British Society for Rheumatology

NATIONAL EARLY INFLAMMATORY ARTHRITIS AUDIT (NEIAA)

QUALITY IMPROVEMENT PLAN July 2020

INTRODUCTION

Rheumatoid arthritis is a long-term condition that can lead to disability, morbidity, and can impact significantly on quality of life. Randomised trial data provide a robust evidence base for early intervention and have led to the publication of NICE clinical guidelines and quality statements. These guidelines and statements recognise that the first months after onset of symptoms represent a critical time in patients' journeys. There is a window of opportunity to establish effective treatment that will reduce immediate symptoms and improve the long-term trajectory of the disease. NEIAA is collecting information on all new patients over the age of 16 seen in specialist rheumatology departments with suspected inflammatory arthritis in England and Wales. Information is gathered from the first appointment for all patients with suspected inflammatory arthritis and/or axial spondyloarthropathy, and during the first 12 months of specialist care for patients with rheumatoid pattern inflammatory arthritis, assessing performance against the NICE quality statements.

A quality improvement (QI) plan is necessary as NEIAA data show there is significant room for improvement in performance against the 7 NICE quality statements (2013 version)[1] for all Trusts and Health Boards. Evidence suggests that episodic audit activity is ineffective at driving lasting change, but as NEIAA is a continuous data collection process[2] and provides real time results to Trusts and Health Boards, it is well placed to support activities aimed at improvement in patient care, in line with the wider NHS strategy.

We published the first iteration of this plan in 2019 and are reviewing it on an annual basis.

IMPROVEMENT GOALS

The focus for quality improvement for the first year of the plan was to target quality statements 1, 2 and 3 (2013 version) with quality statement 3 (time to starting treatment) the priority. The rationale for this was that time to treatment initiation is the most important factor in predicting clinical outcome based upon the first year of data from NEIAA, and is within the control of secondary care services.

Analyses of performance for the second NEIAA annual report have identified that all three specific goals of the NEIAA quality improvement plan were met and exceeded. The specific goals and associated improvements are listed below:

1. Increase the proportion of people referred by their GP within 3 working days by 5%; 6% improvement achieved
2. Reduce the delay in first rheumatology appointment, aiming to increase the proportion of patients achieving quality standard 2 by 5%; 10% improvement achieved
3. Shorten the time from referral to starting treatment, increasing the proportion of patients achieving quality standard 3 by 10%; 10% improvement achieved.

[1] NICE updated its Quality Standard for Rheumatoid Arthritis (QS 33) in January 2020, reducing the number of Quality Statements from 7 to 5. NEIAA is measuring performance against the Quality Statements set out in the 2013 iteration of QS33.

[2] Data collection was suspended temporarily in March 2020 as a result of the COVID-19 pandemic,

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The impact of the COVID-19 pandemic on rheumatology services is likely to have been substantial due to staff being seconded to acute in-patient work, and the suspension of outpatient services in many Trusts. The priority for Trusts and Health Boards over the next 12 months will therefore be to re-establish services. There will also be an urgent requirement for Trusts and Health Boards to adapt the way in which many of their services are delivered. As such, the immediate QI priorities for NEIAA are to support services in trying to maintain the improvements gained prior to the pandemic and to limit any deterioration. In addition, we will make adaptations to data collection processes to reflect the new ways of working and will continue to support quality improvement work using NEIAA data, where the local context allows.

IMPROVEMENT METHODS

NATIONAL

1. The BSR has already started work to support its members in developing their services in the post COVID 19 era. The NEIAA team have made changes to the NEIAA web platforms to support continued capture of required data through remote consultations (video, telephone). These data may provide insights into whether these new modes of consultation have any impact on patient outcomes.

2. The Best Practice Tariff (BPT) for early inflammatory arthritis in England, introduced in 2019, offers an additional payment if the care provided to patients meets 6 criteria linked with key aspects of care assessed within NEIAA. NEIAA provides automated reporting to Trusts to enable Clinical Commissioning Group (CCG) level reimbursement and this financial incentive should help drive QI work within departments. At the time of writing, the BPT is suspended as a result of the COVID19 pandemic, but quarterly BPT reports are available on the NEIAA website and activity will resume as soon as feasible.

