How will The King's Fund report impact diabetes care?

Brian Karet

Much fanfare heralded the publication of The King's Fund (2011) report on primary care in March this year. It has taken 2 years and gone through two chairmen, Niall Dickson and Ian Kennedy, and because of the way it gathered data through a series of seminars, is a bit out of date. The context of modern primary care is, however, clearly set out. We are dealing with an ageing population and increasing demands and expectations in an era of reduced public spending. Nevertheless, there are some important messages and implications of the report as its findings will be used to drive through some of the changes proposed in the Health and Social Care Bill currently stuttering its way through parliament. The report gives an honest and not always pleasant picture of primary care in England, highlighting:

- Variations in the quality of diagnosis – suggesting that cases highly suspicious of upper gastrointestinal cancer were frequently not referred urgently.
- Huge differences in referral rates across the country for some forms of cancer.
- Variations in the quality of referrals.
- Variation in the quality of prescribing highlighted by large differences in statin prescribing with little difference in outcomes. This could lead to tighter enforcement of prescribing guidance and formularies.

The report also highlights concerns that continuity of care is getting worse, despite evidence that being able to see the same GP is more important to patients than how quickly they can get an appointment.

Continuity of care is not just important, but if it is undertaken well, it should result in more coordinated and less disjointed care. This does not always happen as data highlighted by the report show:

- In the lowest performing practices, just over 25% of patients were able to see their preferred doctor.
- Big variations in admission rates for individuals with conditions that could be treated in the community.
- Just 10% of people with a long-term condition reporting they have an agreed care plan.

Despite a wealth of evidence, much of what happens in primary care is not evidence-based and that applies particularly to people with long-term conditions. UK general practice, unlike much of secondary care, has been almost universally computerised for 10 years. The systems, however, have neither been used to collect useful data linking interventions and outcomes, nor to highlight and disseminate variations in care.

The report's recommendations for change in primary care are in five areas:

- Promoting the concept of integrated care both within and between practices that focuses on the needs of the patient and has professional, medical and non-medical input outside of traditional primary care.
- True user engagement, which involves people being integrally involved in decisions about their care.
- GPs moving from being "gatekeepers" to "navigators" – coordinating care for people with complex needs, signposting people to other public services and being held accountable for the quality of care provided.
- Promoting the concept of "federated" practices with GPs and other healthcare professionals working under one management structure to one quality-driven system of care.
- General practice moving from a single patient focus to a locality and population responsibility, taking a greater role in public health issues such as obesity and mental health, and reaching out to deprived communities.

In diabetes much of this is already happening with the development of care planning and diabetes networks. The problem is that it is not happening everywhere and we risk ignoring the issues brought out in this report at our peril. ■

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King's Fund (2011) *Improving the Quality of Care in General Practice. Report of an Independent Inquiry Commissioned by The King's Fund.* The King's Fund, London. Available at: http://bit.ly/m2lpyq (accessed 23.05.11)