NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Rheumatoid arthritis in over 16s

NICE quality standard

Draft for consultation

June 2013

August 2019

This quality standard covers assessing, diagnosing and managing rheumatoid arthritis in over 16s. It describes high-quality care in priority areas for improvement.

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This quality standard will update the existing quality standard on rheumatoid arthritis in over 16s (published June 2013). For more information see update information.

This is the draft quality standard for consultation (from 5 August to 3 September 2019). The final quality standard is expected to publish in January 2020.

Quality statements

Statement 1 Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 days of presenting in primary care. **[2013, updated 2019]**

Statement 2 Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met. **[2013, updated 2019]**

Statement 3 Adults with rheumatoid arthritis are given opportunities to take part in educational activities that support self-management throughout the course of their disease. **[2013, updated 2019]**

Statement 4 Adults with rheumatoid arthritis and disease flares or possible treatment-related side effects receive advice within 1 working day of contacting rheumatology services. **[2013, updated 2019]**

Statement 5 Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services. **[2013, updated 2019]**

In 2019 this quality standard was updated and statements prioritised in 2013 were updated (2013, updated 2019). For more information, see update information.

Statements from the 2013 quality standard for rheumatoid arthritis in over 16s that are still supported by the evidence and may still be useful at a local level, but are not included within the current quality standard:

- People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

The 2013 quality standard for rheumatoid arthritis in over 16s is available as a pdf.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services) which should be considered alongside these quality statements.

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 4 For draft quality statement 1: Is referral within 3 days of presentation achievable? Is there an alternative timescale that should be used?

Question 5 For draft quality statement 2: Which of the two areas covered in the statement do you consider to be the priority area for quality improvement? Early commencement of treatment with cDMARDs, or regular monitoring of treatment until treatment target achieved?

Question 6 For draft statement 2: Is the target of starting treatment within 6 weeks of referral achievable?

Question 7 For draft quality statement 3: Are the timeframes for offering educational activities within 1 month and annually used in the process measures for this statement appropriate?

Question 8 For draft quality statement 3: Should offering educational activities annually happen as part of the annual review (draft quality statement 5)?

Question 9 For draft quality statement 4: Is the timeframe of receiving advice within 1 working day of contacting rheumatology services achievable?

Local practice case studies

Question 10 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please provide details on the comments form.

Quality statement 1: Referral

Quality statement

Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 days of presenting in primary care. **[2013, updated 2019]**

Rationale

Rapid referral of adults with suspected persistent synovitis is important to avoid delay in diagnosis and treatment. Rapid referral is particularly important for adults with inflammation of more than 1 joint, or the small joints of the hands and feet as they are likely to have persistent synovitis and poor prognosis. Early diagnosis and treatment of rheumatoid arthritis improves long-term outcomes, physical function and quality of life.

Quality measures

Structure

a) Evidence that healthcare professionals in primary care can recognise persistent synovitis.

Data source: Local data collection, for example, training records and evidence of continuous professional development covering inflammatory arthritis.

b) Evidence that systems are in place for adults with persistent synovitis to be referred to rheumatology services within 3 days of presentation.

Data source: Local data collection, for example, agreed referral pathways.

Process

Proportion of adults presenting in primary care with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, who are referred to rheumatology services within 3 days.

Numerator – the number in the denominator who are referred to rheumatology services within 3 days of presenting in primary care.

Denominator – the number of adults presenting in primary care with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet.

Data source: Data for time to referral is collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

Outcome

a) Time from presentation to diagnosis for adults with rheumatoid arthritis.

Data source: Local data collection, for example, audit of patient record.

b) Health-related quality of life score for adults with rheumatoid arthritis.

Data source: Data for quality of life score, including symptoms, wellbeing, impact on daily life and work, is collected at baseline, 3-month and 12-month follow-up as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

What the quality statement means for different audiences

Service providers (such as GP practices) ensure that healthcare professionals can recognise the signs and symptoms of inflammatory arthritis. They agree pathways for urgent referral (within 3 days of presentation) of adults with suspected persistent synovitis of more than 1 joint, or the small joints of the hands and feet.

Healthcare professionals (such as GPs, nurses or allied health professionals) recognise the signs and symptoms of inflammatory arthritis, and are aware of local referral pathways. They refer adults with suspected persistent synovitis of more than 1 joint, or the small joints of the hands and feet, to rheumatology services within 3 days of presentation.

Commissioners (such as clinical commissioning groups) ensure that service specifications include referral criteria and referral pathways to ensure that adults presenting with suspected persistent synovitis of more than 1 joint, or the small joints of the hands or feet, are referred to rheumatology services within 3 days of presentation.

