Hywel Dda Health Board Hospitals Diabetes Service Report

August 2012

Introduction

The diabetes service within Hywel Dda Health Board is primarily delivered in primary care which is in turn served by 4 specialist units based in the District General Hospitals (Bronglais, Glangwili, Prince Philip and Withybush). There is an approximate population of patients with diabetes of 20,000 (10,000 in Carmarthenshire, 5,000 in Pembrokeshire and 5000 in Ceredigion). Inequalities exist across the Health Board in terms of service provision and access to resource and since the formation of the Health Board we have been working at redressing these inequalities. Within the Health Board there are exemplar Primary Care units that provide state-of-the-art diabetes care near to patient homes and we have recently developed extra locations for delivery of secondary care clinics within the community setting.

Current Secondary Care staffing levels (for patients over 16 years of age)

Carmarthenshire

Consultants in Diabetes and Endocrinology: 3
Diabetes Nurse Specialists: 5 (WTE)
Community Diabetes Nurse: 3 (WTE)
Podiatrists: 0.4 (WTE) Specialist Diabetic Podiatry
Dietitians: 0.5WTE band 6 dedicated diabetes post with limited sessional input from other dietitian

Ceredigion

Consultants in Diabetes and Endocrinology: 1
Diabetes Nurse Specialists: 1.6 (WTE)
Community Diabetes Nurse: 0.8 (WTE)
Podiatrists: 0.2 (WTE) Specialist Diabetic Podiatry
Dietitian: 1WTE band 7 dedicated diabetes post, also functions as HB wide clinical lead for diabetes in dietetics

Pembrokeshire

Consultants in Diabetes and Endocrinology: 1
Diabetes Nurse Specialists: 1.2 (WTE)
Community Diabetes Nurse: 0.8 (WTE) funded by Pharmaceutical company funds – terminates in December 2012
Podiatrists: 0.5 (WTE) Specialist Diabetic Podiatry
Dietitian: 0.48 WTE band 6 dedicated diabetes post

Recent developments in the local diabetes services

Key points

- A secondary care clinic has recently been established on Cardigan Hospital. Community clinics are already held in Aberaeron, Amman Valley, Machynlleth and Tywyn.

- A certificate level module in Diabetes developed between Swansea University and the Health Board is now accredited as suitable training for the GP Local Enhanced Service in Diabetes in Hywel Dda Health Board. Seven courses involving over 100 participants (from all areas of the Health Board) have been held so far, including one held in Carmarthen and one in Aberystwyth. The next course is also scheduled to be undertaken in Carmarthen.

- In Carmarthenshire the Community Diabetes Nurse Specialists and the Dietitian, deliver the XPERT structured education course for people with type 2 diabetes. Our follow up data demonstrates that this programme is successful at improving metabolic control in these patients. Similar courses are now being delivered in Ceredigion and the first one in Pembrokeshire has just completed. These will be facilitated by employing part time community diabetes nurses in these counties. In Ceredigion, the Diabetes Nurse Specialists and Dietitian deliver 5 courses per year. Resources for these courses are currently limited with an absence of dedicated administration support and the patient education packs are funded by charitable funds.

- Diabetic outpatient activity is becoming more sub-specialised, with (for example) significant numbers of diabetic pregnancies and a rapid increase in the use of insulin pumps.

- The National Diabetes Inpatient Audit showed that over 1 in 6 inpatients in Hywel Dda Hospital have a diagnosis of diabetes, confirming the fact that people with diabetes require considerably more hospitalisation than the rest of the population. It was also noted that diabetic foot inspections on the ward were very poor; we are trying to put in place a new foot inspection check to be carried out for every patient referred onto the wards. This will be carried out by nursing staff, with red flags for diabetic foot problems to be referred to the multidisciplinary foot team on all secondary care sites within 24-48 hours (in keeping with new NICE guidelines).

- Open Access diabetic Podiatry clinics are run, one session per week on 3 of the 4 secondary care sites for rapid access for diabetic foot emergencies linking primary care diabetic foot problems into a secondary care multidisciplinary team clinic, with access to diabetologist, vascular input, orthopod links and access to plaster technicians and surgical appliances. On the 4th site (Withybush Hospital) there are twice weekly specialist Podiatry hospital based Diabetes foot clinics.

- Iechyd Hywel: Workplace cardiovascular health checks for those over the age of 40 began in September 2009. The pilot project was undertaken in Carmarthenshire and over 800 checks were performed in the first two years on employees of Tata Steelworks and Hywel Dda Heath Board. The pilot project was a finalist in the 2010 Wales NHS Awards. This pilot was also awarded the Hywel Dda Best of Health Award: Excellence in Improving Health and Wellbeing. In the next month the program will begin offering checks to staff in Pembrokeshire.

- The number of clinical contacts made by members of the Carmarthenshire diabetes team in various settings last year was 15,674. Access to this information across the Health Board is compromised by the lack of an electronic patient record outside of Carmarthenshire. This facility was established within the Carmarthenshire hospitals before reconfiguration in to the current tri-county Health Board.

- Audit of the Carmarthenshire electronic records for the 1,496 patients followed up in the Trust's outpatient clinics show a high level of completeness of the clinical record. Mean duration of diabetes was 22.3 years for Type 1 patients and 14.6 years for Type 2 patients. Not surprisingly, diabetic complications are common in this secondary care cohort, with 35% recorded as having microvascular disease and 25% with macrovascular disease. Despite the advanced nature of the diabetes, cardiovascular risk factor mean values in these patients were: HbA1c 8.5%, blood pressure 134/71 and cholesterol 4.1, respectively. Once more this information for Ceredigion and Pembrokeshire is not readily available due to the lack of an electronic database.

New clinical developments

Insulin pump therapy is now administered to increasing numbers of patients with type 1 diabetes. There are now over 100 adults and 50 children on insulin pumps in Carmarthenshire. An audit of insulin pump usage and effectiveness has been performed this year that has demonstrated excellent results. Ceredigion currently have 16 adult patients and 5 children receiving insulin via pump therapy. In Pembrokeshire there are currently 19 patients on pump therapy. There is no specific funding for the pumps, funding is via the general diabetes budget.

The service for **Diabetes in Pregnancy** for Carmarthenshire has further developed with the establishment of a weekly multidisciplinary clinic at GGH which includes obstetric and diabetes consultants, midwives, diabetes nurse specialist and dietitian. During 2011 a total of 93 patients attended this clinic (255 visits), consisting of 17 with type 1, 7 with type 2 and 61 with gestational diabetes. This information is less readily available in Pembrokeshire and Ceredigion due to the lack of electronic patient records. However, in Pembrokeshire there is a weekly diabetes in pregnancy multidisciplinary clinic.

