NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Draft quality standard for rheumatoid arthritis

1 Introduction

Rheumatoid arthritis is an inflammatory disease that typically affects the small joints of the hands and feet but any joint can be affected. It is a systemic disease, which means that it does not just affect the musculoskeletal system but can affect the whole body, including the lungs, eyes and small blood vessels (vasculitis). Medical management with drug therapy aims to relieve symptoms and modify the progress of the disease and the functional impairment associated with it.

There are approximately 580,000 people with rheumatoid arthritis in England alone, suggesting there may be as many as 690,000 people affected in the whole of the UK. Around 1.5 men and 3.6 women develop rheumatoid arthritis per 10,000 people per year, which translates into approximately 26,000 people developing the condition per year in England, and about 30,000 across the UK. The overall occurrence of rheumatoid arthritis is 2 to 4 times greater in women than men. Onset is generally between the ages of 40 and 60 years, but people of all ages can develop the disease.

Rheumatoid arthritis can result in a wide range of complications, and has a significant personal impact for people with the disease and their families and carers. It also has an economic impact on the NHS and society in general. Approximately one-third of people stop work because of the disease within 2 years of onset, and this prevalence increases thereafter. The total costs of rheumatoid arthritis in the UK, including indirect costs and work-related disability, have been estimated at around £2.4 billion per year.

This quality standard covers the diagnosis and management of rheumatoid arthritis in adults (16 years and older). For more information see the scope for this quality standard.

- NHS Outcomes Framework 2013-14
- Improving outcomes and supporting transparency: Part 1: a public health outcomes framework for England, 2013–2016
- The Adult Social Care Outcomes Framework, 2013-14.

The table below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

The adult social care outcomes framework 2013-14	
Domain 1: Enhancing quality of life for people with care and support needs.	**Overarching measure** 1A Social care related quality of life **Outcome measures** *People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation* 1E The proportion of adults with a learning disability in paid employment
NHS outcomes framework 2013-14	
Domain 2: Enhancing quality of life for people with long-term conditions.	**Overarching indicator** 2 Health related quality of life for people with long term conditions **Improvement areas** *Ensuring people feel supported to manage their condition* 2.1 Proportion of people feeling supported to manage their condition *Improving functional ability in people with long-term conditions* 2.2 Employment of people with long-term conditions
Domain 4: Ensuring that people have a positive experience of care.	**Overarching indicators** 4a Patient experience of primary care 4ai GP services 4b Patient experience of hospital care **Improvement areas** *Improving people's experience of outpatient care*

	4.1 Patient experience of outpatient services
Public health outcomes framework 2013-16	
Domain 1: Improving the wider determinants of health	**Objective** Improvements against wider factors that affect health and wellbeing and health inequalities. **Indicators** 1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness

Draft quality standard for rheumatoid arthritis

Overview

The draft quality standard for rheumatoid arthritis requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole rheumatoid arthritis care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with rheumatoid arthritis.

The quality standard should be read in the context of national and local guidelines on training and competencies. Implementation of this quality standard is based on all healthcare professionals involved in the diagnosis and management of rheumatoid arthritis having sufficient and appropriate training, and competence to deliver the actions and interventions described in the quality standard.

No.	Draft quality statements
1	People presenting to a GP with symptoms or signs of inflammatory arthritis are referred to a rheumatology service within 1 working day of presentation.
2	People with suspected inflammatory arthritis are assessed by a rheumatology service within 2 weeks of referral.
3	People with newly diagnosed active rheumatoid arthritis are offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service.
4	People with rheumatoid arthritis are offered educational and self-management activities starting around the time of diagnosis.
5	People who have uncontrolled active rheumatoid arthritis receive monthly treatment escalation until the disease is controlled to an agreed target.
6	People with rheumatoid arthritis have access to a multidisciplinary team with inflammatory arthritis expertise.
7	People with rheumatoid arthritis have rapid access to the rheumatology service for advice or treatment.
8	People with rheumatoid arthritis are offered referral for a specialist surgical opinion if surgery may be indicated.
9	People with rheumatoid arthritis have a comprehensive annual review.

Other quality standards that should also be considered when commissioning and providing a high-quality rheumatoid arthritis service are listed in section 7.

