

NICE impact

Arthritis



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Zoë Chivers, Director of Support and Services at Versus Arthritis, considers NICE's role in improving outcomes for people with arthritis.

Arthritis and other musculoskeletal conditions impact over 20 million people in the UK and affect every aspect of a person's life including their mental, social and financial wellbeing. There are significant health inequalities associated with arthritis, with women and those

living in areas of high deprivation being most impacted.

Arthritis is also a major component of multimorbidity, and the loss of mobility and dexterity can prevent people managing their health and maintaining their independence.

Timely diagnosis, treatment and self-management support can enable people with arthritis to maintain their health and quality of life. NICE guidance plays a vital role in setting high standards for the care patients should receive, and ensuring it is implemented effectively.

Why focus on arthritis?

Arthritis is an umbrella term encompassing conditions in which there is pain, swelling and stiffness in the joints. Since 2001, we have published a [suite of guidance and advice covering the diagnosis and management of different types of arthritis](#).



20 million

people in the UK live with arthritis or another musculoskeletal condition (Source: [Global Health Data Exchange](#), 2019)



28 million

working days lost each year due to musculoskeletal conditions in the UK (Source: [Office for National Statistics, Sickness absence in the UK labour market dataset](#), 2018)



£120 billion

estimated cost of osteoarthritis and rheumatoid arthritis to the NHS over the next decade Source: [Versus Arthritis, State of Musculoskeletal Health](#), 2021

In this report, we look at the uptake and impact of our guidance on osteoarthritis, rheumatoid arthritis (RA) and spondyloarthritis (SpA). Topics covered were identified as priorities during discussions with stakeholders, and highlight both successes and areas for improvement in arthritis care.

We recognise throughout the report that the health and social care system is complex and there are many factors that influence changes in practice and outcomes, including increased uptake of NICE guidance. We work with partners to support these changes.

We have published

3

guidelines

1

COVID-19
rapid guideline

3

quality
standards

33

technology
appraisals

16

interventional
procedures
guidance

Osteoarthritis

Osteoarthritis refers to a condition where there is joint pain accompanied by functional limitation and reduced quality of life. It mainly affects people over the age of 45, and is more common in women, people living in areas of high deprivation, and people with obesity. Osteoarthritis is a long-term condition, but it doesn't always get worse, and symptoms can gradually improve with effective treatment and support. ([Versus Arthritis: State of Musculoskeletal Health](#), 2021)



8.5 million

people are living with osteoarthritis in the UK

Source: [Global Health Data Exchange](#), 2019

Our [guideline on osteoarthritis](#) recommends that adults aged 45 or over should be diagnosed with osteoarthritis clinically without investigations if they have activity-related joint pain and either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

The primary treatments for osteoarthritis are non-surgical, and include lifestyle changes, supportive therapies and medication to relieve pain. In some cases, when other treatments have not helped or the joint pain or functional limitation is severe, surgery can repair, strengthen or replace a damaged joint.



“There is a real opportunity to develop and improve the data we collect on musculoskeletal conditions in primary and community settings, to help us plan and deliver effective integrated care. Having a clear understanding of what we are doing and its effectiveness is key to developing musculoskeletal services”

Chris Mercer, Consultant physiotherapist, Clinical Lead for the Primary Care and Community Workstream, BestMSK Health Programme

Non-surgical management

After diagnosis of osteoarthritis, people should have an assessment that covers pain, impact on daily activities and quality of life. This assessment helps to support self-management by focusing on individual goals and preferences, allowing healthcare professionals to provide holistic patient-centred advice and support. Self-management is an important area of focus in our [guideline and quality standard on osteoarthritis](#).



4 in 5

people with osteoarthritis have at least 1 other long-term condition, such as cardiovascular disease or depression

Source: [Versus Arthritis, State of Musculoskeletal Health, 2021](#)

Before consideration of or referral for joint surgery, we recommend that adults with osteoarthritis should be supported with non-surgical core treatments for at least 3 months. Core treatment options include providing information to support a better understanding of the condition, muscle strengthening and aerobic exercise, and interventions to achieve weight loss for people who are overweight or obese.

These treatments support people to manage their condition and can help to relieve symptoms. Ensuring that they are tried before referral for surgery may reduce unnecessary referrals. Those people who do have surgery are more likely to have better long-term outcomes if core treatments have been given preoperatively.

Implementation of non-surgical treatment options

[The Central London Community Health NHS Trust](#) set up a healthy knee group to provide education to people with knee osteoarthritis who have been referred to physiotherapy by their GP. After attending, 77% of people were happy to self-manage their condition and only 10% needed further review with a physiotherapist.

[The Staffordshire and Stoke on Trent Partnership NHS Trust](#) set up a 6-week programme focusing on personalised education and exercises to improve strength and fitness. After attending this programme, 52% of people reported reduced pain scores and 95% had improvement in at least 1 functional measure.

