Diabetes: Using data tools to improve outcomes

Presenting – Nicola Bowtell
Facilitating – Dominic Gallagher and Jan Bond
National questions – Rachel Clark
Talk Outline

• Introducing the case study
• Background
• Diabetes – a quick overview of available tools
• Using tools to explore
  • risk factors
  • treatment targets
  • care process
  • complications
• Looking at diabetes at lower geographies
• Diabetes – linking expenditure and outcomes
• Additional resources
• Questions
The health of people in Somerset is varied compared with the England average.

Deprivation is lower than average, however about 14.1% (13,100) children live in poverty. Life expectancy for both men and women is higher than the England average.

Life expectancy is 6.9 years lower for men and 3.7 years lower for women in the most deprived areas of Somerset than in the least deprived areas.
Background
Overview

- 62% of adults were overweight or obese in England in 2012
- 6% of people aged 17 years or older had diagnosed diabetes in England in 2013
- Prevalence of both obesity and diabetes is rising in England
- 90% of adults with type 2 diabetes aged 16-54 years are overweight or obese
- In England, 12.4% of people aged 18 years and over with obesity have diagnosed diabetes, five times that of people with a healthy weight
- Men with a raised waist circumference are five times more likely to have diagnosed diabetes than those without a raised waist circumference; women are over three times more likely
Adult diabetes prevalence in England 2012-2030

Source: Yorkshire and Humber Public Health Observatory (YHPHO) Prevalence Model for local authorities and clinical commissioning groups published November 2012 by YHPHO. Access the tool.
Note: Includes people age 16 years or older who have all types of diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation.
Risk factors for developing type 2 diabetes

- aged over 40
- male
- Asian or black ethnic background
- a family history of diabetes
- an increased BMI and/or waist circumference
- ever had high blood pressure, a heart attack or a stroke
- socioeconomic deprivation
Increased risk of diabetic complications in people with diabetes compared to the general population in England

<table>
<thead>
<tr>
<th>Diabetic complication</th>
<th>Additional risk of complication among people with diabetes</th>
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<tbody>
<tr>
<td>Angina</td>
<td>+ 76%</td>
</tr>
<tr>
<td>Myocardial Infarction (heart attack)</td>
<td>+ 55%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>+ 74%</td>
</tr>
<tr>
<td>Stroke</td>
<td>+ 34%</td>
</tr>
<tr>
<td>Renal Replacement Therapy (ESKD)</td>
<td>+ 164%</td>
</tr>
<tr>
<td>Minor Amputation (below the ankle)</td>
<td>+ 337%</td>
</tr>
<tr>
<td>Major Amputation (above the ankle)</td>
<td>+ 222%</td>
</tr>
</tbody>
</table>


Note: The calculations compare the prevalence for people with diabetes with the prevalence in the general population in the same Clinical Commissioning Group or Local Health Board during the period from 1 April 2010 to 31 March 2012, using the HES and PEDW records. Diabetic ketoacidosis (DKA) and retinopathy treatments are not included as these only affect people with diabetes.
Cost implications of diabetes

• It is estimated that overweight, obesity and related morbidity will cost the NHS £9.7 billion by 2050 with wider costs to society estimated to reach £49.9 billion

• Prescribing for diabetes accounted for 9.3% of the total cost of prescribing in England in 2012-13

• It is estimated that in 2010-11 the cost of direct patient care for those living with type 2 diabetes in the UK was £8.8 billion and the indirect costs were approximately £13 billion

• The number of NHS-commissioned bariatric surgery procedures performed for the management of obesity is increasing rapidly in England
Diabetes: A quick overview of available tools
Diabetes: Main tools

- Diabetes Profiles
- Healthier Lives: Diabetes and Health Checks
- NHS Atlas of variation
- Right Care Atlas
- Diabetes outcomes vs expenditure tool (DOVE)
- Diabetes foot care profiles

And

- PHOF
- National General Practice Profiles
- Local Health
Data and Knowledge Gateway: Finding data tools

- Specific conditions
- Lifestyle factors
- Wider determinants of health
- Health protection
- Different population groups

NCVIN

- Covers family of diseases with a common set of risk factors: Heart, Stroke, Diabetes, Renal

- Create links between national and local audits and registries e.g. Vascular Database, National Diabetes Audit

Key resources

- CVD Commissioning for Value Focus Packs
- Diabetes Footcare Activity Profiles
- Outcomes versus expenditure tools (Diabetes Tool Cardiovascular Tool)
- Diabetes prevalence model for LAs and CCGs

Healthier Lives: Diabetes

Diabetes affects 6% of adults in England

Adults with diabetes have excess risk of a range of complications including major vascular disease (heart attack and stroke) and microvascular disease (kidney disease, amputation, retinopathy).

