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Research paper

Patient and practitioner views of a new rheumatology (Tier 2) primary care service

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ABSTRACT

The rheumatology Tier 2 service in Oldham was implemented to see patients in a primary care setting for their initial assessment. They were treated and discharged within the service, or referred on to secondary care in order to limit inappropriate attendance in secondary care and fast-track patients with inflammatory disease to the rheumatology consultant. The aim of this study was to evaluate patients' and general practitioners' (GPs') views about the transfer of rheumatological services from secondary to primary care. Patients and GPs were from a single primary care trust in Oldham,

north west England. A thematic analysis of interview data was taken, and findings showed high patient satisfaction with the service, favouring the primary care environment to a hospital setting. GPs reported on cost-effectiveness of the service and better management of the disease. The Tier 2 service has the potential to set a new direction for multi-agency care within a primary care setting.

Keywords: patient perspective, primary/secondary care interface, rheumatology care, waiting times

How this fits in with quality in primary care

What do we know?

New schemes are rapidly emerging for assessment in primary care of chronic diseases previously managed predominantly in secondary care.

What does this paper add?

Evaluation of a new rheumatology scheme showed that patients favoured the primary care to secondary care setting in terms of access and communication, and that general practitioners felt that it resulted in better disease management and a more cost-effective service.

Introduction

Arthritis and related rheumatological conditions affect one in five people in the UK, causing varying degrees of disability.¹ Rheumatoid disease can occur at any age from infancy onwards, but given demographic changes there is concern that with an ageing population the number of people suffering from inflammatory arthritis is set to increase.²

There is, therefore, a pressing need to engage in forward planning to understand and respond more

efficiently to rheumatology needs in terms of assessment, care and follow-up.³ Recent reports show that care of patients with chronic disease has been reactive, unplanned and episodic, which has resulted in the inappropriate use of secondary care services.⁴ The government has responded to this evidence, requiring new ways to treat and see patients efficiently and appropriately.

An important first step in the process of this development was to expand primary care services. The GP is often the first point of contact for a patient when they need treatment or access to other services in the NHS.⁵ Recent Department of Health publications place chronic disease management at the top of the government agenda, and targets have been implemented into the National Public Service Agreement for improving the outcome for people with long-term conditions.^{6,7} Linked to these are National Service Frameworks, demonstrating that new systems and approaches in primary care can lead to both physical and psychological improvement for patients and their families suffering from the impact of chronic disease.⁸ Health-care policy demands the 'provision of these primary care services to be based on an assessment of the need of individuals and populations and the skills required to meet those needs'.⁹

This present study builds on earlier work from May 2003, when the rheumatology team undertook a three-month evaluation of new patient referrals. The initial findings indicated that approximately 40% of referrals could be seen and treated in primary care by a multidisciplinary team (a GP with a specialist interest in rheumatology, a nurse consultant and a physiotherapist who specialises in musculoskeletal conditions).

By September 2005, the rheumatology Tier 2 service had been operational for 18 months, and the number of referrals into the service had averaged 118 new patients each month. The multidisciplinary team involved in the service had seen, treated and discharged 61% of new patients; 14% of patients had been referred on to secondary care following a full assessment of their symptoms as these patients were deemed to have an inflammatory arthritis requiring early intervention and long-term follow-up.

Practitioners wanted to ensure provision of a flexible integrated service that was responsive to client needs, but also to involve patients in the service changes to guarantee these outcomes.⁹ Therefore an evaluation of patient perspectives of the service was undertaken. The importance of lay perception is that it brings together different aspects of the disease from onset, treatment and effect, and provides insight into the social impact of the disease to understand the patients' expected benefits to health and mobility.¹⁰

Methods

Design

A research approach was employed that would respond to the experiences of the sample as patients encountered the new service and GPs established it.¹¹ Using a qualitative descriptive analysis, data were

anonymised and categorised by frequency to develop a theoretical scheme that explained the patient data.^{12,13} Themes were identified and divided into core- and subcategories.¹⁴ The coding was developed by the second author and verified by both the first author and a member of staff with research experience from the rheumatology team. As the sample was small no software was used. All patients were interviewed on a one-to-one basis using semi-structured interviews.

Sample

The target population was patients and GPs. The patient group comprised those who had a rheumatology Tier 2 appointment ($n = 10$). The study aimed to include in its sample frame patients who best represented the local population and also patients with a range of characteristics; however, this proved difficult as patients from the ethnic community declined to be interviewed even though interpreters were offered in the covering letter. It was felt that if any further research was carried out it would put strategies in place to overcome this difficulty.

