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7CCSMPRJ

Individual Project Submission 2024 - 2025

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scrutinize Hypoglycemia in hospitalised patients with
diabetes to classify, anticipate and analyse hypoglycemic
episodes [Knowledge Exchange Project with NHS England]
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Word Count: ===== Word count goes here =====

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A handwritten signature in blue ink, appearing to be "Sks", written over a horizontal line.

Date: August 5, 2025



Department of Informatics
King's College London
United Kingdom

7CCSMPRJ Individual Project

**GluCORRECT - Harnessing Artificial
Intelligence to scrutinize Hypoglycemia in
hospitalised patients with diabetes to classify,
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England]**

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Student Number: K24012370
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Supervisor: Dr. Rita Borgo

This dissertation is submitted for the degree of MSc Advanced Computing.

Acknowledgements

I would like to express my sincerest gratitude towards my project supervisor, Dr. Rita Borgo, for her invaluable advice and consistent direction throughout the course of this project. Her mentorship and ideas have been instrumental in shaping the development of this work, leading to its successful completion.

I am also deeply thankful & appreciative of my industry advisor, Dr. Piya Sen Gupta, for providing the dataset that has served as the foundation of this work. Her contributions have significantly enhanced the practical relevance and quality of this project.

Ultimately I would like to thank my friends and my parents, especially my dad, without whose sacrifices I would not be where I am today.

Abstract

Project Variant: Variant 4 - Develop a weighted score and design score to predict risk of a hypoglycaemic episode before it occurs.

It is well known that hypoglycemia as well as hyperglycemia are common adverse events in patients who receive blood sugar control medication, and they are also one of the most frequently cited causes of hospital admissions in people with diabetes. National quality improvement programmes from the Healthcare Quality Improvement Partnership (HQIP) and the study of ambulance call-out data have shown that ***lack of awareness*** by both affected individuals and their attendants is associated with a dramatically increased rate of complications, amongst other factors. Guy's & St. Thomas' NHS Foundation Trust (hereafter referred to as GSTT) has found, after careful deliberation and departmental review, that hypoglycemic episodes have been occurring with unusual frequency. The Trust now seeks to take measures to resolve such problems with a greater focus on prevention combined with early corrective action. This research project has been undertaken in close collaboration with GSTT, one of the largest NHS trusts in the UK and an indispensable element of London's healthcare system, with almost 24000 staff across 5 major hospitals, handling over 3 million patients a year and generating an annual turnover of over £3 billion.

This analytical study serves as a foundation and proof-of-concept to aid GSTT in pre-emptively reducing hypoglycemia within hospitalised inpatients, by utilising statistics & machine learning techniques. Through exploratory data analysis I draw out relevant conclusions about the dataset around patient age, ethnicity and

I go on to identify the significant factors responsible for hypoglycemia within the dataset provided by the industry advisor from GSTT through exploratory data analysis, while also . I explore how they can be utilized to devise a risk score, to classify patients based on their risk of hypoglycemia.

RESULTS: HbA1c values identified as risky - 56 or so eGFR ethnicity major is glucose value

In conclusion, exhibit my findings with potential ways of applying them in practise in hospitals.

All abbreviations and symbols used in the report must be listed and defined in alphabetic order.

Nomenclature

GSTT	Guy's and St Thomas' NHS Foundation Trust
HQIP	Healthcare Quality Improvement Partnership
"Hypo" or "Hypos"	Hypoglycemic episode(s)
"Inpatient"	Referring to the the fact that a patient is required to stay overnight in order to be treated (in case of surgeries or long term observation for example)
NCAPOP	National Clinical Audit & Patient Outcomes Programme
NDA	National Database Audit
NDISA	National Diabetes Inpatient Safety Audit
NHS	The publicly funded healthcare system of the United Kingdom, the National Health Service.

a	The number of angels per unit area
A	The area of the needle point
c	Speed of light in a vacuum inertial frame
h	Planck constant
LMI	Linear Matrix Inequalities
N	The number of angels per needle point

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1 Introduction

1.1 Clinical Overview

Hypoglycaemia (also known as a “hypoglycaemic episode” or a “hypo” for short) is the condition that occurs when the human body’s blood glucose (sugar) level drops below the normal healthy range of 4.0 to 6.0 mmol/L. While it can affect anyone, it is most common in diabetic individuals who are prescribed drugs like insulin or metformin to inhibit glucose. Hypoglycaemic events are relatively simple and straightforward to resolve, but they need to be treated immediately to avoid serious damage to the brain and heart as a result of loss of consciousness or arrhythmias. High-sugar consumables are generally effective in correcting mild cases and are commonly recommended for immediate treatment, but severe cases of hypoglycaemia such as when the person is unconscious or having a seizure can only be resolved with an urgent, immediate glucagon injection to prevent them from deteriorating into a coma (or in rare cases, even leading to death).

