

University of Wales

Trinity saint David

Arthritis (Chronic pain)



Module: - Community Care and Management of Long-term conditions (LCHS 7003-BIRM)

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Table of Contents

Definition	4
Primary Classifications	4
Osteoarthritis;.....	Error! Bookmark not defined.
Rheumatoid Arthritis: -.....	4
Other forms; -.....	4
Global statistics.....	4
United Kingdom Statistic.....	5
Prevalence.....	4
Societal and Health impact.....	5
Main Body.....	Error! Bookmark not defined.
Physical implications	6
Psychological implications:	6
Social implications.....	6
Social isolation	6
Financial pressures	6
Tabel explain physical, psychological and social.....	7
The United Kingdom Model for Care	8
This model has important tools	8
The global health care model we use is chronic	9
Element of chronic care model	9
Local and national health and social care policy agendas	10
National agendas- England.....	10
Local agenda -Manchester.....	10
Development initiatives to improve RA care	11
Earlier identification and referral.....	11
Integrated RA multidisciplinary clinics	11
Flare and Rapid-access pathway.....	11
Supported self-management program.....	11
Health-inequality improvement.....	11
Outcome measurement.....	11
Person-centred care approach	12
Digital access and health literacy	12

Skill and attitudes.....	Error! Bookmark not defined.
Self-management and support self-management.....	13
End-of-life and palliative care	13
Recommendations for improvement.....	14
Conclusion	15
References	16

The aim of this booklet

This booklet provides an information overview of rheumatoid arthritis (RA) as a long-term condition. It considers how physical, psychological and social needs interact, and how health and social care services can improve outcomes through early intervention, integrated care, supported self-management, shared decision-making and person-centred planning.

Definition

Arthritis (chronic pain) is not a single disease entity; it is an umbrella term describing more than 100 different conditions that affect the joints, surrounding tissues, and other connective tissues (Arthritis Foundation, 2026). The term originates from the Greek words “arthro” meaning Joint and “it is” meaning inflammation.

Primary Classifications

While there are many subcategories, most cases globally fall under two distinct pathophysiologic pathways. While this project mainly focusing on Rheumatoid Arthritis but revising Osteoarthritis and Other forms.

Osteoarthritis: -the most common form of arthritis in adults characterised by chronic pain and loss of mobility. The most common form of arthritis, characterised by mechanical, degenerative wearing down of articular cartilage over time. This leads to bone-on-bone traction, severe chronic pain, and structural remodelling (WHO,2023).

Rheumatoid Arthritis: - a systemic, chronic autoimmune inflammatory disorder. The body's immune system attacks the synovial lining of joints, causing painful swelling, bone erosion systemic fatigue and potentially severe joint deformities if left unmanaged. While rheumatoid arthritis is a systemic autoimmune disease that affects multiple body systems, the joints of the hands, wrists, feet, ankles, shoulders, and elbows are most affected (NICE,2020).

Other forms - includes metabolic joint disease (such as gout) juvenile idiopathic arthritis affecting children and seronegative spondyloarthropathies' (like psoriatic arthritis and ankylosing spondylitis)

Prevalence

Global statistics

An estimated 600 million people worldwide are living with arthritis, about 70% of people living with rheumatoid arthritis are women and 55% are older than 55 years

as well as 13 million people with rheumatoid arthritis experience severity levels (moderate or severe) that could benefit from rehabilitation (WHO, 2023).

United Kingdom Statistic

In the UK arthritis is a primary public health challenge heavily impacting the National Health Service (NHS). Social care infrastructure and workplace productivity. Over 10 million people in the UK live with arthritis meaning approximately one in six individuals are affected by the condition (NHS, 2026). RA is a significant long-term condition in the UK. The British Society for Rheumatology (BSR) reports that more than 400,00 adults in the UK have RA, which is approximately 1% of the population, and that around 20,000 new patients present each year (BSR, 2026).

A 2025 UK Parliament answer reported that 0.8% of people aged 16 years and over in England had RA recorded on practice disease registers in 2023/24 equivalent to approximately 4600,000 people. The recorded prevalence had remained broadly stable since data collection began in 2013/14 (UK Parliament, 2025). Gender women bear a disproportion burden, making up about 60% to 61% of osteoarthritis cases and experiencing higher rates of rheumatoid arthritis.

