

**Collection of case studies from the national  
clinical audit for rheumatoid and early  
inflammatory arthritis**

October 2016

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## **1. Introduction**

This document has been produced to highlight and share best practice between rheumatology services which took part in the national clinical audit for rheumatoid and early inflammatory arthritis.

Following the publication of the 2<sup>nd</sup> annual report in July 2016, the BSR undertook an analysis to identify providers which had performed well in relation to NICE Quality Standard 33 and, specifically, each of the statements within the standard. These providers were contacted and asked to provide case studies to explain how they had achieved these results and confirmation that their clinical lead was happy to provide peer support to other units.

Case Studies and contact details were subsequently compiled from various providers within the 4 NHS regions and Wales, and are enclosed in this document.

For further information about the audit, please contact [Ali Rivett](#), BSR Director of Clinical Affairs.

## 2. London NHS region

### Croydon Health Services NHS Trust

#### Quality Statement 1

To launch the new pathway, the rheumatology department used the opportunity of an invitation to teach the local GPs in March 2014. One of the afternoon's talks was entitled "Early Diagnosis of Rheumatoid Arthritis," where the newly-designed referral form, service and contact details were outlined. The service was then launched in the GP newsletter, choose and book, and in July there was an article in the local newspaper the Croydon Guardian. The referral form was revised, relaunched electronically and will be revised again shortly. GPs will also receive an electronic mailshot to remind them they can use choose and book.

#### Quality Statement 2 and 3

Croydon rheumatology department was already aware of delays in early arthritis patients accessing the service and delays in initiating DMARD therapy. An audit of service provision for RA was carried out in 2010. Data was collected from paper medical records. Initially, patients were identified over a 6 month period in 2010. 46 patients were identified to have a new diagnosis of Rheumatoid Arthritis (RA) during those 6 months or in the last 2 years. The mean age of patients was 52 with 71.7% females. The average time from receipt of the referral letter to first appointment had a mean of 7.8 weeks or 54.6 days. 44 of 46 patients were started on a disease modifying anti-rheumatic therapy (DMARD) on average (mean) 11 weeks after their first rheumatology appointment, the mode was 5 weeks. The average time from referral to initiation of a DMARD was 19 weeks with a mode of 11 weeks. 48% received a diagnosis at their first appointment and 20% had DMARD therapy started the same day.

A business case was composed using the audit data, presented in January 2013 and accepted in April 2013 just in time for the official launch of the Best Practice Tariff. Each component of the business plan was in place by July 2014.

To reconfigure the service the key stakeholders in the hospital were the Medical Director, the financial director and the Chief Executive. The CCG were made aware. Significant investment was required to improve the service to meet the new criteria:-

- Consultant Rheumatologist; Speciality Doctor; Part-time Specialist Nurse; Administrative support; Ultrasound machine

New patient slots for early inflammatory arthritis were ring fenced for each consultant and referrals bypassed the general booking system by either choose and book or direct referral to the rheumatology department on a dedicated form by fax. Dedicated early inflammatory arthritis nursing slots were also created for responsive follow-up. Patients were encouraged to contact the department by telephone for flares or drug reactions. A rheumatologist-run early arthritis ultrasound service was started and any diagnostic dilemmas were referred.

#### Quality Statement 5

Croydon University Hospital has a team of 5 consultant rheumatologists, one specialty doctor and 2 specialist nurses. The agreement to set a treatment target was organic, with all members of the team consciously treating to target. Judicious use of virtual/telephone clinics as well as dedicated early arthritis nursing slots enabled appropriate escalation of treatment.

**Clinical lead – Dr Tazeen Ahmed ([tazeen.ahmed@nhs.net](mailto:tazeen.ahmed@nhs.net))**

## **Lewisham and Greenwich NHS Trust**

### Quality Statement 1

We set up a dedicated early inflammatory clinic in 2013; shortly before the introduction of the Best Practice Tariff for early inflammatory arthritis. As we were setting up a new service we went out to meet the GPs at local and neighbourhood meetings to advertise the service as well as provide some education on early inflammatory arthritis. We provided education on identifying early arthritis and synovitis, which included asking some of our rheumatoid arthritis patients to come to some sessions for GP trainees so that we could demonstrate synovitis and give them some hands on experience.

