Time for Action on Diabetes Management Optimisation

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Purpose of Diabetes Medicine Optimisation Opportunities Pack
May 25 edition

To provide Practices with data and outlining some key **Diabetes Medicine Optimisation Opportunities**, which may support improved patient outcomes and prescribing efficiencies.
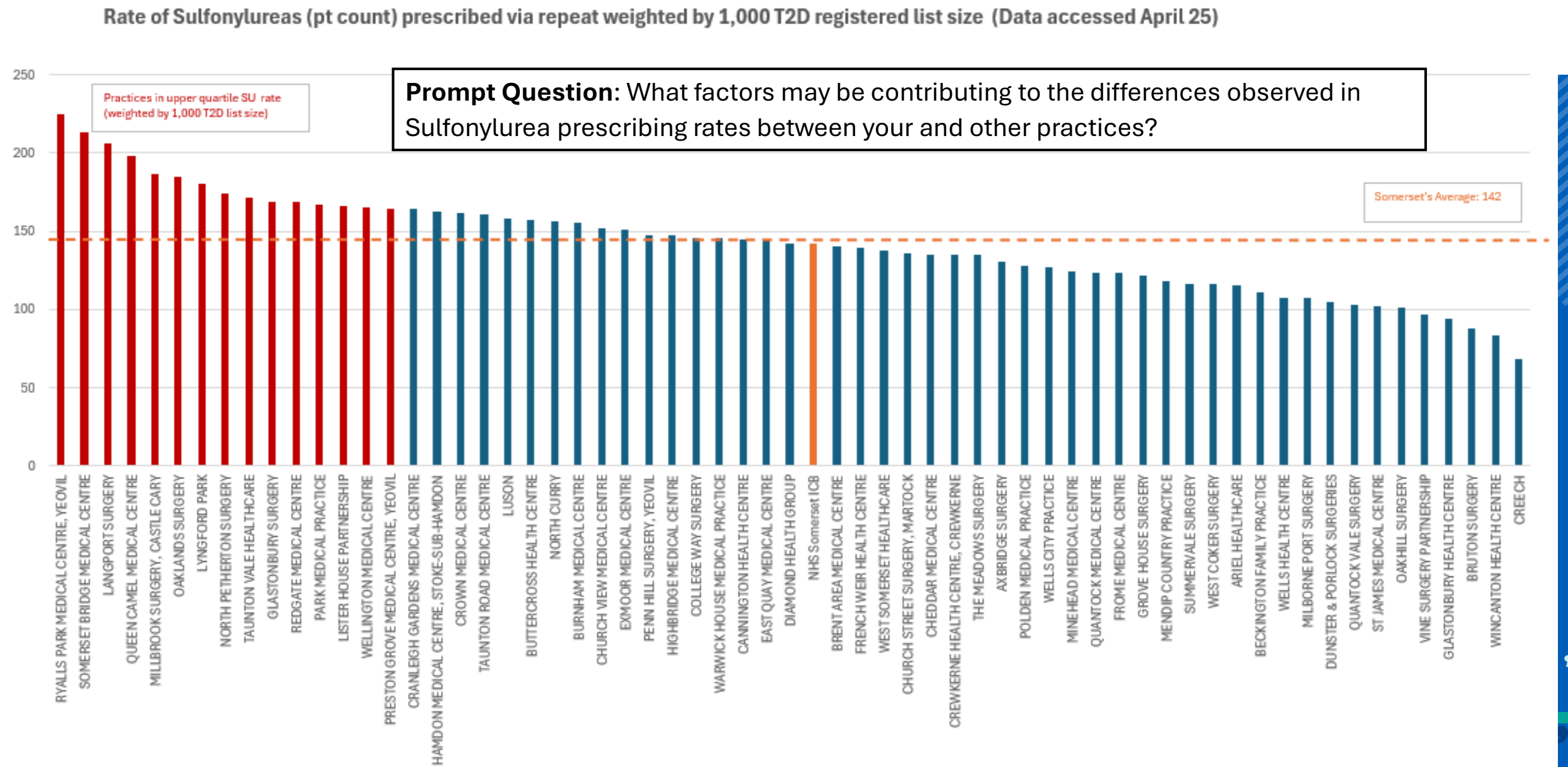
As a first step, the pack share opportunities under the following key themes by practice:

