Give us the tools to deliver quality care

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The National Diabetes Audit (NDA; NHS Information Centre, 2011) for 2009–2010 was published earlier this year and, as is common in construing statistics, can be interpreted in two ways: the bad news, and the good.

There are four elements to consider: registrations, care processes, treatment targets and complications. The prevalence of diabetes continues to grow, so we can assume we are continuing to diagnose and record diabetes. We also know that there are huge numbers of people undiagnosed, and eagerly await the report on HbA_{1c} for diagnosis, when diagnostic rates are expected to escalate. The increase in numbers of people with diabetes then has increased year on year without – surprise, surprise – a similar increase in healthcare professional time to help them self-care.

First, the bad news. We are still not meeting targets; we are doing the measurements, but are inconsistent in our achievements. There is a postcode lottery for care with a wide variance in cost to outcomes. You can look up your area on the Diabetes Outcomes Versus Expenditure (DOVE) assessment tool (Yorkshire and Humber Public Health Observatory, 2011). In Surrey we have high costs for diabetes care but with good outcomes. On one hand, reducing costs is high on the commissioning groups' and PCTs' agenda; on the other, we have a high number of University of Warwick-trained GPs and nurses who are in all likelihood prescribing effectively.

The nine key care processes highlighted by the NDA (measuring weight, blood pressure, HbA_{1c}, urine albumin–creatinine ratio (ACR), serum creatinine, serum cholesterol and assessing eyes, feet and smoking) also suffer from large variances across the country.

So obesity rates continue to rise, particularly in type 2 diabetes (T2D). The NDA found 80% overweight or obese rates in T2D. The government recently announced that it was going to encourage people to consider what they were eating and amend their lifestyles. If healthcare professionals are to help people lose weight and adopt more healthy lifestyles, we need far more support than that. More access to physical activity schemes and structured education for patients would help. Prevention of diabetes is a key area for the NHS in the coming year. I believe that it is a public health concern – there is a recession on and unhealthy food is cheap.

Some other key facts from the NDA. Blood pressure is recorded in around 90% of people with diabetes, with large numbers not meeting best practice. Only 28.2% of those with type 1 diabetes (T1D) are meeting the HbA_{1c} target. The situation is better with T2D, but there is no room for complacency or inertia. Some 73.7% of people with T2D and 54.4% with T1D were checked with an ACR; 74.8% of people with T1D and 92.4 per cent of people with T2D had their cholesterol measured; and 72.5% with T1D and 78.3% with T2D achieved the Quality and Outcomes Framework indicator of <5 mmol/L (NHS Employers, 2010). So that's good too, isn't it? The tighter target of < 4mmol/L was less inspiring, with 30.2% of people with T1D and 40.9% of people with T2D achieving it.

Six months between appointments, and with little time for worthwhile discussion, denies the individual the chance to learn and participate in their own care. Just prescribing increasing amounts of pills and/or insulin is not the whole story. Lifestyle issues raise their head again. The Steno study showed that multifactorial risk intervention greatly reduced mortality (Gaede et al, 2008), but in my experience few people with diabetes know how their medication works, and research shows that few take it as prescribed (Donnan et al, 2002). Try asking the question "When did you last miss a dose?" and you are likely to be surprised at the answer.

In the NDA foreword, the diabetes tzar Dr Rowan Hillson asks the question: "We know what to do, so why aren't we doing it?" We need the tools to do the job. Education is key, but gaining access to it is becoming more difficult (Santry, 2011). Details for the 2010–11 NDA have now been confirmed for primary care. If you work in primary care, do participate. We need the evidence to make the case for improving resources for people with diabetes. ■