To underscore how and why this matters, diabetes is one of the most significant and expensive long-term health conditions faced by the NHS, with recent figures from Diabetes UK suggesting that over 5.8 million people in the UK are living with diabetes, regardless of a formal diagnosis. It is estimated to cost the NHS over £10.7 billion a year, approximately 10% of its entire annual budget, which could go up to £18 billion by 2035 [1]. A stark finding is that almost 60% of this cost (around £6.2 billion) is spent on treating the largely preventable complications of diabetes, such as heart attacks, strokes, blindness, and so on, including hypoglycaemia [2]. Hypoglycaemic instances make up a major component of these preventable costs, mainly accounting for the emergency, ambulance, and acute care expenses associated with diabetes. The Local Impact of Hypoglycaemia Tool (LIHT) suggests that hypoglycaemia can cost up to £2,195 per episode, possibly increasing substantially with a longer stay in hospital [3], and it is estimated that there are up to 100,000 ambulance callouts annually according to the Diabetes Research and Wellness Foundation (DRWF) [4]. DRWF’s study hinted that 1 in 10 individuals that experience a severe hypo (meaning requiring medical intervention or resuscitation) have considerable chances of another one within a fortnight.

1.2 Background

After introspective analysis supported by information from the National Diabetes Inpatient Safety Audit (NDISA) it has been recognized that severe hypoglycaemia and recurrent severe hypoglycaemia have been occurring relatively frequently across GSTT medical facilities. The NDISA forms part of the National Diabetes Audit (NDA), and it maintains that “The prevalence of diabetes continues to increase. In England

between 2017-18 and 2021-22 prevalence of type 1 diabetes went up from 248,240 to 270,935 and the prevalence of type 2 and other diabetes from 2,952,695 to 3,336,980”, as of 2022 [5].

GSTT administers upwards of 500,000 point-of-care glucose tests (POCT) annually, in addition to kidney function and glycated haemoglobin (HbA1c) tests as well. The Trust also possesses blood glucose / ketone data with additional linked data including demographics, dates of admission and discharge, patient as well as family history and current or previous medications. They have two major kinds of patient records, inpatient records for patients that have to stay over the course of one or multiple nights (for example, in case of surgeries or for long term care), and outpatient records where the patient doesn’t require overnight stay. The Trust manages all of this data through their electronic health record management system called Epic, and facilitates patient access to their own records through the MyChart web application.

Hypoglycaemia is a frequent complication amongst inpatients having complex health conditions, especially within those in intensive care settings that have been / are critically ill due to advanced diseases or comorbidities, or in patients following major surgical interventions. The Trust is undertaking proactive measures to identify and mitigate the risk of hypoglycaemic episodes at an early stage, to support better planning, reduce healthcare costs, efficiently allocate hospital resources and also schedule operations optimally. The ideal way to assess risk would along the lines of developing tools to predict individualized risk scores for inpatients after considering all relevant factors. However, this presents a herculean task due to the sheer volume and complexity of factors involved, compounded by the challenges of producing reliable results even within small populations — such as those in remote areas — while also adhering to legal and governmental regulations:

1. Weighing up the risk of hypoglycaemia depends upon numerous aspects such as lifestyle, renal function, recent food intake, blood glucose history and current medication to name a few, making this a highly complicated modelling problem. In addition to this, patients differ widely in age, comorbidities, ethnic factors and even insulin sensitivity. This variability makes it a formidable challenge to develop a model that is generalizable, dependable and unbiased.
2. Any such analytical tool in the vicinity of patient healthcare requires medical evaluation and approval, validation trials, governance oversight as well as ethical considerations. Even a good model may fail if it does not fit the clinical workflow. Initial skepticism towards AI, the effort required to train staff, defining clear responsibilities and limits of liability, and rehearsing procedures or plans of action for every possible scenario will all produce appreciable organizational inertia.