Surgical management

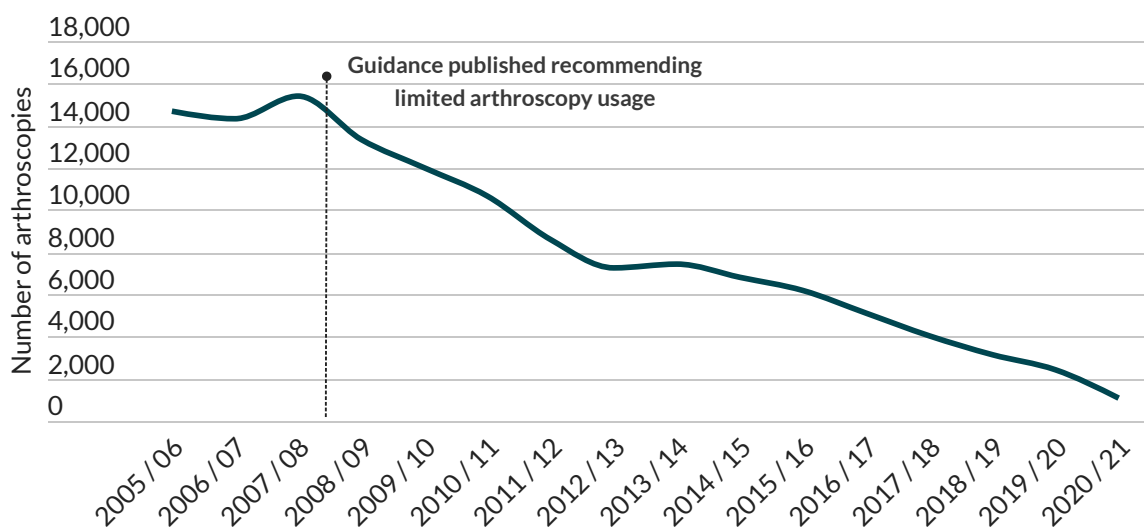
When a person with osteoarthritis has severe pain that is significantly affecting their life, and other treatments have been explored, they may be referred to an orthopaedic surgeon for consideration of joint surgery. This is usually done on the hip and knee joints.

Knee arthroscopy

Knee arthroscopy is keyhole surgery in which the knee joint is flushed to remove fluid and loose bodies (lavage), or broken-down bone and cartilage (debridement). Our guideline on osteoarthritis recommends that this surgery should only be offered under very limited circumstances; when a person has knee osteoarthritis with a clear history of mechanical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies). This is based on clear evidence that arthroscopy is not a clinically effective intervention for most people with osteoarthritis.

There has been a significant drive to reduce the number of unnecessary knee arthroscopies done in the NHS. In 2018, NHS England launched the [Evidence-Based Interventions \(EBI\) programme](#), which uses NICE guidance to identify treatments that are no longer appropriate. The EBI programme aims to reduce the number of inappropriate interventions, to improve the quality of care, and to free up clinical time. Based on our guidance, knee arthroscopy for osteoarthritis is included as a 'category 1' intervention, meaning it should not be routinely commissioned or performed.

The number of knee arthroscopies for adults with osteoarthritis has decreased since 2008, when we published guidance recommending limited arthroscopy usage



Source: [NHS Digital, Hospital Episode Statistics](#)

The [Getting It Right First Time \(GIRFT\) Orthopaedics follow-up report](#) shows that there has been a progressive year-on-year reduction in the proportion of knee arthroscopies which are followed by a full knee replacement within a year. This is a clear indication that there has been a reduction in the number of inappropriate knee arthroscopies being done. Since 2014, there have been over 2,900 fewer arthroscopies requiring subsequent knee replacement, resulting in costs savings of £5.9 million.

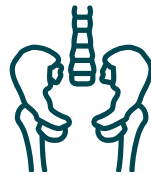
Joint replacement

Joint replacement surgery is when the knee, hip or other joint is fully or partially replaced with an artificial joint. Osteoarthritis is the main reason for joint replacement surgeries in the UK, although most people with osteoarthritis of the hip or knee will not need surgery.

Osteoarthritis was the sole indication for ...



97%
of primary knee
replacements



88%
of primary hip
replacements

... between April 2003 and December 2020

Source: [National Joint Registry Annual Report, 2021](#)

Rehabilitation before and after a joint replacement operation can greatly affect surgical outcomes. Engagement with rehabilitation services before surgery can help prepare people for surgery, increase their ability to manage any complications of surgery, and promote understanding of and engagement with rehabilitation services after surgery. After surgery, prompt self-directed or supervised rehabilitation can reduce the length of stay in hospital, improve surgical outcomes and deliver greater savings.

Our [guideline on primary joint replacement](#) recommends that people who have had a primary elective hip, knee or shoulder replacement should be offered rehabilitation by a physiotherapist or occupational therapist. This should be offered on the day of surgery if possible and no more than 24 hours after surgery. Other recommendations cover self-directed rehabilitation before discharge and providing more support if this does not meet the person's goals.

The 2020 [GIRFT Orthopaedics follow-up report](#) highlights that, since the original 2015 [GIRFT Orthopaedic report](#), there has been a recognition from trusts of the need to invest in physiotherapy to improve quality of care, deliver improved patient outcomes, and make long-term savings.

Many trusts are now investing in physiotherapy services. However, there is still room for improvement; 38% of trusts reported that all people having a total knee replacement receive a multidisciplinary assessment before their surgery to determine achievable rehabilitation goals. Similarly, a third of trusts reported that, as routine practice, all people having a full knee replacement have a follow-up with a specialist physiotherapist within 3 weeks to assess postoperative progress. ([GIRFT, Orthopaedics follow-up report](#), 2020)

The cancellation and delay of elective surgeries during the COVID-19 pandemic has had a significant effect on people awaiting joint surgery. [NHS England's Referral to Treatment figures](#) show that the number of people waiting for trauma and orthopaedic surgery increased by 53% from 460,595 in April 2020 to 704,170 in October 2021.

