



Virtual Roundtable

Exploring and addressing health inequalities in patients with a rheumatic disease: report of a roundtable discussion

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Video 1. Rheumatologists Discuss Health & Health Inequalities in the UK. The video is playable in the HTML version

In a supplement to *Rheumatology* a roundtable discussion was convened to help explore and understand how the provision of rheumatology services across the UK impacted on health inequalities and how that affected patient outcomes. Using the four nations in the United Kingdom (England, Scotland and Wales) as an example, representatives from England (Dr Lesley Kay), Wales (Prof Ernest Choy) and Scotland (Dr Rosemary Hollick) were brought together to discuss the issue with Dr Marwan Bukhari as a moderator. The discussion focused on two major themes: rheumatology service provision and population factors.

The first challenge was identifying the problem. Dr Lesley Kay opened the conversation with her experience in England for ‘Getting It Right First Time’ or GIRFT [1]. GIRFT is part of an aligned set of national programmes within NHS England designed to improve the treatment and care of patients through understanding and reducing variation in service provision. GIRFT undertakes in-depth review of services, benchmarking and presenting a data-driven evidence base to support change. The GIRFT programme has the backing of the Royal Colleges and professional associations.

In rheumatology, GIRFT has determined and benchmarked access to advanced treatments, provision of infusion facilities, access to the multidisciplinary team (MDT), psychology, MSK ultrasound and fast-track early arthritis, giant cell arteritis (GCA) and other services. GIRFT and the National Early Inflammatory Arthritis Audit (NEIAA) provided the workforce data for all members of the MDT working in adult and young people rheumatology, which were the basis of the 2021 BSR workforce report: a crisis in numbers [2]. Many units had gaps in services due to a severe staffing shortage. This leads to care falling short of the NICE quality standards and demonstrated the significant variability in provision across nations and regions. The report also highlighted variations in the composition and provision of MDT care. Most rheumatology departments did not have psychologists, podiatrists, occupational therapists, physiotherapists and pharmacists embedded in their MDT. Health inequalities are inevitable with variation in rheumatology service capacity. In some departments, they did not have access to podiatry.

The panellists discussed the nature and reasons for such variation and gaps.

Composition and skill mix of multidisciplinary teams

The panel discussed the ratio of consultant rheumatologist to population statistics with recommendations from the Royal College of Physicians of one full-time consultant per 86 000 population and recent BSR recommendations of 60 000–80 000 population due to increasing demands of an ageing population with increasing rates of chronic illness and comorbidities [2]. Scotland (one in 111 637), Wales (one in 99 423) and Northern Ireland (one in 106 165) were significantly lower than recommendations. These nations have wide geographical landscapes and providing services into remote

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areas where tertiary care is lacking is a major challenge. Dr Kay commented that this data is very difficult to find as it is not routinely collected. Even collating how much direct rheumatology service is conducted by an individual consultant is inconsistent as many consultant rheumatologists will have additional roles in education, research, management, acute medicine and other extended roles. GIRFT collected the data via survey, BSR has data from the NEIAA organizational questionnaire. What we do know is that more consultants equate to better care and reduced waiting times.

There is enormous variability in what skills mix and competencies denote the title 'specialist nurse in rheumatology', which can be anything from a band 5 to a band 8a in UK terminology, with even less consistency with respect to the skills and competencies defining other rheumatology Allied health professionals roles such as for physiotherapy, occupational therapy, rheumatology pharmacists and psychologists as part of the MDT. There is a difference between having access to a physiotherapy service in the community for a rheumatology patient (a team entirely separate to the rheumatology service and potentially with relatively limited rheumatology background) and having an experienced rheumatology physiotherapist embedded as part of the rheumatology MDT. With respect to the medical workforce, the panel discussed how in more remote areas the ability to recruit and retain skilled members of teams presents an even greater challenge. It was felt that with medical trainee recruitment being centralized, more remote units would be at a disadvantage and trainees will not always think about rural placements; most trainees settle where they have had their training.

