

## Patient perspective

# Understanding issues involved in the transfer of diabetes care to general practice: the patient perspective

Maxine Johnson RGN BSc (Hons) MSc  
Research Associate

Wendy Baird PhD  
Lecturer in Health Services Research

Elizabeth Goyder MRCGP MFPH  
Senior Clinical Lecturer in Public Health

School of Health and Related Research (SchARR), University of Sheffield, UK

### ABSTRACT

**Background** A service innovation was introduced in six Sheffield general practices with patient populations ranging from 2981 to 8511 to deliver a new model of integrated diabetes care in a primary care setting. Within the model, practices collaborated with specialist services, which provided training and advice to general practitioners and practice nurses, so that patients with type 2 diabetes could receive diabetes monitoring, treatment and self-management support from their general practice team rather than a hospital-based team.

**Aim** To explore the views and experiences of patients with type 2 diabetes whose diabetes care, with consent, had been transferred from the hospital clinic to the patient's general practice.

**Setting and participants** Four of the participating practices agreed to take part in the study. A total of 49 patients with type 2 diabetes, diagnosed between 3 and 16 years previously, whose diabetes support had moved to primary care, were approached by practice staff to take part in the interviews.

**Method** Twelve volunteer patients with type 2 diabetes took part in face-to-face semi-structured interviews in their own homes. The interviews were audiotaped, and data were analysed using the 'framework' method.

**Results** The patients interviewed seemed unaware of policy initiatives that preceded the changes in their care delivery. Most respondents were positive about the changes in terms of access, waiting times, and satisfaction with consultations. However, provision of associated services such as chiropody and out-of-hours support was often fragmented, creating a potential risk for some users.

**Conclusions** General practice-based diabetes care is acceptable to patients provided that support is continuous and addresses all aspects of patient need. Provision of services can vary across practices creating a potential risk for some patients.

**Keywords:** chronic disease, diabetes mellitus, family practice, qualitative research

### How this fits in with quality in primary care

#### What do we know?

This study aimed to expand on previous knowledge of patient views on diabetes care in general practice and shared care by exploring the views and experiences of people with long-standing type 2 diabetes on the impact of change to an integrated general practice model of diabetes care.

#### What does this paper add?

An integrated general practice model of diabetes care was regarded by patients as more accessible in terms of location and time and was more acceptable when consultations were considered meaningful and when the full range of diabetes care was available. There was little awareness or understanding of the policy change itself with patients emphasising details of their own care rather than broader issues.

## Introduction

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A growing concern for healthcare providers and policy makers is the effective management of chronic disease.<sup>1</sup> In one particular example, the response to the increasing prevalence of type 2 diabetes has been a move towards provision of primary healthcare services and support of patient self-care.<sup>2-5</sup>

Organisation of chronic care proposed in *The NHS Plan* is guided by primary care trusts, takes account of local need and involves collaboration of services within the area, as well as the clinical development of local practitioners.<sup>6</sup>

The development of primary care services is key to the modernisation of the NHS. However, we need to modernise the relationship between the NHS and GPs, building on what is already good. (p. 78)

In addition, The National Service Framework for Diabetes sets out 10-year aims and standards of care delivery to be adapted locally by primary care trusts and diabetes networks.<sup>7,8</sup> This has led to the implementation of innovative services nationally that differ in design detail.

Early forms of GP involvement were based upon a 'shared model' in which information and care was shared across settings.<sup>9</sup> A review of a range of shared care schemes was carried out by Greenhalgh, who identified enthusiasm, education and commitment of professionals as important to success.<sup>10</sup> More recent work has highlighted the potential changes in professional roles, workload, and ways of collaborating when a shift in care delivery is implemented.<sup>11</sup>

In this study, six volunteer general practices were recruited to a pilot model of care that encouraged collaboration with specialist practitioners from local hospitals to provide GP and practice nurse-led care for people requiring uncomplicated management of type 2 diabetes. The pilot details are described in detail elsewhere.<sup>11</sup>

The impact of changes in diabetes care delivery from the perspective of the service user has been previously investigated in qualitative studies. Murphy *et al* examined preferences before and after the intervention of primary care diabetes surveillance, finding improved patient satisfaction in terms of communication and convenience.<sup>12</sup> Smith *et al* obtained views from patients involved in a randomised controlled trial (RCT) of shared diabetes care in a non-NHS setting, focusing on patient perceptions of diabetes.<sup>13</sup>

