NHS England

Clinically-led Rheumatology Outpatient Guidance

Practical OPD guidance for rheumatology services to maximise efficiency and reduce waiting times for patients

July 2023

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GIRFT GETTING IT RIGHT FIRST TIME

Action on Outpatients Improving access to care

Produced in partnership by GIRFT and the Outpatient Recovery and Transformation Programme

Acknowledgements: Clinically-led Specialty Outpatient Guidance

Co-badged in collaboration with:

British Society for Rheumatology

Royal College of Physicians

Royal College of Surgeons of England
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Foreword and contents: Clinically-led Specialty Outpatient Guidance

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams have produced this guide which outlines actions services can take to tackle escalating demand for outpatient appointments. It provides practical, condition-specific advice for services to focus on which are safe and clinically appropriate for specialities with the highest number of +78 week waits[1].

Aimed at clinicians and operational teams, actions are highlighted for each service to drive quality improvement within outpatient provision. Readers should evaluate their service against the guidance set out and work towards implementing any gaps. Within each section, links to further guidance and resources can be found using the resources links.

This document should be used as template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience.

Further information from GIRFT and OPRT can be found here:
Getting It Right First Time - FutureNHS Collaboration Platform
Outpatient Recovery and Transformation Platform - FutureNHS Collaboration Platform

[1] as of August 2022

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Actions for outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

Action for non-admitted waiting list – new patients

Clinical staff to triage new patient referrals:

- ☑ Is the patient on the right pathway?
- ☑ Can diagnostics be undertaken prior to first appointment or a one stop clinic visit?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, can they be discharged back to GP or moved to PIFU if clinically appropriate?

Action for non-admitted and non-RTT waiting list – follow-up patients

Clinical staff to validate follow-up lists (post-diagnostics):

- ☑ Does the patient need a follow up, or can they be discharged with letter to patient and GP?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, if no further treatment indicated, can the patient be discharged back to GP or moved to PIFU if clinically appropriate?

Actions for the admitted waiting list

- ☑ Clinically review those waiting >1 year, as to whether an intervention is still needed.
- ☑ Day case by default clinical policy.
- ☑ 85% of elective procedures (with minimal exceptions e.g. arthroplasty) delivered as day case.
- ☑ Maximise existing theatre sessions that are staffed and run. Achieve 85% theatre capped utilisation time.
- ☑ Maximise "Right procedure Right place" – moving appropriate procedures into procedure rooms.
- ☑ Develop surgical hub sites - 91 existing & over 50 new hubs, working at GIRFT standards.

Specialty specific actions can be found on the relevant specialty page

Background on outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

In 2021/22, the NHS delivered **95 million outpatient appointments** – almost 2 million appointments per week.

As at Feb 2023 there were **7.22 million patients waiting to start treatment**:

- **6.12 million on a non-admitted pathway**
- 1.10 million on an admitted pathway – waiting for a procedure
- 30,000* patients are waiting over 78 weeks on an open RTT pathway
    - Approx 50% of these (c.15,000) have a decision to admit

The remaining outpatient capacity is used for non-RTT follow ups. 12 specialties have greatest number of patients in this category which are included in this guide. Actions highlighted in this document should become standard practice in managing outpatients.

* October 2022 RTT estimate

Appointments lost to DNAs

- The number of DNAs recorded in HES data for 2021/22 was 7.8 million*
- This is equivalent to around 8% of the total 95 million outpatient appointments actually attended in the same period
- A 25% reduction in these DNAs would release the equivalent of almost 2 million appointments – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog.

*taken from HES data 2021/22, likely understates the true position.

Total OP Appts Attended vs. DNAs reported, 2021/22

Standardising follow-ups and increasing levels of safe discharge will:

- Support a timely and better experience for patients.
- Improve patient flows for patients awaiting treatment and those on long term monitoring.
- Free up valuable diagnostics.
- Improve the clinic experience for clinicians, nursing staff and all allied health professionals.
- Improve training experience for trainees.
- Release surgical time/expertise for theatres, ward rounds and training.

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Patient View – what matters to me?: Clinically-led Specialty Outpatient Guidance

Listening to people who are living with ill health, and to those who are using services is never the wrong thing to do.

We all want to receive communication about our health in a way that suits us and in a way that helps us to make informed choices.

If we can get things right for people with sensory impairments, for people with low literacy and people who speak English at various degrees of fluency, it will make health and care better for all of us.

It's time to put patient choice, [needs] and personalisation at the heart of all NHS communications.

