Written evidence submitted by British Society for Rheumatology (EPW0070)

1. About BSR

British Society for Rheumatology (BSR) is the UK's leading specialist medical society for rheumatology professionals. BSR supports its members to help deliver the best care for their patients, in order to improve the lives of children, young people, and adults with rheumatic and musculoskeletal disease.

BSR members represent the entire profession - from those at the beginning of their career to the most senior consultants, researchers, academics, and health professionals in the multi-disciplinary team. Together, they form a powerful voice for paediatric, adolescent, and adult rheumatology in the UK.

BSR sets standards of practice, education, and learning, and drives improvements through running patient registries and leading the HQIP National Early Inflammatory Arthritis Audit (NEIAA). The NEIAA audit is the largest audit of its kind and has involved over 50,000 patients to date across England & Wales.

2. Methodology

Thank you for inviting us to submit evidence to this inquiry. This submission is based on members' experiences and the Society's substantial research and analysis. BSR undertook its first workforce data collection of the rheumatology workforce in 2020. It is the most detailed understanding of capacity within the specialty. BSR collected data from 80% of departments across the UK. Based on the data collected, BSR was able to determine the composition of the average rheumatology MDT. This data was then compared to the findings of the NEIAA audit, which provided an estimation of the safe ratio of clinicians to the patient population to ensure care meets NICE Quality Standards.

3. Response

Government Commitment under evaluation #1: Planning for the workforce

Commitment: ***Ensure that the NHS and social care system have the nurses, midwives, doctors, carers, and other health professionals that it needs.***

a) Does the commitment have a deadline for implementation?

3.1. BSR is not aware of a government-set deadline to address the current rheumatology workforce crisis. Based on the most recent BSR data, the government has not met its manifesto commitment to the care and treatment of people with rheumatology. Today's NHS and social care workforce does not have *"the nurses… doctors, carers, and other health professionals it needs"* to meet the minimum standards of care in rheumatology defined by NICE.

3.2. This is the most significant NHS rheumatology workforce crisis NHS in living memory. As such, BSR would welcome the government setting a deadline to address gaps and vacancies in the rheumatology consultant/medical, nursing, physiotherapy, psychological, and allied health professional numbers across England.

3.3. Rheumatology is a multidisciplinary branch of medicine that deals with the investigation, diagnosis, and management of patients with arthritis and other musculoskeletal conditions. This incorporates over 200 disorders affecting joints, bones, muscles, and soft tissues, including inflammatory arthritis and other systemic autoimmune disorders, vasculitis, soft tissue conditions, spinal pain, and metabolic bone disease. Rheumatological conditions are often chronic and complex, requiring treatment with advanced high-cost therapies and multidisciplinary management. A holistic approach incorporating occupational therapy, physiotherapy and podiatry lead to improved health outcomes and greater self-efficacy.

b) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

3.4. Several factors have contributed to this commitment not being met:

- The decision taken not to underpin NHS England and Improvement's (NHSEI) Best MSK Health Programme with a clear workforce, training, and education strategy.
- High quality, detailed rheumatology workforce data is not informing local, system, and national decision-making, forecasting, planning, or funding
- The lack of a fully funded, data-driven, long-term national workforce strategy

3.5. The lack of clear targets attached to addressing shortages, vacancies and training gaps in the rheumatology workforce is holding back the implementation and impact of the NHSEI Best MSK Health Programme. It is also impeding the 'radical improvements in quality and availability against national data requirements and clinical standards' prioritised in digital MSK care (2022-23 priorities and operational planning guidance).

3.6. Beyond BSR independent measures, there is no adequate regional or national system in place to record the number of rheumatology multidisciplinary team members working across the NHS. In this vein, BSR was disappointed that the government chose not to include a simple workforce amendment, supported by more than 100 health and social care organisations, to the Health and Care Bill that would commit the government to publish workforce projections. BSR questions how informed, long-term decision-making about workforce needs can be taken without data of this kind made publicly available. Maintaining these (rheumatology MDT) data would support the identification of workforce gaps and recruitment and provide an evidence-based solution to long-term workforce succession planning that the Hunt/Cumberlege workforce amendments call for.

