

NDA – THE LATEST DATA

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Home
Support and guidance
Hospital care
Clinical audit - Hospital care
New: Clinical Audit of Podiatric Management Service (CAPMS)
A-Z of clinical audit
National Three Star Audit
National Audit of Cancer Rehabilitation
National Pulmonary Rehabilitation Audit
National Breast Cancer Audit
National Diabetes Audit
National Diabetes Inpatient Audit
National Pregnancy in Diabetes Audit
National Head and Neck Cancer Audit
National Lung Cancer Audit
National Oesophago-Gastro-Cancer Audit
Patient Experience of Diabetes Services
National Diabetes Footcare Audit (NDAFA)
Female Genital Mutilation Database
Bowel and Colorectal Incontinence Registry
Out of Area Placements (ODAPs)
National Orthognosis Audit (NDA)

National Diabetes Audit

The National Diabetes Audit (NDA) is one of the largest annual clinical audits in the world, integrating data from both primary and secondary care sources, making it the most comprehensive audit of its kind.

To find out more about the NDA Programme check out this short presentation.

2015 - 2016 Audit Collection

The National Diabetes Audit 2015-16 is NOW CLOSED. The last date for data submission was Friday 19 August 2016. The audit team would like to thank you for your continued support of this audit and all your hard work.

You can still register your contact details with the NDA team and we will keep you up to date with the latest information about the audit and how to participate. Please include the following in your email- name, email address, practice name, practice code, clinical system.

Other News

New Reporting Format for the National Diabetes Audit

Report 1: Care Processes and Treatment Targets for 2013-14 and 2014-15 was published on 28 January 2016. This year we published the main report as a PowerPoint presentation to help CCGs and diabetes leads disseminate the findings locally. We also published GP practice and specialist unit reports. The report can be found here <http://www.digital.nhs.uk/pubs/nda/nda/nda/1415>

Lessons Learned from 2013-14 and 2014-15

Following the drop in GP practice participation for 2013-14 and 2014-15 the National Diabetes Team have been busy gathering feedback from Clinical Commissioning Groups (CCGs), Strategic Clinical Networks (SCNs) and GP practices to find out what the barriers were to participation, and what helped enable practices to participate in the audit. We have produced two reports, the main report details the full findings and recommendations, and a summary report that contains the key information. These can be found under Guidance for CCGs and Clinical Networks on the right hand side of this page

What does it measure?

The National Diabetes Audit is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards in England and Wales. The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.

The National Diabetes Audit (NDA) answers four key questions based on the diabetes National Service Framework (NSF):

- Guidance for patients
 - Information for People with Diabetes (2016a)
 - HSCIC fair processing
- Access the audit reports
 - National Diabetes Audits
 - Patient Friendly Reports
- Guidance for GP Practices
 - NDA GP Letter (1436a)
 - Further Information for GPs (256a)
 - Poster for Practices (1516a)
 - Fair Processing (266)
 - 10 reasons why GP practices should participate in the NDA (1616a)
 - Primary Care Extraction Specification v11.1 (6336a)
 - Read Codes for Diabetes and Structured Education v1.0 (2796a)
 - MIQUEST queries information
- Guidance for Specialist Services
 - HSCIC

National Diabetes Foot Care Audit Report

2014-2015



DIABETES FOOT CARE: ARE SERVICES IN ENGLAND AND WALES PUTTING YOUR FEET FIRST?

A summary report about the quality of foot care for people with diabetes. Based on findings from National Diabetes Footcare Audit (NDAFA) 2014-15 in England and Wales.