Sarah Sweeney
Head of Policy, National Voices (HSJ, 2022)

Patients ask us to:

- Make every contact count
- Reduce visits to hospital
- Consider rising cost of living
- Avoid travel and other costs
- Consider how we can tailor our communication and support for different communities

We need to:

- Design services around patient need – at convenient times, locations etc.
- Take into consideration the needs of patients i.e. physical and mental needs, cultural and social-demographic factors
- Personalise care, giving patients choice and control over their healthcare
- Review referrals at the earliest opportunity to minimise wasted time for patients
- Discharge patients when clinically appropriate to free up capacity for new patients and those waiting to be seen
- Ensure all communication with and about patients conforms with the Accessible Information standard

We need to transform outpatient services for the benefit of our patients

Specialist Advice: Clinically-led Specialty Outpatient Guidance

Specialist Advice is an umbrella term for a range of models that facilitate a clinical dialogue between a specialist and referrer prior to, instead of, or about a referral to support the management of patient care.

This can be:

- **Pre-Referral (e.g. Advice & Guidance):** prior to or instead of referral the referring clinician seeks advice from a specialist through synchronous or asynchronous methods.
- **Post Referral (e.g. Referral Triage models that offer Specialist Advice):** where a referral has already been made, the specialist reviews the information, and can either return the referral with guidance or direct the onward referral to the most appropriate clinician, clinic and/or diagnostic pathway.

Reasons for seeking specialist advice

- ☑ Advice on a treatment plan and/or the ongoing management of a patient
- ☑ Clarification (or advice) regarding a patient's test results
- ☑ Advice on the appropriateness of a referral for a patient

Who can provide specialist advice?

- ☑ Trained and commissioned clinical specialists / experts
- ☑ Consultants
- ☑ SAS Doctors
- ☑ Other healthcare professionals in secondary, community or primary care providers, interface or intermediate services, and referral management systems

Benefits of specialist advice

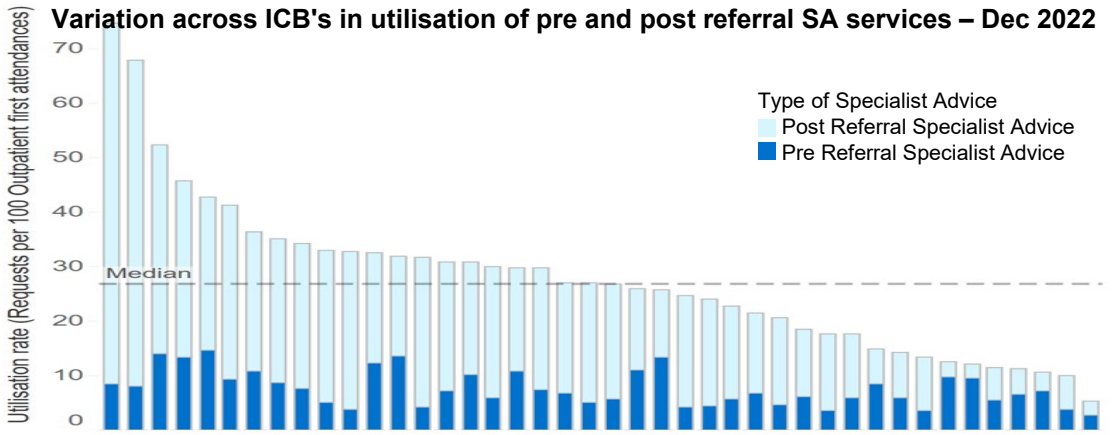
- ☑ Improved patient experience
- ☑ Enables quicker access to the right care and investigations, closer to home
- ☑ Supports shared decision making
- ☑ Collaborative working
- ☑ Sustainable model of care
- ☑ Efficient use of resources

Resource links

OPRT Specialist Advice FAQs

OPRT Introduction to Specialist Advice

Variation across ICB's in utilisation of pre and post referral SA services – Dec 2022



National Picture

- Historically, use of specialist advice was variable across England so a planning guidance target was set for each system to reach 16 advice and guidance requests or equivalent models per 100 OPFA by March 2023.
- This was with the aim of avoiding 1.8 million RTT clock starts in 2023 and is incentivised by Elective Recovery Fund payments.
- Specialist advice utilisation has grown nationally with 75% of systems now reaching the planning target of 16 per 100 OPFA . Pre referral services (A&G type services) account for a third of requests.
- The proportion of requests resulting in an avoided referral (diversion rate) differs greatly between pre referral type services (50%) and post referral type services (15%).

