# Diabetes Community Health Profile - An Overview

Bolton PCT

The Diabetes Community Health Profiles bring together a wide range of data on diabetes in adults into a single source for the purposes of benchmarking. A Diabetes Community Health Profile is available for every PCT in England at http://yhpho.york.ac.uk/diabetesprofiles/default.aspx. It was last updated on 18th January 2011. Further details of all the data sources used in this profile and direct links to the source data are available in the Data Guide (http://yhpho.york.ac.uk/diabetesprofiles/Data%20Guide-1.pdf).

Map of Bolton PCT
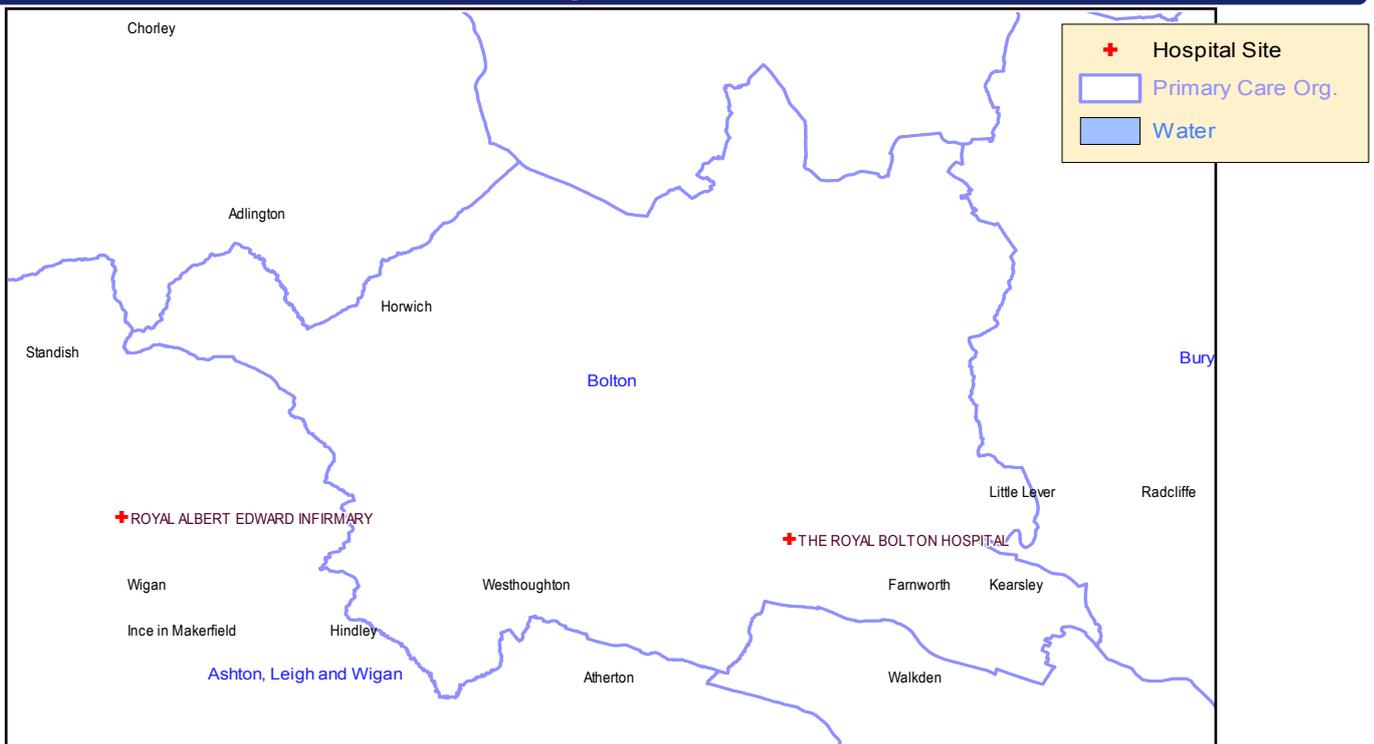
Source : TRUD (NACS) NHS Connecting for Health, ONS PCT Boundaries
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Key Messages

The prevalence of diagnosed diabetes among people aged 17 years and older in Bolton PCT is 6.6% compared to 5.8% in all PCTs with similar diabetes risk factors.

In Bolton PCT 52.1% of all people with diabetes aged 17 years and older have a HbA1c of 7% or less. This is statistically significantly lower than PCTs with populations with similar diabetes risk factors and statistically significantly lower than England as a whole.

