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National Rheumatoid Arthritis Society

# The Year of RA: One Year On

National Rheumatoid Arthritis Society
www.nras.org.uk

## Joint Foreword by the National Rheumatoid Arthritis Society and the British Society for Rheumatology

2009 was a significant year for people with rheumatoid arthritis (RA) living in the UK. Real progress was made towards improving clinical outcomes for people with RA with the publication of NICE Clinical Guideline 79[1] and the 18-week Commissioning Pathway for Inflammatory Arthritis by the Department of Health[2]. The Public Accounts Committee also took evidence[3] for a report[4] it would publish in 2010 concerning NHS services for people with RA. A variety of cross-functional and multi-disciplinary initiatives, epitomised by the work of the Rheumatology Futures Group, showed a real desire to educate patients, the public and healthcare professionals alike, to optimise rheumatology service provision in the UK and to work together to improve the quality and standard of care. Similarly, our parliamentary and political campaigning work uncovered a real appetite amongst policy-makers, politicians and other stakeholders, to work with the National Rheumatoid Arthritis Society (NRAS) to drive these changes and improve patients' lives.

However, while significant progress was being made in policy terms, both the King's Fund and the National Audit Office (NAO) published influential reports[5,6] which highlighted serious shortcomings in service provision for people with RA; and a worrying lack of awareness about RA amongst the public, health professionals and commissioners. As a result, NRAS decided to produce this report, to show the impact of these initiatives "one year on". In doing so, we have been delighted to have the support and endorsement from our professional colleagues at the British Society for Rheumatology (BSR); by working together in this way, the patient and health professional communities are stronger.

2010 is a year in which to build upon the policy developments and NHS initiatives of 2009 and to take a look at what has changed. To help inform this report, we carried out two surveys, which yielded 156 responses from consultant rheumatologists and patients with RA. The surveys were designed to find out - one year on - how these policy developments have changed the way in which services for people with RA are being commissioned or provided, and their impact on patient care – both good and bad.

The survey results - which are documented in this report - show that while there is some fantastic work going on in the field of RA, there are inconsistencies and inadequacies in the level and type of service patients are receiving, and some very worrying trends. For example, one year after the NAO report recommended it, we find it deeply worrying that that only 27% of NRAS members who responded to the surveys have access to a personalised care and management plan.

Our recommendations in this report come against the backdrop of the most radical shake-up of the NHS since its inception in 1948. The Comprehensive Spending Review (CSR)[7] has confirmed there will be a net reduction in NHS purchasing power, and a requirement to find £20 billion in productivity gains[8]. These are challenging times for the NHS and, in this age of financial austerity, it is vital that we look to maintain and protect NHS RA services. We should also seek to improve and optimise best practice to ensure consistency in service provision and patient care. As commissioners come under financial pressures to cut vital services, such as follow-up appointments, we need to ensure that short-sighted financial gains do not get in the way of a truly patient-led NHS focussed on clinical outcomes. The message here is simple – good care does not have to cost the earth.

While GP consortia will offer the opportunity to tailor local services to local requirements, the risk of exacerbating - not eliminating - the postcode lottery has never been greater. It is therefore of vital importance that national guidelines such as NICE Clinical Guideline 79 are implemented; and that third sector providers, like NRAS and the BSR, play a vital role in this respect.

The need for further education on RA for GPs is clear given their enhanced role in care delivery; and we are taking definitive action in wake of the gap left by the inadequate response from the Government to the supportive recommendation on this issue from the Public Accounts Committee. Building upon existing campaigns, such as the 'S-Factor', is vital to ensure that patients are diagnosed quickly and treated effectively.

We hope you find the report both interesting and informative; and that you will support us in our campaigning work to ensure a better life for people living with RA.

Yours sincerely

**Ailsa Bosworth,**
Chief Executive of the National Rheumatoid Arthritis Society

**Samantha Peters,**
Chief Executive of the British Society for Rheumatology

# Contents


## Section 1: 2009 The Year of RA

1.1 Introduction ..... Page 5

1.2 "Perceptions of patients and professionals on rheumatoid arthritis care" The King's Fund – January 2009 ..... Page 5

1.3 National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 79 – Rheumatoid Arthritis: the management of rheumatoid arthritis in adults - February 2009 ..... Page 6

1.4 The 18-Week Commissioning Pathway for Inflammatory Arthritis – July 2009 ..... Page 6

1.5 "Services for people with rheumatoid arthritis" The National Audit Office - July 2009 ..... Page 7

## Section 2: 2010 - The Year of RA One Year On – Views and Perspectives

2.1 Introduction ..... Page 8

2.2 Involving Patients: "No decision about me without me" ..... Page 8

2.3 Poor Understanding of Rheumatoid Arthritis ..... Page 10

2.4 Implementation of National Guidelines ..... Page 11

2.5 The Importance of the Multi-Disciplinary Team ..... Page 12

## Section 3: Case Studies

3.1 Case Study 1: The need for specialist nurses ..... Page 16

3.2 Case Study 2: The need for biologics - Jenny's story ..... Page 16

3.3 Case Study 3: Poor Understanding of RA amongst GPs – Chris' Story ..... Page 17

3.4 Conclusions ..... Page 17

## Appendices

A.1 Appendix 1: Recommendations ..... Page 19

A.2 Appendix 2: Resource and Links ..... Page 20

## Section 1: 2009 - The Year of RA

Rt. Hon. Theresa May MP, NRAS Patron, Home Secretary and Minister for Women and Equality

"The NRAS team, including its network of volunteers, medical advisers, allied healthcare professionals and members, is committed to supporting people with RA and their families.....The '2009 Year of RA' campaign aims to challenge and correct common misconceptions about RA to ensure that people experiencing symptoms such as joint pain and stiffness seek early treatment to prevent joint damage and disability later in life."

### 1.1 Introduction

In political and policy terms, 2009 was a significant year for people with rheumatoid arthritis (RA) living in the UK. The Department of Health's 18 week Commissioning Pathway for Inflammatory Arthritis documented for the first time the services and care that people with RA could expect to receive on their journey from GP referral to specialist consultation and ongoing care. The National Institute for Health and Clinical Excellence (NICE) clinical guideline 79[9] enshrined the need for a consistent approach to RA services and care across England and Wales, and introduced standards and implementation priorities for supporting and treating patients with RA. Reports from The King's Fund and the NAO, however, pointed to serious shortcomings of service provision in the NHS in England and concluded that, although much work was taking place to improve patient's lives, there was still much to be done. Various reports and initiatives in the devolved nations found a similar picture and delivered similar conclusions[10,11].

This section outlines the key policy developments that were introduced in 2009; and provides the background to Section 2, which discusses what impact these developments have had on RA service provision and care.

### 1.2 "Perceptions of patients and professionals on rheumatoid arthritis care "The King's Fund – January 2009[12]

Commissioned by the Rheumatology Futures Project Group, and published in January 2009, The King's Fund report into perceptions of RA care concluded that there was an "unacceptably wide variation" in the nature and quality of care available to the people with RA in England. Research found that despite the chronic and debilitating nature of the illness, the availability and take-up of systematic guidance for professionals about the appropriate care pathway for RA patients remained limited. Moreover, patients with RA struggled to access care; and RA was often perceived as being in the shadow of other more common long-term conditions. The report also concluded that medical education should play a role in increasing the awareness of future GPs about RA, citing medical professionals who said that RA is "given minimal attention and [is] often lost in the focus on orthopaedics."

The King's Fund report identified the following areas of particular concern:

- **Variations in RA care standards and access to multi-disciplinary teams**
- **Knock-on effects of Government's 18 week referral target**
- **Poor clinical understanding about RA**
- **Importance of clinically-led commissioning of RA services**

**Calls to action made by the Rheumatology Futures Project Group**

As a result of the King's Fund report, the Rheumatology Futures Group published a series of recommendations to policy-makers and politicians:

1. **The Department of Health must improve education on RA for primary care healthcare professionals to ensure rapid referral for treatment and supportive long-term care.**

### What is the Rheumatology Futures Group?

The Rheumatology Futures Group is a not-for-profit consortium of the main patient, professional and pharmaceutical organisations involved in RA care. Members are Arthritis Care, the Arthritis and Musculoskeletal Alliance, the National Rheumatoid Arthritis Society, the National Ankylosing Spondylitis Society, St Albans Primary Care Trust, British Health Professionals in Rheumatology, the British Society for Rheumatology, Primary Care Rheumatology Society, Royal College of Nursing, Royal College of Physicians, Abbott Laboratories, Bristol Myers-Squibb, Roche, Schering-Plough (now MSD), UCB Pharma, Wyeth Laboratories (now Pfizer), Helen Johnson Consulting Limited.