December 2014 - updated with 2013/14 QOF data.

http://healthierlives.phe.org.uk/
Healthier Lives: Diabetes - indicators

Treatment targets
- Good blood sugar control
- Good blood pressure control
- People with diabetes meeting treatment targets

Care Process
- BMI recorded in previous 15 months
- Foot check
- Tested for protein in urine
- Smoking cessation advice and treatment
- Flu vaccination
- Eye screening
- People with diabetes having all check-ups
Healthier Lives: Diabetes - indicators

Complications
- Angina
- Heart attack
- Heart failure
- Major amputation
- Stroke
- Kidney dialysis and transplant

Prevalence and risk
- Deprivation
- People over 65
- Diabetes prevalence
- Diabetes: expected prevalence (16+)
- % of population who identify their ethnicity as Asian or Asian British
Using tools to look at risk factors for Type 2 diabetes
Diabetes Profiles: Prevalence and risk view for South West

Diabetes Webinar - Nicola Bowtell
## Diabetes profiles: Prevalence and risk view for Somerset

### Compared with benchmark:
- 🟢 Better
- 🟡 Similar
- 🔴 Worse
- 🔵 Lower
- 💚 Similar
- 🔵 Higher
- 🟤 Not Compared

### Table: Diabetes indicators for Somerset

<table>
<thead>
<tr>
<th>Indicator</th>
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<td>2010</td>
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<td>16.6</td>
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<td>21.7</td>
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<td>Diabetes prevalence</td>
<td>2013/14</td>
<td>28,516</td>
<td>6.3%</td>
<td>5.9%</td>
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<td>GP recorded prevalence of obesity in adults (16+)</td>
<td>2013/14</td>
<td>40,526</td>
<td>8.9%</td>
<td>9.3%</td>
<td>9.4%</td>
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<tr>
<td>Physical inactivity</td>
<td>2013</td>
<td>-</td>
<td>27.7%</td>
<td>27.3%</td>
<td>28.3%</td>
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<tr>
<td>Percentage of population who identify their ethnicity as Asian or Asian British</td>
<td>2011</td>
<td>4,873</td>
<td>0.9%</td>
<td>2.0%</td>
<td>7.8%</td>
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</table>
Diabetes Profiles: Diabetes Prevalence, Somerset
PHOF Inequalities: Vegetable consumption and smoking prevalence by deprivation

Vegetable consumption

Smoking prevalence
PHOF: Recorded diabetes by deprivation in England


- Most deprived decile: 6.8%
- Second most deprived decile: 7.0%
- Third more deprived decile: 6.6%
- Fourth more deprived decile: 6.0%
- Fifth more deprived decile: 5.9%
- Fifth less deprived decile: 6.3%
- Fourth less deprived decile: 6.4%
- Third less deprived decile: 6.4%
- Second least deprived decile: 5.8%
- Least deprived decile: 5.3%

England average: 6.0%
Using tools to monitor treatment targets for diabetes
Diabetes Profiles: Treatment targets South West

Diabetes Webinar - Nicola Bowtell
Longer lives: Blood sugar control
Longer lives – Comparison tables: Treatment targets and deprivation, Somerset CCG

NHS Somerset CCG

1. Select Diabetes indicators you want to compare:
   - Treatment targets
     - Good blood sugar control in people with diabetes
   - Good cholesterol control in people with diabetes
   - People with diabetes meeting treatment targets

2. Select Prevalence and risk factors to compare:
   - Prevalence and risk
     - People with diabetes
     - Diabetes prevalence
     - GP recorded prevalence of obesity in adults (16+)

