

# Rheumatoid arthritis in over 16s

Quality standard

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[www.nice.org.uk/guidance/qs33](https://www.nice.org.uk/guidance/qs33)



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This standard is based on NG100.

This standard should be read in conjunction with QS15 and QS170.

## 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 working days of presenting in primary care. **[2013, updated 2020]**

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 2020]**

Statement 3 Adults with rheumatoid arthritis are given opportunities throughout the course of their disease to take part in educational activities that support self-management. **[2013, updated 2020]**

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 2020]**

Statement 5 Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services. **[2013, updated 2020]**

In 2020, this quality standard was updated and statements prioritised in 2013 were updated **[2013, updated 2020]**. For more information, see [update information](#).

The following statement 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, but is 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](#).

# 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 working days of presenting in primary care. **[2013, updated 2020]**

## 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 because they are likely to have a 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 suspected persistent synovitis to be referred to rheumatology services within 3 working 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 working days.

**Numerator** – the number in the denominator who are referred to rheumatology services within 3 working 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:** The National Early Inflammatory Arthritis Audit collects data on referral within 3 working days of presentation.

## Outcome

Time from presentation in primary care to diagnosis for adults with rheumatoid arthritis.

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

## 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 to rheumatology services (within 3 working days of presentation in primary care) 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 working days of presentation in primary care.

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



**Adults with pain, swelling and stiffness of more than 1 joint, or the small joints of the hands or feet**, are referred within 3 working days of their GP appointment to a specialist in rheumatology. Early referral means that they can be diagnosed and start treatment sooner if they have rheumatoid arthritis.

## Source guidance

- [Rheumatoid arthritis in adults: management. NICE guideline NG100 \(2018\)](#), recommendation 1.1.1
- The 3-working-days timeframe is based on expert opinion and not derived from NICE's guideline on rheumatoid arthritis in adults. It is considered a practical timeframe to enable stakeholders to measure performance. The timeframe is used in the [National Early Inflammatory Arthritis Audit](#)

## Definition of terms used in this quality statement

### Persistent synovitis

Signs and symptoms of persistent synovitis include persistent (not resolving within 3 to 4 weeks) 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 may include malaise, fever, sweats, fatigue and weight loss. [Adapted from [NICE's full guideline on rheumatoid arthritis in adults](#), section 4.1 and from expert opinion]

## 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 2020]**

### Rationale

Starting treatment quickly give the best chance of improving long-term outcomes such as joint damage, joint function and quality of life for adults with active rheumatoid arthritis. Regular monitoring of C-reactive protein (CRP) and disease activity allows for the dose of cDMARDs to be adjusted as needed. Intensive treatment monitoring and adjustment, with the aim of maintaining remission, or low disease activity if remission cannot be achieved, results in better long-term function and quality of life for adults 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 if remission cannot be achieved.

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

## Process

a) Proportion of adults with suspected persistent synovitis who have specialist assessment within 3 weeks of referral from primary care.

Numerator – the number in the denominator who have specialist assessment within 3 weeks of referral.

Denominator – the number of adults with suspected persistent synovitis referred to rheumatology services.

**Data source:** The National Early Inflammatory Arthritis Audit collects data on time from referral to specialist assessment.

b) 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 to rheumatology services.

**Data source:** Local data collection, for example, audit of electronic prescription records. The National Early Inflammatory Arthritis Audit collects data on time from referral to initiation of cDMARD therapy.

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

Numerator – the number in the denominator who had their CRP and disease activity score measured within the past month.

Denominator – the number of adults with active rheumatoid arthritis.

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

## Outcome

a) Disease activity for adults with rheumatoid arthritis.

**Data source:** The National Early Inflammatory Arthritis Audit collects data on mean disease activity score (DAS28) at baseline, 3-month and 12-month follow up.

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

**Data source:** The National Early Inflammatory Arthritis Audit collects data on patient-reported quality of life, including symptoms, wellbeing, impact on daily life and work, in the patient questionnaire at baseline, 3-month and 12-month follow up.