Age prevalence climbs sharply with age while it can affect younger adults and children; nearly 73% of Osteoarthritis cases occur in people over the age of 55. (WHO, 2023). The most affected joint the knee is the most frequently affected joint globally followed by the hand and hip. high body mass index (BMI) and obesity are leading modifiable risk factors driving the global risk of osteoarthritis.

Societal and Health impact

Disability; musculoskeletal conditions, arthritis and leading global contributors to years lived with disability. Projection experts estimate that nearly one billion people will be affected by the year 2050 if current population growth, ageing and obesity trends continue (Habas .C 2026).

Risk Factors (aetiology) of the health condition

Non-modifiable risk factors are characteristics that cannot be changed or controlled by an individual although their effects on disease risk may sometimes be managed. The main non-modifiable risk factors include age, sex, genetics, family history and previous joint injury (NICE, 2020).

Modifiable risk factors that can be changed, controlled or reduced through lifestyle changes, medical treatment, include overweight or obesity, smoking, occupation, activity, physical inactivity, infections and diet and oral health (NICE, 2020).

Why early intervention matters
NICE recommends urgent specialist referral for suspected persistent synovitis and states that initial treatment should ideally begin within 3 months of the onset of persistent symptoms. Early recognition and treatment can reduce inflammation and prevent avoidable joint damage and loss of function. (NICE 2020)

Physical, psychological and social implications for RA

Arthritis creates widespread physical, psychological and social implications for the wider family and care providers who support the patient.

Physical implications: -Caregivers experience physical strain and fatigue from assisting with daily tasks like household chores, mobility support and personal grooming. Disrupted sleep patterns and constant physical help-giving can lead to caregiver exhaustion and a decline in the provider's own physical health.

Psychological implications: -family members and partners face high levels of stress, anxiety and depression also unpredictable nature of arthritis flare-up. Loved ones often experience a feeling of helplessness, guilt and grief over the changes, Capabilities and future of the patient.

Social implications: - daily routines and family schedules suffer from frequent disruptions and role shifts, straining relationships between partners and relatives.

Social isolation: - increases as both patients and caregivers pull back from leisure community and social activities to manage care demands.

Financial pressures: - from lost work productivity job adjustments and healthcare costs add external stress to the household dynamic.

Tabel explains physical, psychological and social

Domain	Possible implications	Care response
Physical	Pain, swelling, morning stiffness, fatigue, reduced mobility, hand or foot problems, functional limitation, joint damage, falls risk, cardiovascular or respiratory complications	Treat-to- target medical therapy, physiotherapy, occupational therapy, exercise and medication monitoring
Psychological	Anxiety, low mood, fear of flare, uncertainty altered body image, sleep problems, reduced confidence and coping difficulties	Routine mood assessment, psychological support, coping strategies and peer support
Social	Reduced employment or productivity, financial pressure, dependence on family or carers, relationship difficulties, social isolation and barriers to participation	Occupational support, social prescribing, welfare advice, care assessment, accessible transport or equipment and workplace adjustment

The United Kingdom Model for Care

The House of Care model is not the only model of care for long-term conditions, but for this long-term condition choosing is the House of Care model for this reason. It is suitable for all people living with long-term conditions, provide a holistic approach to RA use the care and lives to help them achieve the best outcomes possible, its involvement of patients in developing their own care plans through a shared decision-making process with clinicians and provides commissioning with a roadmap for developing RA responsive (NICE, 2020)

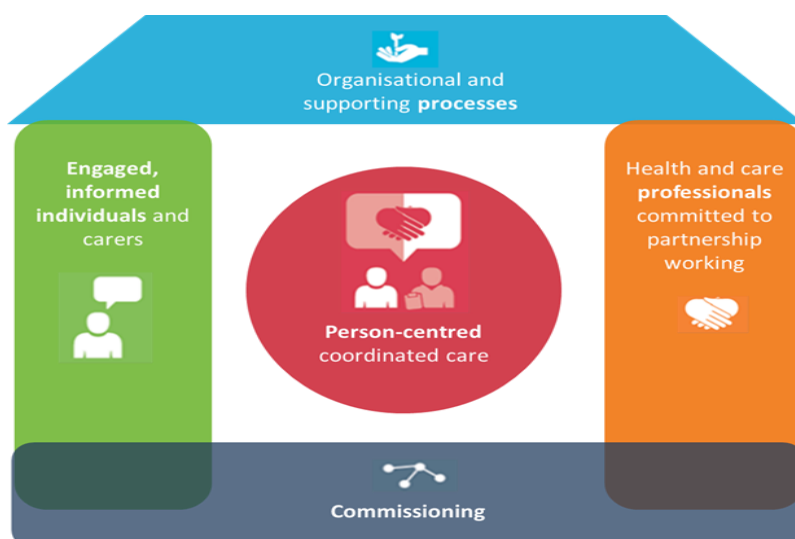
The UK models' frameworks for RA use for this program is House of Care: - a framework for long-term condition care has been created out of a need to change the way long-term conditions are addressed (NHS,2026)

