Drug-related hospital statistics Scotland for 2011/12

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Introduction

This publication reports on hospital discharges relating to drug misuse. It includes information on inpatients and day cases discharged from general acute hospitals and psychiatric hospitals in Scotland. In doing so, it tells us about some of the health impacts of drug misuse.

The information reported in this publication has been collated using data obtained from the following sources:

- Hospital data from ISD General Acute Inpatient / Day cases Records (SMR01) years 2007/08 to 2011/12;
- Mental Health Inpatient and Day Case Records (SMR04) years 2006/07 to 2010/11.

Certain figures (commonly small numbers, for small areas or populations) are not shown. This is as a result of ‘statistical disclosure control’ (SDC) which aims to prevent the release of information that can lead to the identification of individuals. Further information on the SDC methods applied, by ISD Scotland, is available on request.

This publication has two main sections:
1. General hospital discharges
2. Psychiatric hospital discharges
Key points

General Hospital Discharges:

- The overall rate of discharge with a diagnosis of drug misuse has increased over the last 5 years from 111 per 100,000 population in 2007/08 to 125 per 100,000 population in 2011/12. For the latest year (from 2010/11 to 2011/12) the discharge rate increased from 123 to 125 per 100,000 population.
- The rise is entirely due to increases in the older age groups (particularly 35 years and over). In the younger age groups the discharge rates dropped; by 24% for 15-19 year olds; by 23% for 20-24 year olds; and by 15% for 25-29 year olds.
- Opioids were involved in 71% of discharges, which is an increase from 67% in 2007/08. Cannabinoids increased from 7% to 10% and sedatives/hypnotics from 3% to 5%, whereas cocaine dropped from 8% to 5%, other stimulants from 6% to 3% and multiple/other drugs from 15% to 12%. Note that more than one drug can be recorded within a hospital stay.

Psychiatric Hospital Discharges:

- The rate of psychiatric discharges with a diagnosis of drug misuse has remained fairly steady for the last five years (2006/07 to 2010/11) at around 29-31 discharges per 100,000 population.
Results and Commentary

General Hospital Discharges

Latest year (2011/12)

- In 2011/12, the average number of discharges per patient was 1.3 (Table 1.1).
- During 2011/12, there were 6,261 general acute hospital discharges with a diagnosis of drug misuse, a rate of 125 discharges per 100,000 population (Table 1.2).
- Sixty nine per cent of people discharged with a diagnosis of drug misuse were male (4,306) and 31% female (1,955) (Table 1.2).
- The 30 to 34 year and 35-39 year old age groups had the highest rate of discharges with a diagnosis of drug misuse, with 380 and 376 per 100,000 population respectively (Table 1.2).
- Seventy-one per cent of all drug-related discharges had a diagnosis involving opioids (Table 1.3).
- For discharges involving opioids and cannabinoids, the majority of discharges for each drug type were observed in the 30 years and over age group (78% and 56% respectively) (Table 1.3).
- In terms of discharges for cocaine, the majority were aged 20-29 (51%) (Table 1.3)
- Ninety-two per cent (5,780) of discharges were admitted as an emergency rather than a planned (i.e. elective) intake (Table 1.5).
- Eighty-four per cent of cases (5,285) involved an inpatient stay of less than a week (Table 1.6).
- Patients from more deprived areas are more likely to be admitted to hospital with a drug related diagnosis. Those in the 20% and 21-40% most deprived areas had the highest discharge rates with 338 and 149 per 100,000 population respectively (Table A1.8).

Five Year trend – 2007/08 to 2011/12

- There has been an overall increase over the last 5 years in the rate of discharges with a diagnosis of drug misuse. In 2007/08 the discharge rate was 111 per 100,000 population and this has increased in 3 of the last 5 years to 125 per 100,000 population in 2011/12. However from 2010/11 to 2011/12 the observed increase is relatively slight (from 123 to 125 per 100,000 population) (Table 1.2 and Figure 1.1).

Figure 1.1: Rate per 100,000 population of general acute inpatient and day case discharges with a diagnosis of drug misuse by year 2007/08 – 2011/12
The increase in the overall discharge rate is due to increases in the older age groups (30 years and over) in discharges per 100,000 population with a diagnosis of drug misuse in the period 2007/08 to 2011/12. This was most notable in the 35 to 39 year old age group (a rise from 264 to 376 discharges per 100,000 population from 2007/08 to 2011/12) (Table 1.2 and Figure 1.2).

