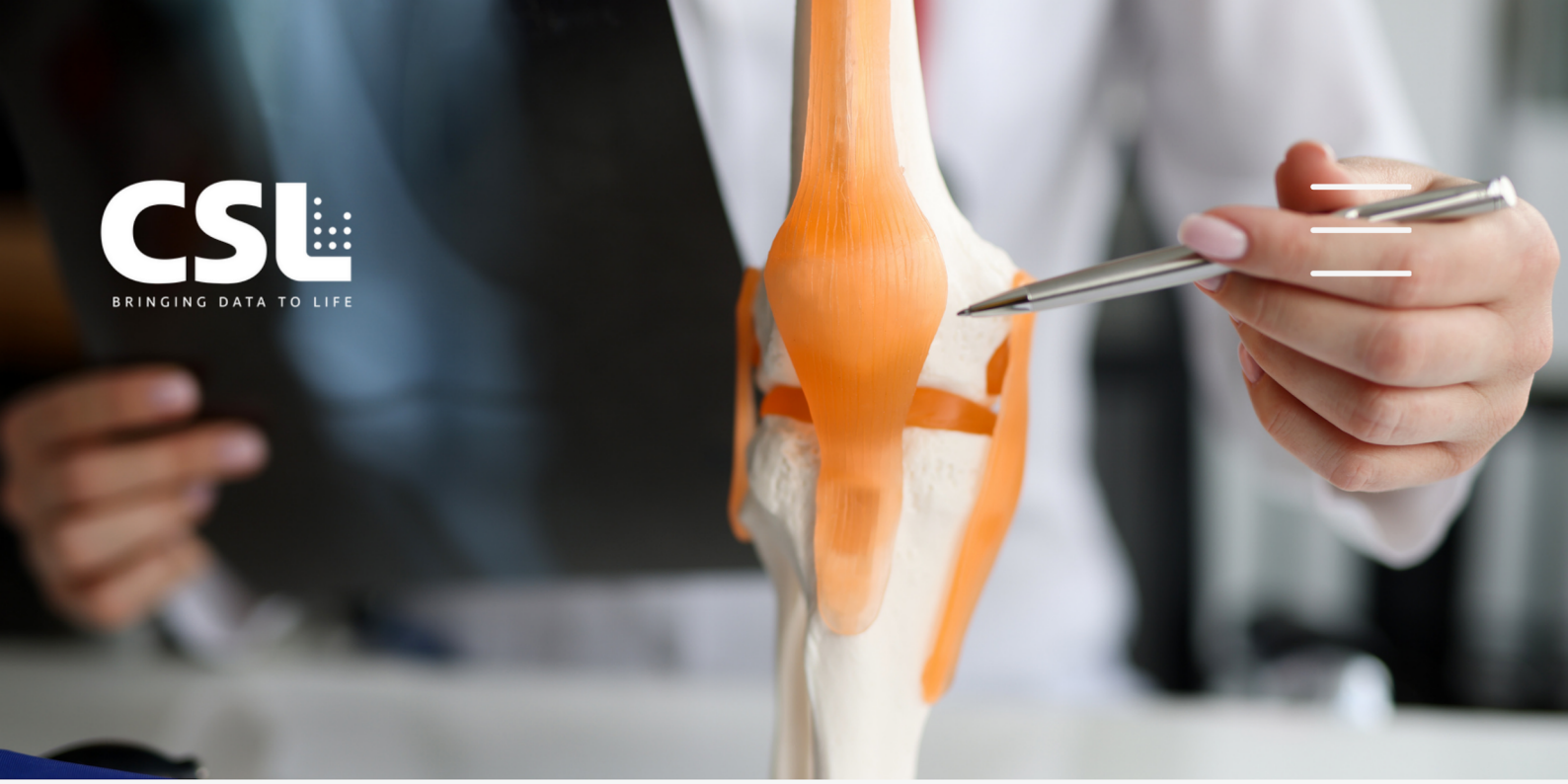

Rheumatology 2024
2023 & Beyond: Achieving Success

Open Data Sources Analysis

Executive Summary

The prevalence of rheumatic and musculoskeletal diseases (RMDs) has substantially increased. This can be attributed to an aging population, enhanced diagnostics leading to earlier detection, and improved survival rates.

This report aims to evaluate the on-going state of Rheumatology, in the context of the specialist guidance from Get It Right First Time (GIRFT), British Society for Rheumatology and the National Early Inflammatory Arthritis Audit (NEIAA). It evaluates how we are performing against the guidance laid out by these reports, as best as possible, using NHS open data and other free sources.

Overview

Rheumatology includes common rheumatic and musculoskeletal conditions:

- An ageing population, earlier diagnosis and improved survival among people with RMD are the main reasons for the increased prevalence [1]
- Musculoskeletal conditions are the leading cause of disability [2]
- Conditions affecting the immune system, bones, joints and muscles as well as soft tissues (connective tissues) [3]

Analysis Summary

This white paper seeks to examine the following key aspects relating to rheumatic and musculoskeletal diseases (RMDs).

