The Rapid Access and Treatment Service:

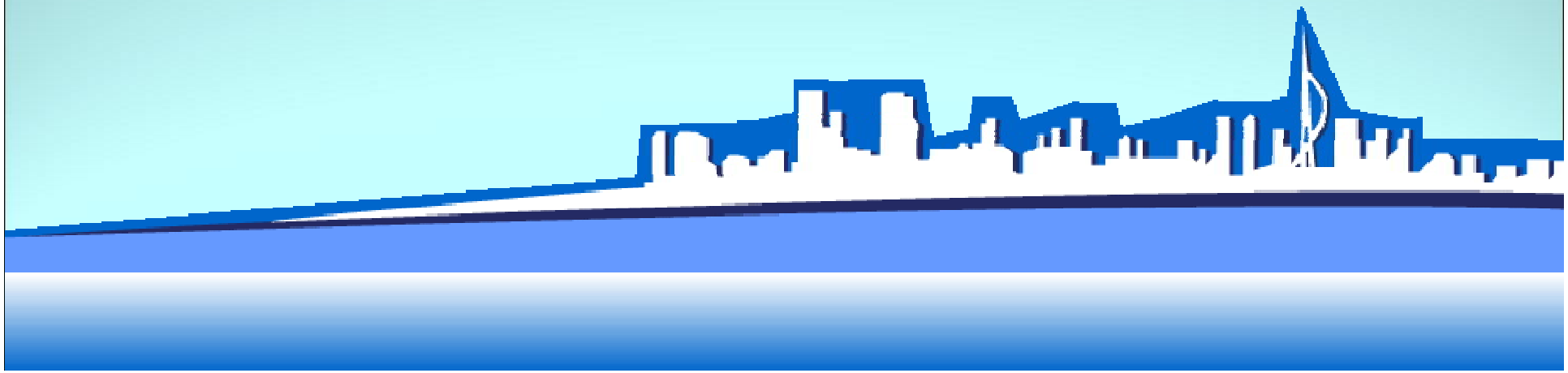
Understanding the patient Journey

The Portsmouth Experience

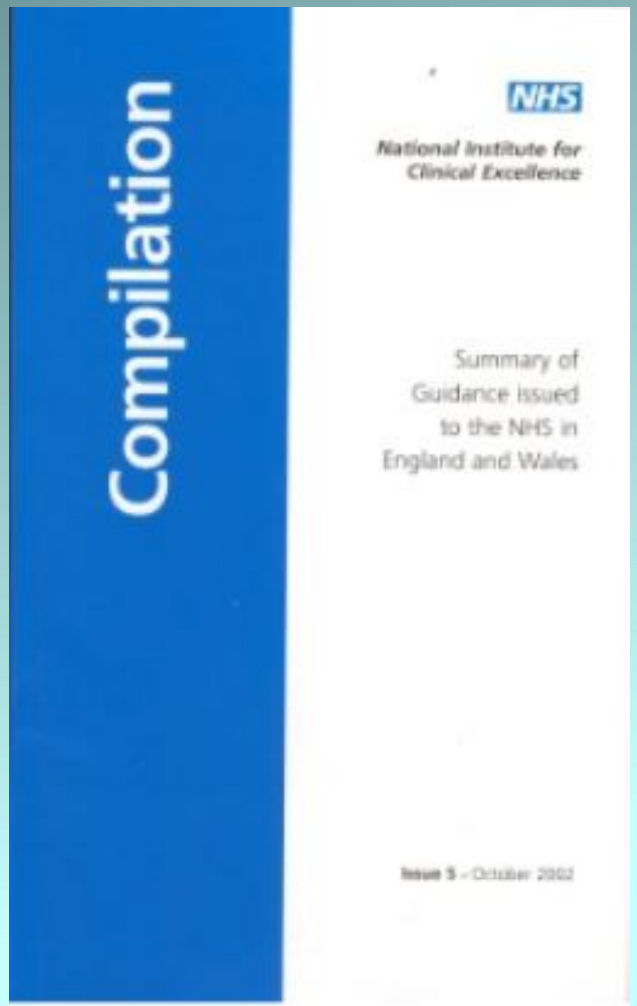
Richard Hull

Consultant Rheumatologist

Clinical Director



North Entrance



Compilation

NHS

National Institute for Clinical Excellence

Summary of Guidance issued to the NHS in England and Wales

Issue 5 – October 2002

HEALTH: National ruling on prescribed treatment means end to postcode lottery

Arthritis patients to get vital drug

by Rebecca Ellmer
Health reporter

ARTHRITIS sufferers in our communities will now get a drug they need, putting an end to the postcode lottery prescribing from today.

Michael Cooper, 39, and manager Lucy Taylor both suffer from the illness but were not able to take on arthritis wondering because they lived in the wrong area.

Had they lived in Southampton or West Sussex they would have already been able to get hold of the drug Enbrel.

But the Portsmouth and south east Hampshire health authority said it could not afford to buy the drugs for the 60 arthritis patients in our community who need it.

Today the National Institute of Clinical Excellence announced that all NHS patients across the country should be prescribed the drug if they need it.

Mr Cooper, of North Walsham, Fareham, said: "It's absolutely wonderful. I cannot begin to tell you how good it is."

Mr Cooper said the drug might mean he will not need an operation on his neck for another five to 10 years.

Mr Cooper has already had both hips, knees and his shoulders replaced as a result of the crippling disease he has had for the past five years.

Schoolgirl Lucy Taylor, who has also tried numerous other treatments to no effect, is also now eligible to try the drug.

Dr Richard Hull, a consultant rheumatologist at Queen Alexandra Hospital, Cosham, said it was good last news for patients.

He said: "I'm absolutely delighted this drug is going to be made available. I'm glad it has been recognised that this is a significant drug that offers people's lives and this is an effective drug at treating it."

He added that patients would have to be assessed for eligibility but he hoped to begin prescribing it within the next month.

Treatment ordered if other means have failed

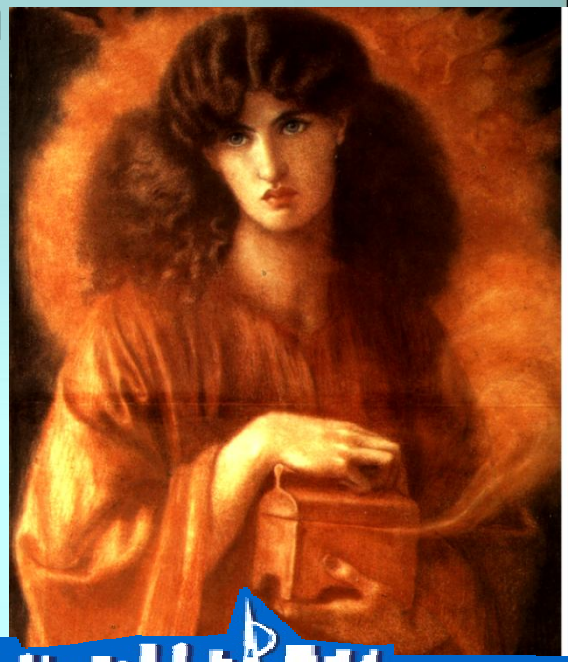
THE National Institute for Clinical Excellence was set up by the government to put an end to postcode lottery prescribing.

This is where medication is available on the NHS in some areas – where the health authority chooses to buy it in – but not in others.

NICE today said all arthritis patients across the country should be able to get the wonderful Enbrel – if other treatments had failed. It is estimated there are 60 patients in our communities who will benefit.

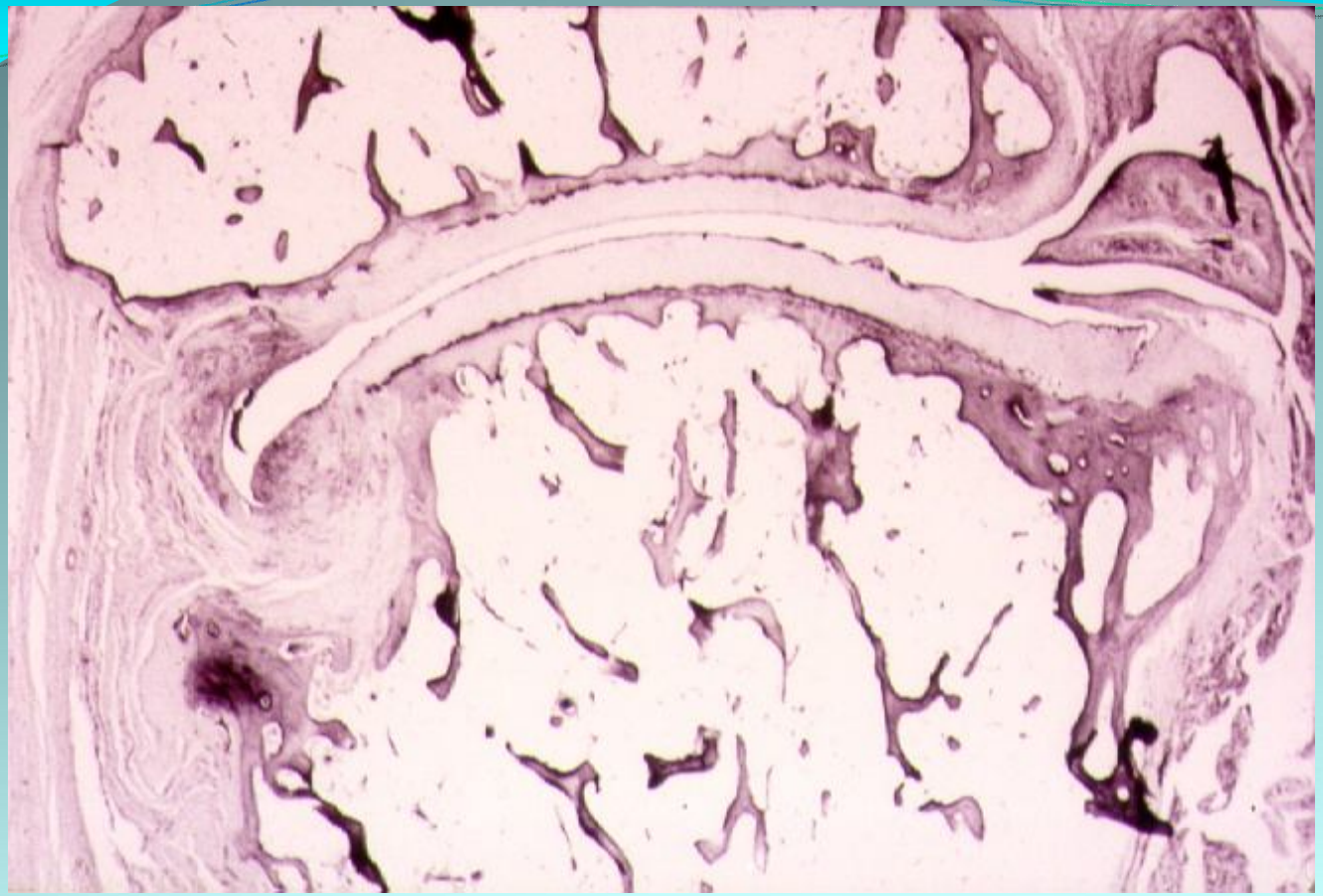
The Breadth of Rheumatic Diseases

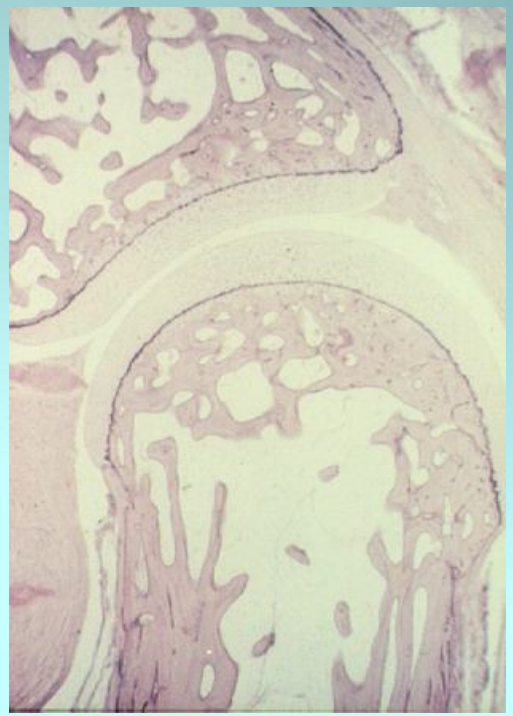
- Soft tissue disease
  - Enthesitis, tennis and golfer elbow
  - Shoulder capsulitis, frozen shoulder
- Mechanical spinal disease, back pain
- Inflammatory arthritis
  - Rheumatoid arthritis
  - Sero-negative spondyl-arthropathies
    - Ankylosing spondylitis
    - Psoriatic arthritis
    - Inflammatory bowel arthritis
    - Reactive arthritis
- Osteoarthritis