Continuous blood glucose monitoring equipment is now available to investigate those patients with erratic glycaemia, particularly those with difficult hypoglycaemia problems. In all hospital sites there is a Hospital wide blood glucose testing capability linked in with pathology systems.

New guidelines for the management of hypoglycaemia, ketoacidosis, diabetes in pregnancy as well as diabetic painful peripheral neuropathy have been developed and are currently being implemented. A bespoke insulin prescribing chart has also being introduced throughout the HDHB hospitals. A further development that is currently in progress is a staff education package that will improve levels of knowledge and competence in our non-specialist staff. This will inevitably improve the care of our in-patients with diabetes.

Health Board Diabetes Nurse Specialists are currently developing **Insulin Passports** for patients with diabetes.

Carmarthenshire Diabetes Patient Record

We now have detailed clinical information on 8,133 people with diabetes. The annual number of patient contact entries by the diabetes multidisciplinary team in 2011 was 15,674. This enables excellent communication between members of the diabetes team and also with patients, their carers and primary care staff. As the electronic record is used by the whole multidisciplinary diabetes team, we often look at each other's entries and this provides a powerful safeguard against errors that could cause harm. Since the EPR system enables us to aggregate

large amounts of data, we can get an accurate assessment of many clinical and laboratory data which reflect upon the quality of the service (see below).
The link to the Telepath system allows automatic transfer of patients' pre-clinic test results to the EPR, although the new units for recording HbA1c (IFCC having replaced DCCT) have required manual entry into the record so far. As mentioned above this system is not available in Ceredigion or Pembrokeshire and current levels of resource do not allow for this to be purchased. The acquisition of an all-Wales electronic diabetes record and database system (as available in Scotland) would negate the need to resource such a system specifically for our localities.

Patient participation

Patients continue to be represented at all stages in the design and delivery of diabetes services. The Carmarthenshire Diabetes Patient Reference Group meets regularly before each Diabetes Network meeting to discuss a range of issues relevant to the local diabetes services. Five members of this group also attend the Network meetings where these issues are further discussed. Efforts are underway to re-establish Diabetes Reference Groups in both Ceredigion and Pembrokeshire; indeed the first meeting of the Ceredigion Patient Reference Group has been arranged for 08/10/2012.

Structured patient education

The Community Diabetes Nurse Specialists and Dietitian, continue to deliver the XPERT structured education course for people with type 2 diabetes funded from charitable sources until NHS funding is forthcoming. In Carmarthenshire XPERT has been running since 2006. In the last financial year 4 programmes were run with one annual update day and an INSULIN XPERT programme completed. Ceredigion has run 5 programmes with 49 people attending. As noted above the Pembrokeshire team has recently recommenced these courses also. On all sites structured education courses for Type 1 diabetes patients (DAFYDD courses) are delivered by the inpatient diabetes teams.

Education of healthcare professionals

The following are examples of educational courses designed and/or delivered by our multidisciplinary diabetes team:

- Annual Diabetes Update Day for certificate trained diabetes staff: the last one was held in June 2012 and was attended by over 100 diabetes care professionals from Carmarthenshire and the rest of West Wales.
- In Ceredigion GP Update half days (spring and autumn) have run successfully for 3 years with excellent feedback for primary and secondary care teams from Ceredigion, south Gwynedd and north Powys.
- Diabetic Foot Training Day for GP's and Practice Nurses enable them to examine diabetic feet competently. Diabetic Foot Assessment training is also running along side a Tissue viability wound healing course for District, practice and ward nursing staff (6 sessions per year across the three counties of Hywel Dda).
- Diabetes Training Days are also organised by the Community Diabetes Nurse Specialists for Care Home and Social Services staff.
- The hospital/community based diabetes team also delivers Merit I and Merit II courses to local GP's and Practice Nurses to enable them to care for patients who require insulin.
- We are now into our fifth year for delivering the Swansea Certificate level module in Diabetes.
- Currently we are working on the development of a staff education and awareness programme to improve the hospital care of patients with diabetes.
- Annual training for all health care workers in county council run care homes in Carmarthenshire with the development of a Diabetes Toolkit
- Diabetes Nurses in Ceredigion have delivered Diabetes Update Days for Registered Nurses and so far this year 77 nurses have attended. They have also arranged an Insulin Master-class which is due to be held on October 3rd and the study day is almost fully subscribed with both Primary and Secondary staff. It is hoped that a condensed version of the Update day can be delivered to F1 and F2 doctors in the Post-Graduate Centre on a rolling basis.

- Supplementing Diabetes specific health care professional training, Motivational Interviewing training has been available within Pembrokeshire for the last 4 years and all the Pembrokeshire hospital diabetes team is trained to a high level. Currently this training is being rolled out across all health board secondary care sites.

Diabetes Planning and Delivery Group (DPDG)

The Hywel Dda Diabetes Network was established in 2008. The Network is an inclusive group with representation from all the important local stakeholders in diabetes. These include the hospital based diabetes teams, Community Diabetes Nurses, GP's, health managers, patients and the voluntary sector. It provides the focus for strategic planning of local diabetes services. In addition individual group members, in their capacity as leaders of the various components of the local diabetes services, are also able to implement agreed developments in service delivery.

To develop the Diabetes Delivery Plan we have used the Diabetes E Health Needs Assessment Tool which has been employed to inform the implementation of the Diabetes NSF in the English PCT's for the last few years. This consists of a questionnaire in 16 sections which we have now adapted for use in Wales. The Delivery Plan document, derived from the questionnaire, lists the actions required to conform to the NSF, who is responsible, the timescale, the priority rating and the resource implications. Many of these actions do not require a significant resource and it is anticipated that these will be completed within a relatively short timescale. An up-to-date Diabetes E assessment is included with this document.

The DPDG has been particularly involved with developing the **Diabetes Enhanced Services Business Case** and the **HDHB Diabetes Care Pathway**

Research and Clinical Trial work

Our Unit presented a study titled "Risk identification in the workplace for cardiovascular disease and type 2 diabetes" at the annual national Diabetes UK Conference in March 2011. Our data was also presented in poster form at the annual British Dietetic Association Meeting. Both Prince Philip (PPH) and Glangwili Hospital (GGH) sites have participated in studies on prandial insulin commencement (LanScape). The GGH site has also contributed to a number of other clinical studies during the last year (TIDE Study, LANScape Study, trial on long acting DPP-IV, a study on new long acting insulin, Once weekly Exenatide study).
At GGH we are also conducting in-house research projects. Two studies have now started and a third is in the development phase.
We currently support 4 PhD studentships linked to Swansea and Aberystwyth Universities and have our first MD student starting in October 2012. 2 of the Carmarthenshire diabetes consultants hold NISCHR clinical fellow awards.