- *Treatment to Threshold Standard (BP, HbA1c, Cholesterol)*
- *Early Onset Type 2 Diabetes management*
- *Diabetes Medicine Safety*
- *Diabetes Medicine Value Optimisation*
- *Access to Evidence-Based Treatment*
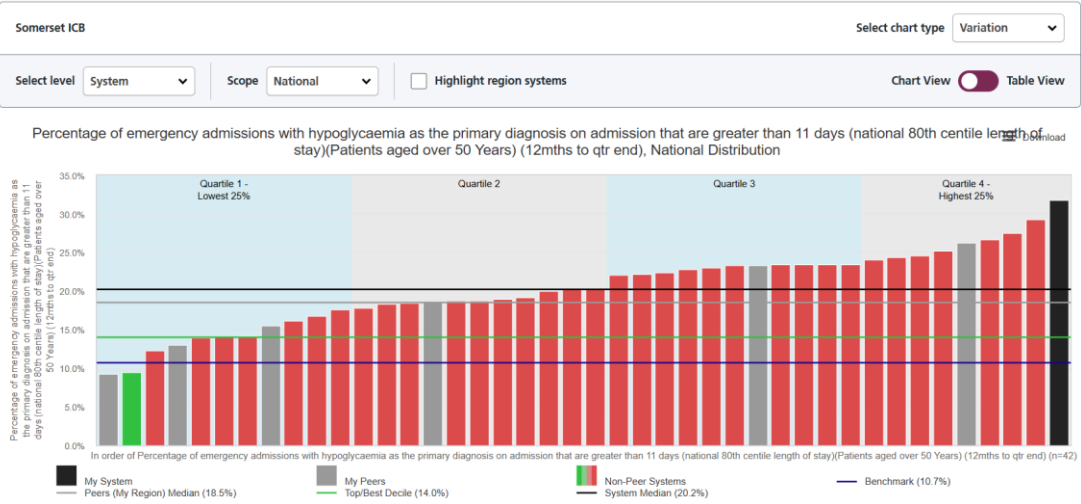- *Diabetes Care Pathway – Care Process Monitoring*

Somerset Diabetes Medicine Optimisation Opportunities - May 2025	Treatment to Target				Early On Set T2D (Age 18-39Ys)		Diabetes Care Pathway - Protect with Appropriate Monitoring Equality of Access to Best Practice Monitoring			
Note: The data reflects the time at which it was extracted from the respective data sources, and the figures are subject to change based on practice activities undertaken.	T2D % Hba1c in range	T2D.% BP in range	T2D % cholesterol - Patient on statin	T2D % all 3 in range	% of EOT2D pt WITH all 8 Key Care processes undertaken in last 12M	Number of women pre-conception counselling NOT complete (females)	Percentage of Diabetes (T1&T2) patients with all 8 care processes undertaken in last 12 months	Percentage of Diabetes (T1) patients with all 8 care processes undertaken in last 12 months	Percentage of Diabetes (T2) patients with all 8 care processes undertaken in last 12 months	Percentage of T2 Diabetes with - BAME / Deprivation decile 1-2 / Learning Disability / Mental Health with all 8 care processes undertaken in last 12 months
Data Sources	Eclipse NDA Live	Eclipse NDA Live	Eclipse NDA Live	Eclipse NDA Live	Eclipse T2D Hub	Eclipse T2D Hub	Eclipse NDA Live	Eclipse NDA Live	Eclipse NDA Live	Eclipse Diabetes Protect
System Target	>75%	>75%	>75%	>75%	>75%	Lower the better	>75%	>75%	>75%	>75%
NHS Somerset ICB Present as either "Average Performance in Percentage" or "Sum of Patient Count"	58.99%	71.94%	75.97%	35.74%	40.46%	522	59.50%	45.67%	60.82%	58.18%
Practice										
ARIEL HEALTHCARE	58.25%	68.71%	72.26%	32.50%	40.00%	14	55.71%	42.37%	56.54%	54.07%
AXBRIDGE SURGERY	69.88%	75.41%	74.18%	43.65%	50.00%	3	77.65%	81.48%	78.28%	76.92%
BECKINGTON FAMILY PRACTICE	70.39%	71.99%	77.48%	43.44%	53.33%	10	69.12%	62.90%	70.21%	57.58%
BRENT AREA MEDICAL CENTRE	68.35%	62.59%	79.86%	41.01%	71.43%	5	56.86%	30.43%	58.27%	37.50%
BRUTON SURGERY	56.33%	59.39%	77.73%	31.44%	0.00%	0	55.91%	43.33%	58.52%	80.00%
BURNHAM MEDICAL CENTRE	51.09%	70.09%	76.93%	31.00%	27.78%	9	51.45%	32.14%	52.62%	41.01%
BUTTERCROSS HEALTH CENTRE	54.19%	68.10%	73.21%	29.86%	45.45%	5	45.75%	21.43%	47.24%	52.63%
CANNINGTON HEALTH CENTRE	59.01%	68.02%	77.03%	31.10%	85.71%	5	71.82%	66.67%	73.26%	64.71%

Example of May 25 Edition, appreciate that it may not yet capture all relevant diabetes workstreams. Your feedback and insights would be invaluable in shaping future updates to ensure alignment with key local priorities and Medicines Optimisation objectives.

