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## Inequalities in CKD management can be overcome

Molokhia *et al*<sup>1</sup> report on chronic kidney disease (CKD) coding in primary care records in a multi-ethnic area of South London, demonstrating lower rates in all ethnic minority groups compared with the white population, which contributes to health inequalities. They also confirm the findings based on the National Chronic Kidney Disease audit<sup>2,3</sup> that absence of CKD coding is associated with worse outcomes for blood pressure management and statin prescribing, and is associated with a greater burden of non-steroidal anti-inflammatory drug (NSAID) prescribing.

However, their study was based on a primary care dataset from 2013. Is it possible that Lambeth practices have improved coding rates since then? In East London there were similar low rates of CKD coding prior to 2015, when a quality improvement project promoting coding for CKD as part of a community renal service was introduced.

We combined feedback to practices, using quarterly dashboards to show performance relative to others, and engaged with the clinical commissioning groups (CCGs) to include CKD coding in Local Enhanced Services contracts. Over a 2-year period we showed a sustained rise in CKD coding to >85% across all the CCGs involved in the programme.<sup>4</sup>

Table 1 shows the dashboard for Newham

CCG (with 7822 CKD cases) from July 2020. It illustrates the high rates of coding across all age bands and all ethnic groups, with the highest recording rates in black African and black Caribbean. Results are similar across all participating CCGs.

This demonstrates the effectiveness of quality improvement programmes, which can improve the reach of effective interventions and decrease the corrosive effects of health inequalities.

There are further improvements to be made in East London — particularly in the offer of statins to younger people with CKD and improving BP control in those with both diabetes and CKD.

Using the opportunities to work across sectors and incentivise primary care in this way can reduce the impact of cardiovascular and end-stage kidney disease for those ethnic minorities at greatest risk.

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## It's time to look again at GP funding

The COVID pandemic has shone a spotlight on long recognised inequalities in health outcomes,<sup>1</sup> which have been widening in recent years.<sup>2</sup> Castle *et al*<sup>3</sup> describe how the general practice funding formula negatively impacts the ability of general practice teams to provide equitable care, with the risk of further widening these inequalities.

The Health Foundation's recent report *Level or Not?*<sup>4</sup> outlines the increased workload for practices serving our most deprived areas. It finds that, once adjustments are made for the associated increased workload in poorer areas, these practices receive 7% less funding per patient than those serving less deprived populations. Unsurprisingly, the report *Who Gets In?* finds that those living in the most deprived areas are less likely to report a positive experience of general practice care.<sup>5</sup>

Boomla and colleagues<sup>6</sup> argued back in 2014 for a fairer distribution of funding to reflect the additional workload in deprived areas. Their data on consultation rates for those in the most and least deprived quintiles of multiple deprivation found vastly increased consultation rates in deprived areas. This reflected Marmot's finding of an 18-year-gap difference in disability-free life expectancy,<sup>7</sup> and highlighted the need to recognise the very tangible additional workload this brings to general practice teams.

The partnership model, which underpins

**Table 1. Newham CCG dashboard, July 2020**

	CKD cases, n	Diabetes	Hypertension	CKD, coded,	Prescribed	
		comorbidity, %	comorbidity, %	%	statin, %	
Age band, <sup>a</sup> years	18–39	94	13.8	44.7	79.8	20.2
	40–59	1268	32.9	59.8	80.2	52.8
	60–79	3847	48.3	75.7	86.4	77.3
	≥80	2257	45.5	85.4	91.3	74.7
Ethnic group	White	2971	29.1	70.0	85.0	66.9
	South Asian	3251	56.5	76.7	87.8	78.8
	Black	1163	49.3	87.7	90.5	65.6
	Other	327	48.6	74.9	83.2	74.3
	Not recorded	109	26.6	67.9	72.5	56.0

<sup>a</sup>Data missing. CCG = clinical commissioning group. CKD = chronic kidney disease.

general practice, involves a single funding stream for partners' income and patient care. During times of significant challenges for the healthcare system, this can lead to stressful and impossible choices for those working in deprived areas with impacts on recruitment, investment into patient care, and the wellbeing of practice teams.<sup>8</sup>

We would argue that it is time to look again at general practice funding to better reflect the workload involved to meet patient need, and mitigate rather than exacerbate the wide health inequalities so worryingly highlighted in this current pandemic.

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## Changes in patient experience associated with growth and collaboration in general practice

These insights from Forbes *et al* into the impact of practice size and collaboration on continuity of care are timely and concerning.<sup>1</sup> Efforts to strengthen collaboration between practices have continued in the UK since the end of the study period, so the trend the authors report up until 2018 may well have progressed.

For at least some patients (notably the most vulnerable and complex), continuity of care has repeatedly been shown to be a key factor in the quality of primary care and the satisfaction of patients and clinicians. Evidence of the continued fall in continuity as reported by patients is therefore a cause of concern, but it seems likely to be amenable to practical action in every practice.

In the early days of the NHS, the single-handed nature of general practices ensured a

strongly personal (and wholly medical) model of care. With the exception of holiday periods, continuity could be 100%. Although this was valued by GPs and patients, general practice was providing continuity by default rather than by design. As we began adopting group practice and multidisciplinary approaches, surveys have pointed to a reduction in continuity. However, this can be seen not as an inherent consequence of size but simply as a failure to design continuity into our model of access.

The opportunity to improve continuity of care lies largely in the hands of practices ourselves. Ensuring that those patients who most need continuity are more consistently signposted to the right person usually involves relatively simple adjustments to a practice's access system, supported by training for reception staff. Although we are unlikely ever to return to the days where one GP shouldered 100% of responsibility for their patients' needs, improving continuity is within our grasp, as long as practices design it in.

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