Successfully implementing even a small-scale solution, within GSTT to begin with, would be a significant strategic breakthrough that serves as a foundational model which other

NHS trusts or institutions could adapt and build upon. This positions this research initiative which is a Knowledge Exchange Project (KEP) with Guy's & St.Thomas' NHS Foundation Trust, an indispensable constituent of London's healthcare system, as a valuable and worthwhile research endeavour.

1.3 Aims and Objectives

This research project has the following objectives:

- **To extract insights from provided dataset for the given time period and population.** GSTT has expressed a strong interest towards gaining a deeper understanding of their inpatient population. The dataset they have provided includes demographic details, length of hospital stay, and ward information in addition to the main clinically relevant variables such as glycated haemoglobin levels, renal function measurements, patient age and so on. This enables a comprehensive, multifaceted analysis. The knowledge gained from this study, such as identifying which hospital wards have more vulnerable or at-risk patients, will be used to enhance staff training, in turn improving both future admissions routines as well as post-discharge support for patients. Every observation, regardless of scale, holds potential to refine hospital processes and operating procedures.
- **To identify the main influencing / contributing factors for hypoglycaemia and develop a weighted risk score to predict episodes (Variant 4 KEP).** The Trust is establishing and implementing measures to "pre-assess" inpatients to evaluate their risk of a hypoglycaemic episode, which will allow medical professionals to design protocols and policies to prevent episodes from occurring as well as take early remediative action as soon as possible to resolve an episode should it occur. I aim to find data-backed values for the key features responsible for hypoglycaemia, through statistical tests and machine learning algorithms, in order to create a risk score. This risk score can then be applied in hospital to determine the best course of action based on the patient's reason for being admitted.

1.4 Report Structure

Section 2 contains a comprehensive, detailed review of similar research carried out by other universities, teaching hospitals and medical facilities including references to relevant medical literature. I have compared and contrasted datasets used, approaches taken and results obtained.

Section 3 delves deeper into the dataset provided by GSTT, elaborating on the raw features provided and those that were derived from them for analysis.

Section 4 (Methodology & Implementation) outlines the statistical and mathematical theory behind the concepts used for analysis, ranging from machine learning algorithms to hypothesis testing methods.

Sections 5 (Main Results) onwards discuss the main research executed within the project and deliberates on the results achieved

Section 6 (Ethical Professional Legal Social issues)

Section 7 (Conclusion and Applicability)

1.4.1 Dissertation Length

This dissertation comprises a total of **wordcount XXXX** words excluding references and appendices.

2 Literature Survey & Review

Various kinds of different prediction models have already been devised and developed for predicting hypoglycemia. Yi Wu and others have systematically compared, and evaluated the applicability of models in clinical practice in a paper in Biological Research for Nursing[1] where it was found that the major predictors were age, HbA1c, history of hypoglycemia, and insulin use. Lin Yang, Zhiguang Zhou have carried out similar research in the Frontiers in Public Health journal[2] uncovering risk factors that could possibly lead to hypoglycemic events, after employing various data driven models based on ML techniques such as neural networks, autoregressive / ensemble learning and such.

In silico proof of concept studies like the one from Zecchin[3] have also been researched to investigate how continuous glucose monitoring short-term glucose prediction algorithms could be exploited to recognise the run up to hypoglycemic episodes, allowing the patient to take appropriate countermeasures to mitigate events. They found that there was a significant reduction in both the time spent in a hypoglycemic event as well as the number of hypoglycemic events.

As this is a Knowledge Exchange Project (KEP) with NHS England I have been provided a real world dataset from GSTT. Medical data is difficult to obtain, and it rarely fits a research objective without needing much modification.