## What the quality statement means for different audiences

**Service providers** (such as rheumatology services) ensure that 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 if remission cannot be achieved, 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. NICE guideline NG100 \(2018\)](#), recommendations 1.2.1, 1.2.3 and 1.4.1
- The 6-week timeframe for starting treatment is not derived from NICE's guideline on rheumatoid arthritis in adults. It is considered a practical timeframe to enable stakeholders to measure performance. The timeframe is used by NHS England and [NHS Improvement's 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 if remission cannot be achieved) 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 adapting treatment depending on the disease activity level and degree of response to treatment. [Adapted from [NICE's guideline on rheumatoid arthritis in adults](#), recommendations 1.2.1, 1.2.3 and terms used in this guideline]

## 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 the [British Society for Rheumatology and British Health Professionals in Rheumatology guideline on prescribing DMARDs in pregnancy and breastfeeding](#).

# Quality statement 3: Patient education

## Quality statement

Adults with rheumatoid arthritis are given opportunities throughout the course of their disease to take part in educational activities that support self-management. **[2013, updated 2020]**

## 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 adults with rheumatoid arthritis are offered educational and self-management activities and signposting to resources provided by patient organisations, 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 signposting 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 who are offered educational activities within

1 month of diagnosis.

Denominator – the number of adults with rheumatoid arthritis.

**Data source:** Local data collection, for example, documentation in patient records or survey of adults with rheumatoid arthritis. The 2019/20 National Tariff Payment System collects data on adults with rheumatoid arthritis and early inflammatory arthritis who are offered education within 1 month of diagnosis.

b) Proportion of adults with rheumatoid arthritis who report at annual review that they have been given as much information as they want about their condition and its management.

Numerator – the number in the denominator who report that they have been given as much information as they want about their condition and its management.

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

**Data source:** Local data collection, for example, survey of adults with rheumatoid arthritis using the Commissioning for Quality in Rheumatoid Arthritis PREMS for RA: patient questionnaire, sections 1 and 3.

## Outcome

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.

## What the quality statement means for different audiences

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

**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 offer verbal and written information at each appointment to improve the person's understanding of their condition and its management. They provide opportunities for adults with rheumatoid arthritis to be involved in decisions on management of their disease and they signpost to relevant patient organisations.

**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 and resources.

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

## Source guidance

- [Rheumatoid arthritis in adults: management. NICE guideline NG100 \(2018\)](#), recommendations 1.3.1, 1.3.2 and 1.3.3
- The 1-month timeframe used in the process measure for this statement is not derived from NICE's guideline on rheumatoid arthritis in adults. It is considered a practical timeframe to enable stakeholders to measure performance. The timeframe is used in the NHS England and [NHS Improvement's 2019/20 National Tariff Payment System](#)



## Definitions of terms used in this quality statement

### Educational activities

Educational activities and self-management programmes can be provided 1-to-1 in a clinic setting, through self-study or computer-based interventions. They can also be provided 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, to improve understanding of the condition and its management, and counter any misconceptions adults with rheumatoid arthritis may have. Educational activities may include lectures or facilitated interactive group discussions to increase knowledge and reduce concerns. Alternatively, regular skills practice, goal setting and home programmes may be used to facilitate behavioural change. The opportunity to take part in existing educational activities and self-management programmes should be offered to adults with rheumatoid arthritis throughout the course of their disease. [Adapted from [NICE's full guideline on rheumatoid arthritis in adults](#), section 5.2]

### 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 and age appropriate. 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](#).

Adults with rheumatoid arthritis should be offered information about planning a pregnancy, pregnancy and breastfeeding at the time of diagnosis and throughout the course of their disease. The information should be appropriate to their age and circumstances.

# 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 2020]

## 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. Rapid involvement of a specialist is essential for patient safety when there are side effects related to treatment. People may also need advice from members of the multidisciplinary team such as physiotherapists or occupational therapists, 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.

**Data source:** Local data collection, for example, service protocols. The [National Early Inflammatory Arthritis Audit](#) collects data on rheumatology services that provide contact details for a specialist advice line.

b) Evidence of availability of staff to give advice to adults with rheumatoid arthritis when they contact rheumatology services.

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

## Process

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:** The [National Early Inflammatory Arthritis Audit](#) collects data on rheumatology services offering access to urgent rheumatology advice within 1 working day.

## Outcome

a) Disease activity for adults with rheumatoid arthritis.

