foundation trust, Manchester, United Kingdom

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Results

A total of 92/143 (64%) patients were referred, a more significant reduction than normal due to the pandemic. Median age [IQR] was 39.5 [28-66.25] years and most referrals (79%) were from primary care.

Table 1 represents information included in the referrals. Thirty-one patients had previously undergone a rheumatology review, of which 11 (35.5%) had a diagnosis of fibromyalgia. The commonest reason for re-referral was worsening of symptoms; 31 (10%) patients were re-referred due to exacerbation of their existing disease. Based on this, we were fortunate that the team were not redeployed.

Our department continued to see all new urgent referrals face-to-face and considered that NEIAA would help to understand the impact of the pandemic on the rheumatology service. Once pressures had eased we recognised the opportunity for rheumatology services to benchmark the care they deliver.

The National Early Inflammatory Arthritis Audit (NEIAA) has provided the powerful lever for improving quality and our department is testimony to this. Data was submitted to the NEIAA online tool during year 3 (September 2020-March 2021) were downloaded for analysis. Data from year 2 was used for comparison.

In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2. In year 3, 154 patients were recruited to the audit compared to 268 in year 2.
Background/Aims
The COVID-19 pandemic has had a significant impact on emergency and scheduled care, affecting both inpatient and outpatient services for all specialties, including Rheumatology. During the first pandemic peak, rheumatology outpatient clinics all became virtual (i.e. telephone or video), except for a single emergency clinic per week. However, this face-to-face clinic, quickly became oversaturated resulting in a waiting list extending above 4 weeks for our patients.

Methods
In the lead-up to the second COVID-19 peak during the winter, we developed a novel, urgent, hot Rheumatology Clinic within our Ambulatory Emergency Care (AEC) department. This whole-day weekly clinic was delivered by a Rheumatology registrar, with consultant support. Its purpose was to provide a service for patients who did not require hospitalisation but required urgent face-to-face Rheumatology specialty review that could not wait for an outpatient appointment. Referrals came from General Practice, Urgent Care (i.e. Emergency Care, Acute Medicine and AEC) and from the Rheumatology department. Pathologies reviewed included vasculitides, inflammatory arthritis and inflammatory connective tissue diseases. The clinic facilitated for patients with suspected new diagnoses or flares of established rheumatological diseases. Furthermore, patients could also undergo urgent joint and soft tissue procedures. All referrals were directed to the Rheumatology registrar to triage. Because of the success of the clinic, it continued beyond the second peak with data gathered from its inception.

Results
Data was collected between November 2020 and June 2021, covering 23 hot clinics. A total of 118 patients were reviewed during this period. The highest number of referrals occurred during the second peak of the pandemic (58 patients over seven clinics compared to 48 patients over ten clinics post-peak). The majority of referrals were from Rheumatology directly (70%) compared with Urgent Care (14%) and General Practice (12%). Most (60%) were seen within 7-days of referral; a further 27% were seen within 7-14 days. The main reasons for review delays beyond seven-days were lack of available clinic (46%) or lack of space (29%). The most common disease encountered was a chronic inflammatory arthropathy (48 patients).

Conclusion
The service has generated positive feedback from all patients. Furthermore, this clinic has benefited both Rheumatology and AEC. Firstly, it ensured timely face-to-face reviews of patients requiring urgent Rheumatology assessments. Secondly, it eased pressure on the Rheumatology department, particularly the outpatient emergency clinic. Thirdly, it ensured that the Rheumatology registrar continued to have Rheumatology training opportunities, particularly when redeployed during the Winter wave on other days of the week. Fourthly, the AEC department have had easier access to Rheumatology reviews. Finally, it has empowered the registrar to manage their own workload and organise the clinic enhancing management and leadership experience. The success of the clinic has resulted in its ongoing continuation.

Disclosure
A. Khan: None. C. Murdoch: None. I. Wamu: None.