Insight from Zoë Chivers

Long-term management of osteoarthritis requires a holistic approach to providing care. Musculoskeletal conditions are under-recognised in both the undergraduate and postgraduate training, and consequently, GPs often lack confidence in delivering this care.

The [decision support tools](#) developed by Versus Arthritis and endorsed by NICE are designed to help doctors and

patients make informed shared decisions about treatment.

Lack of access to community services, like peer support and mental health services, also makes supporting effective self-management challenging. The increasing prevalence of risk factors like obesity and the impact of COVID-19 means that demand for these services is likely to increase further.

Diagnosis and referral of inflammatory arthritis

Inflammatory arthritis is a collective term for a group of conditions, including rheumatoid arthritis (RA) and spondyloarthritis (SpA), that cause inflammation of the tissues around affected joints. RA is an autoimmune condition, where the body's immune system mistakenly attacks the joints. SpA refers to several inflammatory conditions with shared features. These are further divided into those that most commonly affect the spine, termed axial SpA, and those that primarily affect other areas as well as joints, such as psoriatic arthritis (skin) and enteropathic arthritis (bowel), termed peripheral SpA.



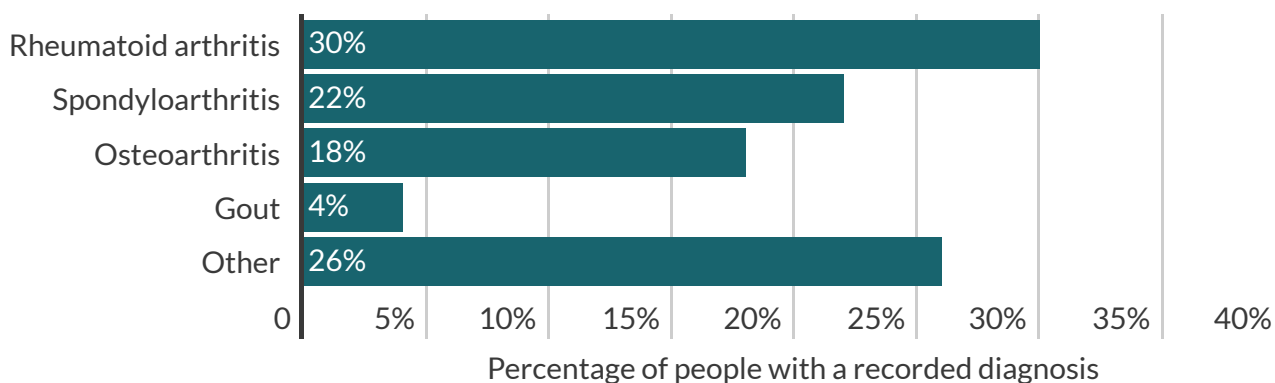
390,000

people are living with rheumatoid arthritis in the UK

Source: [Global Health Data Exchange](#), 2019

Inflammatory arthritis has a range of genetic and environmental risk factors. RA onset peaks between 40 and 60 years of age, and is more common in women, people who smoke, and people who are obese. Axial SpA usually begins between 20 and 30 years of age, is equally common in men and women, and can be more severe in people who smoke. ([Versus Arthritis, State of Musculoskeletal Health](#), 2021)

Diagnoses of people referred into rheumatology with suspected inflammatory arthritis



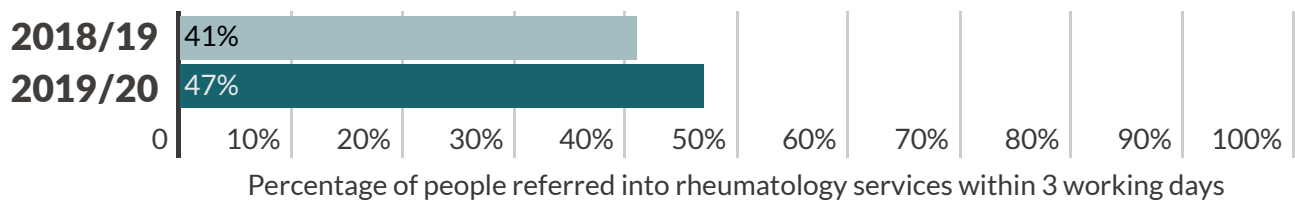
Source: [British Society for Rheumatology, NEIA Audit](#), 2020

Early diagnosis of inflammatory arthritis is an important factor in determining long-term patient outcomes, as symptoms can be greatly reduced or completely remitted with early treatment. Recommendations on the referral and diagnosis of inflammatory arthritis are included in our [guideline on RA](#) and [guideline on SpA](#).

To ensure an accurate and timely diagnosis, our [quality standard on RA](#) states that adults with suspected persistent joint inflammation (synovitis) in more than 1 joint, or the small joints of the hands and feet, should be referred to rheumatology services within 3 working days of presenting in primary care. Similarly, our [quality standard on SpA](#) states that adults with suspected axial or peripheral SpA should be referred to a rheumatologist.

