

# Rheumatoid arthritis in over 16s

Quality standard

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This standard is based on NG100.

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

## Introduction and overview

### *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 cardiovascular system, lungs, heart, eyes and small blood vessels (vasculitis). Medical management with drug therapy aims to relieve symptoms, modify the progress of the disease and the functional impairment associated with it, and reduce the risk of potential comorbidities.

There are approximately 350,000 people aged 16 years or older with rheumatoid arthritis in England alone, suggesting there may be as many as 422,000 people affected in the whole of the UK. Around 2.5 men and 5.4 women per 10,000 people develop rheumatoid arthritis per year, which translates into approximately 17,500 people developing the condition per year in England, and about 21,000 across the UK. The overall occurrence of rheumatoid arthritis is 2 to 4 times greater in women than men. Onset generally occurs 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 with rheumatoid arthritis 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.

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. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. The quality

standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- [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:

<b>The adult social care outcomes framework 2013-14</b>	
Domain 1: Enhancing quality of life for people with care and support needs	<p>1A Social care related quality of life</p> <p>People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs</p> <p>1B Proportion of people who use services who have control over their daily life</p>
<b>NHS outcomes framework 2013-14</b>	
Domain 2: Enhancing quality of life for people with long-term conditions	<p>2 Health related quality of life for people with long term conditions</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions</p>
Domain 4: Ensuring that people have a positive experience of care	<p>4a Patient experience of primary care</p> <p>4ai GP services</p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p>
<b>Public health outcomes framework 2013-16</b>	

<p>Domain 1: Improving the wider determinants of health</p>	<p>Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p>1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness</p>
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## Overview

The quality standard for rheumatoid arthritis states that services should be commissioned from and coordinated across all relevant agencies encompassing the rheumatoid arthritis care pathway. A person-centred approach to provision of services is fundamental to delivering high-quality care to adults with rheumatoid arthritis.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should cross refer across the library of NICE quality standards when designing high-quality services.

Patients, service users and carers may use the quality standard to find out about the quality of care they should expect to receive; support asking questions about the care they receive; and to make a choice between providers of health and social care services.

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people with rheumatoid arthritis should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

## List of quality statements

Statement 1 People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within 3 working days of presentation.

Statement 2 People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

Statement 3 People with newly diagnosed rheumatoid arthritis are offered conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 3 months of onset of persistent symptoms.

Statement 4 People with rheumatoid arthritis are offered educational and self-management activities within 1 month of diagnosis.

Statement 5 People who have active rheumatoid arthritis have their C-reactive protein (CRP) and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

Statement 6 People with rheumatoid arthritis and disease flares or possible drug related side effects receive advice within 1 working day of contacting the rheumatology service.

Statement 7 People with rheumatoid arthritis have a comprehensive annual review that is coordinated by the rheumatology service.

Other quality standards that should also be considered when choosing, commissioning or providing a high-quality rheumatoid arthritis service are listed in [related quality standards](#).



## Quality statement 1: Referral

### *Quality statement*

People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, are referred to a rheumatology service within 3 working days of presentation.

### *Rationale*

Rapid referral of people with suspected persistent synovitis is important to avoid delay in diagnosis and increase the likelihood of early treatment initiation. Given the potentially devastating effects of delayed diagnosis in terms of joint damage and quality of life, people with these symptoms and signs should be considered to need urgent action.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, to be referred to a rheumatology service within 3 working days of presentation.

**Process:** Proportion of people with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, who are referred to a rheumatology service within 3 working days of presentation.

**Numerator** – the number of people in the denominator who are referred to a rheumatology service within 3 working days of presentation.

**Denominator** – the number of people with suspected persistent synovitis affecting the small joints of the hands or feet or more than 1 joint.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, to be referred to a rheumatology service within 3 working days of presentation.

**Primary care professionals** ensure that people with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, are referred to a rheumatology service within 3 working days of presentation.

**Commissioners** ensure they commission services that enable people with suspected persistent synovitis affecting the small joints of the hands or feet, or more than 1 joint, to be referred to a rheumatology service within 3 working days of presentation.

**People with suspected persistent synovitis (inflammation of the joints) affecting the small joints of the hands or feet, or more than 1 joint**, are referred to a rheumatology service within 3 working days of first reporting the problem.

