipids, obesity and physical inactivity and medical/surgical management of complications.

A.4 ***For some patients:*** special care for children and young adults, the elderly, pregnant women, ethnic/cultural minorities, those with physical handicaps or learning difficulties, the blind and the terminally ill. Medical and surgical interventions for cataract, coronary, peripheral and cerebral artery disease, painful peripheral neuropathy and sexual dysfunction.

A.5 ***For a few patients:*** complex medical and surgical Interventions such as retinal surgery, renal dialysis or transplantation, revascularisation procedures. *Care for those with established complications:* rehabilitation and support in cases of severe and multiple disabilities.

**B. *Commissioners should co-ordinate the development of Board wide diabetes registers that collate information from primary and secondary care to assist in monitoring the health of patients with diabetes.***

An information infrastructure is essential for measuring and monitoring the effectiveness of services and the health of patients with diabetes. To achieve this, there is a need for the setting up of a diabetic register at Board level that :-

- Records all known diabetic patients, regardless of whether the patient is followed up in the community, hospital or both.
- Is updated annually.
- Uses the recommended core dataset for monitoring clinical practice and the health of patients with diabetes.
- Provides a mechanism for the interchange of data between primary and secondary/tertiary care services for comprehensive monitoring of services and feedback to purchasers, providers and patients.

- Collates and analyses data into a form suitable for operational use locally, regionally and nationally.
- Enables monitoring of progress towards the targets set in the St Vincent Declaration.

These registers will be under the supervision of Directors of Public Health and have protocols on data access, security and confidentiality.

**C. *Commissioners should ensure that local guidelines are developed to ensure timely referral to specialist hospital services.***

The provision of specialist care to patients with diabetes is particularly important in the following situations.

**C.(1) Kidney Disease**

Diabetic kidney disease, progressing to end-stage renal failure (ESRF) threatens one in three to four people with Insulin Dependent Diabetes and one in ten to twenty of those with non-insulin dependent diabetes. Risk is reduced by good diabetes control. Liability to renal failure can be recognised early by quantitative urine screening for microalbuminuria. Progression may be arrested or slowed by early recognition and treatment.

**Priority needs**

- Regular urine screening for albumin excretion as part of routine patient review.

- Targeted interventions to prevent progression of nephropathy and to protect the cardiovascular system in those showing early indications of renal disease.
- Vigorous correction of blood pressure to conserve renal function when proteinuria is detected.
- Correction of other risk factors for vascular disease, such as dyslipidaemia and smoking.
- Selective anticipatory diagnostic and preventive attention directed to specially susceptible groups, eg the pregnant and certain ethnic subgroups.
- Timely referral to nephrologists by diabetologists.

## **C.(2) Preventing foot complications in diabetes**

### **Key facts**

- Half of lower limb amputations, other than those following trauma, are a consequence of diabetes. In people with diabetes, the risk of amputation is increased 15-fold.
- Some risk factors - smoking, high blood pressure, abnormal blood lipids - are reversible. Others, such as diabetic nerve disease and foot deformity, can be detected early and countered effectively.
- Systematic and regular foot care has been shown to reduce the risk of chronic ulceration and amputation in the lower limb by 50% or more.

- Admission for diabetic foot/leg disease is the single largest component of hospital bed usage by people with diabetes. Almost half of all diabetes-related admissions are for lower limb disease.

#### **Priority needs**

- Regular, systematic screening of feet and legs for detection and correction of reversible risk factors.
- Immediate access to a specialist foot care team for those at high risk.
- Systematic patient education in foot care to reduce chronic ulceration and need for surgery.
- Establishment of multidisciplinary teams, including the chiropodist, shoe fitter, nurse, surgeon and physician to provide care for those with special needs.

### **C.(3) Preventing coronary heart disease in diabetes**

#### **Key facts**

- Risk of coronary heart disease is Increased 2-3 fold in diabetic men and 4-5 fold in diabetic women.
- Mortality after myocardial infarction is about twice as high in the diabetic as in the non-diabetic person.

- Risk factors for coronary artery disease and stroke include raised blood pressure, unhealthy diet, abnormal plasma lipids, smoking and proteinuria as well as the diabetic state itself. Smoking is a major reversible risk factor.

### **Priority needs**

- Risk factor reversal (i.e. control of blood pressure to recommended levels, normalisation of blood lipids and smoking cessation) for the whole diabetic population.
- Education in the prudent 'protective' low saturated fat diet as the norm for people with diabetes and on the danger of obesity.
- Medical and surgical management of coronary heart disease, peripheral vascular disease and cerebro-vascular disease for patients with diabetes on a par with the non-diabetic population.
- Systematic data collection on coronary heart disease in diabetes to monitor effectiveness of interventions.