- RMDs widespread impact on society & the high costs of treatment. Research shows 23.3M working days were lost in 2021 due to musculoskeletal conditions and on average 41K fit notices for MSDs are issued per month. Costs are related to expensive drugs and extensive teams of specialists needed [2] [19] [6]
- Data shows mixed performance against GIRFT guidance. There is a wide disparity of waiting times across Trusts along with huge variance in the 18 weeks standard
- Key areas of focus for 2024 and beyond are early intervention, heath equity and workforce constraints which are impacting patient pathways
- What role Pharma can play in supporting Rheumatology departments

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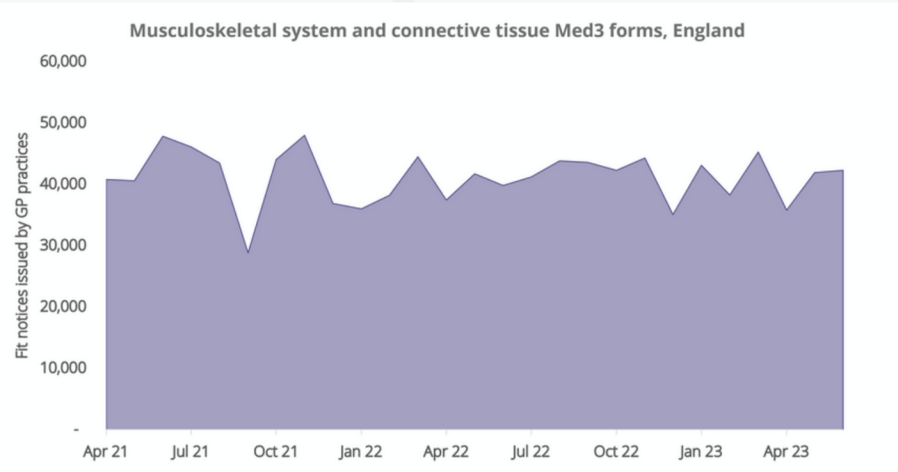
Patient and societal impact of Rheumatology

- More than 200 different RMDs
- RMDs in developed countries has increased by 60% from 1990 to 2010 [1]
- Over 10 million people live with an RMD condition worldwide [2]
- 23.3M working days were lost in 2021 due to musculoskeletal conditions [2]

Significant societal impact of musculoskeletal disorders (MSDs)

The Statement of Fitness for Work (the Med3 form or 'fit note') enables HCPs to give advice to their patients about the impact of their health condition on their fitness for work. It is used to provide medical evidence for employers or to support a claim to health-related benefits through the Department for Work and Pensions (DWP).



Fit notes issued show that on average, HCPs are issuing around 41K fit notices for MSDs per month [19].

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Rheumatology covers many rare diseases

There are approximately 7,000 known “rare” rheumatic diseases [4].

Rare diseases:

- Each rare disease affects fewer than 1 in 2,000 people
- In the UK, 1 in 17 people will be affected by a rare disease
- Rare diseases consume 15% of the healthcare budget
- Health outcomes are poor [5]

RMDs can be resource-intensive to treat

Addressing RMDs necessitates a multifaceted approach due to their resource-intensive nature. A diverse team, including doctors, nurses, therapists, podiatrists, pharmacists, and administrators, is needed to navigate the complexities [3].

Common non-inflammatory Musculoskeletal Conditions (MSKs) place a strain on services, demanding a careful allocation of resources. The cost escalates further due to the use of medicines, such as JAK-Kinase inhibitors, which cost around £9,000 per patient per year [6].

Furthermore, the iterative nature of RMD care underscores the need for repeat reviews, ensuring interventions align with the dynamic needs of patients grappling with RMD complexities.

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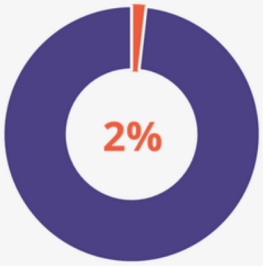
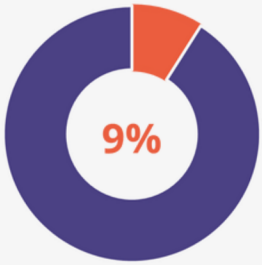
Rheumatology patients' impact in numbers

Rheumatology patients account for 2% of the NHS waiting list, and 9% of the average trust's medication spend.



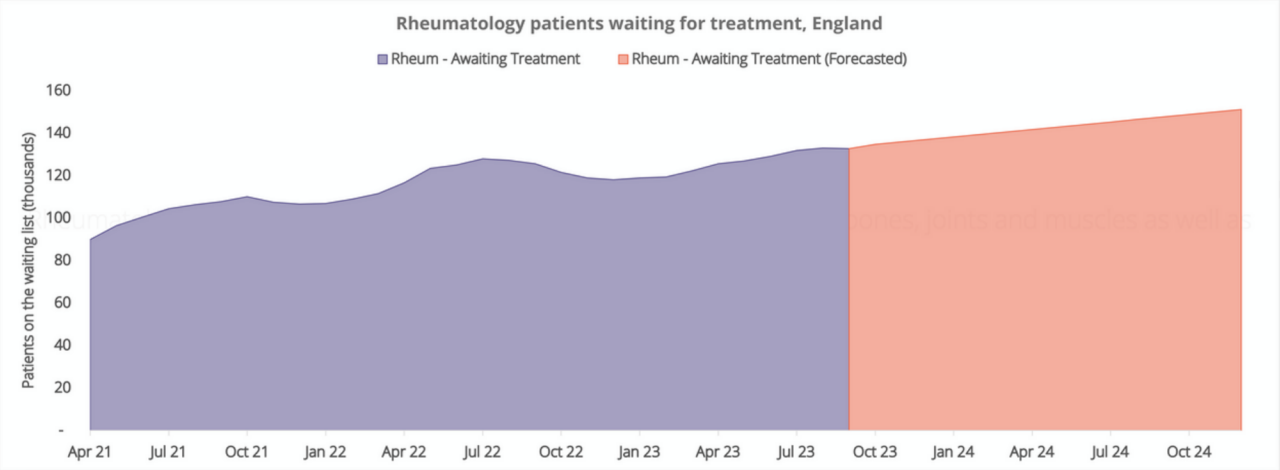


As of September 2023, **2%** of the NHS **waiting list** (7.34M people) are **Rheumatology patients** (132K) [7]