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Reducing ‘Did Not Attends’ (DNAs): Clinically-led Specialty Outpatient Guidance

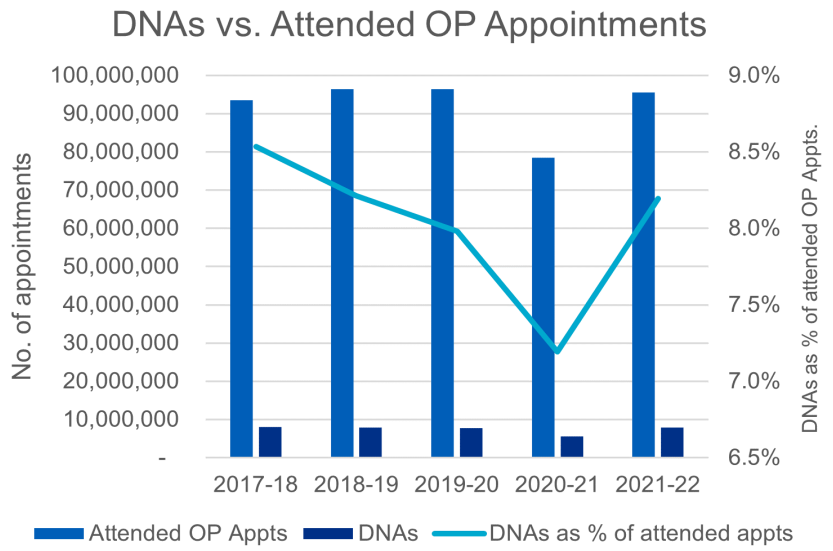
There were 95.6 million attended outpatient appointments in 2021/22. and 7.8 million DNAs. This equates to an average of around 650,000 monthly appointment slots being lost due to missed appointments. This valuable clinical capacity could be used to see other patients, including those who have been waiting for care the longest and those with the most clinically urgent conditions.

Key actions providers can take to help with DNAs are:

- **Send appointment reminders to patients – including letters, emails, SMS and phone call reminders**. This can reduce DNAs by up to 80% and works better when communication is “two way” (patients also prefer this). Organisations should ensure appointment letters and reminders are written in simple language and are accessible to the individual patient.
  - **Information should include: what the appointment is for, with what service and have service contact details.**
  - Review the intervals and frequency of reminder emails and SMS.
  - Ensure hospital maps are clear in letters and emails, and signage in the hospital matches this.
- **Ensure material is health literate to improve communication and access for cancellations and re-booking** to ensure patients can cancel / rearrange appointments easily.
- People in marginalised groups are generally more likely to miss their appointments**. Work with public health colleagues locally to understand what can be done to support patients that are more likely to DNA e.g.**
  - Why higher levels of deprivation might be increase DNAs e.g. transport costs, notice to take day off work or arrange carer for dependants etc.
  - How ethnic and cultural differences might affect attitudes to attendance
  - Ensuring translations are available in languages of all local minority groups
  - Considering additional needs of people with autism or learning disabilities
- **Improve booking processes/standardisation -** consider offering evening/weekend appointments.
- **DNA audits to identify potential causes.**

Key actions providers can take to help reduce impact of DNAs:

- Review the DNA patient's notes and attempt to contact remotely or write with the next steps.
- Implement a “short notice list” – so that any last-minute cancellations can be used by people who are able to attend without advanced warning, e.g. hospital staff, local patients
- Use clinical time lost to DNA for other high priority activities, e.g.:
  - Respond to requests for specialist advice/triage of new referrals, waiting list validation etc.;
  - waiting list validation;
  - review patient notes for people booked into future clinics to see if those appointments are still needed;
- Overbook outpatient clinics where DNAs are frequent and more likely.



Appointments lost to DNAs

A **25% reduction in these DNAs** would release the equivalent of almost **2 million appointments** – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog

Resource links

OPRT Reducing DNAs in outpatient services

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Remote Consultations: Clinically-led Specialty Outpatient Guidance

Remote consultations played an important role in the NHS' response to the COVID-19 pandemic, helping hospitals and clinics reduce the number of physical attendances at their sites. Nearly 25% of all outpatient appointments are now being held remotely, the pandemic proving that remote consultations are a safe and effective way of delivering patient care. Video consultations saved patients more than 530 years of time and £40m in travel costs in 2020/21 alone, also reducing carbon footprint and supporting the Greener NHS agenda. In conjunction with video consultations, online forms can support the NHS in tackling the backlog of elective care, by contributing to the reduction of waiting lists through freeing up clinician and administration time and supporting more flexible and personalised channels to delivering care.

A **remote consultation** is a consultation that takes place digitally over the **telephone, video, online form, or through asynchronous messaging** as opposed to face-to-face.

The decision on whether an appointment will take place remotely should always be clinically-led and based on individual care needs and preferences. If a remote consultation is clinically appropriate, it should always be the patient's choice whether to accept the remote consultation using shared decision making conversation with the clinician.