Data from the 2020 [British Society for Rheumatology National Early Inflammatory Arthritis \(NEIA\) Audit](#) shows that the proportion of people with suspected early inflammatory arthritis (EIA) in England and Wales that were referred into rheumatology services within 3 working days increased between 2019 and 2020.

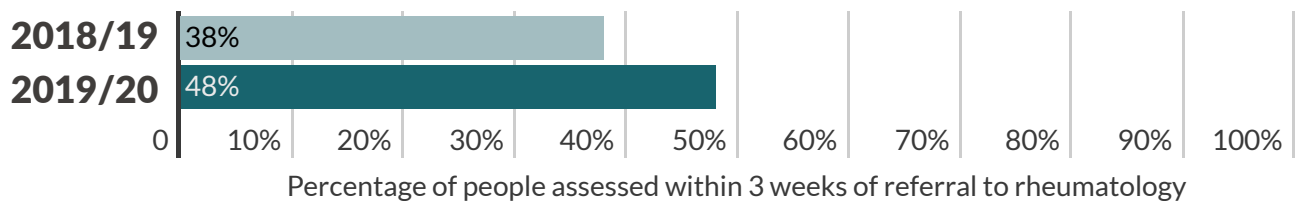
The proportion of people with suspected persistent joint inflammation that were referred into rheumatology services within 3 working days has increased



Source: [British Society for Rheumatology, NEIA Audit, 2020](#)

Once referred, people with suspected persistent joint inflammation should be assessed in a rheumatology service within 3 weeks. Data from the 2020 NEIA audit shows that the number of people referred with suspected EIA being assessed in rheumatology within 3 weeks has increased.

The proportion of people with suspected persistent joint inflammation assessed in rheumatology services within 3 weeks of referral has increased



Source: [British Society for Rheumatology, NEIA Audit, 2020](#)

Delayed referral for axial spondyloarthritis

Axial SpA is a progressive form of inflammatory arthritis that mainly affects the spine, causing stiffness and pain in the lower back and hips. Improving the recognition and referral of axial SpA is important because starting treatment quickly limits damage to the spine and joints, reducing the long-term impact of the disease.



220,000

people are living with axial spondyloarthritis in the UK

Source: [Versus Arthritis, State of Musculoskeletal Health, 2021](#)



24 years

average age of symptom onset

Source: [APPG for Axial SpA Report, 2020](#)



8.5 years

average delay between symptom onset and diagnosis

Source: [APPG for Axial SpA Report, 2020](#)

Our [guideline on SpA](#) and our [quality standard on SpA](#) provide a framework for the commissioning and provision of services for people with axial SpA, as well as other forms of SpA. The 2020 [All-Party Parliamentary Group \(APPG\) for Axial SpA report, Axial Spondyloarthritis services in England, A National Enquiry](#) looks at progress towards implementing our guidance.

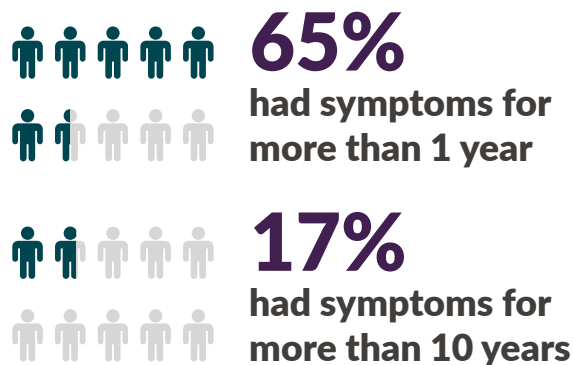


“I saw every healthcare professional you can think of – osteopaths, physios, rheumatologists... I had MRIs, X-rays, blood tests... If I knew then, what I know now about axial spondyloarthritis, I’d have known straight away that it’s what I had. My symptoms were textbook. Eventually, an MRI scan picked up on fusion in my spine and a rheumatologist diagnosed axial SpA”

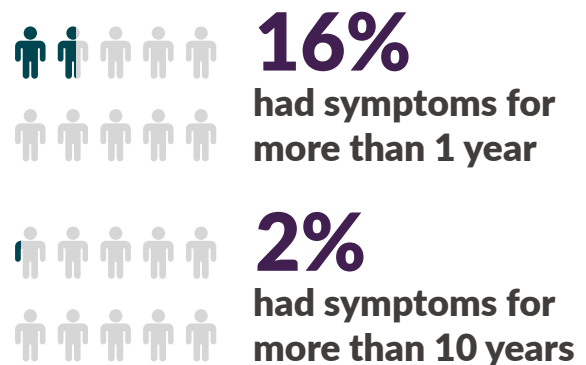
Talia, who had a 15-year delay to diagnosis

Diagnostic delay is common for people with axial spondyloarthritis

Axial spondyloarthritis



Rheumatoid arthritis



Source: [Russell et al, Rheumatology, 2021](#)

We recommend that adults with suspected axial SpA should be referred to a rheumatologist, indicating the need for a specific referral pathway from primary to secondary care for inflammatory back pain. The APPG for axial SpA report shows that only 21% of clinical commissioning groups (CCGs) have a specific pathway in place. Some CCGs indicated that they had alternative arrangements, such as referral to musculoskeletal triage services, however this could increase time to diagnosis.