3 Dataset

3.1 Raw Data

Our industry advisor from GSTT has graciously provided a year's worth of data in multiple .xlsx files, which have been combined into one for the purposes of analysis and research for this project. The **raw fields provided** within the data were:

- **UniqueID:** Unique identifier for the patient and test, which is just a number. Meant to identify same patients (not personally) when considered together with Order Time, Order Date and Age, as same patients can have multiple blood glucose tests during their stay.
- **Order Date:** The date when the glucose measurement was ordered or taken.
- **Order Time:** The timestamp at which the glucose measurement was ordered or taken.
- **Inpatient Admission Date:** The date at which the patient was admitted into the medical facility.
- **Discharge Date:** The date the patient was discharged from the medical facility.
- **Length of Stay:** The amount of time the patient has spent in the medical facility in days and hours (for eg. "5d 6h").
- **Ward:** The ward that the glucose measurement was taken in, usually matches the ward that the patient was admitted to.
- **Last Lab Test Results:** The result of the glucose measurement in mmol/L. Most values in this column are of the format "Manual blood glucose: 8.70 mmol/L" or "POCT Glucose Blood Manually: 2.7 mmol/L".
- **Age:** Age of the patient at the time of measuring blood glucose in years.
- **Ethnicity:** Specific ethnicity of the patient, values ranging from "South American - Columbian" to "Black or Black British - Nigerian" to "Other" or even missing.
- **Gender Identity:** Gender of the patient.
- **HbA1c:** Numerical value of HbA1c in mmol/mol, which is a measure of the average blood glucose over the past 2-3 months. Glucose in the body sticks to red blood cells to be transported around, and gets consumed to generate energy. If the body cannot use up sugar properly then more of it sticks to blood cells and builds up. Red blood cells are active for around 2-3 months, so the reading is generally taken quarterly, and is an indicator for blood sugar problems. [6].
- **HbA1c Date:** Date the HbA1c test was done for that patient.

- **eGFR:** Estimated Glomerular Filtration rate, which is a measurement of how well the kidneys are functioning. This is a percentage from 0 to 90, with anything 91 and over displayed by the NHS electronic health record system (Epic) as ">91" because an eGFR of 91 percent and above indicates healthy renal function.
- **eGFR Date:** The date the eGFR test was conducted.

3.2 Cleaned Dataset

The following variables were **derived from the raw features** and used for analysis:

- **Age_Range:** Categorical variable to store the age category of the patient based on their age to aid in visualisation. Possible values for this column are: "Young (1 to 25)", "Adult / Middle Aged (26-50)", "Older Adult / Old (51-75)" and "Elderly (76-100)".
- **Has_Hypoglycemia:** Binary variable to store whether the patient has hypoglycemia. A glucose measurement of 4mmol/L and below means the patient is hypoglycemic and has 1 in this column, 0 otherwise.
- **Glycemia_Type:** Categorical variable to store the type of glycemia based on the patient's glucose measurement. **For the purposes of this project, the classes we have been instructed to use are (all units in mmol/L):**
 1. "Severe Hypoglycemia" - for blood glucose values 2.2 and below
 2. "Hypoglycemia"- for blood glucose values from 2.3 to 4 both inclusive
 3. "Target Range"- for blood glucose values from 4.1 to 11 both inclusive
 4. "Hyperglycemia"- for blood glucose values above 11.
- **eGFR_Category:** Categorical variable that shows how serious the loss of kidney function is, based on the eGFR percentage. The possible values for this column are:
 1. "eGFR less than 20 - Kidney Failure" - for eGFR less than or equal to 20%
 2. "eGFR between 20 & 40 - Critical Loss of Kidney Function"- for eGFR above 20% but less than or equal to 40%
 3. "eGFR between 40 & 60 - Significant Loss of Kidney Function"- for eGFR above 40% but less than or equal to 60%
 4. "eGFR between 60 & 80 - Moderate Loss of Kidney Function"- for eGFR above 60% but less than or equal to 80%
 5. "eGFR between 80 & 90 - Minor Loss of Kidney Function"- for eGFR above 80% but less than or equal to 90%
 6. "eGFR above 90 - Normal kidney function"- for eGFR above 90% (data has been processed to only include ">91" for this class as healthy eGFR is 91% and above).

- **Wider_Ethnic_Group:** Categorical variable to store the overarching ethnic group based on the one specified in the ethnicity column, as that had a total of 57 unique values. Possible values are: “Unknown or Not Stated”, “White”, “Mixed”, “Asian or Asian British”, “Black or Black British” and “Other Ethnic Groups”.

