Royal College of Nursing

The RCN Rheumatology Nursing Forum

Autumn 2006

Rheumatology BULLETIN

www.rcn.org.uk/rheumatology

'...start looking at how your expertise can be used more widely within your trust - across specialities – and work with patients to give them a voice.'

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Send contributions for the next newsletter by (date) to the Editor:

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Letter from the Chair

As Forum Chair I've been trying to see that we make our contribution by prioritising the real needs of patients and considering "why nurses make a big difference by improving patient outcomes".

It's difficult because all members of the steering committee – like you – are struggling with their workloads. However, one advantage of being self-employed is that I can represent nurses at some of the many meetings being held to try and keep up with the explosion of policy documents that have such a potential impact on care for the future. It's not always possible for other committee members to take more time off.

The biggest piece of work is the Department of Health's musculoskeletal strategy document (see page two). Earlier this year I doubted it would ever see the light of day, but it's now published and it will make a difference so long as we all use it to best advantage and work with it to harness service developments.

The biggest challenge is to demonstrate at the working group meetings the value of the nurse in providing care. We have a lot of evidence, but there's still more to do. This was especially difficult as we were looking from a musculoskeletal perspective when many of us have focused purely on inflammatory arthritis groups.

Now is the time to start looking at how your expertise can be used more widely within your trust – across specialities – and work with patients to build their knowledge to give them a voice in what they should and can expect from health care in the future.

There is a strong drive to build a framework of competencies for all health care staff in the coming years. The plan is that these will be open and transparent to all – and of special relevance, I believe, to independent providers who also might like to develop nurses and practitioners to provide new services. Many of us are trying to ensure that the unique attributes of rheumatology practitioners are properly captured and we are working with Skills for Health (www.skillsforhealth.org.uk) to see that the competencies they are setting reflect our expertise.

But ... it is a challenge and the more people who review these draft competencies and feedback their views, the better. This work will go ahead under the auspices of the DH so we might as well have our say.

Congratulations to Maureen Cox and Kate Gadsby who have been re-elected to the committee. I feel so privileged to work with all the steering group and I value their work and support.

It's difficult for us to gauge whether we are doing a good job so we do need your feedback and comments to keep us on track – especially at the moment while the RCN undertakes a significant review of the structure of the organisation and how forums will function in the future. We are involved in the consultations and will keep you up to date on these, but for the latest news, go to the website and look up the PDF Review – that's not a electronic file, but the Professional Development Framework Review (www.rcn.org.uk/pdf).

And keep up the brave fight to build on the valuable work you're already doing!

Sue Oliver

Long-awaited musculoskeletal framework puts nurses at the heart of reshaping services

BILL FREEMAN, Director of the Arthritis and Musculoskeletal Alliance (ARMA), outlines what lies ahead following the publication of the Department of Health's Musculoskeletal Services Framework (MSF) for England.

The MSF was officially launched on 31 October, having been available online for some months. Its purpose is to support the improvement of services for people with musculoskeletal conditions, focusing on improved care pathways and multidisciplinary approaches between primary, secondary and social care.

'Seeing new patients within 18 weeks is helpful, but not an absolute good within itself.'

It's been endorsed by the Arthritis and Musculoskeletal Alliance (ARMA), an independent charity and umbrella association that brings together service user groups, professional bodies and research organisations in the field of musculoskeletal conditions. We are now working with our members to ensure that it is implemented effectively.

The MSF started life as an initiative to bring down orthopaedic waiting times, but ARMA and its member organisations convinced the Department of Health of the need to expand the project's remit to look at musculoskeletal conditions more holistically.

The project finished its work 18 months ago with the main recommendation being the establishment of clinical assessment and treatment centres (CATS) as the locus for improving care for people with musculoskeletal conditions. If implemented well, these multidisciplinary approaches to delivering care will be characterised by close collaboration between clinicians and allied health professionals in both primary and secondary care.

The MSF's guidance on CATS places nurse practitioners at the heart of the reshaping of services – from independent nurse prescribing to school and home visits for children with arthritis.