- The Department of Health should foster a strong ethos that encourages individualised care plans, as recommended by Lord Darzi's Next Stage Review[13], to provide social, psychological and lifestyle advice in addition to clinical support.
- Greater integration of knowledge about patient treatment is needed between primary care teams and specialist professionals to enable and support patient self-management.

**2. The Department of Health must develop a commissioning pathway for RA with supporting toolkit to ensure robust and consistent standards of care throughout the patient journey.**

- Full implementation of the NICE guideline is needed to end the striking gulf in the quality of RA care and access to multidisciplinary teams (MDTs) and to ensure universally high standards of care, enable patient self management and reduce the long-term costs of RA to individuals, the NHS and society.
- A more comprehensive system of recording activity and coding data on RA patients who receive care is needed to capture the number of admissions through different specialist areas of the NHS for co-morbidities, such as cardiovascular disease. This will provide a greater understanding of the true economic and social costs of RA to the NHS and patients.
- This recommendation could be complemented by more widespread and innovative clinician-driven leadership by specialists in the commissioning process to improve the patient journey for RA patients.

### 1.3 National Institute for Health and Clinical Excellence Clinical Guideline 79 – Rheumatoid Arthritis: the management of rheumatoid arthritis in adults – February 2009[14]

NICE Clinical Guideline 79 was published in February 2009 and provides guidance for the NHS in England and Wales on how best to identify and diagnose RA, which treatments and therapies are effective, and when surgery should be considered. Amongst its many recommendations, NICE listed four areas for priority implementation:

1. *Early referral to a specialist*
2. *Monitoring disease activity*
3. *Access to a multi-disciplinary team*
4. *Access to biologic therapies*

### 1.4 The 18-Week Commissioning Pathway for Inflammatory Arthritis – July 2009[15]

In July 2009, The Rheumatology Futures Group and the Department of Health launched a new 18-week commissioning pathway for inflammatory arthritis (IA). This met one of the primary recommendations of the King's Fund report. The pathway was developed by the Rheumatology Futures Group with the help of healthcare professionals, patient and professional organisations. The IA commissioning pathway which was subsequently endorsed by the DH and launched on the 18 weeks website, formed part of a package of more than 50 pathways, spanning a wide range of conditions and diseases, which had been developed as part of the Department of Health's 18-week initiative.

Compliance with the 18-week target formed part of the NHS performance management framework under the previous Labour administration. Disappointingly, however, in the revised Operating Framework for the NHS in England 2010/11[16], the

### Early Day Motion 1584 – King's Fund Report on Rheumatoid Arthritis: Janet Dean MP – 51 Signatories

'That this House recognises the findings of the King's Fund report Perceptions of patients and professionals on rheumatoid arthritis care, commissioned by the Rheumatology Futures Project Group; notes with concern wide variations in the standards of care for patients with rheumatoid arthritis, poor implementation of service redesign, insufficient clinical involvement in the commissioning process and a limited, understanding of the disease and the needs of patients; recognises the improvements in initial access to care for patients brought about by the introduction of the 18-week waiting time target, but notes that further improvements in access to care need to be made throughout the patient pathway; and calls on the Department of Health to take steps to encourage NHS organisations to improve education and training of primary healthcare professionals to ensure rapid referral for treatment and supportive care and to publish without delay a commissioning pathway for inflammatory arthritis, together with a supporting toolkit to ensure robust and consistent standards of care throughout the patient journey.'

Coalition Government has now dropped this requirement with immediate effect:

*"NHS organisations have made significant improvements in access to elective care. Average waiting times now need to be reduced, in line with international experience. Accountability to patients and greater information transparency, through patient choice and the move towards GP-led commissioning, should now make long waits unacceptable. Performance management of the 18 weeks waiting times target by the Department of Health will cease with immediate effect."*[17]

The elective care commissioning pathways are still available on the Department of Health's website on the basis that the principles of good practice remain relevant and so they continue to be made available for the use of the NHS. The pathways can currently be found at:-

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121431

### 1.5 "Services for people with rheumatoid arthritis" The National Audit Office, July 2009[18]

"Patients with this debilitating and distressing disease are not identified or treated quickly enough and this dramatically affects long-term outcomes and people's ability to remain in work. The NHS should take a more coordinated approach to identifying people with symptoms of early rheumatoid arthritis, so that they get access to specialist care quickly and receive support and advice to help them manage and live with the disease. This would provide better value for money, better outcomes for patients, and lead to productivity gains for the economy. Some of the systemic improvements needed to manage and control this disease also apply to other long-term conditions requiring specialist-led care."

**- Amyas Morse, Comptroller and Auditor General, NAO**

In July 2009, the NAO published its report "Services for people with rheumatoid arthritis", which highlighted that too many people with RA are not being diagnosed or treated quickly enough; and some services for people with the disease are not sufficiently coordinated.

The NAO estimated that RA costs the NHS £560 million annually, and that approximately 580,000 adults in England currently have the disease, with a further 26,000 new cases diagnosed each year[19].

The NAO's economic modelling showed that if an additional 10 per cent of people with RA (approximately 2,600 patients) were treated within three months of symptom onset, this earlier treatment could result in productivity gains of £31 million over five years for the economy due to reduced sick leave and lost employment, at a cost to the NHS of only £11 million.[20]

The NAO report echoed many of the concerns raised in the research published by the Rheumatology Futures Group and The Kings Fund in January 2009. Most notably that:

- People with RA need access to coordinated multi-disciplinary services that can provide a holistic approach to care and the report highlights startling inadequacies in service provision.
- People with RA lack sufficient information and support to help them manage their condition. This can lead to feelings of hopelessness, despair and depression.
- Primary Care Trusts (PCTs) lack the evidence to commission services for people with RA.

The NAO report found that 20% of people with RA delayed seeking treatment for more than a year[21]. Early diagnosis, which is so crucial to delivering clinical outcomes, was further highlighted by the finding that 18% of patients had visited their GP more than 8 times before being diagnosed with RA[22]. The report also found that 60% of GPs did not use specific criteria to help them diagnose RA.[23]

"The NAO report supports the Kings Fund research which found that RA patients are not being diagnosed and referred for specialist treatment early enough to prevent long term joint damage. NRAS are very concerned that RA services are not matching the Government's vision for long term conditions to be delivered closer to home and are not being commissioned to meet local needs. A public awareness campaign like those undertaken to tackle other common chronic diseases would make the public, health professionals and commissioners aware of the urgent need for specialist treatment to prevent rapid irreversible joint damage that can lead to permanent disability and often loss of employment."

**- Ailsa Bosworth, Chief Executive, NRAS**

The NAO made eight recommendations[24] to improve overall outcomes for people with RA. These sought to build upon the recommendations contained in NICE clinical guideline 79[25] and were directed at a variety of partners, including healthcare professionals, PCTs and Government.

## Section 2: 2010 - The Year of RA One Year On – Views and Perspectives

### 2.1 Introduction

2010 provides the opportunity to build upon the policy developments from the "Year of RA", to ascertain what progress has been made to implement some of the key recommendations contained in the King's Fund[26] and NAO reports[27], and to explore what impact, if any, 2009 developments and initiatives have had on the nature and quality of RA service provision and care.

Against a backdrop of the NICE clinical guideline and the 18-week Commissioning Pathway, 2010 had the potential to be a crucial year in improving rheumatology services within the UK. Moreover, the formation of the Coalition Government offers further opportunities and challenges when looking to maintain and improve NHS rheumatology services. However, with the UK still very much feeling the sting of the recession, there is a real danger that efficiency savings may lead to cutbacks in vital aspects of care.

"We have a "Cinderella" disease which does not have a high profile. I think we may suffer as the reduction in budgets within the NHS begins to bite."

**- One Year On Survey Respondent**

The Public Accounts Committee (PAC) published a report on RA in February 2010[28] following the hearing in November 2009, in which the Department of Health was examined on some of the themes identified in previous reports: identifying and diagnosing cases of RA sooner; providing better support for people living with the disease; and how the NHS can work more effectively to improve services for people with RA. The Government's response to the PAC report in the form of a recent Treasury minute[29] has been inadequate; while the Government has broadly agreed with the PAC recommendations[30], the actual commitment to definitive actions has been disappointing so far.

