NHS Scotland: Rheumatology Specialty Delivery Group – Rheumatology Health Professional Workforce Assessment

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1.0 Background

One third of Scotland's population, 1.7million people, live with arthritis and other musculoskeletal conditions.

Musculoskeletal conditions are the leading cause of years lived with disability (YLDs) and the 4th largest cause of Disability Adjusted Life Years (DALY's) in Scotland.

Rheumatology services are key in diagnosing and managing a large number of these musculoskeletal conditions. This demand is increasing with research showing a 40% increase in adults diagnosed with inflammatory arthritis from 2004 to 2020 (Keele).

Accompanying this rise in demand, there is increasingly a variation in timely access to services.

The National Early Inflammatory Arthritis Audit (NEIAA) highlight this variation in their 6th annual report published in 2024.

The workforce is fundamental in service delivery and addressing variation. The British Society of Rheumatologists (BSR) 2021 report "Rheumatology workforce: a crisis in numbers" highlights that in Scotland there is 1 consultant per 100,556 patients.

This figure is well below the BSRs minimum recommendation of 1 per 80,000.

The BSR also acknowledge the considerable variation in the Rheumatology multidisciplinary workforce numbers in the UK.

A key Getting it Right First Time (GIRFT) recommendation is for health boards to address this variation and make full use of the multidisciplinary skill mix. This includes considering enhanced roles for nurses, pharmacists and allied health professionals, to meet increasing demand.

The Centre for Sustainable Delivery's (CfSD) Rheumatology Specialty Delivery Group (SDG) have highlighted excellent examples of enhanced multidisciplinary working, however there is a lack of understanding around the extent of how this has been developed.

The Rheumatology SDG created a questionnaire to gain a better understanding of the current health professional workforce in Rheumatology services across Scotland.

2.0 Objective

This questionnaire aimed to consider:

- What is the variation in the workforce at a professions level between boards and is there a need to improve clarity of roles?
- Are there opportunities to maximise the contribution of the existing health professional workforce?
- Is access to training limiting the potential benefits the health professional workforce can provide?

In this questionnaire the term “health professional” was used to align with the terminology used by the BSR. Specifically, this is aimed at all professions working in Rheumatology with the exception of doctors.

3.0 Methodology

An ‘MS Forms’ survey was designed to capture the information from Health Boards. This was reviewed internally by CfSD and tested by a selection of Health Board volunteers. This was also tested by the BSR Vice President who undertook a similar workforce evaluation in England and Wales.

The form was launched at the SDG meeting, with 2 reminders sent to Health Boards who had not yet responded.

The form was sent to the Management and Nursing Nominated Representatives on the SDG for each Health Board, with the request to return a single response for each Health Board.

4.0 Responses

11 responses were received from the Health Boards. There was no response from:

- 2 island Health Boards
- 1 mainland Health Board

The NHS Golden Jubilee was not included in the questionnaire distribution, as it does not provide a Rheumatology service. Additionally, 2 Health Boards submitted 2 responses which have been consolidated in the following results.

5.0 Current State and Future Training

Health Boards were asked about the current provision of health professional practitioners within Rheumatology services:

- 11 Health Boards (100% of those who responded) said that health professional practitioners see patients in Rheumatology.

5.1. How the current specialist staff are used:

- In 7 Health Boards, health professional practitioners see patients independently (i.e. in a standalone clinic).
- 8 Health Boards had health professional practitioners working independently but with medical supervision (e.g. Consultant elsewhere in the department).
- 4 Health Boards highlighted that the health professional practitioners were <u>also</u> working within medical clinics, not recognised as a separate workload (in addition to the standalone/supervised clinics).

5.2. Active Clinical Referral Triage (ACRT):

ACRT, or new patient vetting, is an important step in the patient pathway.

- In 11 Health Boards (100% of respondents) vetting is undertaken by the medical consultant.
- In 5 of these Health Boards ACRT is exclusively a medical consultant role.
- In a further 4 Health Boards this is a medical only role (Consultant & Specialty Doctor). In 2 Health Boards the health professional team contribute to this process. The breakdown of professions who contribute to ACRT in these 2 Health Boards is as follows:

Nursing/Advanced Nurse Practitioner (ANP)	1 Health Board
Physiotherapist	2 Health Boards
Podiatrist	1 Health Board

* Trainees, Occupational Therapists, Pharmacists, Physicians Assistants do not undertake ACRT in any board.

5.3. New patients:

New patients are seen by health professional practitioners in 6 Health Boards. The breakdown of professions who undertake new patient assessment is as follows:

Nursing/ANP	2 Health Boards
Physiotherapist	6 Health Boards
Occupational Therapist	2 Health Board
Podiatrist	1 Health Board

Nursing New Patient clinics (2 Health Boards)

In 1 Health Board, the nurses see new osteoporosis patients.

In the second Health Board, new patients are assessed by nursing staff for:

- Osteoporosis
- Fibromyalgia
- New onset inflammatory conditions
- Crystal arthritis
- Inflammatory arthritis
- Osteoarthritis.

Allied Health Professions (AHP) New Patient clinics (7 Health Boards)

5 Health Boards in an earlier question indicated that their health professional practitioners see new patients. However, 7 Health Boards provided information on the new patients assessed by AHPs.

The table has included all 7 responses but needs future clarification:

New onset inflammatory condition	4 Health Boards
Back pain	5 Health Boards
Fibromyalgia	3 Health Boards
Hypermobility	2 Health Boards
Osteoporosis	2 Health Boards
Crystal arthritis	3 Health Boards
Inflammatory arthritis	3 Health Boards
Osteoarthritis	4 Health Boards
Connective tissue disorder	1 Health Board

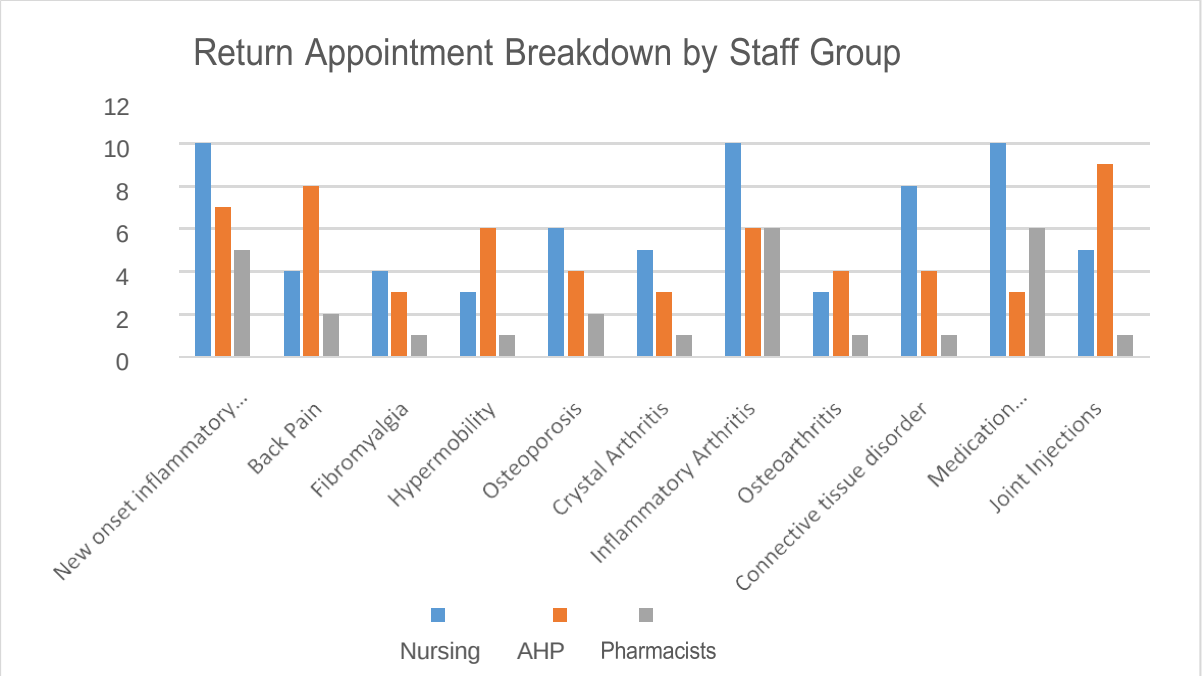
5.4. Return patients:

Return patients are seen by health professional practitioners in 11 Health Boards (100% of respondents). The breakdown of professions who undertake return patient assessment is as follows:

Nursing/ANP	11 Health Boards
Occupational Therapist	5 Health Boards
Physiotherapist	9 Health Boards
Pharmacist	7 Health Boards
Podiatrist	4 Health Boards

Return Patient clinics

Health Boards have a mix of professions that support the delivery of return patient services. The breakdown of the conditions each profession manage in a return capacity is illustrated in the graph below. Please note that 1 Health Board was unsure on this level of detail for both nursing and AHPs.



5.5. Nurse Prescribing & Injections

The Health Boards were asked how many specialist nurses were prescribers:

All	2 Health Boards
More than half	4 Health Boards
Less than half	5 Health Boards
None	0 Health Boards

In addition 3 Health Boards said that staff were awaiting places on prescribing courses while 1 Health Board was currently unsure if their staff were awaiting a

place on a course.

Joint injections were not administered by specialist nurses in 7 of the Health Boards. The other 4 Health Boards did have nurses administering injections, and in 3 of those more than half of the nurses were doing this.

5.6. AHP Prescribing and Injections

The Health Boards were asked how many AHPs were prescribers:

All	1 Health Board
More than half	0 Health Boards
Less than half	6 Health Boards
None	3 Health Boards *(no AHPs in Rheumatology)

1 Health Board was unsure on how many AHPs were prescribers. 1 Health Board has all AHPs (physiotherapists) prescribing however, the number of staff this relates to was not asked.

In addition only 1 Health Board said that staff were awaiting places on prescribing courses, 3 Health Boards were unsure if their staff were awaiting a place on a course.

Joint injections are administered by all AHPs in 2 Health Boards. In both of these Health Boards the only AHPs within Rheumatology services are physiotherapists.

In the remaining 5 Health Boards with AHPs, some staff were administering injections but not all. This may reflect the mix of professions in the other Health Boards (Occupational Therapy and Podiatry).

5.7. Pharmacy Prescribing and Injections

The Health Boards were asked how many pharmacists were prescribers:

All	5 Health Boards
More than half	0 Health Boards
Less than half	1 Health Board
No pharmacists	5 Health Boards

Staff awaiting places on prescribing courses was only reported by 1 Health Board with 2 Health Boards being unsure on this level of detail.

Joint injections were administered by pharmacists in 1 Health Board. This Health Board also had more than half of the specialist nurses and AHPs administering injections.

The same Health Board reported that less than half of the pharmacists were awaiting a place on a prescribing course. No other Health Board was awaiting places on such a course.

5.8. Patient Group Direction (PGD)

PGDs can be utilised to deliver some services where the health professional practitioner does not have a prescribing qualification.

The Health Boards were asked if any PGDs were in place and what they are used for. The following responses were received:

- "We have an early arthritis clinic prescribing protocol for specialist nurses"
- "PGD for intra-articular injections via named AHPs"
- "We have shared care guidelines outlining prescribing of DMARDs and biologics"
- "Yes, for joint injections"
- "PGD for IM Kenalog, IA Kenalog and Lidocaine"
- "We have a PGD for IM Kenalog and I think for subcutaneous methotrexate and biologic drugs"
- "We have a PDG shared across the board which makes it difficult to use without discussing a large % of patients with consultants"
- "PGDs for physiotherapists but our Extended Scope Practitioners prescribe and don't need one"

5.9. Diagnostic Ultrasound

The Boards were asked if health professional practitioners currently use diagnostic ultrasound (not for guided injections). In 3 Health Boards ultrasound was not utilised by the staff, however in 6 Health Boards AHPs were using ultrasound and in 3 Health Boards nurses were using ultrasound within Rheumatology.

Staff were awaiting training in 4 Health Boards for diagnostic ultrasound. This was a mixture of nurses, AHPs and pharmacists.

6.0 Future Plans

Health Boards were asked for information on any local plans for developing the health professional team within Rheumatology. A clear desire to develop the health professional workforce was highlighted in most Health Boards. Some examples of how they are trying to do this are:

- Development of existing roles with nurse specialist training for ANP roles
- Training ANPs to increase complexity of role and contributing the on-call
- Development of existing roles so that NMAHPs can vet and deliver new patient clinics
- Identified need to expand health professional team with Rheumatology pharmacists
- Developing newly recruited Clinical Nurse Specialist (CNS) to be able to inject, use diagnostic ultrasound and prescribe.

It has been highlighted that while there are opportunities and some work to develop roles, it is not without significant local challenges. There are common themes with:

- Not having dedicated time for training including for time
- Rheumatology consultants not having time or space in their clinic to train health professional staff
- Lack of funding to increase workforce or develop roles to a higher band
- Seconded staff moving on for substantive roles

7.0. Conclusion

This report has been undertaken with excellent engagement across NHS Scotland with responses from 11 Health Boards. This report did not seek to evaluate workforce numbers and the specific roles for each profession is somewhat limited.

This was not unexpected given the breadth of professions within the Rheumatology multi-disciplinary team.

The report has gone some way to inform on the 3 objectives however, additional more specific questioning is required in the future.

What is the variation in the health professional workforce at a professions level and is there a need to improve clarity of roles in the health professional Rheumatology workforce?

The Multi-Disciplinary Teams (MDTs) are an integral part of each service with the most consistent profession being nursing, with every service having nurses.

This is not surprising, however it is not known if services have the suggested BSR staffing of a nurse for every Rheumatologist (“Rheumatology workforce: a crisis in numbers” BSR 2021).

There is good, although not full, coverage of physiotherapists but there is less prevalence of other professions in the MDT (Occupational Therapists, Pharmacists and Podiatrists).

There are currently no Physicians Assistants working in Rheumatology services in Scotland.

There is no clear delineation between the patient groups assessed/roles performed and which of the health professional professions undertake these.

This is not dissimilar to the GIRFT report that found significant variation between departments in the skillsets of members of the MDT.
It may be that this approach has evolved from services looking at how existing staff can add to the current service, rather than the more recognised approach of looking at what professional group is most suited to the role.

This has led to significant variation in roles, even within the same profession in each Health Board. This may be through necessity and available clinical capacity as the service develops. However if the roles were looked at through the lens of

knowledge, skills and behaviour, this could enhance the resilience of existing services and identify areas where further capacity could be created.

It may be through a service needs analysis that gaps in the service can be identified. These gaps could be matched to the knowledge skills and behaviours required to deliver the role. This could potentially be beneficial for expanding the scope of the existing workforce while also providing resilience with a mix of professions able to deliver the same role.

This could be a useful area to focus on for future discussion at the Rheumatology SDG.

Are there opportunities to realise any additional benefit from the existing health professional workforce?

The questionnaire did not look to understand details on Whole Time Equivalent (WTE) clinical sessions delivered, and any potential available capacity in current job plans of the health professional staff.

Further questioning would be required to understand this and if there is any correlation between the population adjusted WTE of the health professional workforce, the roles undertaken and the waiting list size.

There does appear to be opportunities to explore the autonomy of the health professional workforce. In some Health Boards the staff work in standalone clinics, many either work with supervision or do not have a recognised separate workload.

Further understanding of this may allow for specific training needs to be identified that could aid in the development of the scope of practice of the existing workforce. This in turn could have the potential to release consultant capacity for work that currently can only be undertaken by the medical team.

There may also be scope to develop the health professional workforce in the delivery of ACRT and new patient assessment. In many other specialties these activities are a familiar role for the health professional team.

While new patient assessments are carried out in some Health Boards the majority of work is in the management of return patients.

The data from this questionnaire and the knowledge of other acute specialties would suggest there is an opportunity for further development of the health professional workforce within Rheumatology. This is also clearly highlighted in the future plans section of this report.

Further discussion at the SDG and additional information may be required in a follow up questionnaire to better inform the future direction the SDG should take in supporting local Health Boards.

Is access to training a limiting factor to the health professional workforce and what is the potential benefit with additional training?

The report suggests there is considerable difficulty with developing the workforce while maintaining service.

This challenge is not limited to availability of training places but includes: availability of local Health Board medical staff to mentor those in training, releasing staff who have a clinical commitment in a service with lengthy waiting lists and financial cost of training.

A nationally coordinated programme of work could address some of these challenges however the requirement for any potential short/medium term mentorship within the local Health Board would need to be quantified.

Once trained the health professional workforce would be able to undertake new roles that would provide capacity within the medical workforce. This would need to be further explored to allow quantification of the capacity gains.

This questionnaire has highlighted considerable potential to develop the workforce in the specialty. Discussions at the SDG and exploration of the individual requirements to achieve would need to be explored.