3. The Getting It Right First Time (GIRFT) programme in England has access to real time provider-level NEIAA data to support Trust inspections and ensure data-driven assessment of departmental efficiency. GIRFT team visits began in 2019, using current and previous audit data set against audit targets and national averages. Reports from these visits will act as drivers for targeted QI work and will help promote shared learning, given the GIRFT aim of reducing variation in care links. Again, GIRFT visits are currently suspended but will resume once feasible.

4. Work has already been undertaken with the Care Quality Commission (CQC) to agree a reporting template using NEIAA data. The CQC receives Trust level data on four metrics that assess the safety and quality of care provided. Although the CQC is primarily focused on assessing quality, it recognises the strength of a culture of quality improvement in driving outstanding care, and is a powerful voice when quality of care

falls well below what would be expected. Links with the CQC are therefore seen as an important component of this QI plan. Again, CQC visits are currently suspended but will resume once feasible.

5. The British Society for Rheumatology (BSR) worked with the Royal College of General Practitioners (RCGP) on an inflammatory arthritis e-learning tool for GPs, launched in 2017 and updated to link to most recent NEIAA resources. The toolkit has been a success, with (as of 31 May 2020) 689 users completing the e-learning module since January 2018 and an average course rating of 4.75 out of 5 stars.

6. BSR is exploring the potential for further activity to raise awareness amongst GPs of the importance of prompt referral (specific to quality statement 1), including work with and with Primary Care Rheumatology and Versus Arthritis to promote this via courses for GPs. This also aligns with the BSR Choosing Wisely UK recommendation on rheumatoid factor and anti-CCP, which targets quality statement 1 by recommending immediate referral of any patient with suspected inflammatory arthritis. An example driver diagram for quality statement 1 was developed with support from primary care representatives, and is available via the audit and BSR website.

7. The BSR is developing a formal quality review scheme, due to launch in 2021. This will be a summative exercise aimed at raising standards across rheumatology services throughout the UK, and participation on the NEIAA will form part of the assessment for services in England and Wales. Allied health professionals and patient representatives are involved in this initiative. Two pilots have taken place in England at the time of writing, both considering NEIAA activity. The inspection report with actions (which must be completed to gain or keep accreditation) plus recommendations (which are not mandatory to complete) will be sent to the inspected service and will be published on the BSR website.

8. BSR has established a special interest group (SIG) for QI, with a view to promoting and publicising QI work. This will act as a platform for promoting and publicising QI activity undertaken in the field of rheumatology with meetings anticipated at future annual national specialty conferences. A well-attended first meeting was held in 2019 and the outputs from this meeting are guiding future QI activity and QI support within the specialty. A main session to launch the SIG was accepted for 2020 conference, including speakers with expertise in using national audit data to drive improvement. Unfortunately, the COVID-19 pandemic led to the cancellation of the BSR annual conference and has delayed further SIG work. An application has been made to run the QI session scheduled for the 2020 conference in the 2021 conference. BSR are exploring alternative avenues for promoting key messages planned from the 2020 conference including a NEIAA webinar.

9. BSR will continue to host practical quality improvement workshops to equip consultants, trainees, nurses and allied health professionals with the methodological skills required to perform QI projects. The first such workshop was due to be held in April 2020 but and is being rescheduled for early 2021. Case studies using NEIAA data will be included to share learning of successful QI projects arising from the audit.

10. BSR will continue to promote best practice via its policy and communications activities and in interactions between senior officers and governments and opinion-formers. This includes highlighting audit findings as part of its parliamentary lobbying activity. Details of other activities undertaken and planned are in the communications section of this document.

11. BSR Best Practice Awards will continue to be used to identify and publicise outstanding service provision within the field of Rheumatology. Four sites won the 2020 Best Practice Awards and the BSR is working with the award-winning Trusts to disseminate information on the work they've done to achieve their awards.

12. Trainees have been targeted to undertake QI work via the Training Programme Directors and the Specialist Advisory Committee. Ways in which NEIAA data can be accessed by trainees for trainee led QI activity were explored during the late 2019 Specialist Advisory Committee meeting. The new specialty curriculum remains in development and trainee led QI work will be incorporated into this, providing a major incentive for trainees to undertake QI work. The programme directors for each region in the UK agreed to promote the use of NEIAA data for this work.

13. The role of patient organisations in supporting the delivery of high-quality care will continue to be explored, as detailed in the patient and public section of this plan.