In spring 2010, NRAS commissioned two surveys from NRAS patient members and consultant rheumatologists designed to find out - one year on - how the policy developments listed in section 1 had changed the way in which services for people with RA were being commissioned or provided, and their impact on patient care. The surveys yielded a total of 156 responses during May-June 2010: 78 responses from consultant rheumatologists and 78 responses from NRAS members.

The results of the survey have been incorporated below in the context of some of the key themes

"This survey has given me finally the opportunity to express an anxiety of which everyone involved in this story has heard and chosen to ignore."

**- One Year On Survey Respondent**

mentioned in the previous section to get a feel for how progress is unfolding in 2010. For full details of the survey, please go to www.nras.org.uk

### 2.2 Involving Patients: "No decision about me without me"

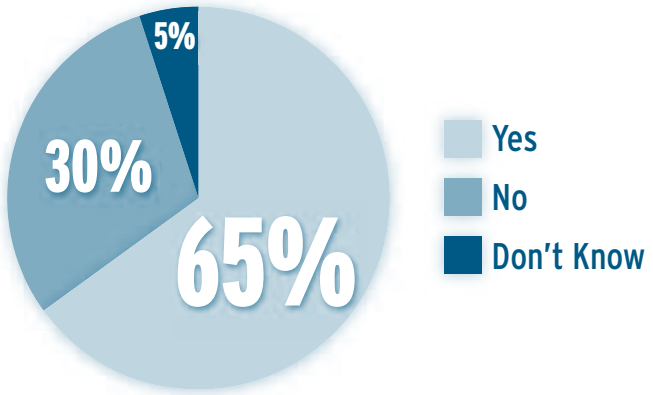
The financial crisis has had an unprecedented effect on people's lives. Despite the commitment from the Government to protect health spending, the survey responses showed that RA patients are increasingly worried that the current need for financial restraint and public sector service cuts will adversely impact upon the NHS services they receive and, ultimately, their care.

Although 65% of respondent consultant rheumatologists feel positive about the future of RA care in the UK, the same is true for less than half of NRAS members (47%) (Figures 1 and 2).

"We provide and will continue to provide a good service – though finances are a concern."

**- One Year On Survey Respondent**

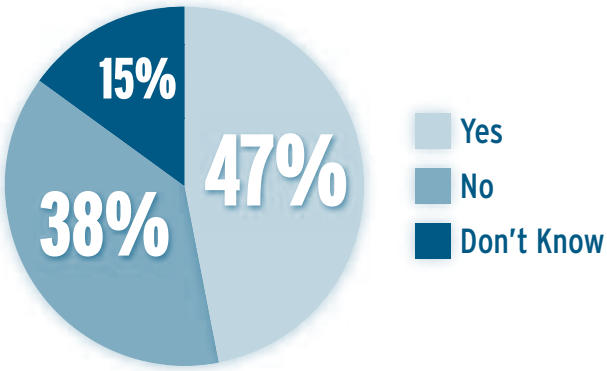
**Figure 1. Do you feel positive about the future of RA care in the UK? (Consultant Rheumatologists)**




"As there are so many people in the UK who are developing RA, I think the services in my area are at breaking point, so more patients get less service. This is why I am not positive. It is getting more difficult to see a general practitioner, so getting to see a consultant will be even worse than it is at present. The way it is going at the moment, God help us in 5 years."

**- One Year On Survey Respondent**

**Figure 2. Do you feel positive about the future of RA care in the UK? (NRAS Members)**



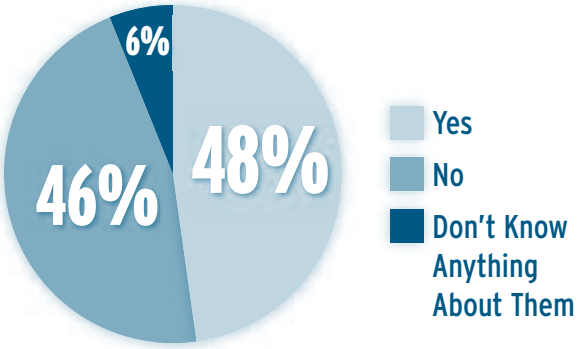

"Things are slowly getting better. NRAS is helping to improve awareness that will in turn help with understanding and treatment/support."

**- One Year On Survey Respondent**

The real challenge to the Coalition Government is to protect rheumatology services in this age of austerity, to drive up standards and to continue to ensure that patients receive the treatment they deserve and need. It is therefore disappointing to see that free prescriptions for people with long-term conditions in England will not be taken forward in the CSR.[31]

A patient-led NHS is an encouraging notion; and it is vital that patients with RA have a right to be involved in the decision-making process as to how they should manage their condition. Personalised healthcare plans are very powerful tools to empower patients to take good care of their health. It is therefore somewhat disappointing that the survey results reveal that less than half (48%) (Figure 3) of consultant rheumatologists' patients have access to a personalised care and management plan.

**Figure 3. Do your patients have access to a personalised care and management plan? (Consultant Rheumatologists)**




It is therefore crucial that the relationship between the patient and the NHS is developed early in the patient journey; and continued for the long-term throughout the lifetime of the condition. It is vitally important that empowered patients do not feel that they are on their own, battling against a disease. A patient-led NHS must not be a smokescreen to remove accountability from the NHS to deliver effective care. In RA, it is vital that patients receive an annual review to ensure their condition is managed effectively going forward. Again, the survey results show that much more work is needed in this respect with more than half (55%) (Figure 4) of patient respondents claiming not to have an annual review. 57% of consultant rheumatologists claim to have seen no change in the past year in accessing a holistic annual review (Figure 5). In a patient-led NHS, it is important that access to fundamental aspects of care is not removed.

**Figure 4. Do you have an annual review with a member of the team which includes an assessment of you as a person, i.e. the impact of the disease on your life as well as progress of the disease and gives access to different member of the team if necessary? (NRAS Members)**

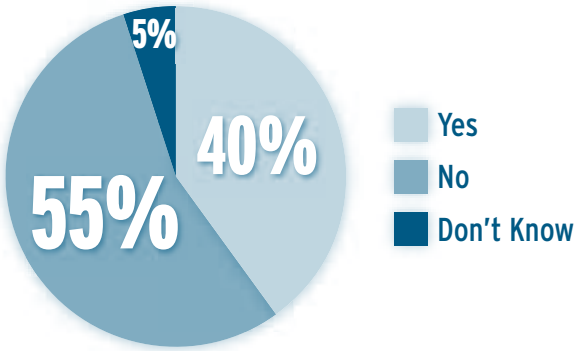
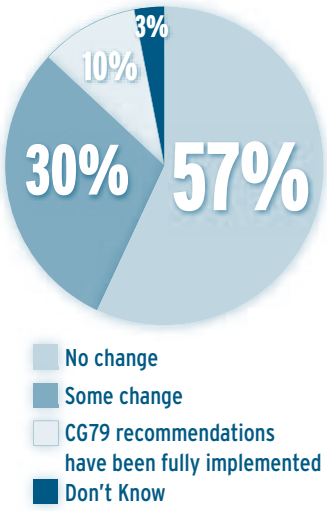



**Figure 5: Changes in access to a holistic annual review (Consultant Rheumatologists)**



## Recommendation 1

The Government has put power and clinical leadership firmly back on the map. Clinicians have real opportunity right now to reconfigure their service in line with evidence based care pathways and have the tools and the exemplar models to build from. It is essential that patients are involved in the re-design of services – 'no decision about me without me', and NRAS can help identify and support local patient champions to contribute to this process.

For a full list of recommendations, go to page 19

"I have always felt appreciative of the care and attention I have received in the eleven years I have had RA and cannot fault those who act on my behalf. I also appreciate all the hard work NRAS do on our behalf, because without being a member and reading the magazines, I wouldn't have a clue what was going on behind the scenes."

**- One Year On Survey Respondent**

### 2.3 Poor Understanding of Rheumatoid Arthritis

"I went to my GP to talk about pain control and was offered anti-depressants! He confused RA with OA and told me I was making too much fuss."

**- One Year On Survey Respondent**

"As I have had RA for 20 years I have a lot of damage to joints and it took GPs 6 years to refer me, then another 3 years to get anti-TNFs."