9% of the **total medication spend** for an average trust is spent on the **Rheumatology** department [6]

Waiting list likely to exceed 150K by end of 2024

Forecasting the current waiting list shows that if trends continue without intervention, the waiting list will be just over 150K by the end of 2024 [7]



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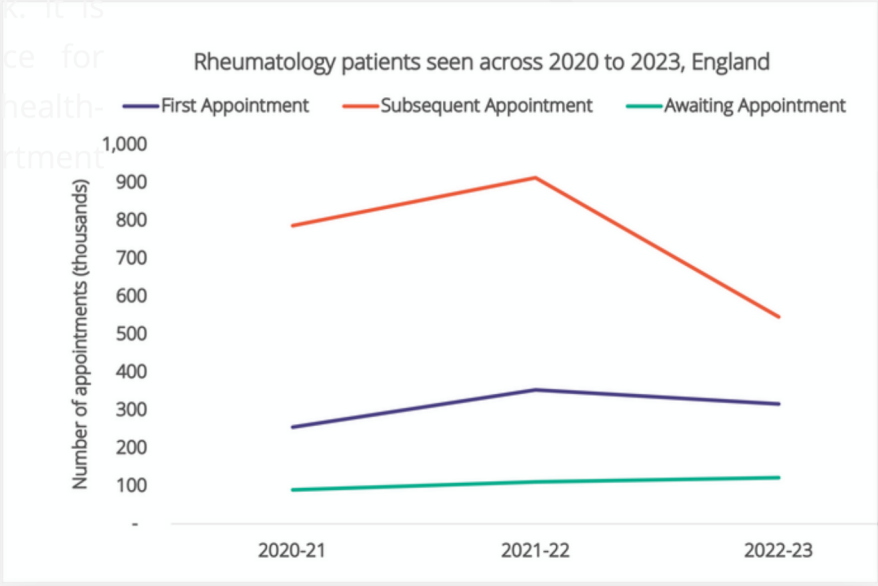
Decrease in subsequent appointments

Both first and subsequent appointments show a decrease in 2022-2023 compared to in 2021-2022.

However, the decrease for subsequent appointments was more significant, potentially indicating that pathways have changed, or that fewer patients are getting their follow-up [8].



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Getting it Right First Time (GIRFT) Guidance

"We recommend that routine referral to treatment (RTT) times for all conditions that require specialist Rheumatology care should not exceed eight weeks.

We found wide agreement among the Trusts we visited that above this level it becomes difficult to ensure a high quality and efficient service for patients, with inefficient use of urgent appointments."

GIRFT 2021

The Original NHS GIRFT report was published in September 2021, with 23 recommendations based on data from 134 trusts.

An updated version was published in April 2023 with practical OPD guidance for 17 services to maximise efficiency and reduce waiting times for patients [6, 9, 10].

GIRFT Recommendations

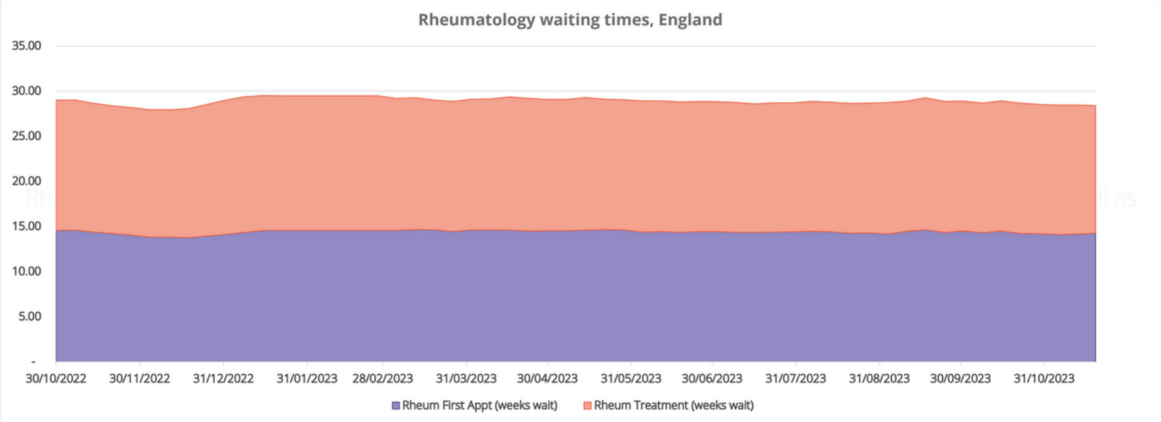
The aim to meet an 8-week standard for Rheumatology specialist referral to treatment times hinges on a blend of approaches.

Namely, non-inflammatory painful conditions to receive care beyond hospital confines, improving accessibility. Specialist Advice models, both pre and post referral, will guide the process, ensuring expertise at every stage. Crucially, reducing Did Not Attend (DNAs) instances streamlines the pathway, optimising resources. Finally, embracing remote consultations amplifies accessibility and interaction, transcending physical barriers [9].