During our education sessions we explained the importance of early referral and although we have encouraged GPs to request blood tests to enable us to make a diagnosis at the first appointment in rheumatology, we ask them not to wait for the results before referring the patient on. We continue to provide sessions and I regularly teach on the GP trainees' education programme.

We have seen an improvement in referrals following our sessions and our continued support of the GP trainee education programme and we hope that this will continue to be reflected in further audits.

### Quality Statement 2

After we set up our early inflammatory arthritis clinic, we audited our own clinic to ensure that we had enough new patient appointments to allow us to see patients within 3 weeks of referral. We also set a 3 week breach time on our clinic and our appointments department will contact us directly if patients are going to breach the 3 weeks, so that we can arrange an extra slot if needed.

At Lewisham, we have one referral template for all MSK, rheumatology and orthopaedics services. All of these services are triaged by rheumatology consultants. Any referrals suggestive of an inflammatory arthritis are triaged to the early inflammatory arthritis clinic. This means that even if the GP has not ticked the urgent box for inflammatory arthritis, but the history is suggestive, we will triage them appropriately rather than arrange an appointment in a general clinic. The turn-around time for electronic triage is 24 hours, which means less delay in appointing patients. This is reflected in our audit results showing that the majority of our patients are seen within the recommended 3 weeks from referral. We would hope that these measures will continue to be reflected in future audits and we will continue to monitor our waiting times.

**Clinical lead - Dr Louise Pollard ([louisepollard@nhs.net](mailto:louisepollard@nhs.net))**

## **Royal Free London NHS Foundation Trust**

### Quality Statement 3

Our Trust has undergone much change over the last three years, with two large Trusts coming together, and we now provide rheumatology clinics on three main hospital sites and four community hospitals. The audit required us to focus on working towards agreed patient pathways.

We developed a standard early RA treatment plan, which included the expectation that patients with RA would be given a diagnosis, information, a single dose of intramuscular steroid, started on hydroxychloroquine, and given information about methotrexate, at their first visit. Optimally, methotrexate would also be started, but we found patients often wanted time to consider and we needed more time than the half hour available to achieve this.

Key elements that helped us were:

- Strong IT, including an electronic EIA referral form available to all our local CCGs, and consultant electronic triage of referrals once received in the Trust. This meant that blood results could be checked, and ordered if not already available, before the patient's first appointment
- An electronic patient record which allows immediate access to all relevant patient information on all peripheral sites, and for (most) GP-ordered tests to be available to hospital clinicians
- A strong team of specialist nurses: we could not have achieved such good compliance without them.
- Having a CNS/s who can prescribe DMARDs including methotrexate is hugely helpful

We re-organised our CNS templates to allow a review within 2 weeks so that methotrexate could be started by the CNS if the patient was willing. Consultants wrote up the initial prescription and a dose escalation plan in the notes at the first visit and ordered the relevant blood tests. We developed an agreed set of baseline data collection (eg. smoking status, alcohol, varicella status) and GP advice (eg flu jab, Pneumovax, shared care protocol and booklets) for patients starting methotrexate, which was reflected in the first clinic letter to the GP. Letters are always copied to patients so that they are engaged with care from the start.

We are fortunate to have half hour clinic slots for EIA patients, and expert specialist nurses. Problems arise when patients with early RA end up in the wrong clinic slots, nurses are unavailable, or capacity is overwhelmed. We have found telephone consultation slots useful, patients use the nurses' helpline, we are liberal with information leaflets, and we encourage patients to access NRAS as well.

**Clinical lead – Dr Caroline Smith ([caroline.smith1@nhs.net](mailto:caroline.smith1@nhs.net))**

## **Ealing Hospital NHS Trust**

### Quality Statement 5

We are a small department (2 consultants, 1 registrar and 1 clinical nurse specialist). However from late 2014 until late spring 2015, we were without a registrar and a nurse specialist. This caused considerable pressure in our clinics but once we appointed a new registrar and a new nurse specialist we were able to reopen many clinics. This made it very easy for us to offer monthly follow-up appointments for our early RA patients - a thing that had always been difficult to do in the past. This, combined with close supervision of our SpR and nurse, meant we escalated treatment very rapidly - certainly faster than we had done in previous times. We also agreed low disease and functional targets with our patients rather than aim for remission which would be much more difficult to achieve within the 3 month timeframe of the audit. These factors resulted in a more aggressive approach to therapy than we had practised previously but the outcome was better disease control than before.