*Note that columns obtained after cleaning the original data to extract a numerical value (such as blood glucose) **have been omitted for brevity.***

Please see Appendix A subsection A.1 for screenshots of the dataset(s).

4 Methodology and Implementation

The content of “Main results” is in “\contents\introduction.tex”

5 Main Results and Findings

The chapter reports the contributions of your work. For example, it could contain the following sub-sections to summarise the contribution of the project such as Theoretical Development, Analysis and Design, Implementation and Experimental Work, Results, Observation and Discussion.

5.1 Interpretation Analysis and Evaluation

It summarises the results obtained from the proposed design and methodology. The way to obtain the results should be described in detail. Analysis and evaluation have to be performed. Comparisons should be made. It should justifies if the project aims, objectives, requirements and specifications have been achieved.

6 Math equations

This section is for demonstration of equations, figures, tables, which is not required for the report.

6.1 Maths

$$\frac{dS_t}{S_t} = rdt + \sigma dW_t, \quad S_0 > 0, \quad (6.1)$$

The equation $\sigma = ma$ follows easily [?].

6.2 Figures

Here is an example [?] of how to insert a picture:

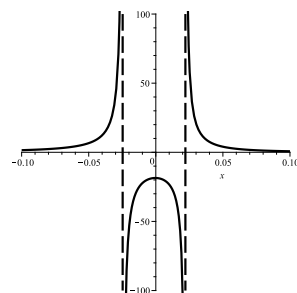


Figure 1: This is the caption for the figure.

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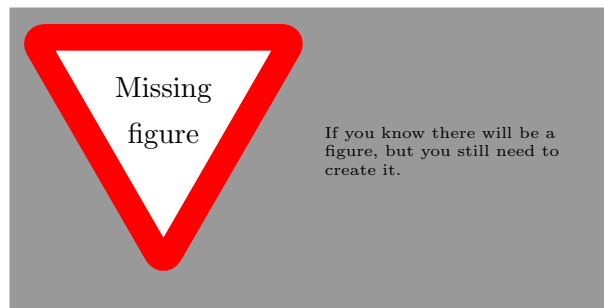


Figure 2: This is the caption for the figure which is not even present.

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or two side-by-side pictures:

This is a small Todo, please take care!