Benefits of remote consultations:

- Improves patient's experiences of care, improving access through increased flexibility in how they interact with healthcare, saving them time and money and reducing the stress of travelling to their appointments.
  - 68% of patients would be comfortable with a remote consultation (ONS, 2020).
  - Average journey time to and from a hospital appointment is 48 minutes (EdgeHealth, 2021).
- Patients are less likely to cancel or not attend their appointments (EdgeHealth, 2021).
- Remote consultations also offer benefits for healthcare professionals, reducing travel time and stress, and enabling more flexible working, meaning more time to spend with patients.

Selecting patients:

- Do you feel your patient/service user would be suitable for a remote consultation (telephone, video consultation or online form)?
- Does the patient/service user require physical examination and/or additional diagnostic tests that mean a physical consultation is necessary?
- Does the patient/service user have access to the right equipment/appropriate help to effectively use remote consultation tools?
- Are there clinical benefits to consulting with the patient/service user remotely – for example, infection prevention and control, lower levels of anxiety for the patient/service user, improved access to NHS services, access to an MDT when staff are not co-located.
- Are there other benefits to the patient/service user – for example, reduced travel requirements, ability to include family or friends in the consultation who are not co-located with the patient/service user.
- Is the patient/service user comfortable (or likely to be comfortable) with the concept of a remote consultation?
- Is this appropriate for this patient considering needs e.g., language, disability etc.
- Is the patient's preference regarding remote consultations recorded in the patient/service user's personalised care and support plan (PCSP)?

Resource links

- OPRT Video consultation Information for Trusts
- OPRT Choosing how to consult with your secondary care patients
- OPRT Video consulting with your patients – a quick guide for NHS staff
- OPRT Video consulting with your NHS – a quick guide for patients
- OPRT Template Video Consultation SOP

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Patient Initiated Follow-up (PIFU): Clinically-led Specialty Outpatient Guidance

Patient initiated follow-up (PIFU) is a system that enables a patient or their carer to initiate a follow-up appointment when they need one (e.g. due to a change in symptoms or circumstances). PIFU **should not be used** in place of discharging patients appropriately.

This helps patients to be seen quickly when required, while avoiding the inconvenience of appointments they don't need.

Most patients come back less often when using PIFU. This creates capacity to see other patients from the waiting list.

Shared decision making between a patient and clinician ensures PIFU is only used for those who are suited to it.

Safety nets should be used to ensure:

- Appropriate review still takes place, if and when required;
- DNA processes are put in place for those on PIFU;
- Relevant diagnostics still occur at the right intervals;
- The patient is able to manage this process.

PIFU **arrangements should be communicated** in a letter to the patient, and copied to the GP, with clear actions noted for the GP as appropriate.

Resource links

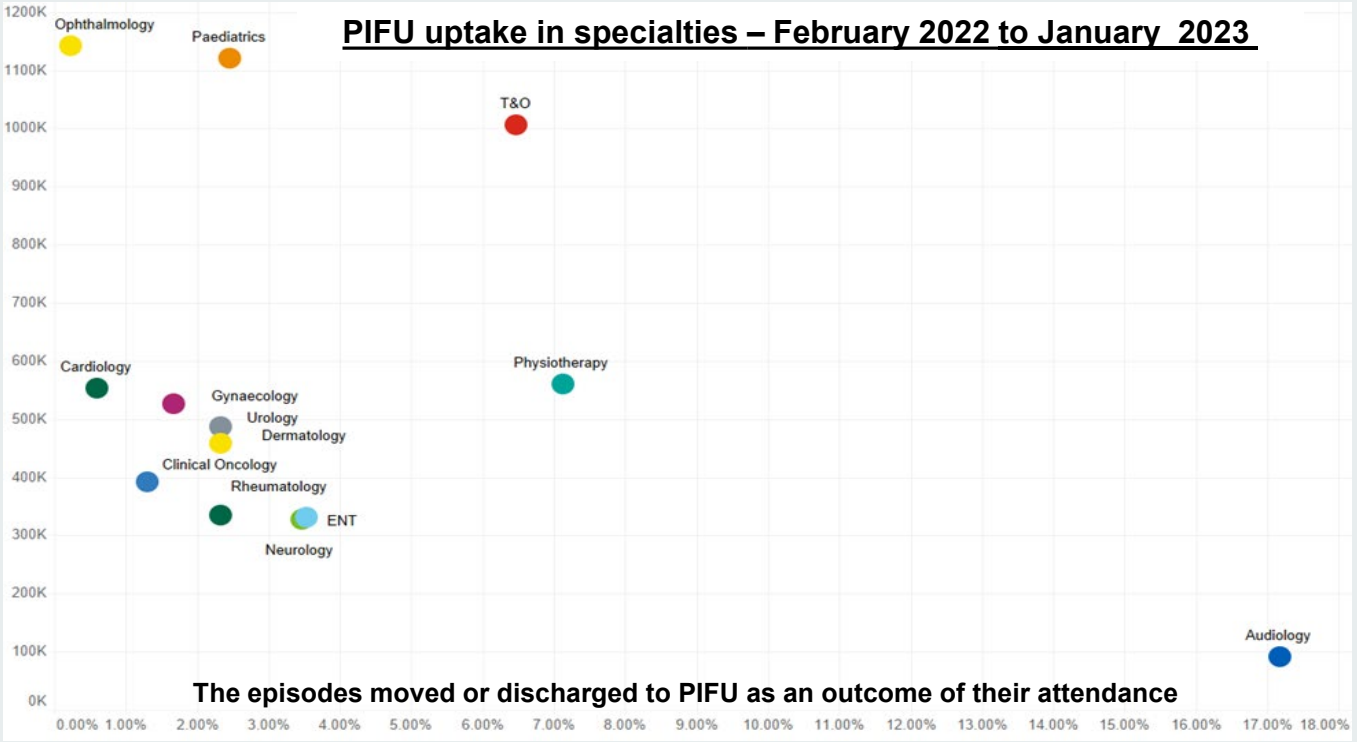
- OPRT PIFU Guidance
- Shared decision making Guidance
- OPRT PIFU implementation plan and checklist
- OPRT Template PIFU SOP