The emergency admission rate for diabetic ketoacidosis and coma in Bolton PCT is 5.1 per 1000 people with diabetes compared to 5.8 per 1000 for all PCTs in its cluster group. In Bolton PCT there were 2.7 lower limb amputations per 1000 people with diabetes between 2007/08 and 2009/10 compared to 2.5 per 1000 across England

Analysis of total spending on diabetes care compared to HbA1c outcomes shows that Bolton PCT is not statistically different from England in spending and not statistically different from England in terms of outcomes.

Demographic Characteristics and Predictive Factors for Diabetes

Age Structure of Population

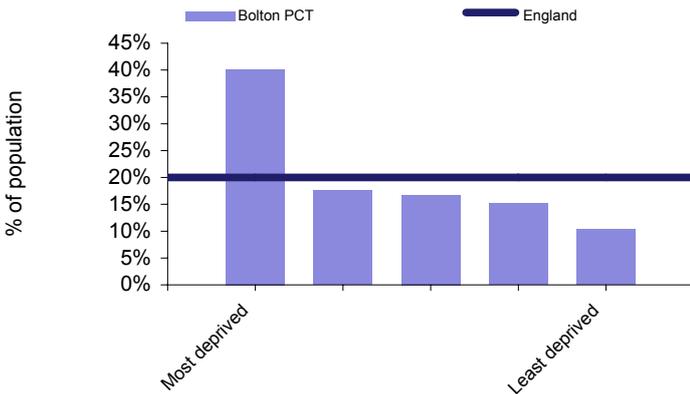Source: ONS mid year population estimates, 2009
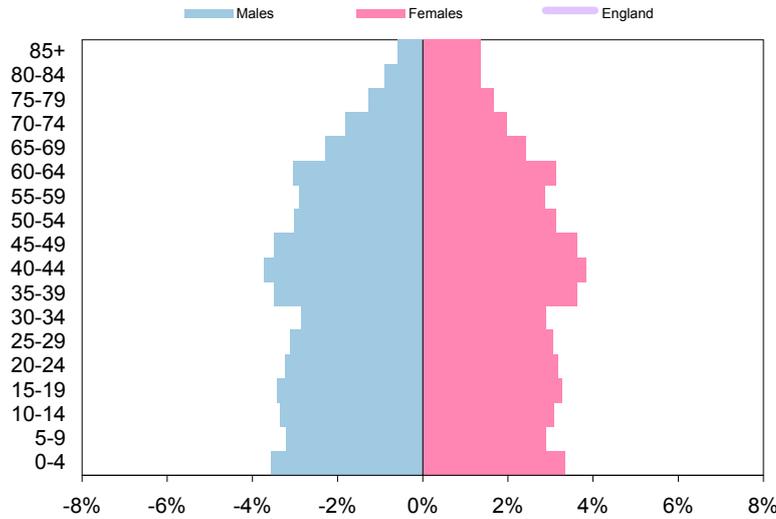
Age is a key factor in diabetes prevalence. Type 1 diabetes tends to be diagnosed in childhood but the prevalence of Type 2 diabetes increases steadily after the age of 45 years.

Diabetes prevalence is higher in areas experiencing deprivation. People living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas. It is known that people from Asian and Black ethnic groups are more likely to have diabetes and tend to develop the condition at younger ages.
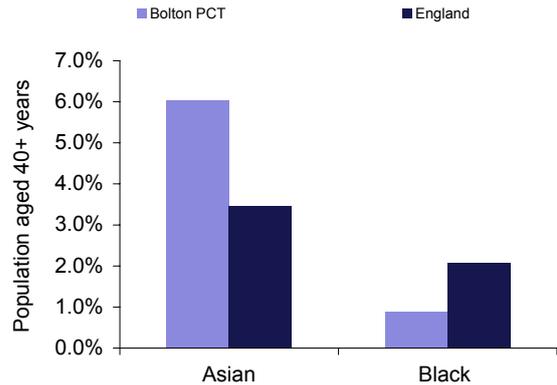
Deprivation in Bolton PCT

Source: IMD2007 and ONS mid year population estimates, 2007

Ethnicity

Source: Calculated from ONS ethnic group population estimate, 2007

Being obese increases the likelihood of someone developing diabetes. It is estimated that 25.1% of adults living in Bolton PCT were obese in 2003-05. This is not significantly different than the whole of England. Across England the prevalence of obesity is rising and it is projected that by 2025 42% of men and 39% of women will be obese.