National Diabetes Inpatient Audit 2011

All Hywel Dda Health Board hospitals undertook the audit last year and will be doing so again this year (week beginning 17th September 2012).

Hywel Dda Health Board Diabetes Local Enhanced Service (LES)

To date only the first phase of the LES has been funded that compensates GP practices for looking after a greater percentage of their diabetes patients. In order to comply better with many of the NSF standards the subsequent phases (that includes aspects such as screening, education programmes and pre-diabetes) would need to be resourced.

Summary

Diabetes related activity with Hywel Dda Health Board is dynamic and highly functional. Indeed many aspects of our service are look upon with envy by our neighbouring Health Boards. Levels of resource relating in particular to electronic patient records/data systems, patient/staff education, dietetic and podiatry services impact on our ability to deliver all aspects of the NSF for diabetes.

Health Board Diabetes self assessment tool **Health Board Name:** Hywel Dda Health Board **Date:** September 2012

Section 1 - Leadership			**NSF standard**
1.1 Does the LHB have a Diabetes Planning and Delivery Group (DPDG)?		**Yes**	All
1.2 Does the LHB have a Diabetes Planning and Delivery Group (DPDG) lead?		**Yes**	All
1.3 What is the name of the LHB DPDG lead?		**Dr Meurig Williams/ Dr Sam Rice/ Claire Hurlin**	N/A
1.4 Does the DPDG have representation from:	CHC	**Yes**	All
	Consultant Diabetologist	**Yes**	
	Diabetes specialist nurse	**Yes**	
	Diabetes UK	**Yes**	
	Dietetics	**Yes**	
	LHB Executive (s)	**Yes**	
	Patient representative	**Yes**	
	Paediatrician	**Yes**	
	Pharmacy	**Yes**	
	Podiatry	**Yes**	
	Primary care	**Yes**	
	Psychology	**No**	
1.5 Does the LHB have a designated clinical lead for Diabetes service implementation?		**Yes**	All
1.6 Has the LHB developed a model of care for the Diabetes service that clearly defines what the population should expect and indicates which elements of the service deliver which activities, where, when and how?		**Yes – Diabetes Model of Care**	2-12

1.7	Has the LHB documented a longer term vision and goals for the Diabetes service?	**No however there is a Clinical Services Strategy which documents the vision for chronic diseases.**	2-12
1.8	Is there a management system in place for monitoring the performance of providers against the model of care?	**Yes – Secondary Care Mechanism for Carmarthen QOF is recorded for Primary Care**	2-12
1.9	Does the LHB obtain the views of primary care teams, Diabetes specialist teams and support services (e.g. eye screening, foot screening etc.) on how the Diabetes services could be developed across the LHB?	**Yes**	2-12
1.10	Does the LHB give feedback to Primary care teams, Specialist (Secondary care) teams and support services on Diabetes service developments?	**Yes**	2-12
1.11	Does the LHB require that providers obtain the views of service users and the wider community on how the Diabetes services could be developed across the LHB?	**Yes Carmarthenshire has a patient reference group. Planned for October in Ceredigion**	3-12
1.12	Does the LHB give feedback to service users and the wider community about service development and service outcomes?	**Yes**	3-12
1.13	Does the LHB require that providers measure patient satisfaction?	**Yes health board wide not specific to diabetes.**	3-12
1.14	Does the LHB require that providers measure staff satisfaction?	**No not specific to Diabetes wider staff survey undertaken across the HB**	N/A

Section 2 – Policy and strategy			NSF standard
2.1	Has the LHB developed a Strategic plan to ensure full compliance with Diabetes NSF by 2013?	**No**	1-12
2.2	Has the LHB developed and documented a Delivery plan to map the activity and milestones (goals for the diabetes service) to ensure full compliance with Diabetes NSF by 2013?	**yes**	1-12
2.3	Are the LHBs Delivery plan in line with diabetes NICE guidance?	**Yes -model of care**	1-12
2.4	Has the LHB assessed the needs of all sections of the population (i.e. adults, children and young people, elderly, minority ethnic groups etc.)?	**Yes for adults**	1-12
2.5	Has the LHB Delivery plan taken into account a comprehensive population needs assessment?	**Yes**	1-12
2.6	Does the LHBs model of care make explicit the roles of the various providers (e.g. primary, secondary, intermediate and community care) in delivering Diabetes services?	**Yes (model of care)**	2-12
2.7	Does the LHB have clear guidelines directing referral to and discharge from Specialist Diabetes services (Secondary Care)?	**Yes for Specialist services (foot, neuropathy, renal).**	4-9
2.8	If so does the LHB require that all providers adhere to the model of care for referral to and discharge from specialist Diabetes services (Secondary Care)?	**No**	4-9
2.9	Does the LHBs strategy include addressing the requirement that all people with diabetes should be offered a personalised care plan?	**No**	3-12
2.10	Does the LHB provide a range of services that support people with Diabetes in making changes to their lifestyle that are based on feedback from care plans?	**No**	3-12
	If yes - Menu of services offered:		
2.11	Does the LHB run a NICE compliant structured education for people with Type 1 Diabetes (newly diagnosed and ongoing)?	**No Programme available but not NICE compliant**	3
If yes:	Name programme:	**Structured Education**	
	Is programme accessible to people in all geographical areas covered by the LHB?	**No**	

	Which professions' input into the programme?	Dietetics	**Yes**	
		Medical	**No**	
		Nursing	**Yes**	
		Podiatry	**No**	
	How many programmes were delivered last year / reporting period?		**5**	
	How many people completed the programme?		**40**	
	Does the LHB have the capacity (number of places) to meet the requirements of:			
			2 - 5%	
	What is the average waiting time to access the programme (weeks)?		**Currently no waiting list**	
2.12 Does the LHB run a NICE compliant structured education programme for people with Type 2 Diabetes (newly diagnosed and ongoing)?			**Yes**	3
If yes:	Name programme:		**Xpert Education Programme**	
	Is programme accessible to people in all geographical areas covered by the LHB?		**No- it is now available in each county but not within each locality:**	
	Which professions input into the programme:	Dietetics	**Yes**	
		Medical	**No**	
		Nursing	**Yes**	
		Podiatry	**No**	
	How many programmes were delivered last year / reporting period?		**Carms: 5 Cere:5 Pembs: 1**	
	How many people completed the programme?		**Carms: Cere: 61 Pembs:5**	
	Does the LHB have the capacity (number of places) to meet the requirements of:		**No**	
			2 - 5%	
	What is the average waiting time to access the programme (weeks)?		**6**	
2.13 Does the LHB require that all providers have access to accurate and consistent patient education materials?			**Yes**	3