Adults with pain, swelling and stiffness of more than 1 joint, or the small joints of the hands or feet, are referred within 3 days of their GP appointment to a specialist in rheumatology for tests such as an X-ray and blood tests. Early referral means that they can start treatment sooner if the tests show they have rheumatoid arthritis.

Source guidance

- Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.1.1.
- The timeframe of 3 days is based on expert opinion.

Question for consultation

Is referral within 3 days of presentation achievable? Is there an alternative timescale that should be used?

Quality statement 2: Treatment

Quality statement

Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met. **[2013, updated 2019]**

Rationale

Starting treatment quickly gives the best chance of improving long-term outcomes such as joint damage, joint function and quality of life. Regular monitoring of C-reactive protein (CRP) and disease activity allows for the dose of cDMARDs to be increased as needed. It is also important for checking whether people are tolerating the treatment, assessing for side-effects, providing support and encouraging adherence. Intensive treatment with the aim of maintaining remission or low disease activity results in better long-term function and quality of life for people with rheumatoid arthritis.

Quality measures

Structure

a) Evidence of local arrangements to start treatment with cDMARD monotherapy for adults with active rheumatoid arthritis within 6 weeks of referral from primary care.

Data source: Local data collection, for example, service protocols and treatment strategies.

b) Evidence of local arrangements to measure CRP and disease activity monthly in adults with active rheumatoid arthritis until they are in remission or have low disease activity.

Data source: Local data collection, for example, service protocols and treatment strategies.

c) Evidence that healthcare professionals in rheumatology services can assess disease activity.

Data source: Local data collection, for example, checklists for components required for assessment of disease activity, documentation of training and competency for healthcare professionals who measure disease activity.

Process

a) Proportion of adults with active rheumatoid arthritis starting cDMARD monotherapy within 6 weeks of referral from primary care.

Numerator – the number in the denominator who start cDMARD monotherapy within 6 weeks of referral.

Denominator – the number of adults with active rheumatoid arthritis referred from primary care.

Data source: Local data collection, for example, audit of electronic prescription records.

b) Proportion of adults with active rheumatoid arthritis who have their CRP and disease activity measured monthly.

Numerator – the number in the denominator who have their CRP and disease activity measured monthly.

Denominator – the number of adults with active rheumatoid arthritis.

Data source: Local data collection, for example, audit of patient record.

Outcome

a) Disease activity score for adults with rheumatoid arthritis.

Data source: Data for disease activity scores at baseline and follow-up are collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Health-related quality of life score for adults with rheumatoid arthritis.

Data source: Data for quality of life score including symptoms, wellbeing, impact on daily life and work, is collected at baseline, 3-month and 12-month follow-up as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

What the quality statement means for different audiences

Service providers (such as rheumatology services) ensure systems are in place for adults with active rheumatoid arthritis to start cDMARD monotherapy within 6 weeks of referral from primary care. They also ensure that staff from the multidisciplinary team are trained to perform monthly monitoring of active rheumatoid arthritis.

Healthcare professionals (such as rheumatology consultants, rheumatology specialist registrars and specialist nurses) start cDMARD monotherapy for adults with active rheumatoid arthritis within 6 weeks of referral. They measure CRP and disease activity monthly until the target of remission or low disease activity is met.

Commissioners (such as clinical commissioning groups) commission rheumatology services that have capacity for adults with active rheumatoid arthritis to start treatment with cDMARD monotherapy within 6 weeks of referral. They check whether services undertake monthly monitoring for adults with active disease.

Adults with active rheumatoid arthritis start treatment within 6 weeks of seeing their GP. They also have monitoring each month until they have achieved their treatment target.

Source guidance

- Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendations 1.2.1, 1.2.3 and 1.4.1.
- The timeframe of starting treatment within 6 weeks of referral is supported by NHS England and NHS Improvement 2019/20 National Tariff Payment System.

Definitions of terms used in this quality statement

Treatment target

A treat-to-target strategy should be used for adults with rheumatoid arthritis. This defines a treatment target (such as remission or low disease activity based on a composite score such as DAS28) and applies tight control (such as monthly monitoring with treatment adjustment) to reach this target. The treatment strategy often follows a protocol for treatment adaptation depending on the disease activity level and degree of response to treatment.