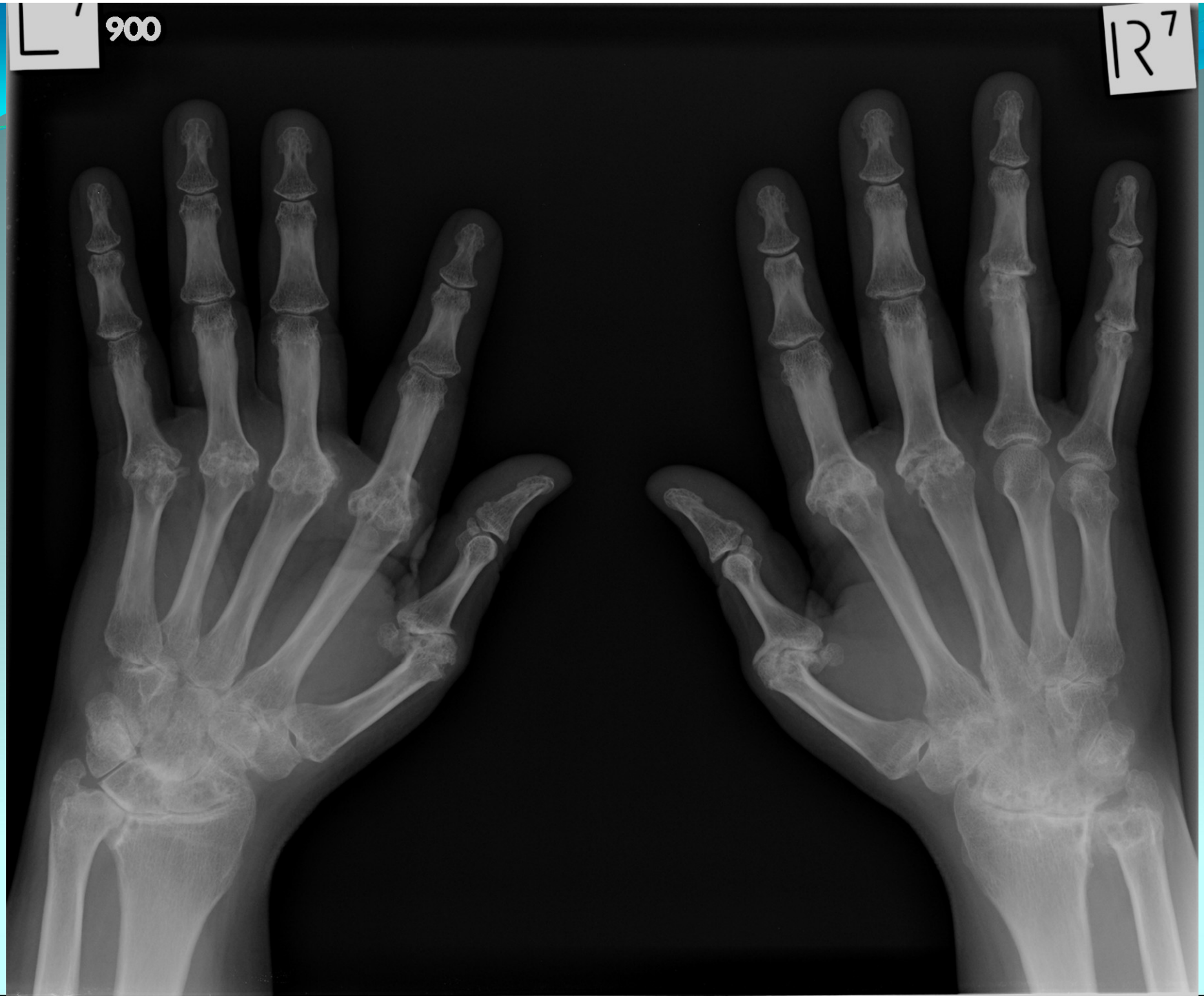


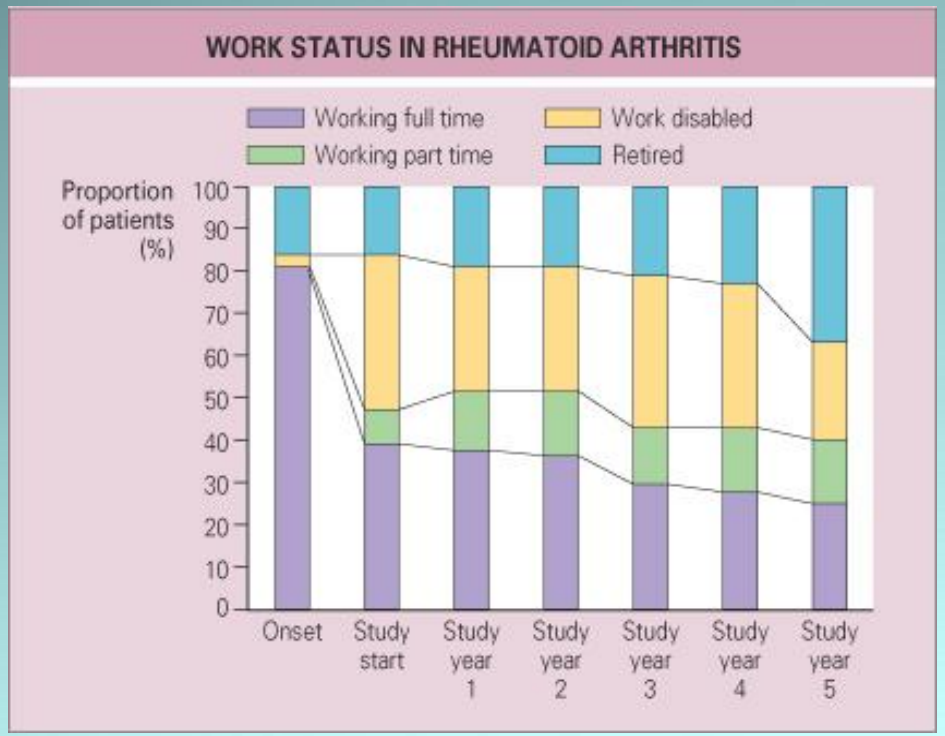
The Breadth of Rheumatic Diseases

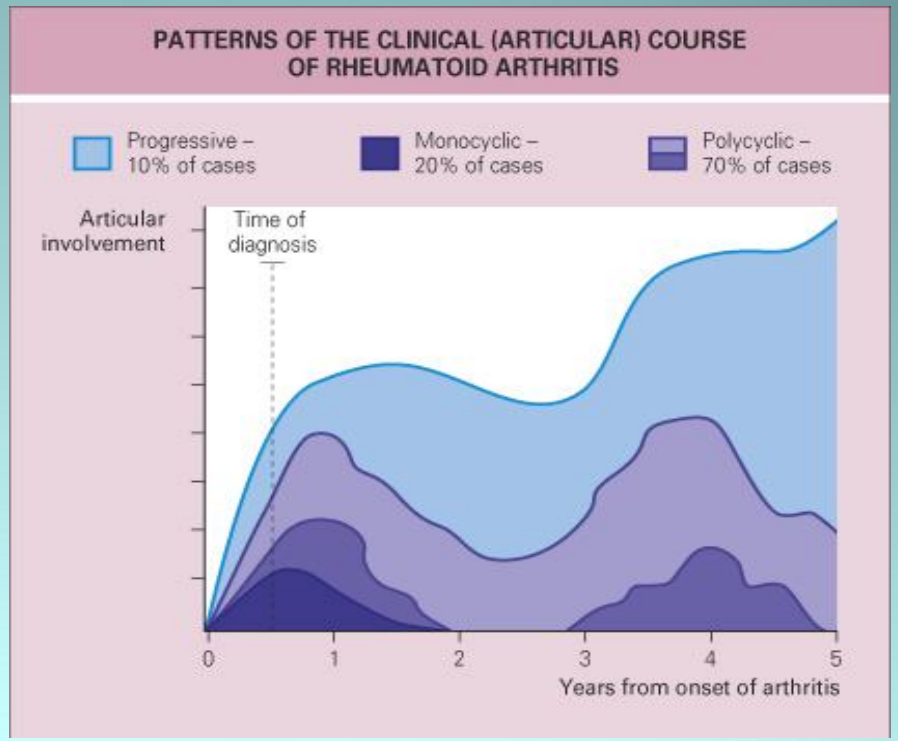
- Joint dysplasia
- Viral arthritis
- Systemic multi-system disease
  - Systemic lupus erythematosus
  - Lupus-like and overlap syndromes
  - Cardiolipin syndromes
  - Scleroderma
  - Dermatomyositis
  - Systemic vasculitis
- Drug-induced syndromes
  - Minocycline lupus
  - Statin myalgia






L
900
R





Hochberg and Silman Rheumatology 2003

A Century of Anti-Rheumatic Therapy

- 1900 Aspirin
- 1920 Gold
- 1940 Hydroxychloroquine, Sulfasalazine
- 1950 Corticosteroids
- 1960 Non Selective NSAIDS
- 1980 Methotrexate
- 1995 Combination DMARDS
  Cox II inhibitor NSAIDS
- 1999 Leflunomide,
  Etanercept, Infliximab
- 2001 Anakinra
- 2003 Adilumumab
- 2007 Rituximab, Abatacept,
- 2009 Cetriluzimab, Tocilizumab

Changing Patterns of management

- Does early treatment affect outcome ?
- How can we predict disease ?

Woolf Br J Rheum 1988, 27 S1, 1-4

- Why early arthritis Clinics ?
- Are they justified when prevalence of RA 20 times incidence

Emery Br J Rheum 1991,30 241-4

- Evidence based early referral
  - Joint damage occurs early
  - Early DMARDS improves RA outcome
  - Early DMARDS improves patient outcome and quality of life
  - Toxicity of DMARDS compared to NSAIDS
  - Early arthritis clinic experience

Emery Ann Rh Dis 2002, 61 290-7

Van der Horst-Bruinsma Br J Rheum 1998, 37, 1084-8

Current Treatment

- Eliminate active disease
- Suppress synovitis and inflammatory markers
- Reduce permanent damage and disability
- Increase survival
- Reduce risk of IHD and CVD
- Reduce incidence of malignancy

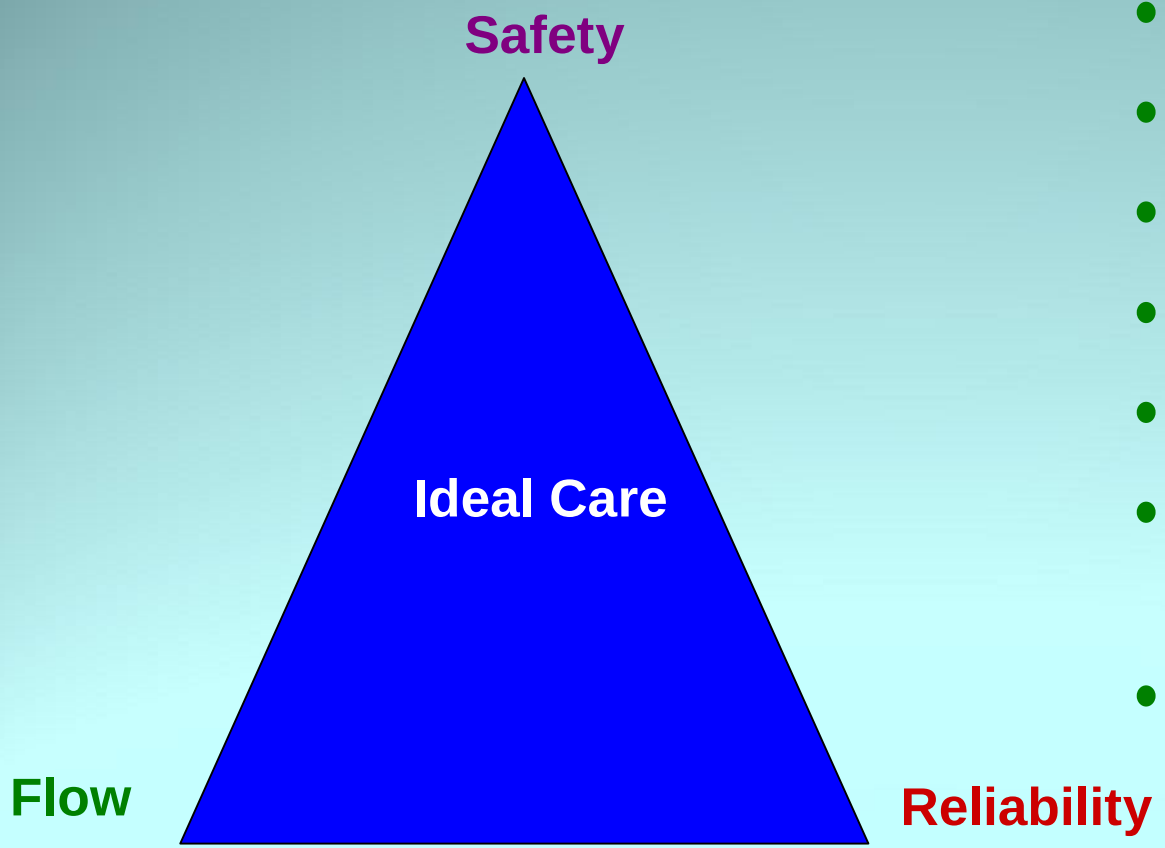
Nice Guidelines on RA 2009

Current Treatment

- Early DMARD therapy
  - Sulfsalazine
  - Methotrexate
  - Anti TNF therapy
  - B Cell Depleters
  - Combination of drugs
- Minimal Oral steroids
- Use of IA Steroids
- Use of IM and IV steroids
- NSAIDS
- Other analgesics

What are we trying to achieve?

