Measuring diabetes care quality in general practice: How are we doing?

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In their comment published in the previous edition of the Journal, Evans and Pereira Gray (2014) refer to a number of issues, including the application of the term "scandal" to the state of care for people with diabetes in primary care and the bundling of care processes measured in the Quality and Outcomes Framework into one composite indicator. We are grateful for this opportunity to respond and contribute to this debate.

The National Diabetes Audit (NDA) has, since its inception in 2004, reported annually on the completion of the NICE-recommended care processes individually and as a care bundle. It has also reported on the achievement of the NICE-recommended intermediate outcome targets for blood pressure, HbA_{1c} and cholesterol, both individually and as a composite.

The National Audit Office (NAO) was tasked by the Public Accounts Committee of the House of Commons to report on diabetes care in England and its report was published in 2012 (NAO, 2012). It concluded that diabetes care needed to improve and cited the evidence that less than half of everyone with diabetes had received all the NICE-recommended care processes. It is probable that the application of the word "scandal" to diabetes care in England may have originated from commentary on this NAO report.

What has not received widespread publicity is that the completion of nine care processes as recorded by the NDA has risen from 6% in 2004 to 46% in 2010–11 (Gadsby and Young, 2013). In 2011–12, the NDA dropped retinal screening from the "bundle" and now reports that 60% of all people with diabetes have achieved all eight care processes, which is a remarkable achievement and is among the best care process delivery results published in the world (Health and Social Care Information Centre, 2014). Diabetes care in England has recently been ranked the fourth best of 30 countries in a pan-European survey (Health Consumer Powerhouse, 2014).

However, the creditable average scores conceal a two-fold difference in care bundle achievement between practices operating in similar geographical areas, which suggests that the NDA is identifying not only long-term "whole system" improvements but also ongoing differences in local care delivery. If the bottom 25% of practices were to be supported and encouraged to achieve care processes delivery rates that "average" practices already achieve, our results would be the best in the world.

The NAO favoured a care composite bundle. This may be felt to be an imperfect measure, but it seems that it is the one that we are stuck with. The intermediate outcome indicators for blood pressure, HbA_{1c} and cholesterol reported separately and as a composite also provide useful information on the quality of diabetes care, and we feel that these results, which demonstrate similar patterns of variation, should also be highlighted.

The NDA shows that diabetes care in England is not a "scandal". Indeed it is among the best in the world. However, in our view, that should not absolve us of the need to address an ongoing two-fold variation in achievement between the best and worst practices. ■

Evans P, Pereira Gray D (2014) Measuring diabetes care quality in general practice: A whole bundle of trouble? *Diabetes & Primary Care* **16**: 236

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