The House of Care is a coordinated healthcare framework that uses the metaphor of a house to help patients with long-term conditions and their clinicians work together on personalised care.” The House of Hare model represents a tangible and proven approach that allows healthcare to embrace care and support planning and fulfil its responsibilities for long- term conditions” (Scotland house of care 2023).

This approach supports and enables people to articulate their own needs and to decide on their own priorities, through a process of joint decision making, goal setting and action planning.

This model has important tools

The right-hand wall: - health and care professional team committed to shared decision making, partnership working.



The left-hand wall: - engaged, informed, empowered individuals and cores ready to engage

The foundation: - more than medicine information and formal sources of support and care sustained by the responsive allocation of resources.

The roof: - organisational processes, policies, systems and arrangements.

All these are built around care and support planning conversation which is at the heart of the house.

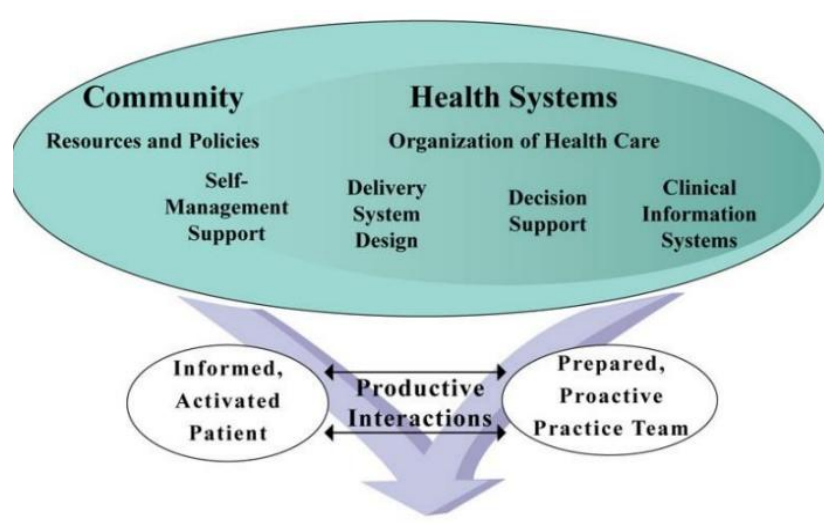
The global health care model we use is chronic

The Chronic care model is an organisational framework designed to transform the treatment of long-term health conditions-such as diabetes, hypertension and heart disease-from a reactive acute approach into a proactive, patient-centred system (International Journal of Cardiology 2018).

The chronic care model was developed in the 1990s as a way of improving care for chronic diseases. This model focuses on linking informed active people with proactive teams of professionals.

Element of chronic care model

In 2002 WHO adopted the chronic care model to focus more on community and policy aspects of improving chronic care (WHO). The chronic care model identifies essential elements of a health care system that encourage high-quality chronic disease care: - the community, the health system, self-management support, delivery system design, decision support and clinical information system (ACT Centre).



(Developed by The MOC Coll Institute ACP-ASIM Journals and book)

Local and national health and social care policy agendas

National and local health and social care policy agendas are increasingly unified in a strategy to shift the delivery of services from hospital to local communities. In the UK policies are driven by the department of health and social care (DHSC) and executed locally through integrated care system (ICSs) and local authorities (GOV.UK).