National Diabetes Foot Care Audit

National Diabetes Audit

National Pregnancy in Diabetes Audit

National Diabetes Inpatient Audit

National Pregnancy in Diabetes Audit Report, 2014

England, Wales and the Isle of Man



Recommendations for women with diabetes

- Take long term care
- Monitor HbA1c and get advice from your diabetes team
- Check your medication
- Keep your blood pressure
- Check up every 1-2 weeks with your diabetes team

Recommendations for healthcare professionals

- Offering pregnancy support to women with diabetes
- Improve pregnancy care
- Take part in NICE campaigns
- Support local professional groups
- Monitor the NICE findings

hscic Health & Social Care Information Centre



National Diabetes Inpatient Audit 2015

National Report
Published 23 June 2016

hscic Health & Social Care Information Centre

National Diabetes Insulin Pump Audit Report, 2013-15

England

Published 1 April 2016



hscic Health & Social Care Information Centre

HQIP

DIABETES UK CARE, CONNECT, GAMBARN

National Diabetes Audit 2013-2014 and 2014-2015

Report 1: Care Processes and Treatment Targets



Version 1.0
Published: 28 January 2016

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

NPiD: Antenatal

NDFA: Foot Ulcers

Transition: NPDA

Hospital Episode Statistics/PEDW

NHS number
Admission for
DKA, Amputation,
Dialysis/Transplant,
Angina, MI, HF, Stroke

Deliveries; NNC

Foot Disease Admission

Specialist Care OPD

ONS (MRIS)

NHS number
Date of death
Cause of Death

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%

<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 |

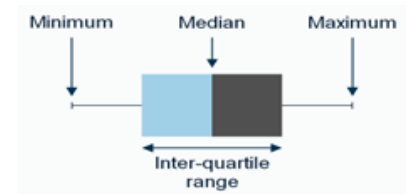
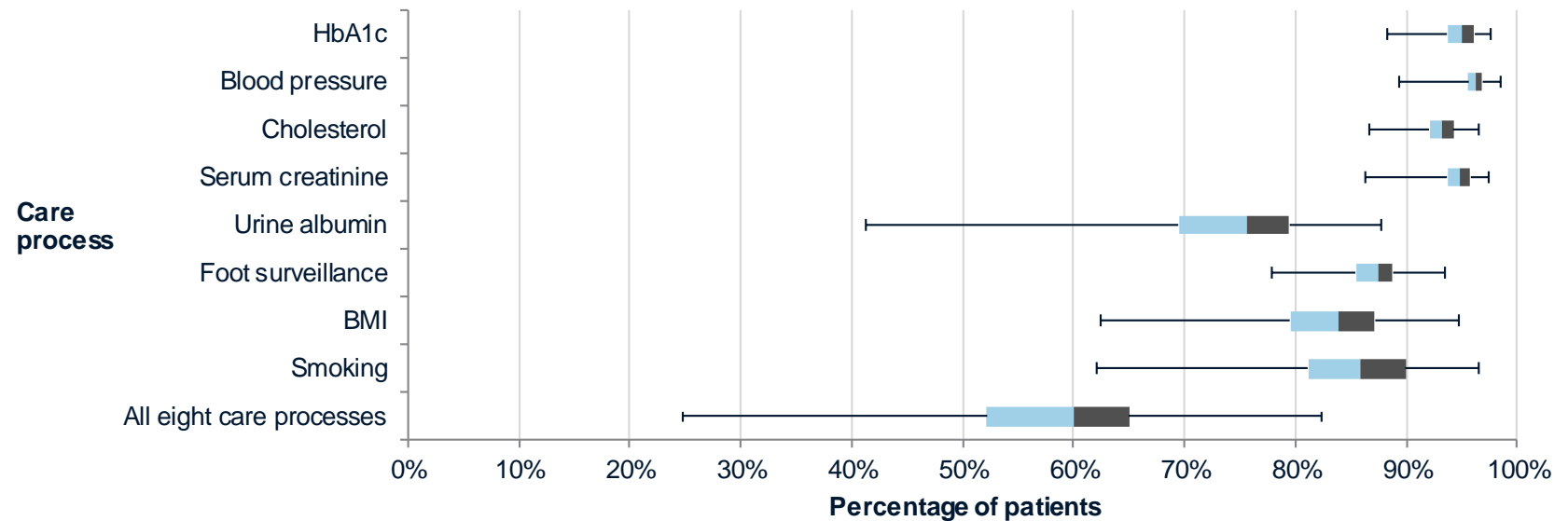
BMI measurement fell in 2013-14 and urine albumin checks dropped in 2014-15. These changes may reflect retirement of the respective QOF indicators.