Observations One - Rising Trends in Sulfonylurea Prescribing

Rate of Sulfonylureas (pt count) prescribed via repeat weighted by 1,000 T2D registered list size (Data accessed April 25)

Prompt Question: What factors may be contributing to the differences observed in Sulfonylurea prescribing rates between your and other practices?

Observations One - Rising Trends in Sulfonylurea Prescribing

Somerset ICB | Select chart type: Variation

Select level: System | Scope: National | Highlight region systems | Chart View / Table View

Percentage of emergency admissions with hypoglycaemia as the primary diagnosis on admission that are greater than 11 days (national 80th centile length of stay)(Patients aged over 50 Years) (12mths to qtr end), National Distribution

In order of Percentage of emergency admissions with hypoglycaemia as the primary diagnosis on admission that are greater than 11 days (national 80th centile length of stay)(Patients aged over 50 Years) (12mths to qtr end) (n=42)

- My System
- Peers (My Region) Median (18.5%)
- My Peers
- Top/Best Decile (14.0%)
- Non-Peer Systems
- System Median (20.2%)
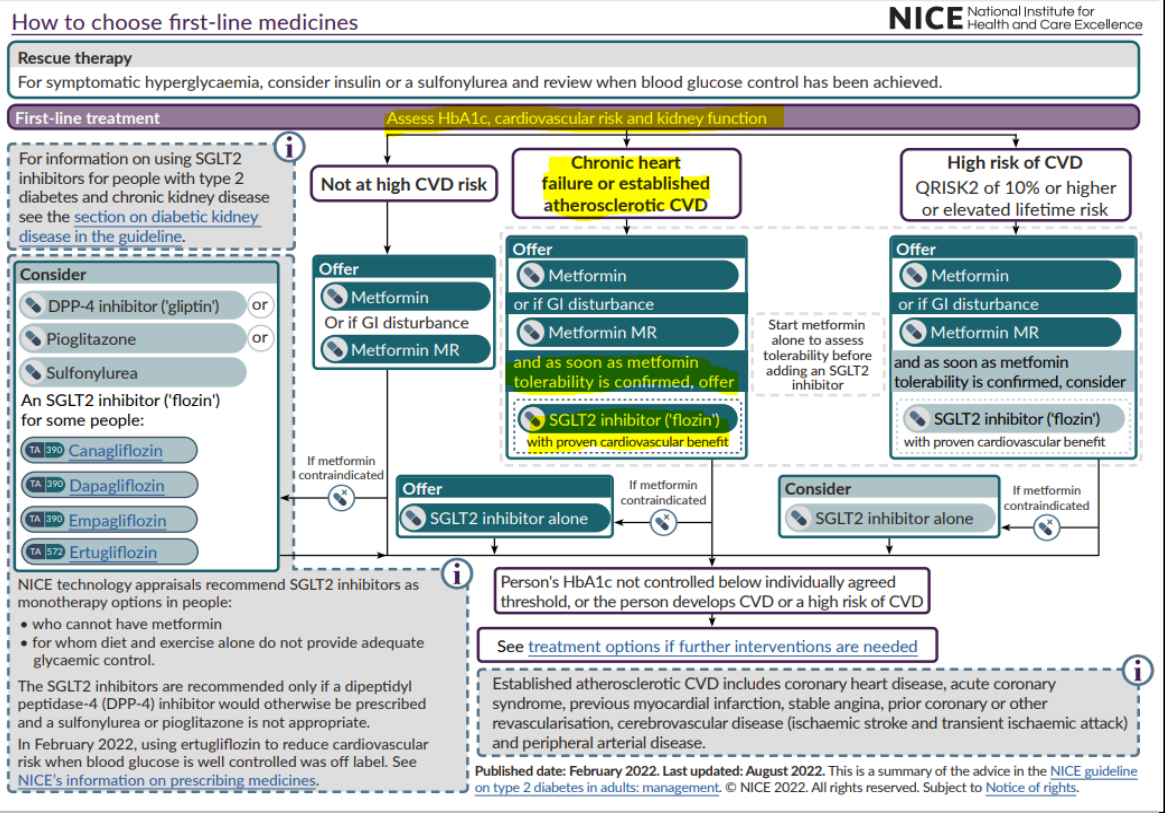- Benchmark (10.7%)

