

## HEALTH AND SOCIAL WELLBEING: DIABETES

### Issue/Problem

### Inequalities in the prevalence of diabetes in Northern Ireland

### Evidence Base (Equality & Inequalities Report)

It is estimated that 40,000 people in Northern Ireland have been diagnosed with diabetes whilst another 25,000 have the condition but do not know it<sup>1</sup>.

This figure is broadly in line with that of the Report of the Chief Medical Officer, which estimated that around 2% of the Northern Ireland population (over 30,000 people) have been diagnosed with diabetes.

*Ref: Report of the Chief Medical Officer (2000) cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:92).*

In 2001/02 just under 1% of deaths and discharges in acute hospitals in Northern Ireland were as a result of diabetes. The majority of activity (59%) was amongst the 15-64 age band, while children (0-14 years) and the older population (65+) years accounted for 9% and 32% of diabetes activity respectively.

*Ref: McWhirter (2002) cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:92).*

### Age and Diabetes

The risk of developing diabetes increases with age. Less than 1% of 16-24 year olds have been diagnosed with diabetes in comparison with 8% of those over 75.

*Ref: 2001 Health and Wellbeing Survey cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:92).*

However, the Northern Ireland Health Promotion Agency has reported that increasing levels of obesity in the population is associated with an increase in Type 2 diabetes in younger people. Type 2 diabetes, a preventable condition, accounts for approximately 85% of diabetes.

*Ref: Health Promotion Agency Journal, Issue 20 cited in "Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:92).*

### **Gender and Diabetes**

In 2001, 4% of males and 2% of females aged 16+ had been diagnosed with diabetes.

*Ref: 2001 Health and Wellbeing Survey cited in “Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:92).*

### **Socio-Economic Status and Diabetes**

In 2001, the highest level of diabetes was amongst the unskilled (6%) while skilled non-manual workers were the least likely to be diagnosed with diabetes (1%). The prevalence of diabetes increased from 1997 to 2001 in all classes except for the skilled non-manual.

*Ref: 2001 Health and Wellbeing Survey cited in “Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:93).*

### **Diabetes, Physical Activity and Weight**

Diabetics in all age groups are more likely to be sedentary than those who are not diabetic. Over 40% of diabetics aged 35-64 were sedentary compared with 21% of non-diabetics in the same age range. People diagnosed with diabetes are less likely to take above the recommended level of exercise than their non-diabetic counterparts.

*Ref: 2001 Health and Wellbeing Survey cited in “Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:94).*

People who are overweight are more likely to develop Type 2 diabetes. Over one third (36%) of people suffering from diabetes believed that they weighed a little more than they should, whilst 30% thought they weighed a lot more than they should.

*Ref: Diabetes UK cited in “Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:94).*

### **Evidence Base (Literature Review)**

Diabetes mellitus is one of the most common chronic disorders in the UK, affecting people of all age groups. The prevalence of diabetes increases with age, it is also more common in people of South Asian, African and African-Caribbean origin. The World Health Organisation predicts a doubling in the number of people with diabetes worldwide between 1995 and 2010<sup>2</sup>.

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Diabetes is a leading cause of blindness, kidney failure and limb amputation and greatly increases the risk of coronary heart disease and stroke<sup>3</sup>.

Ensuring equitable access to high quality diabetes prevention and care is vital, this includes ensuring equitable access for vulnerable groups such as those living in institutional care, those experiencing social deprivation, black and minority ethnic groups, the homeless, travellers, children and young people, and those with a mental illness or learning disability<sup>4</sup>.

Diabetes does not impact on everyone in society equally. Significant inequalities exist in the risk of developing diabetes, in accessing health services and the quality of those services, and in health outcomes<sup>5</sup>.

### *Weight and Physical Activity*

Preventing obesity in the general population and promoting a healthy diet and physical activity can reduce the overall prevalence of Type 2 diabetes in the population. Individuals at increased risk of developing Type 2 diabetes can reduce their risk if they are supported to change their lifestyle by eating a balanced diet, losing weight and increasing their physical activity levels. Multi-agency action is required to reduce the numbers of people who are physically inactive, overweight and obese, by promoting a balanced diet and physical activity across the population<sup>6</sup>.