In contrast, in the younger age groups (29 years and under) the rate per 100,000 population for discharges with a diagnosis of drug misuse shows a downward trend between 2007/08 and 2011/12. The largest overall decreases were seen in the 20 to 24 and 25 to 29 year old age groups, which fell from 212 to 163 and 323 to 275 discharges per 100,000 population from 2007/08 to 2011/12; a 23% and 15% drop, respectively (Table 1.2 and Figure 1.2).

The proportion of male and female discharges have remained stable over the five year period, with numbers and rates per 100,000 population for males consistently more than double for females (Table 1.2).

In terms of deprivation, the two most deprived quintiles (one and two) have seen the biggest increases in discharges per 100,000 population. The discharge rate for the most deprived quintile (quintile one) increased by 15% from 296 to 338 and for quintile two by 16% from 128 to 149 discharges per 100,000 population. The largest decrease of 10% was observed in the least deprived quintile (quintile five) (20 to 18 discharges per 100,000 population) (Table 1.8 and Figure 1.3).
Drugs recorded

- Opioids were the type of drug most commonly indicated in drug-related discharges and their share increased from 67% in 2007/08 to 71% in 2011/12 (from 3,676 to 4,430). The next most frequently recorded specific drug category was cannabinoids; the number of discharges involving these increased from 406 to 609 (from 7% to 10% of all drug-related discharges). The number of discharges where sedatives/hypnotics were indicated also increased over the last 5 years, from 191 in 2007/08 to 340 in 2011/12 (from 3% to 5% of total drug-related discharges) (Table 1.4 and Figure 1.4).
• Conversely, discharges for cocaine decreased from 8% to 5% of all drug-related discharges. Discharges for Other Stimulants decreased from 6% to 3% of all drug-related discharges. A substantial number of cases reported the use of multiple (unspecified) or other drugs, but numbers decreased from 825 to 769 over the 5-year period; a drop from 15% of all drug-related discharges in 2007/08 to 12% in 2011/12. (Table 1.4). Note that the sum of the drug categories does not add up to the total because more than one type of drug can be indicated in a single discharge. Also, the category ‘multiple’ drug types can include any combination of the drugs in the other specific categories or in the ‘other’ category.

• The types of drug recorded varied with age. Opioids were recorded in 20% of cases involving patients aged under 20 years old and in 73% of cases for those aged 20 years old and over. Conversely, cannabinoids were recorded in 37% of cases for those aged under 20 years old and in only 9% of cases involving patients aged 20 years old and over. Cocaine figures were 12% for those under 20 years old and 5% for those aged 20 years old and over (Table 1.3).

• Of all specified drugs, opioids were associated with the highest percentage of hospital stays that were longer than a week (18%) (Table 1.7).

**Geographical profile**

• The rate of drug misuse discharges varied across Scotland in 2011/12 with the highest levels seen in NHS Ayrshire and Arran (263 discharges per 100,000 population), NHS Greater Glasgow and Clyde (148 discharges per 100,000 population) and NHS Tayside (142 discharges per 100,000 population). (Table 1.2).

• NHS Ayrshire and Arran, NHS Grampian and NHS Tayside had the highest proportion of discharges with an Opioid related diagnosis (82% of drug-related discharges within each board) (Table 1.3).
Psychiatric Hospital Discharges

Latest year (2010/11)

- In 2010/11, there were 21,750 psychiatric discharges in Scotland (Scottish residents), of which 7% (1,556) had a diagnosis of drug misuse (a rate of 31 discharges per 100,000 population) (Table 2.2 and Table 2.3).
- Sixty-seven per cent (1,043) of the psychiatric discharges that had a diagnosis of drug misuse involved male patients in 2010/11, compared to 33% (513) of discharges that involved female patients (Table 2.1).
- The 30 to 34 year old age group had the highest rate of psychiatric discharges with a diagnosis of drug misuse, with 100 per 100,000 population, followed by the 25 to 29 year age group with 93 per 100,000 population (Table 2.2).
- Overall, 60% of discharges with a diagnosis of drug misuse were following a length of stay in a psychiatric hospital of 1 week or more, but the percentage increased with age (Table 2.5). Less than half of patients aged under 25 stayed for more than a week, whilst 69% of patients aged 40 and over stayed more than a week.
- In terms of deprivation, quintile one (most deprived) has the highest rate of discharges with 73 per 100,000 population in 2010/11 versus 6 per 100,000 population for the least deprived quintile (Table 2.6).