Comparing 75 General Practices

<table>
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<th>General Practices</th>
<th>Deprivation within CCG</th>
<th>Good blood sugar control in people with diabetes</th>
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<td>WESTLAKE SURGERY</td>
<td>Less deprived</td>
<td>76.9%</td>
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<tr>
<td>MENDIP COUNTRY PRACTICE</td>
<td>Average</td>
<td>71.9%</td>
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<td>BECKINGTON FAMILY PRACTICE</td>
<td>Less deprived</td>
<td>69.9%</td>
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<tr>
<td>VICTORIA PARK MEDICAL CENTRE</td>
<td>Most deprived</td>
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<tr>
<td>CREWKERNE SURGERY</td>
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<td>Least deprived</td>
<td>67.6%</td>
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<td>Less deprived</td>
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<td>OAKHILL SURGERY</td>
<td>Most deprived</td>
<td>66.7%</td>
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<tr>
<td>BRENDON HILLS SURGERY</td>
<td>Most deprived</td>
<td>65.9%</td>
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<tr>
<td>SUMMERVALE MEDICAL CENTRE, ILLMINSTER</td>
<td>Less deprived</td>
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<tr>
<td>GROVE HOUSE SURGERY</td>
<td>Most deprived</td>
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<td>EXMDOOR MEDICAL CENTRE</td>
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<td>IRNHAM LODGE SURGERY</td>
<td>Most deprived</td>
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<td>BRUTON SURGERY</td>
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<td>WIVELISCOMBE</td>
<td>Most deprived</td>
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<td>SOMERTON SURGERY COX’S YARD SOMERTON</td>
<td>Least deprived</td>
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Diabetes: Using tools to look at care
Diabetes profiles: People with diabetes having footcheck – Benchmark region

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<td>88.0</td>
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<td>Swindon</td>
<td>80.8</td>
<td>80.1</td>
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Source: QOF
Diabetes footcare activity profiles

Information on the inpatient care of people with diabetes admitted to hospital for footcare conditions.

Documents

Diabetes Footcare Profiles search tool
html, 0 bytes, published 01/07/2015

Diabetes footcare activity profiles: technical note
Adobe Acrobat Document, 124916 bytes, published 01/07/2015

Diabetes footcare activity profiles: Somerset

Key findings

There have been 2,086 episodes of care for diabetic foot disease between 2011/12 and 2013/14, accounting for 17,611 nights in hospital.

The annual rate of episodes of care for diabetic foot conditions per 1,000 adults with diabetes is significantly higher than the national average.

There were 92 major amputations performed during the three years, giving an annual rate of 1.1 major amputations per 1,000 adults with diabetes, which is significantly higher than the national average.

857 different patients were admitted for foot disease. 58.7% of these had more than one episode of care in the three years, which is significantly higher than the national average.

Of the 857 patients, 16.8% had more than four periods of care, which is not significantly different from the national average.

Example content from the 5 page footcare profiles
Right Care: Casebooks - diabetes


Example: GP led diabetes integrated care in Bexley
Using tools to look at complications
Diabetes Profiles: Complications – Somerset – benchmark region

Diabetes Webinar - Nicola Bowtell
## Diabetes profiles: Major amputations: South West - benchmark England

<table>
<thead>
<tr>
<th>Area</th>
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<td>3.29</td>
<td>2.08</td>
<td>4.93</td>
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</tbody>
</table>

*Source: National Diabetes Audit - 2011-12: Report 2; Table 5: CCG/LHB complication ratios standardised to CCG/LHB observed complication ratios for major amputation. Published by the HSCIC*
Introducing the NHS Atlas of Variation in Healthcare 2015

102 Indicators

NHS Atlas of variation: Indicators on Diabetes

Cardiovascular family of disease: Diabetes (Maps 30-50)

- % of people who receive NICE-recommended care processes by CCG
- % of people who met treatment targets for HbA1c (blood glucose), blood pressure and cholesterol
- Total net ingredient cost of anti-diabetic items per person on GP diabetes registers by CCG
- Additional risk of mortality of people with diabetes compared with general population by CCG
- Relative risk of hospital admissions for heart failure among people with diabetes compared with people without diabetes by CCG
- Relative risk of major lower limb amputation among people with diabetes compared with people without diabetes by CCG
Map 31: Percentage of people in the National Diabetes Audit (NDA) with Type 1 and Type 2 diabetes who met treatment targets for HbA1c (blood glucose), blood pressure and cholesterol by CCG

Context
The main objectives for the ongoing management and care of people with diabetes are:
- to reduce the risk of developing complications such as heart disease, chronic kidney disease, neuropathy (nerve damage), peripheral vascular disease (damage to the blood vessels in the legs), stroke and eye disease.
- Merging these treatment objectives depends on keeping levels of HbA1c (a measure of average blood glucose levels), blood pressure and cholesterol within targets as recommended by NICE (see “Resources”). Among other targets, the National Diabetes Audit (NDA) reports the percentage of people whose:
  - last HbA1c measurement was <58 mmol/mol (3.5%);
  - last blood pressure reading was <140/80 mmHg;
  - last cholesterol measurement was <4 mmol/l.