CATS remain very much part of the framework, but in terms of pursuing its implementation, the government has largely returned to its original 18-week target in orthopaedics.

The 18-week agenda is important, but focusing on this element alone might, at best, be a missed opportunity to improve services across the board and, at worst, seriously misshape services to the detriment of service users, and the quality and continuity of their care.

Seeing new patients within 18 weeks is helpful, but not an absolute good within itself. Implementation of the framework needs also to be concerned with reaching high standards as set out in ARMA's Standards of Care and the quality of long-term management of chronic diseases.

ARMA's endorsement of the MSF is therefore not unconditional

There are some areas for concern for ARMA, which will no doubt overlap with concerns of nursing colleagues.

These are challenging financial times for an NHS unsettled by change and it is regrettable that the framework makes it possible for health trusts to opt out of addressing inadequacies in services for people with musculoskeletal conditions by not following its guidance.

It could also lead to poor or misguided service reform being carried out in the name of the framework, but not within its spirit. We are already seeing independent sector treatment centres (ISTCs) being introduced without consultation with local clinicians or service users, and without any regard for the quality of current local provision, even if it meets the highest standards.

The development of CATS will not be successful without, first, all professions (including nurses and patient groups) being consulted about reshaping services and, second, making sure there is adequate capacity for professions to play a full and effective role within CATS provision.

ARMA is part way through a three year project to establish new local networks which have been identified as key stakeholders in the development of CATS within the MSF.

'The MSF is the closest thing we have to a serious public policy directive for improving services for people with musculoskeletal conditions.'

We will therefore be working with our members, particularly through local networks, to widen the focus of implementation activity beyond orthopaedic waiting times to see that there is a high level of awareness of the MSF across health and social care. This work will be led by an MSF strategy group that ARMA has established to oversee work in this area.

ARMA will also work with its members to ensure good implementation by gathering and sharing intelligence on what is happening around the country and providing information and support to ARMA stakeholders working at a local level. This will include identifying and sharing good practice, but also bringing problems to the attention of the Department of Health.

Despite the reservations outlined here, we have reasons to remain positive and optimistic. The MSF is the closest thing we have to a serious public policy directive for improving services for people with musculoskeletal conditions and it is our job to work together to ensure the opportunities it presents are neither missed nor squandered.

If you want to find out more about ARMA's work on the MSF or how to get involved in an ARMA local network, phone us on 020 7842 0910 or email arma@rheumatology.org.uk

All Party Parliamentary Group reports on English services for inflammatory arthritis

The National Rheumatoid Arthritis Society (NRAS) has just published a report on behalf of the All Party Parliamentary Group for Inflammatory based on a survey in June on the state of inflammatory arthritis services in England.

They contacted 303 primary care trusts and 28 strategic health authorities, and received completed questionnaire back from more than 35 per cent of PCTs and nearly 40 per cent of SHAs. The results make extremely interesting reading.

In some cases they were encouraged to hear about good things PCTs are doing. However, in many other cases, they found a lack of knowledge and information available coupled with an absence of (in some cases) fairly basic services and processes. This gave real cause for concern about the future of specialist rheumatology services and care that people with inflammatory arthritis might receive.

In the light of the recent publication of the Musculoskeletal Framework, this report is very timely. For a copy of the summary or a pdf of the full report, email enquiries@rheumatoid.org.uk

SONYA STEPHENSON presents her study which won the Pfizer Award 2006.

Medical cases highlighted by the Fracture Liaison Service: January–June 2006

The following data show how patients presenting to an orthopaedic unit with fracture can have previously undetected conditions. These data illustrate how important and sometimes severe conditions can be disclosed by relatively simple screening at the time of their fracture.

In the Fracture Liaison Service (FLS) both inpatients and fracture clinic patients are assessed clinically when attending the one-stop FLS clinic for a nurse-led clinic assessment of osteoporosis and falls risk. As part of this assessment a screen of laboratory blood tests are undertaken and Dr Clunie, the consultant rheumatologist who supervises the service, reviews results.