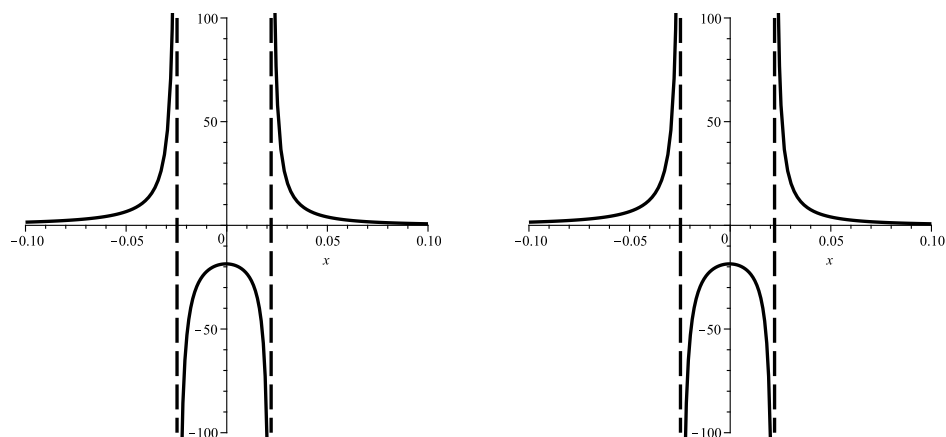


Figure 3: Another caption

7 Legal, Social, Ethical and Professional Issues

Research and projects within the medical domain are always inherently sensitive regardless of the kind of data involved or the presence of human participants. This sensitivity is amplified when a highly prominent industry stakeholder such as the NHS is interested, in view of the fact that it oversees public health across all of the UK. Right from the start, I have prioritized regular and transparent communication with our industry advisor through recurring meetings, while upholding implicit confidentiality agreements regarding the nature of the data and the project's specific objectives. All analysis was conducted within the agreed-upon scope. All deliverables were presented in a coherent and actionable format, thereby reflecting my commitment to their distinct requirements and towards fostering a trustworthy working relationship. Being cognizant of my social and ethical responsibility in this undertaking to advance public welfare, I have submitted an application in KCL's Research Ethics Management Application System (REMAS) which should supplement the agreements and principles established at the time of inception of the project, considering that the project is a KEP with industry (NHS England). According to KCL and REMAS guidelines, this project is classed as "Minimal Risk" [ref], in that it involves the study of pre-existing data that is not available to the general public, but is fully anonymous at the point which I as a researcher gain access to it. The industry advisor has kindly provided us the necessary data after complete anonymization, which removes any risk of personal identification. (Still submitted a Full Application Form instead of a minimal risk application) To further support this and in line with the guidelines listed in the General Data Protection Regulation (GDPR) as well as the Data Protection Act (DPA) 2018, the data was both shared with me and only accessed through secure organization / university credentials, meaning that it did not need to be fetched at all through any resource or API calls, eliminating the risk of interception. It was stored locally for on-machine data analysis and modelling through frequently used, open-source Python libraries, without the involvement of any online tools where the data has to be uploaded for research. Efforts have been taken to determine whether the project requires approval from any external entities, for example the Health Research Authority[ref] <https://www.hra.nhs.uk/planning-and-improving-research/research-planning/student-research/>. This was found to be not necessary. No recruitment of human participants was in the picture. Every care was taken to prevent any conflicts of interest from occurring, whether around other similar research, intellectual property, project objectives or any other sectors. I have also considered reliability measures to minimize the possibility of any kind of "reverse engineering" that may be carried out on my work. This substantiates that I have displayed special adherence to the British Computer Society (BCS) Code of Conduct and Code of Practise[ref], especially the directives regarding "Public Interest" and "Professional Competence and Integrity".

The content of “Conclusion” is in “\contents\conclusion.tex”

8 Conclusion

It is a chapter to sum up the main points and findings of the work; how you achieve the project aims and address the research questions; the contributions and results you have achieved. Future plan and development can be mentioned in this section as well. It is normally in one or two pages.

References

- [1] Diabetes UK, “Cost of devastating complications highlights urgent need to transform diabetes care in the UK.” [URL](#). Accessed: 2025-07-07.
- [2] Diabetes Professional Care, “Almost 60 costs are for ‘preventable’ complications.” [URL](#). Accessed: 2025-07-07.
- [3] Hospital Pharmacy Europe, “Data from health economic model shows cost of managing hypoglycaemia.” [URL](#). Accessed: 2025-07-07.
- [4] Diabetes Research and Wellness Foundation, “Emergency call-outs for diabetes-related condition reduced following hypos education campaign.” [URL](#). Accessed: 2025-07-07.
- [5] NHS Digital, “National diabetes audit 2021-22, report 1: Care processes and treatment targets, detailed analysis report.” [National Diabetes Audit 2021-22](#). Accessed: 2025-07-07.
- [6] Diabetes UK, “What is hba1c?.” .