**- One Year On Survey Respondent**

Both the King's Fund and the NAO reports identified the need to increase knowledge and awareness amongst GPs about the symptoms of RA and the importance of referring suspected cases promptly, so that any delay from onset of symptoms to treatment can be minimised.

"Primary care trusts should improve awareness in primary care, in particular amongst GPs, of how to recognise the symptoms of inflammatory arthritis and of the need to refer suspected cases promptly, so that any delay from onset of symptoms to treatment is minimised. As GPs are likely to see less than one new case of rheumatoid arthritis a year, the Department of Health and the Royal Colleges should cover rheumatoid arthritis in the ongoing continuing professional development of primary healthcare professionals, and promulgate to them the need for early referral of suspected cases."[32]

**- National Audit Office**

Prompt diagnosis of RA is crucial to avoid irreversible damage; and GPs recognising the symptoms of RA is fundamental to this. Earlier this year, the Public Accounts Committee recommended that the Department of Health should launch a targeted campaign or guidance to raise the awareness of GPs and other primary care professionals[33]. The Committee also endorsed the NAO recommendation that the Department of Health should encourage the Royal College of GPs to provide more training on rheumatoid and inflammatory arthritis[34].

The Government's response[35] to the PAC recommendations[36] was, in our opinion, inadequate. Over the summer, NRAS has been working hard to address these shortcomings. NRAS has produced a DVD in collaboration with the RCGP about the early signs and symptoms of RA, the consequences of delaying help, and linked this to the S-Factor poster campaign. So far well over 30,000 people have watched this video, which we hope is helping to reduce delays by individuals with symptoms, which could be inflammatory arthritis, in seeking help. NRAS are also continuing to work with the Royal College of General Practitioners to build awareness amongst GPs and are delighted that Arthritis Research UK has agreed to take over the S-Factor Campaign originally devised and designed by the Rheumatology Futures Group and will be announcing more about a strategy to roll this out in the near future.

### S Factor: Inflammatory Arthritis** public awareness campaign

- Developed by the Rheumatology Futures Project Group (RFPG) and endorsed and supported by Arthritis Research UK, the Royal College of General Practitioners and The Primary Care Rheumatology Society
- Focused around 3 "S" symptoms in the joints – **Stiffness, Swelling, Squeezing**
- The message to the public was that if you have any of these symptoms highlighted in the poster, then seek help from your GP, and crucially don't delay

** The S-Factor campaign also includes ankylosing spondylitis, but we have focused on RA for the purposes of this report

## Recommendation 2

Work must continue to take place to build awareness amongst GPs about the early signs and symptoms of RA. We call upon the Government to support innovative campaigns such as the S-Factor to improve overall knowledge of inflammatory arthritis throughout the country.

For a full list of recommendations, go to page 19

### 2.4 Implementation of National Guidelines

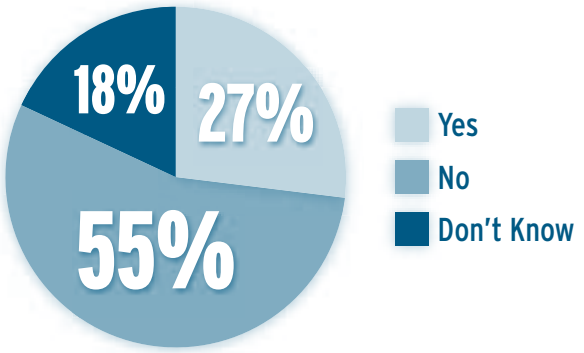
It has been well-documented that a postcode lottery of care exists in the UK and there are significant variations in service provision, as identified by the King's Fund and NAO reports. The Public Accounts Committee also found that there was inconsistency, for example, in the provision of certain drugs for RA patients between PCTs[37].

"The Clinical Guideline is not being implemented in our trust as it is not legally enforceable and we lack the financial resources to implement it."

**- One Year On Survey Respondent**

The introduction of national guidelines across England and Wales, in the form of NICE Clinical Guideline 79, was expected to reduce variations in services and care. However, the survey results show, not only that the postcode lottery still exists, but also that there is a difference of experience between the patients on the receiving end and those providing their care. For example, 48% of consultant rheumatologists claim that their patients have a personalised care and management plan (see Figure 3), while only 27% (Figure 6) of NRAS members claim that they have access to this.

**Figure 6: Are you currently offered a personalised care and management plan?**




55% (Figure 6) of respondent NRAS members do not have access to an annual review of their treatment and care. 50 of the 78 consultant rheumatologist respondents claimed to have a physiotherapist in their MDT, whilst the same number of patient respondents claimed that they had no access to a physiotherapist in their locality.

"Primary care trusts should work with providers to ensure that all people with rheumatoid arthritis are offered a personalised care plan. This plan should include a holistic assessment of the overall well-being of the individual designed around their needs, and support them to return to or remain in work."[38]

**- National Audit Office**

NICE Clinical Guideline 79 made very specific recommendations about access to disease-modifying anti-rheumatic drugs (DMARDs) and biologic therapies[39]. In December 2009, NICE published an implementation uptake report[40] showing what the impact of the guideline recommendations had been on the prescribing of these drugs. The uptake report showed that a 50% increase in the prescribing of biological drugs had taken place in the 12 months to August 2009[41], possibly suggesting that the publication of the guideline had influenced the prescribing of biological therapies.

"At the beginning of my RA journey I did not feel well supported. I would have liked a monthly appointment to monitor the progress of my drugs. On 2 occasions I was left to struggle for 3 months with an inadequate drug level, and very painful joints. The initial management can colour the patient's whole view of a hospital department... While I was put on methotrexate fairly quickly after diagnosis, the use of additional drugs seems quite slow, especially access to biologic drugs."

**- One Year On Survey Respondent**

Interestingly, this increase in prescribing was not necessarily borne out by the survey responses. NRAS members largely saw NICE as a way of restricting therapies, while the consultant rheumatologists generally see NICE guidelines as a positive step, and an opportunity to drive change.

"Treatment options are dictated by NICE and I believe the new Government will not be spending any money in the areas of illness such as RA and most probably we will see services and options cut quite drastically."

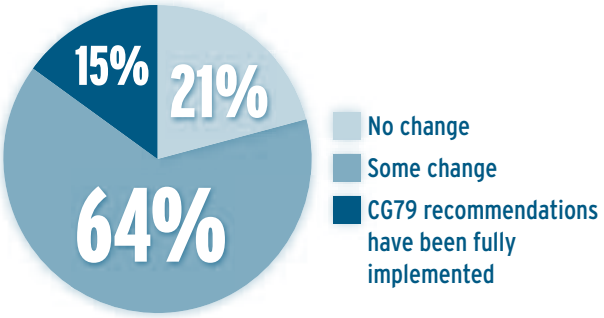
**- One Year On Survey Respondent**

"NICE guidance and BSR/ARMA standards of care have put a focus on RA."

**- One Year On Survey Respondent**

64% (Figure 7) of respondent consultant rheumatologists claim to have seen some change in the prescribing of DMARDs and biologic therapies over the last year. Implementation of NICE clinical guidelines is not mandatory, but the recommendations contained within Clinical Guideline 79 should be a catalyst going forward for standardising high-quality RA care and fostering good practice.

**Figure 7: Changes in prescribing DMARDs and biologic therapies**




While the principle that a system of GP commissioning consortia will reflect local demand is admirable, there is an inherent danger that this shift in care delivery could exacerbate - not eliminate - the postcode lottery. It is therefore crucial that guidelines such as NICE Clinical Guideline 79 are implemented to ensure consistency of care standards in the NHS. The recent consultation on the Cancer Drugs Fund[42] has raised questions about the status of NICE and its guidance in the future and we urge the Government to ensure that NICE Clinical Guideline 79 remains a beacon of consistency and quality in RA care. It is also worth noting that diseases which do not have a high profile at the national level may struggle if they are not implemented effectively locally.

With the changes outlined in the White Paper[43], it is clear that there will be a vacuum for the third sector to fill, in order to drive up standards and encourage uptake.

## Recommendation 3

NRAS would like to work with the BSR and local clinicians to support and encourage uptake of the guidelines at the earliest opportunity. We are already working collaboratively with the BSR and Strategic Health Authorities to promote and encourage commissioning of evidence based pathways and best standards of care and have a pilot running in the East of England on inflammatory arthritis (for more information about the pilot contact jenny@nras.org.uk). NRAS are building on this work to do similar projects in Wales and Scotland.