It is also important that commissioners have programmes to raise awareness of the signs and symptoms of axial SpA in primary care, as recommended by NICE. However, of the 44% (85/191) of CCGs that responded, only 34% (29/85) had these programmes in place.

Insight from Zoë Chivers

Early diagnosis and intensive treatment for inflammatory arthritis is key to improving long-term outcomes and the patient experience. Currently only 48% of patients referred for suspected early inflammatory arthritis are seen within 3 weeks.

Failure to recognise the signs and symptoms of inflammatory arthritis in primary care, combined with a lack of urgent referral to specialist care,

lead to delays in accessing specialist care. Workforce shortages across rheumatology, and significant regional variations in staffing levels, are also leading to unnecessary delays in assessment and diagnosis, which can result in worse patient outcomes. Shortages also make it harder to provide the treatment needed to achieve remission and prevent long-term disability.

Management of inflammatory arthritis

All forms of inflammatory arthritis have similar management strategies coordinated through a multidisciplinary team. Pharmacological treatments are prescribed to relieve painful symptoms and to slow or stop disease progression, thereby limiting future impairment. We recommend that treatment teams should provide ongoing support by promoting self-management through education, coordinating regular reviews, and ensuring access to urgent advice.

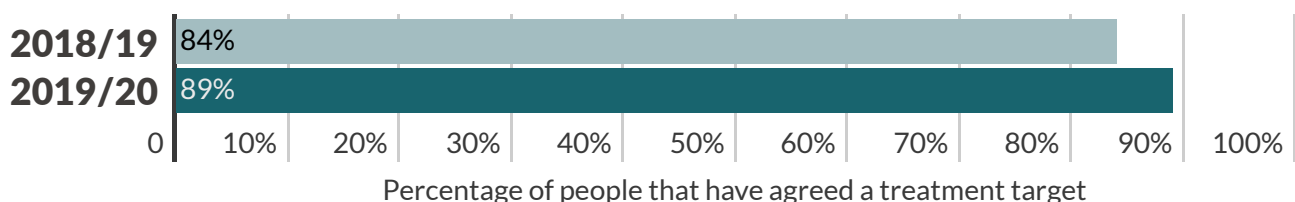
Pharmacological management

Since 2001, we have published over 30 [technology appraisals of medicines for treating inflammatory arthritis](#), meaning people with inflammatory arthritis now have more treatment options. Recent changes in the cost of some medicines to the NHS mean that many more people with inflammatory arthritis now have access to innovative biological medicines.

Starting treatment

Our [guideline on RA](#) recommends treating active RA in adults with the aim of achieving a defined target of remission, or low disease activity if remission cannot be achieved. This approach is called 'treat-to-target'. Data from the [British Society of Rheumatology's National Early Inflammatory Arthritis \(NEIA\) Audit](#) show that most people with RA have a personal treatment target set and agreed.

The proportion of people with rheumatoid arthritis who have had a treatment target agreed has increased

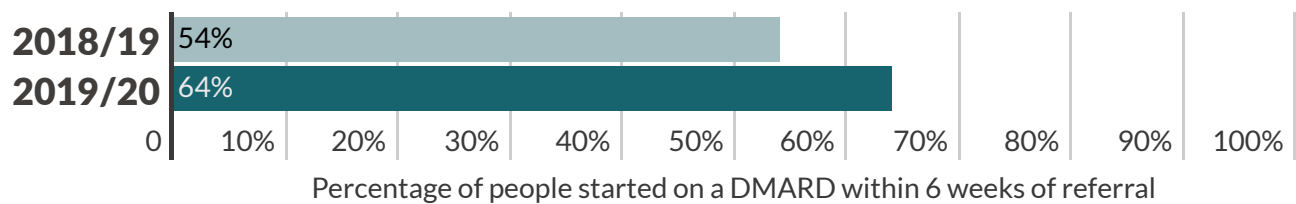


Source: [British Society for Rheumatology, NEIA Audit, 2020](#)

Our [quality standard on SpA](#) states that people with suspected SpA should be referred to a rheumatologist to reduce delays in diagnosis and starting treatment.

Our [quality standard on RA](#) states that adults with active RA should start treatment within 6 weeks of referral, with monthly monitoring until their treatment target is met. This is important because delaying therapy is linked to worse functional impairment, irreversible damage to joints and a lower chance of achieving sustained disease remission.

The proportion of people with early inflammatory arthritis who were started on a disease-modifying antirheumatic drug (DMARD) within 6 weeks of referral has increased



Source: [British Society for Rheumatology, NEIA Audit, 2020](#)

Disease-modifying antirheumatic drugs

For most people with RA and peripheral SpA, we recommend initial treatment with a conventional disease-modifying antirheumatic drug (DMARD), such as methotrexate. For axial SpA we recommend offering a non-steroidal anti-inflammatory drug (NSAID), such as ibuprofen, followed by a DMARD for people whose disease has responded inadequately. Unlike NSAIDs, DMARDs treat the disease, rather than minimising symptoms.

In recent years, many more innovative medicines have become available for people whose arthritis has not responded well enough to first-line treatments. These synthetic and biological DMARDs are more targeted and many work more quickly than conventional treatments.

