Written evidence submitted by The British Society for Rheumatology (WBR0048)

The British Society for Rheumatology is the UK's leading specialist society for rheumatology and musculoskeletal professionals. We support our 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. Our members represent the entire profession - from those at the beginning of their career to the most senior consultants, researchers, academics, nurses and health professionals from across the multi-disciplinary team.

As the voice for paediatric, adolescent and adult rheumatology health professionals in the UK, we are, naturally, concerned with the impact that COVID-19 has already had – and will continue to have – on rheumatology staff's resilience and wellbeing.

Introduction

We welcome the opportunity to respond to this inquiry, as we believe that resilience within the NHS should apply to systems, rather than simply individuals. A focus on individual resilience among NHS staff leads to placing blame with individuals, rather than the systems in which they work. Our focus should be on addressing current rota gaps and unsustainable workloads – building resilience at a system level.

At the peak of the pandemic, rheumatology departments were placed under immense pressure, working with skeleton staff and delivering only the most essential services. Some services had to stop completely. New patient referrals and follow-up appointments had to be carefully triaged to ensure the most urgent patients were seen, while many others had their appointments delayed or cancelled. New systems and ways of working had to be quickly adopted. In future, specialties must have business continuity plans for pandemics in place to support timely and co-ordinated responses. A lot of pressure and responsibility is still being placed on the NHS workforce to redesign services, prioritise patients and meet the growing backlog of work.

Beyond NHS systems and its workforce, patients will have been waiting to be seen, including some who will have suffered permanent harm from delays in diagnosis and treatment. This not only impacts patients at an individual level, but will likely have wider societal and economic impacts. For instance, 25.1 million working days were lost due to osteoarthritis and rheumatoid arthritis and this is expected to increase to 25.9 million annually by 2030, which equals an annual £3.43 billion productivity hit to the economic.[i]

We have consulted with our membership across the UK on a regular basis in recent months in relation to how their services have been operating before, during and after the peak, which informs our submission. We would be happy to provide further information on any issue covered, should the committee find it helpful.

How resilient was the NHS and social care workforce under pre-COVID-19 operating conditions, and how might that resilience be strengthened in the future?

Many departments struggled to know what work could be "stepped down" and what needed to be prioritised. The NHSE speciality guides[ii] were well received once published, and importantly there was input into these guides from speciality leads. They remain resources if rheumatology services ever face a situation again where services need to be "stepped down", but underline the need for continuity plans to be proactively developed to enable timely responses which minimise the impact on staff and care to patients.

The lack of forward planning meant that many departments struggled to move to remote working. Systems had to be put in place (e.g. Attend Anywhere) and IT equipment provided to staff (e.g. laptops) and this took a large amount of time. It is clear that the lack of a co-ordinated IT approach led to additional pressure being placed on services, as different software was rolled out and implemented differently between regions and across the UK. As such, future resilience could be strengthened by a consistent, UK-wide approach to the implementation of IT software to enable collaborative working and effective communication.

Many departments were unable to get advice out to patients on scale, which led to advice lines being overwhelmed with calls. The ability of teams to provide information to patients by text or updates to trust websites would have been hugely helpful to deal with lots of queries. Some services also closed their helplines, which subsequently made departments inaccessible for the majority of their patients during lockdown. The impact of this can be seen in a recent report from the Rare Autoimmune Rheumatic Disease Alliance (RAIRDA), where just under 1,400 patients were surveyed about the impact of COVID-19:

- 80% had experienced a change in their care and treatment
- 37% said that their ability to manage their condition had been affected as a result
- 47% said that the advice they received was "clear and consistent", with 34% saying the advice they received about their level of risk was "unclear and contradictory". A proportion also received no personalised information or advice.[iii]

What has the impact of the COVID-19 pandemic been on resilience, levels of workforce stress, and burnout across the NHS and social care sectors?

We are aware of the ongoing pressure many departments are now facing challenges reinstating face-to-face clinics with many hospital managers questioning why more cannot be done remotely. Face to face consultations are still as important as ever, as some patients need to be physically seen to allow for joint examination and other assessments, as well as blood test to monitor disease activity. Clinicians also have understandable concerns about the safety of escalating and starting treatment if they are unable to examine patients. Despite this pressing need, we found 69% of polled webinar attendees[iv] reported their department have struggled to reclaim office and/or clinic space in order to restart their service and meet the NHS phase 3 directive[v] to restore 100% of outpatient activity from this month. This is why both BSR and Versus Arthritis have launched campaigns to restart services for the health and safety of rheumatology patients.