Five year trend - 2006/07 to 2010/11

- The rate of psychiatric discharges with a diagnosis of drug misuse shows no clear trend over the last five years 2006/07 to 2010/11 and fluctuated around 28-31 discharges per 100,000 population. (Table 2.2 and Figure 2.1).

Figure 2.1: Rate per 100,000 population of psychiatric hospital discharges with a diagnosis of drug misuse by year 2006/07 – 2010/11

- Across the age groups, the largest increase was observed in the 35-39 year olds, where the psychiatric discharge rate per 100,000 population with a diagnosis of drug misuse
rose from 65 in 2006/07 to 83 in 2010/11. The age group with the largest decrease was the 20-24 year olds (the discharge rate dropped from 69 to 51 per 100,000 population) (Table 2.2 and Figure 2.2).

Figure 2.2: Rate per 100,000 population of psychiatric discharges with a diagnosis of drug misuse in any position, by year and age group 2006/07 – 2010/11

- The most deprived category had the highest discharge rates over the last five years fluctuating between 70 and 79 (Table 2.6 and Figure 2.3).

Figure 2.3: Rate per 100,000 population of psychiatric discharges with a diagnosis of drug misuse in any position, by year and deprivation quintile 2006/07 – 2010/11
Drugs recorded

- In 2010/11, the use of multiple/other drugs (including hallucinogens, volatile solvents and multiple drug use and use of other psychoactive substances) was the most commonly recorded drug group resulting in mental and behavioural disorder (55%; 851 discharges). Of specific drug groups, opioids were most frequently recorded; in 32% of psychiatric discharges (502 cases) (Table 2.4).

Geographical profile

- In 2010/11, the highest rate of psychiatric discharges with a diagnosis of drug misuse was seen in NHS Dumfries and Galloway with 65 discharges per 100,000 population. The second highest rate was in NHS Borders with 61 discharges per 100,000 population (Table 2.2). NHS Grampian had one of the lowest psychiatric discharge rates (15 per 100,000 population).
Glossary

EASR  European Age Standardised Rate; the rate that would have been found if the population in Scotland had the same age-composition as the hypothetical standard European population.

Deprivation  The [Scottish Index of Multiple Deprivation](#) (SIMD) is used to calculate deprivation rates. SIMD has 38 indicators in 7 domains (income, employment, housing, health, education, skills and training, geographical access and crime) at datazone level, which have been combined into an overall index. Rates are reported by quintiles. Quintiles divide the population into five equal proportions so that 20% of the population falls into each quintile. The SIMD is updated roughly every three years and the version used depends on the year when the patient was discharged from hospital.

Discharge  This refers to the end of a given period of health care in a hospital setting known as a continuous inpatient stay (CIS). An individual (patient) may account for a number of episodes during a given reporting period. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge.

ICD  The International Statistical Classification of Diseases and Related Health Problems (ICD) revision is used to classify hospital admissions and deaths. The 10th revision is used in analysis.

Inpatient  This is when a patient occupies an available staffed bed in a hospital and either; remains overnight whatever the original intention or is expected to remain overnight but is discharged earlier.

Provisional data  An indication that the data is provisional means that returns from hospitals are not yet complete and the final figure may be different to that recorded when all returns are in.
## List of Tables

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<td>General acute inpatient discharges with a diagnosis of drug misuse in any position - drug type; by NHS board and council area of residence, age group and gender</td>
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<td>1.5</td>
<td>General acute inpatient discharges with a diagnosis of drug misuse in any position - type of admission (by NHS board and council area of residence, age group and gender)</td>
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<td>1.6</td>
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<td>General acute inpatient discharges with a diagnosis of drug misuse in any position; length of stay and drug type</td>
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<td>1.8</td>
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<td>2.2</td>
<td>Psychiatric hospital discharges with a diagnosis of drug misuse in any position (by NHS board and council area of residence, age group and gender)</td>
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<td>Psychiatric hospital discharges; by gender and by main or supplementary diagnosis</td>
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<td>2.4</td>
<td>Psychiatric hospital discharges with a diagnosis of drug misuse in any position; by drug type (by NHS board and council area of residence, age group and gender)</td>
<td>2010/11</td>
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<tr>
<td>2.5</td>
<td>Psychiatric hospital discharges with a diagnosis of drug misuse in any position; by length of stay (by NHS board and council area of residence, age group and gender)</td>
<td>2010/11</td>
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<tr>
<td>2.6</td>
<td>Psychiatric hospital discharges with a diagnosis of drug misuse in any position; by deprivation category</td>
<td>2006/07 - 2010/11</td>
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Further Information
Further information can be found on the ISD website