### *Source guidance*

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.1.1

### *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology National clinical audit for rheumatoid and early inflammatory arthritis.

### *Definitions*

Timeframe derived from expert consensus.

Symptoms and signs of persistent synovitis include persistent (not resolving within 3 or 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 include malaise, fever, sweats, fatigue and weight loss.

Any person with suspected persistent synovitis of undetermined cause whose blood tests show a normal acute-phase response or negative rheumatoid factor should still be referred urgently as they may still have rheumatoid arthritis.

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, radiology with rheumatological ultrasound and MRI experience, and may also have rheumatology doctors in training.

## Quality statement 2: Assessment

### *Quality statement*

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

### *Rationale*

Rapid assessment in a rheumatology service is important to avoid delay in diagnosis and increase the likelihood of early treatment initiation. Given the potentially devastating effects of delayed diagnosis in terms of joint damage and quality of life, people with these symptoms and signs need to be assessed quickly.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with suspected persistent synovitis to be assessed in a rheumatology service within 3 weeks of referral.

**Process:** Proportion of people with suspected persistent synovitis who are assessed in a rheumatology service within 3 weeks of referral.

**Numerator** – the number of people in the denominator who are assessed in a rheumatology service within 3 weeks of referral.

**Denominator** – the number of people with suspected persistent synovitis referred to a rheumatology service.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with suspected persistent synovitis to be assessed in a rheumatology service within 3 weeks of referral.

**Healthcare professionals** ensure that people with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

**Commissioners** ensure they commission services that enable people with suspected persistent synovitis to be assessed in a rheumatology service within 3 weeks of referral.

People with suspected persistent synovitis (inflammation of the joints) are assessed in a rheumatology service within 3 weeks of referral.

## Source guidance

[Rheumatoid arthritis in adults: management](#) (2018) NICE guideline NG100, recommendation 1.1.1

## Data source

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology [National clinical audit for rheumatoid and early inflammatory arthritis](#) and within the Commissioning for Quality in Rheumatoid Arthritis (CQRA) [Patient metric data collection form for recent onset rheumatoid arthritis](#).

## Definitions

Timeframe derived from expert consensus and is consistent with best practice (as defined in the [2013–14 best practice tariff for early inflammatory arthritis](#)).

Symptoms and signs of persistent synovitis include persistent (not resolving within 3 or 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 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, radiology with rheumatological ultrasound and MRI experience, and may also have rheumatology doctors in training.

## Quality statement 3: Starting treatment

### *Quality statement*

People with newly diagnosed rheumatoid arthritis are offered conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 3 months of onset of persistent symptoms.

### *Rationale*

Rapid initiation of treatment optimises the 'window of opportunity' within which effective treatment can improve long-term outcomes such as joint damage, joint function and quality of life. Because the effects of cDMARD monotherapy are not experienced straight away, healthcare professionals should consider using short-term bridging treatment with glucocorticoids to relieve symptoms while people are waiting for the cDMARD to take effect.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with newly diagnosed rheumatoid arthritis to receive cDMARD monotherapy within 3 months of onset of persistent symptoms.

**Process:** Proportion of people with newly diagnosed rheumatoid arthritis who receive cDMARD monotherapy within 3 months of onset of persistent symptoms.

**Numerator** – the number of people in the denominator who receive cDMARD monotherapy within 3 months of onset of persistent symptoms.

**Denominator** – the number of people with newly diagnosed rheumatoid arthritis.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with newly diagnosed rheumatoid arthritis to be offered cDMARD monotherapy within 3 months of onset of persistent symptoms. They also ensure that using short-term bridging treatment with glucocorticoids is considered to relieve symptoms while people are waiting for the cDMARD to take effect.

**Healthcare professionals** ensure that people with newly diagnosed rheumatoid arthritis are offered cDMARD monotherapy within 3 months of onset of persistent symptoms. They also

consider offering short-term bridging treatment with glucocorticoids to relieve symptoms while people are waiting for the cDMARD to take effect.

Commissioners ensure they commission services that enable people with newly diagnosed rheumatoid arthritis to be offered cDMARD monotherapy within 3 months of onset of persistent symptoms. They also ensure that short-term bridging treatment with glucocorticoids is available to relieve symptoms while people are waiting for the cDMARD to take effect.