### *Older People and Diabetes*

It has been suggested that the needs of older people with diabetes in care homes tend to be overlooked. Common problems include a lack of diabetes awareness and training amongst staff, the lack of skills amongst staff in relation to blood glucose monitoring, a lack of skills in regards to injecting insulin, and lack of awareness of the dietary needs for older people with diabetes. In addition to this, poor communication between staff in the care homes, social services, and health professionals has been identified<sup>7</sup>.

The prevalence of diabetes rises steeply with age. The diagnoses of diabetes may be delayed in older people, often the symptoms of diabetes are incorrectly attributed to the ageing process. Older people may also experience discrimination in the regards to the degree of active management of diabetes in comparison to younger people<sup>8</sup>.

### *Children, Young People and Diabetes*

Children and young people with diabetes present a unique set of circumstances and challenges to professionals, parents and

education services. As well as the normal developmental changes that occur throughout childhood, adolescence can be a time of experimentation and rebellion, making diabetes management difficult for all<sup>9</sup>.

Type 1 diabetes accounts for around 90% of diabetes in patients under the age of 25. However, in recent years there has been an increase in the frequency of Type 2 diabetes in children and young people which is associated with the rising levels of obesity in this group<sup>10</sup>.

It is suggested that specific psychological problems such as eating disorders are more common in adolescents with diabetes and that appropriate psychological interventions are essential to help young people develop coping strategies<sup>11</sup>.

### *Ethnicity and Diabetes*

According to Diabetes UK the prevalence of diabetes is around 2.4% in Caucasians, but in some black and minority ethnic groups it can be as much as 3-5 times higher for Type 2 diabetes. The reasons for the increased prevalence are not fully known. However, it is suspected that several factors could play a role including – genetic differences in how the body processes and stores fat; different levels of inactivity and physical fitness; social deprivation, a lack of education and/or employment<sup>12</sup>.

Several barriers prevent black and minority ethnic people with diabetes from accessing the services they need in regards to the management of their condition. These barriers include language barriers, poor knowledge of services, difficulties with transport, and cultural differences in regards to the willingness to seek medical help. The most vulnerable groups are hard to target with lifestyle interventions, as they speak little English, are relatively isolated from mainstream society and have variable knowledge of and motivation to use conventional services<sup>13</sup>.

The main barriers to physical activity for black and minority ethnic groups are believed to be a lack of time, through long working hours and home responsibilities. Other barriers include, the availability, costs and opening hours of leisure and sporting facilities; the fear for personal safety in public open spaces; the absence of other people from one’s own community using facilities, and, actual or potential experiences of racism. For black and minority ethnic women, dress codes, lack of privacy in changing areas and lack of single gender provision can prevent access to physical activity<sup>14</sup>. As physical fitness and weight management are key issues in relation to the prevention of the onset of diabetes, these are key issues for black and minority ethnic communities.

### *Gender and Diabetes*

The frequency of diabetes is higher amongst men in comparison to women. However, women may be at a greater risk of dying than men with diabetes. For example, women often bear the brunt of poverty, and socio-economic differences in the prevalence of diabetes are more marked for women, probably because of differences in smoking rates, food choices and the prevalence of obesity. There is some evidence to suggest that women are less likely to receive routine surveillance checks for the long-term complications of diabetes. Pre-menopausal women with diabetes do not have the same protection against coronary heart disease as women who do not have diabetes. Women also tend to take on the main role of carer if another member of the family has diabetes<sup>15</sup>.

### *Disability and Diabetes*

People with physical disabilities, sensory impairments and learning disabilities experience a range of problems in accessing appropriate diabetes care. People with learning disabilities in particular have problems with weight management and communication difficulties which may lead to delayed diagnosis<sup>16</sup>

### *Socio-Economic Status*

Type 2 diabetes is particularly prevalent amongst those experiencing socio-economic deprivation. Deprivation is strongly associated with higher levels of overweight and obesity, physical inactivity, smoking and poor blood pressure control. Other factors include poor blood glucose control, lower education, worse access to services and referral bias. Those who experience social exclusion may experience a sense of hopelessness which may prevent them developing the confidence to manage their diabetes effectively<sup>17</sup>.