[Adapted from NICE's guideline on rheumatoid arthritis in adults: management, recommendations 1.2.1 and 1.2.3]

Equality and diversity considerations

Some medicines used in the treatment of rheumatoid arthritis should not be prescribed for adults who are planning a pregnancy, pregnant or breastfeeding. Treatment goals may also be different during pregnancy or when breastfeeding. See British Society for Rheumatology and British Health Professionals in Rheumatology guideline on prescribing disease modifying anti-rheumatic drugs in pregnancy and breastfeeding.

Questions for consultation

- Which of the two areas covered in the statement do you consider to be the priority area for quality improvement? Early commencement of treatment with cDMARDs, or regular monitoring of treatment until treatment target achieved?
- Is the target of starting treatment within 6 weeks of referral achievable?

Quality statement 3: Patient education

Quality statement

Adults with rheumatoid arthritis are given opportunities to take part in educational activities that support self-management throughout the course of their disease. **[2013, updated 2019]**

Rationale

It is important that adults with rheumatoid arthritis are involved in making decisions about their care and have a good understanding of their condition and its management. This enables them to get the best from their medicines, to better manage flare-ups, pain and fatigue, as well as improving their overall quality of life. To ensure they get the greatest benefit, it is essential that educational and self-management activities are offered throughout the disease course and at times to suit individual needs.

Quality measures

Structure

Evidence of availability of educational activities for people with rheumatoid arthritis throughout the course of their disease.

Data source: Local data collection, for example, service protocols and treatment plans, or evidence of referral to patient organisations documented in patient record.

Process

a) Proportion of adults with rheumatoid arthritis who are offered educational activities within 1 month of diagnosis.

Numerator – the number in the denominator with a record of an offer of educational activities within 1 month of diagnosis.

Denominator – the number of adults with rheumatoid arthritis.

Data source: Data for adults with rheumatoid arthritis who are offered educational activities within 1 month of diagnosis is collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Proportion of adults with rheumatoid arthritis who have been offered educational activities within the past 12 months.

Numerator – the number in the denominator with record of an offer of educational activities within the past 12 months.

Denominator – the number of adults with rheumatoid arthritis.

Data source**:** Local data collection, for example, documentation in patient record or survey of adults with rheumatoid arthritis.

Outcome

a) Proportion of adults with rheumatoid arthritis who are satisfied with their ability to self-manage their condition.

Numerator – the number in the denominator who are satisfied with their ability to self-manage their condition.

Denominator – the number of adults with rheumatoid arthritis.

Data source: Local data collection, for example, using patient surveys or validated tools such as the Patient Activation Measure (PAM).

b) Health-related quality of life score for adults with rheumatoid arthritis.

Data source: Data for quality of life score, including symptoms, wellbeing, impact on daily life and work, is collected at baseline, 3-month and 12-month follow-up as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

What the quality statement means for different audiences

Service providers (such as rheumatology services) ensure adults with rheumatoid arthritis are offered educational and self-management activities throughout their disease course. They ensure staff have access to and knowledge of educational materials, structured programmes, and patient organisations for rheumatoid arthritis.

Healthcare professionals (such as rheumatology consultants, specialist nurses, and allied health professionals) offer adults with rheumatoid arthritis structured educational and self-management activities throughout the course of the disease.. They provide opportunities for adults with rheumatoid arthritis to be involved in decisions on management of their disease.

Commissioners (such as clinical commissioning groups) commission services that provide educational and self-management activities for adults with rheumatoid arthritis and engage with patient organisations to provide additional support.

Adults with rheumatoid arthritis take part in activities that help them to learn about their condition and what they can do to help (self-management). These activities should be available throughout the course of their disease. They make decisions on management of their condition and have therapies to help them live with rheumatoid arthritis.

Source guidance

- Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, sections 1.3.
- The timeframes used in the process measures for this statement are based on expert opinion.

Definitions of terms used in this quality statement

Patient Activation Measure

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. The Patient Activation Measure (PAM) is a validated, commercially licenced tool for measurement of patient activation via a survey, the use of which is supported by NHS England.

[Adapted from NHS England Patient activation and PAM FAQS]

Equality and diversity considerations

Adults with rheumatoid arthritis should be provided with education and self-management materials and resources that they can easily read and understand themselves, or with support. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. It should be accessible to adults with additional needs such as physical, sensory or learning disabilities. Adults with rheumatoid arthritis should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Questions for consultation

- Are the timeframes for offering educational activities within 1 month and annually used in the process measures for this statement appropriate?
- Should offering educational activities annually happen as part of the annual review (draft quality statement 5)?