People with newly diagnosed rheumatoid arthritis are offered a drug called a cDMARD by a rheumatology service within 3 months of persistent symptoms starting.

### *Source guidance*

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.4.1

### *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology National clinical audit for rheumatoid and early inflammatory arthritis and within the Commissioning for Quality in Rheumatoid Arthritis (CQRA) Patient metric data collection form for recent onset rheumatoid arthritis.

### *Definitions*

Timeframe derived from expert consensus and is consistent with best practice (as defined in the 2013–14 best practice tariff for early inflammatory arthritis).

People with newly diagnosed rheumatoid arthritis are those attending the rheumatology service without a previous diagnosis of rheumatoid arthritis, who have been diagnosed after assessment within the service.

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 consultants, nurse specialists, physiotherapists, occupational therapists, podiatrists and orthotists. It has access to supporting specialties including orthopaedic surgery, psychology,

radiology with rheumatological ultrasound and MRI experience, and may also have rheumatology doctors in training.

Monotherapy with a cDMARD should be offered as the first-line treatment. When starting the new cDMARD, short-term bridging treatment with glucocorticoids should also be considered. An additional cDMARD should be offered in combination in a step-up strategy when the treatment target (remission or low disease activity) has not been achieved despite dose escalation.

People receiving treatment with cDMARD therapy need frequent monitoring to check for any adverse events and assess response to treatment. Certain aspects of this monitoring may be delegated to other healthcare professionals and completed in non-specialist settings under formalised shared care arrangements.



## Quality statement 4: Education and self-management

### *Quality statement*

People with rheumatoid arthritis are offered educational and self-management activities within 1 month of diagnosis.

### *Rationale*

It is important to improve patients' understanding of rheumatoid arthritis and its management through educational activities and self-management programmes to enable them to get the best from their medication, learn how to better manage disease flares, pain and fatigue, and improve their overall quality of life. It is essential that the offer of educational and self-management activities is not a 'one-off', but is repeated throughout the course of the disease to ensure that people with rheumatoid arthritis have the opportunity to participate at a time, individual to them, that will support them to derive the greatest benefit.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to be offered educational and self-management activities within 1 month of diagnosis.

**Process:** Proportion of people with rheumatoid arthritis who are offered educational and self-management activities within 1 month of diagnosis.

**Numerator** – the number of people in the denominator who are offered educational and self-management activities within 1 month of diagnosis.

**Denominator** – the number of people with rheumatoid arthritis.

**Outcome:** Patient experience.

### *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 within 1 month of diagnosis.

**Healthcare professionals** ensure that people with rheumatoid arthritis are offered educational and self-management activities within 1 month of diagnosis.

**Commissioners** ensure they commission services that enable people with rheumatoid arthritis to be offered educational and self-management activities within 1 month of diagnosis.

**People with rheumatoid arthritis** are offered educational activities and self-management programmes within 1 month of diagnosis.

## *Source guidance*

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.3.3

## *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology National clinical audit for rheumatoid and early inflammatory arthritis.

**Outcome:** Local data collection.

## *Definitions*

Timeframe derived from expert consensus.

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, to improve understanding of the condition and its management, and counter any misconceptions people with rheumatoid arthritis may have. They may take an educational approach such as lecture or facilitated interactive group 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.

Further support can be provided for people with rheumatoid arthritis by voluntary organisations such as support groups and charitable organisations, and it may be useful to provide sign-posting

information at this point to ensure people know how to access further support once they have been diagnosed.

The opportunity to take part in existing educational activities and self-management programmes should be offered to people with rheumatoid arthritis throughout the course of their disease on an ongoing basis.

## Quality statement 5: Disease control

### *Quality statement*

People who have active rheumatoid arthritis have their C-reactive protein (CRP) and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

### *Rationale*

Regular monitoring of CRP and disease activity allows for dose escalation of disease-modifying anti-rheumatic drugs (DMARDs). It is also important for checking the need for short-term bridging treatment with glucocorticoids and whether people are tolerating the drug regimen, assessing for side effects, providing support and encouraging adherence.