To achieve their treatment target, a person may have to try multiple conventional and biological DMARDs with different mechanisms of action. In 2020, we updated the [treat-to-target section of our RA guideline](#) to clarify that people can have multiple treatments one after the other to achieve their treatment targets.

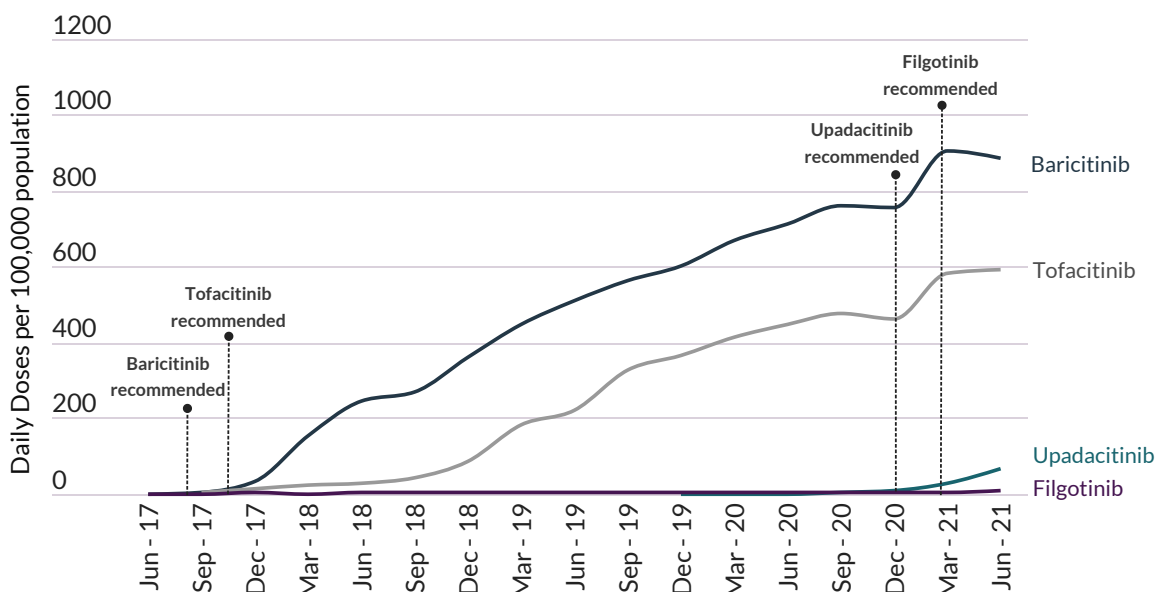
Many of the most commonly prescribed biological DMARDs, such as adalimumab and etanercept, belong to a class of medicines called anti-tumour necrosis factor (TNF) inhibitors. Anti-TNF inhibitors have been approved as a treatment for RA, axial SpA and peripheral SpA.

More recently, we have recommended medicines such as baricitinib and tofacitinib to treat RA and some types of peripheral SpA. These belong to a class called Janus kinase (JAK) inhibitors, and target a different part of the immune pathway. This means that people who either cannot tolerate conventional DMARDs and anti-TNF inhibitors, or whose treatment targets have not been met while having them, might still benefit from JAK inhibitors.

Another consideration is that JAK inhibitors are given in tablet form, unlike most other treatments, which are given by injection or infusion. This may make them more convenient for people to take at home. During the coronavirus pandemic, we published a [COVID-19 rapid guideline on rheumatological autoimmune, inflammatory and metabolic bone disorders](#). It recommends that healthcare professionals should think about whether changes in people’s medicines might be needed during the pandemic, including dosage, route of administration and mode of action.

Since first becoming available, prescribing of JAK inhibitors recommended by NICE has steadily increased. Some of these medicines are also recommended for treating other inflammatory conditions. For example, baricitinib is recommended for treating atopic dermatitis and tofacitinib for ulcerative colitis.

Prescribing of Janus kinase (JAK) inhibitors has increased since baricitinib and tofacitinib were recommended in 2017



Source: [NHS Digital, NICE technology appraisals in the NHS in England](#)

Transitioning to biosimilars

Over the last 20 years, biological medicines have transformed the treatment of inflammatory arthritis, but are much more expensive than conventional treatments. Since 2002, we have recommended several biological treatments for arthritis, helping to ensure fair and equitable access to these high-cost medicines.

Biological medicines are currently the largest cost and cost growth area across the NHS medicines budget. In particular, the cost of biological medicines prescribed to treat inflammatory arthritis is among the highest pharmaceutical cost within many trusts.

Biosimilars are biological medicines that are very similar and clinically equivalent to an existing medicine, but much cheaper. Biosimilars can only be made once the patent has expired on the original licensed medicine. Since 2015, we have, when possible, [considered biosimilars alongside the original biological medicine](#) when approving new treatments. Using a new [commissioning framework](#), NHS England is transitioning towards the use of biosimilar medicines.



£83 million

reduction in rheumatology drug spending between 2017 and 2019, largely driven by the switch to biosimilars

Source: [Getting it Right First Time \(GIRFT\), Rheumatology report](#), 2021

The increasing availability of biosimilar versions of biological medicines has led to estimated cost savings of close to £300 million per year for the NHS. Adalimumab, which is used to treat multiple inflammatory conditions, including arthritis, was the most expensive single medicine for hospitals at a cost of more than £400 million per year. This was recently switched to a biosimilar, leading to savings of over £100 million per year. ([NHS England, News](#), 2019)

As a direct result of these cost savings, we are now able to [recommend several biological treatments](#) to around 25,000 people with moderate RA that has not responded to conventional therapies. These treatments were previously only [recommended for severe RA](#).

