

How are we doing? Diabetes care in Scotland



John McKnight

The NHS in Scotland is now quite different in some ways to that of England, in that we have 14 NHS boards and do not have primary care commissioning. We have continued to use and develop diabetes managed clinical networks in each NHS board area. Each should have a lead clinician and an identified manager with protected time for the network. These people are the local leaders for the multidisciplinary teams in their area. National leadership is provided through the Scottish Diabetes Group (SDG) that is again multidisciplinary, and has support from the Scottish Government Health Directorate. The SDG has a number of subgroups and working groups designed to help develop many different aspects of services for those with diabetes in Scotland.

We have developed, supported and integrated an information system (Scottish Care Information – Diabetes Collaboration [SCI–DC]) that links with many other systems that are routinely used to provide care. This system automatically collects, on behalf of each NHS Board, core diabetes data from primary care, hospital, laboratory, retinal and foot screening services in all NHS Boards through a linkage using our unique patient identifier (the Community Health Index). The information is securely collected and it is made appropriately available to those involved in the care of an individual, while enabling

(with agreed security and confidentiality protection) summary statistics and linkage to other datasets. The information is therefore appropriately used in different ways:

- A person may, through the patient portal, review historical and up-to-date information relating to their own diabetes.
- A primary- or secondary-care-based healthcare professional can review immediate or historical data for an individual or summary data for their practice or practice group.
- Summary data for each NHS Board is collated each year for the Scottish Diabetes Survey that reports on all patients with diabetes in Scotland. We have also been able to link this information to other NHS data to provide a real population-based picture of diabetes in Scotland.

In 2010 there were 237 468 people registered with diabetes in Scotland. Glycaemic control is shown in *Table 1*. It would appear that overall control in many people with type 2 diabetes is good, whereas that of people with type 1 diabetes is not good. This year we will respond to these data and will carefully review the design and delivery of services for those with type 1 diabetes. We have also shown that the probability of admission to hospital is around three times greater in people with type 1 diabetes with an HbA_{1c} level of >95 mmol/mol (>10.8%; 10th decile of HbA_{1c}) compared with

Table 1. HbA_{1c} results from the 2010 Scottish Diabetes Survey (type 1 diabetes *n*=24 466; type 2 diabetes *n*=191 430).

Diabetes type	HbA _{1c} <58 mmol/mol (<7.5%)	HbA _{1c} 58–75 mmol/mol (7.5–9.0%)	HbA _{1c} >75 mmol/mol (>9.0%)
Type 1	22%	40%	38%
Type 2	64%	22%	14%

John McKnight is Consultant Physician, NHS Lothian; Honorary Reader, University of Edinburgh; Chairman, Scottish Diabetes Group.

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61–65 mmol/mol (7.7–8.1%; the 3rd decile), and that this costs NHS Scotland an extra £2.4 million per annum. This year, the SDG has invested in three projects relating to the engagement and care of those with poor glycaemic control. Clearly, primary care has a big potential role in re-engaging this group.

We have developed a system to link our SCI-DC data to other datasets in Scotland including SMR 01 (Scottish Morbidity Record based on hospital inpatient data). Combining these datasets has enabled us to gain a better understanding of the hospital inpatient morbidity associated with diabetes. For example, we have noted that SMR 01 only identifies 59% of those with diabetes (Anwar et al, 2011). This linkage has also found that we spend £301 million on inpatients with diabetes in Scotland and that they stay 2.6 days longer than matched people without diabetes (Govan et al, 2011). The recent National Diabetes Inpatient Audit has demonstrated that there is a need to improve the care and experience of people with diabetes who are admitted to hospital. We have, with Healthcare Improvement Scotland, launched a project to improve inpatient diabetes care and within this to decrease the duration of inpatient stay.

The SDG is supporting other initiatives to enable delivery of more care in the community (see <http://bit.ly/zc596Q> for more information). The retinal screening service is now capturing images of over 80% of those with diabetes. We have launched an education tool for foot screening (Stang, 2011) and are reviewing the structured education packages and their availability across Scotland.

Our information suggests that the prevalence of diabetes is increasing by around 4–5% per annum. Some suggest that this relates to a heavier, less fit population, but the number also increases because diabetes is more common in older people and the general population is living longer. The number with diabetes is also greater as people with diabetes are surviving longer, due in part to the organised care provided through the NHS. In Scotland the data we collect have given us a fantastic insight into diabetes care. We need to use this information to influence and drive further improvements in the quality of the care provided. ■

Anwar H, Fischbacher CM, Leese GP et al (2011) Assessment of the under-reporting of diabetes in hospital admission data: a study from the Scottish Diabetes Research Network Epidemiology Group. *Diabet Med* **28**: 1514–9

Govan L, Wu O, Briggs A et al (2011) Inpatient costs for people with type 1 and type 2 diabetes in Scotland: a study from the Scottish Diabetes Research Network Epidemiology Group. *Diabetologia* **54**: 2000–8

Stang D (2011) *Diabetes Foot Screening. Foot Risk Awareness and Management Education*. The University of Edinburgh, Edinburgh. Available at: <http://bit.ly/xRelAt> (accessed 15.02.12)