The nurse contacted potential participants by letter (patients) and email (GPs). All patients who had a rheumatology Tier 2 appointment on seven pre-selected clinic dates were sent an invitation letter, information sheet and reply slip inviting them to attend an interview lasting approximately 30 minutes. A total of 32 patient invitations were sent, 28 patients had a new patient appointment and four patients were attending follow-up appointments. Thirteen patients agreed to take part in the study; 11 patients had new patient appointments and two patients had follow-up appointments. One patient was included in the pilot study. For the GP selection, the nurse-researcher within the hospital trust had access to an email address that would ensure delivery of an email to all GPs in the local primary care trust (PCT). Eighty-seven GPs were invited to attend a focus group session; the first six GPs who replied positively to the email were included in the study. It was intended that the GP sample would form a focus group ($n = 5$), but with time constraints less than half of the group could attend ($n = 2$). Further data collection was adapted to include one-to-one interviews so the remaining GP sample could be accommodated ($n = 3$).

Ethical considerations

Because the research was carried out by a nurse within the Tier 2 service, issues concerning confidentiality, objectivity and anonymity were discussed by team members before the start of the study. It was reasoned that there was not a conflict of interest for the nurse-researcher, as the Tier 2 service actively sought the

opinions of the patients in an endeavour to be patient led and offer the best service whether that was in primary or secondary care. As a qualitative study, it was necessary that the patients felt supported and had confidence in the researcher to honestly report their opinion of the Tier 2 provision.^{15–18} Every attempt was made to carry out an unbiased and scrupulous study: during the analysis phase, data were anonymised and routinely checked by the nurse-researcher's academic tutor. The study was approved by the hospital trust ethics committee and a university ethics board. The information sheet ensured both anonymity and confidentiality throughout the research process.

Results

Patient findings

Data were organised by themes and two key areas became apparent with two subcategories. Core categories emerging from patient data were *waiting times* and *environment*, together with the subcategories *primary/secondary care interface* and *service provider*. The GP data covered issues relating to the prompt delivery of appropriate medication such as disease-modifying antirheumatic drugs (DMARDs), but also cited *economic factors* as a core category, with subcategories of *seamless service*, *service provision and response*, and *the future development of the service*.

Patient opinion of the Tier 2 service was positive (although one must bear in mind that the sample size was small and end results might benefit from a further study with a larger sample). The shift from secondary care to primary care did not weaken patient confidence in terms of seeing a GP instead of a rheumatology specialist.

Nearly all patients seen in the Tier 2 service (not just the sample included in the study, but all patients) were appropriate attendees, and those with complex rheumatology issues were referred to a more specialist secondary care service. This meant that the right treatment was given to patients within either the primary or secondary care setting, and patients were treated more efficiently as a result. Findings provided good indication of matching service needs to patient outcomes.

Shifting diagnosis and treatment from secondary to primary care was always going to evoke patient response. Before the study began it was expected that findings might be negative, largely because care was transferred from a specialist consultant to a GP.¹⁹ However, findings were positive and are outlined below:

'It bothered me at first that I wasn't going to the hospital.'
(Patient A)

'I think I would like to come here again, I think it's more relaxed in here than the hospital.'
(Patient D)

'I was a little surprised because I didn't know that this place existed until I got the letter, I couldn't understand why not the hospital as that's the normal place to go.'
(Patient F)

'I just go to the hospital I get seen to in the same way I get seen to here; there seemed to be no difference so it's a similar service but much more convenient.'
(Patient C)

'I'd be very happy to come back as I don't like hospitals to start with, so it's not got the hospital atmosphere; it's a more relaxed atmosphere.'
(Patient G)

'I mean the interview that I've just had was very thorough and I wouldn't have thought it would have been any more thorough at the hospital.'
(Patient E)

'You don't get the hospital atmosphere, which you do er ... if you have to go down to the hospital; it's a pleasanter atmosphere I think to wait in a surgery like this.'
(Patient B)

'It's a nicer atmosphere altogether more informal I think ... erm ... the atmosphere at the hospital is formal.'
(Patient D)

The familiarity with the 'local doctor' and a visit to the GP surgery clearly does not invoke the same worry that an appointment at the hospital might:

'For some people it's probably less threatening than having to go to the hospital, you know, it's more of a familiar sort of surrounding. You go to your local doctor and you don't think or worry about going there and coming somewhere like this I think will probably be helpful to a lot of people.'
(Patient G)

'Well it makes a difference somewhere that's nice and quieter. I mean the hospital is so busy busy, you know, you get the noise more and the television is always sort of on in the waiting room and things like that and, you know, people don't always want that, you know, especially if you're worried about something going in to see a doctor.'
(Patient H)

The benefits to patients of 'going in to see a doctor' who is closer to home and part of a familiar general infrastructure of care appear to provide psychological as well as physical advantage.

Patients had to adapt to some important changes such as a different site and a rheumatology team headed by a GP rather than a consultant rheumatologist. Although results indicate that patient satisfaction was established, a number of more complex issues are raised in the discussion.

