

Long Term Conditions – MSK

Patients represented had either:

- Rheumatoid arthritis
- Osteoporosis

Acute v Community

General check-ups and preventative support could easily be done at St Mary's walk-in facility rather than making a GP appointment.

The forum recognised that providing services in the community – which included specialist staff from QA – was a good solution. There was little consensus in terms of specific locations, but agreement that it must suit a large number of people. “If you have a ‘centre’ for something, it can be difficult for some people to get to”.

St Mary's was suggested as an ideal hub as it was nurse-led and most of the group were happy to receive their on-going monitoring so long as the nurses had specialist knowledge. If there were specialist MSK nurses on the team, this would make for an ideal scenario and a good way forward in order to reduce pressure on GPs.

The same set up where a specialist nurse takes the clinic to the more rural community settings would alleviate the need for everything to be centred at QA. It would also enable those who can't or don't have easy access to transport receive medical support and advice in a local community hub/centre.

It was felt that with the increased elderly population, patient expectations needed to be reduced and managed. Some felt that there is too much expectation on the NHS.

Although most participants spoke highly about their GPs, it was felt that they didn't necessarily offer the best community solution, and that GPs should have specialist support.

Clinicians:

Overall, MSK patients saw their GP in face to face consultations more than specialist consultants. However they agreed that many elements of their care, such as monitoring, could/should be overseen by specialist nurses.

All the MSK patients in the group were happy to have a telephone consultation rather than a face-to-face appointment, if this helped reduce pressures, and also to reduce the waiting time to speak to their/a GP.

GPs were not felt to always be up to speed with particular long term conditions like MSK and participants felt that this meant that GPs might delay examination of issues until age-related checks were pertinent. (eg where there was a family history of rheumatoid arthritis

or osteoporosis, patients can often present with the symptoms as early as 40 but reported being ignored until 50/60 years of age.)

If there was a family history it was felt that this shouldn't be overlooked and early intervention and diagnosis could prevent more serious symptoms exhibit themselves.

It was felt that recognising the problem as early as possible – thanks to specialist input - could help alleviate the possibility of falls and more serious accidents requiring long hospital stays/community beds and rehabilitation periods.

The patients agreed that a 6month/annual review with the specialist consultant was adequate to prevent deterioration. More regular check-ups this could be done by specialist nurse/GP.

It was felt that specialist nurses inspire confidence in the patients. If more NHS care was community-based, patients would want specialist MSK trained nurses available. There was a feeling that patients don't need to attend QA if there was a local/community provision made elsewhere.

Information:

The QA rheumatology department hold a number of specialist days in the local communities (Love Your Bones etc) – these are well attended, and highly valued. The events served as a re-introduction/refresher for patients in managing their condition, although work well for both newly-diagnosed and patients who have had their condition for some time.

Helplines - both the (local) rheumatology and (national) osteoporosis helplines were held in very high regard. Both were manned Mon – Fri, and patients could either leave a message or speak to a specialist nurse regarding their concern. If required, further specialist expertise could be sought, and the patient called back.

One of the benefits of the helpline was that it was established to help reassure patients who may be experiencing a range of symptoms such as side effects from a drug, MSK flare ups and blood test queries - all of which could mainly be dealt with by the specialist nurse on duty that day. It means that patients didn't need to book a GP appointment or see a consultant to get their answers (which reduced pressures on the NHS).

The group were more favourable towards NHS Direct, than the 111 service – because the former was manned by clinical staff.

Self-management:

The Osteoporosis Society was hailed as a good source of help, advice and education – albeit participants felt that this could be more then case for those who are better educated / informed / motivated.

Importance of exercise was stressed – the NHS should realise the value of promoting exercise, and the benefits it would bring in terms of keeping patients healthier and fitter. Swimming was felt to be particularly good.

Peer Support:

Unlike a number of other long-term conditions, patients attending the MSK support network mainly attended in order to gain a greater understanding (education) of their condition. They placed great value on hearing talks and speakers – particularly clinical ones, and gaining insight into the latest information and advice around their condition. Emotional support was very much a secondary – if that – consideration.

The group also meant that patients could receive information without taking up precious GP/consultant time, and boosted patient understanding and control.

It was felt that voluntary support groups help to underpin NHS services, particularly in terms of self-management. The group did not expect the NHS to provide the information and support which could be delivered by other groups.

Pharmacists:

All members of the group had on several occasions sought advice about their long term conditions from their pharmacist. They agreed they were an under-used resource and felt they were ideal for supporting GPs in educating patients on a range of services and conditions. (e.g. blood pressure and cholesterol tests).