Observation - Outcome

- **Q3 24/25 admission data** (12months rolling) indicates Somerset has the **highest rate of emergency admissions for hypoglycaemia – length of stay** (as the primary diagnosis) compared to other systems. While we cannot definitively establish a causal relationship from this data alone, these findings warrant further investigation to better understand potential contributing factors and to inform targeted quality improvement efforts.

- Eclipse Live searches identify **over 100 patients** with moderate to severe frailty prescribed sulfonylureas in the past 90 days, with their most recent documented HbA1c being below 48 mmol/mol.

Search result in Eclipse Solution

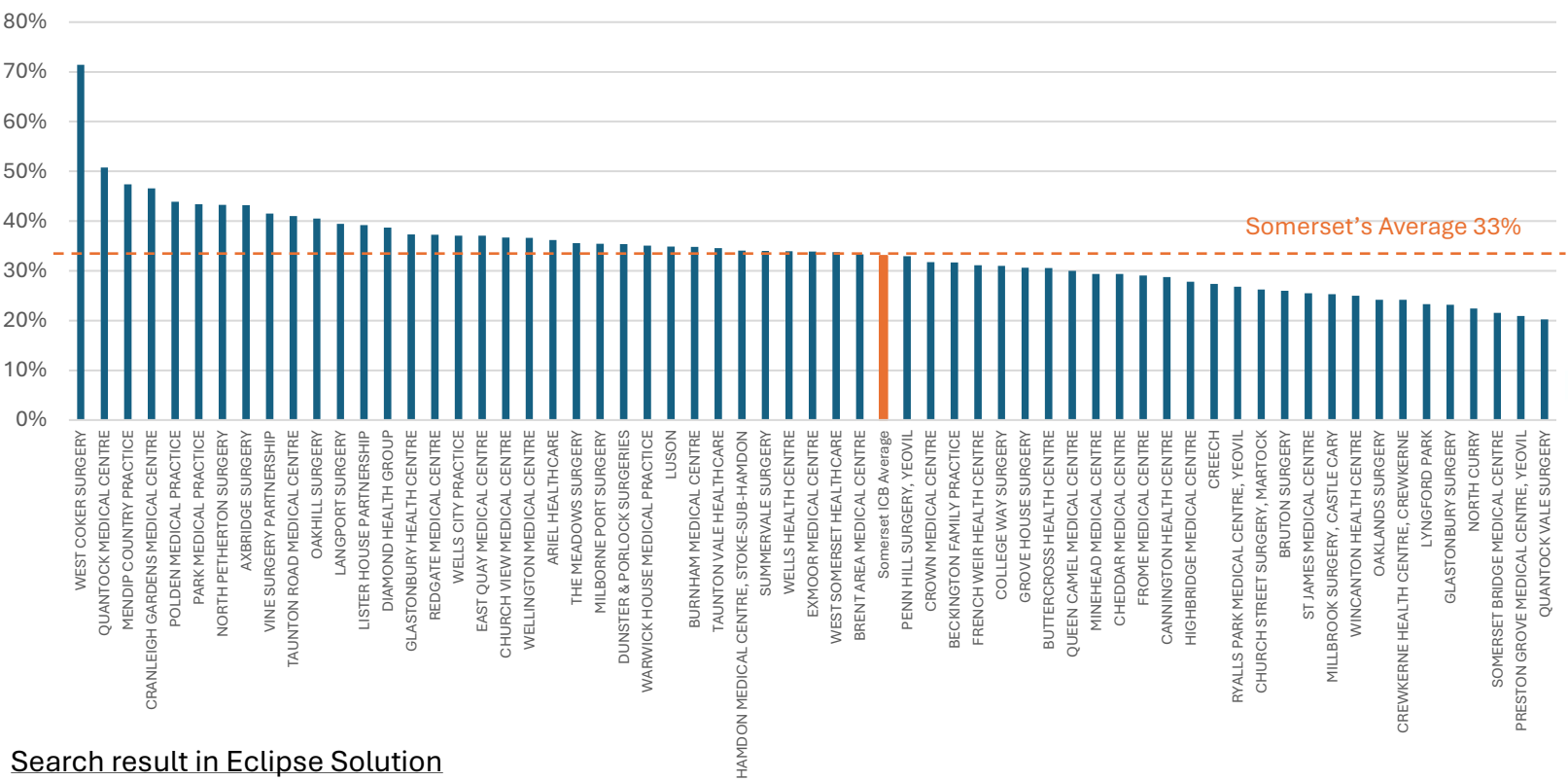|	Diabetes	Diabetes	Diabetes Medicine Value 04b: Patients (all age) with Mod- Severe Frail prescribed a sulfonylurea in last 90 days with HbA1c <48	28/04/2025	101	0
ⓘ			Identified number of patient(all age) with Mod- Severe Frail prescribed a sulfonylurea in last 90 days with HbA1c <48. High risk of hypoglycaemia and falls. Consider review glucose lowering therapy agents as appropriate			