### *Pregnancy and Diabetes*

It is estimated that around a thousand pregnant women have type 1 diabetes. Additionally, it is estimated that around 1-2% of pregnant women will develop diabetes during pregnancy (‘gestational’ diabetes). Once diagnosed women with gestational diabetes require considerable education and support. It is important that regional variations in pre-pregnancy counselling for women with diabetes do not exist and that there are no variations in quality of services provided pregnant women with diabetes<sup>18</sup>.

### *Mental Health & Diabetes*

A joint report by Diabetes UK Northern Ireland and Action Mental

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Health highlights the link between diabetes and mental health. The report states that people with severe mental illnesses are reported to be two to four times more likely to develop Type 2 diabetes<sup>19</sup>. In addition to this, between 20% and 30% of people with diabetes will experience significant depression and the suffering of individuals as a result of such co-morbidity has a detrimental impact in terms of lost productivity and health expenditure. The report makes several recommendations for improvements in this area.

**Is the issue/problem being addressed by current or proposed strategies and policies? On what level?**

*Northern Ireland Taskforce on Diabetes*

In 1996 a CREST<sup>20</sup> Taskforce on Diabetes produced a report entitled “Diabetes Care in Northern Ireland. In December 2002 the Chairman of CREST requested that a new taskforce be reconvened to review diabetes care in Northern Ireland.

The new Taskforce on Diabetes was a joint partnership between CREST and the voluntary organisation [Diabetes UK Northern Ireland](#). The membership of the Taskforce comprised of health professionals working in diabetes services and of representatives of Diabetes UK.

The remit of the Taskforce was to (a) review the 1996 CREST guidelines on diabetes, (b) consider developments in diabetes services in England, Scotland, Wales and the Republic of Ireland and (c) produce updated clinical and service guidance for Northern Ireland with particular reference to consumer issues, public health strategy, resources and screening for diabetes.

[Clinical Guidelines](#) for the Management of Patients with Diabetes have also been published and for the Management of Diabetes in Pregnancy have been published by CREST.

*Report of the Joint Taskforce*

In 2003 CREST published the report of the joint taskforce [“A Blueprint for Diabetes Care in Northern Ireland in the 21<sup>st</sup> Century”](#). The report makes a number of recommendations for the future development of diabetes services in Northern Ireland over the next 5 to 10 years.

*DHSSPS Priorities for Action 2004/2005*

The DHSSPS has committed to prioritise diabetes. This is underpinned in both the DHSSPS [‘Priorities for Action 2004/05’](#) and in the 2003 Report of the Chief Medical Officer [‘Your Health Matters’](#). The Priorities for Action document states that the Department will work closely with Boards during 2004/05 to begin the implementation of the recommendations of the Crest Taskforce Report on the

prevention and treatment of diabetes.

As part of this the DHSSPS has created a [Regional Diabetes Steering Group](#) to oversee implementation of the Board Plan and to monitor progress. The Group will have province wide representation from the DHSSPS, the four HSS Boards and Diabetes UK Northern Ireland<sup>21</sup>.

#### *Regional Diabetic Retinopathy Screening & Funding to Support Additional AHPs*

Commitment has also been given to the roll out of a [regional diabetic retinopathy screening programme](#). Progress has been made in regards to additional Allied Health Professional (AHP) and Nursing staff through Local Health and Social Care Group (LHSCG) funding for primary and community care<sup>22</sup>.

#### *Diabetes and Mental Health*

Each of the Health and Social Services Boards have recognised the need to increase the level of emotional and psychological support for diabetes sufferers in their [local implementation plans](#) and are taking steps to address gaps in service provision.

#### *Diabetes Advisory Groups*

Each of the Health and Social Service Boards has [Local Diabetes Advisory Groups](#) in place. These are multi-disciplinary whose membership comprises of health professionals who provide services for people with diabetes as well as representatives from local community and voluntary groups, local services users, and the parents of children and young people with diabetes.

#### *Other Related Strategies/Policies*

The DHSSPS, its associated bodies and other Government Departments and Agencies are committed to taking action on improving diet and increasing physical activity through a number of long term strategies such as the [Investing for Health Strategy](#), the new [Physical Activity Strategy and Action Plan](#), [Northern Ireland Cycling Strategy](#), and the [Northern Ireland Walking Action Plan](#) etc.