In 2012/13 in England and Wales, 39.9% of people with Type 1 and Type 2 diabetes met all three targets, however, people with Type 1 diabetes were less likely to meet all three targets than people with Type 2 diabetes, 16.1% versus 37.6%.

Patient education programmes, known as “structured education”, are the building blocks of effective care for people with diabetes, which would help towards meeting treatment targets. However, offering structured education to groups of people with diabetes is a low priority among CCGs in 2012/13 in England and Wales.

Of people who were newly diagnosed, 37.6% with Type 1 diabetes and 16.1% with Type 2 diabetes were offered structured education.

Magnitude of variation
For CCGs in England, the percentage of people in the NDA with Type 1 and Type 2 diabetes who met treatment targets for HbA1c (blood glucose), blood pressure and cholesterol ranged from 23.2% to 48.4% (1.1-fold variation). When the seven CCGs with the highest percentages and the seven CCGs with the lowest percentages are excluded, the range is 30.2-42.6%, and the variation is 1.4-fold.

There is no statistically significant association with improvement at CCG level (test for trend, p=0.35, see page 329), suggesting that the degree of variation observed in the percentage of people meeting the three treatment targets is related to how local strategies for people with diabetes are organised.

Options for action
Commissioners and service providers need to review:
- the performance of their CCG not only nationally but also in relation to the best performer among their demographic peers.
- any local variation within the CCG and ascertain the reasons for this variation.
- the organisation of the service for people with diabetes and current practice, with a view to optimising them.

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1 In the most recent NICE guidelines (NG17; see “Resources”), this target has been reduced to <58 mmol/mol (3.5%).
2 Data for one CCG are missing.

---

• Context
• Magnitude of variation
• Options for action
• NICE Evidence
• Resources
NHS Atlas of variation: Opportunity locator tool

- Identifies best performers amongst academic peers
- Quantifies expected benefit of opportunity
- Links to best practice

CCG

LA

Video
NHS Atlas of Variation: Introducing the Opportunities Locator Tool

The NHS Atlas of Variation: Opportunities Locator is a collaboration between Public Health England, NHS RightCare and NHS England. This complimentary tool is to be used alongside the NHS Atlas of Variation Compendium 2015 allowing local commissioners to select and view CCG and local authority maps for their own local population across a wide range of disease areas contained within the Atlas. The locator identifies:

- best performer amongst demographic peers
- quantifies extent of benefit if opportunity is taken
- links to best practice and guidance

The tool should be used alongside the Commissioning for Value packs and Spend and Outcome Tool to inform and direct their pathway improvement efforts.

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### Map Details

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<thead>
<tr>
<th>Key Match</th>
<th>Key Title</th>
<th>Policy Info</th>
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### Performance

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### House

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### Benchmarking

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### Opportunity

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Diabetes Webinar - Nicola Bowtell
% receive NICE care processes

met treatment targets

Total cost of anti-diabetic items per person

Additional risk of mortality

Relative risk heart failure admissions

Relative risk limb amputation
Using tools to explore spend and outcomes for diabetes
Introducing the diabetes outcomes versus expenditure tool (DOVE)

Diabetes outcomes versus expenditure (DOVE) tool

Explore the relationship between spending on diabetes care and clinical outcomes.

Documents

- Diabetes outcomes versus expenditure (DOVE) tool for CCGs: 2013 / 2014
  Microsoft Office XLSM, 1463331 bytes, published 02/06/2015

- Diabetes outcomes versus expenditure (DOVE) tool for CCGs: 2012 / 2013
  Microsoft Office XLSM, 957266 bytes, published 12/02/2014

- Diabetes outcomes versus expenditure (DOVE) tool for practices: 2012 / 2013

Indicators on DOVE

Expenditure

- Total spend diabetes prescribing
- Average spend per item and spend per person
- All diabetic items
- Non-insulin anti diabetic drugs
- Insulin
- Testing items
- Short acting insulin
- Intermediate and long term insulin
- Core non-insulin antidiabetic drugs
- Oral DPP4 antagonists
- Injectable GLP1 antagonists

Outcome

- HBA1c -59,64 & 75
Getting started with DOVE

Outcomes Versus Expenditure Tool - Diabetes

To use the tool select a CCG along with expenditure and outcome from the drop down lists below and then click on quadrant chart.
To access a summary of the information presented in the 2013/14 chart use the buttons in the menu above. To check which CCGs belong within each CCG cluster or Strategic Clinical Network (SCN) select CCG lookups. To return to this page at any point click on the return to menu button.