General questions for consultation:

Question 1	Can you suggest any appropriate healthcare outcomes for each individual quality statement?
Question 2	What important areas of care, if any, are not covered by the quality standard?
Question 3	What, in your opinion, are the most important quality statements and why?
Question 4	Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives?
Please refer to Quality standards in development for additional general points for consideration (available from www.nice.org.uk).	
Statement-specific questions for consultation:	
Question 5	What do you consider to be a reasonable timeframe from diagnosis within which people with rheumatoid arthritis are offered educational and self-management activities, for example within 1 month of diagnosis?

Draft quality statement 1: Referral

Draft quality statement	People presenting to a GP with symptoms or signs of inflammatory arthritis are referred to a rheumatology service within 1 working day of presentation.
Draft quality measure	**Structure:** Evidence of local arrangements for people presenting to a GP with symptoms or signs of inflammatory arthritis to be referred to a rheumatology service within 1 working day of presentation. **Process:** Proportion of people presenting to a GP with symptoms or signs of inflammatory arthritis who are referred to a rheumatology service within 1 working day of presentation. Numerator – the number of people in the denominator who are referred to a rheumatology service within 1 working day of presentation. Denominator – the number of people presenting to a GP with symptoms or signs of inflammatory arthritis.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people presenting to a GP with symptoms or signs of inflammatory arthritis to be referred to a rheumatology service within 1 working day of presentation. **Primary care professionals** ensure that people presenting to a GP with symptoms or signs of inflammatory arthritis are referred to a rheumatology service within 1 working day of presentation. **Commissioners** ensure they commission services that enable people presenting to a GP with symptoms or signs of inflammatory arthritis to be referred to a rheumatology service within 1 working day of presentation. **People who go to see a GP with symptoms or signs of inflammatory arthritis** are referred to a rheumatology service within 1 working day of presentation.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.1.1.1 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** Local data collection.
Definitions	Symptoms and signs of inflammatory arthritis include persistent pain, swelling, heat, early morning stiffness lasting more than 30 minutes and often recurring after longer periods of rest, and loss of function of the affected joint. Occasionally the joints may also be red, but this is unusual. The person may also have systemic symptoms of inflammation, which include malaise, fever, sweats, fatigue and weight loss.

	A rheumatology service comprises a specialist multidisciplinary team, all of whom have expertise in managing rheumatoid arthritis. The team is led by 1 or more consultant rheumatologists and includes nurse specialists, physiotherapists, occupational therapists, podiatrists and orthotists. It has access to supporting specialties including orthopaedic surgery, psychology, diagnostic imaging and laboratory facilities, and may also have rheumatology doctors in training.

Draft quality statement 2: Assessment

Draft quality statement	People with suspected inflammatory arthritis are assessed by a rheumatology service within 2 weeks of referral.
Draft quality measure	**Structure:** Evidence of local arrangements for people with suspected inflammatory arthritis to be assessed by a rheumatology service within 2 weeks of referral. **Process:** Proportion of people with suspected inflammatory arthritis who are assessed by a rheumatology service within 2 weeks of referral. Numerator – the number of people in the denominator who are assessed by a rheumatology service within 2 weeks of referral. Denominator – the number of people with suspected inflammatory arthritis.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with suspected inflammatory arthritis to be assessed by a rheumatology service within 2 weeks of referral. **Healthcare professionals** ensure that people with suspected inflammatory arthritis are assessed by a rheumatology service within 2 weeks of referral. **Commissioners** ensure they commission services that enable people with suspected inflammatory arthritis to be assessed by a rheumatology service within 2 weeks of referral. **People with suspected inflammatory arthritis** are assessed by a rheumatology service within 2 weeks of referral.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.1.1.1 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within Commissioning for quality in rheumatoid arthritis: patient metric data collection form for recent onset rheumatoid arthritis, questions 2.1 and 2.2.
Definitions	A rheumatology service comprises a specialist multidisciplinary team, all of whom have expertise in managing rheumatoid arthritis. The team is led by 1 or more consultant rheumatologists and includes nurse specialists, physiotherapists, occupational therapists, podiatrists and orthotists. It has access to supporting specialties including orthopaedic surgery, psychology, diagnostic imaging and laboratory facilities, and may also have rheumatology doctors in training.

