NHS England

GIRFT
GETTING IT RIGHT FIRST TIME

NHS IMPACT
Improving Patient Care Together

Further Faster Rheumatology Handbook

Master handbook – excluding trust data

Checklists and Resource Links

December 2024, broken links updated March 2026

GIRFT is part of an aligned set of programmes within NHS England

Further Faster - Rheumatology

Introduction

Since we started the Further Faster programme in July 2023 I have continued to be hugely impressed with the commitment, innovation and drive from the clinical and operational teams. We have seen very significant progress in reducing 52-week waits, with trusts in Further Faster Cohort 1 collectively reducing 52wk waits by almost 37% compared with an 8% reduction in all trust that had not been in the programme.

In my regular trust meetings with all specialties in the Further Faster programme it has been fantastic to see such commitment to supporting each other and a real enthusiasm for sharing challenges, ideas and innovations to make things better for patients. This enthusiasm has led to calls from trusts to go even further, and therefore I'm now setting the Further Faster 40 challenge: to reduce the number of patients waiting between 40 and 52 weeks.

Clearly this is an ambitious goal but we've learned a great deal from each other over the last six months and I believe it is achievable if we can maintain the current momentum. Every trust in the programme has shown the ability to adopt and develop ideas that improve care, and we need to continue to build on this. We have captured the best of these, expanding the knowledge base, and have therefore updated this handbook to ensure that all trusts can benefit from the experience and success of others.

We remain steadfast in our aim that by learning from each other and harnessing the solutions that already exist in departments across the country, we can make an incredibly positive impact for our workforce, and for our patients, on a national scale.

Professor Tim Briggs CBE
Chair of GIRFT and NHS England National Director for Clinical Improvement and Elective Recovery

How to use this Handbook

This guide is designed to provide “best practice” across a number of important metrics to help you on your journey to go further and faster towards eliminating 52 and 40 week waits.

The guide is organised along key sections of the pathway and provides checklists against which you can assess your current practice. It is imperative we take the best practice adopted by trusts and implement it.

Resource links signpost you to guidance, metrics and case studies relevant to each element of the checklists.

Review the checklists and prioritise work on those that you think will have the most impact in your system.

Then use this guide to:

- **Assess** whether you are already doing the right things and identify where you have opportunities to work differently and more effectively.
- **Understand** your current service’s strengths and weaknesses compared with peers. The guide will help you to find and review the relevant Model Hospital System Metrics to compare performance.
- **Prioritise** improvement actions based on your findings in relation to weaknesses and opportunities.
- **Signpost** you to relevant guidance and case study examples that will help you to identify what changes you can make to:
    - reduce demand
    - release capacity
    - increase throughput; and
    - reduce length of stay

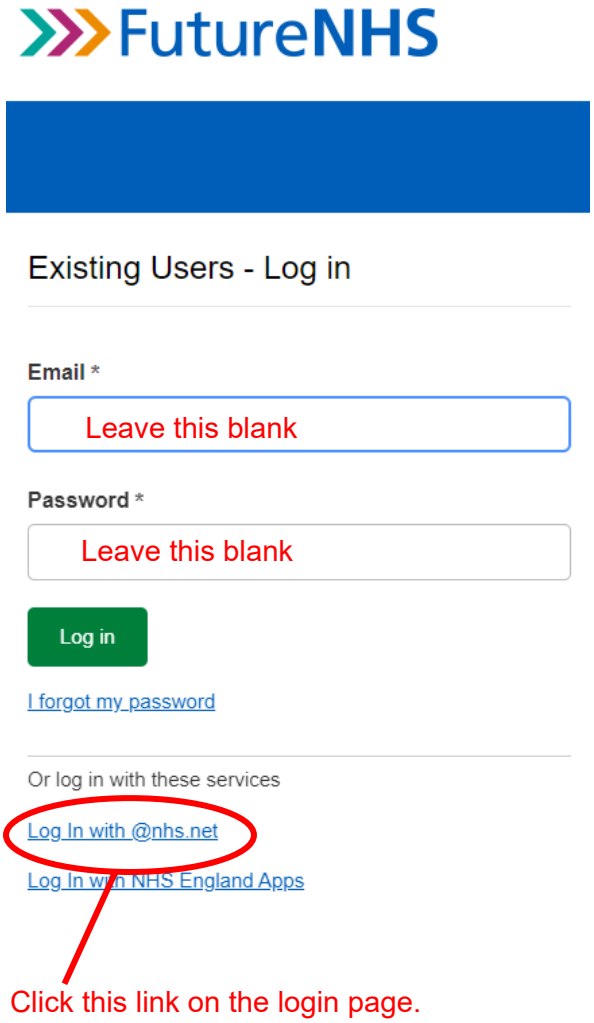
  whilst maintaining and improving quality and outcomes.