This snapshot highlights 470 patients who have had a fragility fracture (aged 50–80 years) over a six-month period who attended the FLS for dual x-ray absorptiometry (DXA). There were 93/470 (20 per cent) where screening suggested previously undetected conditions (see table). Some 47 per cent (44/93) of these conditions were identified in people who did not have a diagnosis of osteoporosis. However, many of these conditions will be of relevance to their future bone health.

From a financial standpoint if bloods were only carried out on patients commencing medication for osteoporosis, phlebotomy costs could be reduced. However, one should question the personal and financial cost of not diagnosing the conditions.

The implication of the data is that routine blood screening in all fracture patients is a very useful clinical intervention and is relevant to each patient's health. If routine screening had not been carried out, concurrent conditions would not have been found.

Some diagnoses can be easily treated (for example, hypothyroidism). However, primary hyperparathyroid disease may need surgery allowing for recovery of the patient and their low bone mineral density (BMD).

Underlying conditions which were previously unknown

	FEMALE	MALE
Hyper/hypothyroidism	21	3
Parathyroid disease	26	3
Male hypogonadism		4
Chronic kidney disease	19	8
Possible myeloma	3	2
Other conditions *	10	6

*pituitary disease, Pagets, thyroxine abuse, celiac, psoriatic arthritis.

Five possible myeloma were referred to haematologists.

Male hypogonadism and possible myeloma required referrals on to specialists.

The patient's GP can often deal with chronic kidney disease and these patients did not all need referring to nephrologists.

Of these 93 additional diagnoses, 43 needed an addendum to the usual GP letter and 55 required a specialist referral.

We have extended our screening of patients with fracture and are planning a further detailed study to look at cost utility of specific blood tests within the FLS.

In summary, the data highlight the need to ask the question: is there a cost to diagnosis?

Sonya Stephenson is Fracture Liaison Nurse/Clinical Lead Rheumatology at the Ipswich Hospital NHS Trust, Suffolk IP4 5PD.

Editor's note: We look forward to hearing Sonya's experience of the American College of Rheumatology Conference in the spring edition.

Newcastle 2006: *Hot topics in rheumatology*
RCN RHEUMATOLOGY NURSING FORUM CONFERENCE

"Police raid Marriott Hotel following tip-off about 120 women desperately seeking joints!"

That was the winning entry in our headlines competition, which provided a bit of fun during the conference dinner. Here's a selection of some of the other printable ones!

- 30,000 leave Newcastle. The great North Run? No – The rheumatology nurses are in town!
- Forget Ant'n'Dec: we've got anti-TNF
- Runners miss nurse meeting by 24 hours
- nurses bring climate changes when discussing Hot Topics
- Angels running north – one day late
- Newcastle Brown Ale sinks RCN Rheumatology Conference.
- If only the NHS was as black and white as Newcastle.
- The Magpies may be under performing, the runners may only manage half a marathon, but rheumatology nurses go the distance
- Rituximab aids "B" cell depletion – Newcastle Brown aids brain cell depletion
- 50,000 Geordie boys make a run for it as nurses arrive for RA forum
- Great North Run won by rheumatology patient – steroid test positive.

Congratulations to all whose posters were exhibited at our 2006 conference. Here's the one that won our poster competition, sponsored by Abbott, followed by an overview of three more – due to space limitations, we'll publish more abstracts in the spring edition.

OVERVIEW OF POSTERS: The next best thing to being there…!

From A Grier, M Molloy, P Minnock, B Bresnihan, D Veale and O FitzGerald from the Department of Rheumatology, St Vincent's University Hospital, Dublin.

A study examining the impact of inflammatory arthritis on human relationships

Inflammatory arthritis describes a group of chronic conditions characterised by pain and stiffness. Chronic illness can lead to loss of interest and social isolation, which has an impact on forming and maintaining relationships. Our poster aims to assess the extent of the impact of inflammatory arthritis on human relationships in order to improve holistic nursing care.

