



# Resource impact statement

Resource impact

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## Indicator

The percentage of patients newly diagnosed with diabetes in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months of entry on to the diabetes register.

## Introduction

This report provides a high-level cost impact assessment for one indicator relating to diabetes piloted for the 2012/13 NICE menu of indicators for QOF. The purpose of the indicator is to provide an education programme to help enable people with diabetes to manage their condition. This is consistent with quality statement 1: structured education of the NICE quality standard on diabetes in adults which states:

‘People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.’

This indicator can either be delivered in-house or by referral to specific external courses.

There are a number of structured educational programmes available for diabetes. Some programmes will be more suitable for type 1 diabetes, and others for type 2 diabetes.

In order to provide an assessment of the estimated costs for this indicator we have used costs for the Dose adjustment for normal eating (DAFNE) programme for people with type 1 diabetes and the Diabetes education and self-management for ongoing and newly diagnosed (DESMOND) programme for people with type 2 diabetes.

## Cost implication

### Patient numbers affected

Analysis of published England level QOF data by the Information Centre from 2004 to present, suggests the number of people recorded with a diagnosis of diabetes on the QOF diabetes register increased by an average of 5.5% per annum. In 2009/10 there were 2.3 million people on the diabetes register which, following current trends, suggests there will be an estimated increase of 127,465 in 2011/12. Assuming the expected uptake for this indicator would be 90%, an estimated target population of 114,719 is assumed. It is estimated that of 90% of these have type 2 diabetes and 10% have type 1 diabetes.

### Current care

Information from pilot data suggests that 60% of GP practices have access to DESMOND courses, but DAFNE courses are less widely available. The pilot data also suggested that 40% of GP practices provided in-house structured education, but that generally, people with type 1 diabetes were either referred or seen and advised by secondary care services. The cost of implementing this indicator is therefore based on the estimated costs of DESMOND and DAFNE courses.

For costing purposes it has been assumed that in people with type 2 diabetes 60% attend DESMOND or similar courses, and 40% of diabetes education is delivered in-house by the GP practice. Analysis suggests that delivering the equivalent course in-house costs 27% less.

For type 1 diabetes, analysis suggests that attendance at a DAFNE course has a similar cost to treatment in secondary care.

A survey in 2009 by Diabetes UK found that 36% of people with diabetes said that they had attended a course to help them manage their diabetes since they were diagnosed. This compares to Diabetes UK's 2006 survey where only 10% of people with diabetes had attended a course in the previous 12 months. This suggests an average annual increase in attendance at structured education programmes of 5.3%.

Publication of the NICE Quality standard for diabetes in adults and Commissioning guide on patient education programmes for people with type 2 diabetes is expected to have further increased the provision and therefore uptake of structured education programmes.

Given the available information on uptake of diabetes structured education courses and anticipated increases in uptake, a current baseline of 50% is assumed.

## Proposed care

The NICE commissioning guide on patient education programmes for people with type 2 diabetes, uses a benchmark for potential annual uptake of structured education programmes in people aged 15 years and older newly diagnosed with type 2 diabetes of 75%. This has been used as the expected level of future uptake for structured education programmes to estimate the costs associated with implementing this indicator.

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The cost of implementing this indicator, based on the assumptions outlined above for the current baseline and expected future achievement is set out in table 1.

**Table 1 Estimated cost of referral to a diabetes structured education programme for England**

Detail	Units	Units
No. of people eligible for structured education		127,465
Expected uptake	90%	114,719

Current baseline (people currently receiving structured education)	50%	57,359
Future activity	75%	86,039
Number of people requiring structured education	25%	28,680
People with type 2 diabetes	90%	25,812
% delivery of external courses for type 2 diabetes	60%	15,487
% delivery of in house courses for type 2 diabetes	40%	10,325
Cost of type 2 structured education programme (external)	£64	£991,168
Cost of type 2 structured education programme (in-house)	£47	£485,259
People with type 1 diabetes	10%	2,868
Cost of type 1 structured education programme	£325	£932,088
Total estimated baseline costs for diabetes structured education programmes		£2,408,515

The pilot data stated that implementation of this indicator 'represented little in the way of new work'. Therefore it is reasonable to assume that there will be little additional work for GP practices as a result of implementation of these indicators. There will, however, be additional commissioning costs for the increase in structured education programmes as outlined above.

## Sensitivity analysis

The cost analysis above assumes that the increase in provision of structured education programmes maintains the same proportion of external and internal structured education programmes, namely a 60/40% split. Pilot data suggested that GP practices would prefer to refer to DESMOND and DAFNE courses rather than delivering in-house structured education if these were available.

A sensitivity analysis has been performed to predict cost behaviour if this relationship changes in the future. If the split is 70% to 30% external/internal then the cost range will be £1.6 million to £2.5 million, and if the split is 80% to 20% external/internal then the cost range will be £1.7 million to £2.7 million.

## Potential savings

The NICE cost impact and commissioning assessment for the quality standard on diabetes in adults draws attention to potential savings resulting from the use of diabetes structured education programmes. It states that: 'there is some evidence for the positive effects of structured education, which is reviewed in 'Structured education and diabetes' developed by NHS Diabetes.

Some programmes have demonstrated improvements in biomedical outcomes and this could be expected to result in a reduction in the number of repeat visits for treatment. Emergency hospital admissions may also be avoided, the costs of which (for a non-elective diabetes-related admission for hypoglycaemic or hyperglycaemic disorders) range from £816 to £3570 (national tariff 2011/12)'.

Implementation of this indicator will also support the implementation of the NICE menu indicator NM28 around diabetes dietary review as information on diet is delivered as part of structured education programmes.

## Conclusions

The direct cost of implementing the proposed diabetes structured education indicator is not expected to be significant for GP practices. It is, however, anticipated that there could be additional commissioning costs for the provision of structured education programmes.

Based on current provision of diabetes structured education programmes and assuming an uptake of 90%, the incremental cost of implementing this indicator is estimated to be £2.41 million. These costs may be offset by a reduction in future GP visits for people with diabetes, and avoidance of future emergency diabetes-related hospital admissions.

## References

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