Organisation of care

We recommend that adults with RA or SpA should have ongoing access to a range of services and specialists in multidisciplinary teams. This should provide opportunity for periodic assessments of the effect of the disease on their lives (such as pain, fatigue, mobility, ability to work, impact on relationships and quality of life) and help them to manage their condition.

These multidisciplinary teams should include:

- specialist physiotherapy
- podiatry services
- occupational therapy
- psychological services.



“My experience of over 20 years under the care of the same rheumatology consultant gave me confidence in both the medical support and therapy that I received. I believe this continuity and knowledge of my particular circumstances enabled me to stay in employment and secure a successful career, that I may not have otherwise found without this support.”

Person with arthritis, on their experience of a rheumatology coordinated annual review

Of the 118 trusts that provided information to the [British Society for Rheumatology National Early Inflammatory Arthritis \(NEIA\) Audit](#), 93% provided access to physiotherapy, 76% to podiatry services, 95% to occupational therapy services, and 38% to psychological services. Specialist clinics were also available in many departments, with 77% providing early arthritis clinics, and 44% of trusts providing a dedicated axial SpA clinic. ([APPG for Axial SpA Report](#), 2020)

As part of their ongoing care, adults with RA should have a comprehensive annual review. Our [quality standard on RA](#) states that this should be coordinated by rheumatology services. Data from [NHS Digital's Quality and Outcomes Framework](#) (2020 data) indicates that 81% of people with RA on a GP register had a face-to-face review in the previous 12 months.

However, the NEIA audit shows that only 48% of people with a diagnosis of RA were reported to have had an annual review 12 months after diagnosis. The proportion of people having this first annual review also showed large regional variation, ranging from 15% in London to 65% in the Northeast.

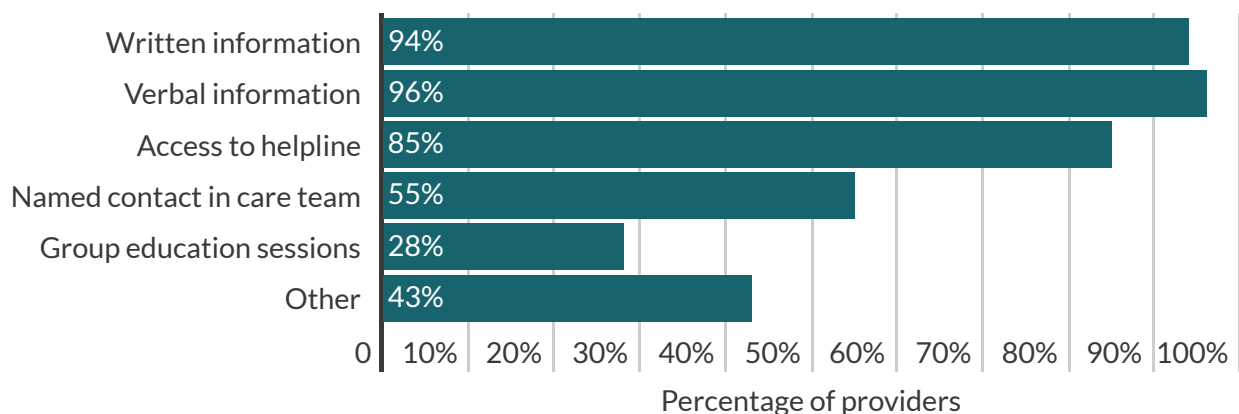
Education and support

It is important that adults with inflammatory arthritis have a good understanding of their condition and its management. This will empower them to be more involved in shared decision making, to better manage pain, disease flares and fatigue, and to improve their quality of life.

To encourage this, we recommend that adults with RA should be given opportunities throughout the course of their disease to take part in educational activities that support self-management. Information provided by rheumatology departments for the NEIA audit indicates that 96% of people diagnosed with early inflammatory arthritis were offered access to education and information on self-management.

We also recommend that adults with SpA should be given information about their condition, which healthcare professionals will be involved with their care, and how and when to get in touch with them.

Information and support is provided in a number of ways following a diagnosis of axial SpA



Source: [APPG for Axial SpA Report, 2020](#)

Shared decision making is of particular importance when deciding on the appropriate medicine to manage someone’s condition. Most people will be unfamiliar with the benefits and risks of biological medications and will need guidance before making an informed choice. Information on shared decision making is included in our [shared decision making guideline](#).

We recommend that the choice of treatment for axial SpA should be made after discussion between a person and their clinician about the advantages and disadvantages of the available treatments. All trusts have reported that they offer some form of guidance before offering biological treatment, with the majority (56%) providing information through clinic appointments. ([APPG for Axial SpA Report](#), 2020)

While it is encouraging to note such high levels of information and support provision being reported by trusts, there are still areas for improvement. An unpublished survey done by arthritis advocate groups in 2019 showed that only 41% of people said that their consent was sought when switching treatments from an originator medicine to a biosimilar version. This may suggest differing perspectives from clinicians and patients on the level of support and information provided. ([APPG for Axial SpA Report](#), 2020)

Living with a long-term condition: mental health and wellbeing

People with long-term physical conditions such as arthritis have a higher rate of mental health conditions. In England, 14% of all people report feeling anxious or depressed, which rises to 24% in people with a long-term musculoskeletal condition ([Public Health England, Musculoskeletal Conditions](#)).

