Warwick Medical School

NDA – THE LATEST DATA

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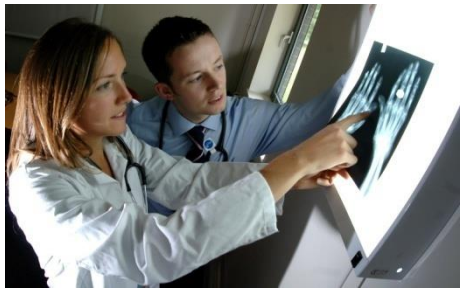
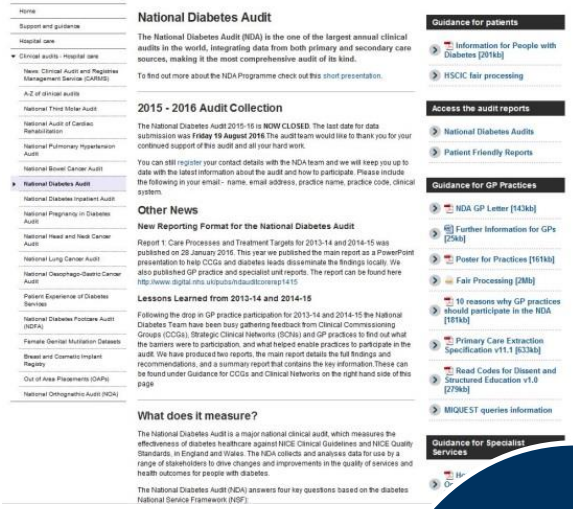
GP Clinical Lead National Diabetes Audit



THE UNIVERSITY OF WARWICK

https://digital.nhs.uk/nda



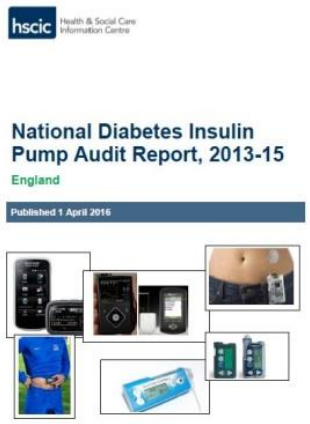
https://digital.nhs.uk/footcare

National Diabetes Foot Care Audit

National Diabetes Audit

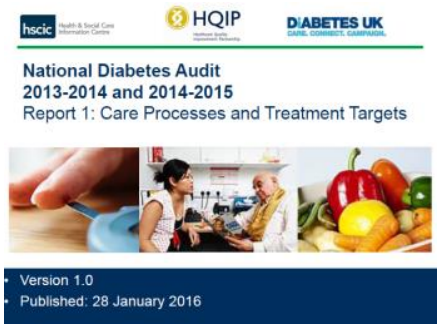
National Pregnancy in Diabetes Audit

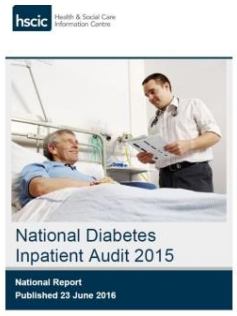
https://digital.nhs.uk/npid



National Diabetes Inpatient Audit

https://digital.nhs.uk/diabetesinpatientaudit





NDA Continuous Linked Data

GP and Specialist Electronic Records (Routine Records)

Core NDA (2004):

NHS number, Diabetes Type, Year, Sex, Post Code (IMD), YoB

BMI, Smoking, BP, HbA1c, TC, eGFR, UACR

Education, Pump Data, Foot (& Eye) checks

Hospital Episode Statistics/PEDW

NHS number

Admission for

DKA, Amputation, Dialysis/Transplant, Angina, MI, HF, Stroke

ONS (MRIS)

NHS number

Date of death

Cause of Death

NPiD: Antenatal

Deliveries; NNC

NDFA: Foot Ulcers

Foot Disease Admission

Transition: NPDA

Specialist Care OPD

Unlinked (snapshot):

NaDIA: Inpatients (2011): Patient Experience, PEDS (Piloted 2013-14)

NDA Reports – Core Audit

- 2014/15 Collection – Care Processes & Treatment Targets report published Jan 2016. Complications & Mortality Report due end Jan 2017
- 2015/16 Collection - Participation data just published. Care Processes & Treatment Targets due Jan 2017

NDA Participation Rates – Core Audit

- 2011/12 = 87.9% of practices in England & Wales
- 2012/13 = 70.7%
- 2013/14 & 2014/15 = 57%
- 2015/16 = 82.4%

For 2015/16 https://www.digital.nhs.uk/pubs/ndauditpart1516 shows CCG/LHB participation rates and also which GP practices have participated in each CCG/LHB.