The impact of general medicine training being coupled to rheumatology was discussed. While it is an advantage to have generic medical training (GIM), this aspect results in a high burden of on-call time away from the rheumatology team and that can make supporting trainees pastorally more of a challenge, especially during blocks of on-call away from the unit. Rotas and rotating across a vast geography make the experience of training more difficult and balancing family and work is an increasing challenge. The panel discussed the risk of this in terms of losing workforce to other specialties without GIM linkage or to other counties where work-life balance is perceived to be better supported during training and beyond. It was felt that there was a definite trend for trainees moving to countries with less demanding hours, a better work-life balance and better remuneration.

The size of units was also discussed, with larger units having more resilience to support vacancies and being able to provide more specialized services. This could also create different outcomes, especially for more complex patients.

Other issues discussed include that the NHS is not well organized to cope with succession planning for the ageing of the teams, there is a crisis in recruitment and limited HR processes or financial resource to support development or training posts to address the skills mix required to replace those colleagues who will be predicted to retire soon. In rheumatology in general [2] it is a challenge to attract rheumatology-experienced nurses and doctors into the specialty, given that there is limited exposure to it since moving to an outpatient-based service.

Population factors

The panel discussed how inequalities in rheumatology health-care provision might arise from local population factors, which include geography and demographics.

Provision of care is impacted by geography. Examples of remote island clinics where late presentation of more severe disease and florid symptomatology were given and echoed in coastal and geographically isolated areas across all nations of the UK. This inequality in access to specialty services translates into inequality in access to advanced therapies and multi-disciplinary care.

Demographic factors including ethnicity, language, social, economic, education, health literacy, digital divide (competency and access), and behaviours are also important. Although the evidence for a social class gradient is more robust in non-inflammatory musculoskeletal conditions, this perhaps reflects the progress made by the rheumatology community on inflammatory pathways over the years. There is the issue of how the health literacy and behaviour of patients could influence the outcome, with a definite disadvantage in poorer areas. Geography is also linked as patients who live in remote areas were less informed of available help, therefore present late to rheumatology and have a worse outcome. Waiting times variation in different areas was also discussed and was felt to also influence outcome. Patients could also have differing levels of digital access and competence. Access to quality high-speed broadband for digital consultation is variable in different parts of the country and therefore digital solutions to meet geographical challenges are not always achievable, impacting health inequalities further. Income was also mentioned as a determinant of outcome and we already have evidence that levels of education as a surrogate of socioeconomic status can influence access to treatment [3, 4].

Potential solutions

The lack of consistent national data on inequalities and outcomes was also discussed and it was felt that surrogates like the number of rheumatologists per head of population would show this as certain areas like London have significantly more rheumatologists per head of population than areas like Northern Ireland. However, as a counter it was also commented that in London there were fewer supporting staff available due to the cost of living in London. Deprivation, ethnic diversity, wealth gap and lifestyle-related risk factors are often higher in inner city areas and may increase the risk of significant illness and poor outcomes.

The panel discussed potential solutions including having specialist networks whereby a hub-and-spoke method is used in which patients are discussed from a remote clinic to a central MDT. In England, specialist commissioning has already begun to deliver improvements in access to expertise and medications for rare and complex diseases, an example being that of systemic lupus erythematosus and access to drugs like rituximab and belimumab through networked MDTs across an Integrated care board footprint, with specialist centres supporting local rheumatologists to access drugs locally for patients. Variations in outcome of services of vasculitis in Scotland was also cited as an example. A good solution was an example of virtual MDTs including remote access for advice to any rheumatologist for rare diseases such as IgG4-related disease with advice being offered from one centre with access from all over the country to discuss cases.

In summary, the roundtable concluded that inequalities in rheumatology provision exist across the UK and it can be extrapolated to be more severe in less well-developed health systems. Innovative solutions are in their infancy but as a

rheumatology community we should continue to strive to have equality in access to health for all our patients.

Data availability

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