Quality statement 4: Rapid access to specialist care

Quality statement

Adults with rheumatoid arthritis and disease flares or possible treatment-related side effects receive advice within 1 working day of contacting rheumatology services. **[2013, updated 2019]**

Rationale

It is important that adults with rheumatoid arthritis and disease flares or treatment-related side effects can access rheumatology services rapidly to prevent any further joint damage. Disease flares can be disabling and frustrating. Rapid involvement of a specialist is essential for patient safety when there are side effects related to treatment. People may also need rapid access to individual members of the multidisciplinary team when they are having difficulties with activities of daily living.

Quality measures

Structure

a) Evidence of local arrangements for adults with rheumatoid arthritis to contact rheumatology services, including the multidisciplinary team.

Data source: Local data collection, for example, service protocols. Data on rheumatology services that provide a telephone advice service is collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Evidence of availability of staff to respond to patient-initiated contact with rheumatology services.

Data source: Local data collection, for example, staffing rotas.

Process

a) Proportion of adults with rheumatoid arthritis who receive advice from rheumatology services within 1 working day when experiencing a disease flare or possible treatment-related side effects.

Numerator – the number in the denominator who receive advice from rheumatology services within 1 working day.

Denominator – the number of adults with rheumatoid arthritis and a disease flare or possible treatment-related side effects who contact rheumatology services.

Data source: Local data collection, for example, patient surveys, audit of patient record. Data for rheumatology services offering patient advice within 1 working day is collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Proportion of adults with rheumatoid arthritis who have contact details for members of the multidisciplinary team.

Numerator – the number in the denominator who have contact details for members of the multidisciplinary team.

Denominator – the number of adults with rheumatoid arthritis.

Data source: Local data collection, for example, patient surveys.

Outcome

a) Disease activity score for adults with rheumatoid arthritis.

Data source: Data for disease activity scores at baseline and follow-up are collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Health-related quality of life score for adults with rheumatoid arthritis.

Data source: Data for quality of life score, including symptoms, wellbeing, impact on daily life and work, is collected at baseline, 3-month and 12-month follow-up as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

What the quality statement means for different audiences

Service providers (such as rheumatology services) ensure staff are available to respond to adults with rheumatoid arthritis within 1 working day when they are experiencing disease flares or possible treatment-related side effects. They ensure systems are in place so that adults with rheumatoid arthritis know how to contact members of the multidisciplinary team when they need to.

Healthcare professionals (such as rheumatology consultants, specialist nurses and allied health professionals) respond quickly when contacted by people with rheumatoid arthritis, and within 1 working day if the person has a disease flare or possible treatment-related side effects. They provide periodic assessment of everyday living needs and make sure the person knows they can be contacted again if needed.

Commissioners (such as clinical commissioning groups) commission rheumatology services that have capacity to respond rapidly when people with rheumatoid arthritis contact the service, including access to the multidisciplinary team.

Adults with rheumatoid arthritis get advice quickly when they have a flare up of their condition or they have possible side effects from treatment. They have therapies that improve their day-to-day life when they need them.

Source guidance

- Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendations 1.9.1.
- The timeframe of receiving advice within 1 working day of contacting rheumatology services is based on expert opinion and supported by guidance from the British Society for Rheumatology and the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

Definitions of terms used in this quality statement

The multidisciplinary team

A multidisciplinary approach to managing rheumatoid arthritis incorporates various health professions such as specialist nurses, physiotherapists, occupational therapists and podiatrists, as well as rheumatologists. The composition of the team may vary in an individual centre, but emphasis should be placed on the tasks required to care for the individual's needs. The adult with rheumatoid arthritis may be an active member of the team.

[Adapted from NICE’s full guideline on rheumatoid arthritis in adults: management]

Question for consultation

Is the timeframe of receiving advice within 1 working day of contacting rheumatology services achievable?

Quality statement 5: Annual review

Quality statement

Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services. **[2013, updated 2019]**

Rationale

Annual review is important to ensure that all aspects of rheumatoid arthritis are under control and quality of life is maximised. It provides an opportunity to assess how the person is managing their condition and to identify any further support they may need in the future. This includes support from individual members of the multidisciplinary team. It provides an opportunity to assess other aspects of health, such as cardiovascular risk and bone health, and to establish how the disease is affecting a person's life, including any effect on psychological wellbeing.

Quality measures

Structure

Evidence of arrangements to ensure that adults with rheumatoid arthritis have a comprehensive annual review by rheumatology services.

Data source: local data collection, for example, service specifications

Process

a) Proportion of adults with rheumatoid arthritis diagnosed more than 12 months ago who had a comprehensive review within the past 12 months.