3.7. The forthcoming NHSEI/HEE workforce strategy must be fully funded and clearly set out how it intends to address workforce vacancies and shortages in defined, specialised services. BSR would welcome clearer guidance on the consultation and engagement process leading up to the strategy's publication. The NHS workforce requires a mix of skills and speciality expertise necessary to meet the needs of defined specialised services. Its commitment to increasing the general nursing workforce is welcome, but the NHS also requires a consistent pipeline of specialist nurse practitioners with an interest in rheumatology, and it is unclear whether the government's activities will achieve this quickly enough in rheumatology at the necessary scale, and geographic mix required.

c) To what extent has the Covid-19 response affected progress on targets?

3.8. The rheumatology crisis existed before COVID, with the pandemic exacerbating already existing workload pressures. 60% of webinar polling respondents reported that staff

shortages and vacancies during the pandemic impacted their department's ability to restore their services.[1] In addition, the pandemic has required new ways of working and new skills of the multidisciplinary team whilst conversely reducing education and training opportunities

d) How has this commitment been interpreted in practice at local authority/care provider/trust level?

3.9. A combined system approach to workforce planning is preferable to individual providers or authorities working in isolation. More work must be done to develop and support collaborative workforce planning approaches at a system level. Clinicians and healthcare professionals at all levels should be part of the workforce planning process.

3.10. We would welcome the Expert Panel's consideration of:

- How national programmes (such as NHSEI Best MSK) when developed for local implementation are underpinned by the necessary workforce (incl. planning/funding) to deliver new pathways and ways of working
- What role rheumatology ICS leads will take in workforce planning and what this should look like

e) Does data show achievement against the target (if applicable)?

3.11. The BSR 2020/1 workforce data collection – which focused on care delivered by defined rheumatology services - found that there are not enough consultants or specialist nurses in rheumatology, and access to certain members of the multidisciplinary team (MDT), including psychologists and pharmacists, is not sufficient.

3.12. At a minimum, all rheumatology services should have access to occupational therapy, physiotherapy, podiatry, psychology and pharmacy services, in line with NICE guidance (e.g. NICE. Guideline [NG100]: Rheumatoid arthritis in adults: management; NICE. Guidelines [NG65]: Spondyloarthritis in over 16s: diagnosis and management).

BSR report *Rheumatology workforce: A crisis in numbers* found:

- The ***NHS does not have enough rheumatology consultants*** and does not meet the recommended consultant to patient population ratio.
- ***Adult rheumatology specialist nurse numbers must increase*** to ensure departments are adequately staffed, with a specialist nurse to consultant ratio of at least 1:1. BSR report '*Specialist nursing in rheumatology, the State of Play*' found that specialist rheumatology nurses had insufficient administrative support, overburdened workloads, and inadequate job and succession planning. Furthermore, 83% of survey respondents reported there were currently aspects of care that their team was unable or delayed in providing because of excessive workload.[2]

- ***43% of respondents said that a pharmacist was not employed as part of their MDT***. Where there was a pharmacist role employed, this averaged 0.6 WTE.

[1] BSR. Webinar on 3 September 2020. Response rate of 25, which may be representative of 25 departments.

[2] BSR. Specialist nursing in rheumatology, the State of Play. https://www.rheumatology.org.uk/Portals/0/Documents/Policy/Reports/Specialist_nursing_rheumatology_2019_State_of_Play.pdf?ver=2019-04-24-170948-180. Accessed 4 September 2020.

- ***40% of respondents said that a physiotherapist was not employed as part of their MDT.*** Where there was a physiotherapist role employed, this averaged 0.9 WTE.
- ***46% of respondents said that an occupational therapist was not employed as part of their MDT.*** Where there was a pharmacist role employed, this averaged 0.7 WTE.
- ***72% of respondents said that a podiatrist was not employed as of their MDT.*** Where there was a podiatrist role employed, this averaged 0.2 WTE.
- ***83% of respondents said that a psychologist was not employed as part of their MDT.*** Where there was a psychologist role employed, this averaged 0.03 WTE.

3.13. **Vacancies are high** across the rheumatology MDT and are greatest among consultants:

- Consultant 12%
- Specialist nurse 7%
- Allied Health Professionals 8%

3.14. Patients require specialists to oversee their care. However, too often nurses and allied health professionals split their time across rheumatology and more generalist clinical care.