Getting patients better faster and safer

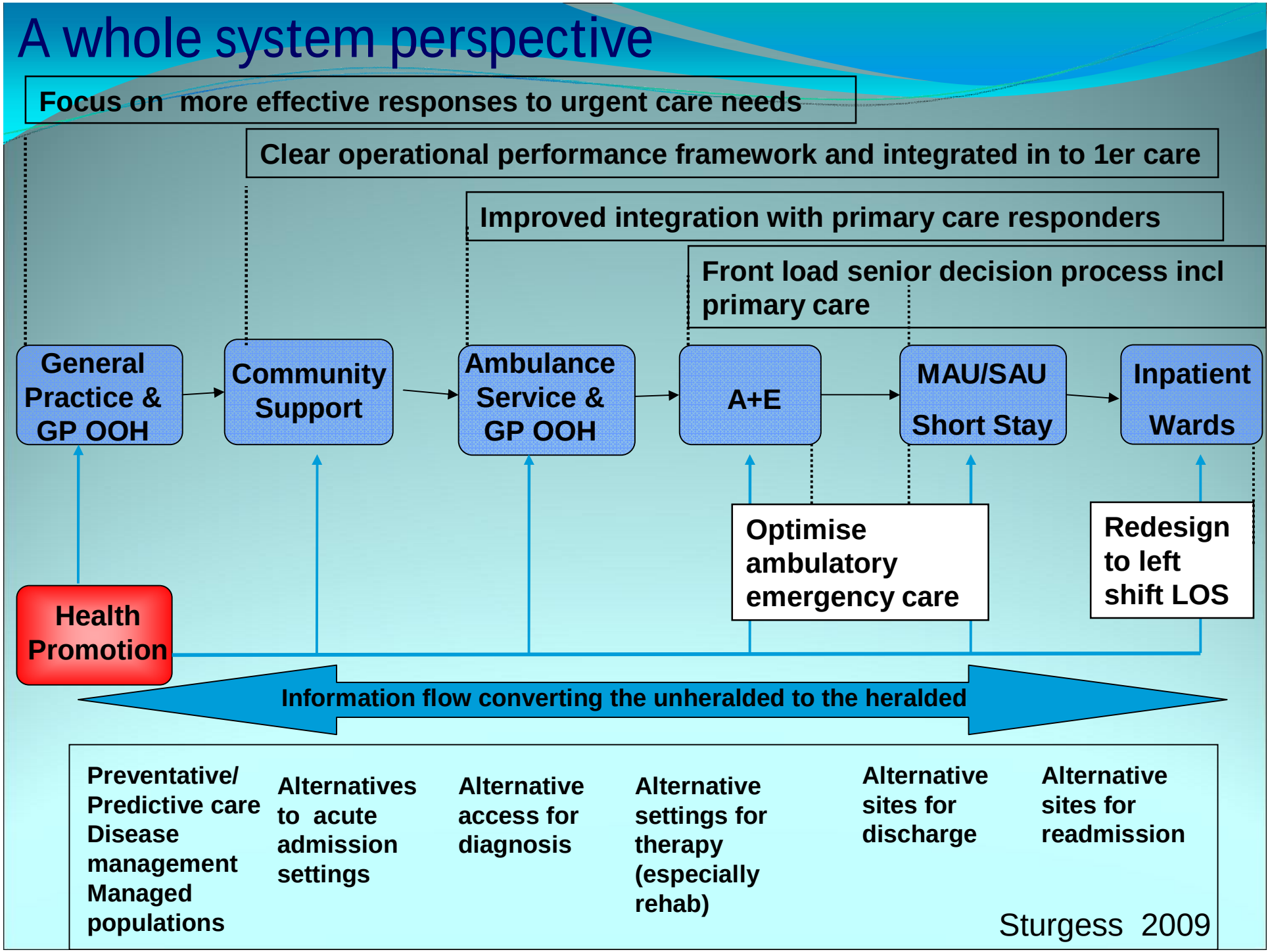


Pursuing Perfection

- **No avoidable deaths**
- **No harm**
- **No unnecessary pain**
- **No waste**
- **No delays**
- **No feelings of helplessness**
- **No inequality**

Sturgess 2009

A whole system perspective



Sturgess 2009

18 Week Commissioning Pathway Inflammatory Arthritis (Joint Pain)

Show/Hide Mer

1.0 Joint or Back Pain

Metric
1.6 Escalation thresholds & decision aids

1.7 Red Flags
Work absence, problems with ADLs

1.1 Symptom Description
Patient most often complain of pain with significant early morning stiffness, problems dressing and other ADLs

1.2 Incidence & Prevalence
Inflammatory arthritis covers a range of conditions including Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis

1.3 Self Assessment & Self Care
Early presentation and referral is vital to minimise long term disability
Exercise, healthy diet and maintaining ideal body mass index
Smoking is linked to the onset of RA

1.4 Primary Prevention
Smoking cessation

2.0 Primary Assessment
The History to include, pattern of joint involvement, stiffness (early morning), swelling and inflammation of joints, relation of joint symptoms to rest. Family History, Smoking.
The examination should check for the presence of joint swelling (synovitis) tender tenderness (arthritis) reduced movement. Mental health assessment.

2.1 Dx thresholds & decision aids

Metric
2.6 Escalation thresholds, QOL meas., decision aids, remote advice

2.7 Red Flags
Monoarthritis - consider septic arthritis

2.2 Diagnostics (Dx)

2.2.1 No diagnostic required

2.2.2 Imaging
Indications for xray guidance: MRI/RRR and Right Test, Right Time, Right Place

2.2.3 Path.
Routine bloods in suspected inflammatory arthritis - see supplementary

2.2.4 Phys. meas.

2.3 Treatment thresholds & decision aids

2.4 Treatments (Tx)

2.4.1 Reassurance, information, self help
All patients should have written information and a management plan

2.4.2 Active monitoring
Share care protocol for DMARDS

2.4.3 Physical, psych. therapy

2.4.4 Medication
Relief of pain - Analgesics using WHO analgesic ladder
DMARDS using shared care protocol

2.4.5 Preop. Assess.

2.4.6 Invasive Tx
Joint injections as part of shared care protocol

2.5 Rehabilitation & Review
PROM2 and QoL measures - Euroqol EQ5D, HAD see commissioning leaflet for further PROM's and KPIs

5.0

3.0 Specialist Assessment
Comprehensive Assessment in rheumatology service. This could be in secondary care or in a community based (ACTS) with consultant input. The assessment should be by a MDT. In patients with high distress, early involvement of psychological medicine is helpful - see chronic pain pathway

3.1 Dx thresholds & decision aids

3.2 Diagnostics (Dx)

3.2.1 No diagnostic required

3.2.2 Imaging
See supplementary

3.2.3 Path.
See supplementary

3.2.4 Phys. meas.

3.3 Treatment thresholds & decision aids

3.4 Definitive Treatments (Tx)

3.4.1 Reassurance, information, self help
Individual education from named nurses

3.4.2 Active monitoring
Objective measurement of disease activity i.e. DAS28

3.4.3 Physical & psych. therapy
Importance of MDT assessment, psychology input, biopsychosocial pain management

3.4.4 Medication
Pain relief via management plan, early initiation of DMARDs and steroids. Biologics as per NICE

3.4.5 Preop. Assess.

3.4.6 Invasive Tx
Injections, shared care in orthopaedics

3.5 Rehabilitation, Review & QOL measurement

Metric
3.6 Escalation thresholds & decision aids

3.7 Red Flags
Life threatening complications

4.0 Supra-specialist Assessment
Comprehensive assessment in supraspecialist unit, Full MDT assessment. Patients with linked multi organ disease - renal or lung should be seen for in multidisciplinary clinics

4.1 Dx thresholds & decision aids

4.2 Diagnostics (Dx)

4.2.1 No diagnostic required

4.2.2 Imaging
See 2.2.2

4.2.3 Path.
see 2.2.3

4.2.4 Phys. meas.

4.3 Treatment thresholds & decision aids

4.4 Definitive Treatments (Tx)

4.4.1 Reassurance, information, self help

4.4.2 Active monitoring

4.4.3 Physical & psych. therapy

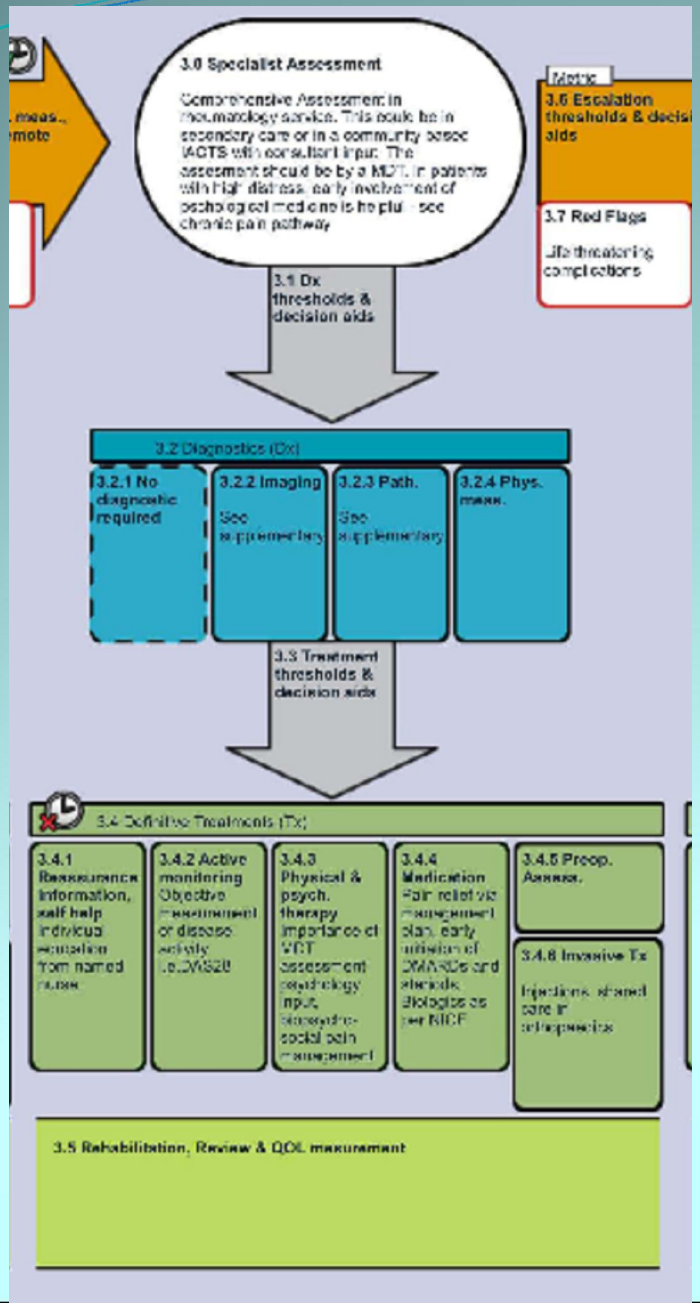
4.4.4 Medication
Experimental treatment in non responsive disease

4.4.5 Preop. Assess.

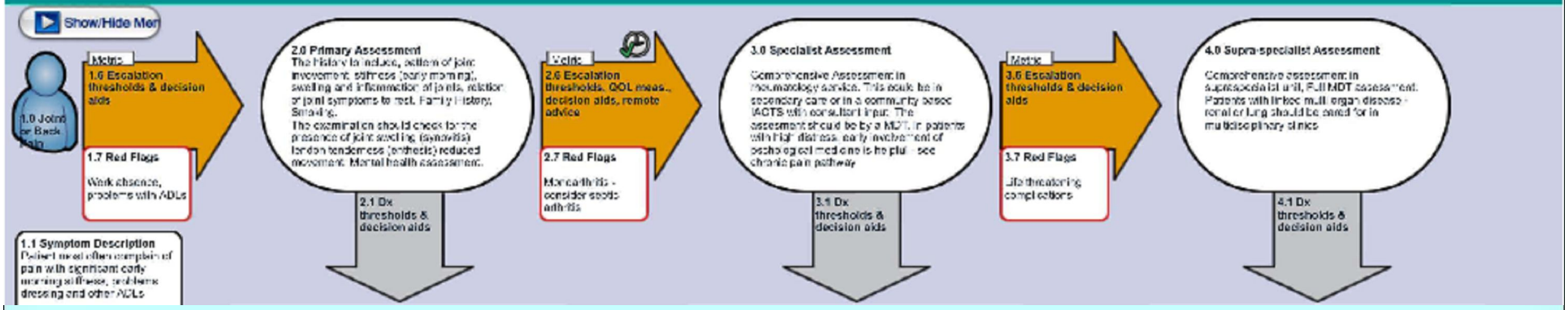
4.4.6 Invasive Tx
Cervical spine surgery