PIFU can be used:

- ☑ After treatment
- ☑ After surgery
- ☑ People with long term conditions
- ☑ Alongside time appointments e.g. for tests
- ☑ Alongside remote consultations
- ☑ Patients can share responsibility with a carer or guardian

Minimum quality standards for PIFU

- ☑ All patients and/or carers should have a shared decision making conversation where PIFU explained to them, and they have the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used (see resource information on **shared decision-making**).
- ☑ A standard operating procedure (SOP) that includes patient safety nets (giving rapid access back to specialist care if needed) should be in place.
- ☑ Patients moved to PIFU pathways should be tracked on the provider's IT system and clinical records.
- ☑ Services should report and monitor key PIFU metrics e.g. number of patients who are on a PIFU pathways



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Latest Clinically Appropriate Date (LCAD): Clinically-led Specialty Outpatient Guidance

Why LCAD is important

When used effectively, LCAD is a powerful tool for understanding demand and enables safer management of patients who need following up in outpatients:

- LCAD captures the clinician's view on the latest date by which the patient should be followed up, in order to maintain a reasonable margin of clinical safety.
- Where completed in PAS systems, this data is collected as part of the Commissioning Data Set (CDS). However, the LCAD field needs to be enabled within the provider's patient administration system (PAS) system to allow data collection.

Collection and submission of LCAD is required but not mandated, therefore **at present there is considerable variation in submission of this data**, making analysis of future follow-up demand data difficult (as it is not reported nationally).

In contrast, new patient (18 weeks or RTT) data is mandated and collected nationally, with clear targets, validation and performance reporting. This disparity can lead to inequity in access to treatment, and can have an adverse effect on patient outcomes if RTT waiting times overshadow follow-up lists.

Consistent and accurate recording/reporting of LCAD enables the measurement of future follow up demand, which will guide mitigating actions to prioritise patients.

Resources

NHS Data Model & Dictionary

Benefits of LCAD
Enables providers to define the demand for follow up to enable **effective capacity planning**
To **understand follow up demand, and follow up backlogs, because they pose a greater risk of unwarranted avoidable harm (e.g., permanent sight loss) to patients whose care is delayed**
Used in conjunction with **clinical risk stratification** to differentiate and help prioritise options and resources for high, medium and low risk patients. It is an essential part of **failsafe** framework
Optimise clinical outcomes for patients by **reducing the risk of avoidable patient harm due to delayed follow up**
Minimise litigation risks and subsequent cost of claims for avoidable harm or negligence

The non-RTT follow-up backlog

- **Follows ups make up more than two thirds of delivered OP activity (65m of 95m appointments).**
- Non-RTT follow-ups are the least visible part of outpatient activity because it is not mandated to report this activity at local or national level.
- Using LCAD is a **data driven approach to understand the hidden or unreported demand for follow up**.
- **LCAD enables better management of follow-ups, and means risks can be identified and mitigated earlier** to avoid patients coming to harm.

MANAGEMENT ACTION:

- Ensure PAS system has a functional LCAD field which can be extracted for the CDS version 6.3.
- Use the adoption of CDS6.3 to optimise LCAD data flow.
- Encourage cultural and process ownership.