NHS Digital has also published an interactive dashboard, where people can select their CCG/LHB and see participation rates for the past 3 years - NDA Participation 15-16 dashboard

Care Processes – Time Series

Percentage of people with diabetes in England and Wales receiving NICE recommended care processes by care process, diabetes type and audit year

	Type 1						Type 2 and other[3]					
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
HbA1c	85.7	86.0	83.0	79.8	80.9	83.2	92.7	93.1	90.9	93.1	93.5	94.8
Blood pressure	88.9	88.7	88.4	87.7	87.0	89.0	95.8	95.7	95.6	95.4	94.9	96.1
Cholesterol	79.1	78.8	77.8	77.3	77.4	78.7	92.9	92.8	92.1	91.9	92.4	92.8
Serum creatinine	81.0	81.2	81.1	80.3	78.8	80.5	93.6	93.5	93.5	93.2	93.4	94.5
Urine albumin*	56.2	58.4	59.2	56.5	63.9	55.9	73.9	76.7	77.5	74.7	84.4	74.6
Foot surveillance	71.7	71.5	72.8	71.5	70.7	72.4	85.3	85.5	86.4	85.8	86.2	86.7
BMI	83.6	83.4	83.7	83.3	76.8	74.9	90.8	90.5	90.9	90.9	85.7	83.1
Smoking	80.8	78.6	79.0	79.2	77.4	77.9	87.5	85.4	85.7	86.3	85.5	85.2
Eight care processes[4]	42.4	43.3	43.2	40.8	44.5	38.7	61.1	62.3	62.1	61.2	67.6	58.7

Blood tests and Blood Pressure are more reliably performed than other care processes. Recent declines in UACR & BMI measurement.

* There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) prior to 2013-14; please see the NDA Data Quality statement

Care Processes – National Time Series

Percentage of people with diabetes in England and Wales receiving NICE recommended care processes by care process, diabetes type and audit year

Blood tests and Blood Pressure are more reliably performed than other care processes

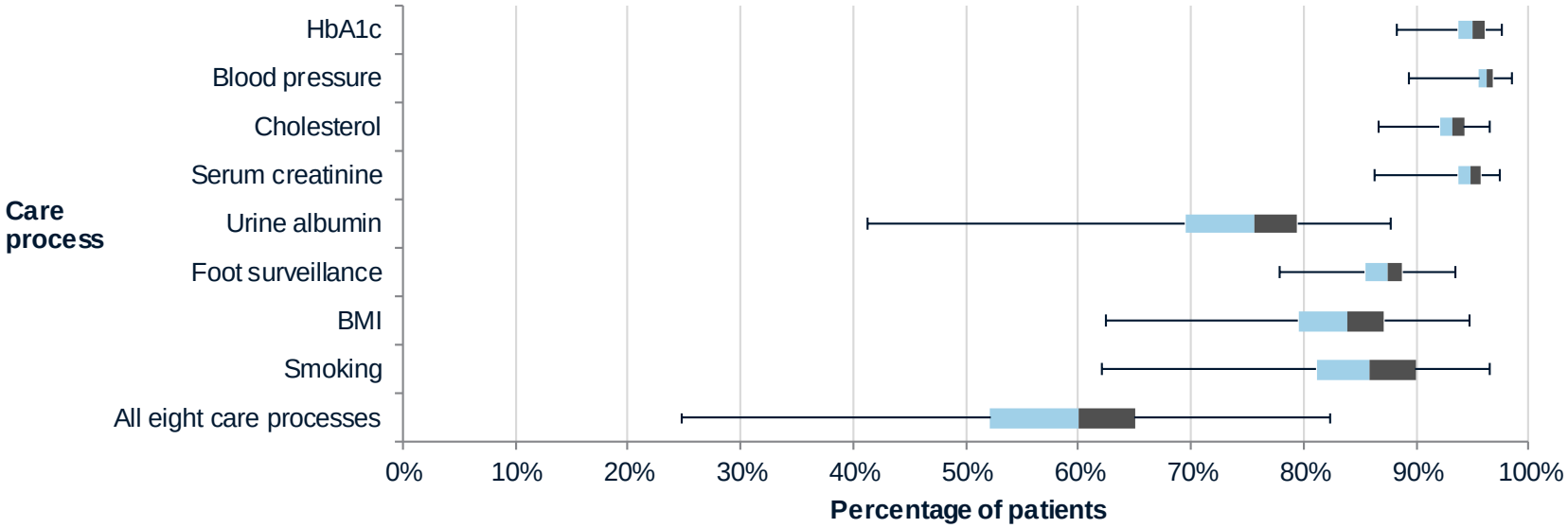
	Type 1						Type 2 and other[3]					
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
HbA1c	85.7	86.0	83.0	79.8	80.9	83.2	92.7	93.1	90.9	93.1	93.5	94.8
Blood pressure	88.9	88.7	88.4	87.7	87.0	89.0	95.8	95.7	95.6	95.4	94.9	96.1
Cholesterol	79.1	78.8	77.8	77.3	77.4	78.7	92.9	92.8	92.1	91.9	92.4	92.8
Serum creatinine	81.0	81.2	81.1	80.3	78.8	80.5	93.6	93.5	93.5	93.2	93.4	94.5
Urine albumin*	56.2	58.4	59.2	56.5	63.9	55.9	73.9	76.7	77.5	74.7	84.4	74.6
Foot surveillance	71.7	71.5	72.8	71.5	70.7	72.4	85.3	85.5	86.4	85.8	86.2	86.7
BMI	83.6	83.4	83.7	83.3	76.8	74.9	90.8	90.5	90.9	90.9	85.7	83.1
Smoking											85.5	85.2
Eight care processes [4]											67.6	58.7

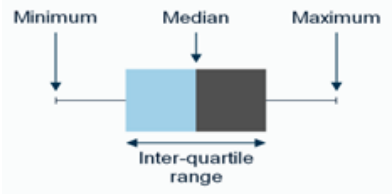
BMI measurement fell in 2013-14 and urine albumin checks dropped in 2014-15. These changes may reflect retirement of the respective QOF indicators.