Draft quality statement 3: Initiating treatment

Draft quality statement	People with newly diagnosed active rheumatoid arthritis are offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service.
Draft quality measure	**Structure:** Evidence of local arrangements for people with newly diagnosed active rheumatoid arthritis to receive a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service. **Process:** Proportion of people with newly diagnosed active rheumatoid arthritis who receive a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service. Numerator – the number of people in the denominator who receive a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4weeks of assessment by a rheumatology service. Denominator – the number of people with newly diagnosed active rheumatoid arthritis.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with newly diagnosed active rheumatoid arthritis to be offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service. **Healthcare professionals** ensure that people with newly diagnosed active rheumatoid arthritis are offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service. **Commissioners** ensure they commission services that enable people with newly diagnosed active rheumatoid arthritis to be offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service. **People with newly diagnosed active rheumatoid arthritis** are offered a combination of disease-modifying antirheumatic drugs and short-term glucocorticoids within 4 weeks of assessment by a rheumatology service.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.4.1.1 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained with Commissioning for quality in rheumatoid arthritis: patient metric data collection form

	for recent onset rheumatoid arthritis, question 2.3.
Definitions	Active rheumatoid arthritis can be defined as a disease activity score (DAS28) of greater than 2.6, or disease that cannot be considered as being adequately controlled.The combination of disease-modifying antirheumatic drugs should ideally include methotrexate, and at least 1 other DMARD (for example sulfasalazine, hydroxychoroquine, leflunomide or cyclosporine). A rheumatology service comprises a specialist multidisciplinary team, all of whom have expertise in managing rheumatoid arthritis. The team is led by 1 or more consultant rheumatologists and includes nurse specialists, physiotherapists, occupational therapists, podiatrists and orthotists. It has access to supporting specialties including orthopaedic surgery, psychology, diagnostic imaging and laboratory facilities, and may also have rheumatology doctors in training.

Draft quality statement 4: Education and self-management

Draft quality statement	People with rheumatoid arthritis are offered educational and self-management activities starting around the time of diagnosis.
Draft quality measure	**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to be offered educational and self-management activities starting around the time of diagnosis. **Process:** Proportion of people with rheumatoid arthritis who are offered educational and self-management activities starting around the time of diagnosis. Numerator – the number of people in the denominator who are offered educational and self-management activities starting around the time of diagnosis. Denominator – the number of people with rheumatoid arthritis. **Outcome:** a) Patient satisfaction with knowledge about their condition. b) Patient experience.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with rheumatoid arthritis to be offered educational and self-management activities starting around the time of diagnosis. **Healthcare professionals** ensure that people with rheumatoid arthritis are offered educational and self-management activities starting around the time of diagnosis. **Commissioners** ensure they commission services that enable people with rheumatoid arthritis to be offered educational and self-management activities starting around the time of diagnosis. **People with rheumatoid arthritis** are offered educational activities and self-management programmes starting around the time of diagnosis.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.2.1.3.
Data source	**Structure:** Local data collection. **Process:** Local data collection. **Outcome:** a) and b) Local data collection.
Definitions	Educational activities and self-management programmes can be provided 1-to-1, through self-study or computer-based

	interventions or in formal organised group sessions led by rheumatology healthcare professionals or trained lay leaders with arthritis or other chronic conditions. Different formats may be used, and should include patient information supported by written resources. They may take an educational approach such as lecture or discussion sessions to increase knowledge and reduce concerns; or a behavioural approach, including regular skills practice, goal setting and use of home programmes to facilitate behavioural change.
Question for consultation	What do you consider to be a reasonable timeframe from diagnosis within which people with rheumatoid arthritis are offered educational and self-management activities, for example within 1 month of diagnosis?

Draft quality statement 5: Disease control

Draft quality statement	People who have uncontrolled active rheumatoid arthritis receive monthly treatment escalation until the disease is controlled to an agreed target.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people with uncontrolled active rheumatoid arthritis receive monthly treatment escalation until the disease is controlled to an agreed target. **Process:** a) Proportion of people with uncontrolled active rheumatoid arthritis who receive monthly treatment escalation. Numerator – the number of people in the denominator who receive monthly treatment escalation. Denominator – the number of people with uncontrolled active rheumatoid arthritis. b) Proportion of people with previously uncontrolled active rheumatoid arthritis whose disease is currently controlled, who received monthly treatment escalation until the disease was controlled to an agreed target. Numerator – the number of people in the denominator who received monthly treatment escalation until the disease was controlled to an agreed target. Denominator – the number of people with previously uncontrolled active rheumatoid arthritis whose disease is currently controlled. **Outcome:** a) Time from diagnosis to disease control. b) Composite disease activity score. c) Function of joints.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with uncontrolled active rheumatoid arthritis to receive monthly treatment escalation until the disease is controlled to an agreed target. **Healthcare professionals** ensure that people with uncontrolled active rheumatoid arthritis receive monthly treatment escalation until the disease is controlled to an agreed target. **Commissioners** ensure they commission services that enable people with uncontrolled active rheumatoid arthritis to receive monthly treatment escalation until the disease is controlled to an agreed target. **People with uncontrolled active rheumatoid arthritis** receive monthly treatment escalation until the disease is controlled to an agreed target.