CLINICIAN ACTION:

- Promote the understanding of LCAD's relevance to identifying risk and reducing harm linked to follow up back log.
- Promote the relevance of LCAD in identifying unwarranted variation within the system and region.
- Promote the usefulness of LCAD in identifying opportunities for mutual aid within systems.

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Outpatient Clinic Letters: Clinically-led Specialty Outpatient Guidance

Letters following an outpatient appointment form an integral part of an outpatient attendance, providing valuable information on the consultation and the plan for the patient's ongoing management. They enable continuity of care within the provider, and as care is transferred/shared with colleagues in other specialities and primary care.

Outpatient clinic letters have at least three different audiences, each of which will have different requirements for what they need to be able to take from the contents. In view of this clinic letters must be clear, concise, in plain English and be structured with headings to allow quick and easy reference for all concerned. For patients , there should be an appreciation of their needs by considering adaptations e.g. those with visual impairment needing larger text in line with Accessible Information standard

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	Patient / Carers	Primary Care	Secondary / Tertiary Care
Requirements	Patients often won't remember all that is discussed in clinic. The letter serves as a summary of their consultation to act as a reminder of what was discussed and what they can expect to happen next, or what they may need to do	In view of the high volume of letters these are primarily dealt with by admin, coders and pharmacy. Need to easily understand and identify information on any changes to the patient's diagnosis or management and any actions required by primary care	A summary of the care received to date and the patient's relevant history with a clear plan for the ongoing management to ensure that if the patient is seen by a different healthcare professional they are able to provide good continuity
Key Features	• Letter written to patient with a copy to other healthcare professionals • Avoidance of medical jargon and acronyms, ensuring patients / carers can understand the information • Clearly highlighting actions that they need to undertake and any follow up • Contact details for any later queries	Summary of the key information that is structured and in plain English: • Diagnoses (highlight any new ones) • Changes to medication • Planned Investigations • Management Plan (who is responsible) • Actions for Primary Care to arrange • Any follow up or escalation plan • Contact details for queries / escalation	• Significant past medical history (if not easily accessible through the electronic health record) • Treatment Summary • Management Plan • Next steps for escalation • Any plans for follow up

Resource links AOMRC – Guidance for outpatient clinic letters

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Rheumatology: Clinically-led Specialty Outpatient Guidance

Specialist Advice

Specialist Advice is a referral optimisation strategy to ensure people receive optimal care, by the right team, in a timely way and as close to home as possible. With the exception of emergency pathways (e.g. Giant Cell Arteritis) **all outpatient referrals to rheumatology should ideally come via the specialist advice route.**

Specialist advice can be used to support conditions that should be more appropriately managed in the community e.g. Crystal arthropathies, Polymyalgia rheumatica, Osteoporosis, unless complex or not responding to conventional treatment.

OPRT/GIRFT Rheumatology Specialist Advice guidance

CLINICAL ACTION:
Refer to BSR Specialist Advice guidance (recommended scenarios).
SYSTEM ACTION:
ICBs to agree pathways and implement a "Specialist Advice" first service between primary and secondary care.
Systems to support providers to have IT functionality/connectivity for Specialist Advice.

Secondary care triage of referrals

Clinical review: Triage of referrals is very important and provides opportunity to ensure patients are seen in the right place by the right clinical team, and identify where it is appropriate to:

- request further referral information when needed;
- refer patient for any diagnostics that are needed prior to 1st appointment;
- return referral to referrer with specialist advice (in line with any local agreements);
- redirect or return inappropriate referrals (with clear reasons for refusal); and/or
- triage to the correct clinic.

Clinical criteria and SOPs for referral vetting can support triage for consistency across the waiting list, with clinically appropriate prioritisation.

CLINICAL & SYSTEM ACTION:
Agree trust/system clinical criteria and SOP for triage and implement consistently across the ICB/ region.

Provision of care for non-inflammatory conditions

Soft tissue MSK conditions, hypermobility syndromes, non-inflammatory back pain, fibromyalgia and osteoarthritis should be diagnosed and managed by primary care or community MSK services as defined in NHS England MSK Community Improvement Framework, making best use of:

- First Contact Practitioners, or MSK Practitioners in community triage services to support shared decision making with regard to diagnosis;
- personalised evidence informed resources and interventions to support self management.

CLINICAL & SYSTEM ACTION:
Clinical and system leaders to collaborate to enable an integrated approach across primary, community and secondary care working with the voluntary community and social enterprise sector.
Rheumatology to provide expert opinion via Specialist Advice to support community teams where diagnostic uncertainty exists about the possibility of an inflammatory condition.