Government commitment	**Achievement against target (where information available)**
Increase in the number of students in medical training of 1,500 a year	The Getting It Right First Time (GIRFT) Rheumatology Speciality report found: • Training numbers have not increased, despite the expansion of rheumatology as a specialty. • Trainees unevenly distributed across the country. • Due to the introduction of mandatory dual training within General Internal Medicine, all trainees are spending 15-20% less time in rheumatology.
50,000 more nurses	BSR workforce audit found more specialist rheumatology nurses are needed across the UK to improve patient outcomes (see above).

26,000 more primary care professionals	Best MSK Health programme aims to integrate 26,000 additional primary care roles e.g. First Contact Practitioners, health coaches and social prescribers - funded by Additional Roles Reimbursement Scheme (ARRS) by end 22/23. In response to a Parliamentary question (from 2020) asking how many first contact practioners had been employed by GP practices since 2019 the government responded that there were '69 physiotherapists working in general practice as of June 2020'.

Effectively funded?

f) Were specific funding arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?

3.15. We are not aware of specific funding arrangements to address shortages and gaps in the numbers of rheumatology consultants, nurse specialists, pharmacists, and psychologists in rheumatology services.

3.16. The five-year framework for GP contract reform committed to "invest £891 million to fund an additional 20,000 workforce across five staff groups including MSK First Contact Practioners (FCPs) to support general practice". FCPs are intended to be the first point of contact for the patient and provide expert assessment, checks for red flags, advice on self-management and/or exercise and social prescription. The role aims to enhance the quality of care given by the primary care workforce and is expected to reduce inappropriate referrals into secondary care. Appropriate training is crucial to the role and the ability to effectively triage and refer.

3.17. According to this parliamentary answer, the Government does not provide direct funding to allied health professionals to become first-contact practitioners. The government states that Health Education England 'is investing in the development of capability frameworks and credentials to support advanced practice across nursing, midwifery and allied health professions including physiotherapy'. In response to this Parliamentary question (2020) asking how many first contact practitioners had been employed by GP practices since 2019 the government responded that there were '69 physiotherapists working in general practice as of June 2020'.

g) Impact for patients and service users?

3.18. The crisis in the Rheumatology workforce is affecting the quality, safety, and ability to access timely rheumatology care. It is also increasing health inequalities and reducing quality of life- both socially and economically, amongst rheumatology patients.

3.19. Rheumatology conditions affect all age (but increase with age) and ethnic groups. They are more common in areas of greater poverty, and a leading cause of disability (after mental health), and the biggest cause in the elderly. The widespread impact costs the NHS £10.2 billion every year,[3] with the healthcare cost of these conditions predicted to reach £118.6 billion over the next decade.[3]

3.20. Rheumatology patients are waiting longer to access care. The following table set out Consultant led Referral to Treatment Waiting Times (RTT) data.

Rheumatology	Completed, including unknown clock starts		Incomplete, March 2020	
	Admitted	Not admitted	Total	% <18 wks
Feb 2022 (latest)	1,084	23,526	111,540	69.2%
April 2021			93,434	76.3%
2019/20	23,684	327,411	88,009	85.0%
2018/19	25,702	326,410	89,105	89.9%
2017/18	23,751	298,892	76,250	90.7%

3.21. Low levels of consultant provision lead to unacceptably high caseloads for the whole MDT and affect patient outcomes. The HQIP NEIAA audit found that only 48% of patients referred for suspected early inflammatory arthritis are seen within three weeks, meeting the NICE target, with substantial geographical variations persisting.

3.22. The HQIP NEIAA audit found 83% of specialist rheumatology nurse survey respondents reported that there were aspects of care that their team was either unable to provide, or that were regularly delayed because of excessive workload.