4.5 Rehabilitation, Review & QOL measurement

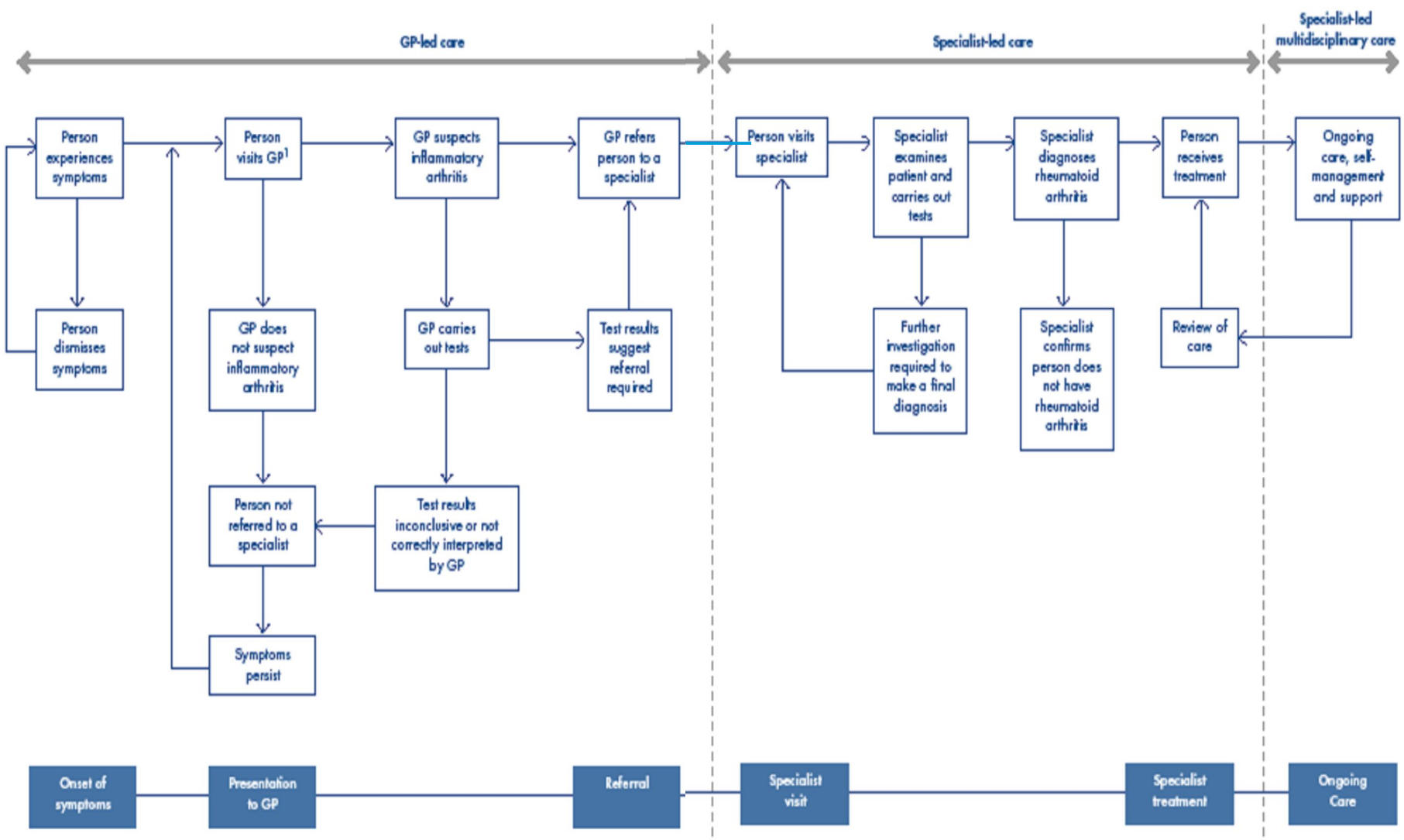
Pathway template design copyright © S Laitner and S Normanton 2007 at Pathwaysforhealth.org, all rights reserved.
Terms and Conditions apply


3.0 Specialist Assessment
Comprehensive Assessment in rheumatology service. This could be in secondary care or in a community based ACTS with consultant input. The assesment should be by a MDT. In patients with high distress early involvement of psychological medicine is helpful - see chronic pain pathway
Metric
3.6 Escalation thresholds & decision aids
3.7 Red Flags
Life threatening complications
3.1 Dx thresholds & decision aids
3.2 Diagnostics (Dx)
3.2.1 No diagnostic required
3.2.2 Imaging
See supplementary
3.2.3 Path.
See supplementary
3.2.4 Phys. meas.
3.3 Treatment thresholds & decision aids
3.4 Definitive Treatments (Tx)
3.4.1 Reassurance information, self help individual education from named nurse
3.4.2 Active monitoring Objective measurement of disease activity
3.4.3 Physical & psych. therapy importance of VRT assessment psychology input, biopsycho-social pain management
3.4.4 Medication Pain relief via management plan, early utilisation of DMARDs and steroids, Biologics as per NICE
3.4.5 Preop. Assess.
3.4.6 Invasive Tx
Injections, shared care in orthopaedics
3.5 Rehabilitation, Review & QOL measurement

18 Week Commissioning Pathway Inflammatory Arthritis (Joint Pain)



2 The typical diagnosis and treatment pathway for people with rheumatoid arthritis



Source: National Audit Office

NOTE

1 People may also first present to a practice nurse.

Delays in Access

- Recognition of musculo-skeletal symptoms in the patient
- Delay in referral from primary to secondary care
- Delay in seeing patients in secondary care

  Role of choose and book and call centres
- Inability to access care when in a flare of established disease

Kings Fund Report on RA Care Jan 2009

Portsmouth Rheumatology

- Population 600,000
- New patients 3,000 per annum
- Old patients 12,500 per annum
- Day cases 2,100 per annum
- Referrals 250 per month

Fast-track Service 2001

Portsmouth Hospitals NHS Trust - Department of Rheumatology
Rheumatoid Arthritis Referral

To	**From**
Christine Pledge Rheumatology Department Queen Alexandra Hospital Cosham Portsmouth PO6 3LY Tel 023 9228 6251 Fax 023 9228 6862	Dr..... Address..... ....Tel.. .....Fax..... .....

Name of Patient.....
Date of Birth.....
Hospital Number.....(if known)
Address.....
.....
.....Postcode.....Tel...
.....

History and Findings Date of referral.....200....

1 Clear-cut finding of swollen joints _____

2 Significant early morning stiffness (>1h) _____

3 Inadequate response to non-steroidal anti-inflammatory drugs _____

4 Struggling to cope at home and work _____

Other Relevant Facts

Length of Symptoms

Distibution of arthritis

Systemic Symptoms

Investigations

FBC.....Hb.....g/dl WBC.....x10^{9}/l Plts..... x10^{9}/l

ESR.....mm/h

RhF.....

Xrays (if performed)

Yours sincerely

.....

- To be accepted all questions in the History and findings box should be positive
- Other information is helpful but is not vital for the referral to be accepted
- A negative rheumatoid factor is not a reason for not seeking referral
- Do not refer patients with trauma wrongly in system
- If you consider a joint infected, you should refer directly to rheumatology or orthopaedics
- Consultant advice is always available. A consultant is always on call
  - Dr Thomas 023 9228 4784
  - Dr Hull 023 9228 4333
  - Dr McCrae 023 9228 4437
  - Dr Lechingham 023 9228 4199
  - Dr Mackey 023 9228 4199

RGH 11.04.01

- Clear-cut finding of swollen joints
- Significant early morning stiffness (>1h)
- Inadequate response to non-steroidal anti-inflammatory drugs
- Struggling to cope at home and work

Access to Care

- PCT approval - recognising an Acute Rheumatology service
- Trust approval - Contracting and business planning
- Funding Stream - admission avoidance
- GP Access – use of GP magazine and teaching
- Patient Access
  - Patient Advice and Information Line
  - use of patient conferences

Edwards Ann Rh Dis 2009, 68(S3), 529

Rheumatology Rapid Access and Treatment Service

New patients to the Department

Calls to the Registrar from
- G.P
- MAU
- A&E
- Other Consultants Teams

Patient able to attend Rheumatology

Patient Unwell and current inpatient QAH/SMH

SpR take following details:-
* Patient Details
  e.g Hospital Number, Patients Names, Contact numbers (Home/ Ward or Dept)
* Informs referring person that either the patient, ward or department will be contacted re time of appointment
* If from A&E or patient awaiting discharge, patient could wait in discharge lounge

HCSW Responsible for R.A.T.S Appointment:-
* Completes R.A.T.S Check List
* Check room availability and prepares room
* Orders Notes
* Checks with patient they know where to attend
* Arrange transport/ porters as required
* Informs Rheumatology reception

Patient seen in current inpatient ward
SpR completes inpatient referral documentation

Existing Patients know to the Department

Referral from
* G.P
* MAU
* A&E
* Other Consultants Teams
* Consultant/ SpR, CNS- abnormal blood tests, wound reviews

Rheumatology Advice and Information Line
* Self Referral via Rheumatology Advice and Information Line

Patient able to attend Rheumatology

Patient Unwell and current inpatient QAH/SMH

HCSW Responsible for R.A.T.S Appointment:-
* Completes R.A.T.S Check List
  Confirms with the CNS leading the R.A.T.S patient can be seen by CNS or needs to be by SpR or Consultant
* Check room availability and prepares room
* Orders Notes
* Checks with patient they know where to attend
* Arrange transport/ porters as required
* Informs Rheumatology reception
* if required contacts SpR or Consultant on patients arrival to department

Patient seen in current inpatient ward
SpR completes inpatient referral documentation

Rheumatology Rapid Access and Treatment Service

New patients to the Department

Calls to the Registrar or Consultant from
- G.P
- MAU
- A&E
- Other Consultants Teams

Patient able to attend Rheumatology Department

SpR take following details:-
* Patient Details
  e.g Hospital Number, Patients Names, Contact numbers (Home/ Ward or Dept)
* Informs referring person that either the patient, ward or department will be contacted re time of appointment
* If from A&E or patient awaiting discharge, patient could wait in discharge lounge

HCSW Responsible for R.A.T.S Appointment:-
* Completes R.A.T.S Check List
* Check room availability and prepares room
* Orders Notes
* Checks with patient they know where to attend
* Arrange transport/ porters as required
* Informs Rheumatology reception

Patient Unwell and current inpatient QAH/SMH

Patient seen in current inpatient ward
SpR completes inpatient referral documentation

Rheumatology Rapid Access and Treatment Service

Existing Patients know to the Department

Referral from
* G.P
* MAU
* A&E
* Other Consultants Teams
* Consultant/ SpR, CNS- abnormal blood tests, wound reviews

Rheumatology Advice and Information Line
* Self Referral via Rheumatology Advice and Information Line

Patient able to attend Rheumatology

HCSW Responsible for R.A.T.S Appointment:-
* Completes R.A.T.S Check List
  Confirms with the CNS leading the R.A.T.S patient can
  be seen by CNS or needs to be by SpR or Consultant
* Check room availability and prepares room
* Orders Notes
* Checks with patient they know where to attend
* Arrange transport/ porters as required
* Informs Rheumatology reception
* if required contacts SpR or Consultant on patients arrival to department

Patient Unwell and current inpatient QAH/SMH

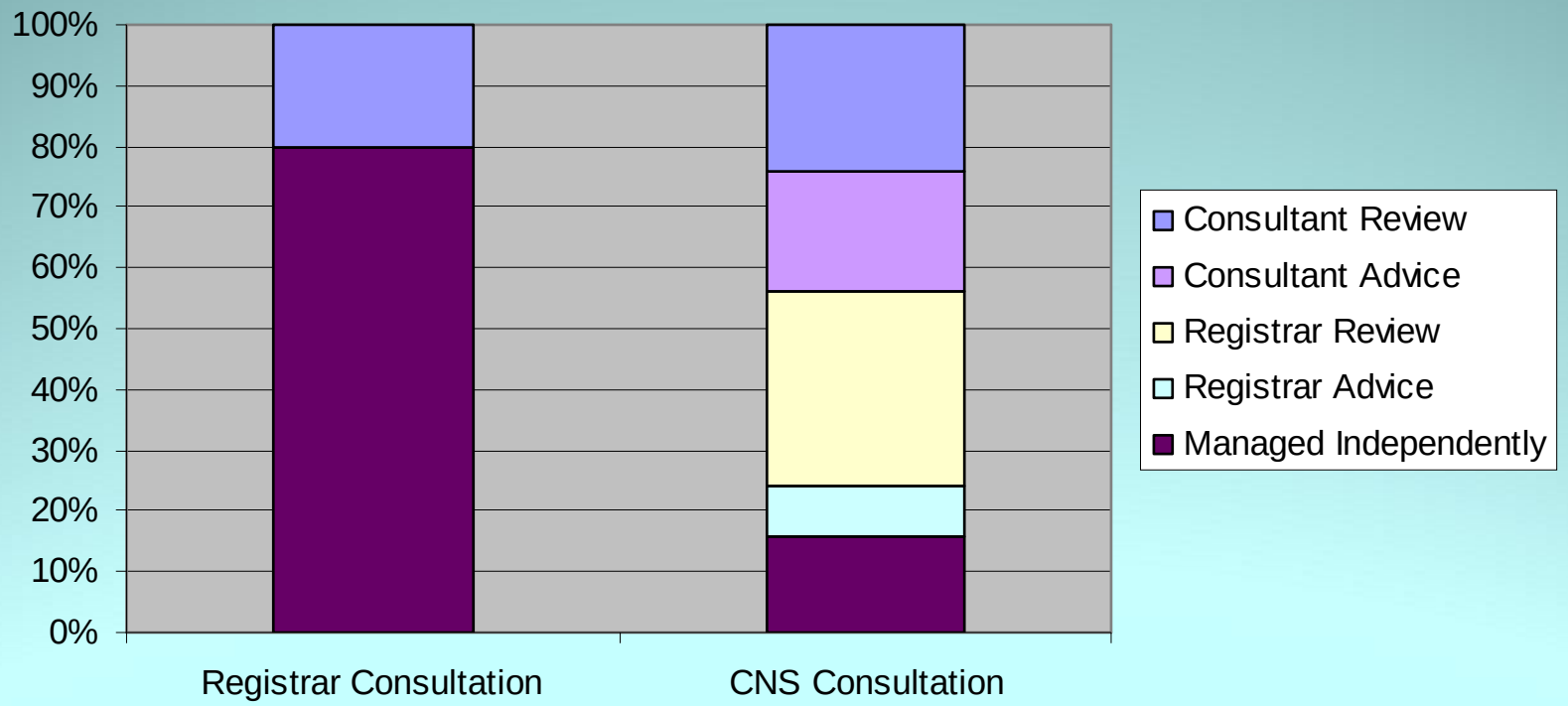
Patient seen in current inpatient ward
SpR completes inpatient referral documentation