2.14 Does the LHB require that policies, protocols and guidelines developed and/or used by all providers are based on evidence and/or accepted good practice?	**Yes**	2-12
2.15 Does the LHB have a performance management system in place to identify variation in the quality of service provision?	**No**	2-12
2.16 Does the LHB have a plan to address variation in the quality of service provision?	**Yes -action plan in place**	2-12
2.17 Does the LHB have a system to identify barriers to equitable service provision?	**Yes**	2-12
2.18 Does the LHB have a plan to overcome barriers to inequitable service provision?	**Yes**	2-12
2.19 Does the LHB require that, where necessary, providers make interpreters/care coordinators available to support patient consultations and education programmes?	**Yes**	3-6

Section 3 - Staff		**NSF standard**
3.1 Are there clear arrangements for the co-ordination of all staff involved in the Diabetes services to deliver the LHBs model of care?	**Yes**	2-12
3.2 Does the LHB require that providers have professional development plans in place for all staff involved in the delivery of the Diabetes services?	**Yes**	2-12
3.3 Does the LHB require that providers have a programme in place that provides continuing professional education to ensure the effective delivery of the model of care?	**Yes**	3-12
3.4 Does the LHB require that providers of Diabetes specialist services (Secondary care) take an active role in delivering and coordinating education programmes for all health care professionals who come into contact with people with Diabetes?	**Yes**	3-12
3.5 Does the LHB specify the competencies and accreditation required by service providers to deliver Diabetes care at each level of the Primary care service?	**Yes**	4-12
3.6 Does the LHB specify the competencies and accreditation required by specialist service providers (Secondary care) to deliver Diabetes care?	**Yes**	4-12
3.7 Does the LHB require that clinical staff involved in the Diabetes services are trained in techniques to support self care?	**Yes**	**3-12**
3.8 Does the LHB require that clinical staff involved in the Diabetes services are trained to support personalised care planning?	**No**	**3-12**
3.9 Does the LHB require that clinical staff involved in the Diabetes services are trained to help patients make changes in their lifestyles?	**Yes**	**3-12**

Section 4 - Prevention of Type 2 Diabetes				**NSF standard**
4.1 Does the LHB have a programme for raising awareness of the risk factors for Diabetes amongst its population? AS in paper copy			**No - in progress work ongoing to implement the LES.**	1
If yes:	By what means:	Promotional campaign	**Yes / No**	
		Educational leaflets	**Yes / No**	
		Other: specify	**Yes / No**	
	Is it evaluated?		**Yes / No**	
4.2 Does the LHB have a programme for improving diet and nutrition targeted at sub-groups of the population at increased risk of developing Diabetes?			**Yes**	1
If yes:	Groups with established	Cardiovascular disease	**Yes within cardiac rehab**	
		Cerebrovascular disease	**Yes – dietetic input to stroke services**	
		Family history	**No**	
		Gestational Diabetes	**Yes – input as required on referral from primary or secondary care**	
		Hypertension	**No**	
		Obesity	**Yes not equitable provision but plans in place to deliver equitably**	
		Peripheral vascular disease	**No**	
		Pre-Diabetes	**With workforce as part of Hywel's Health**	

			only	
		Renal disease	**No**	
		Other: specify	**No**	
	Uptake?			
	Is it evaluated?		**Yes where programmes / service are delivered**	
4.3 Does the LHB have a programme for reducing overweight and obesity targeted at sub-groups of the population at increased risk of developing Diabetes?			**No but will be addressed using the LES for diabetes and obesity pathway group has been established**	**1**
If yes:	Groups with established	Cardiovascular disease	**No**	
		Cerebrovascular disease	**No**	
		Family history	**No**	
		Gestational Diabetes	**No**	
		Hypertension	**No**	
		Obesity	**Yes**	
		Peripheral vascular disease	**No**	
		Pre-Diabetes	**No**	
		Renal disease	**No**	
		Other: specify	**No**	
	Uptake?		**Uptake limited by capacity to deliver**	
	Is it evaluated?		**Yes for MD specialist intervention**	
4.4 Does the LHB have a programme for increasing physical activity targeted at sub-groups of the population at increased risk of developing Diabetes?			**Yes**	1

If yes:	Groups with established	Cardiovascular disease	**Yes**	
		Cerebrovascular disease	**Yes**	
		Family history	**Yes**	
		Gestational Diabetes	**No**	
		Hypertension	**Yes**	
		Obesity	**Yes**	
		Peripheral vascular disease	**Yes**	
		Pre-Diabetes	**Yes**	
		Renal disease	**No**	
		Other: specify		
	Uptake?		**Limited by resource/ Unsure**	
	Is it evaluated?		**Yes**	
4.5 Are the LHBs Diabetes and Cardiovascular disease risk factor management programmes complementary?			**Yes for staff No for patients**	1
4.6 Does all information and communication with the local population regarding prevention of Type 2 Diabetes take into account cultural sensitivities, language barriers and people with special needs?			**No**	1
4.7 Does the LHB undertake periodic surveys to test public awareness to ensure that public education programmes are correctly focused?			**No - some work occurs in one county at annual update on X-pert diabetes education programme**	1

Section 5 – Identification of people with Type 2 Diabetes				**NSF standard**
5.1 Does the LHB have a programme for raising awareness of the signs and symptoms of Diabetes amongst its population?			**No**	2
If yes:	By what means:	Promotional campaign		
		Educational leaflets		
		Other: specify		
	Is it evaluated?			

5.2	Does the LHB require that health and other professionals most likely to come into contact with people with undiagnosed Diabetes are aware of the signs and symptoms of Diabetes?		**Yes**	2
5.3	Does the LHB require providers to follow-up and regularly test people who have previously been found to have impaired glucose tolerance?		**Yes**	2
	If YES for how many:			
			26 - 50%	
5.4	Does the LHB require providers to have guidelines for follow-up and regular testing of women with a history of gestational Diabetes?		**Yes**	2
	If YES for how many:			
			76 - 100%	
5.5	Does the LHB have a programme for screening other individuals at risk of developing Diabetes?		**No in one county there is a project supporting this. The development of the LES should address this.**	2
If YES who :	Groups with established:	Cardiovascular disease		
		Cerebrovascular disease		
		Family history		
		Gestational Diabetes		
		Hypertension		
		Obesity		
		Peripheral vascular disease		
		Pre-Diabetes		
		Renal disease		
		Other: specify		
	Uptake?			
	Is it evaluated?			

