Out of Hours

Is the 'scandal' of diabetes care in general practice fact or fiction?

At a national conference in 2013 (the Nuffield Trust Summit), I was challenged about the alleged unacceptable standard of diabetes care in general practice. Similarly Diabetes UK¹ refers to the 'scandal' of inadequate standards of care.

If standards are to be of value to patients and professionals they need to be based on good research and be achievable in usual clinical practice. They must also meet the requirements for ethical and compassionate care. We are satisfied that the current criteria are based on good research and agree with the nine clinical targets promoted by the Department of Health and Diabetes UK following NICE guidance in 2012.² However, we have serious reservations. Are these standards sensible and ethical and are the national figures accurate?

The current Health and Social Care Information Centre³ (HSCIC) asks the audit question: *'What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?'* and Diabetes UK¹ aims to ensure that: *'All people with diabetes to receive the agreed essential care standards to reduce complications, costs and premature death.'* These national targets allow no exemptions and assume that 100% achievement is both possible and desirable.

Diabetes audits are published on the basis that the number of people receiving the intervention forms the numerator, and the known population of people with diabetes the denominator. The unstated implication is that all people with diabetes should receive every intervention every year. All types of diabetes at any stage of diagnosis are included, unlike the QOF in the GP NHS contract.⁴ The nine interventions are reported cumulatively so that failure of any one patient to receive any one of the nine standards leads to that patient being reported as having had suboptimal care.

We question these assumptions and call for recognition when standards are not sensible. Given that 4.25% of the population in England and Wales has type 2 diabetes and that this tends to affect older people, a significant number of people with diabetes will be seriously ill at any point in time and some will be dying. Imposing all nine standards of care on such people at such a time is not just inappropriate, but unethical and lacking in compassion.

The basis of medical practice in the UK

is that it is advisory. And there is evidence that patients sometimes dissent from medical advice; for example, by not cashing prescriptions.⁵ If an adult patient, with mental capacity declines care, is it appropriate that the doctor(s) are blamed for apparently poor results? If a patient is offered appointments for a diabetic check and then fails to attend, why is that patient not responsible? All this has justified 'exception reporting' in the QOF. In 2005/2006, 6% of patients with diabetes were excepted by their GPs.⁶ However, there is no exemption component in the National Diabetes Audit (NDA). Auditors are insensitive if they deny adult patients with capacity their common law right to decide whether or not to accept medical advice.

The assumption that failure to complete any one of the nine interventions means the patient is receiving sub-standard care must be questioned. If a patient with diabetes has had a leg and/or foot amputation they remain included in the population for whom peripheral pulses should be recorded, even though they have no foot pulses to record.

Early in 2013, we discovered that our practice was being credited with achieving 23% coverage for eye screening, whereas our in-house search showed the level of achievement was 79%. We now understand from the HSCIC that this is a data collection problem potentially affecting all general practices using the VISION (INPS) computer system. This will skew the audit results of British general practice by indicating a lower than correct level of achievement. The recently issued NDA figures for 2011/2012 have acknowledged this problem and have excluded eye screening from the results. However, at the time of writing we are not aware of any public acknowledgment that the results for 2010/2011 (and presumably previous years) were in error.

The national system needs reform. An approximate allowance for dying or seriously ill patients, or patients with amputations for example, plus those who decline care could be achieved by making the national target perhaps 90% or 95%. Signed evidence of a patient declining should be accepted as grounds for removal from the target denominator. Levels of achievement should be reported separately for each evidence-based target and the interactivity convention played down. The number of general practices affected by the computer problem should be reported transparently. The level

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of best possible performance in real life general practices should be published and researched, to spread good practice. Each standard should be reported separately, stating the best possible performance. Diabetes UK, the NHS, and the RCGP all have a part to play in constructing sensible standards. A stronger general practice voice is needed at the standard-setting table.

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