Personnel

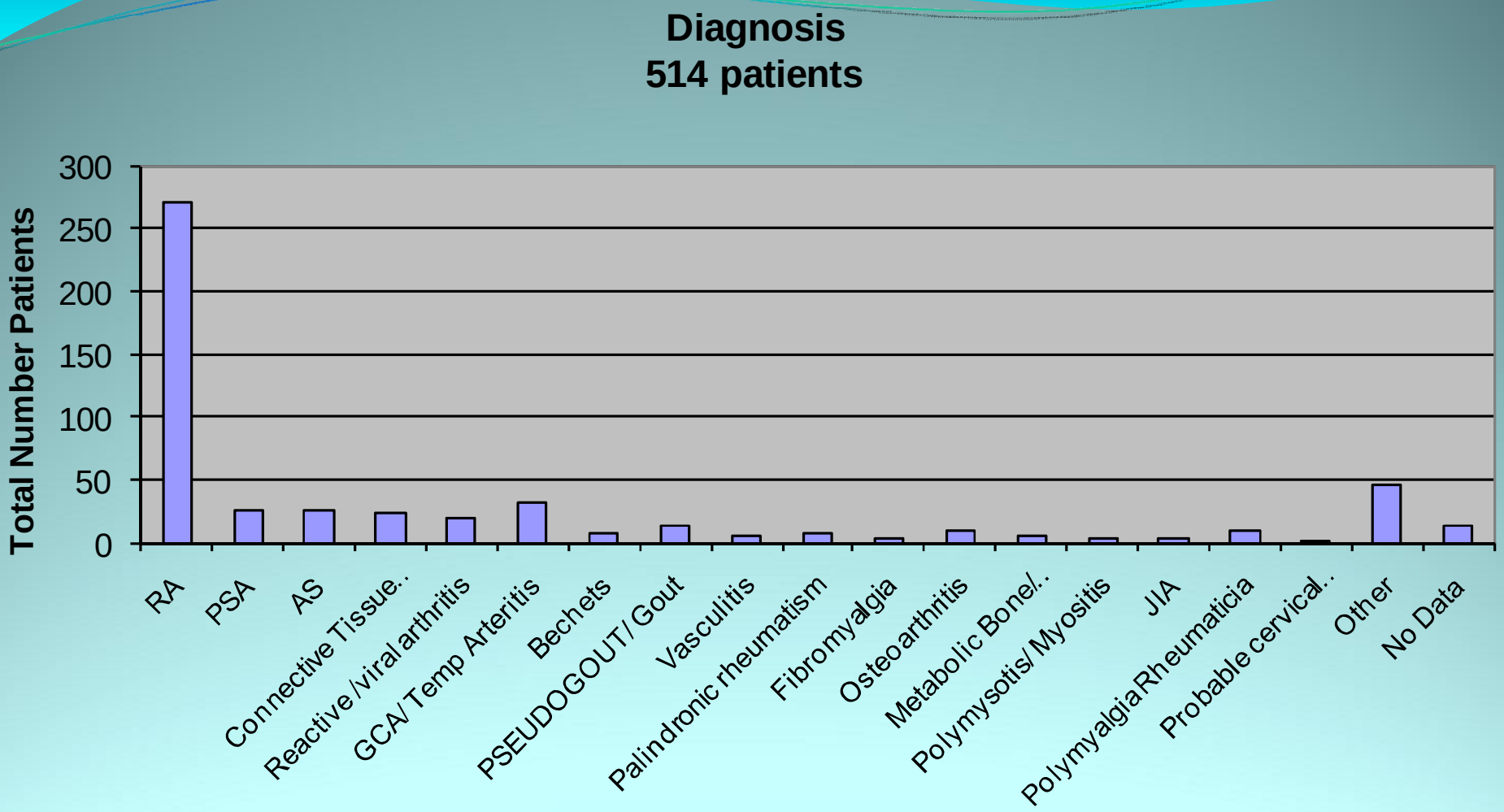
- Specialist nurses
- Specialist registrars
- Consultants

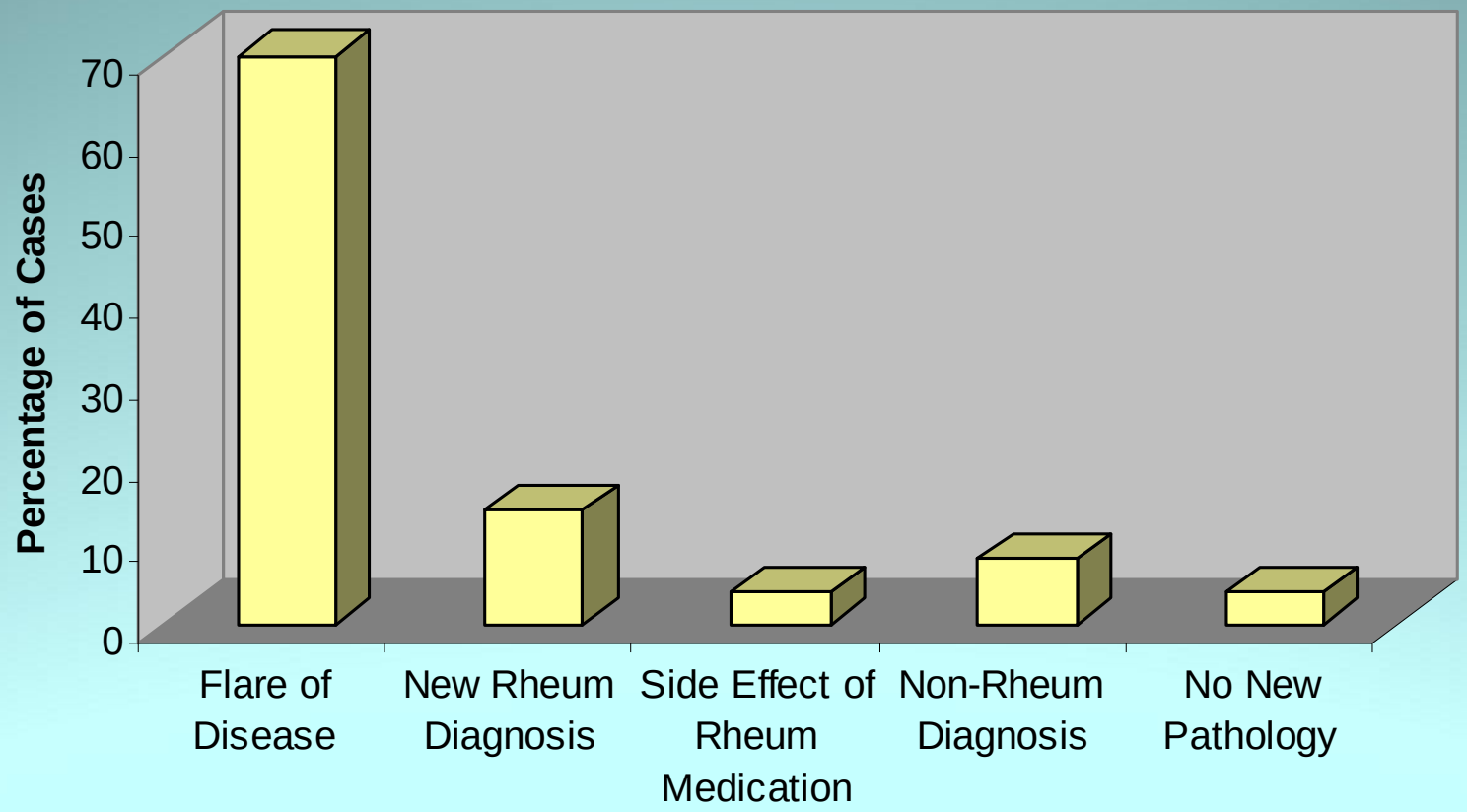
- Administrative staff (HCSW)