Reminder on Prescribing Consideration:

In line with the growing outcome evidence and national guidance, NICE NG28 now encourages the identification of those T2D patients with either atherosclerotic cardiovascular disease (ASCVD), chronic heart failure or high risk of CVD. For patients falling into any of these categories (either at initial assessment or during follow-up), consider offer **SGLT2 inhibitor with proven cardiovascular benefit**. The choice of treatment should always be based on individual clinical circumstances, including comorbidities, contraindications, weight, and risks related to polypharmacy. (See NICE NG28 Visual summary on first-line medicines for type 2 diabetes.)

How to choose first-line medicines

NICE National Institute for Health and Care Excellence

Rescue therapy
For symptomatic hyperglycaemia, consider insulin or a sulfonylurea and review when blood glucose control has been achieved.

First-line treatment — Assess HbA1c, cardiovascular risk and kidney function

For information on using SGLT2 inhibitors for people with type 2 diabetes and chronic kidney disease see the section on diabetic kidney disease in the guideline.

Not at high CVD risk

Chronic heart failure or established atherosclerotic CVD

High risk of CVD
QRISK2 of 10% or higher or elevated lifetime risk

Consider
- DPP-4 inhibitor ('gliptin') or
- Pioglitazone or
- Sulfonylurea

An SGLT2 inhibitor ('flozin') for some people:
- TA 390 Canagliflozin
- TA 390 Dapagliflozin
- TA 390 Empagliflozin
- TA 572 Ertugliflozin

Offer
- Metformin
- Or if GI disturbance
- Metformin MR

If metformin contraindicated

Offer SGLT2 inhibitor alone
If metformin contraindicated

Offer
- Metformin
- or if GI disturbance
- Metformin MR
- and as soon as metformin tolerability is confirmed, offer SGLT2 inhibitor ('flozin') with proven cardiovascular benefit

Start metformin alone to assess tolerability before adding an SGLT2 inhibitor

Offer
- Metformin
- or if GI disturbance
- Metformin MR
- and as soon as metformin tolerability is confirmed, consider SGLT2 inhibitor ('flozin') with proven cardiovascular benefit

Consider SGLT2 inhibitor alone
If metformin contraindicated

Person's HbA1c not controlled below individually agreed threshold, or the person develops CVD or a high risk of CVD

See treatment options if further interventions are needed

Established atherosclerotic CVD includes coronary heart disease, acute coronary syndrome, previous myocardial infarction, stable angina, prior coronary or other revascularisation, cerebrovascular disease (ischaemic stroke and transient ischaemic attack) and peripheral arterial disease.

NICE technology appraisals recommend SGLT2 inhibitors as monotherapy options in people:
- who cannot have metformin
- for whom diet and exercise alone do not provide adequate glycaemic control.

The SGLT2 inhibitors are recommended only if a dipeptidyl peptidase-4 (DPP-4) inhibitor would otherwise be prescribed and a sulfonylurea or pioglitazone is not appropriate. In February 2022, using ertugliflozin to reduce cardiovascular risk when blood glucose is well controlled was off label. See NICE's information on prescribing medicines.

Published date: February 2022. Last updated: August 2022. This is a summary of the advice in the NICE guideline on type 2 diabetes in adults: management. © NICE 2022. All rights reserved. Subject to Notice of rights.