Mixed performance against GIRFT guidance

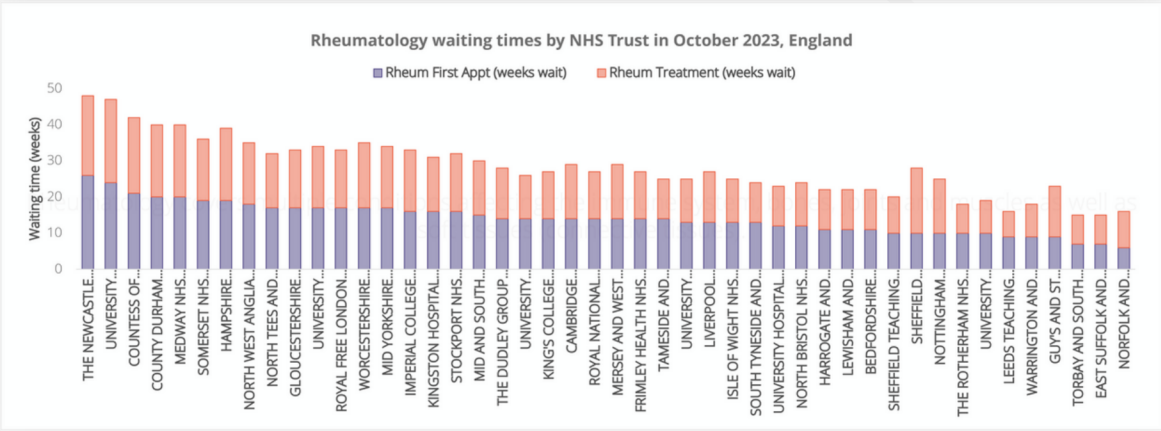
Slight downward trend in waiting times

Average waiting time in weeks shows a slight downward trend for both first appointment and treatment [11].



Disparity in waiting times across Trusts

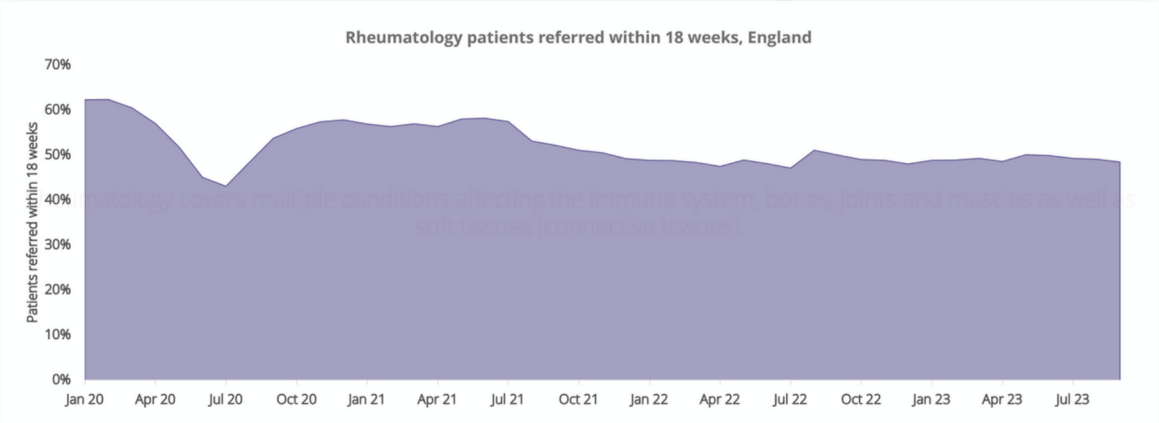
However, there is a wide variance between top and bottom waiting times across Trusts, with first appointment's ranging from 6 to 26 weeks, and treatment ranging from 7 to 23 weeks [11].



Stable referral waiting times

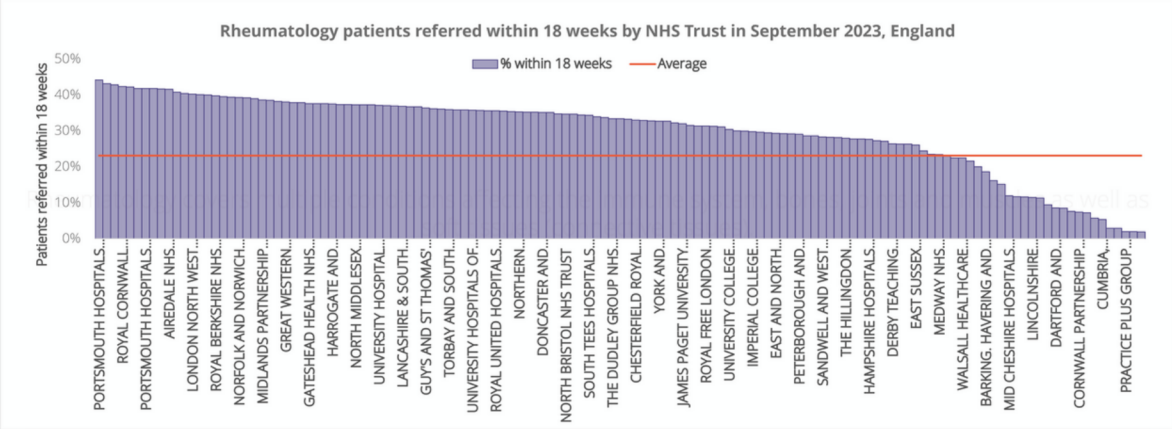
The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks from the day of referral. Waiting lists are examined at a set date at the end of each month. Ideally, there should be no patients on the list that have been waiting for more than 18 weeks since referral [20].

From the end of 2021, we see a stable trend in the % of patients referred within 18 weeks, hovering around the 50% mark [7].