Br med J 2009, 339, 1050

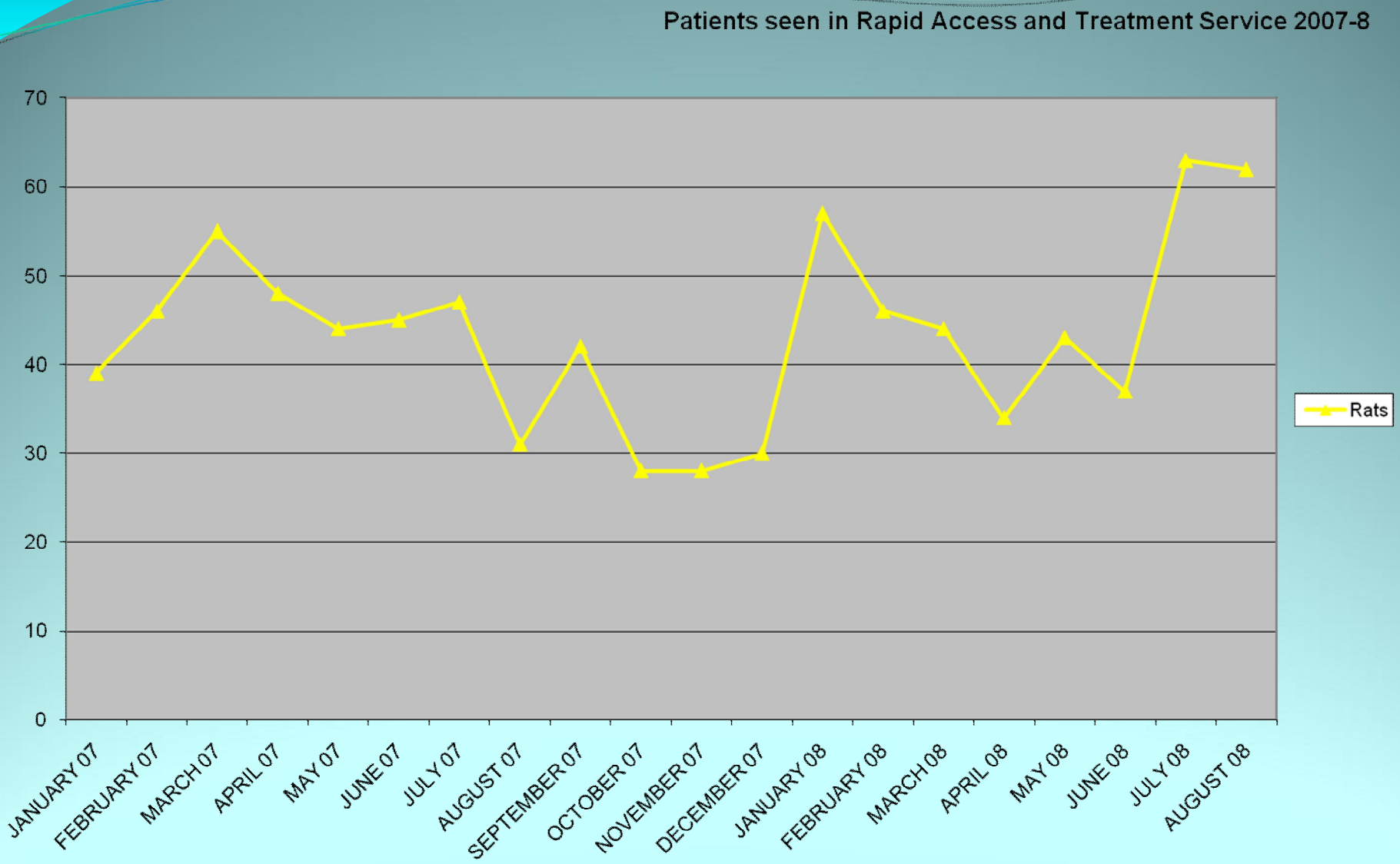


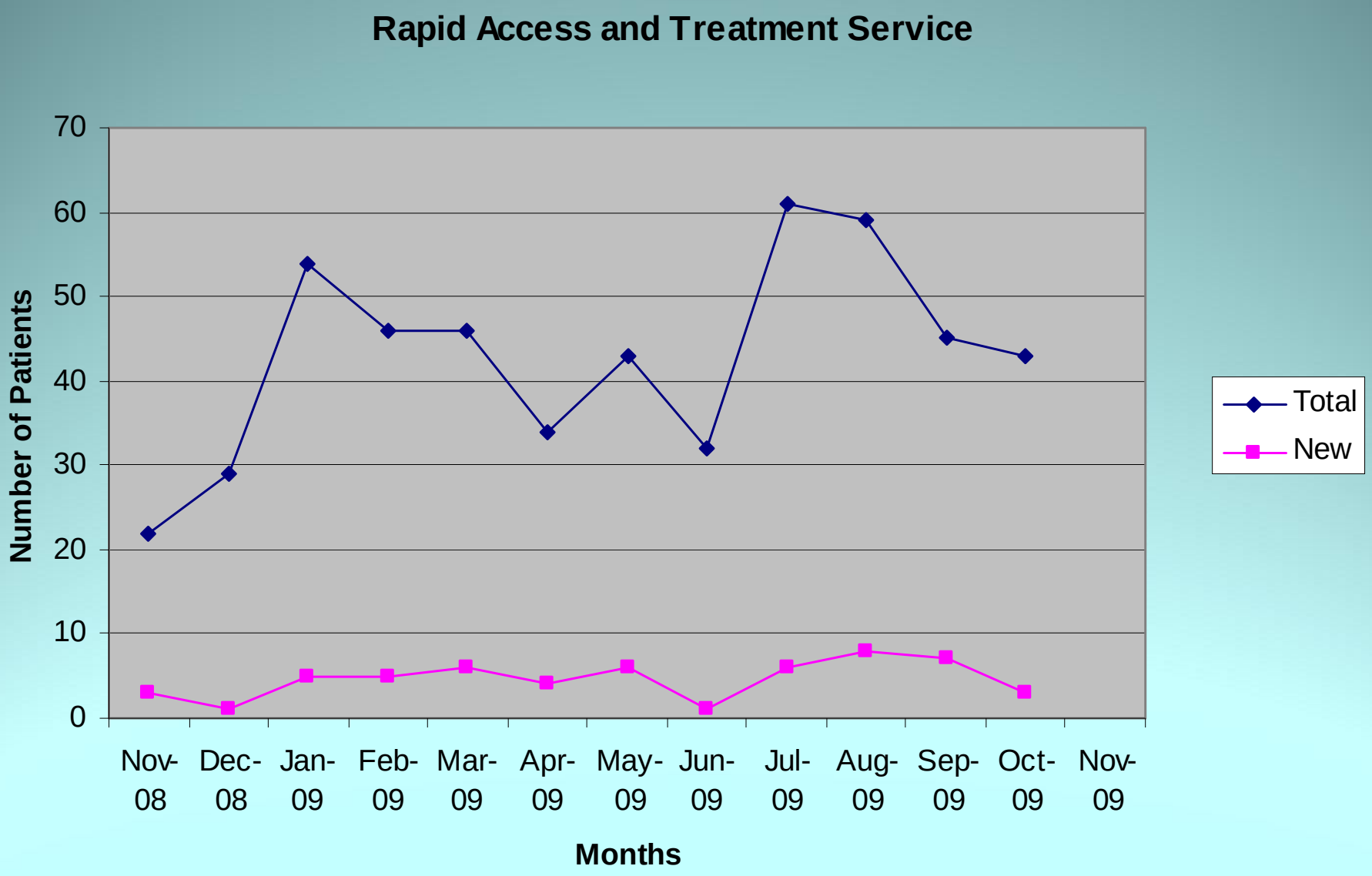
Edwards Ann Rh Dis 2009, 68(S3), 529

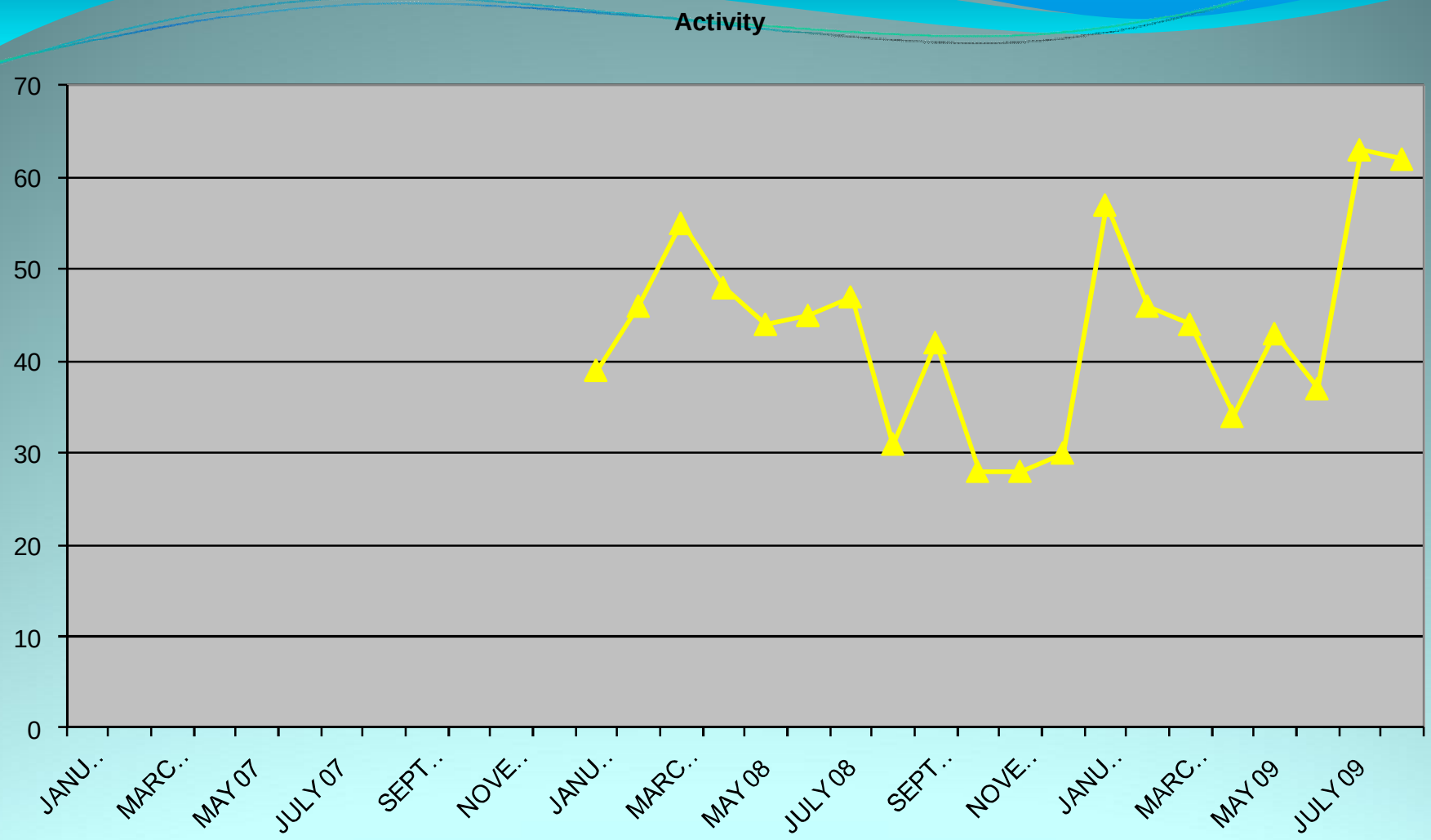

Diagnosis
514 patients
Total Number Patients
300
250
200
150
100
50
0
RA
PSA
AS
Connective Tissue..
Reactive /viral arthritis
GCA/ Temp Arteritis
Bechets
PSEUDOGOUT/ Gout
Vasculitis
Palindronic rheumatism
Fibromyalgia
Osteoarthritis
Metabolic Bone/..
Polymysotis/ Myositis
JIA
Polymyalgia Rheumaticia
Probable cervical..
Other
No Data

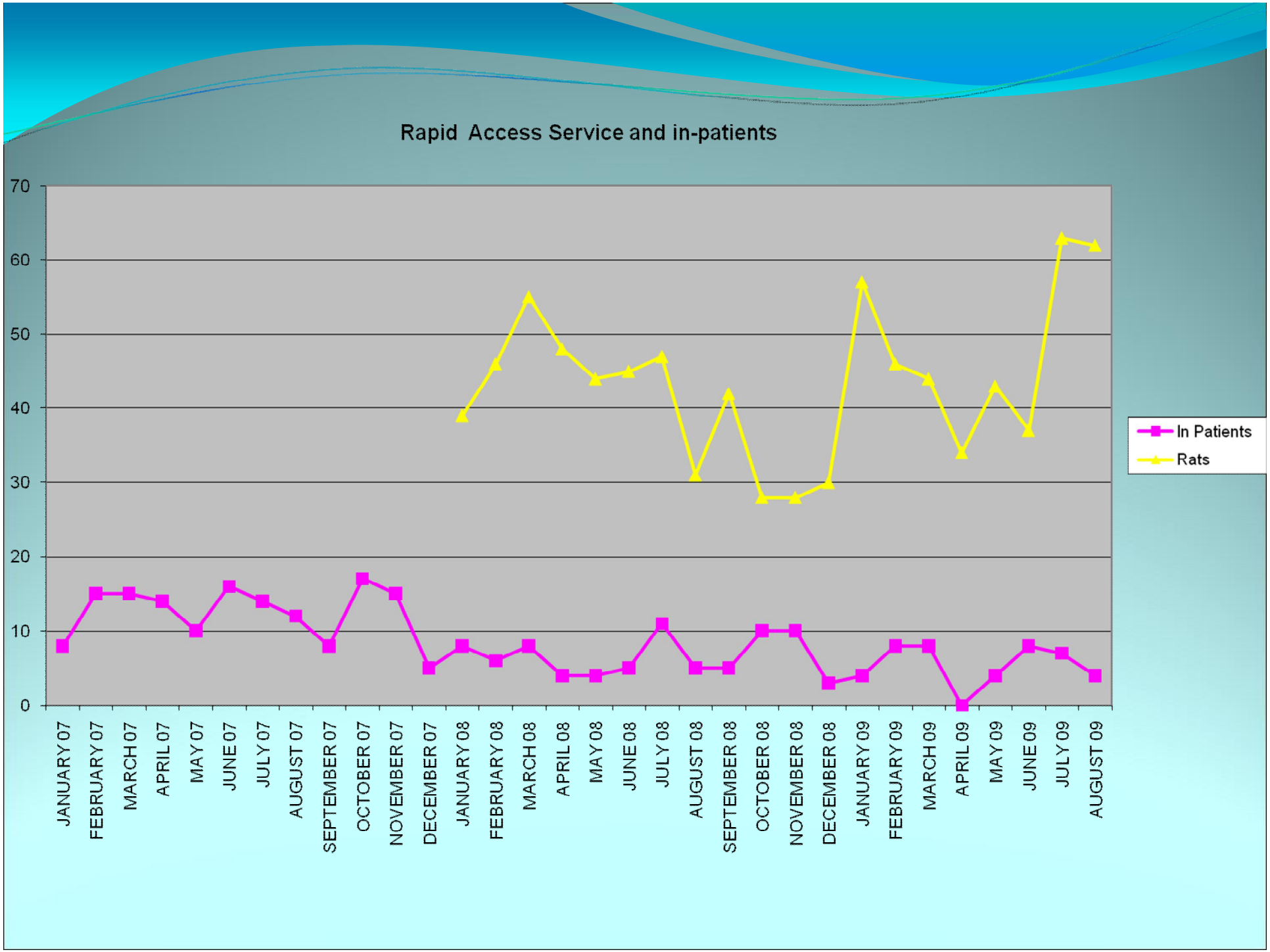


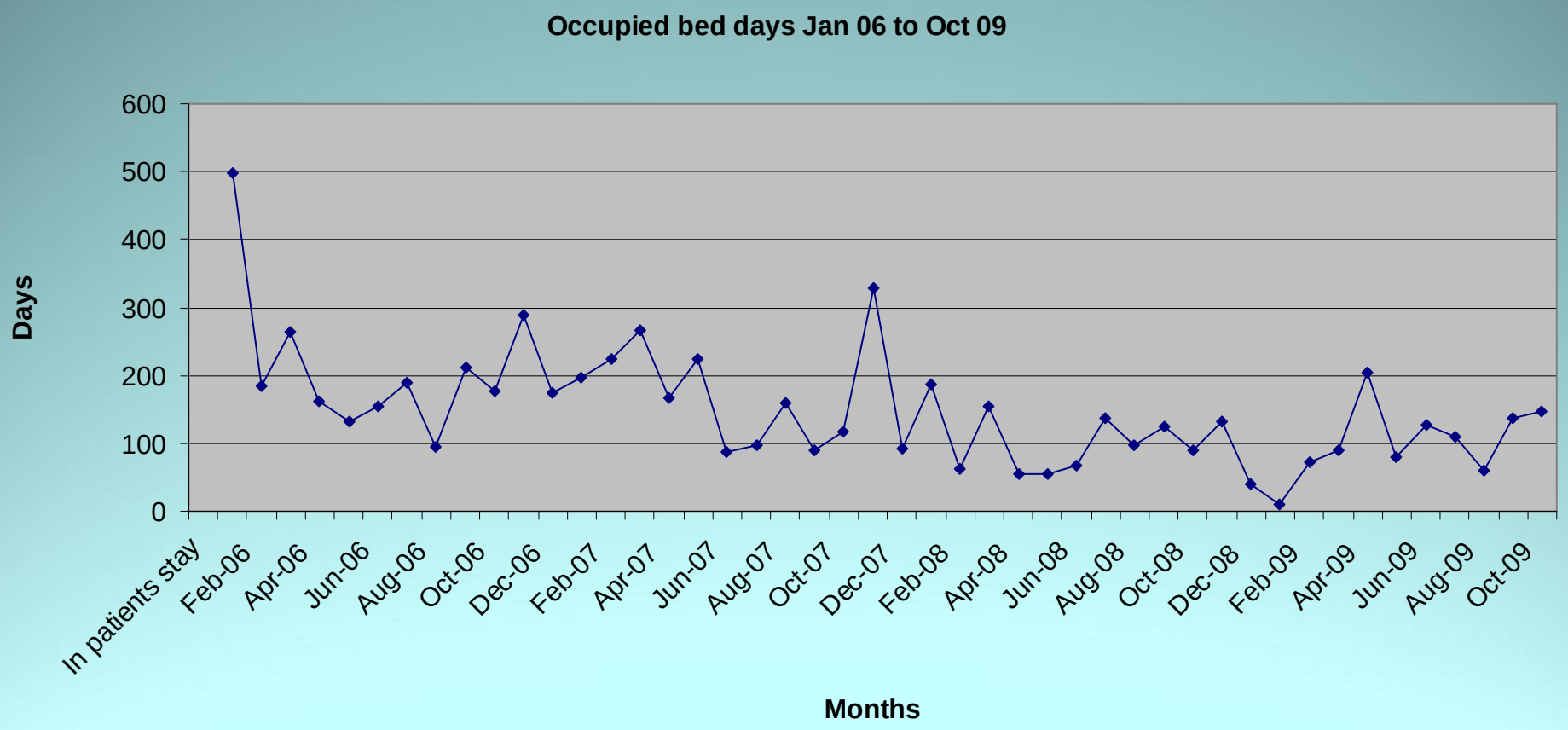
Edwards Ann Rh Dis 2009, 68(S3), 529


Patients seen in Rapid Access and Treatment Service 2007-8
70
60
50
40
30
20
10
0
JANUARY 07
FEBRUARY 07
MARCH 07
APRIL 07
MAY 07
JUNE 07
JULY 07
AUGUST 07
SEPTEMBER 07
OCTOBER 07
NOVEMBER 07
DECEMBER 07
JANUARY 08
FEBRUARY 08
MARCH 08
APRIL 08
MAY 08
JUNE 08
JULY 08
AUGUST 08
Rats