After reflecting on all of this, I think the following are the important factors:

1. The consultants leading the service need to be committed to making this happen.
- 2, There needs to be close supervision by consultant rheumatologists of trainees and nurses who may be seeing the patients to ensure they escalate treatment appropriately
3. There needs to be adequate capacity in clinics to see patients in a timely fashion. Traditionally most rheumatology clinics tend to be fully booked 2-3 months in advance so under normal circumstances it is almost impossible to see patients within a month. We were lucky that we could do this. The extra capacity could be additional (difficult in these financially constrained times) or carved out of existing capacity e.g. dedicated slots for monthly escalation patients only.

**Clinical lead – Dr Michael Naughton: ([michael.naughton@nhs.net](mailto:michael.naughton@nhs.net))**

## Midland and East of England

### Luton and Dunstable University Hospital NHS Foundation Trust

#### Quality Statement 3

Key to our results against this statement lies in detailed analysis undertaken in the department, following which a robust business plan was instituted for the transformation of rheumatology services and development of a formative 5-year plan.

- An Early Inflammatory Arthritis (EIA) pathway was set up with the introduction of EIA clinics every week to help reduce time from diagnosis to start of definitive therapy.
- Set treatment protocol was developed with corticosteroids and hydroxychloroquine initiated at first visit followed by rapidly escalating methotrexate regimen two weeks later in DMARD clinic thus ensuring standardised approach to early initiation of treatment, drug education and timely review.
- One lead clinical nurse specialist was supervised to achieve prescriber status to avoid any delay in issuing prescription for DMARD therapy.
- Having recognised that these patients were unidentifiable in the pooled workload, a dedicated referral proforma was devised, advertised locally and GPs educated about its utility. Communication exercise with CCG chair of long term conditions helped get the pathway news disseminated widely.
- Regular educational programme for primary care empowered GPs to refer suspected EIA patients through the pathway instead of routine review requests.
- Ultrasound has been incorporated into the early arthritis clinic with longer slots to improve diagnostic accuracy thereby reducing the time to initiation of DMARDs.
- Winning capital bid through competitive selection process led to implementation of multi-purpose database Infoflex to help acquire quality data in a live setting.
- Four extended scope physiotherapists were mentored to identify potential inflammatory arthritis patients with appropriate triage to the service.
- A pathway coordinator was recruited to track and monitor adherence to the pathway with regular discussions to troubleshoot early and avoid 'missing' patients.
- Six monthly health education forums for general public helped raise awareness of the service.
- In a response to a patient survey which highlighted issues such as cancellation and re-booking of appointments, a new partial booking system was introduced which achieved reduction in cancelled appointments, less re-scheduling and lower DNA (did not attend) rate.

We sincerely believe that the above changes will highlight further success, particularly in other quality standards, in future audit and we look forward to contributing to this national initiative.

**Clinical lead - Dr Muhammad K Nisar ([Muhammad.nisar@ldh.nhs.uk](mailto:Muhammad.nisar@ldh.nhs.uk))**

## **Dudley Group NHS Foundation Trust**

### Quality Statement 6

At Dudley, we have an established Early Arthritis Clinic since 2009 in response to the publication of the NICE guidelines on the management of rheumatoid arthritis. Over the last 2 years we have made a number of changes to our service to improve access and initiation of treatment for patients with early inflammatory arthritis. This has been in response to the national audit and our own departmental audits evaluating our early arthritis service:

- We have developed a referral proforma for GPs which allows us to appropriately prioritise patients with suspected inflammatory arthritis. We also have incorporated 'Suspected Inflammatory Arthritis' slots within our new patient clinics so that these patients can be prioritised and seen sooner in accordance with NICE quality standards.
- We have actively engaged in educating GPs about the importance of early referral for patients with suspected inflammatory arthritis. This has been via education sessions and written communication.
- We have refined our care pathway and DMARD protocol for patients with early Rheumatoid Arthritis so that their care is standardised throughout the department.
- All patients with suspected inflammatory arthritis are followed up in the Early Arthritis Clinic for the first year. We have developed a 'treat to target' approach and have the opportunity to review patients every 4 weeks in order to escalate their treatment if required.
- We have trained our outpatient nurses to carry out the DAS28 assessment for all patients in addition to routine observations prior to being seen in the early arthritis clinic.
- We have monitored access times to the early arthritis clinic and expanded the clinic (with a research fellow and international clinical fellow) to ensure we have the capacity to see early arthritis patients rapidly after initial referral and also if they are flaring.
- We have a Rheumatology Helpline and a named specialist Nurse and Consultant so that patients can access the department for advice and support should they need it.

**Clinical lead - Dr Ravinder Sandhu - [Ravinder.Sandhu@dgh.nhs.uk](mailto:Ravinder.Sandhu@dgh.nhs.uk)**

## **Ipswich Hospitals NHS Trust**

### Quality Statement 1 and 2

The development of the Best Practice Tariff for Early Inflammatory Arthritis provided the department and the Trust with the stimulus to set up a dedicated Early Arthritis Clinic. This was something that we had considered over the years as being desirable but had not managed to achieve. We created a once weekly clinic staffed by two doctors and a nurse specialist. This was organised on a generic basis enabling us to guarantee that the service was always staffed irrespective of leave. The clinic had a mix of new and follow up appointments to ensure that we not only could see new patients within the 3 week time period but also offer follow up appointments to escalate treatment appropriately.

New referrals were directed to the service following consultant review of the referral letter electronically. We also developed a referral form indicating the clinical features that we would expect in a patient with new onset inflammatory arthritis and to indicate whether appropriate blood tests had been performed.

The HQIP audit started after our clinic had been well established and provided an ideal opportunity to audit our practice. It is very gratifying to see that our decision to develop a generic Early Inflammatory Arthritis clinic performs well against the NICE guidance.

**Clinical lead - Dr Richard Watts ([richard.watts@ipswichhospital.nhs.uk](mailto:richard.watts@ipswichhospital.nhs.uk))**

## **West Suffolk NHS Foundation Trust**

### Quality Statement 2

We have the shortest waits in East Anglia and have done for over 2 years. The time we take to see 50% of all new referrals (not just possible early arthritis) varies between 2 to 3 weeks and we take 6 to 7 weeks to see 90% of all referrals. We see plenty of patients and are efficient in outpatient usage.

In addition we have dedicated “Early Arthritis” clinics – however these are open to “Choose and Book” referrals from the GP.

We achieve this by trying hard to get it right first time and treat ASAP or discharge if no need for a rheumatological intervention. We use nurses for as much RA/PsA/AS follow up as possible, with generous use of nurse helplines which frees up doctor time to see new patients. With a close Treat 2 Target model, we get rapid control with good remission/low disease activity rates in RA then follow up annually with access to the helpline.

All of the consultants manage the patients in the same way varying treatment for “patient specific” not “doctor specific” reasons. We review our treatment plans and change as the evidence changes. For instance we are working out how to use sub cut MTX 25mg our default RA first line treatment as the data from Finland and Canada are really very good.

We have visited lots of units to talk about our service and how to turn evidence into everyday practice. We have hosted 4 large supra regional meetings in Cambridge with up to 80 attendees.

**Clinical lead - Dr David O'Reilly ([david.oreilly@wsh.nhs.uk](mailto:david.oreilly@wsh.nhs.uk))**

## **East and North Hertfordshire NHS Trust**

### Quality Statement 6

The department developed a number of strategies to improve management of EA patients: To ensure patients are seen as quickly as possible, all referrals are triaged and potential EA patients fast-tracked to our early arthritis clinic. Patients are also sent an 'EA pack' to arrange core investigations in advance of their first appointment. The pack additionally provides basic information about early inflammatory arthritis and potential medication that may be started. Our Musculoskeletal Radiologists provide first-appointment MSK ultrasound slots which run in tandem with EA appointments; these slots have proven particularly useful when assessing patients with coexisting fibromyalgia and osteoarthritis. Once the diagnosis is confirmed, DMARDS are started and further educational material provided by a specialist nurse. For most patients, this happens at their first appointment but some patients need more time and the drug start is deferred accordingly. Patients continue to attend the EA clinic until their treatment target has been achieved.