Section 6 – Initial management			**NSF standard**
6.1 Do the LHBs providers use NICE compliant guidelines for the initial assessment and care of adults presenting with Diabetes in health care settings?		**Yes**	3,4
6.2 Does the LHB monitor the use of NICE compliant guidelines for the initial assessment and care of adults presenting with Diabetes in health care settings?		**No**	3,4
6.3 Does the LHB require that people with newly diagnosed Diabetes receive Specialist dietary advice?		**Yes**	3,4
If YES for how many:			
		76 - 100%	
6.4 Is NICE compliant structured education offered to people newly diagnosed with Diabetes?		**Yes for Type 2 diabetes only**	3
If YES for how many:			
		2-5%	
6.5 Does the LHB require the agreement of personal care plans with all people newly diagnosed with Diabetes?		**No**	3
6.6 Are psychological support services available to people with diabetes at diagnosis and whenever necessary?		**No**	3
If Yes which of the following are available:	Counseling		
	Motivational interviewing		
	Cognitive behavioural therapy		
	Consultation with Psychologist		
6.7 Do all information/education materials provided for people newly diagnosed with Diabetes take into account cultural sensitivities, language barriers and people with special needs?		**Yes**	3
6.8 Does the LHB have a system for monitoring whether people with newly diagnosed Diabetes are offered a structured education programme?		**No**	3

Section 7 – Annual review			**NSF standards**
7.1 Does the LHBs model of care require that all people with Diabetes are offered an annual review (or more frequent reviews where clinically indicated)?		**Yes**	4,5,10,11
7.2 Does the LHB require that the annual review includes the following key components of Diabetes care:	Body mass index?	**Yes**	4,5,10,11
	Dietary management?	**Yes**	
	Physical activity?	**Yes**	
	Tobacco consumption?	**Yes**	
	Alcohol consumption?	**No**	
	Perception, comprehension and priorities of Diabetes care?	**No**	
	Psychological wellbeing?	**No**	
	Glycated haemoglobin and target level?	**Yes**	
	Blood pressure and target level?	**Yes**	
	Blood lipids and target level?	**Yes**	
	Urinalysis for microalbuminuria?	**Yes**	
	Urinalysis for proteinuria?	**Yes**	
	Serum creatinine?	**Yes**	
	eGFR?	**Yes**	
	Foot examination for neuropathy, peripheral vascular disease, foot deformity, pathology and neglect?	**Yes**	
	Eye examination including visual acuity and fundus examination by a means or technique recommended by the National Screening Committee?	**Yes**	
	Individualised target approach?	**Yes**	
7.3 Does the LHB require providers to have a policy that encourages re-engagement with people who do not attend for annual reviews (DNA)?		**No**	4,5,6,10, 11
7.4 Does the LHB monitor the uptake of influenza and pneumococcal vaccination by people with Diabetes?		**Yes**	4
7.5 Does the LHB require that providers agree and update annual care plans with people with Diabetes under their care?		**No**	4-5
7.6 Do the LHBs providers share results of annual reviews (e.g. biomedical results etc.) with people with Diabetes, in advance of their consultation?		**No**	4-5
7.7 Do the LHBs providers, when undertaking reviews, assess biomedical measures, e.g. HbA1c, against previously recorded levels?		**Yes**	4-5

7.8	Do the LHBs providers, when undertaking reviews, assess biomedical measures, e.g. HbA1c, against NICE guideline targets?	**Yes**	4-5
7.9	Do the LHBs providers review patients frequently until they have attained their personal treatment targets?	**Yes**	4-5,11
7.10	Do the LHBs providers agree goals and action plans for self care with people with Diabetes as part of the annual care planning session?	**Yes –within model of care document**	4-5,11
7.11	Does the LHB require providers to collect and audit feedback from care planning sessions?	**No**	4-5,11

Section 8 – Metabolic management			**NSF standards**
8.1	Do the LHBs providers have NICE compliant guidelines for the use of oral or non-insulin injectable hypoglycaemic agents?	**Yes**	4
8.2	Do the LHBs providers have NICE compliant guidelines for commencing insulin treatment in people with Type 1 Diabetes?	**Yes**	4
8.3	Do the LHBs providers have NICE compliant guidelines for commencing insulin treatment in people with Type 2 Diabetes?	**Yes**	4
8.4	Do the LHBs providers have NICE compliant guidelines for the use of combined insulin and oral hypoglycaemic agents in people with Type 2 Diabetes?	**Yes**	4
8.5	Do the LHBs providers ensure that people with Diabetes routinely receive education regarding self management following changes in therapy?	**Yes**	4
8.6	Does the LHB provide NICE compliant insulin pump therapy services?	**Yes**	4
8.7	Do the LHBs providers have NICE compliant guidelines for glucose self-monitoring in Type 1 Diabetes?	**Yes**	4
8.8	Do the LHBs providers have NICE compliant guidelines for glucose self-monitoring in Type 2 Diabetes?	**Yes**	4
8.9	Does the LHB monitor the rates of Diabetic emergencies?	**Yes**	4
8.10	Do the LHBs providers have NICE compliant guidelines for the prevention and management of severe hypoglycaemia?	**Yes**	4
8.11	Do the LHBs providers have NICE compliant guidelines for the prevention and management of Diabetic ketoacidosis?	**Yes**	4
8.12	Do the LHBs providers have guidelines for the prevention and management of hyperosmolar coma?	**Yes**	4

Section 9 - Risk factors for cardiovascular disease		NSF standards
9.1 Does the LHB ensure provision of smoking cessation programmes that are delivered in accordance with Thorax Smoking Cessation Guidelines?	**Yes**	4
9.2 Do the LHBs providers have NICE compliant guidelines for the identification and management of hypertension in people with Diabetes?	**Yes**	4
9.3 Do the LHBs providers have NICE compliant guidelines for the identification and management of hyperlipidaemia in people with Diabetes?	**Yes**	4
9.4 Do the LHBs providers have NICE compliant guidelines for the identification and management of obesity in people with Diabetes?	**Yes**	4
9.5 Do the LHBs providers have NICE compliant guidelines for identifying a lack of physical activity in people with Diabetes?	**No**	4
9.6 Do the LHBs providers give weight management advice to people with Diabetes under their care who are obese?	**Yes**	4
9.7 Do the LHBs providers give advice, where appropriate, to people with Diabetes on increasing physical activity levels?	**Yes**	4
9.8 Do the LHBs providers give advice, where appropriate, to people with Diabetes on limiting excessive alcohol intake?	**Yes**	4
9.9 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic antiplatelet therapy?	**Yes**	4
9.10 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic lipid lowering therapy?	**Yes**	4
9.11 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic ACE inhibitor therapy?	**Yes**	4
9.12 Do the LHBs providers give people with Diabetes information about the benefits of cardiovascular risk factor management in Diabetes?	**Yes**	4

