Eugene Hughes

The mercy of quality

The National Service Framework (NSF) implementation document (when it comes) and the new contract for GPs are both set to exert a major influence in diabetes care. Not so much in its delivery perhaps, as in its monitoring. It seems likely that diabetes is one of the conditions that will have 'tiered quality markers'. I also have it on good authority that the pot of gold we are eagerly anticipating to arrive with the second part of the NSF will be 'built into' these quality markers. In other words, don't expect the sugar fairy to leave bundles of cash on your desk to enable you to decide how best to improve diabetes care in your surgery – you will have to work for it. However, there is the promise that you will be able to bid for 'start-up' money to achieve a certain quality level, which will be supplemented by 'reward' money if the targets are met.

But who will decide what constitutes 'quality'? We know from previous experience that the government, and therefore PCTs (who do whatever the government tells them to do), have an unhealthy obsession with number-crunching exercises. Will these sorts of measures be appropriate to diabetes care? For example, it might seem a good idea to count how many patients with diabetes in a practice have achieved target values of HbA_{1c}, blood pressure or total cholesterol. You could even have 'league tables' of best performance locally, or between PCTs. But think about this for a second. Does it really tell you anything about the quality of care? There are too many confounding factors: mobile populations, ethnicity, age–sex distribution, patient choice – these all have to be factored into the calculation. Suppose I have one hundred people with diabetes who all start off with a HbA_{1c} of 10%, and that, by intensive management of glycaemic control and by exercising best practice, I manage to get them all down to 8.5%, I might appear to have failed (if we look only at target values), but I will have reduced microvascular and probably macrovascular risk, if we are to believe the UK Prospective Diabetes Study (UKPDS). Suppose again that I go one step further, and achieve perfect results in all my patients, only to find that they all move out of my area, to be replaced by a nightmare group with appalling control? Unlikely, with my stable population base, but not so funny in central Birmingham.

The measuring of numbers is therefore problematic. Measures of process are perhaps more reliable. How many patients have had retinal screening this year? How many have had a foot assessment? How many have had an annual review? But even these sorts of measurements fail to address the issue of action. If you found a raised blood pressure, what have you done about it? If your patients are not receiving adequate footcare, what are you doing about it? What is the PCT doing about it?

The measures of quality that we agree upon have to be seen to be fair, valid and comparable. It is time to engage with PCTs to work out sensible quality measures before unrealistic measures are 'suggested'. PCTs themselves do not have to take on this burden unaided. There are pilot schemes around the country that are looking at just this problem. QUIDS (quality indicators for diabetes services) is a scheme that has been jointly funded by the National Institute for Clinical Excellence, Diabetes UK and the NHS executive North West, to develop service indicators for diabetes care. Their website (www.quids.org.uk) deserves a visit.

Some are born with quality, some achieve quality, others will have quality thrust upon them; that is unless they seize the opportunity to engage in a meaningful, informed dialogue with the powers that be. ■

Eugene Hughes is Editor of *Diabetes and Primary Care* and General Practitioner at Seaview, Isle of Wight