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Appendix

A1 – Background Information

Hospital activity data are collected across the NHS in Scotland and are based on nationally available information routinely drawn from hospital administrative systems across the country. The principal data sources are the SMR01 (acute inpatient and daycase) and SMR04 (psychiatric inpatient and daycase) returns.

**SMR01 – Hospital general and acute inpatients and day cases**

SMR01 is an episode based patient record relating to all inpatient and day cases discharged from specialities other than mental health, maternity, neonatal and geriatric long stay specialities in NHS Scotland. A record is generated for each inpatient and day case episode, of which there are about 1,200,000 each year. Attendances at Accident and Emergency that do not result in an admission are not included. Each individual patient may have more than one stay and hence the number of people discharged within a year will be less than the total number of discharges. The SMR01 basic data set encompasses patient identification and demographic information, episode management information and general clinical information. Items such as waiting time for inpatient or day case admission and length of stay may be derived from the episode management information.

When figures are broken down by geographical area or age the numbers in some categories can be very small. In these cases both differences between categories and trends over time should be interpreted with caution because they may be misleading.

The tables presented in the first section of this report are derived from the SMR01, and contain information about patients admitted to general hospitals (mainly for emergency treatment), where drug misuse is diagnosed as a factor in the patient's treatment. Up to six diagnoses are recorded per admission, and episodes with either a main or a supplementary diagnosis of drug misuse are included. Poisonings and overdoses are not included unless a diagnosis of drug misuse is also recorded. In the tables of drug type (A1.3 and A1.4), there is an element of double counting as episodes may be associated with, for example, diagnoses of both opiate and cocaine misuse. Drugs misuse is recorded using the International Classification of Diseases 10th Revision (ICD10) Codes. The following codes were used in the analysis presented in this section:

<table>
<thead>
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<th>ICD 10 Code</th>
<th>Description</th>
<th>ICD 10 Code</th>
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<td>F11</td>
<td>Opioids</td>
<td>F15</td>
<td>Other Stimulants</td>
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<td>F12</td>
<td>Cannabinoids</td>
<td>F16</td>
<td>Hallucinogens</td>
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<td>F13</td>
<td>Sedatives / Hypnotics</td>
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<td>Volatile Solvents</td>
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<td>F14</td>
<td>Cocaine</td>
<td>F19</td>
<td>Multiple / Other Psychoactive Substances</td>
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</table>

Some caution is necessary when using these data as (a) drug misuse may only be suspected and may not always be recorded by the hospital, and (b) where drug misuse is recorded, it may not be possible to identify which drug(s) may be involved.

If multiple drugs have been noted in case notes, the advised coding is to record each substance in a separate diagnosis position where possible. Sometimes the coder may be forced to use the unspecific ICD-10 code F19 ("multiple drugs"). For example, if case notes only state "multiple drug use" there is no way of identifying which substances were
involved. Sometimes the F19 code may be used if the patient has many other diagnoses recorded, leaving insufficient space to record specific drugs separately. There may be more than one specific drug mentioned in the case notes but due to only 6 positions being available on the SMR01 form, the coder would be forced to group the drugs into the single code F19.

SMR04 – Mental health inpatient and day case return

The statistics in the second section of this report are derived from data collected through the mental health inpatient and day case return (SMR04), which records information at admission and discharge. On the SMR04 form up to six separate diagnoses can be recorded on discharge. A diagnosis in the first position is the main diagnosis on discharge. A diagnosis ‘in any position’ refers to the occurrence of a diagnosis in any of the six positions (including main and supplementary).