Section 10 – Hospital admissions		**NSF standards**
10.1 Do Diabetes Healthcare teams have immediate access to the names and location of individuals with Diabetes in the Hospital at any given time?	**No**	7-9
10.2 Do the Hospitals keep an up to date list of Diabetic patients placed onto a surgical waiting list?	**No**	7-9
10.3 Do the Hospitals have NICE compliant guidelines for the management of people with Diabetes admitted for surgery?	**Yes**	8-9
10.4 Do the Hospitals have NICE compliant guidelines for blood glucose monitoring in people with Diabetes admitted to hospital?	**No**	7-9
10.5 Do the Hospitals monitor adherence to guidelines?	**No**	7-9
10.6 Do the Hospitals have guidelines for managing people with Diabetes admitted to hospital with a Diabetic emergency, e.g. hypoglycaemia, Diabetic Ketoacidosis or hyperosmolar coma?	**Yes**	7
10.7 Do the Hospitals have guidelines for managing people with Diabetes admitted to hospital for day case procedures eg Endoscopy, Barium enema?	**No**	8
10.8 On admission, do the Hospitals identify and code people with Diabetes appropriately on their information system?	**No**	7-9
10.9 Do the Hospitals have NICE compliant guidelines for the management of hyperglycaemia in patients who are acutely unwell?	**Yes**	7-8
10.10 Do the Hospitals ensure that during an inpatient stay, the person with Diabetes and the team caring for him or her receive advice from a trained multidisciplinary team with expertise in Diabetes?	**Yes**	7-9
10.11 Do the Hospitals have effective and comprehensive programmes in place to support and train ward staff in the management of Diabetes?	**No – education takes place differently across the 3 counties. A Hywel Dda education programme to be implemented**	7-9
10.12 Do the LHBs hospital providers monitor the uptake of training of ward staff in the management of Diabetes?	**No – general training programme in place which**	7-9

	incorporates diabetes	
10.13 Do the Hospitals have systems in place to monitor the acceptability / effectiveness of care and take action as appropriate?	**Yes Diabetes inpatient audit**	7-9
10.14 Do the Hospitals have systems in place to monitor significant events in people with Diabetes admitted to hospital and take action as appropriate?	**Yes**	7-9
10.15 On discharge are people with Diabetes given the contact number of who they should contact if they have any problems?	**Yes**	7-9
10.16 Do LHBs have supportive discharge strategies in place?	**Yes**	7-9

Section 11 – Eye screening	**Y**	**NSF standards**
11.1 Does the eye screening programme provide an Annual report including number offered appointments and screened by HB locality?	**No All Wales Programme**	10
11.2 Does the eye screening programme provide an Annual report including offered appointments and screened by GP practice?	**No All Wales Programme**	10
11.3 Does the eye screening programme provide an Annual report of the names of those who failed to attend for their retinal screening appointments by GP practice?	**No All Wales Programme**	10

Section 12 – Renal screening and management		**NSF standards**
12.1 Do the LHBs providers have NICE chronic kidney disease and Diabetes compliant guidelines for screening for and management of early Diabetic nephropathy?	**Yes**	10-11
12.2 Do the LHBs providers ensure referral for specialist/nephrological opinion of people with Diabetes who have an estimated glomerular filtration rate that meets the criteria stated in the NICE Chronic Kidney Disease: national clinical guideline for early identification and management of adults in Primary and Secondary care?	**Yes**	10-11
12.3 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes and microalbuminuria?	**Yes**	11
12.4 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes and macroalbuminuria?	**Yes**	11

12.5 Do the LHBs providers have NICE compliant guidelines that specify that all people with microalbuminuria and proteinuria are prescribed an ACE inhibitor unless there are contraindications?	**Yes**	11
12.6 Does the LHB require that all people with advanced chronic kidney disease (stages 4 and 5) have access to a multidisciplinary team?	**Yes**	11
12.7 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes who have advanced kidney disease or who require renal replacement therapy?	**Yes**	11
12.8 Have the LHB and its providers agreed a care pathway (including conservative and end of life care) to support people with Diabetes who have end stage renal failure?	**No to be incorporated in the model of care**	11
12.9 Do the LHBs providers monitor performance against the markers of good practice described in the Renal NSF (Parts 1 & 2)?	**No**	11
12.10 Does the LHB provide Diabetes specific education to Health Professionals delivering Renal care?	**No**	11
12.11 Is there a person or group that has responsibility for quality assurance and clinical governance of the renal screening programme?	**No**	10

Section 13 - Foot care and lower limb complications		**NSF standards**
13.1 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of at risk feet?	**Yes**	10-11
13.2 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of Diabetic foot ulcers and their complications?	**Yes**	10-11
13.3 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of neuropathic pain?	**Yes**	10-11
13.4 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of other Diabetic foot pathologies, including Charcot neuroarthropathy?	**Yes**	10-11
13.5 Is there a comprehensive LHB-wide programme to screen for Diabetic neuropathy and peripheral vascular disease?	**Yes**	10
13.6 Is there a specialist multidisciplinary foot care team to assess and manage limb threatening Diabetic foot disease?	**Yes**	11
13.7 Are there written guidelines for Accident and Emergency teams on the assessment and initial management of people admitted to Accident and Emergency with active Diabetic foot disease?	**No**	11

13.8 Is there a documented requirement within Hospitals for a Consultant experienced in Diabetic foot disease to assess and advise on the management of patients presenting with symptoms and signs of foot infection within 4 hours of admission to Accident and Emergency?	**No- Plans are in place.**	11
13.9 Is there a documented requirement within Hospitals for a Vascular surgeon to assess and advise on the management of patients presenting with symptoms and signs of critical limb ischaemia within 4 hours of admission to Accident and Emergency?	**No- Plans are in place**	11
13.10 Is there a documented requirement within Hospitals for members of the Specialist Diabetes team to be involved in agreeing a care plan for Diabetes management for the person presenting with active Diabetic foot disease within 4 hours of admission to Accident and Emergency?	**No**	11
13.11 Is there a documented requirement within Hospitals that the care of a person presenting with active Diabetic foot disease is transferred to a team with expertise in the management of active Diabetic foot disease within 48 hours of admission?	**Yes**	11
13.12 Is there a documented requirement within Hospitals that the team providing the continuing management of the person admitted with active Diabetic foot disease works with other healthcare professionals who have the appropriate skills necessary to assess and treat foot lesions e.g. podiatrists, vascular team, orthopaedic surgeons, orthotics etc?	**Yes**	11
13.13 Are there Hospital wide antibiotic guidelines specifically for the management of diabetic foot infections?	**Yes**	11
13.14 Is there a documented requirement within Hospitals that, following the diagnosis of active Diabetic foot disease, people with Diabetes are given clear written information about what care to expect during their in-patient stay?	**No**	11
13.15 Does discharge planning from Hospitals include assessment of the other medical and social needs of the patient and their dependents?	**Yes**	11-12
13.16 Does discharge planning from Hospitals include arrangements for inspection and dressing of ulcers in the community by the patient, carer, and/or healthcare professional where appropriate?	**Yes**	11
13.17 Following discharge from Hospital is there a system in place for the long term surveillance of the person with Diabetes?	**Yes**	11-12
13.18 Is patient education provided following identification of a new foot problem?	**Yes**	3,11
13.19 Do the LHBs providers ensure that a patient's blood glucose control is optimised following identification of a new foot problem?	**Yes**	4,11
13.20 Is a patient's cardiovascular risk assessed and managed following the identification of a new foot problem?	**Yes**	4,11
13.21 Is advice on foot care an integral part of all Diabetes education programmes provided by the LHB?	**Yes**	3-5
13.22 Has the LHB agreed a care pathway with its providers to support people with Diabetes undergoing minor and major	**No**	7-8, 11-