* There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) prior to 2013-14; please see the NDA Data Quality statement

Care Processes, Type 2 diabetes – Variation by CCG/LHB

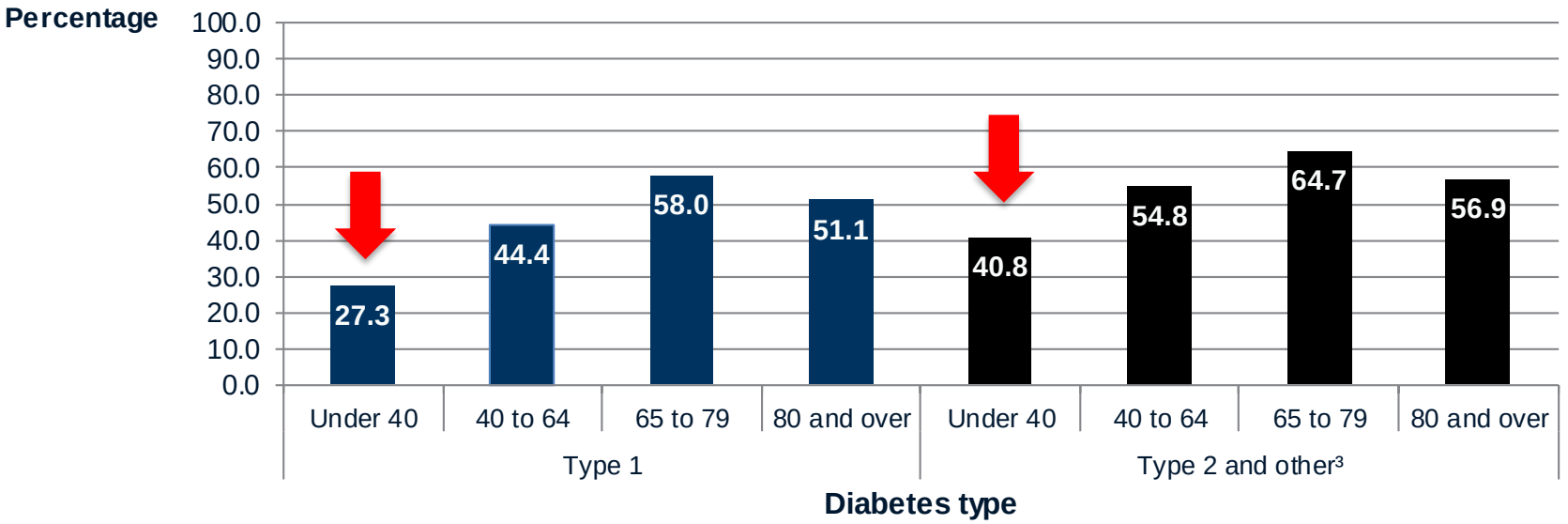
The range of CCG/LHB care process completion for people with Type 2 diabetes in England and Wales, 2014-15





Care Processes – Variation By Age

Percentage of all people with diabetes in England and Wales receiving all eight NICE recommended care processes[4] by age and diabetes type, in 2014-15



People with diabetes aged <40 are less likely to receive all their annual care processes

Treatment Targets – Time Series

Percentage of people with diabetes in England and Wales achieving their treatment targets by diabetes type and audit year

	Type 1						Type 2 and other					
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
$HbA1_c$ ≤ 58 mmol/mol	28.7	28.1	27.0	27.2	29.4	29.9	66.6	66.5	65.8	64.9	66.8	66.1
Blood Pressure ≤140/80*	68.5	68.8	72.2	73.4	76.4	76.4	60.8	61.4	66.6	68.6	73.6	74.2
Cholesterol < 5mmol/L	72.6	72.0	71.1	70.2	71.5	71.3	78.2	78.0	77.4	76.7	77.8	77.5
Meeting all three treatment targets	16.9	16.5	16.5	16.1	18.6	18.9	35.0	35.1	37.4	37.3	41.4	41.0