Diabetes Area Classification

The Diabetes Area Classification for PCTs is a grouping of all PCTs in England based on the main risk factors for diabetes. It allows PCTs to compare and benchmark diabetes services against a group of PCTs that have similar diabetes related characteristics. The following were used to identify the groups

- % of population aged 40 to 64 years
- % of population aged 65 years or older
- % of population aged 40 years and older from Asian ethnic groups
- % of population aged 40 years and older from Black ethnic groups
- Synthetic estimate of obesity
- Indices of Deprivation 2007 (average score)

Bolton PCT is in   Purple Group

Purple group has a relatively young population and high levels of deprivation
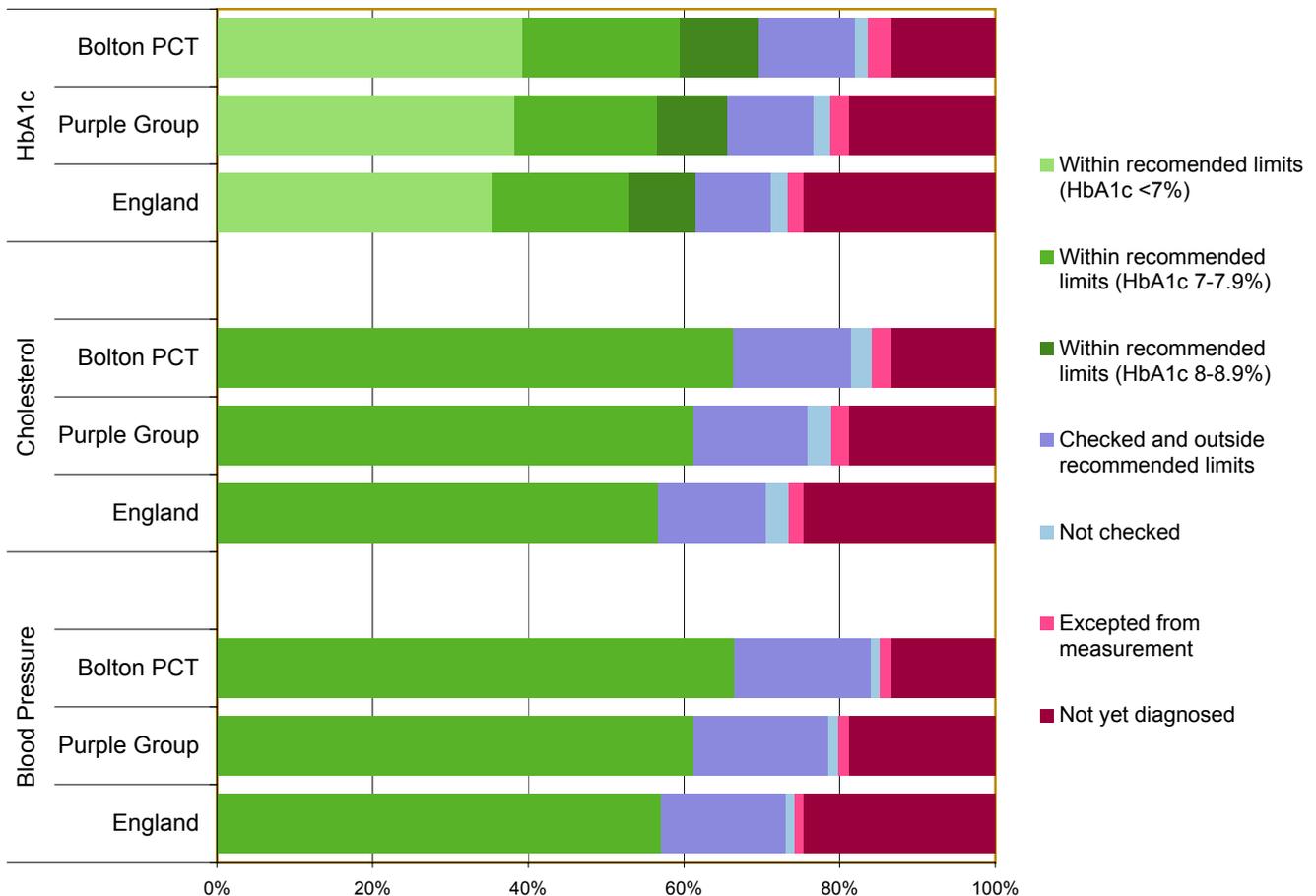
Quantifying Diabetes

In 2009/10 there were 14770 people aged 17 years and older diagnosed with diabetes in Bolton PCT. There is also an estimated 2252 adults with undiagnosed diabetes. The chart below compares the prevalence of diabetes in Bolton PCT with the cluster group and England as a whole.