Accessing Resource Links

Many of the links in the handbook will take you to resources on Future NHS.

These have been made much easier to access because you can now use your @nhs.net login details to sign in.

To do this you need to click on the option at sign in:



You will then be taken to the nhs.net login page. Enter details as usual and you will then be redirected into Future NHS automatically.

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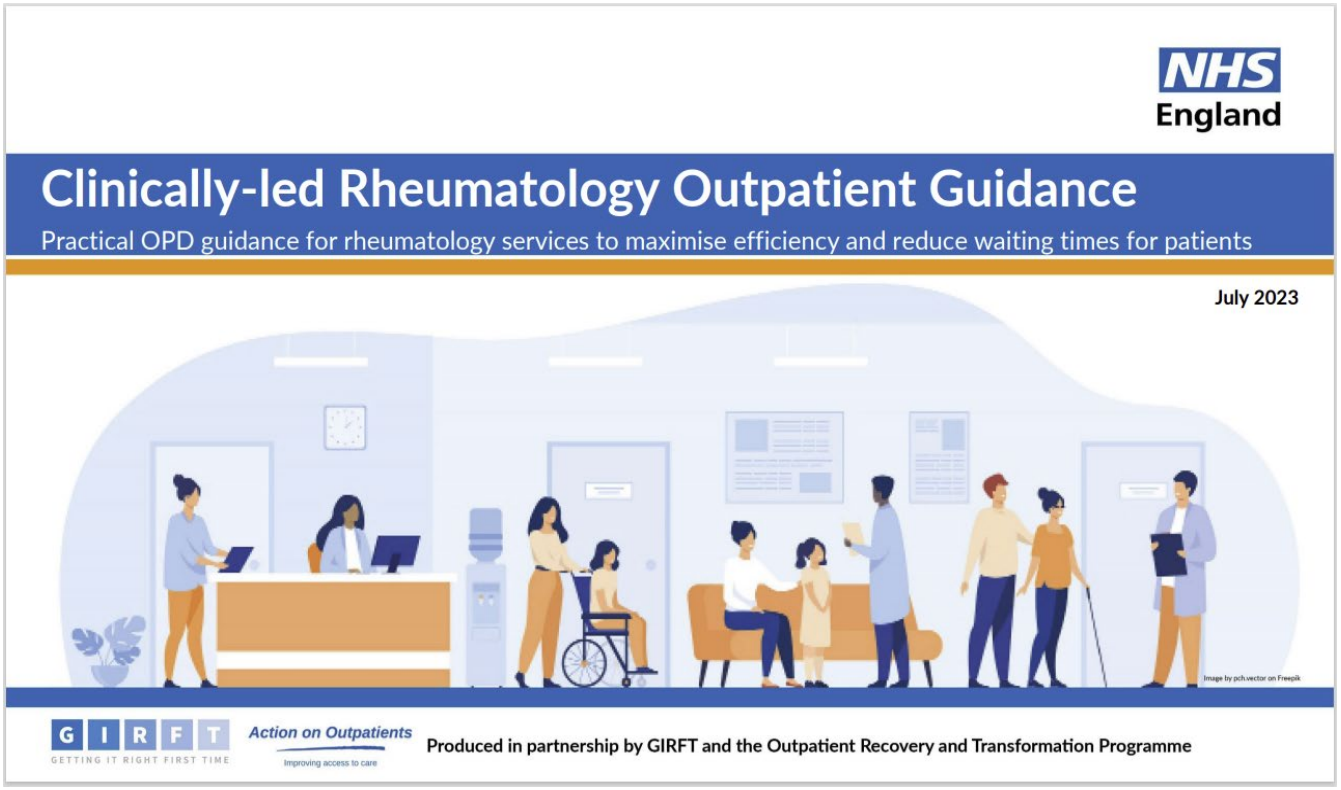
Context

The biggest opportunities for eliminating 52-week waits are likely to be found in the outpatients part of the pathway (as that is where the highest number of patients are waiting). Rheumatology is a predominately outpatient-based specialty, with a significant number of patients under hospital care for management of long term conditions and supported self-management, so there is an important role to play in effective monitoring of these patients as well as safety netting considerations such as LCAD. Effective management of referrals (including triage), DNAs, clinic capacity, follow up (including PIFU) and discharge can have a huge impact on reducing the burden in this area. The following checklists will help trusts to identify where they might need to focus improvement work.