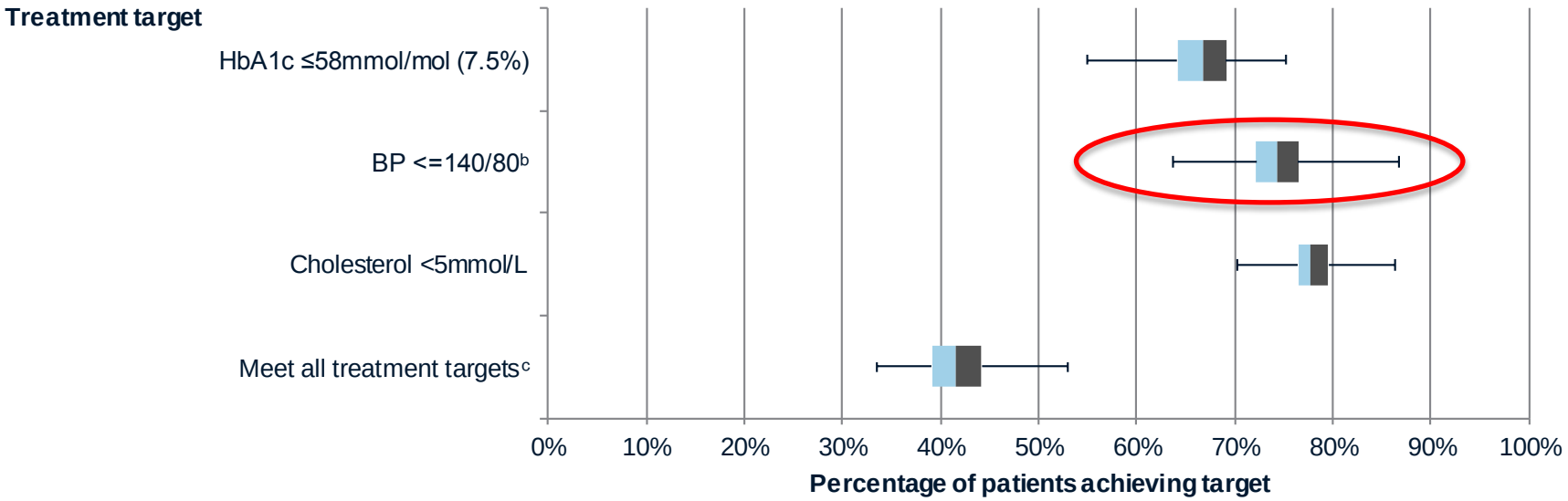
* The blood pressure target does not exactly match NICE (<140/80) but was changed to align with the relevant QOF indicator (≤140/80).

2004-05: HbA1c ≅40%, BP ≅50%, Cholesterol ≅55%

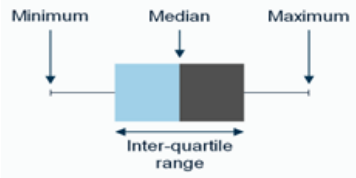
Type 2: HbA1c and Cholesterol rates stable;
Type 1: HbA1c slight improvement (?) and Cholesterol rate stable;
T1 & T2 BP improved steadily -> Improved 3 target bundle rate

Local variation - Treatment Target – Type 2 Diabetes

The range of CCG/LHB treatment target achievement for people with Type 2 and other diabetes in England and Wales, 2014-15

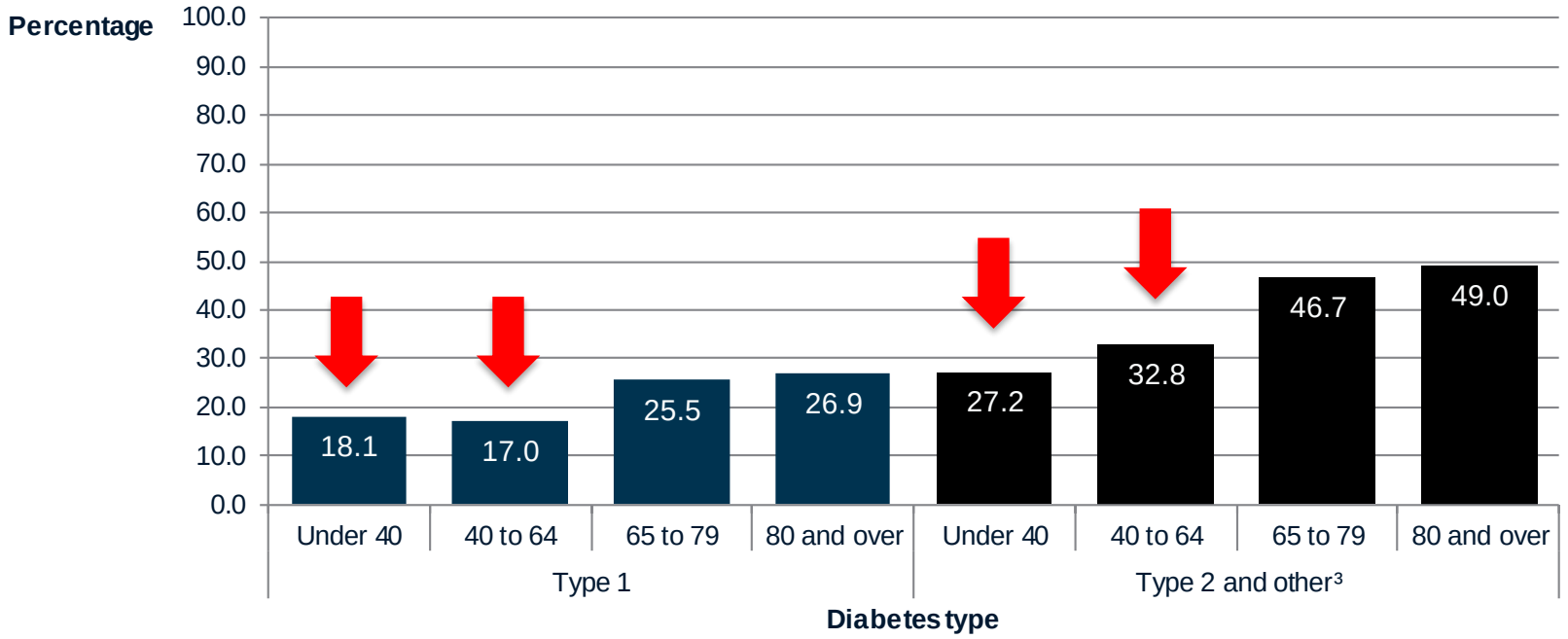


Range of variation in treatment target achievement is appreciable



Treatment Target – Variation By Age

Percentage of all people with diabetes in England and Wales achieving all three treatment targets (HbA1c≤58 and BP≤140/80 and Cholesterol<5) by diabetes type and age group, 2014-15



