is that it is advisory. And there is evidence that patients sometimes dissent from medical advice; for example, by not cashing prescriptions. 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. 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 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.