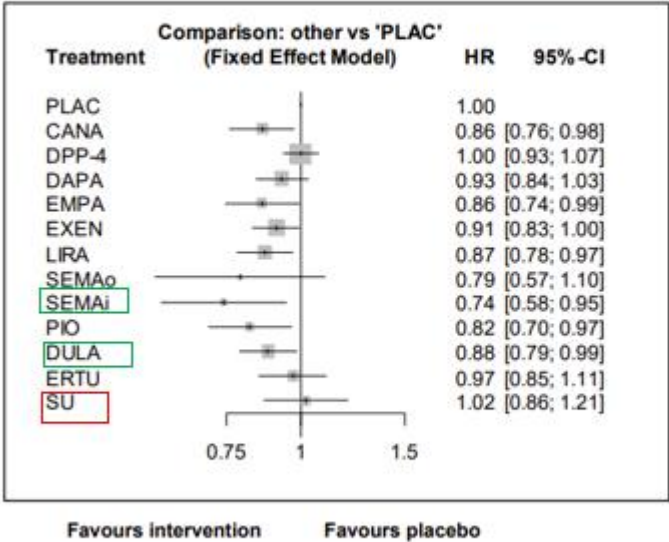# Observations Two – SGLT-2 in T2D Patient with history of CVD

Observation
- ePACT2 data shows an increasing trend in SGLT-2 inhibitor prescribing within Somerset ICB, with dapagliflozin having the highest growth among individual agents.
- However, there **remains a significant unmet need** in optimizing SGLT-2 use for patients with type 2 diabetes (T2D) and a history of cardiovascular disease (CVD), as recommended by NICE NG28. As of May 2025, Eclipse data indicates that only around **33%** of T2D patients with CVD are prescribed an SGLT-2 inhibitor.

Percentage of T2D patient with hx of CVD and on SGLT2 in last 90 days
(Priority group to start SGLT2 as per NG28 CVD evidence) – May 2025

Somerset's Average 33%

Search result in Eclipse Solution

| Diabetes | Diabetes | **Diabetes Medicine Access 01: Type 2 DM + hx of CVD not on SGLT2** Priority group for switching to SGLT2. NICE NG 28 suggests that T2 diabetics with chronic heart failure or established atherosclerotic CVD be offered any SGLT-2 (except ertogliflozin) in addition to metformin | 01/06/2025 | 6059 | 0 | View / Run / Edit / Delete |
| Diabetes | Polypharmacy Review | **Diabetes and Gout - switch gliptin to SGLT2?** SGLT2s offer additional urate lowering by increasing uric acid excretionhttps://diabetesonthenet.com/wp-content/uploads/9.-Distilled_Gout.pdf | | | | |

Caterpillar plot for 3-point MACE

Figure 26 Relative effectiveness of all options versus placebo. (Hazard ratios with 95% confidence intervals and line of no effect as the vertical line at 1).

Treatment	Comparison: other vs 'PLAC' (Fixed Effect Model)	HR	95% -CI
PLAC		1.00	
CANA		0.86	[0.76; 0.98]
DPP-4		1.00	[0.93; 1.07]
DAPA		0.93	[0.84; 1.03]
EMPA		0.86	[0.74; 0.99]
EXEN		0.91	[0.83; 1.00]
LIRA		0.87	[0.78; 0.97]
SEMAo		0.79	[0.57; 1.10]
SEMAi		0.74	[0.58; 0.95]
PIO		0.82	[0.70; 0.97]
DULA		0.88	[0.79; 0.99]
ERTU		0.97	[0.85; 1.11]
SU		1.02	[0.86; 1.21]

Favours intervention   Favours placebo

NICE NG28 3-point MACE (CVD death, nonfatal MI and nonfatal stroke)

NICE NG28 Ref: b-pharmacological-therapies-with-cardiovascular-and-other-benefits-in-people-with-type-2-diabetes-pdf-10956473392

Observation Three- Patients with all 8 diabetes care processes undertaken in the last 12 months

- With your continued support and effort, the completion rate of diabetes care processes remains high (61%) and has significantly improved compared to the 2020/21 baseline. This positive trend has been further supported by the introduction of the 8 Care Processes incentive scheme indicator in 2022/23.

- **Foot screening** and **microalbuminuria checks** continue to be the **least completed** care processes. This likely contributes to our persistently high amputation rates and remains a key area for focused improvement.

Diabetes: Number of admissions with a Minor Amputation Procedure (36months to Q3 24/25 end data)

Small numbers (less than or equal to 7) have been suppressed.

