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 31st January 2012. 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).

The prevalence of diagnosed diabetes among people aged 17 years and older in NHS East Sussex Downs and Weald is 5.3% compared to 5.4% in all PCTs with similar diabetes risk factors.

In NHS East Sussex Downs and Weald 58.7% of all people with diabetes aged 17 years and older who are not excepted from the Quality and Outcomes Framework have a HbA1c of 7% or less. This is statistically significantly higher than PCTs with populations with similar diabetes risk factors and statistically significantly higher than England as a whole.

Of the people with diabetes included in the National Diabetes Audit in NHS East Sussex Downs and Weald 5.7 per 1000 had had a stroke in the previous year compared to 6.9 per 1000 across the whole of England. In NHS East Sussex Downs and Weald 4.4 per 1000 of people with diabetes had a myocardial infarction in the previous year compared to 5.8 per 1000 in all PCTs in its cluster group.

Analysis of total spending on diabetes care compared to HbA1c outcomes shows that NHS East Sussex Downs and Weald is not statistically different from England in programme budgeting spending and not statistically different from England in terms of HbA1c outcomes.
Demographic Characteristics and Predictive Factors for Diabetes

**Age Structure of Population**

- % 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)

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 NHS East Sussex Downs and Weald**

- % of population aged 40+ years

Being obese increases the likelihood of someone developing diabetes. It is estimated that 23.6% of adults living in NHS East Sussex Downs and Weald were obese in 2006-08. This is not statistically significantly different from 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.

**Ethnicity**

- % of population

**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)

NHS East Sussex Downs and Weald is in **Yellow Group**

Yellow group has a greater proportion of the population aged 40+ years with generally low levels of deprivation.
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, cholesterol, retinal screening, peripheral pulses and neuropathy testing in the 15 months ending 1st April 2011. The estimated number of people with undiagnosed diabetes is also shown.

### 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, cholesterol, retinal screening, peripheral pulses and neuropathy testing in the 15 months ending 1st April 2011. The estimated number of people with undiagnosed diabetes is also shown.

### Quantifying Diabetes

In 2010/11 there were 15037 people aged 17 years and older diagnosed with diabetes in NHS East Sussex Downs and Weald. There is also an estimated 7799 adults with undiagnosed diabetes. The chart below compares the prevalence of diabetes in NHS East Sussex Downs and Weald with the cluster group and England as a whole.

### Source

- **Diagnosis**: Quality and Outcomes Framework, 2010/11 and APHO Diabetes Prevalence Model
- **Treatment targets**: Quality and Outcomes Framework, 2010/11 and APHO Diabetes Prevalence Model
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 NHS East Sussex Downs and Weald there were 180 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 11.4% fewer deaths between the ages of 20 and 79 years.

### Prevalence of Complications

The chart below shows the prevalence of complications as recorded in the National Diabetes Audit. This gives the percentage of people with diabetes included in the National Diabetes Audit with a hospital admission that mentions the complication. These figures are not age standardised therefore variation in the demographic characteristics of people with diabetes may impact on the prevalence of complications.

### Provision of Services and Care

The chart below provides data on patient experience for people with a long term condition from the GP patient survey (not just those with diabetes). It shows, (i) the percentage of all people with a long term condition that have discussed with their doctor or nurse the management of their health problem, and of those, (ii) those who agreed with their doctor or nurse on how best to manage their health problem, (iii) those that feel that they have definitely received enough support for managing their health problem and (iv) those who had been told they had a "care" plan.
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 2010/11
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 2010/11.

Spending on Diabetes Prescriptions and HbA1c Outcomes for 2010/11
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 2010 and March 2011 against the standardised proportion of people with a HbA1c measurement of 7% or less for 2010/11.
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:*