This study follows the work of Lawton *et al* who, after interviews with people newly diagnosed with diabetes, proposed an intervention in which specialist healthcare professionals provided training and support in primary care.<sup>5,14</sup>

The study aimed to expand on this knowledge by exploring the views and experiences of people with long-standing type 2 diabetes about the impact of change, and the acceptability of receiving care in the general practices involved in the pilot, rather than the hospital setting. In doing so it sought to identify problems perceived by patients in relation to accessibility and continuity of care, in order to inform local general practices and primary care trusts. The views of patients are important in evaluating the impact of new ways of delivering diabetes care, determining patient satisfaction with new services and ensuring that potential problems are addressed. Although the study focuses on a diabetes-specific service change, the issues raised may be similar for patients with other chronic diseases, such as coronary heart disease and chronic obstructive pulmonary disease.

## Methods

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The study was carried out with the permission of all GPs in four of the six Sheffield practices involved in a pilot model of specialist supported diabetes care services (SSDCS) for at least 12 months. Patients who were to be affected by the pilot were approached by GPs and practice nurses, and provided with information about the study. Those that were interested in taking part were invited to return their contact number to the researcher in a prepaid envelope. The researcher then telephoned the patient, provided more information if necessary, and then arranged a convenient time for the interview to take place. A relatively small sample size was anticipated as, at the point of recruitment, a total of 49 patients had experienced a change in their care within the four practices. Such a sample size was regarded as acceptable to this study, since the aim was to explore in-depth issues pertinent to patient experience of a discrete type of service delivery, rather than to provide a broad overview of general diabetes services.<sup>15</sup>

Face-to-face interviews of up to 45 minutes' duration were conducted by one of the authors (MJ) in patients' homes. The interviews were audiotaped, and written consent was obtained from each participant. The topics for discussion were based on the changing course of diabetes service delivery since the commencement of the pilot, and are summarised in Box 1. The topic guide had been developed in collaboration with members of an advisory panel, and the first two interviews served as a pilot. Minor adjustments were made to the interview schedule to improve the clarity of questions, for example, to distinguish care delivery issues from those to do with treatment.

**Box 1** Interview topic guide

- Age
- Household composition
- Employment/caring
- General health
- Health-maintenance strategies
- Diagnosis of diabetes (when, who by, experience)
- Main caregivers (who, how often, nature of advice/care)
- Experience of hospital care (access, likes, dislikes, relationships)
- Experience of transfer of care
- Experience of GP care (access, likes, dislikes, relationships)
- How changes have affected daily life, self-management
- Any other suggestions, e.g. improvement of care

Data were transcribed verbatim and analysis was carried out mainly by MJ. WB and EG also had access to the transcripts, with categories and the process of analysis being discussed at regular meetings. The 'Framework' approach was used to analyse the data.<sup>16</sup> This method was developed as a pragmatic way of handling qualitative data, particularly for use in policy research. The method involved becoming familiar with the data before charting chunks of data according to categories and subcategories, and by respondent. This formed the basis for further inspection identifying links, patterns and contradictions within and between responses. Finally, major themes were identified, as described in the results section, and interpreted in the context of the research questions posed and related literature. The pilot interview data were included in analysis because there had been no significant changes made to the majority of the interview schedule.

## Results

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A total of 12 patients consented to be interviewed. The participants, whose characteristics are displayed in Table 1, resided in areas across Sheffield.

### Valued aspects of care

Respondents did not seem to be aware of the pilot in terms of policy change, instead they focused upon the implications of service delivery for daily living and for self-management of diabetes.

**Table 1** Participant characteristics

Characteristic	Number
Number of participants	12
Number of practices	4
Age range (years)	54–83
Sex	
males	8
females	4
Nationality	
British	10
Irish	1
African-Caribbean	1
Treatment	
insulin	11
oral medication	1

### Access to care

Respondents had all experienced care at both the hospital and general practice, and between them had various experiences of access. Travel to clinics ranged from walking, public or hospital transport, to car travel. There was therefore no consensus regarding satisfaction with access, although the hospital clinic tended to incur more travel or parking problems, and waiting:

'You can wait up to two or three hours, and another time you might be in and out in 20 minutes, and you've got to pay for parking at t'hospital.' (Male, aged 54 years)