We have published a [guideline on the recognition and management of depression in adults with a chronic physical health problem](#). We have also published a [guideline on primary and secondary chronic pain](#), which recognises that the experience of pain is always

influenced by social, emotional and biological factors.

The [NHS Long Term Plan](#) aims to continue the expansion of Improving Access to Psychological Therapies (IAPT) services for adults and older adults with common mental health disorders, with a focus on those with long-term health conditions. To help meet this goal, we worked with NHS England to produce [advice on digitally enabled therapies for use in IAPT services](#), with the aim of expanding the provision of psychological therapies and improving access to digital services.

Managing disease flares

It is important that adults with inflammatory arthritis who experience disease flares can quickly access rheumatology services for advice. We recommend that adults with RA having disease flares or treatment-related side effects should receive advice within a day of contacting rheumatology services.

Encouragingly, over 92% of people with a diagnosis of RA were provided with access to rheumatology specialist advice. However, emergency advice (within 24 hours) was only available in 50% of trusts. ([British Society for Rheumatology, NEIA Audit, 2020](#))



“I’ve realised as a long-term patient I need to ask my questions as well as listen carefully to options presented. This helps me to make an informed choice of treatment to support my body at a time of flare which in turn helps strengthen my mental health ready to live through the more difficult times. I find now I recover more quickly from a flare-up each time I experience one”

Anna, who has lived with psoriatic arthritis for 30 years

We recommend that SpA flares are managed in either specialist care or primary care depending on the person’s needs, indicating the need for a personalised care plan. Data from the APPG report shows that only 12% of providers offered a written care plan to support people with a flare. Several providers offered alternative arrangement, including verbal information or leaflets (51%), a helpline (40%), general care plans (4%) or a specialist flare clinic (4%). However, many providers (25%) did not provide a written plan, with no alternative arrangements in place. This represents an area for significant improvement.

Insight from Zoë Chivers

Managing inflammatory arthritis requires ongoing support from a multidisciplinary care team that includes specialist nurses, physiotherapists, podiatrists, occupational therapy and mental health support, as well as access to health and wellbeing services relating to smoking cessation, physical activity and nutrition.

Workload pressures mean that services are currently struggling to deliver all the specialist support needed, especially

those focused on education and non-pharmacological treatments, which makes good long-term self-management more difficult for patients.

These pressures also mean that specialists are often unable to provide advice within 1 working-day of contacting rheumatology services for disease flares or possible treatment-related side effects, in line with NICE quality standards.

What is NICE doing next?

Throughout this report we have highlighted examples showing how uptake of our guidance has contributed to improvements in arthritis care. Improvements include the reduction in referral, assessment and treatment initiation wait times for people with inflammatory arthritis and the provision of education and support for people with all forms of arthritis. We have also highlighted the transition to biosimilars and expanded access to high-cost biologic medicines, and the reduction in unnecessary knee arthroscopies for people with osteoarthritis.

While developing this report, we have engaged with the following stakeholders to identify further implementation challenges and available support across the healthcare system:

- NHS England and NHS Improvement
- Getting It Right First Time (GIRFT) programme
- All-Party Parliamentary Group (APPG) for Axial Spondyloarthritis
- Versus Arthritis
- British Society for Rheumatology
- National Axial Spondyloarthritis Society
- Chartered Society of Physiotherapy.

Stakeholders have identified the following key priority areas:



Reducing diagnostic delays for inflammatory arthritis, particularly for axial spondyloarthritis



Improving access to psychological therapies for people with long-term physical health conditions



Improving access to physiotherapy both pre- and post-surgery for people having joint replacements



Improving data collection on the diagnosis and management of osteoarthritis in primary care

We will continue to encourage implementation of our guidance and help the wider system address priority areas. To do this, we will:

- Continue to support the National Axial Spondyloarthritis Society, who work to transform the diagnosis and care of people living with axial SpA. We will support their initiatives by contributing to the development and promotion of the Aspiring to Excellence and Clinical Champions programmes.
- Continue discussions with the BestMSK Health programme, who are developing primary and community MSK Transformation toolkits. We will agree options for supporting the embedding of NICE guidance within these toolkits and to support their promotion once published.
- Continue to contribute to meetings of the APPG for Axial Spondyloarthritis. We will support them in raising awareness of, and focusing discussion on, reducing delays to diagnosis and improving services for people with axial SpA.
- Work with RightCare to support the development of MSK-related scenarios, showing optimal patient pathways, by contributing to working groups and embedding NICE guidance where available.

Our partners are also doing work in these priority areas, which is underpinned by NICE guidance. For example:

- The Adult Improving Access to Psychological Therapies (IAPT) programme has been developed to increase access to evidence-based psychological therapies within the NHS. This programme includes a focus on people with long-term conditions, and should improve access for people with arthritis.
- The First Contact Practitioners (FCP) programme involves placing physiotherapists directly into GP practices to diagnose and treat patients who come into the clinic with musculoskeletal problems.

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