amputation, both pre and post operatively?		12
13.23 Do the LHBs providers compare, year on year, the Diabetic lower limb pathway achievement rates on the percentage of people screened?	**No**	10
13.24 Do the LHBs providers compare the percentage of people identified as having at risk feet, year on year?	**No**	10
13.25 Do the LHBs providers compare the percentage of people identified with new ulceration year on year?	**No**	10
13.26 Do the Hospitals compare the percentage of new minor amputations year on year?	**No**	11
13.27 Do the Hospitals compare the percentage of new major amputations, year on year?	**No**	11
13.28 Do Hospitals monitor the number of admissions related to active Diabetes foot disease and those who are readmitted with recurrent ulcer?	**No**	7-8,11
13.29 Do Hospitals monitor the number of people with Diabetes who develop an avoidable foot problem?	**No**	10,11
13.30 Can the Hospitals demonstrate that it acts on the findings of its monitoring processes on inpatient management of active Diabetic foot disease?	**No**	7-8,11
13.31 Is there a person or group that has responsibility for quality assurance and clinical governance of the foot screening programme?	**No**	10

Section 14 – Children and young people with Diabetes		**NSF standards**
14.1 Does the LHB require that providers of services for children and young people with Diabetes have NICE compliant guidelines?	**Yes**	5-6
14.2 Upon diagnosis is the child or young person referred the same day to a paediatrician who has a special interest in diabetes?	**Yes**	5
14.3 Is the long term care of children and young people with Diabetes managed by a Paediatrician who has a special interest in Diabetes?	**Yes**	5
14.4 Do children and young people with Diabetes have access to a paediatric trained Diabetes specialist nurse?	**Yes**	5
14.5 Do children and young people with Diabetes have access to a Paediatric dietitian who has a specialist interest in Diabetes?	**Yes**	5
14.6 Do children and young people with Diabetes have access to a Paediatric trained psychologist /counsellor if needed?	**No**	5-6

14.7	Do providers of services for children and young people, including young persons' clinics, measure patient satisfaction with and the appropriateness of services?	**Yes but not consistently**	5-6
14.8	Do providers of services for children and young people, including young persons' clinics, encourage the active participation of service users/carers in service development?	**Yes but not consistently**	5-6
14.9	Does the LHBs model of care clearly define what care children and young people with Diabetes and their families should expect to receive, where, when and how?	**Yes**	5
14.10	Is there a structured education programme for newly diagnosed children and young people with Diabetes and their families?	**No**	3,5
14.11	Is education adjusted to the development stage of the child or young person and repeated regularly?	**Yes, but not as a structured education programme**	3,5
14.12	Do providers of Diabetes services for children and young people provide education and written protocols for school staff regarding the identification and management of children and young people with Diabetes?	**No, but work has been undertaken to develop joint guidance with education in 1 county which will then be used as a template for HB wide approach**	5
14.13	Do hospital providers have NICE compliant guidelines for the management of children and young people admitted with Diabetic ketoacidosis?	**Yes**	7
14.14	Do providers of Diabetes services for children and young people have NICE compliant guidelines for optimising glycaemic control towards normal levels?	**Yes**	5-6
14.15	Do hospital providers have NICE compliant guidelines for the management of children and young people with Diabetes requiring surgery?	**Yes**	5-6,8
14.16	Do the hospitals monitor adherence to guidelines?	**No**	5-6,8
14.17	Do children, young people with Diabetes and their families have access to 24 hour per day emergency telephone contact?	**Yes**	5-6
14.18	Are all children and young people with Diabetes reviewed at least annually and followed up at least three times a year?	**Yes**	5-6
14.19	Do all children and young people with Diabetes have an HbA1c measurement at each review visit (at least three times per year)?	**Yes**	5-6

14.20 Does the LHB require that providers of Diabetes services for children and young people adopt a care planning approach that encourages the child/young person and carer to discuss particular issues and ask questions at each review?	**No**	5-6
14.21 Does the LHB ensure provision of NICE compliant insulin pump therapy services for children and young people with Diabetes?	**Yes**	5-6
14.22 Do all young people with Diabetes over the age of 12 have their eyes screened annually as part of a systematic programme that meets National Screening Committee standards?	**Yes**	5-6,10
14.23 Do all young people with Diabetes over the age of 12 years have their urine tested for microalbuminuria (overnight AER or first morning ACR) annually?	**Yes**	5-6,10
14.24 Do all young people with Diabetes over the age of 12 years have their blood pressure measured annually?	**Yes**	5-6
14.25 Are children and young people with Diabetes screened for thyroid and coeliac disease in line with NICE guidance?	**Yes**	5-6
14.26 Do providers of services for children and young people, including those following transition, have a policy that encourages re-engagement with children and young people who do not attend for annual reviews?	**No**	5-6
14.27 Is there ongoing local audit of the structures, processes and outcomes of care for children and young people with Diabetes?	**Being developed as part of the HDHB paediatric diabetes group**	5-6
14.28 Do the services for children and young people with Diabetes participate in the National Diabetes Audit?	**Yes and Brecon Group audit**	5-6
14.29 Do providers of services for children and young people ensure there is planned and agreed (with the young person) transfer of the young person with Diabetes from the paediatric Diabetes service to the adult Diabetes service?	**Yes – approach varies across the HB sites**	5-6
14.30 Does the local adult Diabetes specialist team run a young persons clinic following transfer?	**Yes but not in all sites**	6