EA patients are also invited to attend an annual patient education meeting with presentations from consultants, specialist nurses, OT's, PT's, podiatrists and patient speakers; representatives from our local NRAS group also attend. The department has developed a series of video recordings titled 'The Patients Perspective' of inflammatory arthritis which is available through the trust's webpage and complements our information leaflets. In relation to QS 6, the same specialist nurses who manage our rheumatology advice-line also support the early arthritis clinic and this dual-role allows them to quickly identify and respond to queries arising from early arthritis patients. Advice-line and other contact details are provided to the patient at their first specialist nurse appointment.

We recognise the importance of metrics and have developed an in-house electronic EA database on a Microsoft Access platform. The database was upgraded to include National audit metrics which helped minimise the extra time needed to collect audit data. The database also allowed us to keep track of patient flows and make service adjustments depending on available resources. Simplified paper audit forms were designed and used by colleagues less familiar with the electronic database and later entered by trained secretarial staff. We also collaborated closely with the trust's audit department who transcribed data from the local database and paper audit forms to the national database. We would be happy to be involved in developing a similar electronic database with BSR support for national use.

We have since made service changes to ensure annual review appointments happen within the first year. After much effort, we recently secured a rental MSK ultrasound device with pharma assistance; it is to be used in follow-up EA clinics and to support our injection clinic. We have had limited success engaging the CCG in service improvement.

**Clinical lead - Dr Bhatiya Wijeyekoon ([j.wijeyekoon@nhs.net](mailto:j.wijeyekoon@nhs.net))**

## North of England

### Lancashire Care NHS Foundation Trust

#### Quality Statement 1

The audit has highlighted that nationally there is a significant delay in patients being referred to rheumatology. We were very encouraged by our local results, which demonstrated that GPs were performing better than the national average, though we acknowledge that there is still much room for improvement. Over the last 5 years since the rheumatology service transferred from a hospital based service to the community, we have had the opportunity to undertake various GP engagement initiatives. These have helped us raise the profile of rheumatology and particularly the importance of referring patients with suspected inflammatory arthritis promptly. We have been invited to speak at various primary care meetings attended by GPs and practice managers, and provided laminated posters for GPs to display in their waiting areas highlighting to patients symptoms to look out for.

Getting involved with GP education has been another aspect we feel has influenced our local results. We have been invited each year to present a workshop on the formal GP education programme and have also arranged our own primary care education day which was endorsed by the RCGP. We deliver formal teaching sessions each year to the first and final year GP trainees. We have undertaken two separate pathway events where we have involved GPs and patients in the process of mapping a patient's journey with rheumatoid arthritis through the service. A particular focus was what happens before the patient is referred to rheumatology and having the insight of primary care colleagues and patients in this process to understand the potential barriers to referral has been invaluable. After reviewing the second annual report we are keen to highlight to GPs how they are performing. We have agreed to write a letter to all GP surgeries highlighting our local results and hope this positive reinforcement will encourage GPs to continue to refer patients early.

#### Quality Statement 5

A treat to target approach is something that we have worked hard to embed within the team. This comes in part from our involvement in the national "Treat to Target" which we contributed a number of patients to prior to the onset of the audit. A workshop attended by various consultants and specialist nurses also got us thinking about how we undertake a DAS28 assessment and, following this, we organised a formal afternoon of training to standardize how we do things. These two interventions have helped us as a team to appreciate how important the DAS28 is in assessing patients and informing treatment decisions. As a team we have agreed that every time a patient is seen a DAS28 is undertaken and if not a reason is given as to why an assessment has not been done. Our engagement as a team with the DAS28 has also helped us to empower our patients to understand the assessment and we ensure that every newly diagnosed and our established patients are provided with one of the NRAS information booklets about the DAS28.