* 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

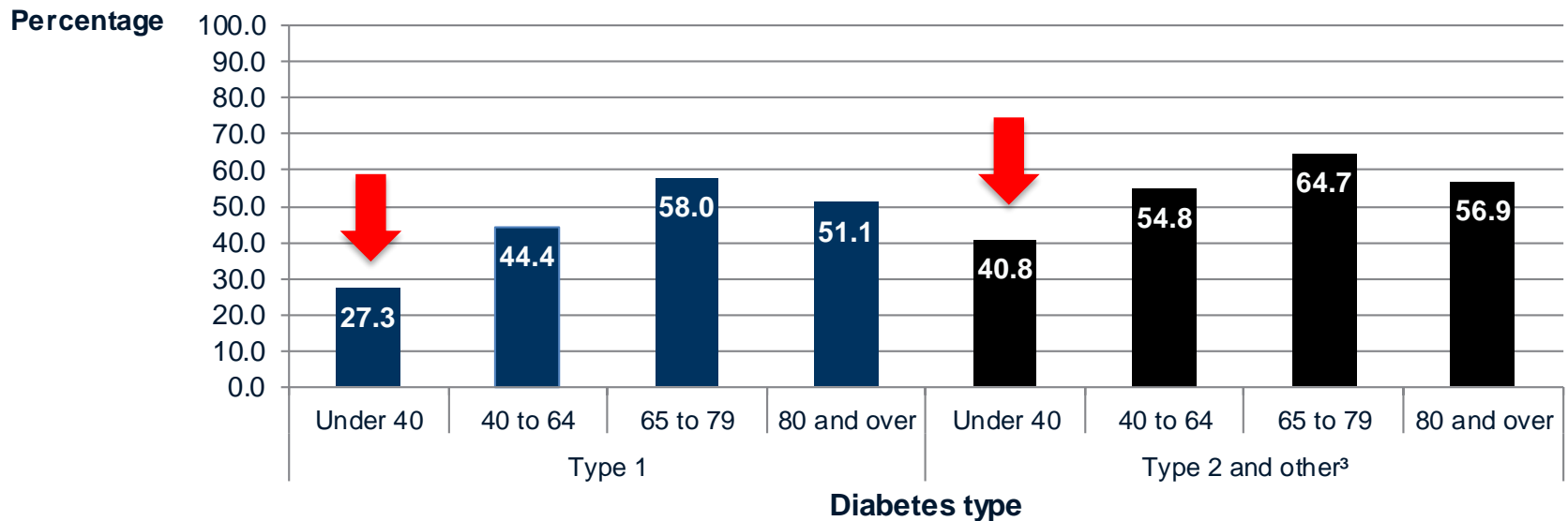
– Variation by CCG/LHB

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 processes⁴ 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 |
| HbA1c ≤ 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%

