Primary and secondary diabetes care – an end to foxes and hedgehogs

In his 1953 classic essay, Isaiah Berlin divided people into "hedgehogs", perceived as having a narrow focus on an important single idea, and "foxes", who draw on a wide variety of experiences, and for whom the world cannot be "boiled down" to a single idea. The temptation is to divide the diabetes world into diabetes consultants with one narrow focus, ready to "curl into a ball" when attacked, and primary care teams as the wily foxes, more adaptable to changing circumstances. In an adjoining comment, Partha Kar suggests that the role of the diabetes consultant should evolve and take on a wider focus of leadership and education (Kar, 2012; pages 328–9 of this issue).

GPs and their teams have always recognised that a core primary care competence is the ability to understand the "big picture", while dealing with its different parts and promoting successful inter-professional working. It would also appear that the adaptability of primary care teams is going to be really stretched over the next year by dramatic changes in the Quality and Outcomes Framework (QOF), commissioning in England and the emerging revalidation requirements for GPs.

Reading a hard-hitting editorial by Rayman and Kilvert earlier this year, entitled "The crisis in diabetes care in England", it is difficult to escape the impression that there is a lot of work required from both primary and secondary care teams in order to improve diabetes care in general and eliminate the regional variations in care, as exemplified by the variations in diabetic foot amputations in England (Rayman and Kilvert, 2012).

The data behind this editorial come from the (English) National Diabetes Audit and is developed into the Atlas of Variation in Healthcare for People with Diabetes (Health and Social Care Information Centre, 2012a; NHS Right Care, 2012).

Rayman and Kilvert wonder why diabetes care in England is worse than equivalent developed nations. GPs and consultants are criticised equally: GPs for having a "tick-box" mentality driven by QOF, where the process is measured but clinical care not improved; consultants for overseeing poor inpatient diabetes care and large variations in the provision of specialised services. The authors see solutions in true integrated care, where people with diabetes move seamlessly between primary, community and secondary care depending on need. This is the Scottish model, which is committed to integrated care and has already shown improvements in foot amputation (Kennon et al, 2012). The adversarial approach between primary and secondary care, as exemplified by the foxes and hedgehogs analogy, cannot help to improve these standards.

Those of us involved in primary diabetes care for a long time have seen enormous improvements, often achieved in incremental steps. The last of these important steps was the GP contract introduced in 2004, and the associated QOF standards for diabetes care. The achievement targets have just been published and show very good, uniform care across the four nations (Health and Social Care Information Centre, 2012b). However, none of this has impressed the UK Parliamentary House of Commons public accounts committee, who have met and criticised the standard of diabetes care in England under the banner heading "Reform QOF to tackle 'depressingly poor' progress on diabetes" (House of Commons, 2012).

Colin Kenny

Colin Kenny is a GP in Dromore, County Down, Northern Ireland.

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The Parliamentary report calls on the department to scrap separate QOF targets for diabetes, worth approximately 76 points, and replace them with a single indicator payment for completing all nine tests.

The British Medical Association (BMA) is likely to take a less than sanguine view of this suggestion. It is an old adage that if you want something done, ask a busy person, but there is a sense that this is being stretched to the limits with workload for primary care teams.

The General Practice Committee of the BMA has been engaged with the Department of Health in detailed negotiations, and felt it was making progress only to have a new Secretary of State arrive and demand a complete re-evaluation of QOF, behind a cloak of austerity. Worryingly for patients, the suggested diabetes achievement targets stray well out of the safe target ranges and the proposed public health targets have little evidence-based implementation. On this basis, 2013 is set to be a year of turmoil.

The person with diabetes, perhaps bewildered, worried about the long-term complications and consequences of diabetes, deserves better. He or she needs to encounter an empowered primary care team, with the time to meet his or her individual needs. When referred into secondary care, a consistent service is needed for patients across the UK and Ireland with, as Kar observes, the highest governance and accountability standards. GPs who believe in the art of general practice place the patient at the centre of the consultation, whilst attempting to bring the best contemporary evidence to aid decision-making about care.

These decisions are frequently complex and Kar is right to widen our focus into the multi-morbidities associated with diabetes. The growing prevalence of chronic illnesses and multi-morbidities threatens to occupy much of primary and secondary diabetes care as the prevalence of diabetes increases along with an ageing population (Mercer et al, 2012).

The fox and hedgehog is based on a classic Greek fable in which the plodding hedgehog is the hero, as the fox outstretches himself in spite of his wit and apparent cleverness. The current UK coalition Government would appear to feel that it is acceptable to outstretch GPs. Kar evokes Taoist philosophy to encourage his secondary care colleagues to widen their focus and role, and adapt to a changing environment by altering their direction of travel.

The new commissioners of care in England may facilitate these changes. People with diabetes deserve care based on best evidence, tempered by compassion, for their multi-morbidity. This can best be achieved by all those delivering care working together seamlessly. Henry Ford was no philosopher, but a pragmatist who said:

"Coming together is a beginning; keeping together is progress; working together is success." ■

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