Huge variance in 18 weeks standard across Trusts

As with average waiting times however, we see a significant variance in the 18 weeks standard wait time across Trusts (including small scale providers), with performance ranging from 4% to 44% [7].



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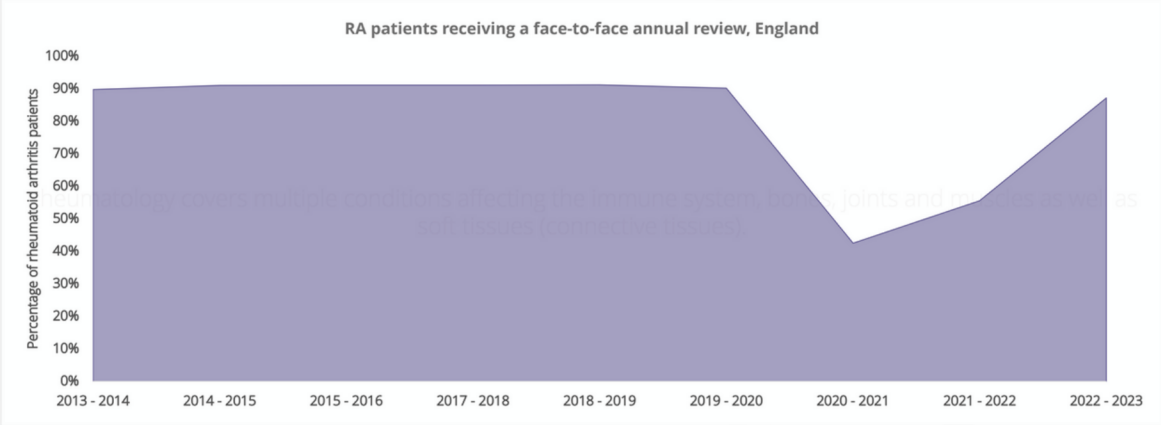
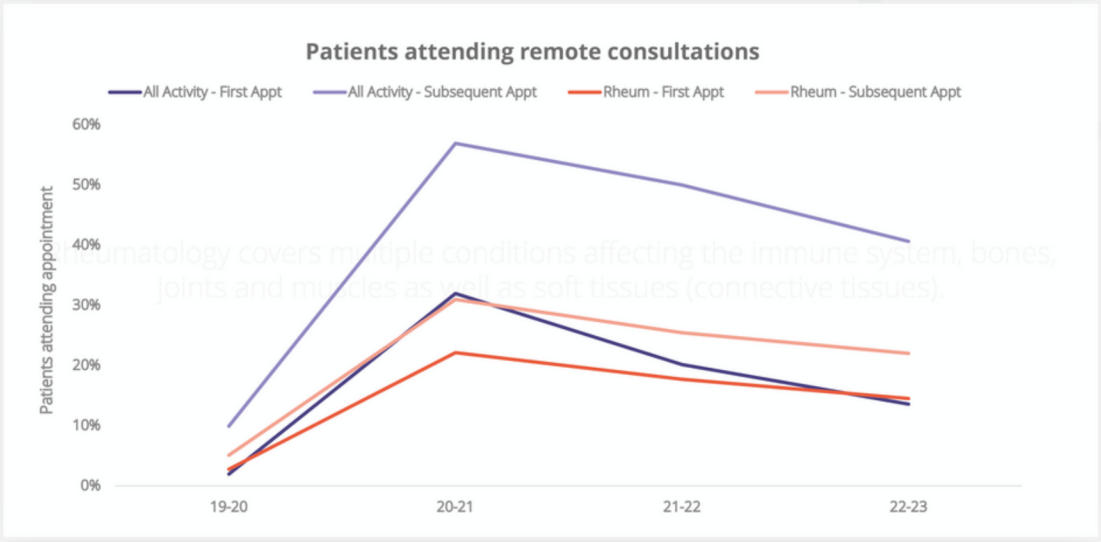
Annual reviews slightly below pre-covid level

87% of registered Rheumatoid Arthritis patients in 2022-2023 had an annual review with their GP – below the 90% achieved in 2019-2020 [12].



Downward trend in remote consultation data

There appears to be a decline in remote consultations, with Rheumatology maintaining a higher percentage of remote usage. However, it is important to note that we only have one period of data unaffected by COVID (2022-2023), where there was especially high adoption of remote consultations. Therefore, it may be that the long-term trend sees remote consultations increase going forward[13].



