Commissioning for Quality in Rheumatoid Arthritis (CQRA): Case Study

Summary

A nurse-led community-based rheumatology service was established to provide patients with local more convenient care and to optimise resource use – both in terms of healthcare professional resource and financial resource. One of the critical success factors for the nurse-led community service was to be able to demonstrate the quality of service being delivered based on outcomes that are clinically meaningful. The nurses wanted to develop a system that would capture not only how many patients were using the service but also their diagnosis and management, enabling them to measure the quality of care that patients received. They decided to use the clinical commissioning metrics developed by Commissioning for Quality in Rheumatoid Arthritis (CQRA) to measure and demonstrate the quality of the service they were providing in line with NICE guidance.

The CQRA metrics cover: speed of referral (for patients with recent onset disease who are ≤2 years from diagnosis); and for all patients, regularity of disease activity assessment; rapidity of treatment escalation to achieve clinical remission or low disease activity; and regularity of comprehensive patient review. Incorporation of the metrics into the existing system was very simple requiring only the support of the IT manager and initial consultation to get the integrated system up and running. Use of the CQRA quality commissioning metrics has demonstrated that patients are receiving a quality service and has provided healthcare professionals with patient population and patient management data that demonstrates alignment of their clinical practice with best practice.

In the changing NHS the ability to demonstrate value for money and the delivery of a high quality service is increasingly important: the Vitality Partnership Rheumatology Service has achieved this by successfully integrating CQRA quality commissioning metrics into their existing information system.

CQRA is a Joint Working Partnership between the NHS, academia, patient organisation, National Rheumatoid Arthritis Society (NRAS) and industry, Roche Products Ltd

Situation and challenge

In 2008 the NHS launched the '*Care closer to home project*' marking a move to increase the range and scale of health services delivered within the community setting rather than within the acute setting. At around this time, Dr Ben Empson, a local General Practitioner with a Special Interest (GPSI) in Rheumatology, was working within an acute trust and felt that the time was right to develop a community-based rheumatology service. He was also a member of the Vitality Super Partnership with 40,000 patients looking to integrate specialist services into a larger primary health care organisation. One of the reasons for patients being treated in hospital was because their GPs may not have the specialist skills and knowledge for management of patients requiring medications such as disease modifying anti-rheumatic drugs (DMARDs). Repatriation of patients from the hospital to a community setting with provision of the specialist skills needed to manage patients, would not only provide patients with local more convenient care and reduce disengagement, but would also optimise resource use – both in terms of healthcare professional resource and financial resource. For example moving some of the routine follow-up activity for rheumatology patients such as drug monitoring would undercut the tariff by 30%. In addition, patients would be able to see the most appropriate member of the healthcare team allowing more effective management of their condition and freeing up specialist rheumatologists for more acute cases.

Meeting the challenge

A specification was developed for a pilot to assess whether this transfer would be feasible and beneficial to both patients and healthcare providers. One finding from the pilot study, which included around ten participating practices, was that around one-third of patients who had been diagnosed with rheumatic disease were lost to follow-up and were no longer attending hospital appointments or were not engaging with the service, indicating a hidden cohort of patients. A community-based service would help to ensure that fewer patients were lost to follow-up. A triage service was established where patients with new musculoskeletal (MSK) problems could be referred in to the service and worked up by a GPSI or an extended scope physiotherapist to ensure that patients received the most appropriate care from the most appropriate health practitioner. The triage service included three types of MSK presentations. Patients presenting with structural or muscular issues or those with chronic pain could be effectively managed by GPs, specialist nurses, GPSIs or physiotherapists. The third group of patients presenting with suspected inflammatory arthritis (IA) were worked up and a sessional rheumatologist employed to manage these patients. Following the success of the pilot project, Sandwell and West Birmingham Hospitals NHS Trust decided to develop an alliance with the Vitality Partnership using a Service Level Agreement

(SLA). This was arranged in 2010 where the Trust's academic rheumatologists have been managing IA patients in the community-based service and delivering this care under the community tariff. As a result of this, patients with IA who need specialist rheumatology care are screened out from the rest of the MSK population and referred more appropriately. In addition, a nurse-led clinic was established such that any patient diagnosed with IA was case managed by the nursing team to allow tight control of their disease with regular monitoring of disease activity score (DAS). This facilitated titration of medication with patients moving along the drug pathway to the most appropriate drugs to control their disease in the shortest time period possible.