Method

A quantitative and qualitative patient survey was developed based around the topic of forming and maintaining relationships. This survey was conducted over a six-week period with patients attending the rheumatology outpatient clinic of a Dublin hospital. This constituted a convenience sample.

Results

Of 114 surveys completed, 79 were by females, 19 by males and 16 respondents did not indicate their gender. Some 68 respondents were in a relationship, five separated and 10 widowed; the remainder described themselves as single.

- 83.9 per cent of respondents aged 41–60 said their arthritis has made them feel isolated from family and friends
- 36.8 per cent of all respondents said arthritis puts a strain on relationships with family and friends
- 51.78 per cent described their arthritis as having a negative impact on communication and intimacy
- 42.1 per cent said family and friends do not have a good understanding of their condition.

Conclusion

Effective communication with patients, their family and friends, and involvement of family members in education sessions is important in the promotion of healthy relationships. Using the findings of this survey in a positive and practical way may enhance patient care.

From Alison Hill, Lead Rheumatology Nurse, Healthcare at Home Limited, Bristol.

Patient satisfaction with Remicade clinics run by Healthcare at Home nurses in NHS centres

Healthcare at Home nurses are working closely with NHS professionals in rheumatology, gastroenterology and dermatology to provide nurse support to run Infliximab (Remicade) infusion clinics in NHS centres across the UK and Ireland. This study measured patient satisfaction and evaluated the competence of Healthcare at Home nurses in managing these clinics.

Method

Patients attending Remicade clinics during 1 February–31 March 2006 were invited to complete a satisfaction questionnaire dealing with five main areas of the service:

- frequency of infusions
- clinical aspects of the service
- quality of the nurses
- travelling to hospital
- quality of life.

Completed, anonymysed questionnaires were analysed at Healthcare at Home.

Results

Healthcare at Home nurses currently attend around 130 clinics a month, treating up to 1,000 patients. Approximately 30 per cent (n=264) of all patients completed the questionnaire. Of them, 80 per cent had eight-weekly infusions and 70 per cent were treated for RA. Patients rated continuity of care from nursing staff, access to a clinician and clarity of information as very important. Patient comments indicated they were highly satisfied with Healthcare at Home nurses. Some 17 per cent lived over one hour away from the hospital and 39 per cent relied on others for transport. Despite this, 90 per cent said that getting to hospital for treatment was very or fairly convenient. Patients find Remicade treatment effective, with 65 per cent feeling much better and 27 per cent feeling somewhat better.

Conclusion

There's high patient satisfaction with Remicade clinics run by Healthcare at Home nurses.

From Anne Meadows, Rheumatology Nurse Specialist, at Edith Cavell Hospital, Peterborough.

A nurse-led cardiovascular screening clinic in the rheumatology department

Mortality is increased in RA, partly due to an increased incidence of cardiovascular disease. Our clinic aims to identify and act on modifiable risk factors for cardiovascular disease.

Method

Patients with RA aged 45–60 are given a 45-minute appointment with the nurse specialist. Diet, smoking, alcohol and exercise habits are examined and blood pressure, BMI, blood lipids and inflammatory markers measured. Referrals are made to the multidisciplinary team where appropriate and a follow-up is advised with the GP or practice nurse if abnormal results are found.

Results/findings

Many patients were able to reduce BP and lipid levels by diet, medication or both, but lifestyle changes were proving difficult. Any reductions in smoking and weight loss tended to be short term, and old habits and lifestyles soon resumed. We have therefore become more actively involved in helping patients alter their lifestyles. We now refer directly to the NHS smoking cessation clinics and also to exercise classes for people with chronic diseases. We provide information on Walking for Health programmes. Compared to five years ago we are now seeing fewer patients at their initial assessment who have hypertension, hyperlipidemia or are smokers, whereas there has been a 50 per cent increase in those classified as obese. Waist circumference is now also included in the assessment.