1. Chosen CCG
   NHS Airedale, Wharfedale and Craven

2. Expenditure
   Total spend on diabetes prescribing

3. Outcome
   People with diabetes with a HbA1c of 59mmol/mol or less

4. Go to the chart
   Quadrant chart
DOVE – example output: Summary of expenditure: Somerset CCG

Summary of expenditure

This section of the tool allows spending on diabetes care in two CCGs to be compared to national, sub-national and diabetes cluster levels of spend. The CCG selected on the tool main menu is automatically used, and an additional CCG can be selected using the drop down menu below. This information is presented to give context to any potential change in spending levels a CCG may wish to consider, after analysis of the information presented in this tool and consideration of local factors affecting delivery of diabetes services. Also a simple guide is included to show the level of increase/reduction in expenditure required for the CCG to enter the highest or lowest 25% of national spend, as well as showing the average (median) spend.

To use the tool, select the expenditure category of interest and a CCG to compare from the drop down lists below.

The CCG currently selected is NHS Somerset. To change this return to the main menu.

Expenditure Category:

- Total spend on diabetes prescribing
- CCG for comparison:

NHS Somerset

Key facts

To help to understand the scale of change in expenditure required to move the CCG from its current level, a number of statements are provided below:

1. a summary of the current position of the CCG
2. the change required to move the CCG into the lowest 25% of CCGs nationally for spend per person with diabetes or item, if they are not already in this position.
3. the change required to move the CCG out of the highest 25% of CCGs nationally for spend per person with diabetes or item, if they are not already in this position.

NHS Somerset

1. The current total spend on diabetes prescribing per person in NHS Somerset CCG was £266.69. This ranks the CCG 45 of 211 CCGs on the diabetes QOF register nationally. The CCG’s total spend for this indicator in 2012/14 was £7,887,787.
2. The total spend on diabetes prescribing per person with diabetes in NHS Somerset for this CCG is currently within the lowest 25% nationally.

NHS Merston

1. The current total spend on diabetes prescribing per person in NHS Merston CCG was £384.21. This ranks the CCG 91 of 211 CCGs on the diabetes QOF register nationally. The CCG’s total spend for this indicator in 2013/14 was £3,760,854.
2. The total spend on diabetes prescribing per person with diabetes in NHS Merston CCG is currently outside the lowest 25% nationally. If the CCG were to change commissioning prescribing practices to a level required to enter the lowest 25% of spending CCGs, then the CCG would have to lower spend by £13,69 per person with diabetes, the equivalent of £55,600.
3. The total spend on diabetes prescribing per person with diabetes in NHS Merston CCG is currently outside the highest 25% nationally.

Note: for each category, a value of 1 is entered if the CCG has the lowest value in England/diabetes cluster group/strategy clinical network.
DOVE - example output: Quadrant Chart – Total spend on diabetes prescribing with HbA1 of 75 or less – Somerset CCG

Outcomes Versus Expenditure Tool - Diabetes quadrant chart for NHS Somerset

Total spend on diabetes prescribing compared to people with diabetes with a HbA1c of 75mmol/l or less (including exceptions) for NHS Somerset compared with other CCGs in the 7th most deprived CCG decile

Overview

This chart shows the total spend on diabetes prescribing compared to people with diabetes with a HbA1c of 75mmol/l or less (including exceptions) for NHS Somerset.

In NHS Somerset the total spend on diabetes prescribing was £266,083 and the rate of people with diabetes with a HbA1c of 75mmol/l or less (including exceptions) was 16.4%. In the 2013/14 GOSF, the diabetes prevalence for this clinical commissioning group (CCG) was 6.1%.

Comparing with similar CCGs

Your chosen CCG can be compared to similar CCGs based on location, demographic characteristics or deprivation by selecting a group from the list below:

- CCG deprivation deciles

Your chosen CCG is in the 7th most deprived CCG decile.