A Appendix

A.1 Dataset

	UniqueID	Order Date	Order Time	Order ID	Inpt Admsn Date	Discharge Date	Length of Stay	Ward	Last Lab Test Results	Age	Ethnicity	Gender	Identity	Last HbA1c	Last HbA1c Dt	Last eGFR	EGFR Date	Admit Weight
266	265	05.06.2025	10:58:03	2485956356	05.06.2025	06.06.2025	1d 9h	GH RICHARD BRIGHT WARD	Manual blood glucose: 6.20 mmol/L	64	Not stated/Undefined	Male		82	19.12.2024	23	27.06.2025	
267	262	05.06.2025	11:02:08	248598252	05.06.2025	06.06.2025	1d 9h	STH GYNAECOLOGY WARD	Manual blood glucose: 10.80 mmol/L	52	Black or Black British - Unspecified	Female				77	06.06.2025	
268	267	05.06.2025	11:02:22	248593863	05.06.2025	06.06.2025	1d 9h	STH GYNAECOLOGY WARD	Manual blood glucose: 12.00 mmol/L	52	Black or Black British - Unspecified	Female				77	06.06.2025	
269	267	05.06.2025	11:21:12	248568251	05.06.2025	05.06.2025	3h	STH ADMISSIONS WARD	Manual blood glucose: 10.10 mmol/L	56						78	05.06.2025	
270	269	05.06.2025	11:58:35	248596846	24.01.2025	157d 18h		STH WILLIAM GULL WARD	Manual blood glucose: 5.20 mmol/L	59	Black or Black British - African	Female		43	20.01.2024	58	01.07.2025	121 kg
271	3	05.06.2025	11:59:38	248598330	25.05.2025	18.06.2025	24d 2h	STH WILLIAM GULL WARD	Manual blood glucose: 10.40 mmol/L	88	White - Any other White background	Choose not to disclose		53	30.04.2024	59	18.06.2025	
272	4	05.06.2025	12:06:47	248590954	05.06.2025	06.06.2025	1d 9h	GH RICHARD BRIGHT WARD	Manual blood glucose: 5.70 mmol/L	64	Not stated/Undefined	Male		82	19.12.2024	23	27.06.2025	
273	262	05.06.2025	12:21:30	248598333	16.05.2025	27.06.2025	42d 1h	STH SARAH SWIFT WARD	Manual blood glucose: 11.90 mmol/L	76	White - British			61	27.06.2025	61	27.06.2025	
274	273	05.06.2025	12:54:34	249011417	17.05.2025		45d 9h	STH HILLIERS WARD	Manual blood glucose: 7.40 mmol/L	74	Black or Black British - Caribbean			54	22.04.2024	50	30.06.2025	95 kg
275	11	05.06.2025	13:43:17	249031415	31.05.2025		30d 18h	STH WILLIAM GULL WARD	POCT glucose Blood Manually En...: 7	52	White - English				>90	27.06.2025	55 kg	
276	275	05.06.2025	14:16:46	249045211	04.06.2025	07.06.2025	3d 3h	GH FLORENCE WARD	Manual blood glucose: 4.80 mmol/L	74	White - English	Male				32	24.06.2025	
277	276	05.06.2025	15:07:28	249067395	04.06.2025	20.06.2025	16d	STH GI PAGE WARD	Manual blood glucose: 7.20 mmol/L	81	Not stated/Undefined			61	13.11.2023	82	20.06.2025	
278	277	05.06.2025	15:07:40	249067474	01.06.2025	06.06.2025	5d 16h	STH ALEXANDRA WARD	Manual blood glucose: 6.50 mmol/L	78	Black or Black British - Caribbean	Female		39	24.04.2025	5	17.06.2025	
279	278	05.06.2025	15:42:24	249082295	06.06.2025	06.06.2025	16h	STH ADMISSIONS WARD	Manual blood glucose: 9.60 mmol/L	68	Black or Black British - African	Male		47	03.05.2024	58	06.06.2025	
280	279	05.06.2025	15:56:30	249087656	01.06.2025	09.06.2025	8d 17h	STH ALBERT WARD	Manual blood glucose: 5.70 mmol/L	34	Black or Black British - African	Male			>90	25.06.2025		
281	280	05.06.2025	16:07:02	249091566	05.06.2025	06.06.2025	1d 10h	GH ASTON KEY WARD	Manual blood glucose: 6.10 mmol/L	72	Black or Black British - Caribbean	Female		43	17.04.2024	60	06.06.2025	
282	281	05.06.2025	16:59:47	249109429	05.06.2025	06.06.2025	1d 9h	STH GYNAECOLOGY WARD	Manual blood glucose: 7.50 mmol/L	52	Black or Black British - Unspecified	Female			77	06.06.2025		
283	267	05.06.2025	17:36:36	249118534	05.06.2025	06.06.2025	1d 10h	GH ASTON KEY WARD	Manual blood glucose: 6.30 mmol/L	72	Black or Black British - Caribbean	Male		43	17.04.2024	60	06.06.2025	