We were very heartened when we saw our results with regards to QS 5. We felt that it reflected the team approach to ensuring every patient is appropriately assessed and involved in the initial treatment plan. Following the publication of the first annual report we reflected on our results and agreed as a team that we would ensure that our initial clinic letter would document our treatment plan and agreed treatment goal with the patient. As a team we reviewed our appointments to ensure that the specialist nurses were seeing patients on a monthly basis and this has been reflected in our pathway.

**Clinical lead – Dr Elizabeth Macphie ([Elizabeth.Macphie@Lancashirecare.nhs.uk](mailto:Elizabeth.Macphie@Lancashirecare.nhs.uk))**

## Sheffield Teaching Hospitals NHS Foundation Trust

### Quality Standard 2

The second year of the audit coincided with significant organisational change in Sheffield, with the introduction of an outcomes based contract encompassing the whole of musculoskeletal care in the city (including rheumatology, orthopaedics, pain service and community physiotherapy).

As part of this, all GPs are required to refer patients electronically via a single point of access, using a standard proforma on which they select the specialty most appropriate for the patients clinical problem. The referrals are triaged electronically by a senior clinician from that specialty, with the ability to move the referral electronically to an alternative specialty if appropriate. The patient is then offered an appointment via a telephone contact centre. We had previously used a number of different referral forms across the MSK specialties including an early inflammatory arthritis form, and collaboratively took the most clinically useful parts of these forms and combined them into a single document used for all patients. Included in this form are direct questions about joint swelling, duration of symptoms, and risk factors for RA, including family and smoking history, as well as a free text area for GPs to describe the patients symptoms in detail, completion of which is mandatory. An initial investigation set including CRP and autoantibodies was also mandatory prior to GP referral, with results available at the point of triage. All patients suspected of having an early inflammatory arthritis were triaged to our early arthritis clinic, which runs on 3 days each week with morning and afternoon slots available. We also have an arrangement with our immunology lab, that they will automatically process anti-CCP antibodies for patients appointed to the EAC on samples they store following the GP request for RF, in order that the result is available when the patient is seen (as GPs in Sheffield cant request CCP). The electronic referral process reduced the delays that come when handling paper, and also provided consistent high quality referral information and investigation results that were absolutely key in making good triage decisions and getting the right patients into our early inflammatory arthritis clinic, and then allowing us to start combination DMARD treatment at the first visit in most cases as sufficient information is available to make a confident diagnosis.

Based on the data from the first year of the audit, we were able to more accurately map the demand for the early arthritis service and therefore increased the available capacity for the second year in order that we see patients quickly - we have an internal target of 2 weeks from triage of the referral. In part this has proved possible by a reduction in the total number of patients seen by Rheumatology as a consequence of the electronic triage process described above, which reallocates around 10% of referrals received to alternative specialties (pain, extended scope physio or orthopaedics) where it is clear from the information that the patient has a non-inflammatory problem. This has resulted in a significant reduction in our overall new patient waiting times, as well as those for early inflammatory arthritis. The next stage of our project is the introduction of a software platform to support the collection of patient reported outcome data across the MSK contract which we hope will further enhance our service. In the meantime the audit has been a key driver in the improvements we have been able to implement to the benefit of our patients over the last year.

**Clinical lead – Dr James Maxwell ([James.Maxwell@sth.nhs.uk](mailto:James.Maxwell@sth.nhs.uk))**

## **Doncaster and Bassetlaw Hospitals NHS Foundation Trust**

### Quality Statements 2 and 4

We feel that the good results in Doncaster is mainly the results of good teamwork involving all the consultants, rheumatology nurses, physiotherapist and occupational therapist in providing the early inflammatory arthritis service. This service was set up specifically in response to NICE QS33 and best practice tariff. All the consultants work together and patients were pooled when they are seen in this service. In addition, an integrated care pathway was created for this service and specific clinic slots were created for this service. This has enabled us to see most patients within 3 weeks of referral and treatment started within 6 weeks of referral.

