Author's response to reviews

**Title:** Quality of Diabetes Care Worldwide and the Feasibility of Implementation of the Alphabet Strategy - Global Alphabet Strategy Implementation Audit (GAIA) Project: an international audit of diabetes care, questionnaire, and pilot implementation study

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**Author's response to reviews:** see over
Dear Sir/Madam,

Re: Response to reviewer’s comments.

We have read Dr Stewart’s report with great interest and sincerely thank her for all the valuable comments and criticisms. We have addressed these and rewritten the manuscript and hope this has improved the manuscript. The individual points are addressed below, our comments in italics to aid clarity.

Introduction

The introduction highlights the global burden to health services of diabetes and evidence that effective treatment can prevent the development of complications. It also highlights that even in UK, familiar with auditing and monitoring the quality and outcomes of diabetes that fewer than 50% of people receive all 9 NICE annual care processes and less that 20% achieve all treatment targets.

We are introduced to what checklists are, how their transition into healthcare has been limited and when they have been employed in medicine there has been considerable success. (Introduction, paragraph 2)

At this point I feel the authors have been somewhat selective in the references they use to support the success of checklists in improving health outcomes. Indeed, the author of one of the papers cited (Ref 15 – Pronovost et al 2006) subsequently co-authored a critique in the Lancet (Bosk et al, vol 374 August 8, 2009) entitled ‘‘Reality check for checklists’’ in which it is proposed ‘‘the widespread deployment of checklists without an appreciation of how or why they work is a potential threat to patients’ safety and high quality care’’.

We have addressed these, included these references and made alterations to our manuscript to provide a more balanced view.
Methods

The methods for the worldwide audit are well described. However, the method for the questionnaire study does not contain any description of analytic methods. There is no mention on how patients that were taken through the AS and educational posters were selected.

*We have provided more details on the questionnaire and pilot study methods addressed the reviewer’s comments in the re-written draft.*

The paper refers to the structured questionnaire being shown in Appendix 1, but the appendix 1 submitted is not the questionnaire.

*Apologies for this error, the appendix 1 now contains the correct questionnaire.*

A description of why rural India was selected for the pilot implementation site against other potential sites would be useful.

*A description and rationale for selecting the rural India for the pilot study is given in the re-written manuscript.*

The methods of the implementation includes the use of chi-squared test and I think it would be useful for readers to be given some justification on the appropriateness of this test for a between group comparison.

*We have highlighted that chi-squared test was used to compare the percentage proportions of people achieving care processes.*

Results

Data is presented to support the main findings from the diabetes care audit. Supplement 8 – achievements of various BP and HBa1c targets is labelled both table 5 and 4. Very limited data are shown to support the results of the questionnaire study, or pilot implementation study.

*We have also included more results for the questionnaire study and pilot implementation in India, as well as a breakdown of the professions of the people completing the questionnaires.*

Questionnaire study

Although there seems to be instructions on the Alphabet strategy questionnaire (supplement 3) that the questionnaire for each centre should be completed by a minimum of 5 per team, including 2 patients and 3 healthcare professionals, the authors report that questionnaires were completed by a range of one to seven people per centre – we are not told how many and which healthcare professionals (eg doctor, nurse) and how many patients completed the questionnaire. The authors say the results for the first 9 questions are shown, along with their average respective percentage on the VAS but I could not see that these formed part of the 8 supplements submitted.

*As above. We are thankful for these comments. The revised manuscript addresses these points and we believe the manuscript is substantially improved.*
Pilot implementation study

Here, table 6 to demonstrate the diabetes care parameters before and after introduction of the checklist appears to be missing from the supplements submitted. As data from the questionnaire study and table 6 appear to be missing from the submission it is difficult to judge if the author’s assertions about the acceptability and improvements etc. are warranted.

*We are not entirely clear if some of the attached tables and figures (in particular table 6) were not included in draft sent to Dr Stewart. Table 6 appears to clearly show data before and after implementation of the Alphabet Strategy. We have included this again in the new submission.*

Discussion

The authors acknowledge (paragraph 4) that there are barriers to effective diabetes treatment in developing countries. The inclusion of the description of the ‘POETIC’ approach is interesting, and this highlights the need for team delivered and integrated services. I do feel there is a place for more discussion on these aspects – as Bosk et al (op cit) point out it is a mistake to assume that technical solutions (checklists) can solve an adaptive (socio-cultural) problem. The Alphabet Strategy may well have the potential to contribute to improved clinical outcomes. It requires that health care professionals, users and carers all subscribe to a single systematic approach to diabetes management. The study refers to the use of the Alphabet strategy checklist, which in the way it is presented seems to focus on clinician led processes of measuring and checking. Whilst patients are offered advice, on smoking, weight etc, there is nothing explicit in the checklist template to say that this should be patient centred (this seems to come with the underlying ‘Poetic’ philosophy). There is evidence that when consultations become more centred on achieving QOF targets harm to the patient-clinician relationship can occur (Glasziou et al BMJ 2012 345: e5047 When financial incentives do more good than harm: a checklist).

*We thank the reviewer for these comments and acknowledge that checklists potentially provide a technical solution to a problem, and that they face sociocultural barriers. We also acknowledge that checklists if applied inappropriately with little preparation become essentially useless and unused tools. Whilst the Alphabet Strategy unashamedly aids the clinician to focus on necessary care processes for comprehensive care, a checklist should not encourage ‘robotic’ or ‘strait-jacket’ medicine. Clinicians should be involved and educated along with the patients about the checklist and the purpose. The revised manuscript addresses these in the discussion. Introduction of any checklist requires intense background work before potential implementation of the process.*

Abstract

Given the socio-cultural problems in developing countries the authors highlight in the paper, and the contention from Bosk et al (op cit) that what a simple checklist can achieve is ‘on its own - not much’ as they are ‘weak interventions' I believe the authors need to be much more cautious in their statement (in the abstract) that the AS may provide a unique, cost effective approach in delivering high quality care in diabetes.

*We have toned down this message in the revised manuscript.*
I have offered these comments in the spirit of collegiality and hope they appear as such - it is interesting work. However, I feel the limitations of the paper as described above require a major revision, in particular the reporting of the questionnaire study and the pilot implementation study.

*Once again we thank the reviewer for all the extremely valuable comments. We have addressed all of these to the best of our ability and believe the manuscript is substantially improved from the previous version.*

*I have included our criteria for authorship and conflicts of interest after our manuscript as suggested in the BMC template.*

Yours sincerely,