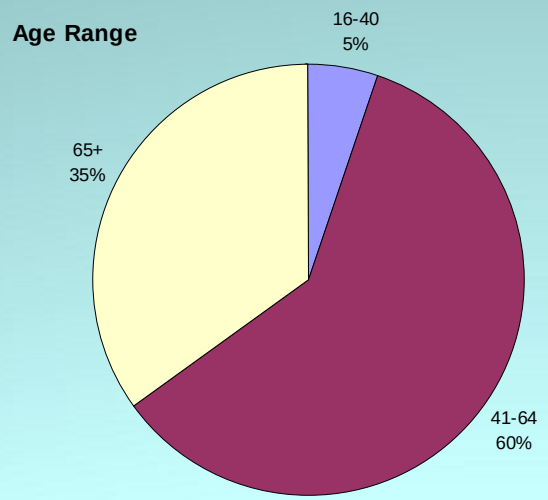

Rapid Access and Treatment Service
Number of Patients
70
60
50
40
30
20
10
0
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Months
Total
New

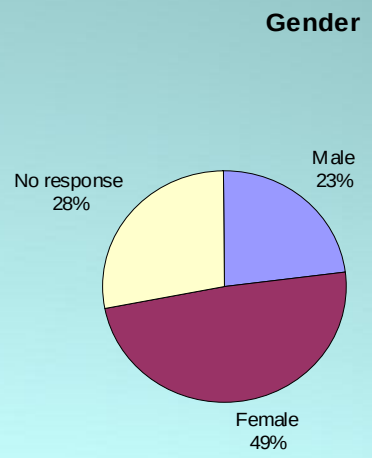

Activity
70
60
50
40
30
20
10
0
JANU..
MARC..
MAY 07
JULY 07
SEPT..
NOVE..
JANU..
MARC..
MAY 08
JULY 08
SEPT..
NOVE..
JANU..
MARC..
MAY 09
JULY 09

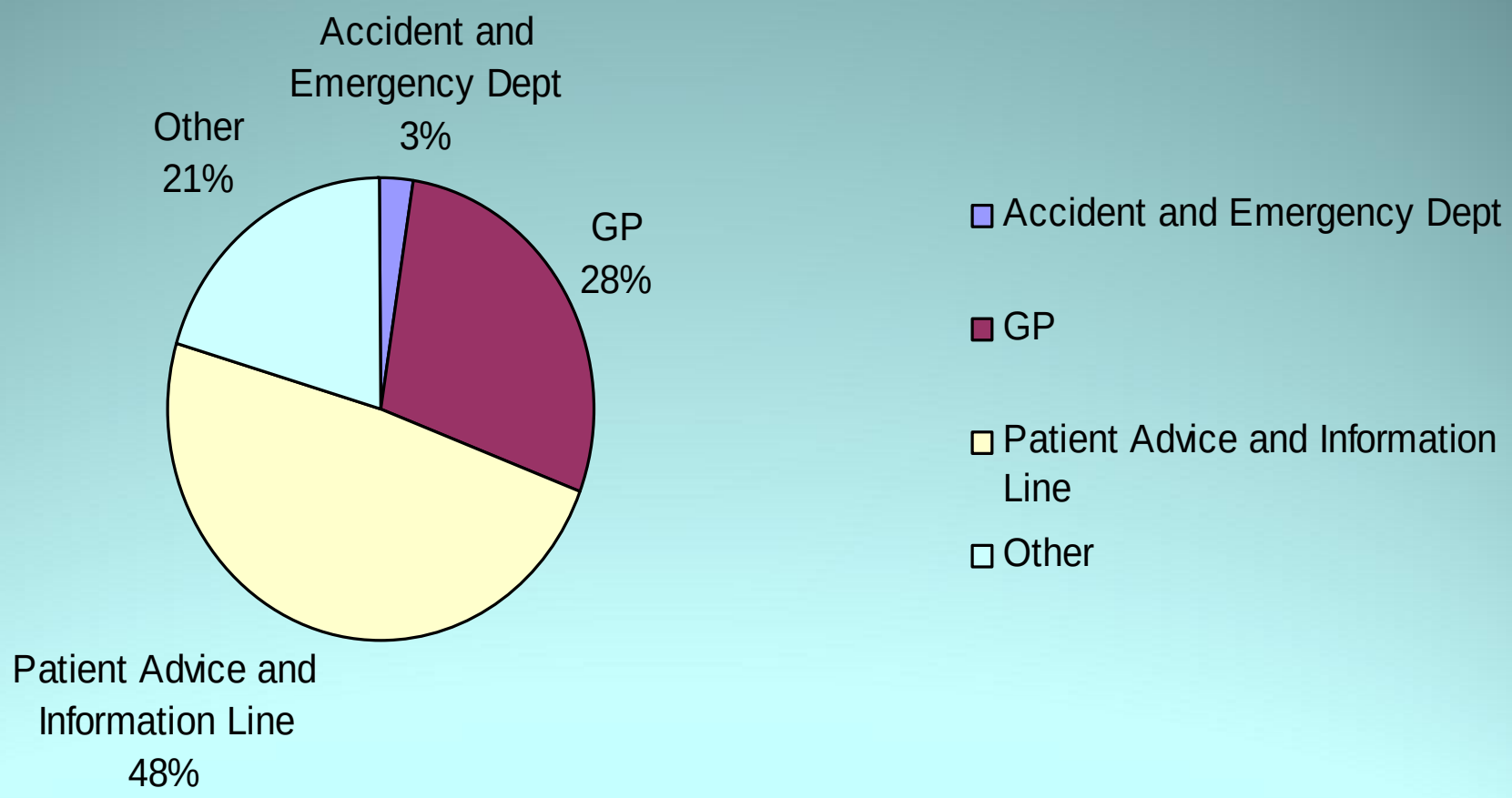

Rapid Access Service and in-patients
70
60
50
40
30
20
10
0
JANUARY 07
FEBRUARY 07
MARCH 07
APRIL 07
MAY 07
JUNE 07
JULY 07
AUGUST 07
SEPTEMBER 07
OCTOBER 07
NOVEMBER 07
DECEMBER 07
JANUARY 08
FEBRUARY 08
MARCH 08
APRIL 08
MAY 08
JUNE 08
JULY 08
AUGUST 08
SEPTEMBER 08
OCTOBER 08
NOVEMBER 08
DECEMBER 08
JANUARY 09
FEBRUARY 09
MARCH 09
APRIL 09
MAY 09
JUNE 09
JULY 09
AUGUST 09
In Patients
Rats


Occupied bed days Jan 06 to Oct 09
Days
600
500
400
300
200
100
0
In patients stay
Feb-06
Apr-06
Jun-06
Aug-06
Oct-06
Dec-06
Feb-07
Apr-07
Jun-07
Aug-07
Oct-07
Dec-07
Feb-08
Apr-08
Jun-08
Aug-08
Oct-08
Dec-08
Feb-09
Apr-09
Jun-09
Aug-09
Oct-09
Months

Patient Demographics



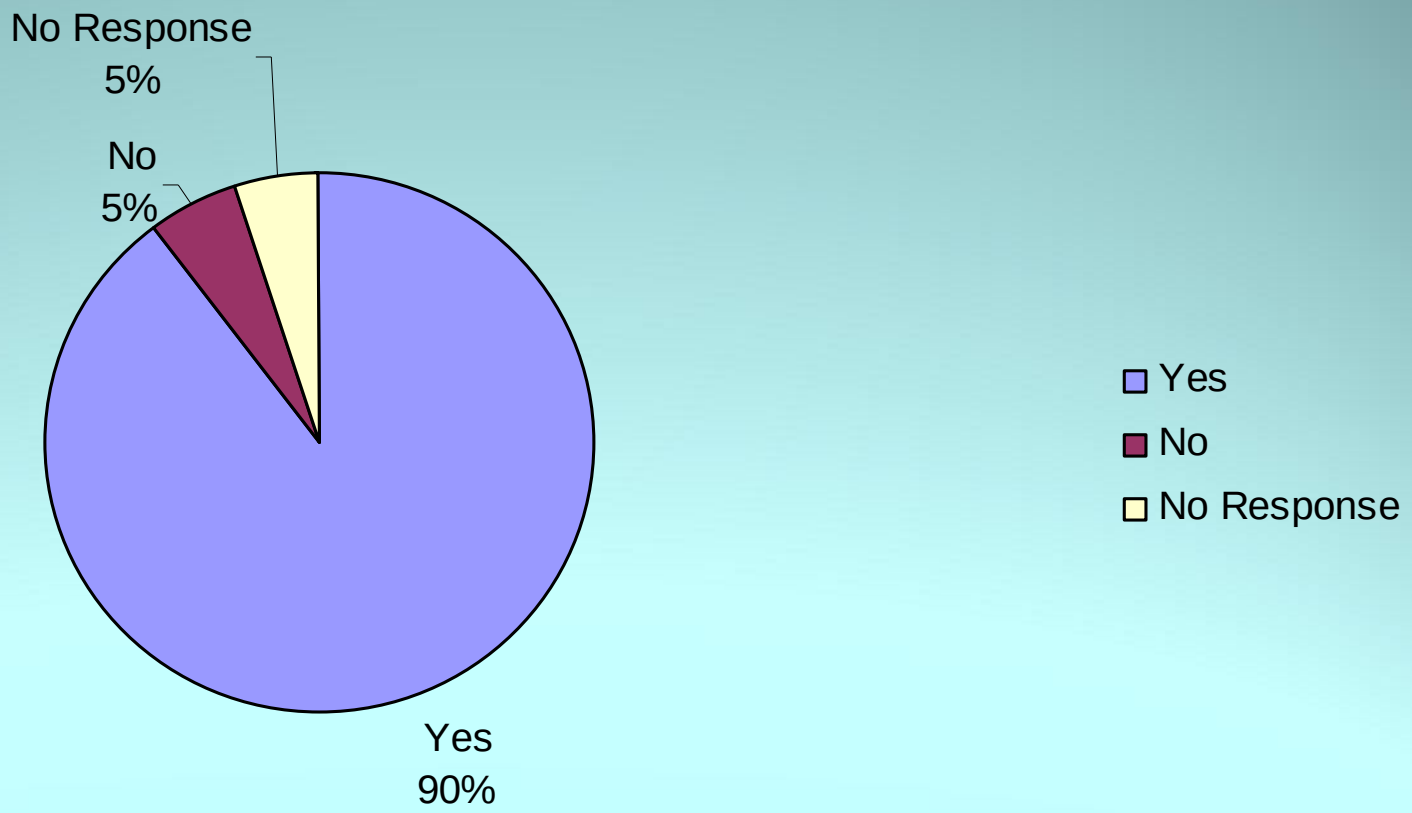



Accident and Emergency Dept 3%
GP 28%
Patient Advice and Information Line 48%
Other 21%
Accident and Emergency Dept
GP
Patient Advice and Information Line
Other

Do you think that the Rapid Access and Treatment Services was well run/ organised?

- All staff were very helpful
- I was seen very quickly
- Very prompt, staff can't help where they are working
- I was concerned as to when I would hear my appointment date- a phone call to the department secretary soon allayed my fears
- First class service

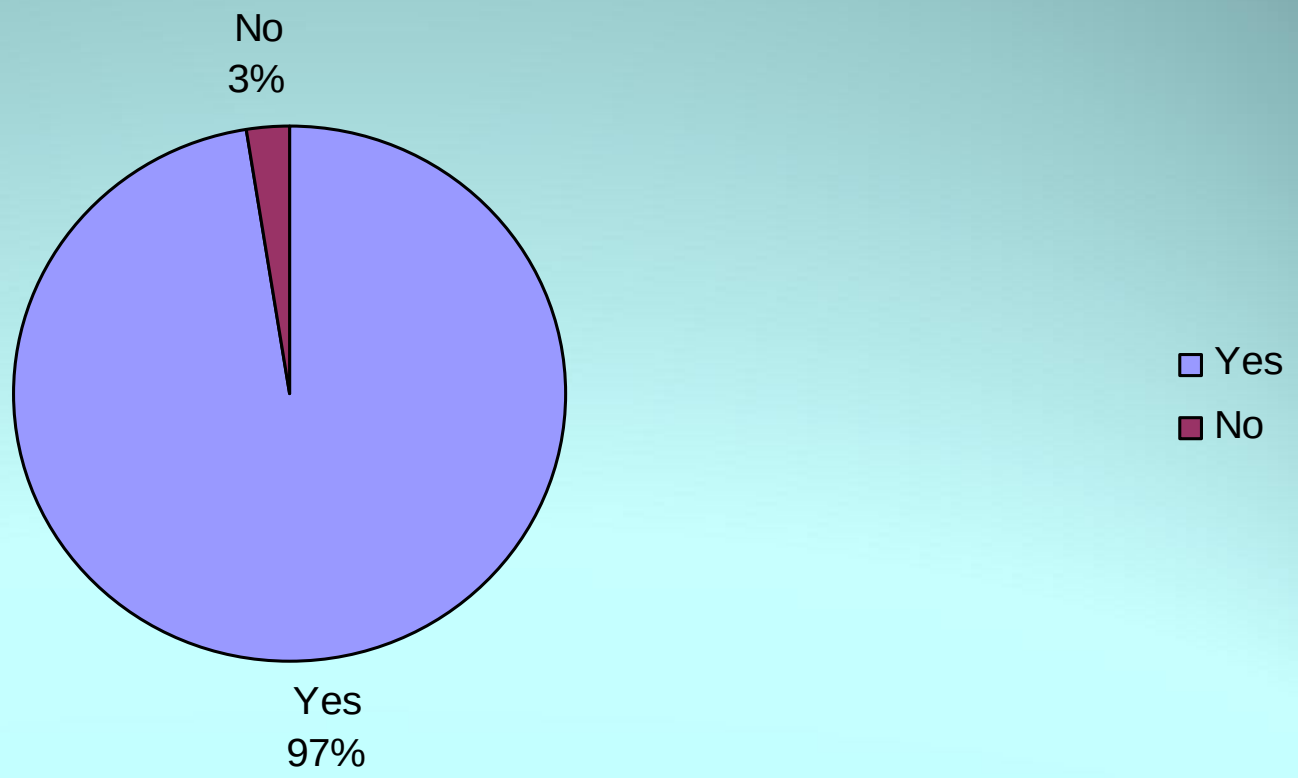
Were you involved in the descision about care and treatment during your visit?