- My System
- Peers (My Region)
- System Median
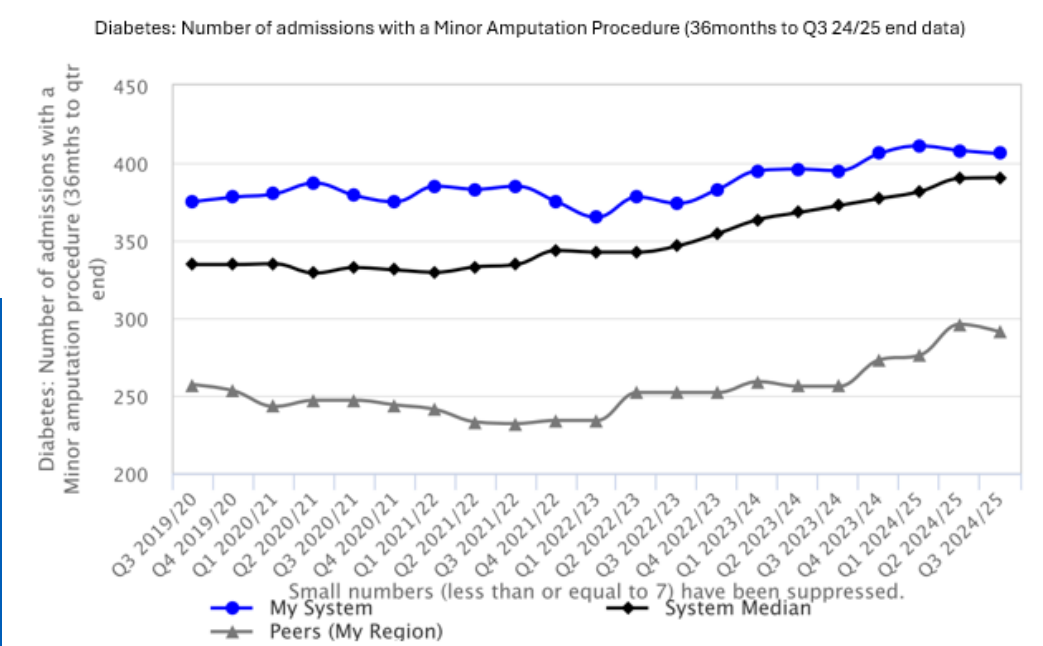
Observation – outcome :

Somerset's amputation rate by quarter

Prompt Question:

What factors may be contributing to the differences observed in 8 care process completion rate between patient's cohort T1D vs T2D or T2D vs T2D with BAME/IMD 1-2/LD/MH?

Somerset Diabetes Medicine Optimisation Opportunities - May 2025	Diabetes Care Pathway - Protect with Appropriate Monitoring Equality of Access to Best Practice Monitoring			
Note: The data reflects the time at which it was extracted from the respective data sources, and the figures are subject to change based on practice activities undertaken.	Percentage of Diabetes (T1&T2) patients with all 8 care processes undertaken in last 12 months	Percentage of Diabetes (T1) patients with all 8 care processes undertaken in last 12 months	Percentage of Diabetes (T2) patients with all 8 care processes undertaken in last 12 months	Percentage of T2 Diabetes with - BAME / Deprivation decile 1-2 / Learning Disability / Mental Health with all 8 care processes undertaken in last 12 months
Data Sources	Eclipse NDA Live	Eclipse NDA Live	Eclipse NDA Live	Eclipse Diabetes Protect
System Target	>75%	>75%	>75%	>75%
NHS Somerset ICB Present as either "Average Performance in Percentage" or "Sum of Patient Count"	59.50%	45.67%	60.82%	58.18%
Practice				
LYNGFORD PARK	65.77%	60.87%	66.75%	63.75%
MENDIP COUNTRY PRACTICE	53.90%	47.06%	54.97%	40.00%
MILBORNE PORT SURGERY	68.26%	63.64%	68.78%	70.00%
MILLBROOK SURGERY, CASTLE CARY	55.31%	50.00%	56.32%	52.63%
MINEHEAD MEDICAL CENTRE	47.33%	32.56%	48.51%	42.55%
NORTH CURRY	51.90%	46.67%	52.49%	57.14%

Call for Action & Review:

With your continued collaboration, we can work together to improve outcomes and support better health for our patients.