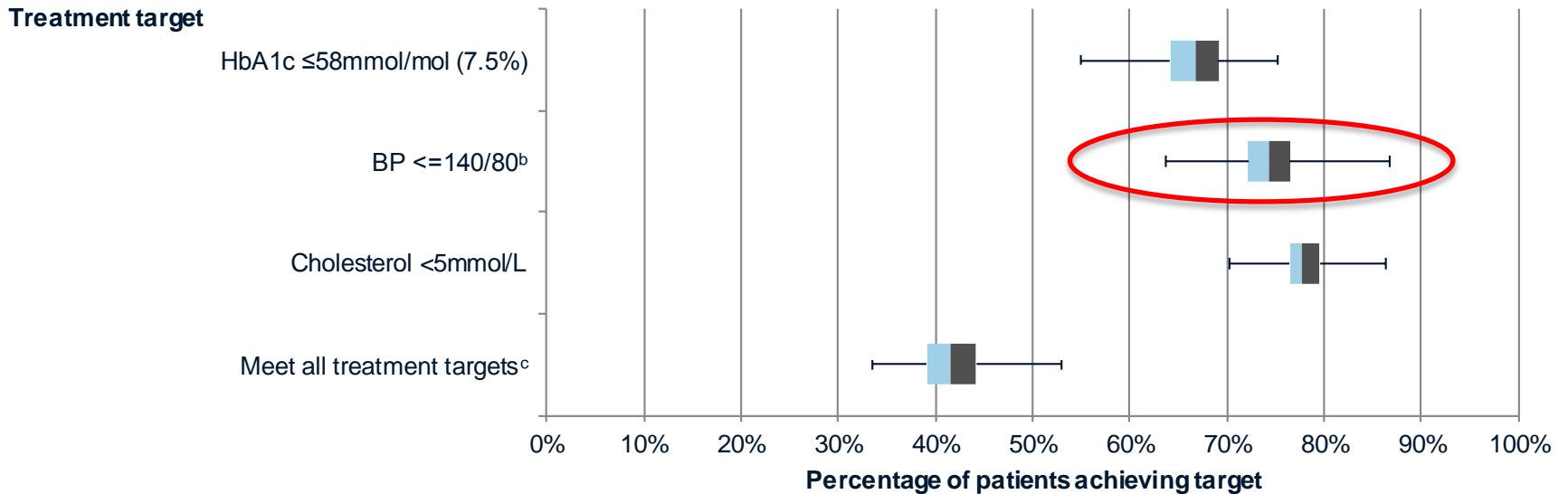
Type 2: HbA1c and Cholesterol rates stable;

Type 1: HbA1c slight improvement (?) and Cholesterol rate stable;

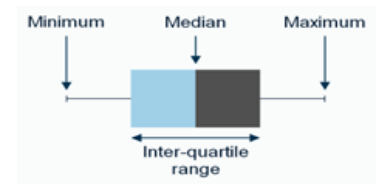
T1 & T2 BP improved steadily -> Improved 3 target bundle rate