For a full list of recommendations, go to page 19

### 2.5 The Importance of the Multi-Disciplinary Team (MDT)

Both the NAO report and NICE Clinical Guideline 79 stressed the importance of ensuring that people with RA have access to coordinated multi-disciplinary services. The MDT, through a combined approach, brings together the skills and knowledge of all the team members; and is crucial to delivering demonstrable health outcomes and high quality care. Specifically, the NICE guideline cited having access to a named member of the team as a high priority for implementation.[45]

## Third Sector in Action: East of England Inflammatory Arthritis Pathway[44]

In the East of England Strategic Health Authority (SHA), a pilot is underway which shows how the third sector is taking a novel approach to tackling some of the most prominent issues in RA care. A working group, initiated by NRAS, has been established comprising patient organisations NRAS and the National Ankylosing Spondylitis Society (NASS), the Medical Director and Chair of the Long Term Conditions Board for the East of England SHA, and local consultant rheumatologists from across the region. There was a general understanding that financial pressures would increase the requirement to commission services efficiently using the best evidence available. The aim of the group was to develop agreed standards for commissioning services for patients with RA and other inflammatory arthritides. The group agreed 10 key standards that can be downloaded at www.nras.org.uk. One of the most innovative standards is the notion that all patients with suspected IA should be seen within an MDT approach within in two weeks of referral. This follows the model that was successfully introduced for cancer care. The project showed that through active collaboration a range of specialties can be brought to together, to improve the knowledge base and have a positive impact on care.

"Primary care trusts need to assess the number of people with rheumatoid arthritis in their population, and identify what specialist and multidisciplinary services they need and how to design and deliver them…"[46]

**- National Audit Office**

However, the survey results confirm that access to MDTs is patchy across the country.

Whilst consultant rheumatologists are the member of the MDT most likely to be seen by the patient, 65% (Figure 8) of NRAS members who took the survey claim to see their consultant only "rarely". This is a concern, as continuity of care is something which patients value highly. Worryingly, only 24% (Figure 9) of respondent consultant rheumatologists claim to have seen some positive change over the past year in terms of patients being able to access a named person in the MDT.

**Figure 8: How often do you see your consultant rheumatologist? (NRAS Members)**

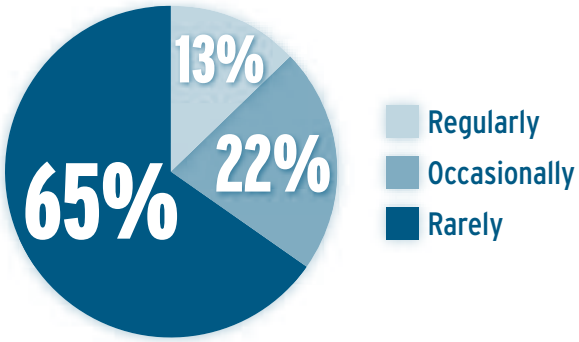
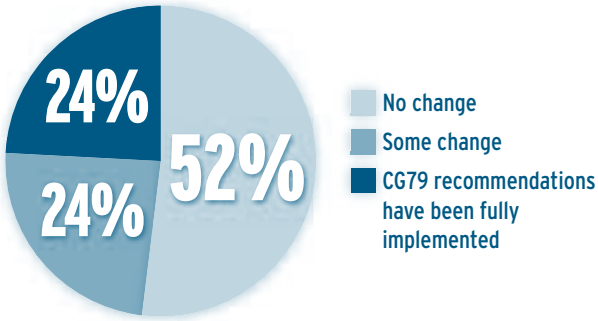



**Figure 9: Changes in access to a named person (consultant rheumatologists)**




"Multidisciplinary team partnership working is a core element to the seamless delivery of good patient care as highlighted by the Quality for All Darzi report of June 2008. There is a concern that in the absence of a multidisciplinary team approach, individuals may work in isolation, care may either be fragmented or duplicated and this will in turn affect the quality of care received by the patient"[47]

**- NICE Clinical Guideline 79**

The surveys also reveal that access to physiotherapists, occupational therapists, podiatrists and clinical psychologists or counselling services is severely lacking. Occupational therapy aims to improve a person's ability to perform daily activities and participate in valued life activities and roles at work, in the home, leisure and socially; facilitate successful adaptations in lifestyle; and to prevent or minimise functional and psychological problems[48]. It is therefore crucial that access to these members of the MDT is improved to ensure that patients are receiving the good care that they are entitled to.

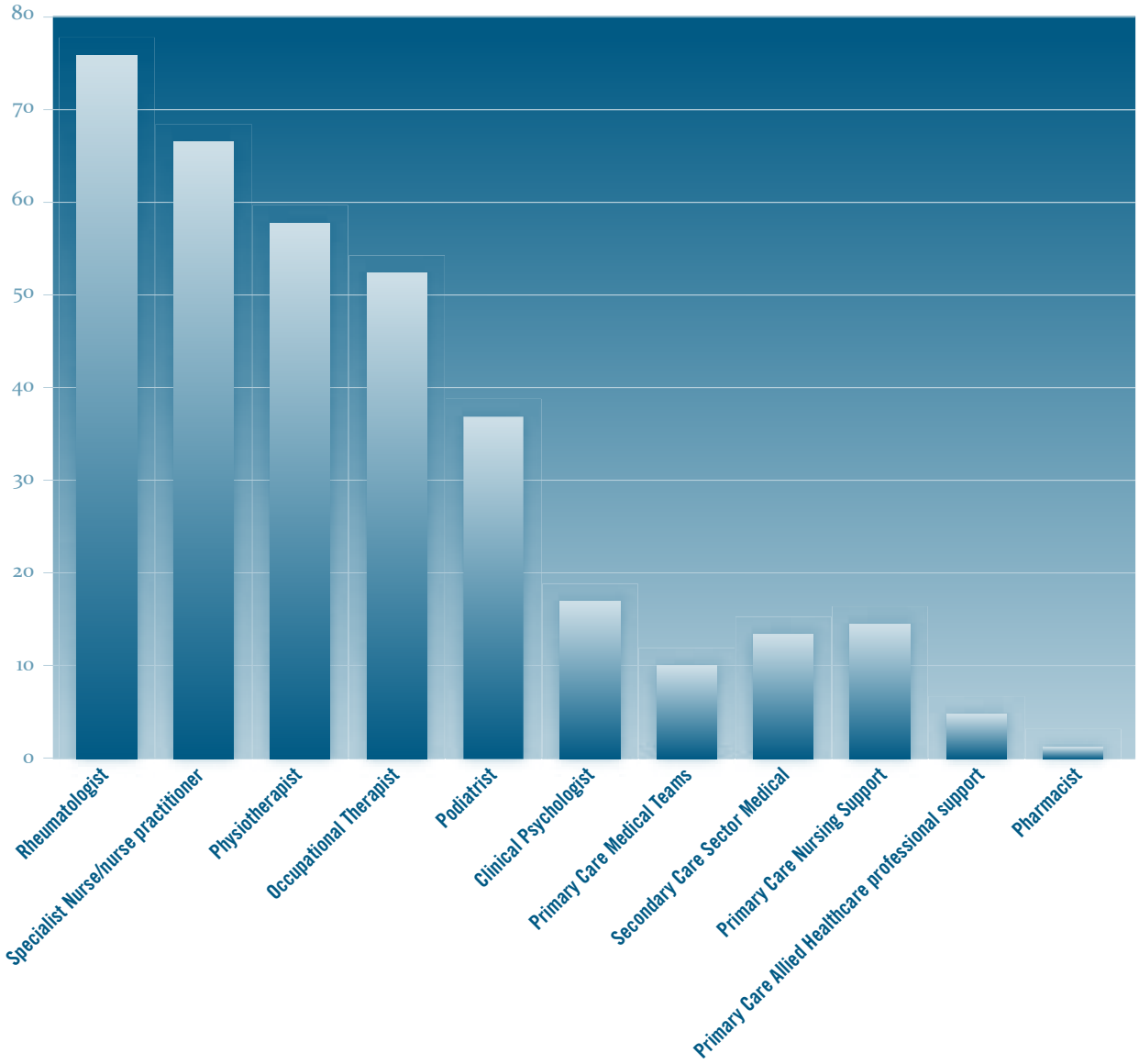
Moreover, whilst over 50 of the 78 rheumatologist respondents confirmed that their own MDT does include a physiotherapist (Figure 10 - overleaf), roughly the same number of NRAS member respondents claimed to have no access to a physiotherapist (Figure 11 - overleaf).