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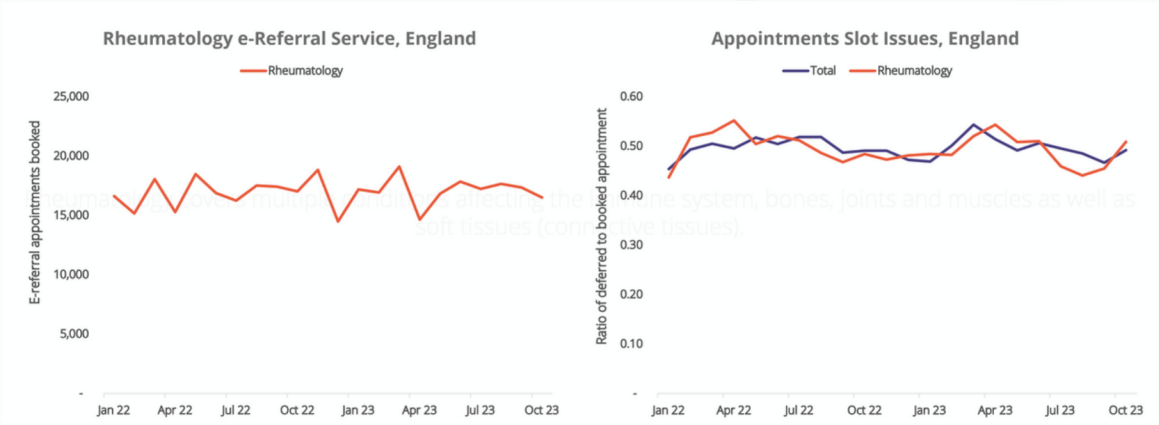
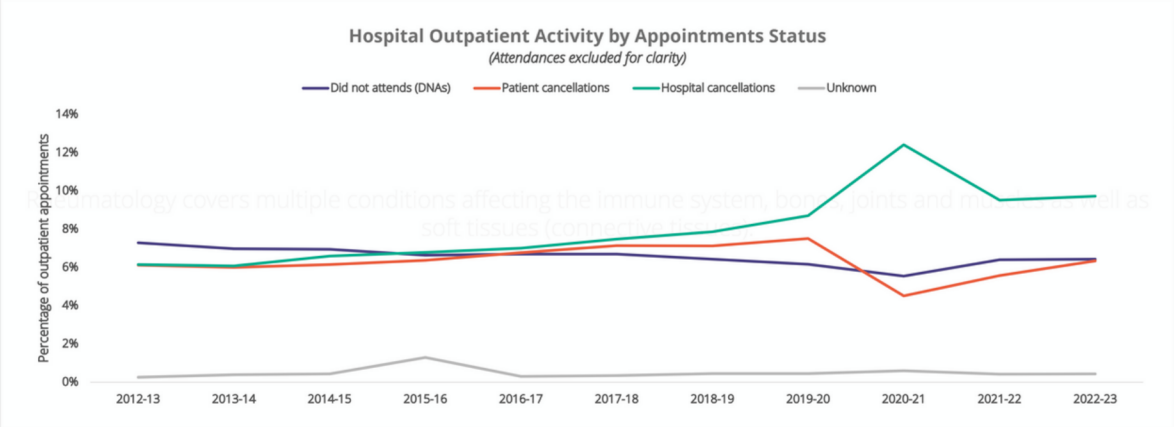
Rheumatology accounts for 2% of e-bookings

On the broader question of digital adoption, Rheumatology services account for 17k e-bookings per month, with a similar ratio of deferred appointments to booked, compared to the NHS average. This suggests that digital adoption has been relatively successful [14].



NHS: DNAs steady decline halted by Covid

In lieu of Rheumatology-specific data, we can see that DNAs saw continual steady decline until 2021-2022, where they shot up to 2018-2019 levels. This data indicates that the NHS has to get back on track at reducing DNAs [13].



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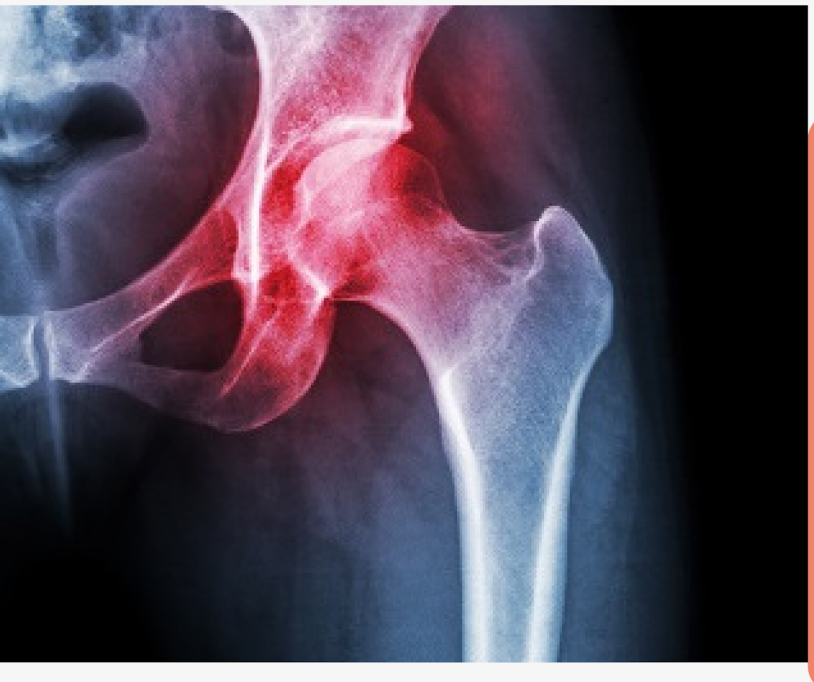
Key areas of focus for 2024 & beyond: Getting Rheumatology Right

Trends and themes in 2024 and beyond.



Early intervention

- Public awareness
- Early Intervention pathways

Health equity

- Regional
- Ethnic
- Gender
- Age

Workforce

- Expansion
- Multi-Disciplinary Team effectiveness

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report

The NEIAA State of the Nation Report, published by the British Society for Rheumatology in October 2023, encapsulates data collected from April 1, 2022, to March 31, 2023.

