National Institute for Health and Care Excellence

Rheumatoid arthritis update

Consultation on draft quality standard – deadline for comments 5pm on 03/09/19

Please email your completed form to: QSconsultations@nice.org.uk

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.
We would like to hear your views on these questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?
2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?
3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.
4. For draft quality statement 1: Is referral within 3 days of presentation achievable? Is there an alternative timescale that should be used?
5. For draft quality statement 2: Which of the two areas covered in the statement do you consider to be the priority area for quality improvement? Early commencement of treatment with cDMARDs, or regular monitoring of treatment until treatment target achieved?
6. For draft statement 2: Is the target of starting treatment within 6 weeks of referral achievable?
7. For draft quality statement 3: Are the timeframes for offering educational activities within 1 month and annually used in the process measures for this statement appropriate?
8. For draft quality statement 3: Should offering educational activities annually happen as part of the annual review (draft quality statement 5)?

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

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

Organisation details

Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank)	The Royal College of Physicians and Surgeons of Glasgow
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	none
Name of person completing form	Dr Richard Hull, Honorary Secretary with experts in the field
Supporting the quality standard Would your organisation like to express an interest in formally supporting this quality standard? More information.	Yes
Type	**[Office use only]**

Comments on the draft quality standard

Comment number	**Section**	**Statement number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
Example 1	*Statement 1 (measure)*	*1*	*This statement may be hard to measure because…*

			The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments. The College welcomes this Qualiity Standard in an important area. It does however recognise some of the standards are ambitious and may be hard to achieve reflecting differing expertise especially in primary care, differing commissioning practices throughout the UK and varying resources
1	QUESTION 1		*Does this draft quality standard accurately reflect the key areas for quality improvement?* Yes There is however a need for a standard to address drug therapy in patients once stable. Good practice would suggest that dose tapering should be considered when dideases has been controlled.
2	QUESTION 2		*Are local systems and structures in place to collect data for the proposed quality measures? If not how feasible would it be for these to be put in place?* Routine collection of this data will be highly variable throughout the UK. Some of the outcomes form part of the HQIP/BSR funded National Clinical Audit of Rheumatoid Arthritis and early inflammatory arthritis in England and Wales, and will be recorded as part of the audit. This does not apply in all 4 nations of the UK. There is no equivalent in Scotland or Northern Ireland so data collection in these areas is likely to be difficult. The currently collected audit data pertains to early disease only. Recording outcomes in patients with established disease is likely to be difficult. In Scotland a pilot disease registry is being tested and funding for roll out of this would facilitate data collection.
3	QUESTION 3		*Do you think each of the statements in the draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.*

			See responses to individual quality statements. In Scotland, funding of the Rheumatology quality registry would facilitate this type of quality measurement and patient engagement. Highlighting and facilitating drug tapering could be both a quality indicator (harm reduction) and a source of potential cost saving but would need initial investment in return outpatient capacity and a programme of health literacy. This would be in line with the Scottish "Realistic Medicine" agenda.
4	QUESTION 4	1	*Is referral within 3 days of presentation achievable? Is there an alternative timescale that should be used?* Referral within 3 days is aspirational but achievable. The key point in the process is making the decision that referral is indicated. This depends on the knowledge and skills of the health professional involved. Although the referrer will usually be the general practitioner, the patient may be seen by a nurse, physician assistant or physiotherapist. As the standard is currently worded, many patients with conditions other than new onset inflammatory arthritis may be referred eg Osteoarthritis. While rheumatologists and their staff recognise synovitis. Many non-specialists could refer anyone with a swollen joint from any cause. The document cites "*suspected persistent synovitis of more than 1 joint, or the small joints of the hands and feet*". Since this is a clinical diagnosis, there is no delay for investigations. "Persistent" should be defined. The second clause requires clarification. "*affecting more than 1 joint, or the small joints of the hands and feet,"*– either delete "or the small joints of the hands and feet" or qualify: "1 large joint or the small joints of the hands and feet".
5	QUESTION 5	2	*Which of the two areas covered in the statement to you consider to be the priority area for quality improvement? Early commencement with cDMARDs, or regular monitoring of treatment until*

			treatment target achieved? Both are important but starting treatment is the greater priority if regular monitoring for some patients could only be achieved by delaying starting treatment in others. In the sections that deal with monitoring, the guidance stipulates measurement of CRP and disease activity. Not all centres routinely measure CRP. ESR or PV (plasma viscosity) can also be used to assess disease activity. Is the mandating of CRP measurement deliberate? Long term monitoring is also important for consideration of continuing need for the drugs and possible step down in dosage and or drugs
6	QUESTION 6	2	*Is the target of starting treatment within 6 weeks of referral achievable?* Yes
7	QUESTION 7	3	*Are the timeframes for offering educational opportunities within 1 month and annually used in the process measures for this statement appropriate?* Yes Rewording the statement to encompass the principles of shared decision making would be preferable. The current statement implies stand-alone educational "events" rather than building patient empowerment into the essence of the consultation and engendering a culture of active listening so that the patients' preferences, priorities and values are central to every consultation.
8	QUESTION 8	3	*Should offering educational activities annually happen as part of the annual review?* This may be acceptable in some areas. Another method could be for a less didactic approach as the model of incorporating it into annual review may not work in every centre. The principle of giving education is more important than how or when it is delivered.
9	QUESTION 9	4	*Is the timeframe of receiving advice within 1 working day of contacting rheumatology services achievable?* Yes It will however be challenging especially in smaller units or those who do clinics on multiple sites. Many units currently work to a target of 2 working days which is more realistic.
10	QUESTION		*Do you have an example from practice of implementing the NICE guideline(s) that underpins this*

	10		*quality standard? If so, please provide details on the comments form.* No

Insert more rows as needed

Checklist for submitting comments

- Use this form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- Please provide concise supporting information for each key area. Provide reference to examples from the published or grey literature such as national, regional or local reports of variation in care, audits, surveys, confidential enquiries, uptake reports and evaluations such as impact of NICE guidance recommendations
- For copyright reasons, do not include attachments of **published** material such as research articles, letters or leaflets. However, if you give us the full citation, we will obtain our own copy
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