

care records. We calculated rates of maltreatment-related coding before (January 2010 to December 2011) and after (January 2012 to December 2012) implementation of the coding strategy in 11 English practices. The strategy was developed in collaboration with the audit leads in the 11 practices. These GPs were selected for expertise in child safeguarding or another relevant area.

The strategy centred on encouraging GPs to use, always and as a minimum, the Read Code 'Child is cause for concern' if they 'considered' maltreatment (as defined in NICE guidance<sup>2</sup>) had any safeguarding concerns. We also undertook a service evaluation of the strategy.

In the 25 106 children age 0–18 years registered with these practices we found increased recording of any maltreatment-related Code (rate ratio [RR] = 1.4; 95% confidence interval [CI] = 1.1 to 1.6), child protection procedures (RR 1.4; 95% CI = 1.1 to 1.6), and cause for concern (RR 2.5; 95% CI = 1.8 to 3.4) after implementation of the coding strategy. Clinicians cited the simplicity of the coding strategy as the most important factor assisting implementation and time and competing priorities as the greatest barriers.

The coding strategy improved coding of maltreatment-related concerns in a small sample of practices with some 'buy-in'. Further research should investigate how coding relates to ongoing management of the family and can support the doctor–patient relationship.

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## How can we communicate better with social services?

The article in the July issue by Brodie and Knight brings many questions. Are multidisciplinary team meetings not part of normal QOF-related primary care? Were the school nurses and health visitor funded from the Local Enhanced Service monies? There is no comment as to whether social services were invited and if so, attended. Safeguarding is indeed an important subject and huge amounts of time are spent on training and retraining. In our area though it is not lack of knowledge of the process or of those children who are or might be vulnerable, but the black hole of the 'system'.

Joined-up face-to-face meeting with the social services component of safeguarding might enhance the benefit and let us know as GP what 'they know' about the children and vulnerable adults in our shared care and what, if anything positive, can be done about them.

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## 'Good diabetes care' and the NDA

The article from Pereira Gray and colleagues in the June edition of the *BJGP* questions whether the terms used to define 'good

diabetes care' are sensible and suggests there should be exemptions in the National Diabetes Audit (NDA).

The NDA collects information on all people with diabetes from practices that contribute (which was 88% of practices in England in the 2011–2012 audit). It does this to enable peer comparisons to be made to support quality improvement. Its purpose is developmental, not summative like QOF, which is focused on financial reward. Exemptions undermine valid inter-service comparison. There are justifiable clinical reasons for non-attainment of treatment targets but these are likely to be evenly distributed; and the NDA reports on the influence of factors such as age, type and duration of diabetes, ethnicity and socioeconomic status. Interestingly the NDA has shown no correlation with these 'usually quoted' reasons for non-achievement of treatment targets. We believe it is best and fairest to use everyone with diabetes as the denominator.

The twofold difference in care bundle achievement between practices operating in similar, geographical areas suggests that the NDA is identifying important differences in care delivery, and that this should drive diabetes quality improvement. Evidence-based treatment targets offer treatment goals to be negotiated with individual people with diabetes. No one suggests that they would or should be achieved in everyone, but the NDA, by reporting on everyone with diabetes shows that patients of similar practices have widely different chances of reaching them.

Standard setting is a separate process to data collection and we would agree that a strong general practice voice is needed at the standard setting table.

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