Identifying CCGs

To locate any CCG on the chart, make a selection from the list below. The selected CCG will be highlighted on the chart with a dark circle. This will not change your chosen CCG.

- NHS Mansfield and Ashfield

You can also click on any point in the chart in order to identify that CCG:

Your selected CCG is: NHS Ealing
NHS RightCare Atlas: Spend on non-elective diabetes admissions

RightCare Atlas: Introducing Diabetes indicators

Endocrine, nutritional & metabolic disorders: Diabetes

- Diabetes Prevalence
- % of all diabetes patients meeting all 3 treatment targets
- % of all diabetes patients receiving eight care processes
- % of all diabetes patients receiving retinal screening
- Spend on primary care spend on diabetes
- Spend on non-elective admissions
- Additional risk of complications for myocardial infarction
- Additional risk of complication for heart failure
- Additional risk of complication for stroke
Using tools to look at diabetes at lower geographies
Introducing the National General Practice Profiles

Introduction

These profiles are designed to support GPs, clinical commissioning groups (CCGs) and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population.

In addition to viewing individual practice profiles, you can view summary profiles for CCGs. Each practice can be compared with the CCG and England, and also with the practice deprivation decile.

Using a variety of graphical displays such as spine charts and population pyramids, the tool presents a range of practice-level indicators drawn from the latest available data, including:

- local demography
- Quality and Outcomes Framework domains
- disease prevalence estimates
- admission rates
- patient satisfaction

Recent updates

January 2015
- NHS comparators up to 12/13
- Updates to the Child health domain

December 2014
- QOF updated to 2013/14
- New Musculoskeletal domain
- ADS populations from Jan 2014
- GP survey data updated to 13/14

QOF indicators are now shown as intervention rates (denominators include exceptions)

http://fingertips.phe.org.uk/profile/general-practice
Topic - diabetes

- Diabetes QOF prevalence (17+)
- Hypertension: QOF prevalence
- Obesity: QOF prevalence (16+)
- Diabetes admissions (per 1,000)
- Estimated % of detected diabetes prevalence
- Last HbA1c is 59, 64, 75
- Last BP 150/90 and 140/80
- Measured cholesterol
- Recorded micro-albuminuria test last 12 months
- Treated with inhibitors
- Record of retinal screening
- Foot examination
- Dietary review in last 12 months
- Newly diagnosed referred to education programme (W 9 months)
- Males asked about erectile disfunction
- Advice given on erectile disfunction
- Flu vaccination coverage
Example output NGPPs: Newly diagnosed patients w. diabetes referred to education

100% to 22.2%
Using Local Health to map risk factors - Obese adults, Somerset

Available from: www.localhealth.org.uk
Local Health: Obese adults, Somerset – selecting wards with highest prevalence
Local Health: Obese adults, Somerset – the ward with highest prevalence

Highlighted ward – Yeovil without South Somerset
Local Health: Ward Profiles

Public Health England

Local Health

Ward profile
Local Health: Example detailed reports – Yeovil without South Somerset

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Lower Tier Local Authority (South Somerset)</th>
<th>Upper Tier Local Authority (Somerset)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency hospital admissions for all causes</td>
<td>103.6</td>
<td>90.4</td>
<td>93.3</td>
<td>100</td>
</tr>
<tr>
<td>Emergency hospital admissions for CHD</td>
<td>117.9</td>
<td>84.9</td>
<td>81.9</td>
<td>100</td>
</tr>
<tr>
<td>Emergency hospital admissions for stroke</td>
<td>81.6</td>
<td>93.3</td>
<td>103</td>
<td>100</td>
</tr>
<tr>
<td>Emergency hospital admissions for MI</td>
<td>91.8</td>
<td>79.5</td>
<td>71.2</td>
<td>100</td>
</tr>
<tr>
<td>Emergency hospital admissions for COPD</td>
<td>115.3</td>
<td>75.3</td>
<td>73.6</td>
<td>100</td>
</tr>
</tbody>
</table>

---

**Emergency hospital admissions, SARs, 2008/9 to 2012/13, Selection (comparing to England average)**

- **Significantly better than England**
- **Not significantly different**
- **Significantly worse than England**

[Graph showing comparative data]
Triangulating data at lower geographies - NGPPs: Locating GP surgery level data for the ward with highest obesity prevalence in Somerset – Yeovil ward
NGPPs: Oaklands Surgery Yeovil

