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LETTER TO THE EDITOR

What does a primary care annual review for RA include? A national GP survey

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Sir

Patients with rheumatoid arthritis (RA) are at increased risk of comorbidities particularly cardiovascular disease and osteoporosis [1, 2]. NICE standards of care for rheumatoid arthritis (RA) recommend patients should receive a holistic annual review that should include an assessment of disease activity and severity, active screening for and management of comorbidities [3] and assessment of the impact of RA on quality of life. In 2013, RA was included in the Quality Outcomes Framework (QOF) of the UK general practice contract. General practitioners (GPs) were incentivised to provide a face to face annual review for RA patients, including cardiovascular and fracture risk screening, mirroring the routine care for patients with other long-term conditions such as diabetes—a model which improves quality of care and clinically important outcomes [4]. The aims of this study were to investigate what domains GPs report including in their annual review for patients with RA and to determine the role of the multidisciplinary team in providing these reviews.

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We conducted a national cross-sectional survey in 2013 to investigate the primary care management of RA. Five thousand randomly selected GPs were asked to complete a brief questionnaire investigating their management strategies for patients with RA. Participants were presented with a predefined list of 12 measures that could be included in an annual review (presented in Table 1: including cardiovascular disease, osteoporosis and depression screening) and asked to indicate which measures they routinely included. Furthermore, GPs were asked which screening tools they used for cardiovascular disease and osteoporosis screening and which members of the multidisciplinary team conducted these reviews.

One thousand three hundred eighty-eight (27.8 %) completed questionnaires were returned. The majority (1052, 75.6 %) of responders were GP partners, with a mean (SD) age of 47 (9.4) years. Seven hundred five participants (50.8 %) were female. The majority of responding GPs (1083, 80.4 %) felt that a primary care annual review was of benefit to their RA patients, although only 712 (51.2 %) GPs felt that RA should be included in the QOF component of the GP contract. Nine hundred thirty-nine (67.7 %) GPs indicated they were aware of the NICE Standards of Care for RA, although only half (693, 49.9 %) felt they impacted on their clinical practice. Only 767 (55.3 %) GPs thought their patients had access to an annual review in secondary care.

The individual measures that GPs reported including in their annual review are detailed in Table 1. The most frequently incorporated components were medication review (1232, 88.8 %), followed by cardiovascular risk assessment (1139, 82.1 %). The latter was most commonly performed by practice nurses using QRISK (1214, 87.5 %). Osteoporosis risk assessment was also commonly performed (1118, 80.5 %), usually by GPs themselves (1023, 73.7 %), with a minority of GPs thought osteoporosis screening for their patients was

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Table 1 Measures included in a primary care annual review

Measure	*N* (%)
Medication review	1232 (88.8)
Cardiovascular disease risk assessment	1139 (82.1)
BP measurement	1139 (82.1)
Osteoporosis risk assessment	1118 (80.5)
Pain levels/analgesia review	1052 (75.6)
DMARD monitoring	956 (68.8)
Depression screening	859 (61.8)
Mobility assessment	808 (58.2)
RA flare frequency	569 (41.0)
Measurement of RA disease activity	556 (40.1)
Screening for RA complications	329 (23.7)
DAS28 measurement	27 (1.9)

performed in secondary care (192, 13.8 %). Assessments of RA disease activity (556, 40.1 %) or disease complications (329, 23.7 %) and routine use of DAS28 (27, 1.9 %) were uncommon.

This large general practice survey suggests that despite NICE advocating a holistic annual review for patients with RA, at present primary care reviews focus on key QOF domains such as cardiovascular disease and osteoporosis screening. Further studies will be required to determine whether screening still occurs now that RA is no longer incentivised in the QOF. Importantly, key comorbidities associated with a poor outcome, such as depression, are not routinely screened for, meaning opportunities for intervention are missed. The disease-specific components of annual review such as disease activity and assessment of complications still largely occur in secondary care.

Good communication systems are needed across the healthcare setting to prevent duplication of screening and fragmentation of care for these patients, to ensure that annual review is truly holistic and to ensure that common comorbidities such as depression are not neglected in this patient group.

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Compliance with ethical standards

Disclosures None.

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