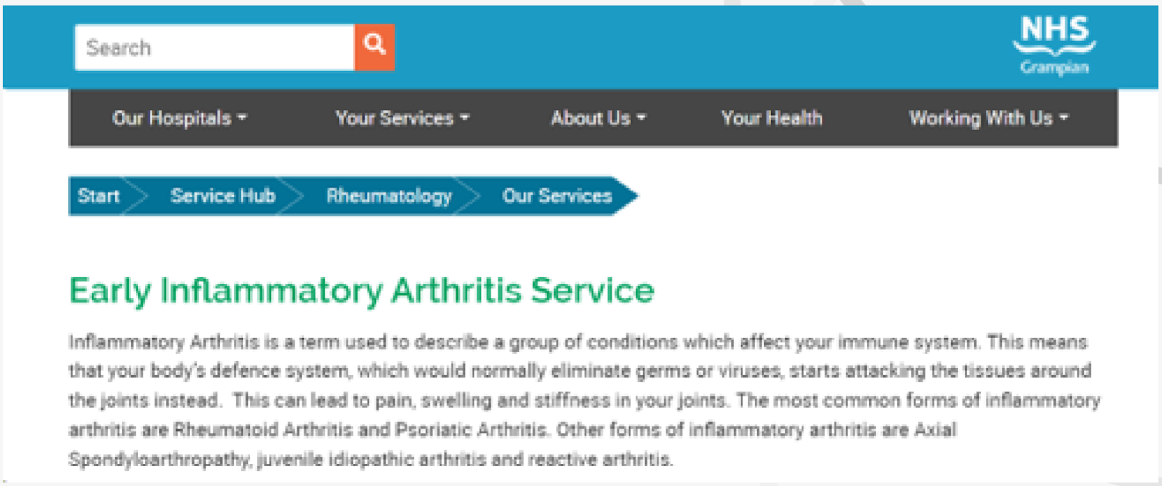
Commissioned by the Healthcare Quality Improvement Partnership (HQIP) as an integral part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), the audit seeks to elevate patient outcomes through quality improvement (QI) initiatives, with a particular focus on increasing the impact that clinical audits, outcome review programs, and registries have on healthcare quality in England and Wales [15].

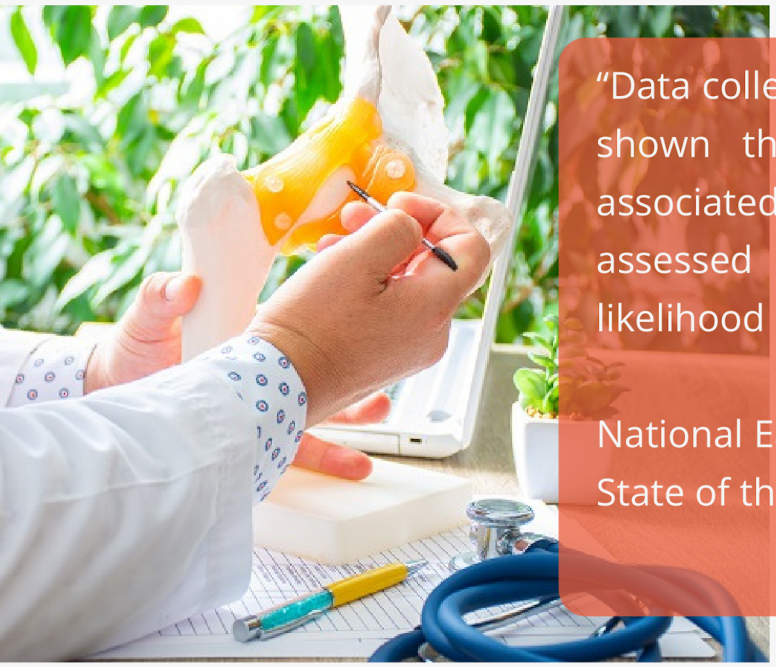
Early Intervention

Early intervention pathways appear to be crucial in timely treatment of RMDs.

1. Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected Early Inflammatory Arthritis and early referral into specialised Rheumatology services

2. Early Inflammatory Arthritis (EIA) pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA [15]





"Data collected in the last five years of NEIAA have shown that having a dedicated EIA clinic is associated with a 40% greater likelihood of being assessed within 3 weeks and a 70% greater likelihood of starting treatment within six weeks."

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023 [15]

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Health Equity

Several social, economic and demographic factors are known to be correlated with RMDs.

Deprivation

- Deprived areas have an increased prevalence of osteoarthritis
- People living in more deprived areas are more likely to be overweight or obese
- The risk of developing osteoarthritis increases by 3% for every 5cm increase in waist circumference

Ethnicity

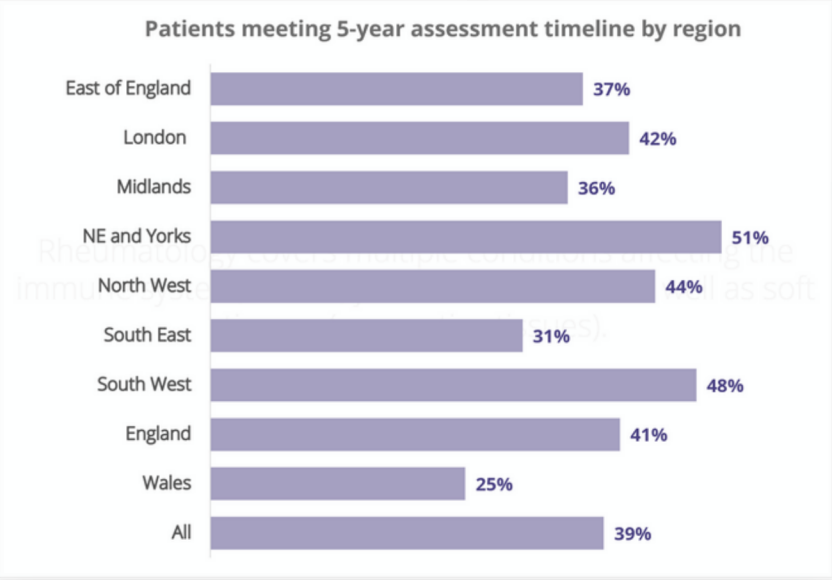
- Those most likely to report a long-term MSK condition in England are people from a South Asian ethnic group
- The prevalence of chronic pain differs between some ethnic groups

Age

- MSK conditions affect people of all ages but become more common with increasing age [16]

There are significant regional variances in services.