284	281	05.06.2025	17:55:00	249122117	05.06.2025	06.06.2025	1d 1h	GH SARAH WARD	Manual blood glucose: 6.50 mmol/L	69	White - English				>90	05.06.2025		
285	284	05.06.2025	18:03:54	249123786	22.04.2025		70d 9h	STH MARK WARD	Manual blood glucose: 5.10 mmol/L	68	White - British			47	12.04.2024	30.06.2025	75 kg	
286	285	05.06.2025	19:02:34	249132405	03.06.2025	07.06.2025	4d 13h	GH ASTON KEY WARD	Manual blood glucose: 10.80 mmol/L	50	Black or Black British - Any other Black	Female		109	10.06.2025	>90	10.06.2025	
287	118	05.06.2025	19:25:07	249134589	17.05.2025		45d 9h	STH HILLIERS WARD	Manual blood glucose: 6.00 mmol/L	74	Black or Black British - Caribbean			54	22.04.2024	50	30.06.2025	95 kg
288	11	05.06.2025	19:26:43	249134739	05.06.2025	12.06.2025	6d 21h	STH WILLIAM GULL WARD	Manual blood glucose: 11.10 mmol/L	65	White - English	Male				70	30.06.2025	
289	288	05.06.2025	19:27:27	249134791	30.04.2025	61d 17h		STH WILLIAM GULL WARD	Manual blood glucose: 13.00 mmol/L	59	White - Any other White background	Male				72	26.06.2025	62.3 kg
290	12	05.06.2025	19:56:11	75513886	05.06.2025	06.06.2025	14h	STH ADMISSIONS WARD	Manual blood glucose: 9.20 mmol/L	41	Black or Black British - Caribbean			63	06.06.2025	63	06.06.2025	
291	290	05.06.2025	20:42:10	249140609	14.04.2025		77d 17h	STH SOMERSET WARD	Manual blood glucose: 3.40 mmol/L	35	Any Other Ethnic Group	Male			81	29.06.2025	77 kg	
292	148	05.06.2025	20:42:48	249140642	14.04.2025		77d 17h	STH SOMERSET WARD	Manual blood glucose: 4.30 mmol/L	35	Any Other Ethnic Group	Male			81	29.06.2025	77 kg	
293	148	05.06.2025	20:44:12	249140769	06.06.2025	07.06.2025	1d 13h	STH SOMERSET WARD	Manual blood glucose: 6.60 mmol/L	53	Black or Black British - Caribbean	Female		40	08.12.2023	>90	05.06.2025	
294	293	05.06.2025	21:07:45	249142353	06.06.2025	06.06.2025	16h	STH ADMISSIONS WARD	Manual blood glucose: 6.60 mmol/L	68	Black or Black British - African	Male		47	03.05.2024	58	06.06.2025	
295	279	05.06.2025	21:07:45	249142357	06.06.2025	06.06.2025	16h	STH ADMISSIONS WARD	POCT Glucose Blood Manually E...: 11	68	Black or Black British - African	Male		47	03.05.2024	58	06.06.2025	
296	279	05.06.2025	21:16:33	249143099	05.06.2025	06.06.2025	1d 1h	GH SARAH WARD	Manual blood glucose: 12.40 mmol/L	69	White - English				>90	05.06.2025		
297	284	05.06.2025	21:43:01	249144918	21.05.2025		40d 19h	STH ALEXANDRA WARD	Manual blood glucose: 6.20 mmol/L	82	Not stated/Undefined					53	01.07.2025	67.2 kg
298	297	05.06.2025	22:01:57	249146383	25.05.2025	18.06.2025	24d 2h	STH WILLIAM GULL WARD	Manual blood glucose: 11.00 mmol/L	88	White - Any other White background	Choose not to disclose		53	30.04.2024	59	18.06.2025	
299	4	05.06.2025	22:13:12	249147160	24.01.2025		157d 18h	STH WILLIAM GULL WARD	Manual blood glucose: 6.10 mmol/L	59	Black or Black British - African	Female		43	20.01.2024	58	01.07.2025	121 kg
300	3	05.06.2025	22:46:05	249149081	06.06.2025	10.06.2025	4d 9h	STH MARK WARD	Manual blood glucose: 5.20 mmol/L	72	Asian or Asian British - Arab	Male		64	13.05.2024	59	26.06.2025	
301	300	05.06.2025	23:44:45	249152341	14.04.2025		77d 17h	STH SOMERSET WARD	Manual blood glucose: 5.80 mmol/L	35	Any Other Ethnic Group	Male			81	29.06.2025	77 kg	
302	148	06.06.2025	16:48:01	249383961	07.06.2025	14.06.2025	7d 18h	STH ALEXANDRA WARD	Manual blood glucose: 6.80 mmol/L	99	Black or Black British - Caribbean	Female			26	16.06.2025		

Figure 4: Raw dataset

