

Is information transformed into insight in Scotland?



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Scottish Government (2010) *Diabetes Action Plan 2010. Quality Care For Diabetes In Scotland.* Scottish Government, Edinburgh. Available at: <http://bit.ly/xE2YnE> (accessed 09.02.12)

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“The goal is to transform data into information, and information into insight”
Carly Fiorina, Hewlett Packard.

The Chairman of the Scottish Diabetes Group provides us with a timely update and summary of the state of play with respect to diabetes care in Scotland on page 14. It is no mistake that Dr McKnight focuses on the establishment of local, regional and national datasets. The forensic analysis of this database focuses the minds of everyone involved in caring for people with diabetes, from those in high Ministerial Office all the way across to frontline healthcare professionals.

It is indeed fortunate that we in primary care have access to user-friendly, real-time, and nationally uniform data screens. This Scottish Care Initiative – Diabetes Collaboration (SCI–DC) has a sophisticated functionality and there is a challenge for primary care healthcare professionals to ensure regular and accurate data uploads.

How easy it was, up until relatively recently, to explain under-performance with patient behaviour, or socioeconomic deprivation, or list size, and a host of other soft excuses. Through data linkage, one can now compare performance with just about any other practice you care to mention, and match findings to the local “competition” including those with almost identical practice characteristics.

This is, of course, as it should be, and in my opinion will continue to provide a stimulus for ever-improving diabetes care in Scotland, a gentle stick to the QOF carrot.

The widely available information on care processes and outcomes also challenges provision at a more strategic level. The information gathered forms a kind of rolling benchmark against which improvements can be judged. The Scottish Diabetes Action Plan does, and will continue to, reset standards across diabetes outcomes. This approach is predicated on minimising failure in terms of service, targets, clinical achievements and management. If things are done well, and are measured to be so, then we take some satisfaction

and move on. Detailed and comprehensive data analysis can shed light on where we have fallen short. Service reconfiguration (and accompanying resources) can be effectively redeployed, data gathered and another round of audit can inform further improvements.

While this all sounds ticketyboo, there really is no place for complacency. In this small country of ours, we have 49000 people wandering around with a life-shortening and life-altering disease they know nothing about. Since 2001, 1250 people have lost limbs and 10000 more have suffered foot ulcers (Scottish Government, 2010).

Minority ethnic communities present special challenges both in terms of prevalence, incidence, and “hard-to-reach” status. This is one of the major stimuli for inequalities in health and the figures make for interesting reading. In Scotland, you are eight times more likely to suffer from type 2 diabetes if you are of Pakistani origin than your Caucasian counterpart (Scottish Government, 2010).

Dr McKnight also makes a plea for primary care to re-engage with people with type 1 diabetes. He has a point; for reasons not yet fully characterised, the type 1 diabetes burden in Scotland is among the highest in Europe. There are issues, of course; for example, the type 2 diabetes workload (88% of all people with diabetes in Scotland), non-uniform skill, and lack of confidence in treating people with type 1 diabetes in the community. Clearly, more dialogue between primary and secondary care is necessary.

Curiously, perhaps, this brief update makes no direct mention of drugs, treatment algorithms or management plans. Bio-informatics seems to form its core. However, successfully meeting the challenges of the Diabetes Action Plan(s) (Scottish Government, 2010) over the next 20 years will result in saving over 10000 lives and prevent serious complications in three-times as many.

It is self-evident, then, that the new paradigm of health informatics is an integral part of primary care diabetes management for reasons not only of health planning, but also as a proven driver for improved individual patient outcomes too. ■