Numerator – the number in the denominator who had a comprehensive review within the past 12 months.

Denominator – the number of adults with rheumatoid arthritis diagnosed more than 12 months ago.

Data source: Local data collection, for example, audit of patient record. Data on provision of an annual review by rheumatology services is collected as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

b) Proportion of adults with rheumatoid arthritis who have an assessment for referral to members of the multidisciplinary team as part of an annual review.

Numerator – the number in the denominator with a record of assessment for referral to members of the multidisciplinary team.

Denominator – the number of adults with rheumatoid arthritis who have an annual review.

Data source: Local data collection, for example, audit of patient electronic health records for use of questionnaires such as health assessment questionnaire (HAQ), EuroQoL-5D or MSK-HQ for assessment for multidisciplinary team referral.

c) Proportion of adults with rheumatoid arthritis assessed for comorbidities as part of an annual review.

Numerator – the number in the denominator with a record of assessment for comorbidities.

Denominator – the number of adults with rheumatoid arthritis who have an annual review.

Data source: Local data collection, for example, audit of patient record for cardiovascular risk assessment, osteoporosis risk assessment and evaluation for depression as part of an annual review.

Outcome

Health-related quality of life score for adults with rheumatoid arthritis.

Data source: Data for quality of life score, including symptoms, wellbeing, impact on daily life and work, is collected at baseline, 3-month and 12-month follow-up as part of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis.

What the quality statement means for different audiences

Service providers (such as rheumatology services) ensure that systems are in place to invite adults with rheumatoid arthritis for a comprehensive annual review and use protocols to refer to members of the multidisciplinary or surgical team.

Healthcare professionals (such as rheumatology consultants, specialist registrars and specialist nurses) provide a comprehensive annual review for all adults with rheumatoid arthritis. The review includes assessment of disease activity, functional ability and development of comorbidities or disease complications. They also assess the need for referral to other members of the multidisciplinary or surgical team. They have the expertise to assess the effect the disease is having on a person's life.

Commissioners (such as clinical commissioning groups) ensure that service specifications include the provision of a comprehensive annual review for adults with rheumatoid arthritis. They monitor services to check whether these annual reviews are being done.

Adults with rheumatoid arthritis have a check-up in the rheumatology service each year. The check-up includes an assessment of the arthritis and complications, as well as a check for heart disease, bone disease and depression. They are asked about how the arthritis is affecting their day-to-day life and are referred to other services (such as physiotherapy and occupational therapy) if needed.

Source guidance

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.9.3.

Definitions of terms used in this quality statement

Comprehensive annual review.

A comprehensive annual review includes:

- assessing disease activity and damage, and measuring functional ability (using, for example, the health assessment questionnaire [HAQ])
- checking for the development of comorbidities such as hypertension, ischaemic heart disease, osteoporosis and depression
- assessing symptoms that suggest complications such as vasculitis, and disease of the cervical spine, lungs or eyes
- organising cross-referral within the multidisciplinary team
- assessing the need for referral for surgery

- assessing the effect the disease is having on the person's life.

[NICE's guideline on rheumatoid arthritis in adults: management, recommendation 1.9.3]

The multidisciplinary team

A multidisciplinary approach to managing rheumatoid arthritis incorporates various health professions such as specialist nurses, physiotherapists, occupational therapists and podiatrists, as well as rheumatologists. The composition of the team may vary in an individual centre, but emphasis should be placed on the tasks required to care for the individual's needs. The adult with rheumatoid arthritis may be an active member of the team.

[Adapted from NICE's full guideline on rheumatoid arthritis in adults: management]

Update information

August 2019: This quality standard was updated and statements prioritised in 2013 were replaced.

Statements are marked as:

- **[2013, updated 2019]** if the statement covers an area for quality improvement included in the 2013 quality standard and has been updated.

Statements numbered 1, 3, 4, 5, 6 and 7 in the 2013 version have been updated and are included in the updated quality standard, marked as **[2013, updated 2019]**.

Statement 2 from the 2013 quality standard for rheumatoid arthritis in over 16s is still supported by the evidence and may still be useful at a local level, and is listed in the quality statements section.

The 2013 quality standard for rheumatoid arthritis in over 16s is available as a pdf.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been included in the NICE Pathway on rheumatoid arthritis, which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and

Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes for adults with rheumatoid arthritis:

- disease control
- health-related quality of life
- employment
- satisfaction with the support to manage their condition
- experience of GP and outpatient services

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the NICE guideline on rheumatoid arthritis to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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