The Coalition Government has set out in its White Paper[49] a radical 'root and branch' reform of the NHS, making GPs responsible for commissioning healthcare services, including those for people with RA. It is therefore absolutely vital that the importance of the MDT approach – recognised by Health Ministers as an important model - is retained in any changes to models of care delivery. We have heard some reports of the fragmentation of MDTs with specialist nurses being sent back onto the wards, thus reducing time with patients who need their specialist skills and experience, and allied health professional posts disappearing.

"The expectation that the number of rheumatology specialist nurses is increasing is based on the rounded care model for rheumatoid arthritis which is built around a multidisciplinary team approach. Multidisciplinary teams within rheumatology services see some of the functions traditionally carried out by consultant rheumatologists appropriately transferred to other members of the team, such as specialist nurses. National Institute for Health and Clinical Excellence clinical guideline 79 "The management of rheumatoid arthritis in adults" makes the multidisciplinary team, including a specialist nurse, a key priority for implementation"[50]

**- Paul Burstow,**
**Minister of State for Health, July 2010**

**Figure 10: What is the composition of your multi-disciplinary team? (Consultant Rheumatologists)**




"Rheumatology Specialist Nurses have been identified as playing a vital role in ensuring that patients who suffer from rheumatoid arthritis receive the support they require to develop confidence in managing their own condition.

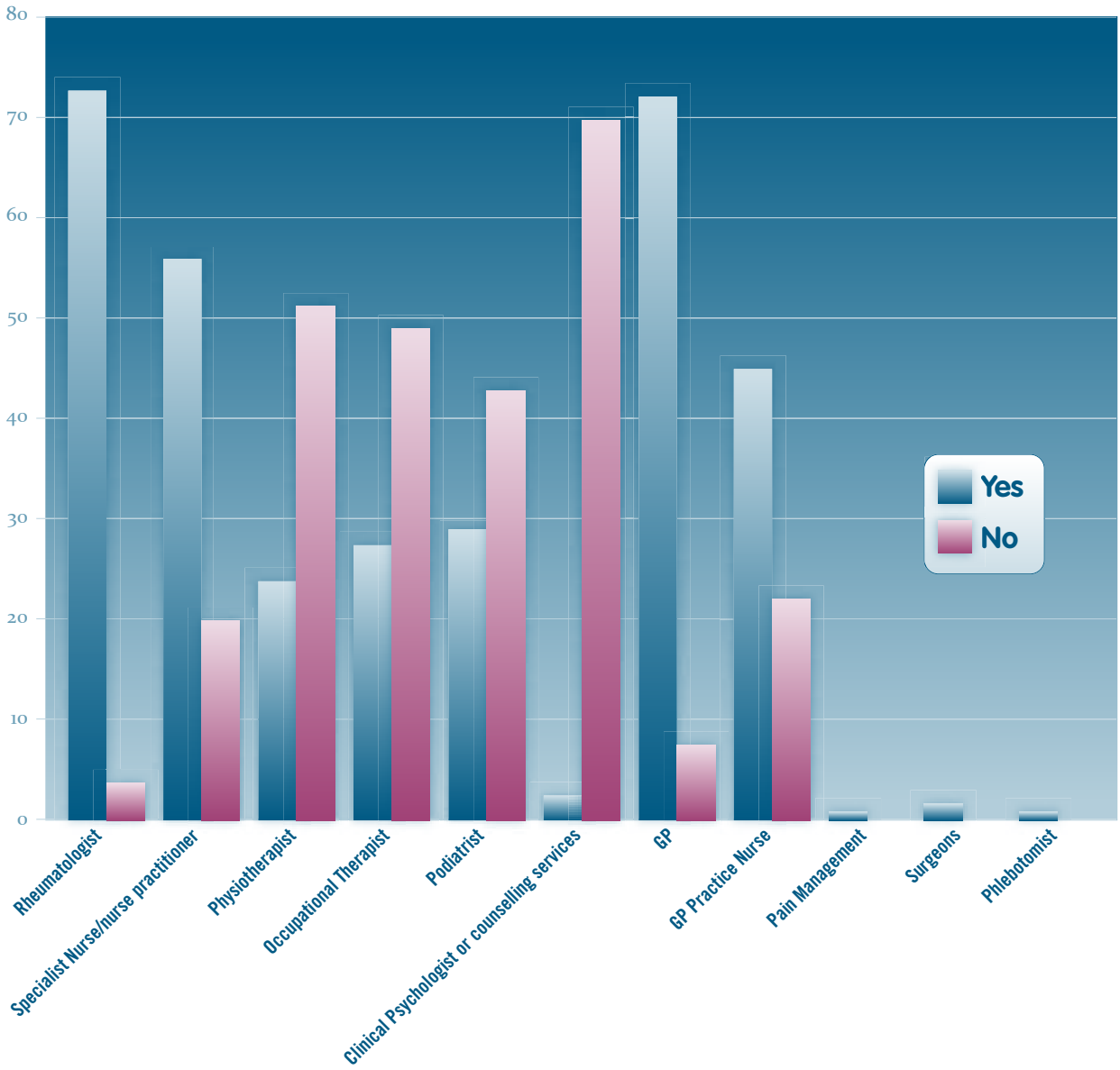
The CSR may have ring-fenced NHS funding, but examples are emerging from the RCN 'Frontline First' campaign of rheumatology specialist nurses being removed from the clinic setting and required to work on hospital wards due to financial pressures and a lack of understanding of the CNS Role. This is an inefficient use of scarce resources.

The 'Pandora Report'[51] illustrated the scope of the work that rheumatology nurses undertake (also see p16). It has shown that the nurses deliver significant benefits to patient care and has quantified the value this work adds to the employing organisation and general health economy.

We must strive to protect the vital specialist role in rheumatology services that these nurses provide. We are not looking for expansive investment; just the recognition of the role these nurses play on the frontline in delivering health outcomes, patient satisfaction, and value for money."

**- Maureen Cox, Chair Royal College of Nursing Rheumatology Forum**

**Figure 11: Which of the following do you have access to? (NRAS Members)**




## Recommendation 4

We call upon the government to acknowledge the need to retain the specialist skills in these teams, built up over years, and essential for the holistic care of people with RA, and ask them to reinforce this message with commissioners. We also urge consultants to use all the evidence-based tools at their disposal to make the business case to retain team members whose jobs are at risk and affirm NRAS's and the BSR's support in this.

For a full list of recommendations, go to page 19

## Section 3: Case Studies

### Case Study 1: The need for specialist nurses

The King's Fund report highlighted that patients who receive care from a rheumatology service, which included nursing and MDT support, report greater satisfaction with their care and more confidence in managing their own condition, compared to those who do not[52]. The rheumatology nurse specialist (RNS) is therefore an integral part of the MDT caring for patients with RA[53].

In 2010, the Royal College of Nursing published a report entitled "*Capturing the essence and demonstrating the value of the clinical nurse specialist*"[54]. The report, which used the software-based, workload-modeling tool called Pandora, examined the contribution that the RNS makes towards high-quality care. The report found that RNSs have a crucial role to play in the field of rheumatology, including:-

- Applying specialist and specific knowledge and skill to manage physical and psychological morbidity
- Alleviating physical and psychological suffering
- Using vigilance of physical symptoms and drug toxicity to trigger rescue work
- Coordinating complex care and refer onto other professionals as part of the MDT, particularly the community services
- Providing patients with a contactable, knowledgeable, accessible professional
- Providing clinical expertise to patients, families and other professionals, e.g. GPs
- Resolving unsatisfactory experiences.

The role of nurses in delivering significant benefits in health outcomes and cost-savings is often overlooked by NHS organisations[55]. The report highlights the real danger that specialist nursing posts will become more vulnerable due to the financial constraints being put on the NHS. The Coalition Government has already announced in the CSR that one-to-one nursing for cancer patients would not be taken forward[56]. It is absolutely vital that the Government acknowledges the role the RNS plays in rheumatology services and looks to maintain their role in delivering outcomes. In July 2010, the RCN launched a "frontline first"[57] campaign which looks to expose NHS budget cuts that are harming patient care, find waste in the NHS and champion nurse-led innovations. Cutting RNS roles and the time they spend in the clinical setting is shortsighted; and will only lead to a detrimental effect on the care and well-being of RA patients.