'The longest it's been to see t'doctor [GP] after appointment time is like half an hour, that's longest, it's usually five, ten minutes.' (Male, aged 63 years)

There was also more scope to obtain appointments for diabetes review at the practice that fitted in with the patient's lifestyle, particularly for working patients:

'It's better for me to go to my GP than have to have time off work and go to the hospital ... It's more convenient as well.' (Female, aged 49 years)

'It's better for me to go to t'GP. Well, you've always got to get permission at work to go up.' (Female, aged 57 years)

Two respondents, however, were not so positive about their experience of access at the general practice. One patient was particularly concerned about out-of-hours access:

'I mean, what do you do like that, at four o'clock, she's [practice nurse] gone home, now you've no back-up ...' (Male, aged 66 years)

Another suggested that reviews could be more frequent:

'... like going every four months ... the doctors are very busy, and I understand that, but I think we could do with a more regular thing.' (Female, aged 74 years)

It would appear from responses that, while not all patients voiced dissatisfaction with access to hospital care, there was a difference in accessibility in terms of time and convenience. Expectations of accessibility to care might change along with alterations to service provision, for example access may be more convenient, but advice may not be available at times that are important to the patient.

### *Meaningful consultations*

Responses showed that the extended length and more intimate style of consultations had a positive impact on patient satisfaction and appeared to be more important than waiting times. Most patients valued the time that GPs and practice nurses spent talking and listening. They were prepared to wait longer while other patients received such attention in the knowledge that their turn would come:

'She [practice nurse] never makes me feel that she's rushed because somebody else is waiting to come in, she'll deal with it there and then, so I know that if she does that for me, she does that for other people as well, so I don't really mind.' (Female, aged 66 years)

'Well, you can like sit down and talk to them [practice nurse] better than, more than what you can at t'hospital, somehow, I feel more confident, calmer.' (Male, aged 62 years)

In contrast, waiting was seen as pointless if the consultation is unsatisfactory.

'You used to walk in, book in [hospital], go and see the nurse with a sample of urine, then you used to go round and sit outside t'doctors, you see, you're sat outside ages, you go in, they ask you three or four questions, and that were it.' (Male, aged 63 years)

A range of experiences with different practitioners was expressed in the accounts and respect was seen as a factor in patient acceptance of advice and evaluation of their care. Practitioners were respected when they in turn showed respect for the patient, manifested in willingness to spend time, giving or seeking out information and maintaining interactions that addressed the concerns and interests of the patient:

'It's the rapport, 'cos we talk about all sorts of things, motor cars, holidays, as well as my complaints ... we've just got a good rapport, that's all.' (Male, aged 78 years)

Seeing familiar professionals regularly helped to maintain continuity of care. This was more apparent in the GP practices where patients attended more

frequently, providing the opportunity for continuity of care:

'They know you, for a start, and you just get better care, that's my opinion, they've got time for you for a start, and er, they do talk to you, well, mine does ... and if you've any questions, they'll answer 'em, any problems ...' (Female, aged 57 years)

This was not always the case at the hospital clinic, where medical practitioners changed over frequently:

'He said "I work for so and so the consultant", he was a doctor, qualified and everything, you know, I saw about three different ones ... you never saw, kind of saw, the main man, if you go only once, you never saw him.' (Male, aged 63 years)

However, for some respondents there remained links with the hospital clinic, and in some cases strong bonds had been formed with the diabetes nurse specialists who played a major role in initiating patients onto insulin.

Some respondents had found that they could contact known specialist nurses at times when the practice was inaccessible, providing a sense of continued support. This was important for some who, though self-caring, were occasionally unsure how to cope with fluctuations in their glycaemic control.

### *Comprehensive care*

Most respondents seemed to be satisfied with the clinical care and monitoring that they received at their practice, which was perceived to be similar to that received at the hospital. There were comments about lack of feedback of test results at both sites, particularly where patients themselves felt responsible for being proactive in obtaining information. Chiropody services were more fragmented; respondents could attend a dedicated foot clinic at the hospital or in the community, the GP practice, or a private chiropodist. There appeared to be a high demand for funded chiropody services:

'I used to go down to the surgery, but er, it started off once in eight weeks ... then it got to, it worked its way gradually er, I should imagine because of er, workload, it got to about 17 weeks, and that were no good, so I stopped that altogether, and we managed to get a private chiropodist.' (Male, aged 78 years)

Provision appeared to vary according to area, and may have been related to socio-economic factors. There was the risk that patients who could not afford to pay and/or did not have adequate access to a foot clinic or NHS-funded chiropody services may have been missed, resulting in an increase in foot complications.