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☑ Checklist: Pre-Referral Optimisation

GIRFT has observed considerable variation in the application of clinical referral triage, waiting list validation and use of specialist advice/guidance. Judicious implementation of these often results in significant freeing of capacity and it is worth considering the potential benefits of reallocating some clinic time to enable these functions to be carried out effectively.

Check	Good Practice	Resource Links
☐	A system is in place for regular administrative and clinical validation of all patients that have been on the non-admitted pathway for 12wks or more (see resources). Digital solutions should be used to support validation where available.	**Guidance, articles and presentations:** Rheumatology Outpatient Guide pg. 7 Choosing Wisely BSR Recommendations Rheumatology Specialist A&G GIRFT Rheumatology National Report BSR resources for advice, referral and triage BSR Adult Rheumatology Referral Guidance NHSE Validation toolkit and guidance NHSE Clinical Prioritisation of OPWL NHSE framework: Community MSK Advice & Guidance at York & Scarborough GIRFT in action: triage and assessment clinics **Pathways:** GIRFT Axial Spondyloarthritis Pathway GIRFT Connective Tissue Disease Pathway GIRFT Inflammatory Arthritis Pathway GIRFT Giant Cell Arteritis Pathway
☐	All referrals are clinically triaged and where appropriate referred to relevant sub-specialties, or MSK services in the community, or returned with appropriate specialist advice and guidance (as appropriate) before offering first appointment.	
☐	There is an effective system in place to manage referrals for specialist advice and guidance, including standard responses for the most common queries. See the BSR resources in the guidance section for standard responses to referrals and requests for specialist advice.	
☐	Job plans include dedicated time for clinical validation, clinical triage and provision of specialist advice and guidance.	

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☐	Good systems are in place to ensure diagnostics are undertaken prior to first appointment where appropriate, or a one stop clinic visit is offered.	**Case studies:** Non-clinical validation of long waiters at Leicester Royal United Hospitals Bath Triage of Referrals

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☑ Checklist: 1st Appointment Optimisation

Optimisation of the 1st appointment is essential to ensuring effective use of resources and implementation of efficient pathways. One-stop clinics can reduce waiting times to start definitive treatment e.g., for early inflammatory arthritis, and following GIRFT pathways helps to reduce unwarranted variation and maximise efficiency.

Check	Good Practice	Resource Links
☐	One stop clinics are in place, where appropriate, including for patients with multi-system disease attending multiple specialties.	**Guidance:** Rheumatology Outpatient Guide NEIAA Homepage NEIAA Clinic Visit Framework **Pathways:** GIRFT Rheumatology Pathways
☐	GIRFT best practice pathways are adopted locally.	
☐	All consultants and rheumatology clinicians have been made aware of the rheumatology GIRFT pathways.	
☐	Discharge criteria are reviewed and the % of patients discharged at first rheumatology consultation is monitored.	
☐	Appropriate trainee supervision is accounted for within clinic templates to support decision making and optimal patient care at the 1st appointment.	
☐	Clinicians are trained to develop skills to support outpatient delivery e.g. triaging referrals, providing advice and guidance, asynchronous/remote consultations, discharge and safety netting.	
☐	Rheumatology teams are supported to enrol all suitable patients in the National Early Inflammatory Arthritis Audit (NEIAA) and they review their NEIAA data regularly to evaluate service performance and identify areas for improvement in patient care.	
☐	Diagnostic coding is captured for all outpatient appointments to allow for identification of patient cohorts and review of clinical case mix. This supports service planning and targeting of interventions for specific pathway groups.	