"A number of respondents stated that they had to work unpaid overtime to cope with their clinical commitments and waiting list initiatives, and others had introduced weekend or evening clinics. Some had increased workloads due to extra/new consultants coming into post. A number of ward-based nurses had been asked to work extra shifts due to staff shortages or sickness, and a number of nurses working in outpatient departments had been asked to work on rheumatology or general medical wards."[58]

**- Royal College of Nursing "Pandora Report"**

"Sadly in previous years when financial constraints have hit, it is the nurse specialist role that has been targeted, as I am sure many of you will know... So why is this? Well, firstly as we discussed in Pandora, nobody really knows how we fill our time – some would say disappearing into an office with a large mug of coffee or tea (little do they know this is to sustain many hours of telephone advice). But secondly we are not even sure that all nurses with various titles undertake exactly the same type of work or have similar levels of expertise."

**- Sue Oliver, RN MSc FRCN, Independent Nurse Consultant, Past Chair of the RCN Rheumatology Forum and Past Joint Chair of the Rheumatology Futures Project**

### Case Study 2: The need for biologics - Jenny's story

Jenny, an NRAS Member, is a final year university undergraduate and was diagnosed with RA last December, aged 21.

Jenny started basic treatment on methotrexate in February 2009, and in March, when her DAS score was 4.7, the drugs hydroxychloroquine and leflunamide were added into her regimen. At this point in time, Jenny was told that she had "a poor prognosis." Over the next few months she had a very turbulent time during the run up to her final exams in June. Jenny developed torrential diarrhoea on leflunamide, and the only thing that made any difference to her disabling symptoms and profound fatigue, was her monthly treatment of intramuscular (IM) depomedrone. A previous fit and sporty girl, she stopped all her sporting activities and many of her social activities. A year ago she was skiing, rowing for the university, playing tennis, playing her guitar and enjoying a very active social life. Jenny rates the profound fatigue associated with the disease as the worst symptom; and over the past year she has lost about a stone in weight.

Over the summer during a summer work placement in Holland, her arthritis got worse. After seeing a local Dutch rheumatologist, Jenny was told that she should be started on biological therapy, but that the rheumatologist could not do this, as Jenny was not insured.

The Dutch rheumatologist sent a follow up email to the consultant in the UK restating his view that Jenny was an "ideal candidate for biological therapy", although he understood that there were difficulties in obtaining the treatment in the UK.

Jenny could not begin biological therapy, as her disease activity score (DAS) was not over 5.1. The NHS requirement for 2 scores in excess of 5.1 a month apart, and then a further month's wait for permission from the PCT, suggests that at best, it will be several months before Jenny can get treatment. Given the uncertainty as to whether she will achieve this score, there is no guarantee that she will ever be deemed eligible for biological therapy under the current NICE criteria.

The BSR and BHPR have published eligibility criteria for the first biological therapy in RA; and present sound evidence to demonstrate that the threshold for treating RA with biological drugs should be decreased from 5.1 to 3.2[59]. NRAS supports and contributed to this BSR document.

Jenny is a determined young lady. As she embarks on her final research year at university her sole ambition is to keep on course to obtain a first in her chosen subject, and to get well enough to resume her old activities. She now has a better understanding of how serious her disease is, and how disabling it could become in the future if not brought under control. She also knows that all her plans and ambitions are contingent on getting effective treatment.

It is harrowing to see a young person struggling with uncontrolled RA; and there are many more like Jenny, who fall into the category of RA patients who don't respond to the standard combination of DMARDs, but don't quite make the 5.1 DAS score.

It is crucial that the UK addresses the variation in access to biological therapies and aspires to meet the health outcomes being delivered in Western Europe and the US. Financial pressures on PCTs to enforce strict eligibility criteria are having a detrimental effect on patients like Jenny. This important issue must be tackled; so Jenny, and those like her, can fulfill their dream of a better life with RA.

### Case Study 3: Poor Understanding of RA amongst GPs – Chris' Story

As identified in both the King's Fund and the NAO reports, poor understanding of RA amongst GPs leads to delays in diagnosis and referral. This can have a severely detrimental effect on patients' lives.

Chris Lloyd, an NRAS member and survey respondent, feels frustrated with her disease. Chris is only 63, and although she still has a small business, she has had to let 75% of her work go, as she does not have the energy to serve her clients fully.

Chris finds that her GP is generally unsympathetic to her pain issues; and was disappointed when her GP confused RA with OA and told her she was making too much fuss.

Chris has very much lost faith with her GP surgery and avoids it as much as possible. Chris has her blood tests at the local hospital, as when she went to the GP surgery, she was kept waiting for 55 minutes by the nurse.

Chris believes that increasing awareness of RA amongst GPs would help refer suspected cases promptly, so that any delay from onset of symptoms to treatment is minimised. She also feels that better liaison between consultants and GPs regarding the on-going support necessary for RA sufferers needs much improvement.

Chris feels RA has destroyed her life and the effect on the rest of her family has been dire. There are so many things that Chris wants to do - such as walking the dogs, playing with her grandchildren, even go shopping; but the fatigue caused by disease is overwhelming, and is ignored as a symptom by healthcare professionals.

Chris's story shows us that RA can have a devastating effect on people's lives; prompt diagnosis and referral from GPs is vital to avoiding irreversible damage. Chris wholeheartedly supports the NRAS recommendation to build awareness amongst GPs about the early signs and symptoms of RA.

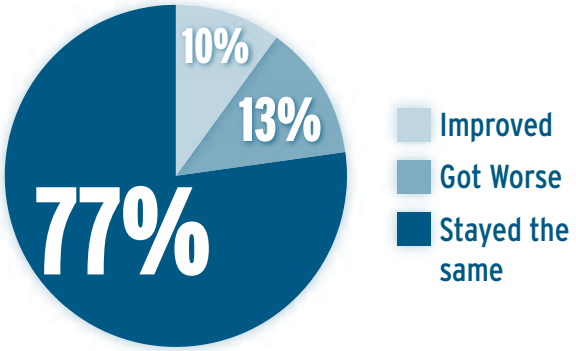
### Conclusions: The Outlook for RA

In political and policy terms, 2009 was a significant year for RA. The Department of Health's 18 week Commissioning Pathway for Inflammatory Arthritis and the NICE Clinical Guideline 79 both had the potential to make a real difference to the nature and quality of services provided and the care that people with RA would receive. Reports from The King's Fund, the NAO and, more recently, the Public Accounts Committee, all pointed to serious shortcomings of service provision in the UK and concluded that, although much work was taking place to improve patient's lives, there were real opportunities to improve patient care.

This report - and the results of the two NRAS

surveys - have confirmed that there are a number of areas where RA service provision and care has demonstrably improved over the last year, but also that some significant and challenging issues remain, and that these challenges have been amplified by the current financial crisis.

**Figure 12: How has the service that you've received changed in the last year (NRAS members)?**




We are entering a period of radical reform in the NHS, as set out in the Government's White Paper. The removal of the 18-week target is particularly worrying; and it is important that standards and focus do not slip as we move forward with ongoing NHS reforms. If the Coalition Government is going to focus on health outcomes, **then patient care and outcomes must be at the heart of this**.

The requirement for GPs to commission services only emphasises the need to ensure that RA/IA is a key component of GP training, as recommended by the Public Accounts Committee.

The exacerbation of the postcode lottery is a real danger falling out of the formation of GP commissioning consortia. It is absolutely vital that national guidelines aimed at driving up care are fully implemented. There is a clear role here for the third sector to support and encourage uptake of the guidelines at the earliest opportunity, whilst driving up clinical standards through evidence-based tools.

"I feel NRAS does a tremendous job in raising public awareness of the disease. I am also impressed by the NRAS publications and information. I have been generally lucky with my case, having an excellent rheumatologist and team, but realise in some locations care is patchy. Good RA should be available for everyone, not by postcode."

**- One Year On Survey Respondent**

There is a clear consensus of concern from the surveys that the recession and budget cuts are likely to have a negative impact on RA care. It is vital that all the hard work and dedication in the rheumatology departments, and from the MDT, is harnessed by encouraging and implementing sound clinical leadership at locality level to ensure that patients receive the quality of care they are entitled to.

We have already begun to see examples of where cost is being put before care in patient follow-up ratios. PCTs are not paying trusts for follow-up appointments in excess of new target follow-up ratios[60]. With the NICE Clinical Guideline 79 and the appropriate clinical pressures for rheumatologists to see, treat and monitor patients with early RA, there is a crucial need to provide enough follow up capacity for early inflammatory disease - but not at the expense of patients with established disease. This sort of shortsighted practice, justified by financial pressures, needs to be rooted out to ensure that patient care and clinical outcomes are not affected by the recession.