- Diagnosed diabetes
- Estimated total diabetes
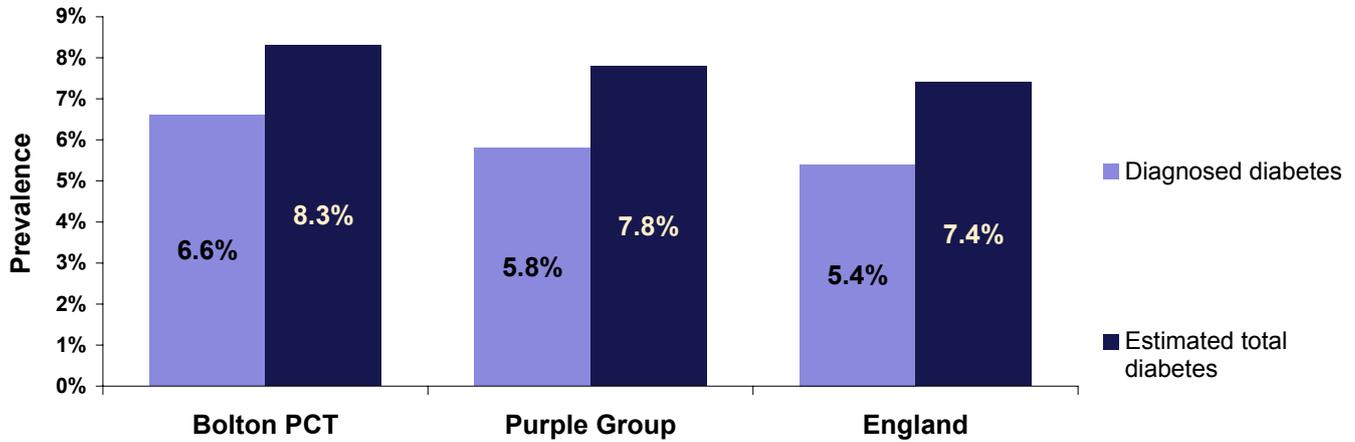
Source: Quality and Outcomes Framework, 2009/10 and APHO Diabetes Prevalence Model

## Care Processes and Treatment Targets

The chart below provides a breakdown of the key aspects of clinical management of patients with diabetes and highlights the measurement and attainment of HbA1c, blood pressure and cholesterol targets in the 15 months ending 1st April 2010. The estimated number of people with undiagnosed diabetes is also shown.

- Within recomended limits (HbA1c <7%)
- Within recommended limits (HbA1c 7-7.9%)
- Within recommended limits (HbA1c 8-8.9%)
- Checked and outside recommended limits
- Not checked
- Excepted from measurement
- Not yet diagnosed

Source: Quality and Outcomes Framework, 2009/10 and APHO Diabetes Prevalence Model

