1. Glucose control is very important in averting disabling microvascular complications in people with diabetes, and the current target recommendation of HbA_1c <7% should be continued.
2. There is good evidence for strict glycaemic control in patients with type 1 diabetes, as they have lower rates of co-morbid conditions and glycaemia is therefore the main mediator of micro- and macrovascular risk.
3. a. In patients with type 2 diabetes, comprehensive, multi-factorial risk management is necessary and beneficial in reducing events and mortality.
   b. However, glycaemic control may need to be individualized for patients based on the duration of diabetes, baseline level of control, history of hypoglycaemia and general health. While intensive treatment and stricter targets may be appropriate for those at low risk with shorter duration of disease, highly vigilant care with less aggressive targets may be appropriate for older, frail people and those at higher risk and with long-standing disease.

Taken together, the evidence presented suggests that there are sizeable benefits in applying all currently proven interventions early, intensively and extensively in all newly diagnosed and low risk patients, with more attentive, gradual care for those at high risk of morbidity and mortality. Yet, despite US$ 116 billion being spent each year on the direct medical care of people with diabetes,[18] implementation of proven interventions remain grossly suboptimal even in the USA.[19,20] The challenge of translating existing evidence (e.g. control of glucose, blood pressure, lipids, use of aspirin and angiotensin-converting enzyme inhibitors [ACE-I] or angiotensin-II receptor blockers [ARB], and regular examination of the eyes, feet and urine) into clinical practice and quality of care improvement must therefore be at the forefront in the minds of those who care for people with diabetes.

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Letter from Glasgow

THE HEAT TARGETS

First, let me get the news out of the way. I have moved to a new post as Director of Public Health and Health Policy at NHS Lanarkshire. Lanarkshire lies just to the south and east of Glasgow in Scotland. Like the rest of Scotland it has health problems of coronary heart disease, stroke, cancer and mental health including others. Lanarkshire health lags behind the Scottish average and one of the reasons for this is the nature of the population and the legacy it carries. Lanarkshire was part of the industrial heartland of Scotland with extensive employment in coal mining and heavy industry. That

is now in the past as newer industries replace the old ones in this post-Industrial age, but socioeconomic differences in health remain marked and ensure that, for example, the life expectancy of people in Lanarkshire remains less than the Scottish average.[1]

My move is one that is back to 'mainstream' public health and it is a huge agenda though immensely interesting. Public health in the NHS in Scotland and the UK encompasses:

- health improvement (concerned with reducing mortality and morbidity, increasing healthy life expectancy and reducing health inequalities)
- health protection (concerned with protecting the population against communicable disease risks and environmental health hazards), and
- health services (concerned with ensuring clinical and cost-effective health services meet the healthcare needs of the population).

There are numerous areas in which I am now involved—getting my head round all the issues has been a steep learning curve. However, one of the areas which I am now much more intimately acquainted with is the HEAT targets. Mention the word 'HEAT' to anyone in NHSScotland and there may be a smile, a sharp intake of breath or simply a sigh. HEAT is the acronym given to performance targets for NHSScotland set by the Scottish Government (*http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273*, accessed 7 January 2009).

HEAT stands for

- Health improvement: Improving life expectancy and healthy life expectancy of the people of Scotland
- Efficiency: Improving the efficiency and effectiveness of NHSScotland
- Access to health services: Improving the accessibility and availability of health services, and
- Treatment appropriate to individuals: Ensuring patients receive high quality services that meet their needs.

The HEAT system was part of the SNP (Scottish National Party) minority Scottish Government's direction for the NHS published in the 'Better Health Better: Action Plan'.[2] This followed the SNP's emergence as the largest party (by one seat) in the Scottish Parliamentary elections in May 2007 but they built on the previous Scottish Government (a Labour/Liberal Democrat coalition) who had first proposed the HEAT system.

The HEAT targets are those against which, each year, NHS boards in Scotland are judged by the Scottish Government of how Boards are performing in the Annual Review process. These targets fit into the 5 strategic objectives of the Scottish Government which are summarized by the following: of developing a Scotland which is 'wealthier and fairer, healthier, safer and stronger, smarter, and greener'. The strategic objective of 'healthier' aims to 'help people sustain and improve their health, especially in disadvantaged communities ensuring better local and faster access to health care' (*www.scotland.gov.uk/About/purposestratobjs*, accessed 7 January 2009).

The 14 local (territorial) NHS boards, which have the remit of improving the health of their population, and assess the healthcare needs and provide health services for the population they serve, each produce a Local Delivery Plan incorporating the HEAT targets, and how they will meet them. They also include how NHS boards will work with local authorities and the 'Community Planning Partnerships' they have with them. This recognizes the importance of local authorities in both influencing the health of the population, e.g. through transport policies and the services they provide such as social services and education.

So what do the HEAT targets look like? In 2008–09 there are 7 health improvement (H) targets, 7 efficiency (E) targets, 7 access (A) targets and 9 treatment (T) targets. The health improvement targets are intrinsic to public health:

H1 Reduce mortality from coronary heart disease among those below 75 years of age in deprived areas.
H2 80% of all 3–5-year-old children to be registered with an NHS dentist by 2010–11.
H3 Achieve agreed completion rates for child healthy weight intervention programme by 2010–11.
H4 Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines[3] by 2010–11.
H5 Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.
H6 Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008–9 to 2010–11.
H7 Increase the proportion of newborn children exclusively breastfed at 6–8 weeks from 26.6% in 2006–07 to 33.3% in 2010–11.

Of course, these HEAT health targets do not cover the whole range of public health and health improvement activities but do provide a focus for discussion for NHS Boards when they are reviewed by Nicola Sturgeon, the Scottish Cabinet Secretary for Health and Wellbeing in the summer/autumn each year. These meetings are called Annual Reviews and are held in public and chaired by the Cabinet Secretary or her deputy, the Minister for Public Health.

The HEAT targets are not a one-off but build on previous achievements. Already NHSScotland has had guidance on the HEAT targets for 2009–10 and what the Scottish Government expects in them. The work on those new targets has already started to ensure that the NHS in Scotland is performing to the best of its ability. The health service in Scotland will receive £33 billion (US$ 49 billion) over the next 3 years, so it is only right that the public can be assured that their taxes are being spent wisely. HEAT targets are one form of that public accountability.

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