**Clinical lead – Dr Chee-Seng Yee, Consultant, [chee-seng.yee@nhs.net](mailto:chee-seng.yee@nhs.net)**

## South of England

### Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

#### Quality Statement 1

We have met with the CCG and mailshot GPs about the importance of early referral. We have got an early synovitis protocol that GPs can use and book patients in to the early synovitis clinic on choose and book. We have secured funding for anti-CCP testing by GPs, that are done (together with ESR, CRP, and RF) at the time of referral. Again this has been publicised to GPs so that they are aware of the service.

#### Quality Statement 4

We have a formal 1.5 hr education session once a month (10 x yr). This is run by a Speciality Doctor and a rheumatology practitioner. This has been running for 5 years and has been audited twice with excellent patient feedback. It is an informal session around a table with the medical team as facilitators but largely patient lead. We have a framework around which we work including:

- drugs, monitoring and safety, managing side effects; fatigue and fatigue management; work related issues and supply NRAS employee and employer booklets; exercise with awareness of our in house 6 week move to improve physio run exercise programme and sign post to local weekly NRAS pilates class and aqua exercise; local NRAS support and quarterly meetings at the hospital often with speakers; diet and its myths!; analgesia and its appropriate use; offer referral to hand OT and podiatry

We also have a wide range of NRAS and ARC booklets available. This session is set up on our booking system as a clinic which ensures that we are remunerated for the session and also provides patients with a valid clinic appointment for their employers.

Patient pathway at diagnosis: EIAC seen by consultant and diagnosis made. Hydroxychloroquine and steroids started, DMARD info given, CXR and baseline bloods done and then the patient is rebooked within 10 days to have longer session with rheumatology practitioner to begin education, answer initial concerns, consent and start Methotrexate if indicated, given in house early arthritis booklet, helpline info, NPSA methotrexate booklet and invited to formal education session (above). Helpline: Answer machine available 24/7 with return of calls <24hours M-F. This line is manned during office hours by dedicated administrative staff, who arrange rheumatology practitioner call back as necessary.

Patients do not have care plans but are given copies of their clinic letters which we try to format in standard way across the department. This development in 2013 arose from an audit that aimed to standardise RA clinic letters and provide the patient with a modified care plan to encourage empowerment and self-management, using this structure:

- Diagnosis; current rheumatology medication; blood results; current problems; on examination; plan/goals; GP action; next review; blood monitoring

**Clinical lead – Dr Neil Hopkinson ([Neil.Hopkinson@rbch.nhs.uk](mailto:Neil.Hopkinson@rbch.nhs.uk))**

## **Portsmouth Hospitals NHS Trust**

### Quality Statement 2

We believe the presence of dedicated administrative staff booking to our clinics is a major factor in our results – we can talk to them directly (their offices are in our dept) to help prioritise patients once referral letters have been seen and graded (EIA pathway, urgent non EIA pathway and routine). They also understand what we are trying to achieve and why.

We have a consultant buddy system so when a consultant is away, a colleague is responsible for dealing with their admin – including grading of referrals – so there are no delays in referrals being assessed and graded.

We have set up an EIA pathway and patients felt to have potential EIA are graded as such on referral letters to prioritise their appointments.

We have restricted appointments available via choose and book – some urgent and EIA appointments are available via C&B but many are reserved for us to book to ourselves via our dedicated admin team.

We have approximately 40% of all new appointments reserved for urgent cases and in addition have a rapid access treatment service that allows us to see patients in a more timely fashion when needed.

In addition, we have an on-call service and GPs can liaise directly through this to arrange urgent appointments.

**Clinical lead – Dr Jo Ledingham ([jo.ledingham@porthosp.nhs.uk](mailto:jo.ledingham@porthosp.nhs.uk))**

## **Taunton and Somerset NHS Trust**

### Quality Statement 5 and 6

We have over the last 6 years established urgent access early arthritis clinics with slots allocated directly by rheumatology team members and we aim to keep the waiting time to less than 3 weeks.