The new twenty year [Regional Strategy](#) sets out a number of provisions for people with diabetes. One of the key outcomes is to ensure that everyone with diabetes is screened annually for the risk of kidney disease so that problems can be identified early and managed in a community-based setting. An additional outcome is to reverse the current trends in the prevalence of diabetes in Northern Ireland. The drive towards responsive integrated services (set out in both the new Regional Strategy and the new [Primary Care Strategy](#))

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will play a key role in addressing the problem.

Other developments likely also likely to have a positive impact include the community pharmacy strategy (e.g. in terms of medicines management and diabetic screening) and the new GP contract (through offering incentives and awards) for the better management of chronic diseases).

### *Some Examples of Other Initiatives/Projects*

- Diabetes and Endocrinology is a Recognised Research Group of the Northern Ireland Research and Development Office with a network of research being undertaken between Queen's University Belfast, the University of Ulster and service providers.
- A multi-professional course on Diabetes Care has been introduced in the University of Ulster.
- Information leaflets in a range of languages and formats have been produced by Boards which offer advice and information on diabetes (e.g. the Chinese Welfare Association worked in co-operation with the Belfast Local Diabetic Services Group to produce a booklet and audio tape on diabetes for the Chinese Community)<sup>23</sup>.
- The NHSSB Local Diabetic Services Group have developed a Diabetes Integrated Care Handbook which provides a resource for those involved in managing diabetes in the Northern Board area. It provides advice and information on available services, best practice, basic procedures and appropriate contacts within the area.
- Local Health and Social Care Groups are working with local community pharmacists to provide a diabetes screening service for high-risk groups.
- Craigavon and Banbridge Local Health and Social Care Group recently hosted a workshop for people with diabetes and their carers and a wide range of health professionals to share views on the development of local services. A working group has been set-up from workshop participants who will be tasked with drawing up proposals on how funding should be invested to further develop local services for people with diabetes<sup>24</sup>.
- An initiative to improve care and support for people with Diabetes in the North-West, led by Foyle HSS Trust has been established. The Chronic Disease Management Team provides clinics and advice at venues across the area to adults with diabetes<sup>25</sup>. The initiative is support by the North West's Local Health and Social Care Group (LHSCG).

**Is the problem amenable to further intervention by the DHSSPS or other?**

### **Northern Ireland Diabetes Taskforce Report**

The report of the joint taskforce "[A Blueprint for Diabetes Care in Northern Ireland in the 21<sup>st</sup> Century](#)" identified a number of areas for early intervention:

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- *User Forum and Empowerment* – effective user participation is essential in developing and managing services to ensure a patient centred approach is adopted.
- *Education for Professionals and People with Diabetes* – people with diabetes need consistent education and information to help them manage their condition effectively. Professionals require training and updating in a timely and effective manner.
- *Emotional and Psychological Support* – there is a need for the provision of appropriate emotional and psychological support services to assist people in coming to terms with a diagnosis of diabetes and having a life long chronic condition.
- *Integrated Diabetes Care in Primary and Secondary Care* – diabetes services must be delivered in the most appropriate place and provide consistent high quality care. Close working between primary and secondary care services are essential.
- *Workforce Planning* – in order for comprehensive quality services to be delivered, a range of appropriately trained staff will be needed. Workforce planning is needed to agree the numbers, types of staff and skills required in the future.
- *Children and Young People* – Type 1 diabetes is the most common metabolic and third most common chronic disease of childhood. Services for children and their families are crucial to the delivery of good diabetes care.
- *Information Management and Diabetes Register* – the availability of a diabetes register would facilitate regular monitoring and screening systems to be put into place.

### Primary Care Interventions

[Diabetes UK Primary Care Services Recommendations](#) for People with Diabetes<sup>26</sup> include:

- The identification of all registered patients who have clinically diagnosed diabetes and those at increased risk of developing diabetes. Establish and maintain practice records.
- Practices should agree practice guidelines for the management of diabetes which should include the following issues – prevention of Type 2 diabetes; identification and diagnosis for people with diabetes; initial assessment and care at diagnosis; initial and ongoing education; the provision of dietary advice; continuing care.
- Certain groups of patients should be followed up by a specialist team (e.g. children and young people with diabetes; pregnant women or women with diabetes considering pregnancy; people with complex psychological problems etc).
- There should be clear patient-centred individualised care plans agreed with each person with diabetes that are tailored to meet the needs of the individual, and where appropriate, their carers.
- There should be personal diabetes records that can be shared

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with and access by all the health professionals involved, as well as the service user.