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☑ Checklist: Follow-up Appointment Optimisation

Implementing approaches and processes such as Latest Clinically Appropriate Date (LCAD) and standardised follow-up intervals is essential for safely managing and understanding outpatient follow-up demand. **The following good practice points should be considered alongside those outlined in the remote appointments and PIFU sections of this handbook.**

Check	Good Practice	Resource Links
☐	Clinical discharge criteria are agreed and utilisation of the criteria is monitored.	**Guidance:** Rheumatology Outpatient Guide; BSR Giant Cell Arteritis guidelines; GIRFT Rheumatology National Report; BSR Lupus guideline; NICE Rheumatoid Arthritis guidelines **Pathways:** GIRFT Rheumatology Pathways **Presentations:** Managing long term follow up - Leicester
☐	Follow-up intervals are standardised for core conditions and who will undertake the follow-up is specified. BSR and NICE guidelines are used for frequency of monitoring and follow-up appointments where available (see resources).	
☐	A 'treat to target' strategy is in place for adults with active rheumatoid arthritis.	
☐	Annual review is in place for stable patients, with access to the MDT.	
☐	LCAD recording and review is implemented to enable measurement of future follow-up demand and to support patient safety in this follow-up cohort.	
☐	Shared care arrangements are optimised with clinicians in other specialties and primary/community care e.g. for DMARD monitoring, denosumab and SC methotrexate administration, to reduce unnecessary hospital appointments.	

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☑ Checklist: Reducing and managing missed appointments (DNAs)

Nationally, around 6.9% of outpatient rheumatology appointments are lost to missed appointments, but there is considerable variation in this amongst trusts. This is a huge drain on use of clinic capacity and although some factors are outside the immediate control of trusts, there are many things that can be done to help reduce failed attendances. Taking action on areas the trust can control makes a very tangible difference.

Check	Good Practice	Solutions & Resources
☐	Language and communication methods consider patients who do not speak English, cannot read due to literacy or visual issues, or who do not have smartphones or email.	**Guidance:** Rheumatology OP Guide - pg.8 OPRT: Reducing DNAs in Outpatients OPRT Missed Appointments Process **Model Health Metrics:** DNA Metrics MHS **Case study:** Royal Devon – Management of Rheumatology DNAs Use of AI to reduce missed appointments **Patient letter templates:** OPRT appointment confirmation letter
☐	All patients receive appointment reminders – including letters, emails, SMS and phone call reminders. Appointment reminders provide 'two-way' communication with patients and follow health literacy principles.	
☐	Booking processes are standardised and effective and patients find them easy to engage with.	
☐	Consider providing appointments during evenings/weekends for patient convenience, ensuring the full range of required services is available.	
☐	DNA rates are monitored routinely, and DNA audits are conducted regularly to understand potential causes.	
☐	Understanding of DNA rates is used to inform clinic planning to maximise use of clinic capacity.	
☐	A list of patients that can attend at short notice is held to fill last minute cancellations.	
☐	DNA patients' notes are reviewed, and attempts are made to contact them remotely or to write to them with next steps. Services take action to understand the reasons why patients miss appointments.	
☐	Clinic time lost to DNAs is used effectively e.g., for clinical triage, validation etc.	

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		OPRT appointment reminder letter

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☑ Checklist: Outpatient Activity and Capacity

From visits and clinical discussions we have observed that there is currently considerable variation in outpatient clinic templates. It is vital that we maximise use of clinical time and understand capacity, so reducing this variation and sharing the impact of other **initiatives such as holding 'super-clinics' (see checklist below),** ensuring appropriate use of specialist advice and guidance to try and reduce the demand for new patient appointments, e-vetting, and maximising use of remote consultations and PIFU pathways (see other sections) will help trusts to consider what opportunities are available within existing resources.

Check	Good Practice: Outpatient Activity and Capacity	Resource Links
☐	All clinic templates have been reviewed and standardised since returning to business as usual after the pandemic taking account of clinical case-mix complexity, the need for supervision and training of non-consultant staff, predictable demand to provide urgent appointments without overbooking, and different working practices such as use of remote appointments.	**Guidance & articles:** Rheumatology OP Guide (LCAD section) OPRT Specialist Advice: Clinical Responsibility & Medicolegal FAQs GIRFT in action: triage and assessment clinics **Case study:** London Rheumatology Mass Clinic Model **Presentations:** London Rheumatology Mass Clinic Model **Model hospital Metrics:** Rheumatology OP Metrics on MHS
☐	Deliver regular super-clinics to boost outpatient capacity.	
☐	The balance between priority for first appointments and follow ups is reviewed regularly.	
☐	Maximise use of Advice and Guidance to top decile performance and maximise one-stop clinics.	
☐	Contribute towards increasing the proportion of outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across all specialities.	
☐	Clinics and services are in place enabling suitably trained non-medical workforce to support throughput (e.g. nurse-led annual review, DMARD escalation, Patient Education Programmes (PEP) including working with third sector organisations).	
☐	Ensure supporting services are available and have capacity e.g. imaging, phlebotomy and medication counselling, to support maximum throughput, reduce unnecessary visits and decrease clinic delays.	
☐	Ensure specialty trainees have a clinic template which maximises education opportunities and allows for discussion with senior colleagues on cases depending on complexity.	