People aged <65 less likely to achieve the NICE treatment targets

Type 2 Diabetes Treatment Target Achievement

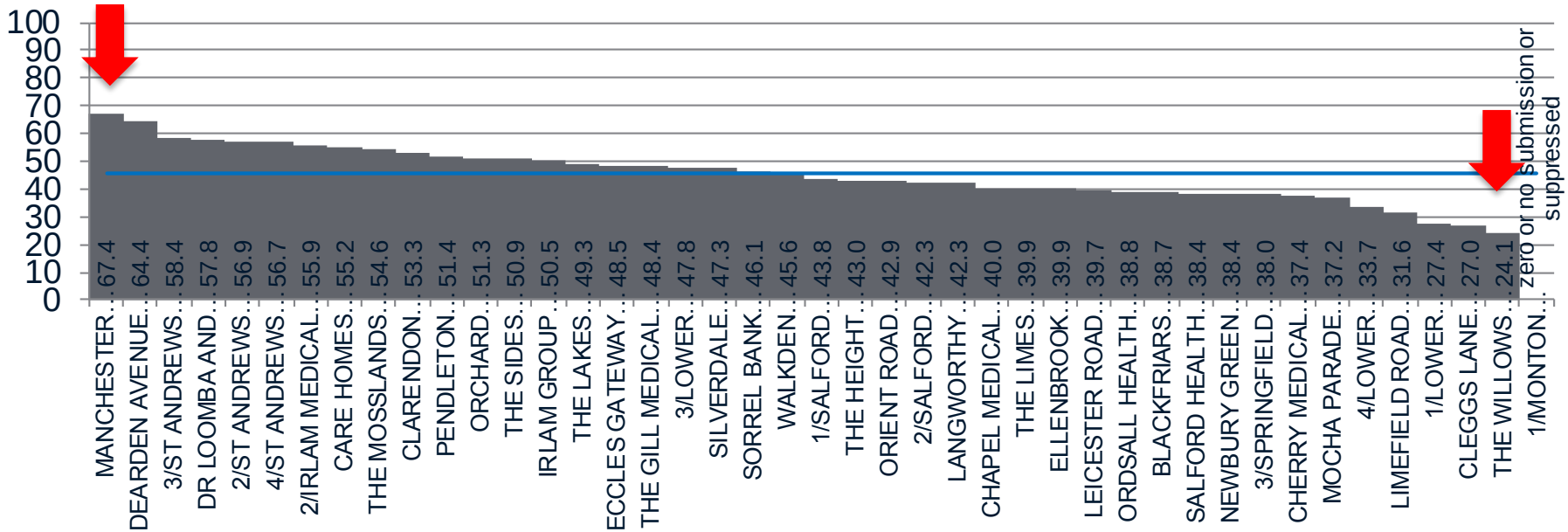
2012-3 & 2014-15 Treatment target achievement for people with Type 2 or other diabetes

	NHS SALFORD CCG (2013-4)	NHS SALFORD CCG (2014-5)	ENGLAND
	Percentage completed	Percentage completed	Percentage completed
HbA1c < 48 mmol/mol (6.5%)	34.5	35.3	29.5
HbA1c <= 58 mmol/mol (7.5%)	69.6	68.9	66.5
HbA1c <= 86 mmol/mol (10.0%)	93.1	92.6	93.5
Blood Pressure <= 140/80	**71.3**	**76.1**	74.3
Cholesterol < 4 mmol/L	42.5	44.6	42.2
Cholesterol < 5 mmol/L	**78.4**	**80.2**	77.6
All Three Treatment Targets	**43.1**	**45.9**	41.3

T2 Treatment Target bundle – Salford Practices

2014-2015 percentage of people with Type 2 or other diabetes achieving the All Three Treatment Targets treatment target in NHS SALFORD CCG, comparison by GP practice