## **C.(4) Preventing complications of pregnancy in diabetes**

### **Key facts**

- Established diabetes is the most common medical disorder complicating pregnancy in the UK, occurring in about 4/1,000 pregnancies.

- Diabetes increases the risk of pregnancy complications including obstructed labour, intrauterine death and congenital abnormality.
- Improvement in co-ordinated diabetes and obstetric management and special care before conception demonstrably reduce risk and Improve outcome.
- A regional audit of pregnancies occurring in women with diabetes is currently being carried out.

#### **Priority needs**

- Targeting of women with diabetes who need pre-conception counselling and early referral for specialist care.
- Pregnancy, labour and delivery of women with diabetes to be undertaken only in specialised units.
- Management by professional staff with training and experience in diabetes care to secure optimal outcome.
- Screening for gestational diabetes and implementation of appropriate management.

### **C.(5) Children and young people**

#### **Key facts**

- The needs of children and young people deserve special attention.
- The Northern Ireland Diabetes Study Group have recorded an annual incidence of 20 per 100,000 for diabetes in childhood, with two peaks at 11 years and 1-2 years. The diagnosis of diabetes in a child and the demands and uncertainties of its course and treatment can be difficult for parents and their families.

- While good blood glucose control reduces the long term risk of complications, it also increases the incidence of hypoglycaemia.
- During adolescence the conflict between the demands of treatment and the increasing independence of teenage years can result in family disruption and interruptions in educational progression.

### **Priority needs**

- These unique sets of circumstances require ready access to clinical psychology and child and adolescent psychiatry services to ensure that children and adolescents achieve their social and educational potential without increasing the long-term risks of complications. Parents and families require access to information and contact points for help and advice in emergencies.
- There is a need for collaboration between paediatric and adult diabetes care teams particularly at the stage of transition to adult care.

## **D. Diabetic Retinopathy**

***A retinal screening policy for diabetes mellitus should be developed in Northern Ireland to ensure that all patients with diabetes have effective annual screening carried out. By 1999 all patients known to have diabetes mellitus should have annual screening carried out.***

### **Key facts**

- Diabetic retinopathy is the commonest cause of blindness in the working age population in Northern Ireland.
- Intensive diabetes control reduces the risk of retinopathy by half in insulin-dependant diabetes mellitus.
- Annual screening for retinopathy detects those at risk before visual symptoms occur. Screening may be carried out by retinal photography.

### **Priority needs**

- A formally structured retinopathy screening programme for all patients with diabetes should be developed in Northern Ireland using one or more of the methods of proven efficacy.
- Arrangements for the follow up, treatment and counselling of patients with diabetic retinopathy should be outlined together with the provision of support and retraining for people who are visually impaired as a result of their diabetes.

## **E. Research and development**

### **Key facts**

- A research strategy that is actively and continuously evaluated ensures the most cost-effective research and development agenda.
- Collaboration between the multiple agencies sponsoring and funding research into diabetes (including government, charities and industry) could prevent duplication.

### **Priority needs**

- Continued development of measures of personal well-being, treatment satisfaction and other subjective aspects of diabetes care; patients' and carers' psychological needs; tools for measuring patients' knowledge, skills and beliefs; strategies for motivation and empowerment in self care.
- Critical analysis of the support given by research and development strategies to the achievement of the St. Vincent targets, with particular emphasis on the role of central co-ordinating functions and the establishment of evaluative approaches at local level.

## **F. Education and training**

### **Key facts**

- Continuing education of those involved in diabetes care is necessary if high standards are to be maintained.
- The high prevalence of diabetes in the population means that all those working in hospital, primary and community care will encounter persons with diabetes.

- Current training programmes tend to neglect the psychosocial aspects of diabetic disorders.

### **Priority needs**

- Review of educational programmes of all diabetes care specialties including medical, nursing, dietetic, ophthalmic, podiatric, pharmaceutical and psychology professions.
- Development of a multiprofessional educational approach.
- Establishment of joint hospital/primary care audit approaches.

## **3. THE WAY FORWARD**

In addition to endorsing the general thrust of the report of the UK Task Force this report has focused on 3 key priority areas for Northern Ireland, namely, (1) local strategies and purchasing plans; (2) the development of diabetes registers; and (3) the production of local clinical guidelines to ensure timely referral to specialist services. The Northern Ireland Task Force was most encouraged that diabetes has been highlighted by the Department of Health and Social Services in the draft Regional Strategy for 1997-2002 and that the 3 areas above have been Identified as priority areas for purchasers. The 1994 Clinical Standards Advisory Group Report "Care for People with Diabetes" also reinforces many of the recommendations of the UK Task Force Report.