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

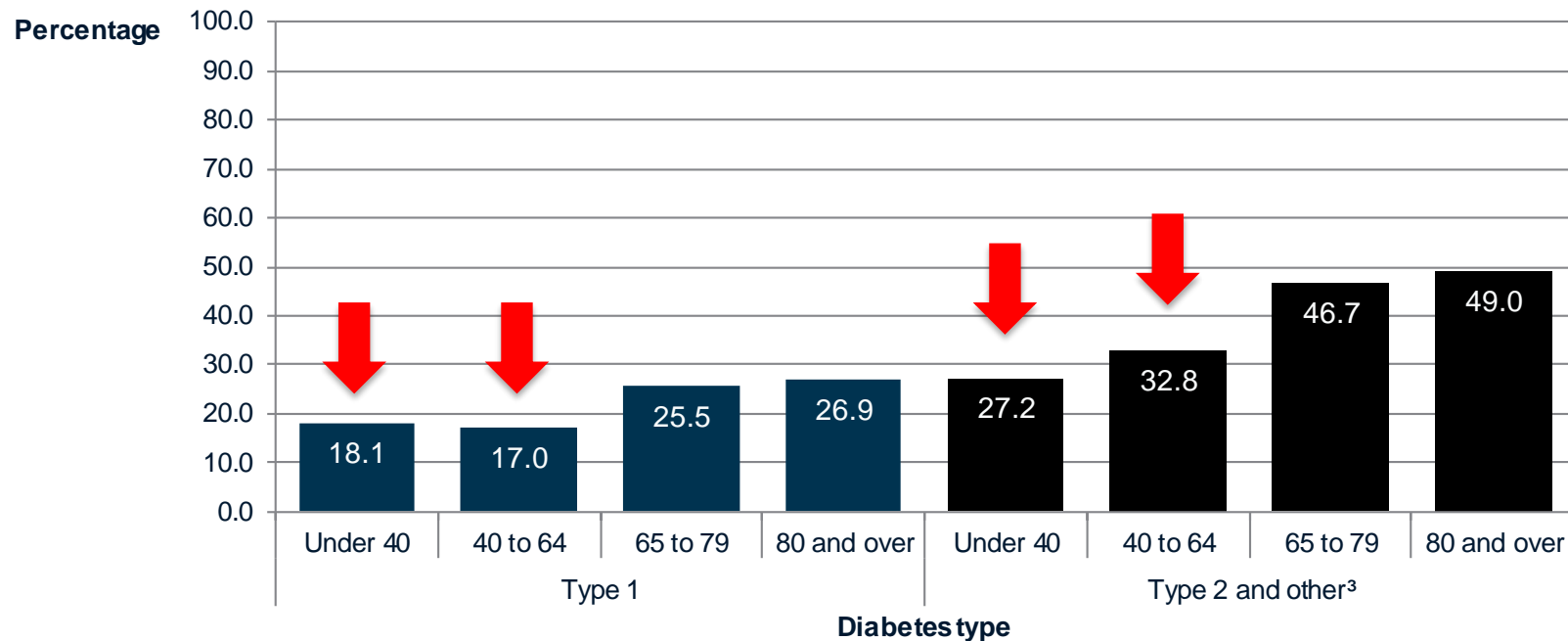


Range of variation in treatment target achievement is appreciable



Treatment Target – Variation By Age

Percentage of all people with diabetes in England and Wales achieving all three treatment targets (HbA1c \leq 58 and BP \leq 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

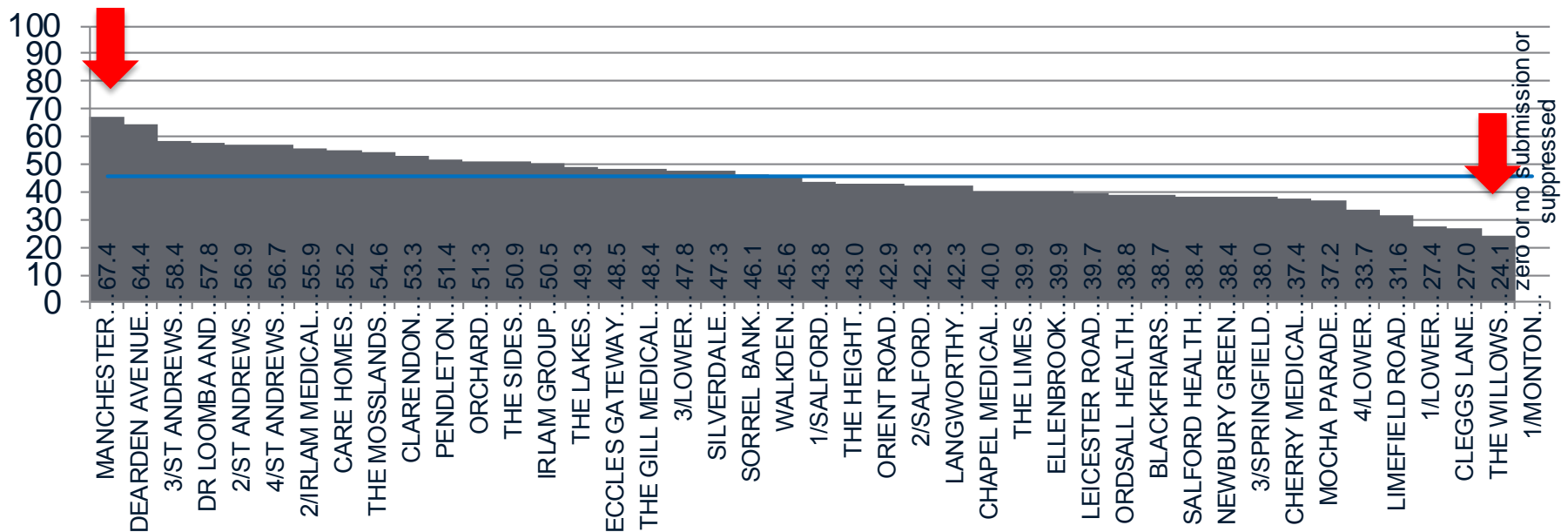
2012-3 & 2014-15 Treatment target achievement for people with Type 2 or other diabetes