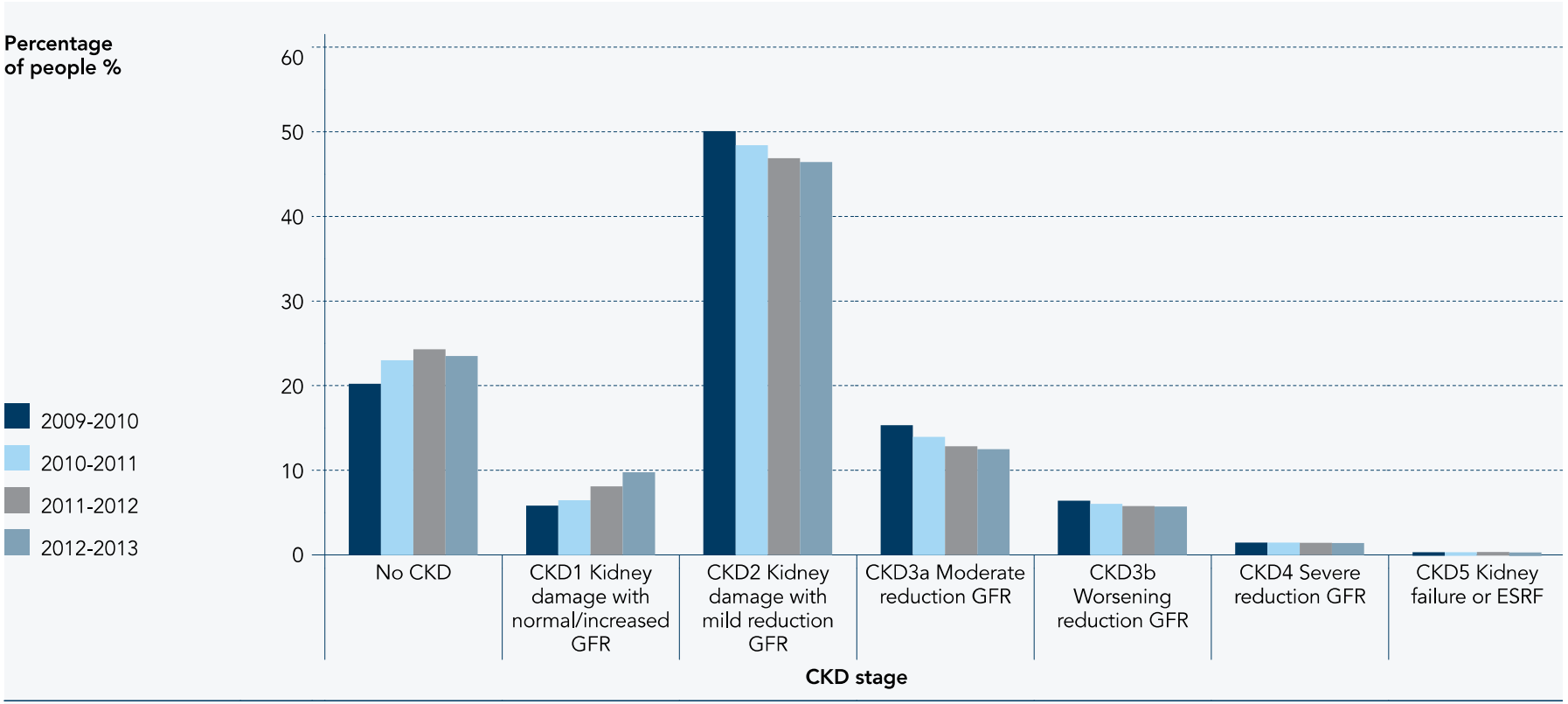
REMARKABLY WIDE DISTRIBUTION



Standardised Ratios for Diabetic Complications
Type 2 diabetes, 1yr follow up 2011-2012

Complication	Country	Total expected	Observed	Standardised ratio	95% CI Limits[a]		Additional risk of complication among people with diabetes %
					Lower	Upper	
Angina	England	30,248	71,294	236	234	237	135.7
	Wales	1,467	3,257	222	214	230	122.0
	England and Wales	31,716	74,551	235	233	237	135.1
Myocardial Infarction (heart attack)	England	8,473	15,969	188	186	191	88.5
	Wales	414	700	169	157	182	69.2
	England and Wales	8,886	16,669	188	185	190	87.6
Heart Failure	England	22,703	50,395	222	220	224	122.0
	Wales	1,256	2,579	205	197	213	105.3
	England and Wales	23,959	52,974	221	219	223	121.1
Stroke	England	12,094	19,343	160	158	162	59.9
	Wales	649	927	143	134	152	42.8
	England and Wales	12,743	20,270	159	157	161	59.1
Major Amputation (above the ankle)	England	326	1,429	438	416	461	338.1
	Wales	22	99	445	362	542	345.2
	England and Wales	348	1,528	439	417	461	338.5
Minor Amputation (below the ankle)	England	362	2,884	797	768	826	696.8
	Wales	21	130	615	514	730	515.0
	England and Wales	383	3,014	787	759	815	686.8
Renal Replacement Therapy (ESKD)	England	2,613	8,432	323	316	330	222.7
	Wales	136	390	286	259	316	186.3
	England and Wales	2,749	8,822	321	314	328	220.9

Percentage of people with Type 2 diabetes at each CKD stage as well as those with no CKD by audit year