Incidence of Complications

The chart below shows the incidence of complications as recorded in the Hospital Episode Statistics.
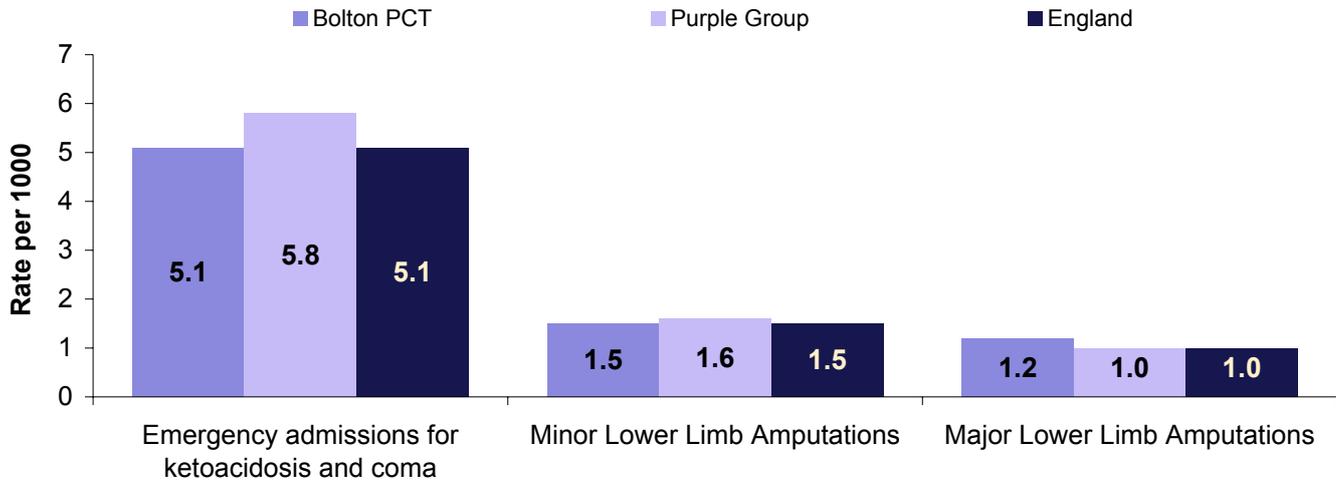
Source: Hospital Episode Statistics (HES) The NHS Information Centre for Health and Social Care, 2007/08, 2008/09 and 2009/10

Across England people with diabetes are twice as likely as people without the condition to die between the ages of 20 and 79 years. It is estimated that during 2005 in Bolton PCT there were 171 deaths in this age group that would have been avoided if people with diabetes had the same mortality rates as those without the condition. If diabetes had not had this impact there would have been 12.1% fewer deaths between the ages of 20 and 79 years.

Provision of Services and Care

The chart below provides some data on indicators of patient experience of diabetes healthcare from 2006. It shows (i) the proportion of people who almost always discuss goals for their diabetes care during appointments, (ii) the percentage of people who have attended a diabetes education event, (iii) the percentage of people who saw a member of a hospital diabetes specialist team during their last hospital inpatient stay and (iv) the proportion of people indicating that all inpatient staff were aware that they had diabetes are also reported. The final two sections of the chart show the percentage of all people with a long term condition that have discussed management with primary care staff and those that feel that they have definately received enough support for managing their long term condition from the GP Patient Survey. Please note these data refer to all people with a long term condition not just those with diabetes.
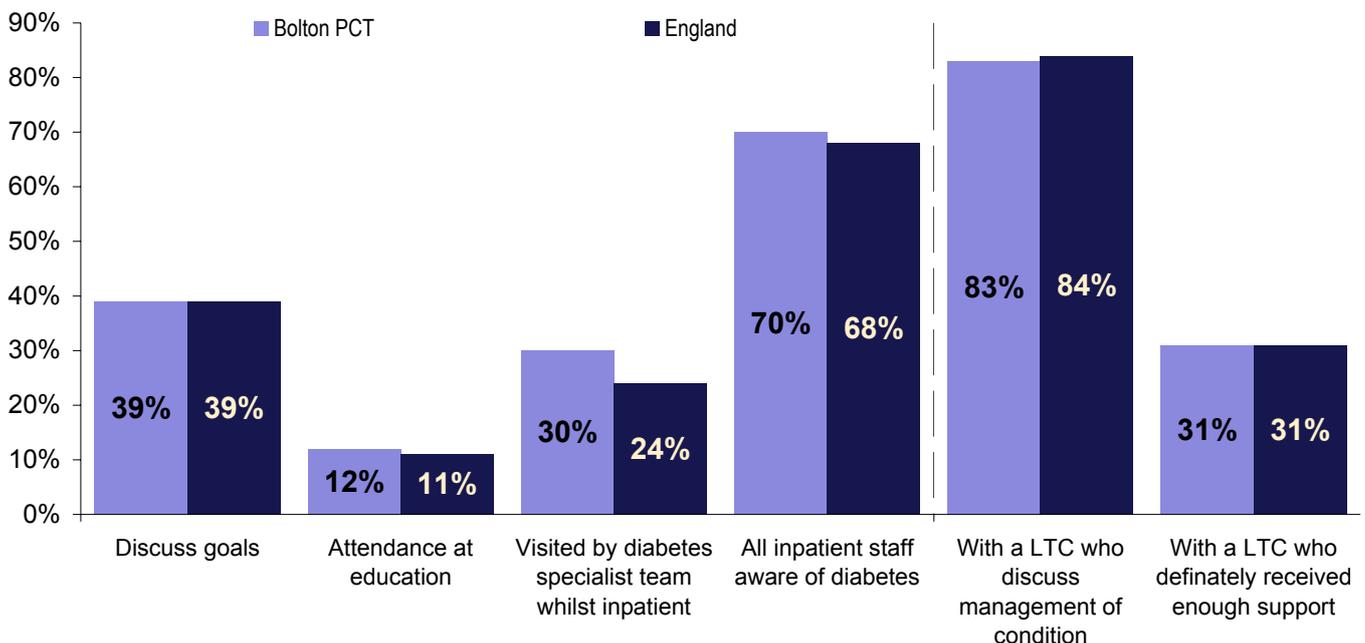