To identify list of patients with missing care process and drive quality improvement opportunities, access PID Eclipse, visit https://secure.nhspathways.org when using HSCN/N3. Log in with your existing Eclipse username and password. If you do not have login credentials, please contact the support team at support@prescribingservices.org & cc'd your PM in the email in order to gain authorisation.
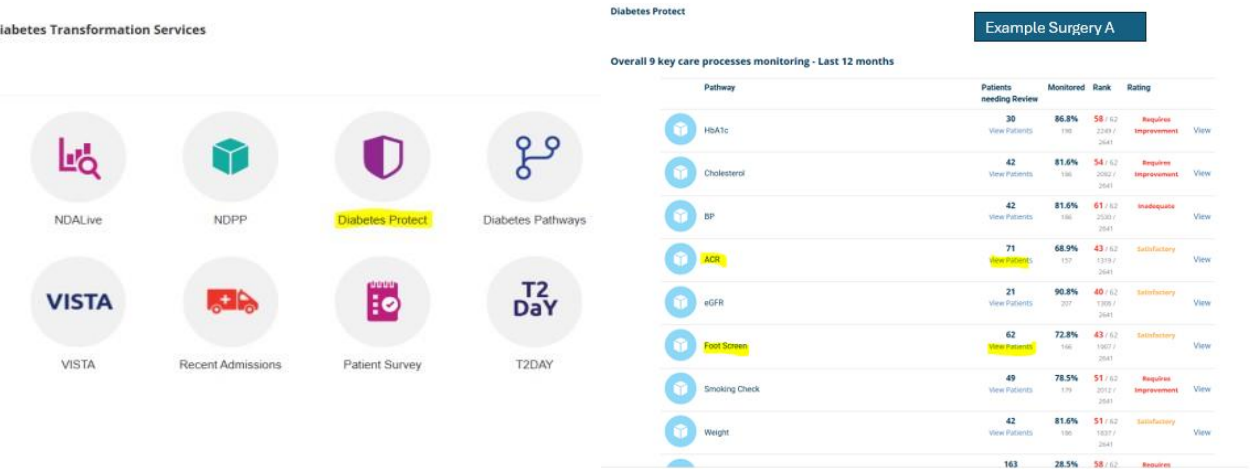
Local **Diabetes Eclipse live searches** has been created to support Practices and PCNs in championing diabetes medicine safety, improving medication value, and enhancing access to evidence-based interventions.

Version 2 – 2025:

Diabetes Medicine Safety (Rationale)
- **Diabetes Medicine Safety 01: Metformin in eGFR <30** (Risk of lactic acidosis)
- **Diabetes Medicine Safety 02: SGLT2 inhibitor use in T1D patient** (Not Recommended: Risk of DKA)

Diabetes Medicine Value Optimisation (Rationale)
- **Diabetes Medicine Value 01: Switch other gliptins to generic sitagliptin** (If gliptin indicated, prescribe cost effective gliptins)
- **Diabetes Medicine Value 02: Patients >=65 with Mod- Severe Frail prescribed a sulfonylurea in last 90 days & HbA1c <48** (Risk of hypoglycemia and fall)
- **Diabetes Medicine Value 04: Review Dapagliflozin 5mg optimisation** (Aim to prompt review and optimize dose as per SmPC/BNF)
- **Diabetes Medicine Value 04b: Patients (all age) with Mod- Severe Frail prescribed a sulfonylurea in last 90 days with HbA1c <48**
- **Diabetes Medicine Value 05: Type 1 diabetics not prescribed insulin in last 1 year** (Aim to prompt review of compliance or diagnosis coding entry)
- **Diabetes Medicine Value 06: Type 2 diabetes (25-84Ys, exclude already with hx of CVD) with QRISK >=20%, not on statin** (Prompt review; offer atorvastatin 20 mg for the primary prevention of CVD to people with type 2 diabetes who have a QRISK3 10% or greater 10-year risk of developing CVD- NICE)
- **Diabetes Medicine Value 07: Statin Primary prevention for people age =>40Ys with type 1 diabetes, not on statin** (Prompt review; offer atorvastatin 20 mg for the primary prevention of CVD to people with type 1 diabetes who those who are age 40 or over)
- **Diabetes Medicine Access 01: Type 2 DM + hx of CVD not on SGLT2** (Prompt review; NICE NG 28 - T2D with established CVD to be offered any SGLT-2 (except ertogliflozin) in addition to metformin)

Available here: [Diabetes-Eclipse-Modules-Somerset-Local-User-Guide-May-25.pdf](#)

Eclipse VISTA Pathway – Diabetes Hub Demo

NHS Pathways

Eclipse Live – Local Searches

Eclipse Login Page

Time for Action on Diabetes Management Optimisation

If you have any queries* or feedback, please contact the Somerset ICB

Medicine Management Team via:

somicb.medicinesmanagementteam@nhs.net