National agendas- England

RA sits within the wider musculoskeletal and long-term conditions agendas. The Department of health and Social Care majors on condition as one of the six majors' conditions and promotes, early diagnosis. Long-term management, personalised support and integration between physical and mental health services. (DHSC 2023)

The ten-years health plan for England, published in 2025, sets out three shifts; hospital to community, analogue to digital and sickness to prevention. These directions are relevant to RA because many aspects of long-term disease management can be strengthened through community services, digital access, prevention and supported self-management (DHSC 2023)

Local agenda -Manchester

The Greater Manchester integrated care partnership strategy (2023- 2028) prioritises prevention, health inequalities, integrated neighbourhood care, support for people to manage their own health, good work, carers and living well with long-term conditions. It is a joint forward plan the specifically includes person-centred neighbourhood models, and social prescribing. Personalised care, long-term condition management (NHS Greater Manchester, 2023)

Why policy matters for RA
These agendas create an opportunity to move RA care from a predominantly hospital-centred model towards proactive, integrated and community-based care. Development initiatives should therefore combine rheumatology expertise with primary care, rehabilitation, mental health, employment support and voluntary community organisations.

Development initiatives to improve RA care

Focus on multimodal frameworks to shift from traditional trial-and-error medicine to targeted systematic management

The following initiative-care awareness national and local policy into practical development

Earlier identification and referral

strengthen primary-care awareness of persistent synovitis and inflammatory symptoms use clear referral pathways, monitor referral to specialists and diagnosis time.

Integrated RA multidisciplinary clinics

bring rheumatology specialist nursing, physiotherapy, occupational therapy, pharmacy, psychology and social support closer together with coordination.

Flare and Rapid-access pathway

Give people a clear plan for recognising flares, who to contact and how to obtain a specialist advice reducing avoidable emergency attendance.

Supported self-management program

provide structured education on medication how to use. Give how to manage fatigue, pain and sleeping exercise to build emotional wellbeing flare planning and communication with service after peer support and health coaching (NICE 2019).

Patient empowerment and digital therapeutics

healthcare initiatives have adapted programs like the strengthening and stretching for rheumatoid arthritis of the hand program into scalable digital training platforms. These free tools give patients direct access to physical therapy exercises that significantly improve hand functionality outside a clinic setting. (NIHR)

Health-inequality improvement

Use local population data to identify groups experiencing poorer access or outcomes; provide accessible information, interpreters and culturally appropriate engagement (NICE, 2017)

Outcome measurement

Measurement not only disease activity but also the patient pain. At the same time looking fatigue, function of the patient mood frequently changed. As well as the patient employability or quality of life and patient experience access and inequalities.

Person-centred care approach

Person-centred care approach means that the individual is treated as an active Partner rather than a passive recipient of treatment NICE states that people using NHS services should receive care tailored to their needs and preferences and should be supported in shared decision-making (NICE 2019/2021)

Person-centred care enables people to make informed decisions that are right for them and empowers them to self-care for their long-term conditions in partnership with health and care professionals (NHS 2022)

Person-centred care focusing on active engaged in their health social care handle individuals as uniform and forcing to acting passive recipients of a standard routine.

For a person with RA, a person-centred assessment should explore

What matters most to the person now-for example, walking independently, working, caring for children, cooking, worship, socialising or sleeping.

The person's understanding of RA, medicines, prognosis and treatment choices.

Pain, fatigue, stiffness, mobility, hand function and ability to perform activities of daily living Mood, anxiety, sleep, confidence and coping.

Employment, housing, finances, transport, family responsibilities and social support.

Cultural, language, spiritual and communication needs.

Digital access and health literacy

The person's preferences about who should be involved in decisions and care planning.

A practical personalised care and support plan should record agreed goals, actions, responsibilities, follow-up arrangements and what to do if symptoms worsen. It should be reviewed because RA and people's priorities change over time.

Working with patients in a more person-centred manner places new demands on health professionals on; these skills required excellent listening, communications and negotiation skill, and the capacity to respond flexibly to people's individual needs. (Future Healthcare Journal)

The real-world challenges faced by clinicians and healthcare systems in delivering person-centred care should not be underestimated. The greatest challenge to change is probably culture. The NHS will continue to struggle with huge financial pressures often resulting in the rationing of expensive treatment. (Future Healthcare Journal)

Person-centred care is a care principle that helps patient satisfaction and excellent health outcomes as well as the health professional. Dignity, compassion, and respecting is the first care. Coordinated care increases treatment and support across all professional. The third one is enabling independence it is helping their own strengths, skills and confidence to use the right decisions and manage their everyday lives. The last one is personalised care helping the patient with day-to-day support to fit the specific person (NICE,2019) (NHS, 2026)

Example of shared decision-making
Instead of saying “you need to exercise” a clinician might ask, “what physical activity would you enjoy or feel able to do, and what makes it difficult at the moment?” The team can then agree a realistic activity plan, refer to physiotherapy or community activity, and review progress together.