The nurse-led community service model that has been established means that rheumatologists do not have a follow-up cohort such that their new to follow-up ratio is lower than the national average. Patients are only referred to rheumatologists when needed and as soon as needed, rather than at conventional time intervals that may not correlate with medical need. This has meant that the waiting time for new patients has been reduced to two weeks or less. In addition, rheumatologists are freed to case manage complex patients and to pursue their academic and research interests. Another success of the nurse-led service has been to take research into the community and the service is taking part in the DELAY study – a study looking at the reasons why patients may delay approaching their GP or specialist with their symptoms – which is critical in the timely management of IA to prevent joint damage and other complications. There are now six GP outlets throughout the borough that the nurse-led services operate from. The service has two specialist nurses, one fully-trained GPSI and one in training, an extended scope physiotherapist and a healthcare assistant who is being trained to assistant practitioner level (band 4). The aim is that once the patient is stabilised their routine monitoring and annual review can be carried out by the assistant practitioner with rheumatology nurse support.

Benefits and replicability

Establishing a nurse-led community rheumatology service has yielded several benefits for both the healthcare service and for patients. As well as reducing the tariff by 30%, patients are being treated by the most appropriate person at the right time. This has reduced waiting time for patients requiring acute rheumatologist services and ensured regular routine monitoring for patients with tight control of their disease within their own community. Importantly for IA patients, they have rapid access to the nurse-led team during flares. The triage service has optimised access to rheumatologists and made more effective use of their time, allowing improved case management based on need. Being in the community has also made the team more aware of other services

available outside of the hospital setting. As a result, there has been increased use of these additional services to provide a more comprehensive package of care for patients.

The team has also been able to access a fast track orthopaedic service which means that joint replacements can now be carried out generally within an eight-week period from referral to surgery. A major benefit of the nurse-led service is that nurses are best placed to educate empower and tightly control patients particularly if they are also able to prescribe and administer joint injections. Currently administration of medication requiring Intravenous infusion (such as some biologics) is carried out in the hospital setting with follow-up and outcome measurement being carried out back in the community setting, but the feasibility of providing an infusion service within the community is being assessed. Subcutaneous delivery of some of these medicines also facilitates community-based administration.

Other hospitals within the borough are now actively migrating their patients onto the community based service with the development of new SLAs, highlighting the replicability of this model. In addition, the nurse-led team has been commissioned by another Clinical Commissioning Group and is receiving an increasing number of referrals to the service.

Measuring the quality of the community based service

One of the critical success factors for the nurse-led community service was the ability to demonstrate patient recorded outcome measures. By using a primary care clinical database that was READ coded, templates could be designed to capture clinical outcomes. Information Technology (IT) systems used in most hospital rheumatology departments are not as sophisticated as those used by GP's. This allowed the nurses to develop a system that would capture not only how many patients were using the service but also their diagnosis and management and the quality of care that patients were receiving.

The team decided to use the clinical commissioning metrics developed by Commissioning for Quality in Rheumatoid Arthritis (CQRA) to provide this information and to measure and demonstrate the quality of the service they were providing in line with National Institute for Health and Clinical Excellence (NICE) guidance. The CQRA metrics cover: speed of referral (for patients with recent onset disease who are ≤2 years from diagnosis); and for all patients, regularity of disease activity assessment; rapidity of treatment escalation to achieve clinical remission or low disease activity; and regularity of comprehensive patient review. The metrics were incorporated into their IT system

template so that each time a patient attended a clinic, the information was captured automatically. The template also captures diagnosis, treatment pathway choice, and disease characteristics such as seropositivity. All the information is READ coded allowing the team to interrogate the data as needed for specific patient populations and is web-based to ensure that the data is captured in a central portable database with documentation of each consultation.

Incorporation of the metrics into the existing EMiS web system already in place was very simple requiring only the support of the IT manager and initial consultation to get the integrated system up and running. Use of the metrics has already demonstrated that patients are receiving a quality service and has provided healthcare professionals patient population and patient management data that demonstrates alignment of their clinical practice with best practice. In the changing NHS the ability to demonstrate value for money and the delivery of a high quality service is increasingly important: the Vitality Partnership Rheumatology Service has achieved this by successfully integrating CQRA quality commissioning metrics into their existing information system. The nurse-led team are now evaluating the use of a patient satisfaction survey within the web-based system. They also aim to collect data on work and worklessness – key issues that can have a considerable impact on rheumatology patients.

Find out more

To find out more about the Vitality Partnership Rheumatology Service approach to implementation of CQRA metrics in the primary care setting contact Dawn Homer, Rheumatology Nurse Consultant (dhomer@nhs.net) or Erica Gould, Rheumatology Nurse Practitioner (erica.gould@nhs.net). To find out more about the Vitality Partnership Rheumatology Service go to www.vitalitypartnership.nhs.uk.