

GIRFT rheumatology report outlines how service change could reduce waiting times and improve access to care

Patients with painful conditions such as osteoarthritis and fibromyalgia could be seen faster and closer to home in primary or community settings, freeing up hospital rheumatology clinics for patients with other disorders.

The national report for rheumatology from the Getting It Right First Time (GIRFT) programme shows that patients with these non-inflammatory painful musculoskeletal (MSK) conditions account for a third of new patient rheumatology appointments in some hospitals in England and often wait for long periods on waiting lists.

Redesigning services so these patients can be treated in primary or community settings instead will ensure they are seen closer to home (one of the aims of the NHS Long Term Plan), reduce delays in their treatment and give them better access to physiotherapists, podiatrists and psychologists when they need them. Any large-scale change of this sort should be supported by services co-designed with the patients themselves to best meet their needs, says the report.

This, in turn, would also help to reduce waiting times for patients with other severe rheumatic and MSK disorders (RMDs) – the report recommends that all patients referred for specialist care should be seen in eight weeks or less.

The redesigning of services for non-inflammatory painful MSK conditions is one of 23 recommendations in the new GIRFT report, which has been led by consultant rheumatologists Dr Lesley Kay (Newcastle upon Tyne Hospitals NHS Foundation Trust) and Dr Peter Lanyon (Nottingham University Hospitals NHS Trust), with advice from Professor Alex MacGregor (Norfolk and Norwich University Hospitals NHS Foundation Trust).

The GIRFT process brought to light challenges faced by many units, including rising demand for services, limited resources and an overstretched workforce, meaning many patients with painful non-inflammatory musculoskeletal conditions wait a long time for assessment.

To address these challenges and improve patient care, the report suggests services for non-inflammatory painful musculoskeletal conditions should be provided in primary or community care, supported by services co-designed with patients. Such large scale change would be in the long-term interests both of the health system and patients.

It is estimated that 10 million people in the UK are affected by RMDs, representing a significant burden in terms of disability, quality of life and lost work days. The report shows that while very few rheumatology patients are admitted to hospital as inpatients, there are more than two million outpatient appointments in England every year.

Reflecting on lessons learned from the first wave of the COVID-19 pandemic, the GIRFT report makes recommendations which can improve the care of patients with conditions including

inflammatory arthritis and septic arthritis, and rare autoimmune diseases such as vasculitis and connective tissue diseases, as well as reducing the number of hospital visits to outpatient clinics.

For example, greater use of digital consultations, patient-initiated follow-up and educational videos can ensure patients are not making unnecessary visits to hospital, although support should still be available for patients who are not confident using virtual technology.

The report also recommends a review of specialised rheumatology networks to ensure that patients with rare disorders have rapid access to specialist expertise and effective treatment, regardless of where they live. This can also help to support the workforce in smaller rheumatology units.

Recommendations around rare RMDs are aligned with the Government's new [UK Rare Diseases Framework](#) and may help eliminate any geographical variation in the current system.

The GIRFT report brings together the largest and most comprehensive specialty data set that has ever been assembled for the specialty, including national data sources that have never been used before, such as national prescribing and litigation. Overall, it identifies opportunities to free up between £61.9m and £93.2m a year for the NHS.

This includes an opportunity to better maximise the value and efficacy of the medications used to treat rheumatology conditions, to benefit patients and free up money for the NHS. For example, biologic drugs used in rheumatology are some of the most expensive used in the NHS, but many have a cheaper biosimilar alternative. The report recommends that trusts and departments are supported to make rapid switches to the best value biologic medicines, to significantly reduce the annual rheumatology drug spend in England of £416m.

Report recommendations

- 1 Care for patients with non-inflammatory painful musculoskeletal conditions should be provided outside of hospital in primary and community care settings in line with NHS Long Term Plan ambitions to bring care closer to home for patients.
- 2 Referral to treatment (RTT) waiting times should not exceed eight weeks for all patients who need specialist rheumatology care.
- 3 Trusts should review their management of follow-up appointments and consider alternative models of outpatient care.
- 4 Rheumatology medical training posts should maximise the quality and value of rheumatology-specific training components to ensure competence and meet patient needs.
- 5 Trusts should make full use of the multidisciplinary skill mix and consider enhanced roles for nurses, pharmacists and allied health professionals, to meet increasing demand and

- improve services for patients, in line with the NHS Releasing Time to Care ambitions set out in the interim People Plan.
- 6 Rheumatology services should be planned across a geographic area, with services for some conditions commissioned at integrated care system (ICS)/sustainability and transformation partnership (STP) level to improve efficiency and outcomes overall, with network support for smaller units to make them more sustainable and ensure equity of access for patients.
 - 7 Diagnoses should be coded for outpatients as part of routine activity to enable service planning and benchmarking between trusts.
 - 8 All rheumatology activity should be coded using treatment function code 410.
 - 9 Management of suspected early inflammatory arthritis (EIA) should be improved through clearer referral criteria, effective triage systems and adequate resourcing to meet patient needs and comply with the audited National Institute for Health and Care Excellence (NICE) quality statements.
 - 10 Participation in the National Early Inflammatory Arthritis Audit (NEIAA) should be enhanced by considering how the audit could be integrated into routinely collected data for rheumatology services.
 - 11 All rheumatology units providing care for rare rheumatic and musculoskeletal disorders (RMDs) should collect data on care, caseload and outcomes for people with rare RMDs, using routinely collected data where possible to reduce burden of clinician data collection and submission.
 - 12 People with rare RMDs should have rapid access to specialist expertise and effective treatments to ensure equity of outcomes regardless of geography and reduce the risks of morbidity and mortality.
 - 13 The structure, operation and geographic reach of specialised rheumatology networks should be reviewed and improved to ensure equitable, sustainable provision of specialised care for rare RMDs across and between regions.
 - 14 All trusts should meet the new British Society for Rheumatology guideline for giant cell arteritis (GCA); ensuring referrals are rapidly assessed using the latest techniques and pathways.
 - 15 Trusts should review governance of ultrasound for musculoskeletal (MSK) conditions and giant cell arteritis (GCA) to ensure that the service is sustainable and provide equitable access to ultrasound diagnostic tests for all patients who need them.
 - 16 Pathways for diagnosis and treatment of 'hot joints' should be consistent and led by orthopaedics to ensure 24/7 access for patients, with support from rheumatology as required.

- 17 Trusts should optimise use of day case facilities and consider alternatives to day case admission for some procedures to reduce waiting times and improve the patient experience.
- 18 Trusts should use national medicines data reporting systems, together with local benchmarking, published through the NHS Model Hospital and Model Health System, to enable transparent local and regional comparison of high-cost medicines usage.
- 19 Trusts and departments should continue to be supported to make rapid switches to use of best value biologic medicines, including biosimilars, where clinically appropriate.
- 20 Disease-modifying anti-rheumatic drugs (DMARD) monitoring processes should be standardised across integrated care system (ICS)/sustainability and transformation partnership (STP) footprints and medical specialties, linked to an interoperable electronic monitoring system.
- 21 Adequate resource should be allocated to ensure trust involvement in research and to support submission to relevant patient registries.
- 22 Reduce litigation costs by application of the GIRFT programme's five-point plan.
- 23 Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.