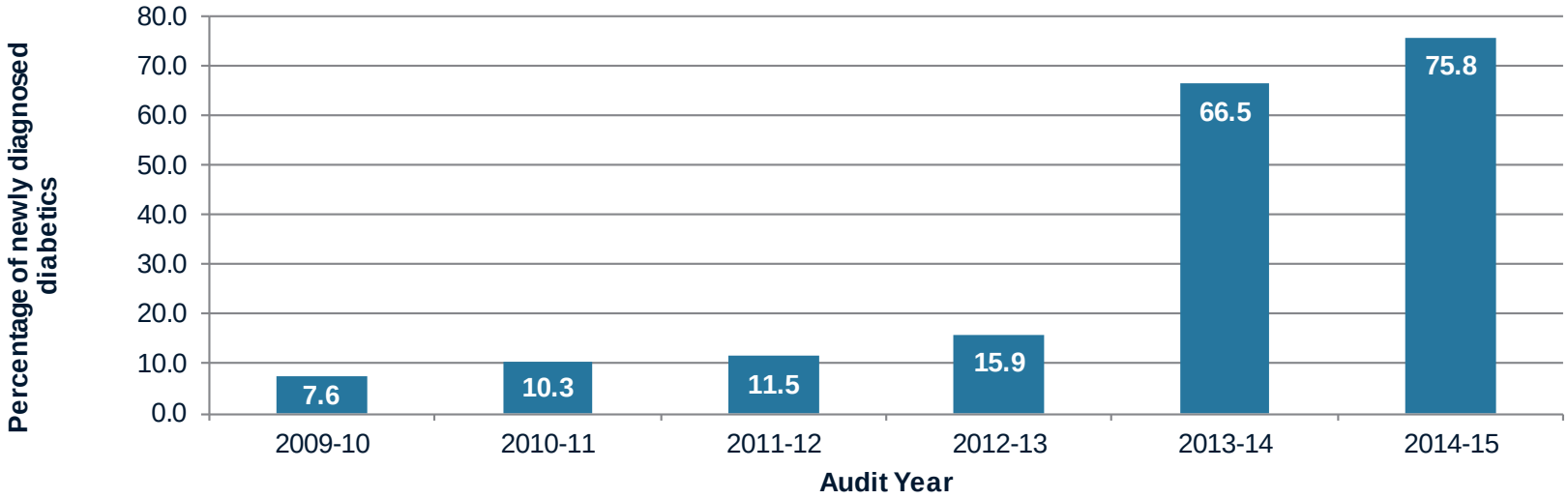
Structured Education NDA time series

Key Findings

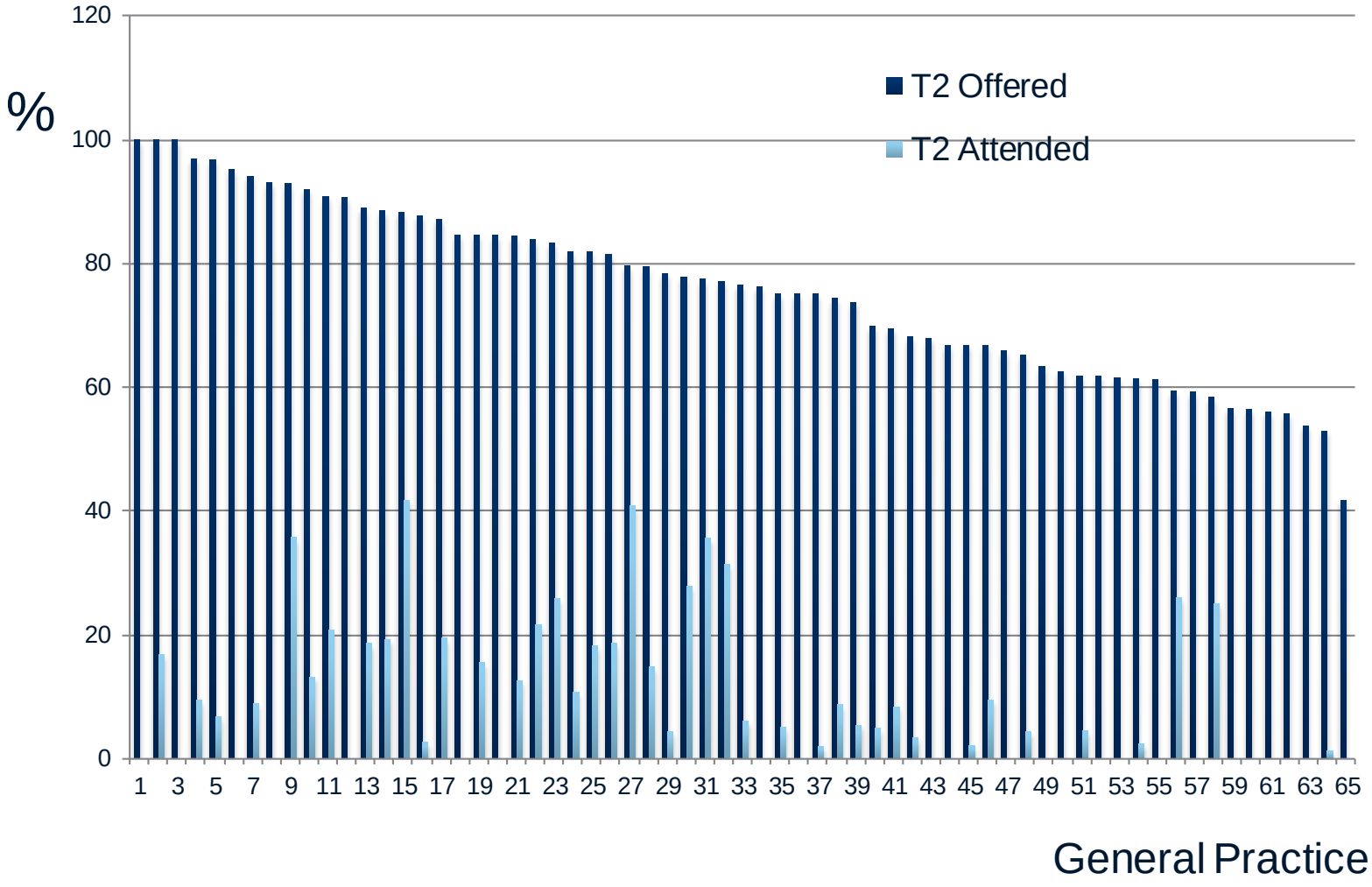
There has been a large increase in records of structured education being offered within one year of diagnosis.