- There should be an agreed named contact to help guide the person with diabetes through the health care system.
- There should be agreed guidelines (including indications for referral to hospital) for primary and secondary care. Services should be co-ordinated between primary and secondary care.
- All people with diabetes should have an annual review with a structured format. The annual review should be for screening, prevention and the treatment of complications. Management goals should be agreed between the person with diabetes and the diabetes team as part of the review.
- All service providers should receive regular education and updating on developments in diabetes care.

### Other Interventions

See [National Service Framework for Diabetes](#) in England.

See also [Audit Commission](#) recommendations arising from a review of diabetes services in England and Wales

### Mental Health Interventions

Recommendations from [‘Mental Health and Diabetes: Challenges for the Future’](#) a joint report by Diabetes UK (NI) and Action Mental Health:

- *Holistic approach to treatment of mental ill health and diabetes* - encouragement of an integrated medical, psychological and social view of health care.
- *Patient involvement in their own care* – patients should be involved in decisions about healthcare. It is recommended that there is user involvement at each stage of the patient’s care pathway.
- *Awareness* – to reduce the personal and economic impact of living with both conditions there must be an improvement in the level of awareness. It is recommended that there is increased and targeted investment in more effective prevention measures.
- *Education* – education is critical in enabling people to manage their conditions on a daily basis. It is recommended that there is access to structured education programmes from the point of diagnosis and on an ongoing basis.
- Given the relatively high use of hospital services by older people, hospitals may offer an effective intervention point for earlier diagnosis and better management of diabetes in older people. Information, education and support should be provided for older people to help them manage diabetes<sup>27</sup>.

## Addressing the Needs of Specialist Patient Groups

### Interventions for Inpatients

- Diabetes teams should develop effective links with ward staff, through regular liaison and training, and produce up to date guidelines on the management of inpatients with diabetes on the wards. There should be clear points of contact for ward staff when they have concerns about patients with diabetes who are under their care<sup>28</sup>.

### Interventions for Older People

- Establish regional diabetes standards for care homes which address the need for staff training and the development of better working partnerships between different diabetes care teams. Diabetes UK has produced a set of [guidelines](#) for the treatment and care of diabetes in care homes.

### Intervention for Children and Young People with Diabetes

- It is essential that appropriate psychological interventions are put in place to help children and young people with diabetes develop coping strategies<sup>29</sup>.
- Following diagnosis home based information packs which involve the whole family are thought to be at least as effective as inpatient instruction<sup>30</sup>.
- Review policy on managing newly diagnosed children and young people, allowing where possible support in the family home. Develop clinic facilities for adolescents, combining staff from paediatric and diabetes teams and take steps to maximise attendance<sup>31</sup>.

### Interventions for Black and Minority Ethnic Groups

- Appropriate standards of care, tailored patient education, and ease of access to services must be provided when needed<sup>32</sup>.
- Support the establishment of advocacy and user groups for people from black and minority ethnic communities who have diabetes.
- Promote physical activity and healthy diets amongst black and minority communities taking into consideration cultural and language differences. Conduct an investigation into the barriers experienced by BME communities in accessing sport and leisure facilities and activities.

### Interventions for Pregnant Women<sup>33</sup>

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- Ensure that effective joint working of obstetric, midwifery and diabetes staff, including the development of multi-disciplinary guidelines for the management of pregnant women with diabetes.
- Ensure that pre-pregnancy counselling is available at adult and adolescent clinics.

<sup>1</sup> Estimated by Diabetes UK.

<sup>2</sup> Diabetes UK. *Recommendations for the provision of services in primary care for people with diabetes*. [www.diabetes.org.uk/hcpreports/primary\\_recs.pdf](http://www.diabetes.org.uk/hcpreports/primary_recs.pdf)

<sup>3</sup> *Ibid*

<sup>4</sup> *Ibid*

<sup>5</sup> Department of Health (2001). *National Service Framework Diabetes*. London: Department of Health.