'I used to go to the hospital for my feet doing ... but it was this time of year, when I should have gone, I think it were every four month I went, and er, it were snowing, and I

can't get, if it's snowing ... so I rang up and told her I couldn't make it, and so of course I've not had a repeat done since.' (Female, aged 74 years)

While clinical outcomes play an important role in evaluating care, the process of that care becomes an important part of the patient experience, and may affect how patients behave in terms of healthcare-seeking behaviour or self-care. Ease of access was important, but patients also valued the time that care providers gave in ensuring that needs were provided for, wherever care was delivered. Where support was unavailable, or care delivery fragmented, there was a risk of patients falling out of the system, with potentially negative consequences for health.

## Discussion

Through semi-structured interviews, this study has explored the views of 12 people with type 2 diabetes whose care delivery has recently changed to an innovative model that involves specialist support in primary care. It has shown that such a model of care can be more accessible in terms of geography and time, and was acceptable when consultations were considered meaningful, and when the full range of diabetes care was available. The policy change itself seemed little understood, with patients emphasising the details of their care rather than broader issues.

For most patients in this study, receiving the majority of diabetes care at their GP practice was acceptable because of improved access, reduced waiting times and greater flexibility of appointments, although there was some concern regarding out-of-hours support. Rapport, the willingness of professionals to listen during medical encounters, continuity and personalisation of care were also important. Comprehensiveness of care varied across sites, particularly in terms of associated care, such as chiropody.

Acceptance could be partly explained in this study because of selection. All participants had given consent for care to be managed in this way and were given, in most cases, the option of a continued link with hospital services. Most of the participants appeared to accept the change in care delivery as beneficial in terms of convenience and personalised continuous care, supporting Horrocks *et al*, who found higher satisfaction with longer consultations, which tend to facilitate better communication.<sup>17</sup>

Consultations are influenced by time factors, the social context of both parties and the expectations and past experiences of the patient.<sup>18</sup> Smith *et al* found that patients visiting the hospital clinic preferred to see the consultant.<sup>13</sup> Although nurses were also valued,

the participants in this study had mixed opinions. When professionals were valued it was for the time, support and information that they were prepared to give in consultations. In addition, participants valued respect and rapport in their consultations, a finding supported by Coyle.<sup>19</sup>

Naji and Hampson *et al* also found accessibility to local services and time saving were the main advantages for patients receiving integrated care for diabetes.<sup>20,21</sup> Preston *et al* examined cancer patient's issues at the primary/secondary interface and supported some of the findings in this study by emphasising the importance of continuity of care, and the powerlessness of patients who experienced long waits, or felt lost in the system.<sup>22</sup>

Respondents in this study were at times anxious that support should be there when they most needed it. Integrated care requires an appropriate and effective structure.<sup>21,23-25</sup> It is interdependent, and calls for sufficient funding and knowledge of available services, effective assessment of need, training for practitioners and co-ordination of services. Only with an effective structure in place can care for patients be continuous and seamless.

Though the sample in this study was restricted by availability of suitable respondents, some of the issues raised are transferable to other contexts where patient care provision has changed, and there is a need to understand the impact from the patient perspective.

## Conclusions

Responses in this study highlight the need for new models of care for people with diabetes to incorporate an integrated support network including acceptable appointment systems, out-of-hours services and access to associated care.

Consultation quality was a key factor in patient satisfaction in this study. Effective ways of managing medical encounters are needed that take into account patient and service requirements.

It is important that research, practice and policy be tailored toward issues that are salient to patients. Exploring the values of individuals with respect to health and health services is particularly necessary to develop an understanding of ongoing support for people with long-term conditions.

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## ETHICAL APPROVAL

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## CONFLICTS OF INTEREST

None.

## ADDRESS FOR CORRESPONDENCE

Maxine Johnson, School of Health and Related Research, University of Sheffield, Sheffield S1 4DA, UK. Tel: +44 (0)114 2220850; fax: +44 (0)114 2220749; email: [M.Johnson@sheffield.ac.uk](mailto:M.Johnson@sheffield.ac.uk)

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