Figures for all discharges relate to the number of episodes not to the number of individual patients admitted or discharged. Each individual may have more than one episode. When figures are broken down by geographical area or age the numbers in some categories can be very small. In these cases both differences between categories and trends over time should be interpreted with caution because they may be misleading.

Diagnosis is recorded on both the admission and the discharge part of the record and diagnosis on discharge may differ from diagnosis on admission. The tables presented here are based on diagnosis on discharge. Drug misuse is defined using the same groups of ICD 10 codes outlined above for SMR01. In Table A2.3 these groups have been merged together into two broad categories:

<table>
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If multiple drugs have been noted in case notes, the advised coding is to record each substance in a separate diagnosis position where possible. Sometimes the coder may be forced to use the unspecific ICD-10 code F19 ("multiple drugs"). For example, if case notes only state "multiple drug use" there is no way of identifying which substances were involved. Sometimes the F19 code may be used if the patient has many other diagnoses recorded, leaving insufficient space to record specific drugs separately. There may be more than one specific drug mentioned in the case notes but due to only 6 positions being available on the SMR04 form, the coder would be forced to group the drugs into the single code F19.

Data Quality

The ISD Data Quality Assurance (DQA) team is responsible for evaluating and ensuring SMR datasets are accurate, consistent and comparable across time and between sources. Details of the quality assurance process for SMRs are published on the DQA methodology webpage [http://www.isdscotland.org/Products-and-Services/Data-Quality/Methodology/](http://www.isdscotland.org/Products-and-Services/Data-Quality/Methodology/). Information on SMR data completeness can be found on the Hospital records Data Monitoring/SMR-Completeness/ [http://www.isdscotland.org/Products-and-Services/Hospital-Records-Data-Monitoring/SMR-Completeness/](http://www.isdscotland.org/Products-and-Services/Hospital-Records-Data-Monitoring/SMR-Completeness/), while information on the timeliness of SMR data submissions can be found on the SMR Timeliness webpage [http://www.isdscotland.org/Products-and-Services/Data-Quality/Methodology/](http://www.isdscotland.org/Products-and-Services/Data-Quality/Methodology/).
Note of Revisions

The Health Improvement Alcohol & Drugs Team aims to continually improve the interpretation of the data and therefore analysis methods are reviewed and sometimes updated. For the publication of 28 May 2013 a number of changes have been made with a minor but appreciable impact on the estimates.

Each continuous hospital inpatient stay (CIS) can include more than one ‘episode’ because a patient can move from one speciality to another. The codes recorded at admission may not be the same as the codes recorded later on in the CIS by another speciality. Where previously only the first episode with a drug-related diagnosis was used to define patient demographics and admission and discharge date for the patient’s hospital stay, for this publication all records (episodes) relating to the hospital stay were included if one or more of these (but not necessarily all) had a drug-related diagnosis in any position in the record. This has a number of implications:

- The new method will result in potentially more codes being used in the analysis.
- The discharge date that defines the year in which the CIS is grouped in, is defined as the discharge date for the last episode of the CIS that has at least one episode with a drug-related diagnosis. This date may be later than the last episode with a drug-related diagnosis (which was used in previous years) and could be in the next financial year. Therefore some hospital stays that were previously included in the figures for Year A, will now be included in the figures for the following year (Year A+1).
- Because a single CIS can include numerous episodes, the length of stay (calculated as the period between the first admission date and the last discharge date) may have increased.

In addition, for the current report, the version of the deprivation score (SIMD) has been updated in line with ISD guidance. For discharges in 2004/05, 2005/06 or 2006/07 SIMD version 2006 was used; for discharges in 2007/08, 2008/09 or 2009/10 the SIMD 2009 version 2 was used; for 2010/11 and 2011/12 SIMD version 2012 was used. Previously the same version (2009-v2) was used for all years, so this change may result in some records having shifted to a different deprivation quintile compared to last year’s publication. Also some minor inconsistencies in the programs used for the analysis have been rectified to ensure methods used for both alcohol and drug-related hospital discharges follow the same logic.

All tables are revised annually to take into account any changes in analytical methods like these outlined above and to include data that may have been missing at the time of the previous publication. The level of submission at the time of publication was sufficiently high to produce reliable statistics; therefore any revisions due to incomplete data returns are expected to be relatively small and are not expected to impact on long-term trends.