Source clinical guideline references	NICE clinical guideline 79 recommendations 1.5.1.1 and 1.5.1.2 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** a) and b) Local data collection. Contained within Commissioning for quality in rheumatoid arthritis: patient metric data collection form for recent onset rheumatoid arthritis, question 4.1. **Outcome:** a), b) and c) Local data collection.
Definitions	Treatment escalation relates to the use of disease-modifying antirheumatic drugs, glucocorticoids or biological drugs, and is undertaken after a face-to-face consultation with a member of the rheumatology service. Disease activity is measured using a composite score such as DAS28. An agreed target is a level of disease activity or functional ability that is agreed with each person as their goal for ongoing management of the disease. Controlled disease represents the agreed target being achieved and the person being satisfied with their functional ability and suppression of symptoms. Uncontrolled disease is any level of disease that doesn't meet the agreed target. Function of joints can be measured using the Health Assessment Questionnaire.

Draft quality statement 6: Multidisciplinary team

Draft quality statement	People with rheumatoid arthritis have access to a multidisciplinary team with inflammatory arthritis expertise.
Draft quality measure	**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to have access to a multidisciplinary team with inflammatory arthritis expertise. **Outcome:** Patient experience.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with rheumatoid arthritis to have access to a multidisciplinary team with inflammatory arthritis expertise. **Healthcare professionals** ensure that people with rheumatoid arthritis have access to a multidisciplinary team with inflammatory arthritis expertise. **Commissioners** ensure they commission services that enable people with rheumatoid arthritis to have access to multidisciplinary team with inflammatory arthritis expertise. **People with rheumatoid arthritis** have access to a team of healthcare professionals with expertise in caring for people with rheumatoid arthritis.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.3.1.1.
Data source	**Structure:** Local data collection. **Outcome:** Local data collection.
Definitions	A multidisciplinary team with inflammatory arthritis expertise comprises a consultant rheumatologist, rheumatology nurse specialist, physiotherapist, occupational therapist, podiatrist, orthotist and psychologist – all with expertise in caring for people with rheumatoid arthritis. Having access means that the patient is, on an ongoing basis, able to contact a member of the multidisciplinary team directly, allowing self-referral into the service as well as access to routine appointments with members of the team.

Draft quality statement 7: Rapid access

Draft quality statement	People with rheumatoid arthritis have rapid access to the rheumatology service for advice or treatment.
Draft quality measure	**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to have rapid access to the rheumatology service for advice or treatment. **Outcome:** Patient experience.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with rheumatoid arthritis to have rapid access to the rheumatology service for advice or treatment. **Healthcare professionals** ensure that people with rheumatoid arthritis have rapid access to the rheumatology service for advice or treatment. **Commissioners** ensure they commission services that enable people with rheumatoid arthritis to have rapid access to the rheumatology service for advice or treatment. **People with rheumatoid arthritis** have rapid access to the rheumatology service for advice or treatment.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.5.1.3.
Data source	**Structure:** Local data collection. **Outcome:** Local data collection.
Definitions	People with rheumatoid arthritis may need rapid access to the rheumatology service for advice and treatment when they experience disease flares, drug side effects or other concerns relating to their rheumatoid arthritis. Access may constitute a telephone call or appointment, depending on the nature of the concern. Services are expected to ensure they have capacity for urgent or next-day appointments to allow rapid access for people with rheumatoid arthritis experiencing flares or a sudden increase in pain or loss of function. A rheumatology service comprises a specialist multidisciplinary team, all of whom have expertise in managing rheumatoid arthritis. The team is led by 1 or more consultant rheumatologists and includes nurse specialists, physiotherapists, occupational therapists, podiatrists and orthotists. It has access to supporting specialties including orthopaedic surgery, psychology, diagnostic imaging and laboratory facilities, and may also have rheumatology doctors in training.