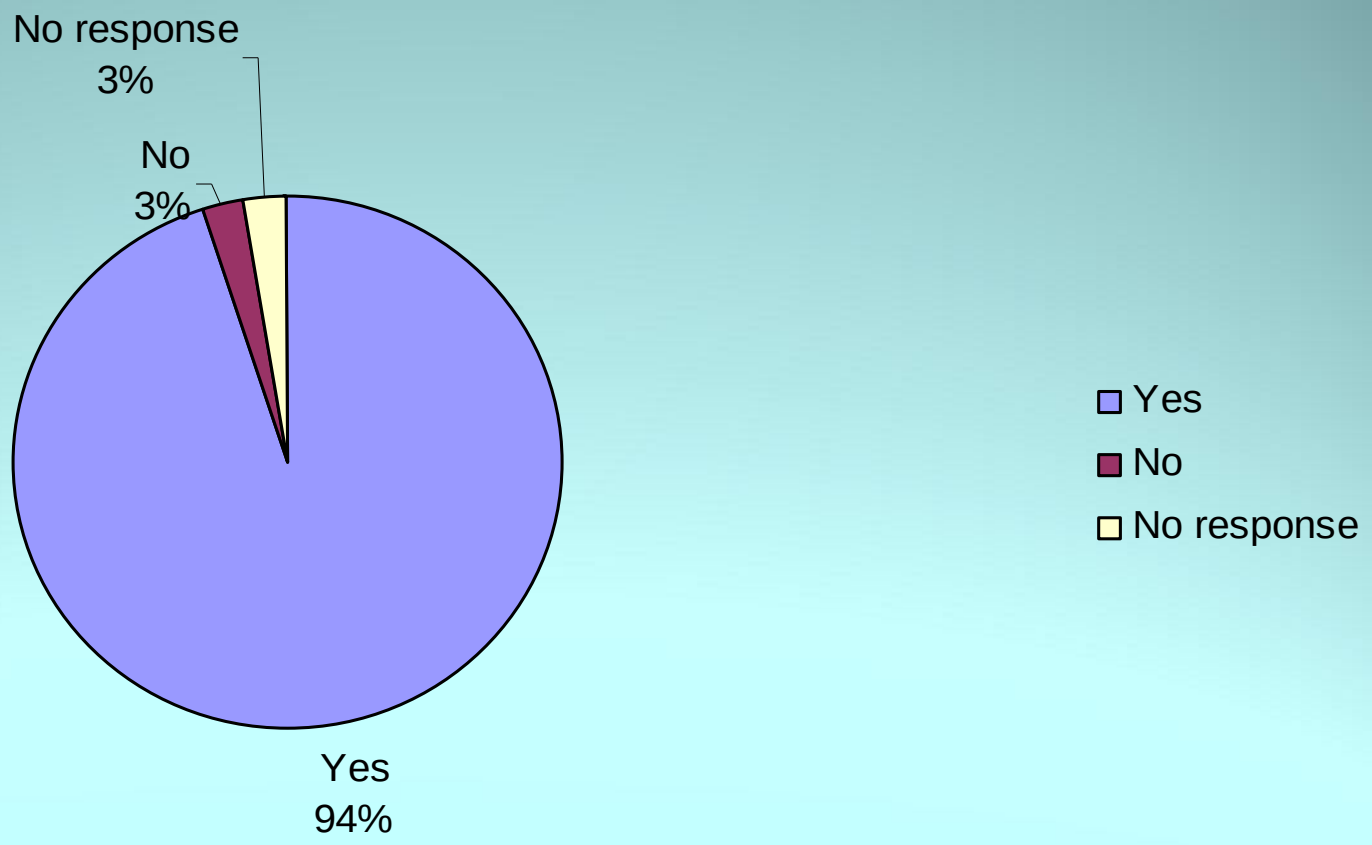
Were you involved in the decision about care and treatment during your visit?

- Cannot remember
- Dr talked treatment through
- I mentioned eye problem I have which needs operation. This helped the doctor decide when I should start my medication

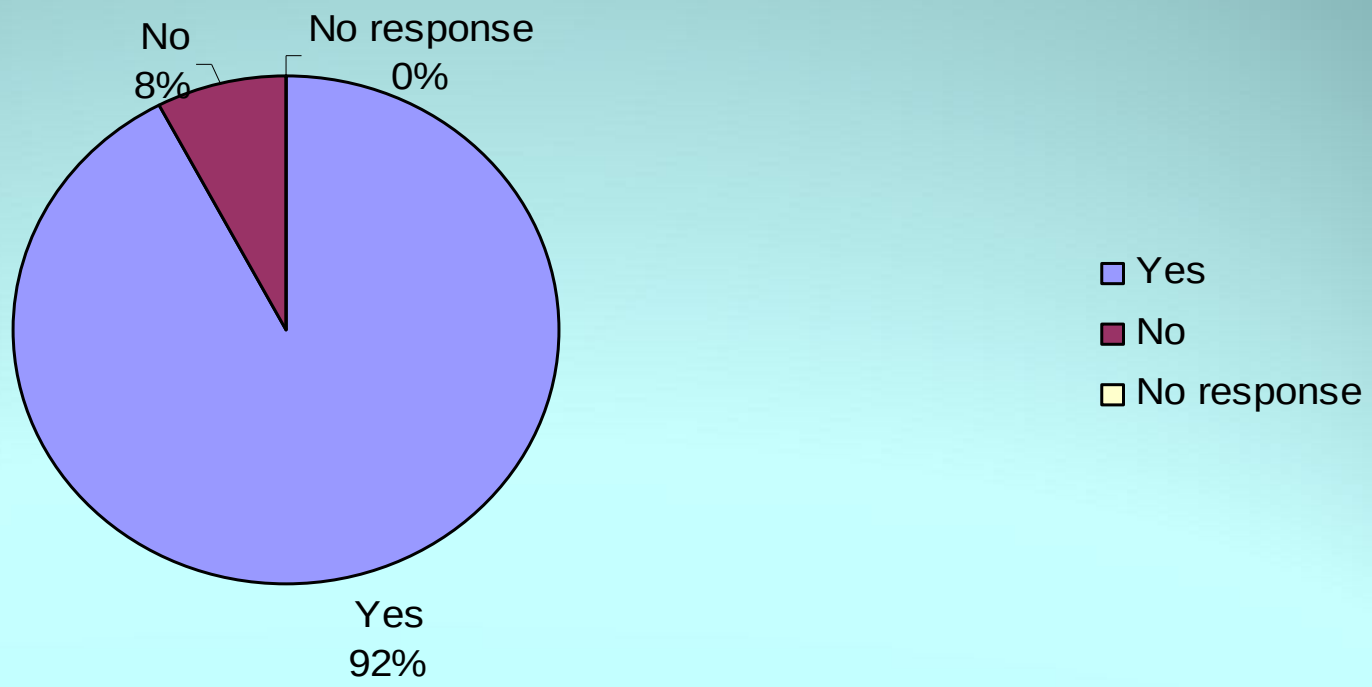
Were you given enough time and privacy during your visit to the department?



If you had important questions to as the Doctor/Nurse, did you get answers that you could understand

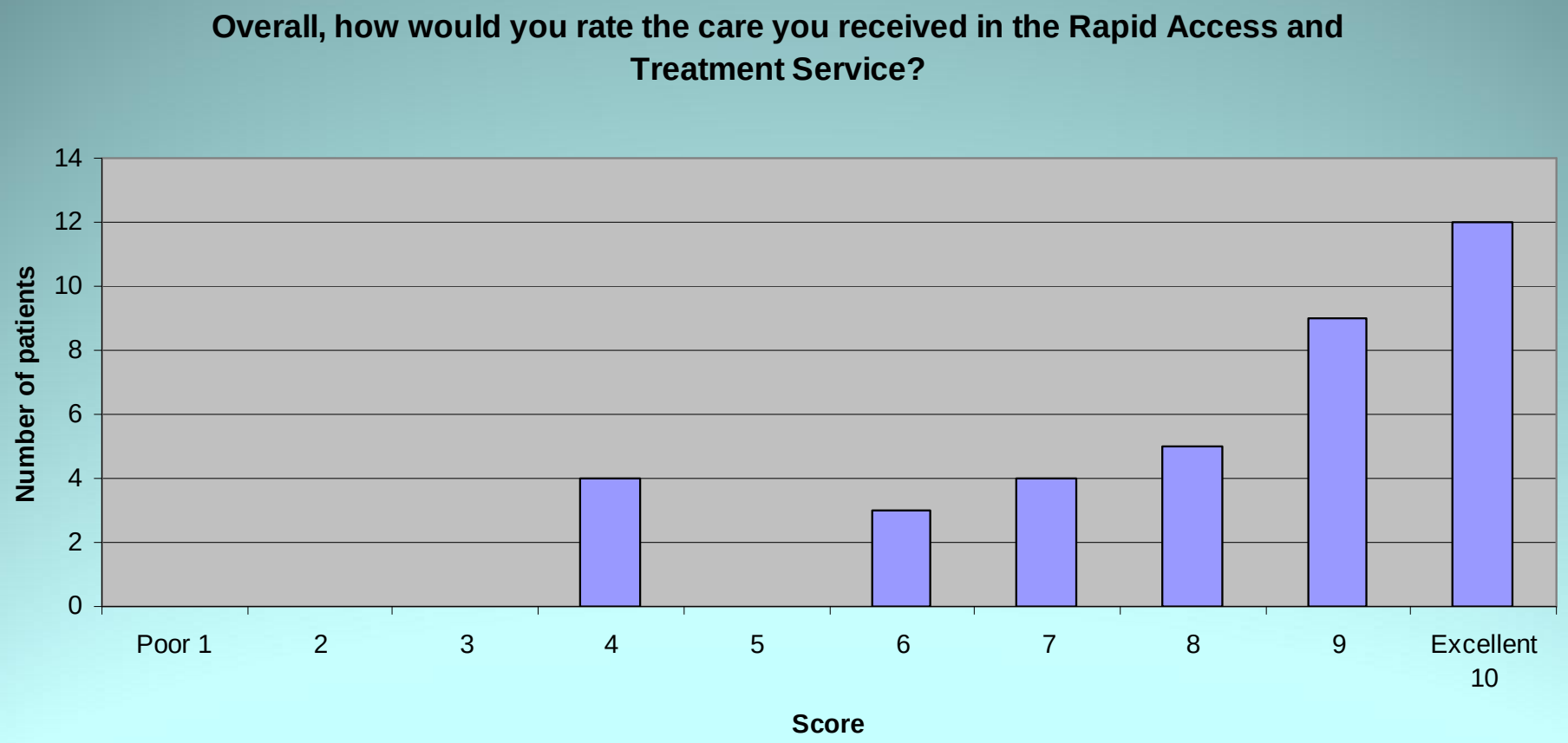


Was the main reason for your Rapid Access and Treatment Service visit dealt with satisfactorily?



Was the main reason for you Rapid Access and Treatment service visit dealt with satisfactorily?

- Considering I saw the GP on the 15th, I was amazed to see a doctor the next day
- Waiting for an appointment at pain clinic
- Yes at the time!
- Remains to be seen with follow up
- Still waiting for nurse to reply to my query - other hospitals were involved in prognosis
- Apart from initial delay
- immediately with a call back appointment
- very prompt
- could not have been better
- Rheumatology Nurse gave me 100% treatment and the doctors and the dept


Overall, how would you rate the care you received in the Rapid Access and Treatment Service?
Number of patients
14
12
10
8
6
4
2
0
Poor 1
2
3
4
5
6
7
8
9
Excellent 10
Score

Other Comments

- service & help by everyone in department
- The treatment of staff and service was very good
- Waiting to be seen by Pain clinic. Still in great pain.
- I was most impressed by the kindness and thoroughness of the doctors.
- I consider I received good care especially as the department is working under great difficulties, and I am confident that your new venue will give you more space
- Not a reflection on the doctor, but the dreadful cramped accommodation
- Excellent treatment from all staff concerned
- The whole experience was very stress free and straight forward, congratulations
- When other hospitals Departments are involved - questions/answers seem to take a long time as I am still waiting for a solution to my immediate problem, I expect everyone is very busy!
- The care/service was excellent
- Excellent care received once I got to speak to someone- GP could not help- had to ring consultant's secretary as needed assistance- He then phoned me
- Top class treatment
- Very satisfactory, I would like to thank all nurses who are great and understanding
- I think all the staff give 100% under difficult working condition
- All staff are very friendly and bend over backward to accommodate us
- It was very helpful- especially regarding the new medication that was mentioned ie side-effects and consequence of using it. Also good information re blood tests results.
- All helpful, friendly and polite

View of Portsmouth 1812

Portsmouth

2009