NHSE MSK improvement framework

NICE OA guidance

NICE Pain guidance

Choice of consultation

Thurah et al, (2022) EULAR remote consultations

Tailored care combining remote (synchronous/asynchronous) and face-to-face attendance should be based on shared decision-making as well as the needs and preferences of people. Remote consultations to communicate with patients and assess their needs without an in-person visit may not be suitable where a physical examination or same day diagnostics are likely to be required.

Remote consultations (telephone or video consultation or online messaging) may be suitable for:

- ✓ Those with long-term, well-controlled conditions requiring routine **drug monitoring follow-up**.
- ✓ Follow-up for **results/discharging patients** after investigations.
- ✓ People who are unable to attend physically.

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Rheumatology: Clinically-led Specialty Outpatient Guidance

Workforce

Maximise the value for patient care at every appointment by:

- ✓ Considering how other MDT members could play a greater role in patient care, education, drug management and monitoring, as well as prescribing.
- ✓ Encouraging research and audit to drive quality and innovation.

Utilising Latest Clinically Appropriate Date (LCAD) data

Patients under rheumatology care require ongoing management to optimise outcomes. This facilitates patient self-management in a responsive manner, whilst ensuring safe monitoring of disease, co-morbidity and medication.
The use of LCAD would enable teams to more safely manage the follow-up workload.

CLINICAL ACTION:
Services to implement recording of LCAD.

SYSTEM ACTION:
Systems to support clinical teams to mitigate risk of patient safety by balancing clinical risk between new and follow up patients, and allocating clinic resource accordingly.

Validating of outpatient waiting list – follow up patients

Overdue follow-up patients should be clinically reviewed regularly to ensure patients are on the appropriate pathway and still need to be seen:

Review	Validation Action
Is patient suitable for discharge without follow up?	Write to patient and GP to explain no further follow up needed.
Follow up appt. required	Offer appointment.

Standardising monitoring of DMARDs across the ICS

Streamlined, electronic monitoring of Disease-Modifying Anti-Rheumatic Drugs (DMARD) is another potential opportunity to reduce outpatient visits, if this is taking place in secondary care. This could be done in shared care arrangements with primary and community care across a geographical area, e.g. at ICB level.

There are significant variations and issues with current practice, including:

- who prescribes initial and continuing treatment, who monitors the therapy, and how repeat prescriptions are issued;
- shared care protocols to enable transfer of monitoring to primary or community care following initial treatment in rheumatology causes confusion, e.g. where GPs manage patients who see consultants at different trusts;
- different monitoring procedures between trusts, primary and community care;
- blood-taking and prescribing carried out in different settings and by different teams.

SYSTEM ACTION:
Monitoring processes should be linked to interoperable electronic monitoring and prescribing systems, standardised across geographic footprints and medical specialties.

BSR/BHPR Prescription and monitoring of DMARDs

Earlier use of biologic drugs

Introduction of biologic drugs at the earliest opportunity in the pathway, in line with NICE guidance, could improve disease control and reduce the need for frequent follow up for uncontrolled disease.

Active case finding of appropriate patients may, over time, reduce numbers of outpatient appointments needed. Such services require increased up-front clinical, nursing and pharmacy support to implement.

GIRFT National report

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Early Inflammatory Arthritis pathway

All services should have a formal pathway for early inflammatory arthritis.

The National Early Inflammatory Arthritis Audit (NEIAA) supports quality improvement in outpatients by measuring achievement of best practice as set out in the NICE quality standards. In future, the audit will expand to include data on rarer diseases.

The NEIAA provides resources to support services to deliver patient-focused quality improvements.

SERVICE ACTION:
Adequate time and support should be provided to facilitate audit participation at all sites.

- GIRFT Inflammatory Arthritis pathway
- NICE Rheumatoid Arthritis in adults guideline
- National Early Inflammatory Arthritis Audit
- NEIAA Clinic visit framework

Additional resources

- Model Hospital metrics

Axial Spondyloarthritis pathway

Services should work towards the best practice GIRFT Axial Spondyloarthritis pathway.

- GIRFT AxSpa pathway
- ASA-EULAR management of axial spondyloarthritis

Giant Cell Arteritis pathway

All services should have a formal pathway for suspected GCA referrals in line with the GIRFT Pathways.

- GIRFT Giant Cell Arteritis pathway
- BSR Giant Cell Arteritis guidelines

Osteoporosis pathways

Osteoporosis care varies across providers, spanning a number of specialities; services should work towards the National Osteoporosis Guideline Group (NOGG) and NICE osteoporosis guidelines if applicable.