Conclusion

Patients with RA will seek medical attention for identified CV risk factors, such as medication for hypertension, but they will not or cannot make lifestyle changes to reduce CV risk such as smoking cessation and weight loss.

From M Uchida, S Garcia Diaz and AR Kinderlerer from the Rheumatology Department, St Mary's Hospital, London.

Compliance with BTS guidelines in assessing risk and managing TB infection in RA patients treated with Anti-TNFa therapy

Patients receiving anti-TNF_ therapy have an increased risk of developing clinical tuberculosis. As the British Thoracic Society recently published new guidelines on the management of TB risk and infection in patients due to start anti-TNFα therapies, we audited our adherence to the guidelines in patients with RA commencing between August 2001 and March 2006.

Method

Data were collected from clinical notes, the local form used to document criteria for treatment with anti-TNFα, the Dawn DMARD monitoring system and interviews with all patients maintained on anti-TNFα treatment in March 2006.

Result

Of 60 patients currently treated with anti-TNFα therapy, five were at high risk of TB reactivation (three were born on the Indian sub-continent and two in Africa) and four of them were appropriately reviewed by the TB team. One patient had a history of TB infection, but had been fully treated. All 60 patients had had a CXR of which three were abnormal. Only 55 per cent had their CXR less than three months prior to starting treatment. Some 38 patients had a tuberculin skin test prior to treatment, five of which were positive. All five had a normal CXR. No cases of active TB were identified. Of eight patients who required chemoprophylaxis for TB, one was unable to complete the course due to side-effects.

Conclusion

We effectively managed the risk of TB infection in patients treated with anti-TNFα. The interval between the CXR and starting treatment was often prolonged. The five patients found to have positive skin tests were treated with chemoprophylaxis. Strict compliance with the new guidelines would suggest that these patients should not have been treated. References available on the Forum website.

RESOURCES FOR PROFESSIONAL DEVELOPMENT

Reason to celebrate! Rheumatology Forum launches telephone guide

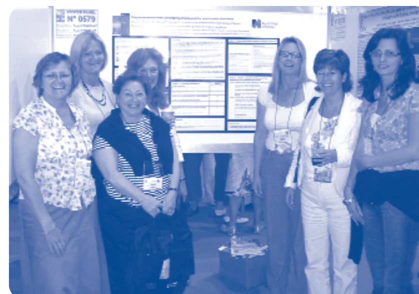
I hope by now you've grabbed a copy of the latest "hot of the press" forum document – our telephone advice line guidance. We launched it at the British Society for Rheumatology (BSR) in May and it was great to see so many members popping up to the stand to collect a copy. If you were lucky enough to be there at teatime on the Wednesday, you may have even enjoyed a celebration drink and nibbles!

The document covers telephone support for all long term conditions. We feel it was a positive step forward, working with other specialist fields of practice, and we hope this will help collaboration locally as well.

We would love to have your feedback and comments (good and bad) if you use to the document to change practice or carry out audits. These documents only stand up to scrutiny if they have a value in clinical practice.

Still raising the flag of rheumatology nurses in the UK and the advice line document, we also had a poster at European League Against Rheumatism (EULAR) this year – another great opportunity to meet up with many of you at the stand. The documents went like hot cakes that day!

We've used some of our forum funds to circulate the document to every PCT and strategic health authority so they will recognise how you are all working and the frameworks we have. It's just one small way of plugging the need for nurse specialist roles and why we have such value.



A few thanks, particularly to all the member of the working party who were fantastic, and especially to Cath Thwaites (from whom we have much more to learn in the coming months on telephone services as it is the focus of her MSc) and Sue Brown who undertook a lot of the hard graft of literature reviews. Trish Cornell kept us on track with budgets and meeting arrangements, and to everyone who was actively involved in reviewing the document by email as it went through its numerous drafts ... a big thank you to all.

If you need a copy of the document you can access it via the publication page on the RCN website or order a copy via RCN Direct on 0845 772 6100.