Section 15 - Pregnancy		**NSF standards**
15.1 Do the LHBs providers have NICE compliant guidelines on the provision of pre-conception advice for all women with Diabetes of child bearing age?	**No**	9
15.2 Do the LHBs providers have guidelines on the provision of contraceptive advice and counseling for younger women with Diabetes on the problems of teenage pregnancy?	**No**	9

15.3 Do the LHBs providers have NICE compliant guidelines for detecting women who develop abnormal glucose tolerance in pregnancy (gestational Diabetes)?	**Yes**	9
15.4 Do the LHBs providers offer frequent medical and obstetric consultation to every pregnant woman with Diabetes in accordance with NICE guidance?	**Yes**	9
15.5 Do the LHBs providers advise all women with Diabetes who are planning to become pregnant to take folic acid (5mg/day) until 12 weeks of gestation?	**Yes**	9
15.6 Does the LHB ensure the provision of insulin pump therapy services for pregnant women with insulin-treated Diabetes who cannot achieve adequate glycaemic control with multiple daily injections of insulin?	**No**	9
15.7 Do the Hospitals ensure that all women with Diabetes have regular access to a specialist dietitian and dietary advice related to their cultural and personal circumstances, before and during pregnancy?	**Not before Yes during but limited ability to respond in a timely way**	9
15.8 Do the Hospitals screen for acceleration of Diabetic complications during pregnancy?	**Yes**	9
15.9 Do the Hospitals have NICE compliant guidelines for the detection and management of neonatal hypoglycaemia and other neonatal complications in babies born to women with Diabetes?	**Yes**	9
15.10 Has the LHB agreed a care pathway with its providers to support women with Diabetes who have a stillbirth or a child with a congenital abnormality?	**No**	9
15.11 Does the LHB require that all women with Diabetes/gestational Diabetes are followed up postpartum?	**Yes**	9
15.12 Does the Diabetes/Obstetric service participate in national or regional collaborative audit of the processes and outcomes of Diabetes pregnancy care?	**Yes**	9

Section 16 - Elderly		**NSF standards**
16.1 Does the LHBs model of care include arrangements for the diagnosis and care of people with Diabetes who are housebound or who live in residential and nursing homes?	**Yes**	4,12
16.2 Does the LHBs model of care require that people with Diabetes who are housebound or living in nursing or residential homes have access to annual review?	**No**	4,12
16.3 Are there systems in place in the hospitals to ensure that Diabetes specialist team support is available to the hospital Care of the Elderly team when they are caring for people with Diabetes?	**Yes**	8
16.4 Do the hospital Care of the Elderly team and the Diabetes specialist team have joint plans for managing elderly people with Diabetes?	**No**	8

16.5	Does the LHB's model of care require that advice and training is provided to proprietors/matrons of nursing and residential homes in the management of people with Diabetes?	**Yes**	4,12
16.6	Does the LHBs model of care require that people with Diabetes who are housebound or living in nursing and residential homes are set individualised treatment targets that take into account the person's general health and wellbeing?	**No- to be incorporated into model of care for Hywel Dda**	4,12
16.7	Does the LHB provide services (including transport) that ensure people who are housebound can access appropriate Diabetes care?	**Yes**	4,12
16.8	Does the LHBs model of care require that people with Diabetes who are living in nursing or residential homes are provided with a healthy diet?	**Yes**	4,12
16.9	Does the LHBs model of care require that advice and training is provided to cooks working in nursing and residential homes on dietary management in Diabetes?	**No**	12
16.10	Does the LHB work with other agencies to ensure that there are programmes in place to promote physical activity for older people?	**Yes**	12
16.11	Does the LHB require that people with Diabetes living in nursing and residential homes have access to the eye screening programme?	**Yes**	4,12
16.12	Does the LHB require that people with Diabetes living in nursing and residential homes have access to foot screening and where need is identified, ongoing foot care?	**Yes**	4,12

Section 17 – Clinical Information systems			**NSF standards**
17.1	Has the LHB provided Primary care with Patient management systems facilitating integrated Diabetes care?	**No Available in one county currently**	4,5,6,8
17.2	Has the LHB provided Secondary care with Patient management systems facilitating integrated Diabetes care?	**No Available in one county currently**	4,5,6,8
17.3	Does the LHB require that all providers (including Primary and Secondary care services for adults and children and young people with Diabetes) participate in the National Diabetes Audit?	**No**	4,5,6,8
17.4	Does the LHB specify the precise diagnostic terms and codes to be used within practices and Secondary care for recording information on the care of people with Diabetes?	**No**	4,5,6,8
17.5	Does the LHB specify the use of national Diabetes dataset standards for the exchange of electronic patient record information between general practice, community and specialist Diabetes care providers (Secondary care)?	**No -Available in one county**	4,5,6,8

17.6 Does the LHB require that providers have guidelines for call/recall?		**Yes**	4,6
17.7 Has the LHB enabled fully integrated sharing of Diabetes related Electronic Patient Record information between care providers?		**No**	4,5,6,8
17.8 Does the LHB recommend that practices use computerised templates for managing people with Diabetes?		**Yes**	4
17.9 Does the LHB offer support to practices in developing and using computerised templates?		**Yes**	4
17.10 Does the LHB recommend an integrated approach to the use of practice-based information systems for Diabetes, Coronary heart disease and Cerebrovascular disease?		**No**	10-12
17.11 Are there processes in place to ensure that all providers of care (e.g. eye screening, specialist team etc.) feed information back to Primary and Secondary care?		**Yes**	10-12
17.12 Does the LHB review at least annually the incidence of the following complications of Diabetes and compare these rates with other LHBs (e.g. via participation in the National Diabetes Audit):	Myocardial infarction?	**No**	4,6,8,10, 11
	Stroke?	**No**	
	Angina?	**No**	
	Minor amputations (below ankle)?	**No**	
	Major amputations (ankle and above)?	**No**	
	Laser retinal photocoagulation?	**No**	
	Blindness?	**No**	
	End stage renal failure?	**No**	
	Death?	**No**	
17.13 Does the LHB require that regularly updated integrated personal Diabetes care records are made available for all people with Diabetes?		**No**	4-12
17.14 Does the LHB have a plan for an IT system that allows patients to access their own clinical records and associated communications (e.g. clinical letters)?		**No**	3
17.15 Does the LHB's approach to integrated communications between care providers include support for the process of care planning and sharing the care plan with patients?		**No**	3
17.16 Does the LHB have a complete repository of the names of individuals with Diabetes within their area?		**Yes**	2
If not:	Who does?		
	Are there any obstacles to sharing this information?	**No**	
	If Yes – specify		
17.17 Do Hospital IT systems ensure Diabetes Healthcare teams have access to the names and location of all individuals with Diabetes in the Hospital at any given time?		**No**	5-9