- NICE Treating severe osteoporosis guidance
- NOGG Full guideline

Rare rheumatic diseases

Specialised rheumatology networks
All rheumatology departments should be adequately supported to participate in their regional specialised rheumatology network. Services not participating in a regional network currently, should make this a priority.

This is to enable access to specialist advice regardless of geography and virtual MDT support for decision making on high cost drugs. Regional decision making can enable local delivery of care thereby reducing the need for patient travel to specialised centres.

Multi-professional clinics (one stop)
For patients with multi-system disease attending multiple specialties, review opportunities to enable co-ordinated care in one stop multi-speciality clinics where appropriate.

Services should be supported to enable recruitment to registry studies where this is mandated by NHS England Commissioning policy e.g., BILAG Biologics Registry.

- NHSE Specialised Rheumatology
- GIRFT Connective Tissue Disease pathway
- BSR ANCA-associated vasculitis guideline
- BSR idiopathic inflammatory myopathy (myositis) guideline
- BSR lupus guideline

GIRFT GETTING IT RIGHT FIRST TIME
Action on Outpatients Improving access to care
Produced in partnership by GIRFT and the Outpatient Recovery and Transformation Programme
#BestMSKHealth Collaborative

Rheumatology: Clinically-led Specialty Outpatient Guidance

Standardising follow-up & Patient Initiated Follow-Up (PIFU)

Many rheumatology patients will typically be on a blended pathway, combining pre-arranged follow-up (in line with LCAD), with the option of contacting the service in-between scheduled appointments should they have a clinical need to do so. PIFU benefits the service by releasing capacity for unplanned appointments, so patients can be seen between scheduled appointments, if required. This gives confidence for patients and clinicians to plan a longer follow up interval.

Follow up appointments

Where patients are not discharged at first appointment, staff should request:

- clinically triggered follow-ups for patients with pending results;
- timed follow-up appointments for new inflammatory disease or unstable disease according to standardised pathways;
- personalised patient-initiated follow-ups (PIFU) for patients with stable disease or disease in remission (see PIFU guidance).

Diagnostic coding should be captured for outpatient appointments to allow for identification of patient cohorts and case mix. This allows service planning targeting of interventions of specific pathway groups.

CLINICAL ACTIONS:

Agree service-wide standard PIFU protocols.

Services to follow BSR and NICE clinical guidelines for frequency of monitoring and follow-up appointments.

BSR Giant Cell Arteritis guidelines

BSR lupus guideline

NICE Rheumatoid Arthritis in adults guideline

Conditions	PIFU suitable for patients with:	PIFU timescale	PIFU NOT suitable for patients with:
Inflammatory arthritis	• Disease duration of ≥2 years, where optimal disease control has been established or they are in remission, either on or off treatment ***and*** • a good understanding of their condition, confident in their ability to manage it and have the skills to do so, including the ability to recognise a sudden or gradual loss of function suggesting a flare-up or reduction in efficacy of their treatment ***and*** • the ability to initiate contact with the service in a timely way (be that the patient themselves or a carer/representative on their behalf).	<2 years with scheduled appointment at end of PIFU period for review.	• with recent onset, or recently diagnosed (e.g. diagnosis of <2 years' duration), where optimal disease control has not been established and/or the individual is still learning about their condition. • Any individuals for whom the healthcare professional has safeguarding, consent, capacity or health literacy concerns. • Any individuals with low levels of knowledge, skill or confidence in their ability to self-manage their condition • Any individuals who would not be able to contact the service in a timely way.
Rare or multi-system rheumatological disorders	• Only in selected clinical cases		• Conditions that may not have any clinical signs of a deterioration in their condition until damage to internal organs has occurred.

OPRT GIRFT Rheumatology PIFU guidance

Top tips for Speciality Outpatients

- Set up admin systems to support remote consultations and PIFU, and ensure clinical and admin teams are trained.
- Agree clinical criteria for validation including discharge, PIFU and virtual appointments to be outlined in a SOP.
- Ensure all teams (operational & clinical) are clear on the discrimination between the PIFU to discharge and PIFU to follow up pathways. Off-boarding (end of PIFU term) will be different between the two cohorts.
- Diagnostic coding should be captured for outpatient appointments to allow for identification of patient cohorts and case mix. This allows service planning targeting of interventions of specific pathway groups.
- Implement LCAD to ensure patient safety of non-RTT patients including a safety net for open pathways.
- Develop same day diagnostics for pathways including early inflammatory arthritis and GCA.
- Proactive tracking systems are required for managing open pathways to avoid patients being lost to follow up.
- “Specialist Advice first” approach for routine referrals
- Rheumatology teams should be supported by trusts to enrol all suitable patients and to review their results regularly to improve patient care to the NEIAA.