These clinics have been expanded so that they occur every week and we now run between 7 and 9 clinics per month. Patients with possible early arthritis are flagged for early review by our specialist nursing (RSN) team (3 WTE RSN) who allocate the patient an appointment in a nurse led clinic as soon as possible. This allows time to review results and response to initial treatment, provide disease education, treatment/drug counselling and to answer questions. Combination disease modifying therapy is usually instigated from that appointment.

We deliberately chose not to run 'a one-stop shop service'. We have found that this allows patients time to consider the diagnosis whilst corticosteroids are used as bridging therapy. Rheumatology nurse specialists then arrange further monthly follow up to monitor progress (some of these appointments maybe by telephone contact) with the aim of achieving targeted level of disease control. For most patients this target is disease remission. Details of our advice line are also confirmed by the RNS who aim to answer the majority of calls within 24 hours. Further medical review is booked at six months (earlier if required) and treatment escalations discussed within the multidisciplinary team before that review if necessary.

**Clinical lead – Dr Cathy Laversuch ([cathy.laversuch@tst.nhs.uk](mailto:cathy.laversuch@tst.nhs.uk))**

## Wales

### Betsi Cadwaladr University Health Board (BCUHB)

#### Quality Statements 1, 2 and 5

BCUHB provides services across the whole of North Wales, with services based in three centres - Wrexham Hospital, Glan Clwyd Hospital and the Peter Maddison Rheumatology Centre in Llandudno. Each of the three individual departments provides hub and spoke rheumatology services into community hospitals across the localities.

In 2012, we developed the North Wales Early Arthritis Network (NWEAN) which brought together multidisciplinary team members across North Wales to establish an evidence based management pathway that all 3 centres have implemented for the management of early inflammatory arthritis. NWEAN is a clinician driven project. The aim is not just to provide treatment protocols but to establish a programme of ongoing improvement in the management of early arthritis and ultimately better outcomes for our patients. This includes adapting to the evolving evidence base, bench marking to standards such as NICE, campaigning for awareness, within the patient and health professional communities and raising early arthritis care as a priority with the Health Board managers as the only rheumatology key performance indicator is a 26 week new patient wait. Particular mention must be given to Dr Sarang Chitale, consultant rheumatologist, who has now left the organisation but was a key clinical leader in driving this work.

This work pre-dated the NICE guidance but included many of the standards and a focus on changing to early instigation of combination DMARDs with rapid escalation. We had already several years of audit cycle in advance of the HQIP project. These audit cycles identified key themes of referral from primary care, time to new appointment and use of combination therapy. The HQIP audit has allowed us to benchmark not only to the NICE standards but with services across the rest of the UK.

- Each centre made changes to adapt services in order to prioritise early arthritis referrals; either in a dedicated early arthritis clinic or by protecting urgent new slots (in Wrexham) for early arthritis referrals.
- Education of GPs and other health professionals seeing MSK patients was initiated through; local training lectures within practises, education of GP trainee cohorts, CMATs education and an early arthritis awareness event. This activity may have helped with achieving audit standard one. Although, in Wales there are no barriers to referral from primary care so the challenge has been more around getting the right information into letters for triage and demand management of other services to prioritise those likely to have an early inflammatory arthritis.
- Target setting with the patient has always been part of the NWEAN pathway. However, the first HQIP audit year highlighted that this was not always adequately documented and that changed between the 2 cycles and has become part of routine practise.

It would be useful to have the statistics broken down by area. For example the Glan Clwyd team diagnosed very few patients in comparison to the other sites as a result of consultant staffing levels and are not achieving standard 2, with very long waiting times which were lost in the numbers. PMRC and Wrexham have far fewer nurses per population head and therefore struggle to achieve timely review and DMARD escalation as per the NWEAN pathway and NICE guidance. Understanding of these local issues is difficult when reporting figures en masse for a Health Board of this size.

Whilst the 3 teams are very happy to have been recognised for our work in this area there are still ongoing threats and challenges to early arthritis services in North Wales and so far the changes have been driven by clinicians and clinical teams without any extra financial investment.

The aim is to achieve excellence in all the NICE domains and this requires support to maintain what has already been achieved and planning to implement state of the art Early Arthritis Clinics across North Wales that are fully funded with appropriate nursing and diagnostic support, including same day ultrasound scanning.

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