Source: Healthcare Commission Survey, 2006 and GP Patient Survey 2009/10

Spending on Diabetes Care and Outcomes

Quadrant analysis charts (shown below) plot spending on an area of healthcare against an outcome measure. The cost and outcome measures have been standardised to allow direct comparisons across different scales. In these charts the outcome is the percentage of patients with a HbA1c of 7% or less. This an important dimension of diabetes care but does not capture all aspects of care. The cost data has been adjusted to take account of the number of people aged 17 years and older diagnosed with diabetes and therefore the results presented here may differ from other presentations of the Programme Budgeting data. PCTs within the dotted box do not have a statistically significant different level of spending and outcomes than England as a whole.

Programme Budgeting Data and HbA1c Outcomes for 2009/10

The chart below shows standardised total spending on diabetes care based on Programme Budgeting data against the standardised proportion of people with a HbA1c measurement of 7% or less for 2009/10.

Source: PBMA data, 2009/1008 and Quality and Outcomes Framework, 2009/10
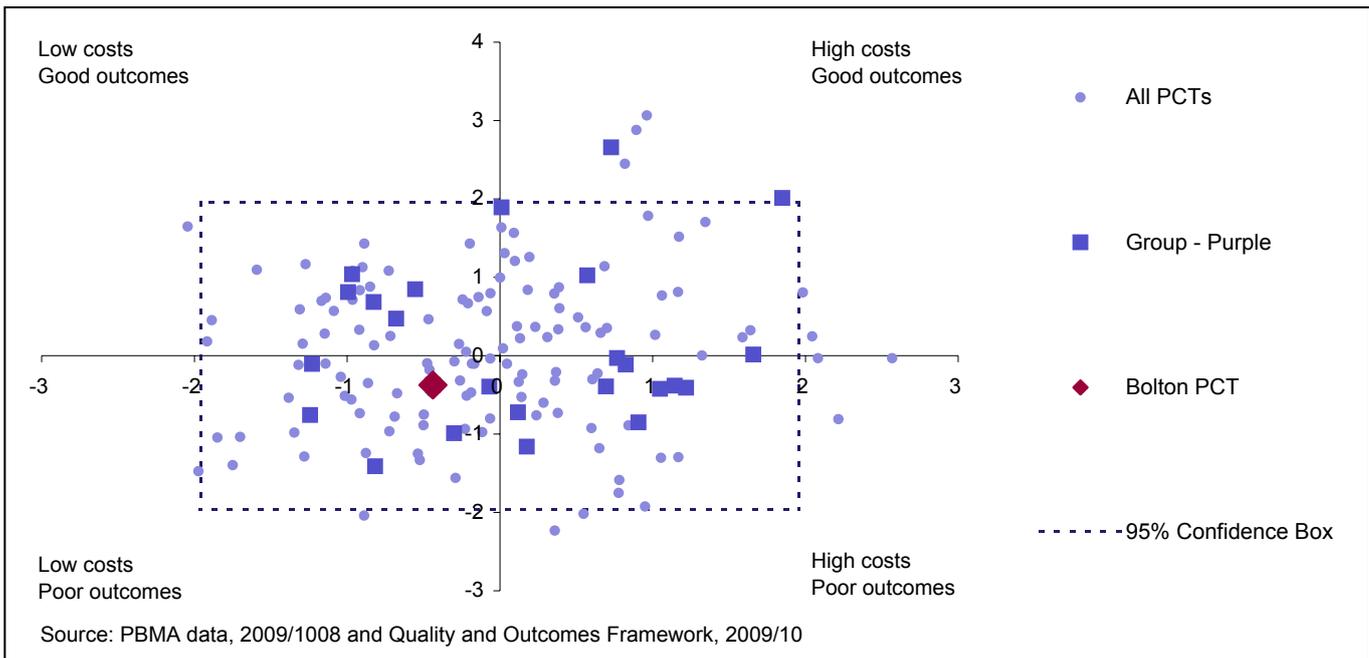
Spending on Diabetes Prescriptions and HbA1c Outcomes for 2009/10

The chart below shows the standardised Net Ingredient Cost (NIC) of all prescriptions for items to treat and monitor diabetes per patient diagnosed with diabetes between April 2009 and March 2010 against the standardised proportion of people with a HbA1c measurement of 7% or less for 2009/10.