Many clinicians are frustrated that patients aren't getting the care they need for these reasons. With much of elective care cancelled and delayed due to COVID-19, services are face with a mounting backlog. By April 2020, the number of people waiting for consultant-led elective care reached four million in the UK.[vi] A UK-wide survey conducted by Versus Arthritis found that 40% of people reported that their appointments for arthritis had been cancelled.[vii]

The problems that the backlog/delays in treatment causes significant stress for patients and more work for departments. With the rheumatology workforce already suffering major gaps and retention issues, the specialty has had no opportunity to recover. In a poll of webinar attendees, 60% of respondents reported that staff shortages and vacancies impacted their department's ability to restore their services.[viii] Now, the workforce faces the prospect of managing a large backlog of patients as we approach winter pressures and a potential second wave, which may again lead to redeployment to other services.

What long term projections for the future health and social care workforce are available, and how many more staff are required so that burnout and pressure on the frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?

Rheumatology services have been tasked with restoring 100% of last year's outpatient activity by September 2020.[ix] This conflicts with our own assessment, which was highlighted in an RCP report that full-capacity in all rheumatology service will not be restored for 12+ months from June 2020.[x] Further evidence is provided from a recent poll of webinar attendees,[xi] which shows that only 27% of services have been fully restored to date, and reflects ongoing difficulties in re-establishing services, complying with social distancing and other requirements.

The primary reason however is that rheumatology as a specialty is under-resourced with rota gaps, roles not being filled and an increasing number of patients. The National Early Inflammatory Arthritis Audit (NEIAA), the most comprehensive analysis of services undertaken in rheumatology, highlights the scale of this problem. Substantial variation in staffing numbers and access to multidisciplinary teams (MDT) exists across England and Wales. The latter is a well-established NICE recommendation, but only 75% of centres can access occupational therapy, physiotherapy and podiatry services (MDT) and psychological support in 39%.[xii] This is important as inflammatory arthritis is a disabling condition for example, and research has shown that a holistic approach incorporating occupational therapy, physiotherapy and podiatry leads to improved health outcomes and greater self-efficacy.

The specialty faced these problems before the lockdown, and the necessity of a drive for staff recruitment across the rheumatology MDT has been made much more apparent due to the stretches outlined in this submission.

To what extent are there sufficient numbers of NHS and social care professionals in training for service and resilience planning? On what basis are decisions made about the supply and demand for professionals in training?

As highlighted above, the number of rheumatology professionals is insufficient to meet demand. In the short-term, trainees have now returned to the specialty following deployment to COVID wards, which will help to manage the backlog of patients in the system for example. A greater number of rheumatology professionals across the multidisciplinary team will still however be required across the UK to meet rising demand. To that end, we welcome the relaxation of the cap on medical student numbers this year, although believe that dual training requirements is likely to ultimately reduce the number of trainees in rheumatology.

Our report *Specialist Nursing in Rheumatology, The State of Play* also highlighted the need for greater resilience among specialist nursing workforce planning. Our survey showed that specialist rheumatology nurses had insufficient administrative support, overburdened workloads, and inadequate job and succession planning. Succession planning is needed to ensure there is an appropriate skill mixed workforce in the future. 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.[xiii] At present, it seems clear that the current specialist rheumatology nurse workforce is insufficient to meet the service demands.

What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce?

There needs to be more information gathered about the impact on staff doctors, nurses and AHPs across all specialities and to understand what areas clinicians are struggling with in order to then

inform what measures will help to reduce stress and burnout. Many clinicians have had to step outside their comfort zone and adopt new ways of working, take long periods without leave, and as a speciality we have endeavoured to support clinicians wherever possible.

For any further information on this submission, please contact Jack Feinmann, Public Affairs Manager at the British Society for Rheumatology.

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[i] Arthritis Research UK (Versus Arthritis), 2017. The Nation's Joint Problem.
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[iii] RAIRDA. Chronic Crisis: The Impact of COVID-19 on people with rare autoimmune rheumatic diseases. https://www.lupusuk.org.uk/rairda-chronic-crisis-report/. Accessed 4 September 2020.
[iv] BSR. Webinar on 3 September 2020. Response rate of 25, which is representative of 25 departments.
[v] NHSE. Third phase of NHS response to COVID-19. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf. Accessed 2 September 2020.
[vi] Davies J (2020) 'QualityWatch: NHS performance summary, April – May 2020'. www.nuffieldtrust.org.uk/news-item/combined-performancesummary-april-may-2020. Accessed 20 August 2020.
[vii] Versus Arthritis. Impossible to Ignore. https://www.versusarthritis.org/news/2020/july/uk-governments-warned-that-millions-with-arthritis-left-behind/. Accessed 4 September 2020.
[viii] BSR. Webinar on 3 September 2020. Response rate of 25, which may is representative of 25 departments.
[ix] NHSE. Third phase of NHS response to COVID-19. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf. Accessed 2 September 2020.
[x] RCP. Returning the NHS to an even keel. https://www.rcplondon.ac.uk/guidelines-policy/returning-nhs-even-keel. Accessed 4 September 2020.
[xi] BSR. Webinar on 3 September 2020. Response rate of 25, which is representative of 25 departments.
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