Further information

Information on ISD Scotland’s major prorammes of work can be found on our website at: http://www.isdscotland.org/Health-Topics/.
Further statistics on inpatient and day-case activity in general acute hospitals are available at: [http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/](http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/).

Further statistics on psychiatric admissions and discharges are available at [http://www.isdscotland.org/Health-Topics/Mental-Health/Psychiatric-Hospital-Activity/](http://www.isdscotland.org/Health-Topics/Mental-Health/Psychiatric-Hospital-Activity/).

If you would like further information on hospital discharges relating to drug misuse then please contact the Health Improvement – Drug & Alcohol Team at nss.isdsubstancemisuse@nhs.net.

For information about the completeness, timeliness and other data quality issues regarding SMR01/SMR04 data submissions contact the Data Management Team at nss.isdDMT@nhs.net.
## A2 – Publication Metadata (including revisions details)

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<td>Continuity of data</td>
<td>See background information</td>
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<td>Revisions statement</td>
<td>Where previously only the first episode with a drug-related diagnosis within a continuous inpatient stay was used to define patient demographics, diagnostic codes and admission and discharge date for the patient’s hospital stay, for this publication all records (episodes) relating to the hospital stay were included as long as at least one of these (but not necessarily all) had a drug-related diagnosis in any position in the record. This results in more diagnostic codes being included in the analysis, a potentially later date of discharge used, and a longer time of stay. More details are given in the Note of Revisions (Appendix A1). Also there were minor revisions to data within this publication due to incomplete data returns at the time of the previous publication. All tables are revised annually to reflect the latest thinking on analysis methods and to use the most complete information.</td>
</tr>
<tr>
<td>Revisions relevant to this publication</td>
<td>In general, revisions and methodology changes have minimal effect on the statistics.</td>
</tr>
<tr>
<td>Concepts and definitions</td>
<td>See Hospital Care: Background Information <a href="http://www.isdscotland.org/Health-Topics/Hospital-Care/">http://www.isdscotland.org/Health-Topics/Hospital-Care/</a></td>
</tr>
<tr>
<td>Relevance and key uses of the statistics</td>
<td>Relevant to understanding problem drug use in Scotland. Statistics will be used for policy making and service planning.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>Quality checks are conducted by ISD. Figures are compared to previously published data and expected trends.</td>
</tr>
<tr>
<td>Completeness</td>
<td>Details of these data submissions issues are available on the Hospital Records Data Monitoring SMR Completeness web page</td>
</tr>
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</table>
| Comparability                      | The NHS Health and Social Care Information Centre (HSCIC) publishes figures on Hospital admissions for drug-
related mental health and behavioural disorders in England but should not be directly compared with published data from Scotland. For more information see the Background information on the ISD Hospital Care website.

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.</th>
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</thead>
<tbody>
<tr>
<td>Coherence and clarity</td>
<td>The report is available as a PDF file with tables clearly linked for ease of use.</td>
</tr>
<tr>
<td>Value type and unit of measurement</td>
<td>Numbers, percentages and European age-standardised rates per 100,000.</td>
</tr>
<tr>
<td>Disclosure</td>
<td>The ISD protocol on Statistical Disclosure Protocol is followed and data relating to very small numbers is suppressed.</td>
</tr>
<tr>
<td>Official Statistics designation</td>
<td>Accredited National Statistic</td>
</tr>
<tr>
<td>UK Statistics Authority Assessment</td>
<td>Completed assessment by UK Statistics Authority, report published 4&lt;sup&gt;th&lt;/sup&gt; April 2012.</td>
</tr>
<tr>
<td>Last published</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; May 2012</td>
</tr>
<tr>
<td>Next published</td>
<td>May 2014</td>
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<tr>
<td>Date of first publication</td>
<td>1998</td>
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<td>13&lt;sup&gt;th&lt;/sup&gt; May 2013</td>
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</table>
A3 – Early Access details (including Pre-Release Access)

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

Standard Pre-Release Access:

- Scottish Government Health Department
- NHS Board Chief Executives
- NHS Board Communication leads

Extended Pre-Release Access

Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

- Scottish Government Health Department (Analytical Services Division)
A4 – ISD and Official Statistics

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

**Purpose:** To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

**Mission:** Better Information, Better Decisions, Better Health

**Vision:** To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD’s statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the [ISD website](#).

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.