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☑ Checklist: Remote Appointments and Virtual Review

Nearly 25% of all outpatient appointments across all specialities are now being held remotely. Remote 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. **Patients are also less likely to cancel or not attend remote consultations** (national average rheumatology DNA rates: 7.3% for face to face vs. 3.3% for remote consultations). In addition, clinic space can be released when consultations are undertaken remotely as they can be delivered in alternative settings such as an office instead of a consulting room

Check	Good Practice	Resource Links
☐	Appropriate use of remote consultations is well understood and monitored routinely within the department.	**Guidance:** Rheumatology OP Guide - pg. 9 **Model Health Metrics:** Remote Consultation Metrics on MHS
☐	Consider use of asynchronous review of patient outcomes and diagnostic tests.	
☐	Percentage of outpatient attendances performed remotely is monitored.	
☐	Remote consultations are used effectively as part of patient initiated follow up (PIFU) arrangements.	
☐	Diagnostic tests results are delivered by letter or remote contact wherever appropriate.	

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☑ Checklist: PIFU

We know that PIFU is an effective and efficient way of managing follow up for many patients, reducing the number of unnecessary appointments whilst ensuring that those patients who do need to be seen can access the service easily. But PIFU rates are much lower than they could be and need to increase significantly.

Check	Good Practice	Resource Links
☐	Patients should not be put on a PIFU pathway where they can appropriately be discharged.	Implementing PIFU: guidance for local systems Rheumatology OP Guide - pg. 16 Quick Guide: PIFU in Rheumatology Implementing PIFU in Rheumatology PIFU: RCT on clinical and cost effectiveness Rheumatology OP Metrics (MHS) Rheumatology Patient Leaflet Oxford remote clinical management GIRFT National Report P47 Plymouth PIFU (Direct Access) Plymouth SOP OPRT PIFU Comms Materials
☐	Develop a Trust Standard Operating Procedure (SOP) for PIFU (see resources).	
☐	Operational and clinical teams are clear on the discrimination between the PIFU to discharge and PIFU to follow up pathways.	
☐	A system is in place for recording PIFU for long-term care and patients on PIFU pathways are tracked on the provider's IT system and clinical records.	
☐	Patients are provided with easy access to PIFU via locally agreed protocols (e.g., digitally or via dedicated telephone service) and appropriate safety netting is in place.	
☐	PIFU to discharge pathways are reviewed regularly and closed in a timely manner.	
☐	Appropriate administrative support (modelled on GIRFT 'Implementing PIFU in Rheumatology' guidance – see resource links) and sufficient ring fenced F2F outpatient FU capacity is available to support patients on PIFU pathways who need earlier review.	
☐	PIFU-activated follow-up appointments are available in a timely manner and timeframes from patients requesting an appointment to being seen are monitored.	
☐	Activated PIFU follow-ups are recorded accurately.	
☐	PIFU rates are reviewed regularly on MHS.	

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Behavioural Science – Context

The improvements and changes recommended in this checklist vary from quite small to much larger multi-dimensional changes, involving numerous stakeholders, and you are encouraged to use your team or Trust's preferred improvement approach to help you on your journey.

Within the GIRFT Academy, we have found a number of practical applications from behavioural and neuroscience, which you may find helpful at different stages of your preferred change process, which we will be introducing to you as the programme progresses including resistors to change/addressing 'threat', recognising 'unwritten rules' at the heart of organisational culture, persuasion and influence, goal setting and habit formation. The GIRFT Academy has also developed a pathway gap analysis process designed to shorten the improvement process and help teams to take ownership of change.

For more information on applying behavioural science you can contact Ruth Tyrrell, GIRFT Academy Director via girft.academy@nhs.net.

Applying Behavioural Science – SCARF® Resistors to Change Toolkit

☑ Checklist: Addressing Resistors to Change

Not everyone perceives change as positive and welcome, therefore, to increase acceptance, it is good practice to understand where resistance to change may come from, the cause of the resistance and what actions to take to address it.

Check	Good Practice	Resource Links
☐	Undertake a stakeholder analysis	SCARF® Multi Stakeholder Assessment Tool
☐	Undertake a SCARF® analysis – understanding fundamental threats of the proposed change & how to address them	SCARF® Model Basic Worksheet SCARF® Resistors to Change Toolkit Guide