GP findings

The GP sample reported an increase in earlier response and management of the disease. GPs stated that this was because the provision of primary care

alleviated some of the congestion common with patients who required urgent review:

‘The assessment is fed back to me very promptly and fits in with my request for a treatment plan.’ (GP X)

‘The biggest bugbear for most GPs I think is waiting times. With this service we can get to see urgent requests and provide treatment.’ (GP Y)

‘I say the key is patients want access fairly quickly, otherwise we are left feeling powerless and they are left feeling helpless.’ (GP Z)

The same GP expressed a paradoxical sense of concern however, suggesting that if patients were seen quickly the service would become a victim of its own success:

‘The one concern I have is that it may be a victim of its own success if waiting times are short for any service I think that there is an automatic direction at that particular low waiting time ... I think that if you improve access to a service dramatically then you run the risk of getting a lot of inappropriate referrals.’ (GP Z)

Using the constant comparative method, the variance of the data showed both its common and distinctive features.²⁰ The above vignette (or deviant statement) was emailed to the GPs to ascertain divergence or agreement.²¹ The collective perception was that the statement stemmed from the fear that improvement would merely alter the pattern of inequality between the two health sectors. It suggests that the level of congestion currently experienced in secondary care might be transferred to primary care. Future reviews may be able to detect the impact of the revised service provision and any consequences evident, which might be born out in this GP perception.

Similarly, although economic factors were a core category, the need to understand the Tier 2 service from pluralistic perspectives was important due to the newness of the service.²² Again, the GPs offered a variety of opinions:

‘I think per patient that is managed it will be more cost-effective because providing that assessment and treatment in primary care it is always going to be cheaper than it is in the hospital setting.’ (GP V)

‘I would actually question whether it’s any cheaper; I actually don’t think it’s any cheaper.’ (GP Y)

‘What it is is a different way of managing someone with long-term problems in a different way. I don’t think it’s any cheaper.’ (GP Z)

‘Economically [if] it can be delivered much more speedily and the likelihood is that the cost to the NHS is going to be considerably less.’ (GP X)

Discussion

Rheumatologist workload showed that up to 75% of clinic appointments were used for planned follow-up patients.²³ In addition, there are not enough rheumatology consultants to meet the challenges of rheumatic disease over the coming decade.²⁴ There is evidence too that, during disease exacerbation, rheumatologists could not offer an adequate response due to the accumulation of follow-up appointments for chronic assessment.²⁵ This has led to dissatisfaction for patients, GPs and rheumatology staff.²⁶ Although the Tier 2 service is still in its infancy, patients expressed that they valued it in terms of location and shorter waiting times in clinic. GPs too, were happier with response times. These findings support the findings of Hewlett *et al.*²⁷ Patients with an arthritic condition were randomised to either shared care with a GP (no routine follow-up but rapid access on request) or traditional hospital care (regular planned review), with no clinical deterioration but some clinical benefit in the shared care group. There was a 33.5% reduction in costs and there was reported to be greater satisfaction and confidence in the system.

The homogeneity of the patient results provides an indication of the degree to which patient satisfaction was reached in terms of environment and waiting times. GPs, too, felt that they provided a quicker diagnosis, response and appropriate medication, or where necessary, referred patients on to a more specialised service.

NHS waiting times are a recurrent news issue and a topical subject for both patients and staff, so findings must be considered in light of this. Primary care facilities are designed to specifically cater for a quick throughput of service users. The findings of the study corroborate this. The patients sampled expressed a preference to be seen in primary care because waiting times were shorter and consultations conducted in a local setting. On the other hand, hospitals are designed around inpatients, with less regard given to outpatient clinics. Evidence suggests that poorly designed waiting areas and prolonged waits are catalysts for abusive incidents, patient dissatisfaction and complaints.²⁸ Excessive waiting induces feelings of helplessness experienced by both healthcare staff and patients.

The patient’s environment was experienced as ‘nice’ and ‘informal’, and of course the GP setting was familiar and local; it provided an opportunity for care without imposing a formal structure.²⁹ Given that the GP is local and often familiar, the patient may perceive a more informal atmosphere with potentially

improved communication and a more positive patient–doctor exchange.³⁰ This change of environment is likely to feel ‘less threatening’ to some patients.

Conclusion

These findings bear up the most recent government white paper advising that ‘people need to be treated sooner, nearer to home and before their condition causes more serious problems’.³¹ Patient expectations have changed dramatically,³² with requirements for greater independence coupled with convenience – a service that does not force them ‘to plan their lives around multiple visits to large hectic sites’³³ – but one that is part of the local infrastructure and meets their personal needs. The primary care setting provides an environment where patient needs are more easily met. This is because the departmental layers that exist in the hospital environment are stripped away, and in the ideal situation professionals that can sometimes be traditionally isolated from each other are unified into a single multidisciplinary team with a common purpose.³⁴ The core team members share an interest in this patient group, yet each has a specific set of knowledge and skills which, when combined, are more effectively used than if used sequentially.

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CONFLICTS OF INTEREST

None.

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