### Diabetes Webinar - Nicola Bowtell

#### CCG: NHS Somerset CCG

**Practice:** L85064 - OAKLANDS SURGERY, YEOVIL

**Address:** OAKLANDS SURGERY, BIRCHFIELD ROAD, YEOVIL, SOMERSET, BA21 5RL

---

**Topic:** Diabetes

#### Comparitor: CCG

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Practice Count</th>
<th>Practice Value</th>
<th>CCG Value</th>
<th>England Average</th>
<th>England Lowest</th>
<th>England Range</th>
<th>England Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: QOF prevalence (17+)</td>
<td>2013/14</td>
<td>151</td>
<td>5.9%</td>
<td>6.3%</td>
<td>6.2%</td>
<td>0.0%</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>Exception rate for diabetes indicators (2013/14 indicators)</td>
<td>2013/14</td>
<td>87</td>
<td>4.8%</td>
<td>6.2%</td>
<td>8.0%</td>
<td>0.0%</td>
<td>56.0%</td>
<td></td>
</tr>
<tr>
<td>Hypertension QOF prevalence (all ages)</td>
<td>2013/14</td>
<td>432</td>
<td>12.3%</td>
<td>16.1%</td>
<td>13.7%</td>
<td>0.0%</td>
<td>47.5%</td>
<td></td>
</tr>
<tr>
<td>Exception rate for hypertension indicators (2013/14 indicators)</td>
<td>2013/14</td>
<td>37</td>
<td>2.9%</td>
<td>3.4%</td>
<td>4.9%</td>
<td>0.0%</td>
<td>81.1%</td>
<td></td>
</tr>
<tr>
<td>Exception rate for smoking indicators (2013/14 indicators)</td>
<td>2013/14</td>
<td>9</td>
<td>0.2%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.0%</td>
<td>42.5%</td>
<td></td>
</tr>
<tr>
<td>Obesity: QOF prevalence (16+)</td>
<td>2013/14</td>
<td>411</td>
<td>15.7%</td>
<td>8.9%</td>
<td>9.4%</td>
<td>0.0%</td>
<td>31.8%</td>
<td></td>
</tr>
<tr>
<td>Diabetes admissions (per 1000)</td>
<td>2012/13</td>
<td>3</td>
<td>0.9</td>
<td>1.0</td>
<td>0.9</td>
<td>0.0</td>
<td>11.9</td>
<td></td>
</tr>
<tr>
<td>Estimated percentage of detected diabetes prevalence</td>
<td>2009/09</td>
<td>110</td>
<td>87%</td>
<td>86%</td>
<td>86%</td>
<td>0%</td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>

**Other Indicators:**

- DM07: Last HbA1c is ≤59mmol/mol in last 12mths (den incl. exc.)
- DM08: Last HbA1c is ≤64mmol/mol in last 12mths (den incl. exc.)
- DM09: Last HbA1c is ≤75mmol/mol in last 12mths (den incl. exc.)
- DM02: Last BP is ≤150/90 (den incl. exc.)
- DM03: Last BP is ≤140/90 (den incl. exc.)
- DM04: Measured total cholesterol (last 12mths) ≤5mmol/l (den incl. exc.)
- DM05: Record of micro-albuminuria test last 12mths (den incl. exc.)
- DM06: Proteinuria/micro-albuminuria treated w inhibitors (den incl. exc.)
- DM011: Record of retinal screening (den incl. exc.)
- DM012: Patients with diabetes who had a foot examination and risk classification (den incl. exc.)
- DM013: Patients with diabetes who had a dietary review (last 12mths) (den incl. exc.)
- DM014: Newly diagnosed patients w.
NGPPs: Obesity prevalence by patients who had a dietary review
Diabetes UK: Resources

Diabetes Webinar - Nicola Bowtell
NHS Diabetes Prevention report – published August 2015

NHS diabetes prevention programme: non-diabetic hyperglycaemia

From: Public Health England
First published: 26 August 2015

Analysis by the National Cardiovascular Intelligence Network (NCVIN), supports the NHS DPP initiated by PHE, NHS England and Diabetes UK.

Documents

- NHS Diabetes Prevention Programme (NHS DPP) non-diabetic hyperglycaemia
  - Ref: PHE publication gateway reference: 2015206
  - PDF, 926KB, 30 pages
  - This file may not be suitable for users of assistive technology. Request a different format.