14. Data download tools are available via the audit website to support use of NEIAA data for QI activity. Further information on what tools are currently available is detailed under the local section of this plan. As requested by HQIP the potential to make real time data publically available will be further explored

15. Tools to support QI activity have been developed, including driver diagrams and clinic prompts and these are available via the audit and BSR websites. From January- July 2020, the driver diagrams on the BSR website was downloaded 222 times.

REGIONAL

1. The BSR actively engages with NHS clinical networks by funding five regional champions to cover each NHS Trust/Health Board in England and Wales. Their role is to engage with local service members with a focus on continual improvement, supporting sharing of best practice, providing educational updates, and building teamwork and leadership. When recovery from the COVID-19 pandemic permits, they will identify QI leads within their regions with expertise in QI. BSR will work with these QI leads and with all relevant local groups and networks to increase capacity in QI. The focus of the regional champions' work will inevitably require some re-adjustment back to supporting Trusts in re-engaging with NEIAA for the immediate future.

2. As an example of some of the work being undertaken regionally, the North West is planning a regional QI collaborative to support sites across the region to use NEIAA data to drive QI, providing meetings to support the download of data and support in QI methodology. Lessons learned from this work will be shared with the NEIAA PWG.

3. Through its collaborative work with Versus Arthritis the BSR is promoting the work it's done with RCGP on the message about prompt referral, via its regional GP courses.

4. Opportunities for training in QI methodology within regions will continue to be explored to maximise practice of methodologically sound QI work. Although the COVID-19 pandemic has had an impact on activity in this area, the BSR will expand the work already undertaken and will work to make this available to medical and allied health professionals.

5. As detailed above, regional Training Programme Directors will promote trainee-led QI activity using NEIAA data in their regions, and existing networks of trainees with an interest in QI will be capitalised upon.

6. The BSR will continue to explore the potential of utilising regional patient groups in supporting QI work and shared learning.

LOCAL

1. NEIAA hosts an online reporting platform with real time feedback at Trust/Health Board level. The website includes the following tools to allow Trusts and Health Boards to easily access and review patterns in their NEIAA performance, as well as supporting documents and webinars to enhance ease of use:
    a. Run charts of waiting times for specialist appointments and for initiating treatment
    b. Latest achievement rates for the 7 quality statements assessed within NEIAA;
    c. Driver diagram templates with examples.
    d. Data download functions, accessible to the audit leads, to allow further deep dive analysis of their Trusts/Health Boards' data, including the patient reported outcomes

2. Quarterly reporting is undertaken at Trust/Health Board level. Trusts/Health Boards at risk of outlier performance for waiting times and treatment delays have been notified by letter and encouraged to review mechanisms for improving their performance. The BSR also plans to provide performance data for waiting times and treatment delays to all Trusts/Health Boards to drive QI work. These processes are suspended at the time of writing as a result of the COVD-19 pandemic, but will resume as soon as is feasible.

3. Trust/Health Board level performance across all quality statements, with case-mix adjustment, is reported through annual reports to provide all Trusts/Health Boards with their benchmarked data for the preceding year. Local audit leads will be encouraged to review these, with particular requests being made through the regional champions where performance is well below the national average for aspects of care assessed by NEIAA. As a result of the COVID 19 pandemic, the second annual report will report on performance across all quality statements but will not explicitly identify outliers.

4. One to one consultancy to support local data analysis and interpretation is available to all Trusts/Health Boards via their regional champions.

PATIENT AND PUBLIC INVOLVEMENT

1. A patient advisory group feeds into the NEIAA project working group and patient representatives have contributed to and approved this QI plan, as well as all aspects of the project including design, analysis, and implementation. The group is currently drafting a "what you should expect from your rheumatology department" leaflet which will be made available to BSR members as part of the package of QI materials on the website

2. Patient support organisations have close working relationships with the NEIAA team and with the BSR. The National Rheumatoid Arthritis Society (NRAS) and the National Ankylosing Spondylitis Society (NASS) are both represented on the NEIAA Senior Governance Group. The NRAS and NASS have independently publicised the findings from the first annual report and will continue to be harnessed to publicise results. A further focus of collaborative work that will be explored with these patient organisations will be to trigger correspondence and interaction with Trusts/Health Boards providing care of a lesser quality to their patients, and to champion those Trusts with excellent results.

3. The NEIAA operations team has worked with the NRAS to develop a national referral process to NRAS for the provision of further education and support to patients with newly diagnosed rheumatoid arthritis with the aim of improving performance against quality statement 6. This "New2RA Right Start Service" has been publicised in the audit newsletter and is included in the clinic prompt resource, available on the BSR website, alongside other QI resources such as the driver diagrams.

4. The BSR has recruited a number of patient assessors, including a member of the NEIAA patient panel, to support the BSR quality review scheme.

5. Collaborative work with patient organisations has included highlighting audit findings as part of its parliamentary lobbying activity.

6. The role of local patient groups in promoting the review of NEIAA data within Trusts/Health Boards and their regions and in driving local initiatives will continue to be explored.

COMMUNICATIONS

NEIAA has a multi-faceted communications strategy, some aspects of which have required alteration as a result of the COVID-19 pandemic:

1. Quarterly newsletters are circulated by email to clinicians participating in NEIAA. Developments in NEIAA are included frequently in BSR newletters, including promotion of reports as they are published.

2. Social media activity is used to increase public awareness of the project.

3. Newsletters and explanatory videos are available to the general public, in conjunction with the NRAS.

4. NEIAA features prominently on the agenda of The BSR annual conference (as noted above, cancelled in 2020 as a result of the COVID-19 pandemic).

5. Webinars are provided regularly, with links to recent webinars available through the BSR and audit websites. A webinar discussing the supplementary report key findings took place at the end of July.

6. Results from the NEIAA reports are used to support parliamentary work to improve awareness amongst MPs of the local results and how improvements can be made.

7. Risk of outlier status notifications are issued quarterly to relevant Trust/Health Board audit leads and to their regional champions. This activity along with communications providing performance data (as detailed above) will resume once feasible and once data collection resumes.

8. The full annual report and linked patient and public report will publicise data in the public arena on an annual basis.

9. Opportunities for further publicising audit results within specialist journals will continue to be explored.

10. Regular face to face meetings/teleconferences/videoconferences are held by the operations team, the patient panel, the project working group and the senior governance group and communications are standing agenda items for these meetings.

11. The regional champions continue to have regular meetings to share learning across regions and provide formal reports on their activity on a 6- monthly basis.

12. Regional champions will be encouraged to engage with existing regional meetings and networks, as well as with British Rheumatologists In Training (BRIT)s representatives in order to share learning on QI within regions.

13. BRITs and other regional trainee representatives will be utilised to cascade training opportunities and resources to support QI amongst trainees.

14. Case studies of quality improvement projects arising from NEIAA data are sought and showcased on the BSR website with the aim of in order to sharing learning. Case studies not only include how Trusts/Health Boards have achieved clear improvements in their service quality but also how Trusts/Health Boards have overcome challenges linked with the audit.
    Case studies are available on the audit website: https://arthritisaudit.org.uk/filesuploaded/case%20studies%20for%20service%20improvement%202019.pdf

MONITORING AND EVALUATION

1. The impact of this QI plan in promoting awareness and encouraging services to take action will ultimately be evidenced by review of Trust/Health Board performance against the NICE quality statements assessed within NEIAA.

2. The operations team (comprising the clinical lead for NEIAA, the IT platform provider, the academic partners responsible for analysis at King's College London and BSR staff leads) report to the project working group quarterly data with updates on audit engagement, clinical care quality, and data quality.

3. The performance of NEIAA is monitored by the Senior Governance Group with quarterly face to face meetings.

4. Markers for impact will also be gained through regional champion reports, which will include information on QI activity in their regions, and through regular meetings of the regional champions. Some examples of the difference that the audit has made to Trusts/Health Boards identified as outliers at the end of year 1 are as follows:

    - 21 trust/health board action plans received
    - 9 new consultant roles created
    - 7 new nursing/allied health professional (AHP) roles created
    - 10 additional/dedicated EIA clinics introduced
    - 8 changes in referral triaging process
    - 4 moves to electronic referrals
    - 4 GP education initiatives

5. Downloads of the QI support tools developed by the NEIAA team will be reviewed and feedback on their value sought through the regional champions and audit leads.

6. Formal feedback will be sought from educational events where NEIAA data are discussed.

7. Patient partners will provide feedback on their QI initiatives through their patient panel meetings and the meetings of the project working group and senior governance group.

8. Feedback on trainee led QI activity will be sought through the BSR's Education and Training Committee and the BRITs.