- Regional variances in service provision is a barrier to outcomes
- "Variation is at a similar level as seen in previous years"
- For example, variance for 5-year assessments target ranges from 25% to 51% [17].



Workforce

Workforce constraints are impacting patient pathways.

- “Our analysis shows that the Rheumatology workforce in both adult and paediatric and adolescent services lacks sufficient staff to provide the level of care recommended by NICE guidance”

- “There are not enough consultants or specialist nurses in Rheumatology and access to certain members of the Multi-Disciplinary Teams, including psychologists and pharmacists, is not sufficient”

- “There is unacceptable variation in workforce provision, without adequate succession planning, which means that other clinicians must address these gaps, leading to long waiting times and delays in the care pathway and consequently, worse patient outcomes, more disability, and loss of work”

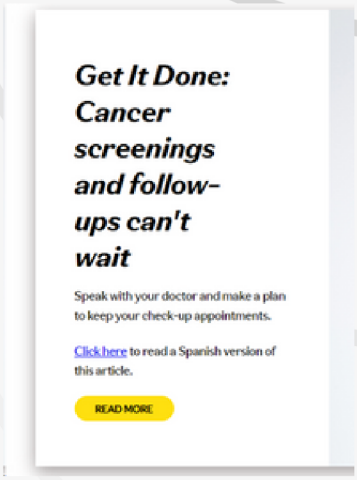
- “These recommendations are based on clinical audit data, which shows more consultants, specialist nurses and access to the Multi-Disciplinary Team leads to better outcomes for patients”

British Society for Rheumatology: Rheumatology workforce: a crisis in numbers [18]

What role can pharma play?

Early Intervention

- Public awareness is a key facet of the Early Intervention strategy
- Pharma can use its voice and resources to raise awareness
- An example includes the "This is Living with Cancer" patient awareness campaign Pharma has run.
- The industry is also uniquely placed to advocate for patient voice in pathway design and implementation



Health Equity

Pharma can support services aiming to address health equity issues in three main ways:

- Service support, ie. regional demographics to facilitate service design
- Awareness, such as running targeted campaigns, e.g. using demographic data to produce health literature in relevant languages
- Research into patient drivers and barriers regarding Rheumatological services and treatment.

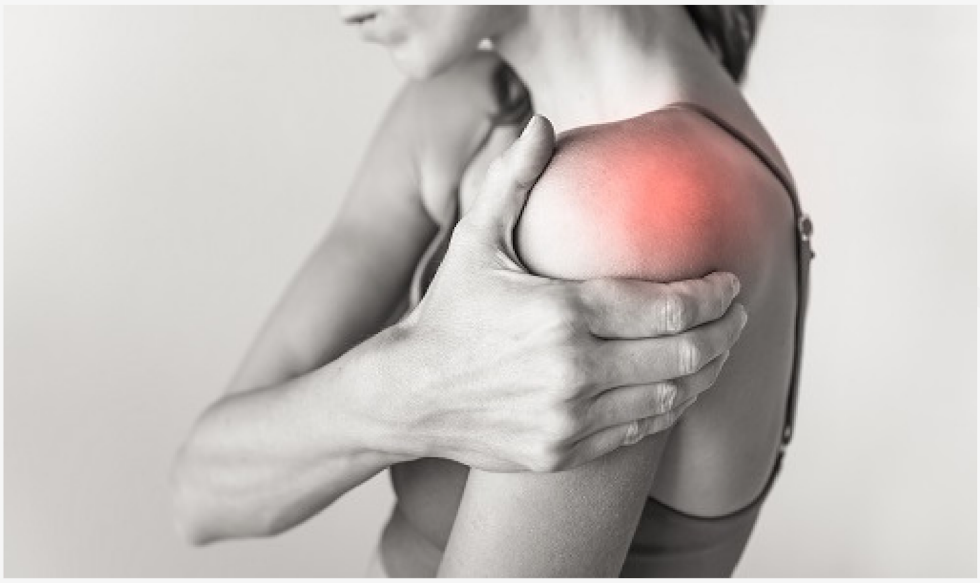
[17]

What role can pharma play?

Workforce

- There may be opportunities for the industry to collaborate with service providers and clinicians to ease workforce issues
- Examples include collaboration on training, materials, or research
- Pharma can also support Trusts by assisting with Multi-Disciplinary Teams optimisation
- Funding support for clinics

[17]



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About CSL

"There is a wealth of data available online, using it effectively can **make all the difference** for pharma companies.

The issue is that it is difficult to collate, clean, and interpret; **this is where we come in**."

Lee Ronan, Commercial Director, CSL

The wealth of NHS data available online provides invaluable insights for healthcare stakeholders, including pharmaceutical companies. However, collating, cleaning, and interpreting this data can be challenging.

CSL monitors, processes, cleans, and standardises unstructured "open data" into usable databases. These databases enable in-depth analysis and the extraction of valuable insights that can inform strategic decisions.

We support our clients in processing and structuring this data to unlock its potential. By effectively employing NHS open data, stakeholders can make informed decisions, address challenges in Rheumatological services and treatment, and ultimately improve patient care.

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