- Prevalence estimates of non-diabetic hyperglycaemia


- Characteristics of people with non diabetic hyperglycaemia
- Analysis of risk scores
- Estimates of prevalence at local level
NCVIN: Audits

NCVIN audits directory

A directory summarising audits conducted by partners within the National cardiovascular intelligence network (NCVIN)

Detail

This directory has information about cardiovascular audits from NCVIN partners. Clinical audits are described by NICE® as a way of "monitoring standards of clinical care to see if it is being carried out in the best way possible”. Use the directory to find out what each audit measures, data collected, setting, funding, participation, frequency and website link.

Diabetes

- Footcare audit
- National diabetes audit
- National Diabetes in Pregnancy Audit (NPID)
- National Diabetes Inpatient Audit (NaDIA)
- National paediatric diabetes audit
- Patient Experience in Diabetes Survey (PEDS)

Stroke

- National sentinel stroke audit
- Sentinel Stroke National Audit Programme (SSNAP)

# Lifestyle and risk factor resources

<table>
<thead>
<tr>
<th>Area</th>
<th>Product</th>
<th>Link</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Local Alcohol Profiles</td>
<td><a href="http://www.lape.org.uk/index.html">http://www.lape.org.uk/index.html</a></td>
<td>Interactive tool on a range of alcohol related indicators by LA</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Alcohol Return on Investment Tool</td>
<td><a href="http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/alcohol-return-on-investment-tool">http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/alcohol-return-on-investment-tool</a></td>
<td>Tool to help decision making on interventions and strategies to prevent and reduce alcohol use at local and sub-national levels</td>
</tr>
<tr>
<td>Drugs</td>
<td>National Drug Treatment Monitoring Systems (NDTMS)</td>
<td><a href="https://www.ndtms.net/default.aspx">https://www.ndtms.net/default.aspx</a></td>
<td>Need to register for some areas of access</td>
</tr>
<tr>
<td>Obesity</td>
<td>Various tools/products</td>
<td><a href="http://www.noo.org.uk">http://www.noo.org.uk</a></td>
<td>Range of products and tools looking at different aspects of obesity created by NOO (National Obesity Observatory)</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Health Impact of Physical Inactivity</td>
<td><a href="http://www.apho.org.uk/RESOURCE/VIEW.ASPX?RID=123459">http://www.apho.org.uk/RESOURCE/VIEW.ASPX?RID=123459</a></td>
<td>HIPI has been developed to estimate how many cases of certain diseases could be prevented in each local authority in England, if the population aged 40-79 were to engage in recommended amounts of physical activity</td>
</tr>
</tbody>
</table>
## Lifestyle and risk factor resources (cont)

<table>
<thead>
<tr>
<th>Area</th>
<th>Product</th>
<th>Link</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
<td>Active people interactive</td>
<td><a href="http://activepeople.sportengland.org/">http://activepeople.sportengland.org/</a></td>
<td>Active People Survey analysis tool</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Return on Investment Tool – Physical Activity</td>
<td><a href="http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/physical-activity-return-on-investment-tool">http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/physical-activity-return-on-investment-tool</a></td>
<td>The physical activity return on investment tool has been developed to help decision making in physical activity programme planning at local and sub-national levels</td>
</tr>
<tr>
<td>Sexual Health and Reproduction</td>
<td>Sexual and Reproductive Health Profiles</td>
<td><a href="http://fingertips.phe.org.uk/profile/sexualhealth">http://fingertips.phe.org.uk/profile/sexualhealth</a></td>
<td>Interactive fingertips tool on a range of sexual health related indicators by LA</td>
</tr>
<tr>
<td>Smoking</td>
<td>Local Tobacco Profiles</td>
<td><a href="http://www.tobaccoprofiles.info/">http://www.tobaccoprofiles.info/</a></td>
<td>Interactive fingertips tool on a range of tobacco related indicators by LA</td>
</tr>
<tr>
<td>Smoking</td>
<td>Return on Investment Tool - Smoking</td>
<td><a href="http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/tobacco-return-on-investment-tool">http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/tobacco-return-on-investment-tool</a></td>
<td>Tool to help decision making in tobacco control at local and sub-national levels</td>
</tr>
</tbody>
</table>
South West webinar series

Future Webinars:
- Liver
- Alcohol
- Best start in life
- Sexual health
- Dementia
- Wider determinants
- Comorbidities
- Adult obesity

Previous webinars available from: www.swpho.nhs.uk/resource/browse.asp x?RID=116744
Thank you

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