Thank you for asking me to review this paper, which reports on an international audit of diabetes care, a questionnaire study on the merits of the ‘Alphabet Strategy’ and the feasibility of implementation in the local healthcare system and a pilot implementation study. This is an interesting area of potential interest to your readership.

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’.

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. The paper refers to the structured questionnaire being shown in Appendix 1, but the appendix 1 submitted is not the questionnaire. A description of why rural India was selected for the pilot implementation site against other potential sites would be useful. 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.

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.

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.

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.

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).

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.

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.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare that I have no competing interests