**Data source:** The [National Early Inflammatory Arthritis Audit](#) collects data on mean disease activity score (DAS28) at baseline, 3-month and 12-month follow up.

b) Functional ability of adults with rheumatoid arthritis.

**Data source:** The [National Early Inflammatory Arthritis Audit](#) collects data on functional ability in the patient questionnaire at baseline, 3-month and 12-month follow up.

## What the quality statement means for different audiences

**Service providers** (such as rheumatology services) ensure that staff are available to give advice to adults with rheumatoid arthritis within 1 working day when they are experiencing disease flares or possible treatment-related side effects.

**Healthcare professionals** (such as rheumatology consultants, specialist nurses and allied health professionals) give advice within 1 working day when contacted by people with rheumatoid arthritis who have a disease flare or possible treatment-related side effects.

**Commissioners** (such as clinical commissioning groups) commission rheumatology services that have capacity to give advice when people with rheumatoid arthritis contact the service.

**Adults with rheumatoid arthritis** know who to contact and how to get advice quickly when they have a flare up of their condition or they have possible side effects from treatment.

## Source guidance

- Rheumatoid arthritis in adults: management. NICE guideline NG100 (2018), recommendation 1.9.1
- The 1 working day timeframe for receiving advice is based on expert opinion and is not derived from NICE's guideline on rheumatoid arthritis in adults. It is considered a practical timeframe to enable stakeholders to measure performance. The timeframe is used by the British Society for Rheumatology and the National Early Inflammatory Arthritis Audit

# Quality statement 5: Annual review

## Quality statement

Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services. **[2013, updated 2020]**

## 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. This includes support from individual members of the multidisciplinary team. It provides an opportunity to assess disease activity and measure functional ability, check for comorbidities, such as cardiovascular disease and osteoporosis, and complications of rheumatoid arthritis, including vasculitis and disease of the spine, lung or eyes. It also provides an opportunity to establish how the disease is affecting a person's life, including any effect on work and on psychological wellbeing.

## Quality measures

### Structure

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

**Data source:** Local data collection, for example, service specifications.

### Process

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 records. The National Early Inflammatory Arthritis Audit collects data on provision of an annual review by rheumatology services. The Quality and Outcomes Framework (QOF) indicator RA002 collects data on the provision in primary care of a face-to-face review in the preceding 12 months.

## Outcome

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

**Data source:** The National Early Inflammatory Arthritis Audit collects data for patient-reported quality of life, including symptoms, wellbeing, impact on daily life and work at baseline, 3-month and 12-month follow up as part of the patient questionnaire.

## What the quality statement means for different audiences

**Service providers** (rheumatology services) coordinate comprehensive annual review for adults with rheumatoid arthritis. They ensure that systems are in place to invite adults with rheumatoid arthritis to attend an annual review and ensure that all elements of the review have been completed. This includes the use of protocols to refer to members of the multidisciplinary or surgical team when necessary.

**Healthcare professionals** (such as rheumatology consultants, specialist registrars, specialist nurses and GPs) 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 each year. The check-up includes an assessment of rheumatoid arthritis and complications, as well as a check for heart disease, bone disease and depression. They are asked about how the rheumatoid 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. NICE guideline NG100 (2018), 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 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 appropriate 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, 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. 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 can often be an active member of the team. [Adapted from [NICE's full guideline on rheumatoid arthritis in adults](#), section 6.1]

## Equality and diversity considerations

Adults with rheumatoid arthritis should be offered information about planning a pregnancy, pregnancy and breastfeeding at annual review. The information should be appropriate to their age and circumstances.



## Update information

**January 2020:** This quality standard was updated and statements prioritised in 2013 were replaced.

Statements are marked as **[2013, updated 2020]** 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 2020]**.

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 our [webpage on quality standard advisory committees](#) 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 from the [webpage for this quality standard](#).

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](#)
- [Quality framework for public health.](#)

## 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 for this quality standard](#) 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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## Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

## Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [National Rheumatoid Arthritis Society](#)
- [Royal College of Nursing \(RCN\)](#)
- [Arthritis Action](#)
- [Royal College of Physicians and Surgeons of Glasgow](#)
- [Royal College of General Practitioners \(RCGP\)](#)
- [Royal College of Physicians \(RCP\)](#)
- [British Society for Rheumatology](#)