### *Quality measure*

**Structure:** Evidence of local arrangements to ensure that people with active rheumatoid arthritis have their CRP and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

**Process:**

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

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

Denominator – the number of people with active rheumatoid arthritis.

b) Proportion of people with previously active rheumatoid arthritis, who had their CRP and disease activity measured monthly in specialist care until they were in remission or had low disease activity.

Numerator – the number of people in the denominator who had their CRP and disease activity measured monthly in specialist care until they were in remission or had low disease activity.

Denominator – the number of people with previously active rheumatoid arthritis, who are currently in remission or have low disease activity.

**Outcome:**

a) Controlled rheumatoid arthritis.

b) Functional ability.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with active rheumatoid arthritis to have their CRP and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

**Healthcare professionals** ensure that people with active rheumatoid arthritis have their CRP and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

**Commissioners** ensure they commission services that enable people with active rheumatoid arthritis to have their CRP and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

**People with active rheumatoid arthritis** have their disease activity monitored every month in specialist care until they are in remission or have low disease activity.

### *Source guidance*

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.2.3

### *Data source*

**Structure:** Local data collection.

**Process:**

a) and b) Local data collection. Contained within the Commissioning for Quality in Rheumatoid Arthritis (CQRA) Patient metric data collection form for recent onset rheumatoid arthritis.

**Outcome:**

a) and b) Local data collection.

## *Definitions*

Remission (for example, a DAS28 score of less than 2.6) is the most appropriate target for most people. For those who are unable to achieve remission despite a treat-to-target approach with appropriate escalation, low disease activity (for example, a DAS28 score of less than 3.2) is an acceptable target.

## Quality statement 6: Rapid access

### *Quality statement*

People with rheumatoid arthritis and disease flares or possible drug-related side effects receive advice within 1 working day of contacting the rheumatology service.

### *Rationale*

It is important that people with rheumatoid arthritis experiencing disease flares or possible drug-related side effects are able to obtain advice from the rheumatology service rapidly, in order to prevent any further joint damage incurring. The sudden loss of function associated with a severe flare can be disabling and frustrating for people, and rapid involvement of a specialist in dealing with any possible drug-related side effects is essential from a patient safety perspective.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with rheumatoid arthritis and disease flares or possible drug-related side effects receive advice within 1 working day of contacting the rheumatology service.

**Process:** Proportion of people with rheumatoid arthritis and disease flares or possible drug-related side effects who receive advice within 1 working day of contacting the rheumatology service.

**Numerator** – the number of people in the denominator who receive advice within 1 working day of contacting the rheumatology service.

**Denominator** – the number of people with rheumatoid arthritis and disease flares or possible drug-related side effects who contact the rheumatology service.

**Outcome:** Patient experience.

### *What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with rheumatoid arthritis and disease flares or possible drug-related side effects to receive advice within 1 working day of contacting the rheumatology service.

**Healthcare professionals** ensure that people with rheumatoid arthritis and disease flares or possible drug-related side effects receive advice within 1 working day of contacting the rheumatology service.

**Commissioners** ensure they commission services that enable people with rheumatoid arthritis and disease flares or possible drug-related side effects to receive advice within 1 working day of contacting the rheumatology service.

**People with rheumatoid arthritis and disease flares or possible drug-related side effects** receive advice within 1 working day of contacting the rheumatology service.

### *Source guidance*

Rheumatoid arthritis in adults: management (2018) NICE guideline NG100, recommendation 1.9.1

### *Data source*

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology National clinical audit for rheumatoid and early inflammatory arthritis.

**Outcome:** Local data collection.

### *Definitions*

Timeframe derived from expert consensus.

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, radiology with rheumatological ultrasound and MRI experience, and may also have rheumatology doctors in training.



## Quality statement 7: Annual review

### *Quality statement*

People with rheumatoid arthritis have a comprehensive annual review that is coordinated by the rheumatology service.

### *Rationale*

Annual review is important to ensure that all aspects of the disease are under control. It provides a regular opportunity to holistically assess the patient in terms of the current management of the disease, and any further support they may need in the future, in order to enable them to maximise their quality of life.

### *Quality measure*

**Structure:** Evidence of local arrangements for people with rheumatoid arthritis to have a comprehensive annual review that is coordinated by the rheumatology service.