| | 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

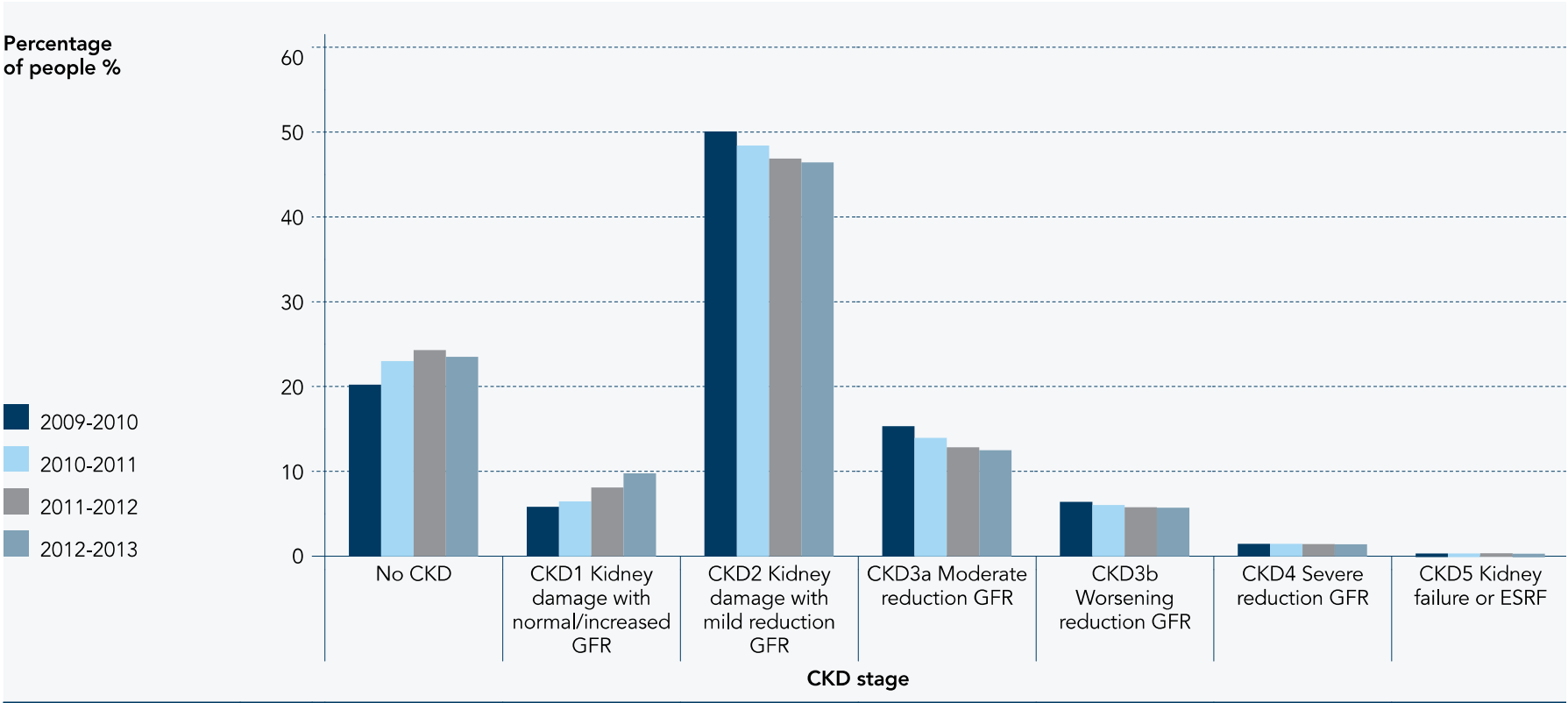


Standardised Ratios for Diabetic Complications

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



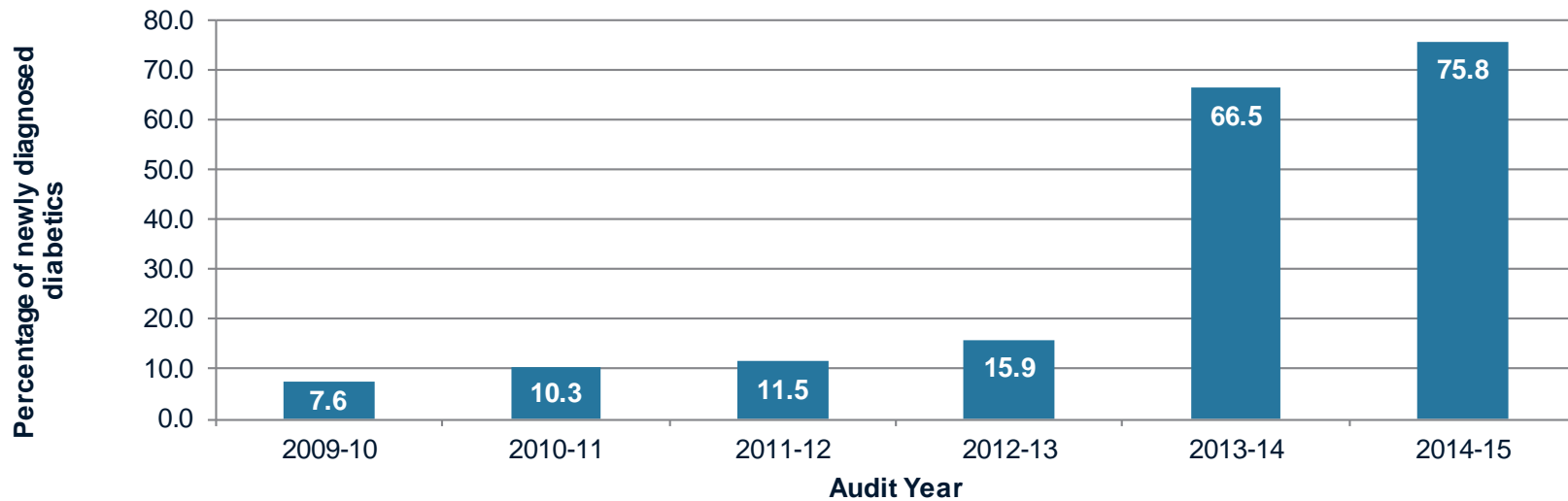
Structured Education NDA time series

Key Findings

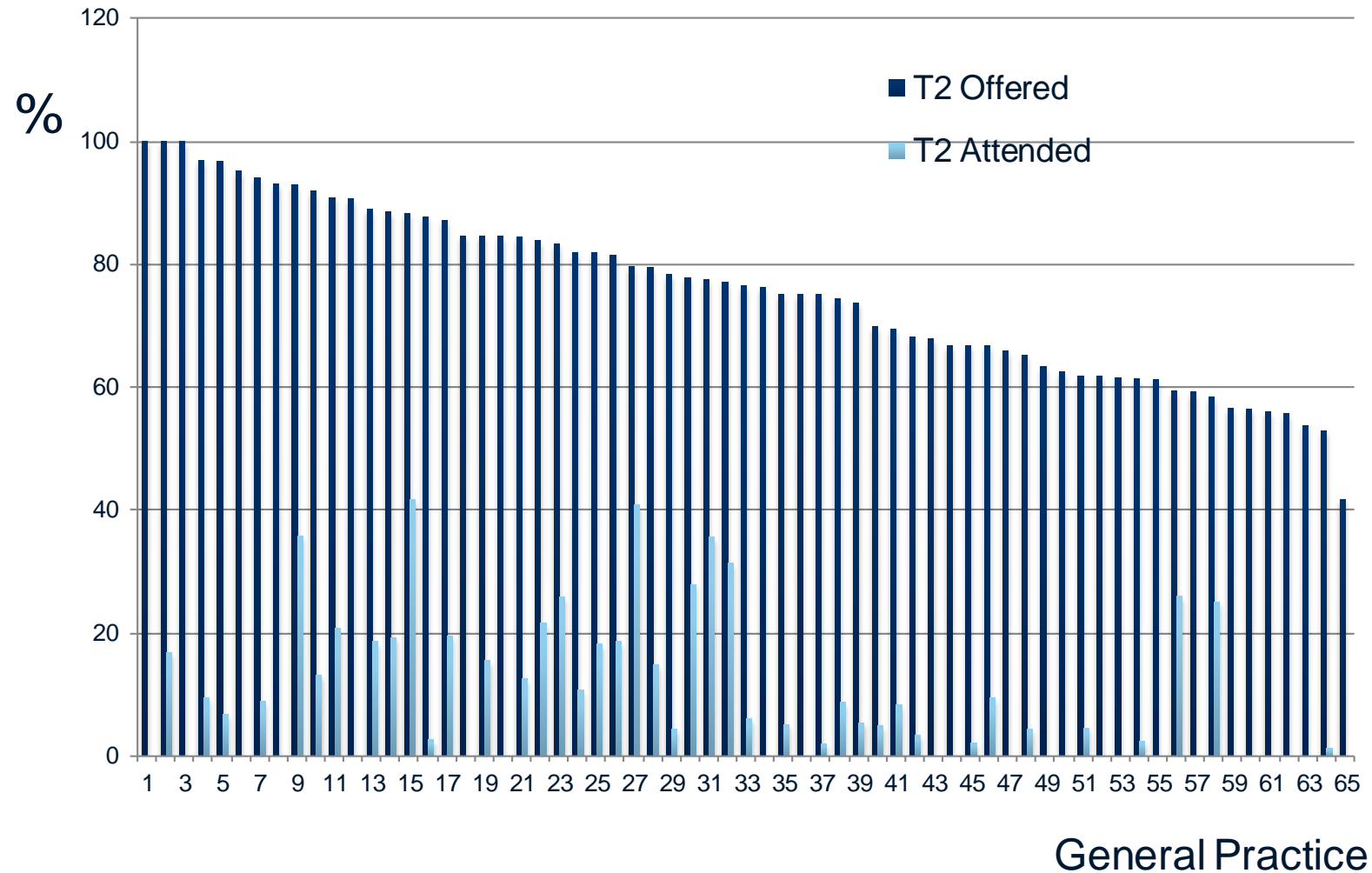
There has been a large increase in records of structured education being offered within one year of diagnosis.

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



Improving Data Recording of
ATTENDANCE
at Diabetes Structured Education

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 I

| 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.



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



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 | <input type="checkbox"/> | 9OLM / XaNTH |
| 2. Did not attend diabetes structured education | <input type="checkbox"/> | 9NiA / XaNTa |
| 3. Attended diabetes structured education | <input type="checkbox"/> | 9OLB / XaKHØ |
| 4. Diabetes structured education completed | <input type="checkbox"/> | 9OLF / XaX5D |

Kind regards,

Diabetes Structured Education Team

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/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.](http://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