Draft quality statement 8: Surgery

Draft quality statement	People with rheumatoid arthritis are offered referral for a specialist surgical opinion if surgery may be indicated.
Draft quality measure	**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to be referred for a specialist surgical opinion if surgery may be indicated. **Process:** a) Proportion of people with rheumatoid arthritis who are offered referral for a specialist surgical opinion if surgery may be indicated. Numerator – the number of people in the denominator who are offered referral for a specialist surgical opinion. Denominator – the number of people with rheumatoid arthritis for whom surgery may be indicated. b) Proportion of people with rheumatoid arthritis who are referred for a specialist surgical opinion if surgery may be indicated. Numerator – the number of people in the denominator who are referred for a specialist surgical opinion. Denominator – the number of people with rheumatoid arthritis for whom surgery may be indicated.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with rheumatoid arthritis to be offered referral for a specialist surgical opinion if surgery may be indicated. **Healthcare professionals** ensure that people with rheumatoid arthritis are offered referral for a specialist surgical opinion if surgery may be indicated. **Commissioners** ensure they commission services for people with rheumatoid arthritis to be offered referral for a specialist surgical opinion if surgery may be indicated. **People with rheumatoid arthritis** are offered referral for a specialist surgical opinion if surgery may be considered.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.6.1.1.
Data source	**Structure:** Local data collection. **Process:** a) and b) Local data collection.
Definitions	Surgery may be indicated if any of the following do not respond to optimal non-surgical management: • persistent pain from joint damage or other identifiable soft

	tissue cause • worsening joint function • progressive deformity • persistent localised synovitis.

Draft quality statement 9: Annual review

Draft quality statement	People with rheumatoid arthritis have a comprehensive annual review.
Draft quality measure	**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to have a comprehensive annual review. **Process:** Proportion of people with rheumatoid arthritis diagnosed more than 1 year ago whose last comprehensive review was within 12 months of diagnosis or the previous review. Numerator – the number of people in the denominator whose most recent comprehensive review was within 12 months of diagnosis or the previous review. Denominator – the number of people with rheumatoid arthritis diagnosed more than 1 year ago.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people with rheumatoid arthritis to have a comprehensive annual review. **Healthcare professionals working in the rheumatology service** ensure that people with rheumatoid arthritis have a comprehensive annual review. **Commissioners** ensure they commission services that enable people with rheumatoid arthritis to have a comprehensive annual review. **People with rheumatoid arthritis** have a comprehensive annual review.
Source clinical guideline references	NICE clinical guideline 79 recommendation 1.5.1.4.
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within Commissioning for quality in rheumatoid arthritis: patient metric data collection forms questions 5.1–5.5 (recent-onset) and questions 4.1–4.6 (established).
Definitions	A comprehensive annual review includes: • assessing disease activity and damage, and measuring functional ability (using, for example, the Health Assessment Questionnaire) • 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, lung or eyes • organising cross referral within the multidisciplinary team • assessing the need for referral for surgery

	• assessing the effect the disease is having on a person's life • offering educational activities and self-management programmes. Elements of the annual review may be undertaken in primary care, for example checking for comorbidities such as hypertension. The rheumatology service is responsible for coordinating the annual review and ensuring that all elements have been completed (as well as preventing any duplication). An outpatient appointment could be arranged with a member of the rheumatology team to coordinate the review. Action should be taken as necessary following the annual review, for example referral to specialist services.

2 Status of this quality standard

This is the draft quality standard released for consultation from 21 January until 18 February 2013. This document is not NICE's final quality standard on rheumatoid arthritis. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 18 February 2013. All eligible comments received during consultation will be reviewed by the Topic Expert Group and the quality statements and measures will be refined in line with the Topic Expert Group considerations. The final quality standard will then be available on the NICE website from June.

3 Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the evidence sources section.

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

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

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their Indicators for Quality Improvement Programme. For statements for which national quality indicators

do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard.

4 Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments will be published on the NICE website with the final version of the quality standard.

Good communication between health and social care professionals and people with rheumatoid arthritis is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with rheumatoid arthritis should have access to an interpreter or advocate if needed.

5 How this quality standard was developed

The evidence sources used to develop this quality standard are listed in appendix 1, along with relevant policy context, definitions and data sources. Further explanation of the methodology used can be found in the Quality Standards Programme interim process guide.

6 Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard (2012).

Appendix 1: Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Rheumatoid arthritis. NICE clinical guideline 79 (2009; NHS Evidence accredited).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

National Audit Office (2009) Services for people with rheumatoid arthritis.

Department of Health (2006) The musculoskeletal services framework.

Department of Health (2005) The national service framework for long term conditions.

Definitions and data sources for the quality measures

References included in the definitions and data source sections.

National Rheumatoid Arthritis Society (2012) Commissioning for quality in rheumatoid arthritis: commissioning metrics forms.