More people with Type 2 diabetes are recorded as being offered education (78%) than people with Type 1 (32%).

Figure 7: Percentage of people newly diagnosed with diabetes being offered structured education in England and Wales by audit year



Offered and Attended 2014-15 Salford GPs



Structured Education

- **Data recording – the current picture**
- The National Diabetes Audit (NDA) 2014/15 shows that whilst 78% of people with Type 2 diabetes and 32% of people with Type 1 diabetes are **offered** structured education, only 1.8% of Type 1 and 5.4% Type 2 were recorded as having **attended**.
- Local evidence suggests that attendance at diabetes structured education is higher, at around 30%. This is likely to be due to huge variability in the notification, coding and recording of this information onto patient electronic records within GP practices.

Standardizing Structured Education Recording
An initiative by NDA, DUK, NHSE, SCNs

Guidance for Diabetes Structured Education Providers, GP practices and Commissioners

Standardised Approach to Recording

The records of a person with diabetes being 'offered' or 'referred' for diabetes structured education is currently well recorded and captured in GP systems. Evidence of this is reflected in the NDA findings.

GP practices are encouraged to continue to record referral to diabetes structured education.

Data capture on **attendance** at diabetes structured education is poor and therefore the guidance below relates to improving recording of the outcome of the referral.

Use of only four standard, generic Read Codes

It is recommended that all education providers use standard, generic Read Codes to communicate the outcome of a referral to diabetes structured education.

TABLE 1

Outcome of referral to diabetes structured education	Vision/EMIS/ other systems	System One
1. Diabetes structured education declined	9OLM	XaNTH
2. Did not attend diabetes structured education	9NiA	XaNTa
3. Attended* diabetes structured education	9OLB	XaKHØ
4. Diabetes structured education completed	9OLF	XaX5D

** Where a structured education course consists of more than one session, and the patient only attends some of the sessions then enter a Read Code of attended. If the patient attends all the sessions and completes the course enter a Read Code of completed.*

The Read Codes above are recommended as the minimum dataset to capture for structured education. Providers and those in primary care who are using more detailed codes – referencing DAFNE, DESMOND or X-PERT can still continue to use these **in addition to the standard, generic codes** as long as they appear in the NDA data submission specification. See Appendix A for a list of all the Read Codes used in the NDA data capture.

/4

Standardizing Structured Education Recording
An initiative by NDA, DUK, NHSE, SCNs

Guidance Notes for Recording

Where possible, electronic administration systems should be used and referral/outcome Read Codes entered onto the system as promptly as possible.

GP practices

Referrals

- Include NHS Number, GP practice number and date of diabetes diagnosis in the referral to Diabetes Structured Education
- Record referral in the patient electronic record

Outcome of referral

- The outcome information, including the standardised Read Codes, will be sent to you by your Diabetes Structured Education provider by email or letter (if direct access to your system is unavailable)
- Record the appropriate Read Code in the electronic patient record as soon as the letter/email is received
- This data will be included in the next NDA data submission, so it is important that any outcome information is transferred to the electronic patient record before the submission deadline. This will also inform you CCG Improvement and Assessment Framework

Diabetes Education Providers

Referrals

- Record the referral, including patient's NHS number, GP practice number and date of diabetes diagnosis in your administrative system

Communicating the outcome of a referral to referring GP practice

- Record the outcome of the referral using the standard Read Codes
- Send the outcome of the referral with appropriate Read Code to the referring GP practice by email/letter (if direct access to the GP system is unavailable). Or enter directly onto the GP system if this is possible

Commissioners

- Ensure that the standardised system of recording Diabetes Structured Education outcome is shared across the commissioning area
- Ensure providers of Diabetes Structured Education can demonstrate that they will follow the standardised Read Codes
- Consider contracting arrangements and ensure procurement and tender requirements conform to this standardised approach
- CCGs with <25% of GP practices participating in the NDA are automatically placed in the 'Greatest Need for Improvement' CCG IAF rating

/6

Appendix B

Diabetes Education
Provider Address

Patient name and address

Dear Dr,

The above patient was referred to our Diabetes Structured Education Programme.

Please transfer the following outcome and identified read code into the patient's record.

Outcome of referral to diabetes structured education	Tick relevant box	Read code
1. Diabetes structured education declined	☐	9OLM / XaNTH
2. Did not attend diabetes structured education	☐	9NiA / XaNTa
3. Attended diabetes structured education	☐	9OLB / XaKHØ
4. Diabetes structured education completed	☐	9OLF / XaX5D

Kind regards,

Diabetes Structured Education Team

/9

CCG ASSESSMENT FRAMEWORK

- The CCG Improvement and Assessment Framework (IAF)3, introduced in 2016, will be the key way in which the NHS will track CCG progress on improving outcomes. One of the diabetes metrics upon which CCGs will be measured is:
- ***People with diabetes diagnosed less than a year, who attend diabetes structured education.***
- The NDA is the mechanism for capturing the data for the CCG IAF.

. So getting recording correct is important!

www.diabetes.org.uk/NDA-structured-education-data.

3 TAKE HOME MESSAGES

- 1 Ensure 100% practice participation in NDA
- 2 Concentrate specifically on improving BP control in people with diabetes
- Get the right Read codes used to record structured education

THANK YOU