Source: Information Centre, 2009/10 and Quality and Outcomes Framework, 2009/10
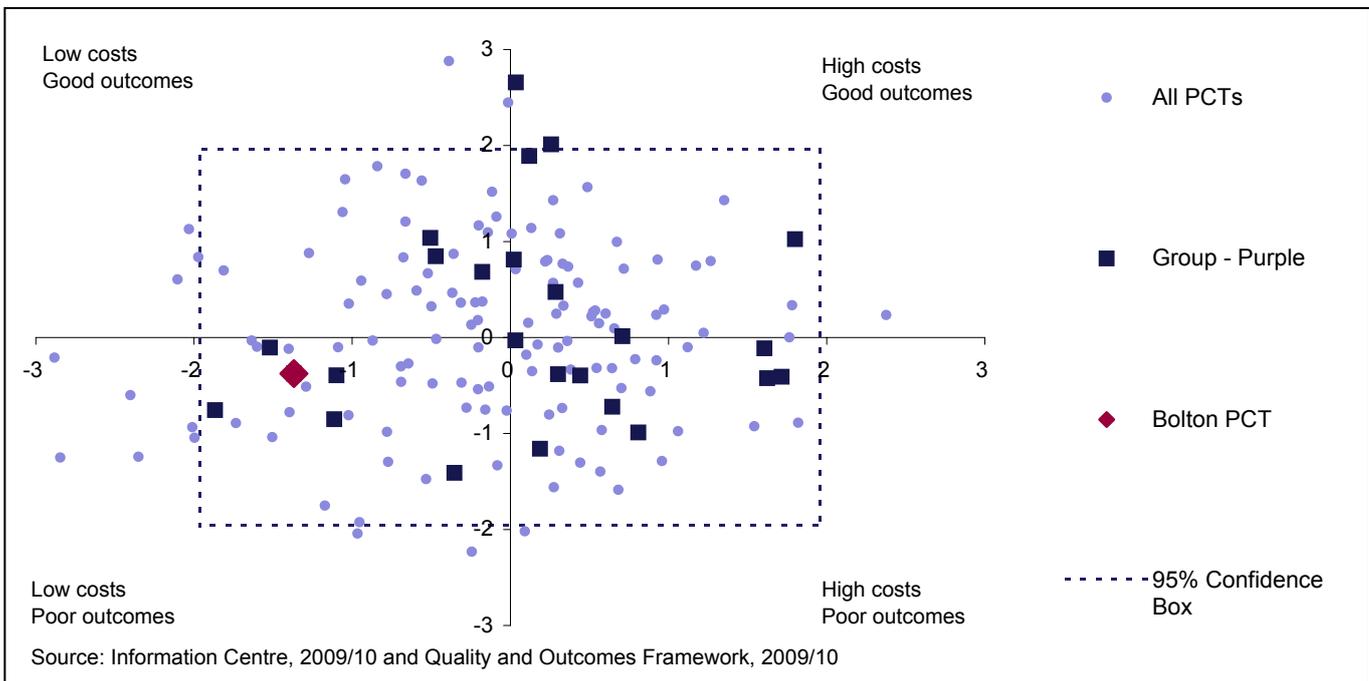
Diabetes Health Intelligence is a strategic programme of Yorkshire and Humber Public Health Observatory providing national diabetes health intelligence.

These profiles have been developed under the auspices of the National Diabetes Information Service (NDIS) which is a collaboration between a range of diabetes related organisations. NDIS is wholly funded by NHS Diabetes.
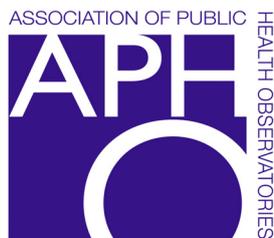
The Association of Public Health Observatories represents a network of 12 Public Health Observatories working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland.

The data within these profiles has been provided by:-