<sup>6</sup> Diabetes UK. *Recommendations for the provision of services in primary care for people with diabetes*. *Op Cit*.

<sup>7</sup> Diabetes UK. ‘Who Cares’. *Diabetes Update*. Summer 2001. [www.diabetes.org.uk/update/summer01/whocares.htm](http://www.diabetes.org.uk/update/summer01/whocares.htm)

<sup>8</sup> Department of Health (2001). *Op Cit*.

<sup>9</sup> CREST (2003) *Report of the Northern Ireland Taskforce on Diabetes: A Blueprint for Diabetes Care in Northern Ireland in the 21<sup>st</sup> Century*. [www.crestni.org.uk/publications/diabetes\\_main\\_report.pdf](http://www.crestni.org.uk/publications/diabetes_main_report.pdf)

<sup>10</sup> British Medical Association (2004) *Diabetes Mellitus: An Update for Healthcare Professionals*. [www.bma.org.uk/ap.nsf/Content/Diabetes/\\$file/diabetes.pdf](http://www.bma.org.uk/ap.nsf/Content/Diabetes/$file/diabetes.pdf)

<sup>11</sup> *Ibid*

<sup>12</sup> Diabetes UK. (2001) Information: Increased prevalence of diabetes mellitus in black and minority ethnic groups. [www.diabetes.org.uk/infocentre/inform/ethnic.htm](http://www.diabetes.org.uk/infocentre/inform/ethnic.htm)

<sup>13</sup> Greenhalgh, P., Collard, A. Noorjahan, B. ‘Sharing Stories: Complex interventions for diabetes education in minority ethnic groups who do not speak English’. *BMJ*, 2005: 330.

<sup>14</sup> Active for Life. *Guidelines: Promoting physical activity with black and minority ethnic groups*. [www.renewal.net/Documents/RNET/Policy%20Guidance/Activeforlife.pdf](http://www.renewal.net/Documents/RNET/Policy%20Guidance/Activeforlife.pdf)

<sup>15</sup> Department of Health (2001). *Op Cit*.

<sup>16</sup> *Ibid*

<sup>17</sup> British Medical Association (2004) *Op Cit*.

<sup>18</sup> Audit Commission. (2000) *Testing Times: A Review of Diabetic Services in England and Wales*. London: Audit Commission.

<sup>19</sup> Buse, J. B. (2002) Metabolic side effects of anti-psychotics. *Journal of Clinical Psychiatry*. 63 (54) in Diabetes UK (NI) and Action Mental Health (2004) *Mental Health and Diabetes: Challenges for the Future*. [www.diabetes.org.uk/n.ireland/downloads/Joint\\_Report.pdf](http://www.diabetes.org.uk/n.ireland/downloads/Joint_Report.pdf)

<sup>20</sup> Clinical Resource Efficiency Support Team (CREST).

<sup>21</sup> Information extracted from Diabetes UK website - [www.diabetes.org.uk/n.ireland/nireland.htm](http://www.diabetes.org.uk/n.ireland/nireland.htm)

<sup>22</sup> *Ibid*

<sup>23</sup> Eastern Health and Social Services Board Press Release. ‘New booklet offers Chinese community guidance on diabetes’. 25 August 1999.

<sup>24</sup> Southern Health and Social Services Press Release. ‘Prioritising Diabetes’. 30 September 2004.

<sup>25</sup> Western Health and Social Services Board Press Release. ‘Diabetes Services High on Local Agenda’. 19 January 2005.

<sup>26</sup> Diabetes UK. *Recommendations for the provision of services in primary care for people with diabetes*. [www.diabetes.org.uk/hcpreports/primary\\_recs.pdf](http://www.diabetes.org.uk/hcpreports/primary_recs.pdf)

<sup>27</sup> Department of Health (2001). *Op Cit*.

<sup>28</sup> Audit Commission. (2000) *Op Cit*.

<sup>29</sup> British Medical Association (2004) *Op Cit*.

<sup>30</sup> *Ibid*

<sup>31</sup> Audit Commission. (2000) *Op Cit*.

<sup>32</sup> Diabetes UK. (2001) *Op Cit*.

<sup>33</sup> Audit Commission. (2000) *Op Cit*.