There are 580,000 RA sufferers in England[61], the equivalent of over 1,000 people in every UK parliamentary constituency[62], which costs the economy £1.8 billion a year in sick leave and work-related disability[63]. The scale of the problem is similar in the devolved nations. The message is clear; this is a problem the Government cannot simply ignore. There has been a massive amount of work put into delivering excellent RA care; and we have a solid foundation to build upon to disseminate and foster best practice, whilst at the same time addressing the inconsistencies and inadequacies in the level of service provision RA patients are currently experiencing.

The recommendations opposite call on the Government to protect and improve the level of service provision for people with RA. Good care does not have to cost the earth; and with hard work, cross-functional working and increased awareness, ***we can*** create a better life for people living with RA.

# Appendices

## Appendix 1: Recommendations

### Recommendation 1: It is essential that patients are involved in the redesign of services

Patients should be treated with the right specialist skills at the right time. There are new models of care, consultant led and with full involvement of a MDT with good integration from primary care colleagues based both in the community and in secondary care. These models seek to fulfill the aims of the Government to provide patient-centric care for people with long-term conditions like RA nearer to where they live.

The Government has put power and clinical leadership firmly back on the map. Clinicians have real opportunity right now to reconfigure their service in line with evidence based care pathways and have the tools and the exemplar models to build from. It is essential that patients are involved in the re-design of services – 'no decision about me without me', and NRAS can help identify and support local patient champions to contribute to this process.

### Recommendation 2: The Government response to the Public Accounts Committee was inadequate; more needs to be done to ensure early referral and greater awareness amongst GPs

The Public Accounts Committee recommended that the Government undertake a public awareness campaign and that action be taken to further educate GPs about RA and the need for early referral. The Government response to this report was inadequate. Over the summer NRAS has been working at government level to address the shortcomings of the Government response to PAC.

Work must continue to take place to build awareness amongst GPs about the early signs and symptoms of RA. We call upon the Government to support innovative campaigns such as the S-Factor poster campaign to improve overall knowledge of the early signs and symptoms of inflammatory arthritis throughout the country.

### Recommendation 3: NRAS will work with the BSR and local clinicians to support and encourage uptake of the NICE RA guidelines at the earliest opportunity

The NRAS survey has shown that little has changed as a result of the introduction of the NICE RA Guidelines for RA (Guideline no. 79)[64], despite the fact that clinicians view it as an opportunity to improve services and care. Historically, it seems to take a long time for guidelines to be translated into widespread clinical practice. Given the overwhelming evidence that now exists for the early and aggressive treatment of RA, with the treat to target (T2T) and tight control regimens recommended and much discussed at international conferences, NRAS is passionate about seeing a more rapid implementation of these guidelines and treatment strategies.

NRAS would like to work with the BSR and local clinicians to support and encourage uptake of the guidelines at the earliest opportunity. We are already working collaboratively with the BSR and Strategic Health Authorities to promote and encourage commissioning of evidence based pathways and best standards of care and have a pilot running in the East of England on inflammatory arthritis (for more information about the pilot contact jenny@nras.org.uk). NRAS are building on this work to do similar projects in Wales and Scotland.

### Recommendation 4: It is essential to retain the specialist skills of the Multi-Disciplinary Team (MDT) and the specialist nurses in particular

We are very concerned that access to MDTs, which is essential in the care of people with RA, is likely to become more difficult due to the reforms outlined in the White Paper and the financial pressures that were announced in the CSR[65]. Despite the Government's assurance about ring fencing the NHS funding, we are already seeing evidence of the fragmentation of MDTs; with specialist nurses being sent back onto the wards, thus reducing time with patients who need their specialist skills and experience, and allied health professional posts disappearing. Quality of care is being sacrificed in a bid to save money.

We call upon the Government to acknowledge the need to retain the specialist skills in these teams, built up over years, and essential for the holistic care of people with RA, and ask them to reinforce this message with commissioners. We also urge consultants to use all the evidence-based tools at their disposal to make the business case to retain team members whose jobs are at risk and affirm the BSR and NRAS's support in this.

## Appendix 2: Resources and Links

This section has been created to enable the reader to access key sources and find out more information about some of the significant issues identified in the report.

### Organisations

| | |
|---|---|
| British Health Professionals in Rheumatology | www.rheumatology.org.uk/bhpr/ |
| The British Society for Rheumatology | www.rheumatology.org.uk |
| King's Fund | www.kingsfund.org.uk |
| National Audit Office | www.nao.org.uk |
| NICE | www.nice.org.uk |
| NRAS | www.nras.org.uk |
| Royal College of Nursing | www.rcn.org.uk |

### Individual Documents

**HM Treasury**

Treasury Minutes on the Tenth to the Eleventh and the Fourteenth to the Thirty Second Reports from the Committee of Public Accounts Session 2009-10. July 2010. ... http://www.official-documents.gov.uk/document/cm78/7885/7885.pdf

**House of Commons Committee of Public Accounts**

Minutes of Evidence: services for people with rheumatoid arthritis. 23rd November 2010 ... http://www.publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/46/09112301.htm

Public Accounts Committee – Tenth Report: Services for people with rheumatoid arthritis ..... http://www.publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/46/4602.htm#evidence

**The King's Fund**

Perceptions of patients and professionals on rheumatoid arthritis care: a consultancy report by The King's Fund for the Rheumatology Futures Group. ... http://kingsfund.koha-ptfs.eu/cgi-bin/koha/opac-detail.pl?biblionumber=41267

**The National Audit Office (NAO)**

Services for people with rheumatoid arthritis ..... http://www.nao.org.uk/publications/0809/services_for_people_with_rheum.aspx

**NICE**

Rheumatoid arthritis: the management of rheumatoid arthritis in adults ... http://guidance.nice.org.uk/CG79

**NRAS**

One Year On Survey Results ..... http://nras.org.uk/campaign/our_latest_campaigns/publications/nras_one_year_on_survey.aspx

10 key standards from the East of England pilot ..... http://nras.org.uk/campaign/our_latest_campaigns/publications/10_key_standards_of_care.aspx

The Economic Burden of Rheumatoid Arthritis ..... http://www.nras.org.uk/includes/documents/cm_docs/2010/e/1_economic_burden_of_ra_final_30_3_10.pdf

**RCN**

Capturing the essence and demonstrating the value of the clinical nurse specialist (Pandora Report) ..... http://nras.org.uk/campaign/our_latest_campaigns/publications/rcn_clinical_nurse_specialists_adding_value_to_care.aspx

Rheumatology Nursing: Results of a survey exploring the performance and activity of rheumatology nurses ..... http://www.rcn.org.uk/__data/assets/pdf_file/0004/264937/003524.pdf

## References and Acknowledgements

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Design work undertaken by Mark Spencer of Dysfunction Media Limited.

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5. The King's Fund. *Perceptions of patients and professionals on rheumatoid arthritis care*. January 2009.
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18. National Audit Office. op.cit.
19. Ibid. p5.
20. Ibid.p8.
21. Ibid. p16.
22. Ibid. p5.
23. Ibid. p19
24. Ibid.pp9-10.
25. National Collaborating Centre for Chronic Conditions. op.cit.
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30. House of Commons Committee of Public Accounts. *Services for people with rheumatoid arthritis. Tenth Report of Session 2009-10*. op.cit. pp7-8.
31. HM Treasury. *Spending Review 2010*. op.cit. p 43.
32. National Audit Office. op.cit. p9.
33. House of Commons Committee of Public Accounts. *Services for people with rheumatoid arthritis. Tenth Report of Session 2009-10*. op.cit. p 38.
34. National Audit Office. op.cit. p9
35. HM Treasury. *Treasury Minutes on the Tenth to the Eleventh and the Fourteenth to the Thirty Second Reports from the Committee of*

*Public Accounts Session 2009-10*. op.cit.

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Full details of the One Year On survey can be found at www.nras.org.uk

## We need your support

There are still many issues to be addressed to improve service delivery and access to best services for people with RA. We would welcome your support to help us achieve our goal of

# "A Better Life for People Living with RA"

Please register your support for NRAS by emailing Jenny Snell, Government Affairs Manager jenny@nras.org.uk or calling 01628 823524

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