Self-management and support self-management

Self-management does not mean managing RA alone. Supported self-management means increasing the person’s knowledge skills and confidence through interventions such as education, health coaching and peer support (NHS 2026) Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patient skill and confidence their health problems, including regular assessment of progress and problem’s goal setting and problem-solving support. (National Academies Press)

A structured RA self-management programme can include.

Medicine management is prescribed safe use monitoring and when to report problems.

Flare planning recognising worsening symptoms and knowing how and when to seek specialist advice.

Fatigue management pacing, prioritising, rest or activity balance and sleep support.

Physical activity uses appropriate exercise to maintain strength, flexibility, cardiovascular health and function.

Pain management to understand medicines alongside non-drug approaches and coping strategies.

Social participation maintaining meaningful activities and engaging in relationships as well as employment where possible.

Mental wellbeing focusing on identifying anxiety or depression and accessing psychological support early.

Health lifestyle we plan to stop or minimise smoking and increase healthy eating, appropriate weight management and at the same time reduce sedentary time.

Self-management programmes should be accessible to people with different levels of health literacy language needs, disability and digital access. Group programmes, one-to-one education, telephone support printed resources and digital options should complement rather than replace one another.

End-of-life and palliative care

RA is usually managed as a chronic condition over many years and is not normally described as a terminal illness. However, people with RA may develop serious complications, frailty or other life-limiting conditions. End-of-life care should therefore be available when clinically appropriate and should not be restricted simply because of the primary diagnosis (NICE, 2019)

Recommendations for improvement.

Implementation should use co-production; people living with RA, carers, clinicians, social care professionals and voluntary or community organisations should help design and evaluate the service. This aligns with Greater Manchester's emphasis on co-design, lived experience, person-centred neighbourhood care and reducing health inequalities. (NHS Greater Manchester, 2023- 2028)

Recommendation	Expected benefit	Suggested measure
Create rapid-access inflammatory arthritis referral pathways	Earlier diagnosis and treatment, reduced preventable joint damage	Referral-to-specialist and symptom-onset-to-treatment intervals
Give every person a named care coordinator or clear point of contact	Improved continuity, navigation and reduced fragmentation	Patient-reported continuity and documented care coordination
Offer annual holistic review disease activity, function, mood comorbidity	Earlier identification of unmet physical, psychological and social needs	Annual-review completion and unmet-needs actions
Embed supported self-management and peer support RA services	Greater confidence, self-efficacy and ability to manage flares and daily life	Participation, confidence or self-management measures and patient experience
Integrate rehabilitation, psychological and social support with rheumatology	Better function, wellbeing and participation fewer avoidable barriers	Access or waiting times and outcomes for outpatient, physiotherapy and psychological support
Develop employment and welfare-support pathways	Reduced work loss and financial or social consequences	Employment or return-to-work outcomes and welfare-support referrals
Use equity monitoring and accessible communication	Reduced inequalities in access, experience and outcomes	Outcomes stratified by deprivation, disability language and other relevant factors
Introduce earlier advance-care planning conversations	Care better aligned with values and preferences during serious illness	Preferred place of care and care-plan review

Conclusion

Rheumatoid arthritis is a lifelong systemic inflammatory condition with consequences that extend well beyond joints. Its prevalence and associated disability make it an important long-term condition for public health and health and social care planning. Effective management requires early diagnosis, treat-to-target medication, multidisciplinary rehabilitation, psychological support, social and employment interventions, and meaningful self-management.

The strongest improvement opportunity is to connect these elements through person-centred and integrated care. National policy increasingly supports prevention, community care, personalised support and reducing inequalities, while Greater Manchester's local strategy provides a strong framework for neighbourhood-based, integrated and co-produced services. End-of-life care should also remain person-led when serious illness, frailty or complication make palliative needs relevant.

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