**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.

### *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 that is coordinated by the rheumatology service.

**Healthcare professionals** ensure that people with rheumatoid arthritis have a comprehensive annual review that is coordinated by the rheumatology service.

**Commissioners** ensure they commission services that enable people with rheumatoid arthritis to have a comprehensive annual review that is coordinated by the rheumatology service.

People with rheumatoid arthritis have a comprehensive annual review that is coordinated by the rheumatology service.

## Source guidance

[Rheumatoid arthritis in adults: management](#) (2018) NICE guideline NG100, recommendation 1.9.3

## Data source

**Structure:** Local data collection.

**Process:** Local data collection. Contained within the British Society for Rheumatology [National clinical audit for rheumatoid and early inflammatory arthritis](#) and within the Commissioning for Quality in Rheumatoid Arthritis (CQRA) [Patient metric data collection form for recent onset rheumatoid arthritis](#). See also, [Quality and Outcomes Framework \(QOF\)](#) indicators RA002, RA003 and RA004.

## 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, for example their employment status and prospects (validated questionnaires are available for assessing quality of life)
- symptom control and pain management
- care planning

- offering educational activities and self-management programmes.

It is not expected that all elements of the annual review would occur at the same time. Some aspects may be undertaken in primary care, for example checking for comorbidities such as hypertension.

Elements of the review may need to occur more or less often than once a year. For example, it may be most appropriate to assess for fracture risk at 24-month intervals, whereas advice on self-management or treatment review may occur more regularly.

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, radiology with rheumatological ultrasound and MRI experience, and may also have rheumatology doctors in training.

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, and activities relating to the review should be documented in notes.

Action should be taken as necessary following the annual review, for example referral to specialist services.

## Using the quality standard

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, healthcare professionals, patients, service users and carers alongside the documents listed in [development sources](#).

The quality measures accompanying the quality statements aim to improve the structures, processes and outcomes of care in areas identified as requiring quality improvement. 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, NICE recognises that this may not always be appropriate in practice when taking account of safety, choice and professional judgement, and so desired levels of achievement should be defined locally.

See NICE's [how to use quality standards](#) for further information, including advice on using quality measures.

## Diversity, equality and language

During the development of this quality standard, equality issues have been considered. [Equality assessments](#) are available.

Good communication between health and social care services and people with rheumatoid arthritis is essential. Treatment, care and support, 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.

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

## Development sources

### *Evidence sources*

The documents below contain recommendations from NICE guidance or other NICE accredited sources that were used by the Topic Expert Group to develop the quality standard statements and measures.

National Institute for Health and Care Excellence (2018) [Rheumatoid arthritis in adults: management](#). NICE guideline NG100.

### *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 within the definitions and data sources sections:

- [Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept for rheumatoid arthritis not previously treated with DMARDs or after conventional DMARDs only have failed](#). NICE technology appraisal guidance 375 (2016).
- [Adalimumab, etanercept, infliximab, rituximab and abatacept for the treatment of rheumatoid arthritis after the failure of a TNF inhibitor](#). NICE technology appraisal guidance 195 (2010).
- [Commissioning for Quality in Rheumatoid Arthritis: commissioning metrics forms](#). National Rheumatoid Arthritis Society (2012).
- [Golimumab for the treatment of rheumatoid arthritis after the failure of previous disease-modifying anti-rheumatic drugs](#). NICE technology appraisal guidance 225 (2011).

- Tocilizumab for the treatment of rheumatoid arthritis. NICE technology appraisal guidance 247 (2012).

## Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).



## The Topic Expert Group and NICE project team

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## Update information

**July 2018:** Changes have been made to align this quality standard with the updated NICE guideline on [rheumatoid arthritis](#). Statements 3 and 5 were amended and the source guidance throughout has been updated.

### Minor changes since publication

**December 2016:** Data sources updated for all statements.

## 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.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE Pathway on [rheumatoid arthritis](#).

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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.

- [ARMA](#)
- [British Association of Prosthetists and Orthotists](#)
- [British Society for Rheumatology](#)
- [Royal College of General Practitioners](#)
- [Royal College of Pathologists](#)
- [Royal College of Radiologists](#)