Sue Oliver

Join the new Health Professionals' Forum on the NRAS website

The National Rheumatoid Arthritis Society's new forum for rheumatology health professionals was launched at the annual general meeting of the BSR/British Health Professionals in Rheumatology (BHPR) in Glasgow this year.

The online forum offers a way for health professionals based in primary and secondary care services across the UK to share ideas, information and comments about all aspects of rheumatology practice including clinical, research, education and/or profession specific subjects.

Access is easy to set up – just go to www.rheumatoid.org.uk and click on "Health Professionals' Area".

Calling all innovators in rheumatology!

Have you developed a new idea to improve services or education for your RA patients? If so you might win £1,500 for your department by entering the NRAS Patients in Focus Award 2007.

Closing date for entries is Friday, 19 January 2007 so get in touch now for details and entry forms on 01628 823524 or email enquiries@rheumatoid.org.uk

Want to study the course, help support it or find out re future developments? Then read on …

The Arthritis Research Campaign: arc Graduate Certificate in Rheumatology Practice

Why should you study the arc GCRP?

It's designed by rheumatology practitioners to help you deliver a holistic, evidence based, patient centred, quality rheumatology service and to promote your clinical, professional and career development in accordance with Agenda for Change.

Who studies the course?

We now have 44 students (30 nurses, six physiotherapists, six occupational therapists and two podiatrists). Nurses work in rheumatology wards, anti-TNF services and outpatient clinics (and we hope from primary care in future). They are band 5 to 7 with RGN, Dip HE or BSc qualifications. Whether they have one year's rheumatology experience or 15 years-plus, the arc GCRP is widening their horizons.

What do students say about the course?

After six months:

- *"I was so excited ... as education in rheumatology until now has been limited. I have found the course very refreshing and valuable to my practice."*
- *"I have enjoyed ...finding out how other trusts have developed their services. .. we are developing services and I wouldn't otherwise have researched the theory the same way... It makes you think more about why you do things."*
- *"My confidence has increased... and seeking out evidence based practice has become second nature ...The workbooks are easy to follow and a very useful aid when time is short as they organise study into achievable blocks."*

How much study is involved?

There are six modules (each 100 hours) studied over 20–36 months. You attend two-three days teaching for five of these at rheumatology centres (two specialise in teaching each module: one in the north and one in south of the UK). The rest is self-directed and practical work-based learning. Workbooks and study materials are accessed via a website – if you need it, we'll help you get to grips with IT!)

Why do you need a mentor? How can you find one?

The mentor helps you develop your clinical and academic skills. This can be a consultant or more experienced rheumatology nurse/ therapist. You can have two mentors, each with different backgrounds. Contact us if you need advice or have difficulty locating a mentor.

When can you start?!

In May or October. If you have already completed a rheumatology course elsewhere (for example, Keele, Nottingham, Bristol, Leeds) and gained credits, you are probably eligible for Accreditation of Prior Learning. If so, start any term.

Attention more experienced nurses!

Why not help us? With mentoring, for example. As the course expands we need a network of potential mentors so get in touch if you would like to help.

Further study opportunities? We are planning an MSc Rheumatology Practice (probably available 2008) to develop the range of skills required for advanced practice. arc is continuing to support these developments actively.

For a GCRP information/application pack (including funding ideas) or promotional posters/postcards for distribution, contact arc.course@brighton.ac.uk (Lisa Harford, Course Administrator).

Any other queries? Just get in touch with Alison Hammond, arc Senior Lecturer and Course Leader, at ah14@brighton.ac.uk or call 01629 55051.

SARAH STEVENSON, Sister at Cannock Chase Hospital, shares her experience of the Allied Health Professionals of Staffordshire Pioneering Rheumatology Education (ASPIRE) course.

ASPIRE to bigger and better things!

Thanks to support from the Arthritis Research Campaign (arc), I was able to undertake the ASPIRE course which consists of two 15-credit degree level modules: *Introduction to arthritis and Allied conditions and management of arthritis*.