Government Commitments under evaluation #2: Building a skilled workforce

Commitment: Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.[4]

a) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

3.23. The following factors mitigate against the government building a skilled rheumatology workforce:

- Lack of career progression opportunities
- Lack of exposure to rheumatology when training
- Need to do more to attract trainees into the speciality
- Rotational posts for Allied Health Professionals and nurses
- Urgent need to expand higher speciality training posts in rheumatology
- Urgent need to review speciality training

3.24. **Lack of career progression opportunities**: BSR want the government to do more to support the progression of the existing workforce. 58% of AHPs, pharmacists and nurses quoted lack of posts and opportunities for career progression.[5] BSR want training opportunities to develop advanced specialist skills, as well as the creation of appropriate roles within secondary care to recognise AHP extended scope roles. Staff should be encouraged to develop their specialist skills and extend their scope of practice with

[3] Best MSK presentation given by Andy Bennett. NHS England and Improvement Lead (May 2022)
[4] BSR (2021) *Rheumatology Workforce: A crisis in numbers*. London. BSR
[5] BSR (2021) *Rheumatology Workforce: A crisis in numbers*. London. BSR

departments providing the opportunities to do so. These roles must be recognised with appropriate Agenda for Change (AfC) banding in line with the specialist skills required and to ensure that they attract qualified candidates.

3.25. **Lack of exposure to rheumatology when training:** Opportunities for clinical exposure to rheumatology during undergraduate and postgraduate studies are inconsistent across the UK. Many of the individuals in BSR interviews could not remember having any rheumatology placements during their undergraduate studies. This was particularly pronounced in paediatric rheumatology. Some who wanted foundation and core/internal medical positions with rheumatology rotations found these were not available. Also, with less care of rheumatology patients taking place on wards, there are fewer informal opportunities for trainees to encounter rheumatological conditions. Rheumatology is a complex specialty requiring a wide breadth of knowledge, but this is often not reflected in curricula and training.

3.26. **Rotational posts for Allied Health Professionals and nurses:** Interpretation is mixed contributing to variation in the quality of care and new ways of working. A clear strategy, underpinned by targets, as outlined by the BSR, and endorsed by others in the rheumatology sector would offer the ideal solution. AHPs, pharmacists, psychologists and nurses also receive minimal exposure to rheumatology, with the exception of physiotherapy and podiatry students, who come to understand rheumatology as a sub-specialism of musculoskeletal disease during their studies. This lack of exposure to rheumatology in course content and placement opportunities means that students are unlikely to explore rheumatology as a specialism option during their studies. A solution to this could be through rotational posts which have been shown to improve staff retention for newly qualified clinicians and those more established in their careers. Many nurses were not aware of rheumatology as a specialist option until they came across rheumatology specialists during rotational posts. Rheumatology wards used to attract nurses into the specialty, but today, rotational posts are the best way to offer this exposure in an outpatient setting

3.27. **Doing more to attract trainees into the speciality**: Taster days during medical rotations allow students to gain more insight into rheumatology. However low staffing levels can discourage first year students to take time away from the ward as it increases pressures on the remaining staff. Attracting trainees into the speciality needs to be a greater priority and this requires encouragement, support, opportunities, and investment. Opportunities need to be created in the form of the above exposure, but also there is a need for an increased number of posts for various members of the MDT in rheumatology

3.28. **Urgent need to expand higher speciality training posts in rheumatology:** Rheumatology has the highest competition ratio of applicants to training places of any specialty. The majority of rheumatology applicants are unsuccessful, due to the lack of available training posts (numbers of which have not kept up with expanding specialty). Consequently, the NHS is not training enough rheumatologists to take up the available consultant posts (see audit data above). There is an urgent need to expand higher specialty training posts in rheumatology to fill consultant vacancies and provide safe care.

3.29. **Review of speciality training*:*** GIRFT has called for a review of rheumatology speciality training to be led by the Special Advisory Committee. Due to the introduction of the IMT programme in August 2020, it is estimated there will be a 15–20% reduction of trainee time in rheumatology. There are also significant variations between Trusts in the

amount of time trainees spend in rheumatology compared to General Internal Medicine (GIM). In addition to this, some trainees spend a significant portion of their time doing tasks that had a low educational value. Trainees with dual accreditation are more likely to split their time between rheumatology and GIM throughout their careers, reducing dedicated time for rheumatology care. BSR support the draft GIRFT report's call for a review of specialty training to ensure that trainees receive a valuable and diverse training experience.

May 2020