We are aware that the St. Vincent targets will not be achieved overnight. We do believe, however, that the high level of concordance between the UK and Northern Ireland Task

Force Reports, the CSAG Report and the 1997-2002 Regional Strategy will greatly assist purchasers and providers in attaining the targets.

## **APPENDIX 1 Membership of Northern Ireland Task Force on Diabetes**

Dr P G McClements (Chairman)	Principal Medical Officer, DHSS CREST Convenor
Mr D Bryce	Product Manager Directorate of Information Systems, DHSS
Dr B Farrell	Consultant in Public Health Medicine, Southern Board
Dr S Garvin	General Practitioner Armagh Health Centre
Professor D R Hadden	Consultant Physician/Honorary Professor of Endocrinology Royal Group of Hospitals Trust
Professor JR Hayes	Consultant Physician/Professor of Medicine Belfast City Hospital Trust
Mrs J Holmes	Dietetic Manager Royal Group of Hospitals Trust
Ms B Monaghan	Chiropodist Belfast City Hospital Trust
Miss A McNeill	Area Co-ordinator British Diabetic Association
Mrs N Webb	Staff Nurse Royal Group of Hospitals Trust
Miss A Lowry Mr G Hannan	CREST Secretariat

### **Former members of Task Force**

Mr D Cowan	Product Manager Directorate of Information Systems, DHSS
Mrs R Orr	Chiropodist Shankill Health Centre

## **APPENDIX 2 – Experts consulted in Northern Ireland**

**Comments on the reports produced by Specialty Advisory Sub-Groups of the UK Task Force were provided by:**

### **Cardiovascular Disease**

Professor DR Hadden	(Physician) Royal Group of Hospitals Trust
Professor JR Hayes	(Physician) Belfast City Hospital Trust
Dr S Garvln	(General Practitioner) Armagh

### **Children and Young Persons**

Dr D Carson	(Paediatrician) Royal Group of Hospitals Trust
Dr C Corkey	(Paediatrician) Newry and Mourne Health and Social Services Trust
Dr V Gleadhill	(Paediatrician) Ulster, North Down and Ards Hospital Trust
Dr J Jenkins	(Paediatrician) United Hospitals Trust
Dr M Quinn	(Paediatrician) Altnagelvin Hospitals Trust

### **Diabetic Foot and Amputation**

Dr R Hannon	(Vascular Surgeon) Belfast City Hospital Trust
Ms B Monaghan	(Chiropodist) Belfast City Hospital Trust

### **Information and Epidemiology**

Mr D Cowan	(Product Manager) Directorate of Information Systems, DHSS
Dr B Farrell	(Consultant in Public Health Medicine) Southern Board
Dr S Garvin	(General Practitioner) Armagh

### **Patient and Carer**

Miss A McNeill	(Patient Representative) British Diabetic Association
Mrs D Shortt	(Patient Representative) British Diabetic Association

## **Pregnancy and Neonatal Care**

Professor DR Hadden (Physician) Royal Group of Hospitals Trust

## **Professional Training**

Mrs P Donnelly (Clinical Psychologist) Royal Group of Hospitals Trust  
Professor JR Hayes (Physician) Belfast City Hospital Trust  
Mrs J Holmes (Dietitian) Royal Group of Hospitals Trust  
Miss S Martin (Dietitian) Belfast City Hospital Trust  
Ms B Monaghan (Chiropodist) Belfast City Hospital Trust  
Dr N Morrow (Chief Pharmacist) DHSS  
Mrs N Webb (Staff Nurse) Royal Group of Hospitals Trust

## **Renal Disease**

Professor AB Atkinson (Physician) Royal Group of Hospitals Trust  
Dr JF Douglas (Nephrologist) Belfast City Hospital Trust

## **Research and Development**

Dr D McCance (Physician) Royal Group of Hospitals Trust

## **Visual Impairment**

Professor DB Archer (Ophthalmologist) Royal Group of Hospitals Trust  
Dr P Bell (Physician) Royal Group of Hospitals Trust  
Dr B Farrell (Consultant in Public Health Medicine) Southern Board  
Dr P Hart (Ophthalmologist) Royal Group of Hospitals Trust  
Dr C Kenny (General Practitioner) Dromore  
Dr K Walshe (General Practitioner) Dundrum