The first module increased my knowledge in immunology, blood investigations, x-rays and the impact the condition has on the individual, work and the family. It helped me understand how body image can impact of the individual and I can now empathise with and relate more confidently to patient's needs in this area.

The second module increased my knowledge in aspects of patient education, drug therapy, surgery and pain management. The course included practical sessions on biologic therapies, splinting and hydrotherapy, as well as a visit to the anatomy suite, which helped me better understand different pathologies

The assessments were varied and related to my clinical role. They also helped others in the unit develop their practice. One assessment involved developing a teaching package to enable ward-based nurses to carry out hand assessments on patients during their admission.

How about you?

Interviews are being held this winter for the April 2007 intake of the ASPIRE course. Contact Sarah Ryan on 01782 556148 or email sarah.ryan@uhns.nhs.uk

Get your 50% discount on Musculoskeletal Care

You may be aware of the relatively new journal for health professionals called *Musculoskeletal Care*. But did you know that members of the RCN Rheumatology Forum can subscribe to the journal at a significant discount – £30 per year instead of the normal price of £45!

Want a taster? You can view papers that have appeared in the journal at www.interscience.wiley.com/journal/msc

To get your 50 per cent discount, either email the subscription team at cs-journals@wiley.co.uk and let them know that you are a RCN member and qualify for this special rate, or contact the Editor, Sarah Ryan, at sarah@ryan1350.fsnet.co.uk

Help! – Benchmarking rheumatology day care services

Caroline Jess writes: "We're interested in linking with any units willing to discuss issues related to the provision of day care services, patient numbers, staffing levels, different treatments administered, risk issues and anything else you would like to review."

Contact Caroline Jess at the Day Care Unit, Nuffield Orthopaedic Centre, Windmill Road, Oxford OX3 7LD. Telephone (01865) 737553/737556. Email: caroline.jess@noc.anglox.nhs.uk

ERAN presents first poster at BSR event

The Early Rheumatoid Arthritis Network (ERAN) presented the first results of this study at the British Society for Rheumatology Conference at Glasgow in May.

ERAN is an observational study, similar to the Early Rheumatoid Arthritis Study (ERAS), but designed to incorporate clinical governance issues such as adherence to guidelines. There are currently 29 member departments in the Network, with many more expressing an interest.

Dr Richard Williams, Chair of the ERAN Audit Committee, presented the poster (Abstract 91) which was set out to audit *Standards of care for inflammatory arthritis*, published by the Arthritis and Musculoskeletal Alliance (ARMA) and in particular standard four on referral times to specialist care.

Based on 527 early rheumatoid arthritis (RA) patients referred to rheumatology departments in the UK who also had 12 month follow-up, the results were:

Here's Wendy Garwood and Cathy Mayes at the ERAN stand.

- The median time from onset of RA symptoms to the first GP referral letter for a rheumatological consultation was six months (Inter-Quartile Range (IQR)= 3–12 months).
- The median time from GP referral to rheumatology consultation was one month (IQR=1–2 months). ARMA Standard suggests <12 weeks.
- Some 467 patients (89 per cent) started on disease modifying antirheumatic drugs (DMARDs) while the remainder managed with steroids and/or non-steroidal drugs. Time to use of first DMARD therapy from initial rheumatology consultation was one month (IQR 0-2).

The study concluded that although there were some differences between centres, patient waits for rheumatological consultation were within recommended standards and the main delay was self referral to GP.

ERAN also hosted a stand at the BSR which proved to be a very successful exercise as it provoked a lot of interest in the Network.

If you are interested in your department becoming an ERAN member or want to know more, contact Wendy Garwood on wgarwood@phlexglobal.com or Cathy Mayes on cathy.mayes@whht.nhs.uk.

Editor's Note: Maureen Cox

You may have noticed a problem with the spring edition in that the titles (especially for forthcoming events) printed as dots and not text. This was a printing error for which the printers apologised, but it was not detected until after the newsletters had been sent out. I hope no one was inconvenienced, particularly the organisers of the various conferences and events.

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The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies