

Guidelines

BSR guidelines on standards of care for persons with rheumatoid arthritis



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Summary of Standards

Aims

- Early identification of persons with rheumatoid arthritis
- Empowering persons with rheumatoid arthritis
- Developing efficient, cost-effective and evidence-based clinical care for persons with rheumatoid arthritis.

Background

This document is intended to help and support the rheumatology team by providing a statement of the minimum standard of care requirements for persons with rheumatoid arthritis. It can also act as the formal record of standards of care as part of the clinical governance process of any rheumatology unit.

Objectives

The aim is to develop nationally accepted measures for the delivery of care for persons with rheumatoid arthritis. These should usually be recorded as part of the normal clinical care of the patient. Specific situations in which patients may require closer than average monitoring are also discussed. The aim is to obtain the best quality of care within the resources available. The need for multidisciplinary team care is also addressed.

The standards address the following areas:

- outcome measures
- special clinical circumstances
- departmental structure.

Review of Standards

The Standards will be reviewed in Autumn 2006 to take into account changes in the evidence and consensus management of rheumatoid arthritis.

The Committee member's declaration of interests are described in Appendix 4.

The committee is very grateful to Rahana Mohammed, Policy and Campaigns Manager, Arthritis Care, and Ailsa Bosworth from the National Rheumatoid Arthritis Society (NRAS), who have discussed these Standards widely within their organizations. We are also very grateful to Sophie Edwards, Chief Executive of the Arthritis and Musculoskeletal Alliance (ARMA), who has also reviewed these Standards.

Production of document

The headings used in this set of Standards were derived following discussions within the committee to reflect the important steps in delivering care for persons with rheumatoid arthritis. Each statement has been assessed against available evidence or consensus reached.

Standards of care for rheumatoid arthritis

Outcome measures

Standard 1: Identification of persons with rheumatoid arthritis

The rheumatology department should see all patients with a likely diagnosis of rheumatoid arthritis within 12 weeks of referral, where this is indicated in the general practitioner's referral letter (C) [letters in parentheses refer to the grades of recommendation listed in Appendix 3] [1].

Standard 2: Empowering persons with rheumatoid arthritis

All persons with rheumatoid arthritis will be encouraged to participate fully in the management of their disease and to take a leading role in the multidisciplinary team. This should include access to self-management programmes, local support groups and appropriate information to manage their own disease. This management should take into account not only the goal of controlling the activity of the disease, thereby reducing the pain,

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Submitted 20 August 2004; revised version accepted 24 December 2004.

Published on the British Society for Rheumatology website in July 2004.

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damage and disability of the disease, but also the psychological, employment and educational opportunities, family and social impact of the disease (B) [2].

Clinical care of persons with rheumatoid arthritis

Standard 3: The multidisciplinary team

All persons with rheumatoid arthritis should have access to the multidisciplinary rheumatology team. This team should include:

- general practitioner
- consultant rheumatologist
- consultant orthopaedic surgeon
- doctors in training (hospital and general practitioner)
- nurse specialist
- physiotherapist
- occupational therapist
- dietician
- podiatrist
- orthotist
- pharmacist
- social worker.

Access to voluntary organizations involved in rheumatoid arthritis management, counselling services, the pain management team, neurosurgery, plastic surgery, neurophysiology and the wheelchair service should also be available. When clinically indicated, access to a member of the multidisciplinary team should be available within 6 weeks of referral (B) [2].

Standard 4: Prescription and monitoring of treatments used to manage rheumatoid disease

The prescription to persons with rheumatoid arthritis of non-steroid anti-inflammatory drugs (NSAIDs), including COX II and biological agents, should follow NICE guidance (A) [3, 4].

Systems should be in place to effectively:

- assess all patients who might be considered to be appropriate for biological therapy as defined by the NICE and BSR guidelines
- register, once consent is obtained, all persons receiving biological agents with the BSR registry
- monitor access to therapy and clinical response
- identify side-effects of therapy and other drugs, including DMARDs, used to manage rheumatoid arthritis. The multidisciplinary team should undertake this monitoring (C) [5].

Standard 5: Annual review

All persons with rheumatoid arthritis should have a formal annual assessment of disease activity, manifestations of extra-articular disease, the effects of the disease on quality of life, employment status, an assessment of disability, drug-related complications and any comorbid conditions. The annual review should identify if any events have occurred which would put the person with rheumatoid arthritis at risk; e.g. introduction of infection at the time of joint injection, and bone marrow damage as a result of drug therapy. This process can be undertaken by a member of the multidisciplinary team such as the rheumatology practitioner (C) [5].

Standard 6: Prevention of steroid-induced osteoporosis

All persons 65 years or older with rheumatoid arthritis taking doses of steroids (usually prednisolone) for 12 weeks or more should be offered bone-protective therapy.

Persons under 65 with no previous fragility fracture should be offered DXA scanning to assess the risk of osteoporosis. If, in

persons under 65 with rheumatoid arthritis, there is a previous fragility fracture or incident fracture during glucocorticoid therapy, bone protective therapy should be considered (A) [6].

Standard 7: Pain management

All persons with rheumatoid arthritis should be given the opportunity to discuss how their pain might best be managed. The advice of a pain management team should be available. Persons with rheumatoid arthritis should understand the benefits and side-effects of analgesic and anti-inflammatory drugs and of other drugs used to achieve better pain control, such as amitriptyline and carbamazepine. They should also know about alternative techniques of effective pain management, including trans cutaneous nerve stimulation (TENS) and behavioural approaches (A) [7].

Standard 8: Collaboration with orthopaedic surgeons

Persons with rheumatoid arthritis who have unacceptable levels of pain despite all previously mentioned approaches and who have significant loss of range of movement of a joint or who have significant limitation of activities of daily living because of structural damage of one or more joints should be offered the advice of and treatment from an orthopaedic surgeon with a special interest in rheumatoid arthritis (B) [2].

Special clinical circumstances

Standard 9: Care of young persons with juvenile idiopathic arthritis/rheumatoid arthritis

All young persons with rheumatoid arthritis should have a smooth transition from the care of a paediatric rheumatology team to that of a rheumatology team, including orthopaedic surgeons who are experienced in the care of adolescents and young adults. This should be in accordance with the Code of Practice of the British Society for Paediatric and Adolescent Rheumatology (BSPAR). Care should include an assessment of the comprehensive needs of the patient at various stages of the disease (C) [8].

Standard 10: Pregnancy for persons with rheumatoid arthritis

All persons with rheumatoid arthritis who wish to become pregnant should be offered adequate and appropriate advice from a rheumatologist, an obstetrician and the multidisciplinary team. In special circumstances, such persons might be cared for in a special clinic; for example, persons with the anti-phospholipid (Hughes) syndrome. Males with rheumatoid arthritis who wish to become a father should also be offered specialist advice (C) [8].

The rheumatology service

Development of patient-centred care

Standard 11: Involvement of users and carers

People with rheumatoid arthritis who use the rheumatology service and their carers will be encouraged to be actively involved in the development, monitoring and evaluation of services (C) [9].

Standard 12: Access to facilities

Where persons with disabilities need access to primary care or hospital services, specially designed facilities should be available, including disabled access to all departments and to washing and toilet facilities. Facilities for wheelchair access must be provided (C) [10].

Standard 13: In-patient management

All persons with rheumatoid arthritis who are admitted to a hospital should have due account taken of any symptoms or disabilities that are due to rheumatoid arthritis or other causes, and, if they are admitted under the care of other specialists, should be offered referral to a rheumatologist. Planning for their admission should take into account any disability. Special arrangements may be necessary for the admission of young persons to appropriate units (C) [9].

Standard 14: Out-patient services

For persons with rheumatoid arthritis, 30 minutes should be made available for the initial consultation with a consultant-led team. Fifteen minutes should be available for subsequent appointments.

If the person with rheumatoid arthritis sees a trainee or another member of the clinical team (for example, a rheumatology practitioner), there should be an opportunity, if appropriate, to discuss the management with the consultant. Where teaching is undertaken in clinic, the number of patients attending the clinic should be reduced by 25% (C) [11].

Applicability and utility

The potential organizational barriers to the successful implementation of these standards include:

- identification and funding of the members of the multi-disciplinary team
- funding of the COX II and biological therapies
- ensuring appropriate staffing to enable data collection for the annual review and the other audit projects
- ensuring that the physical environment of the service providers meets the requirements of people with disabilities
- implementing the Royal College of Physicians (RCP) guidance on the numbers of patients seen in the out-patient department.

These Standards were commissioned by the BSR Clinical Affairs Committee. The committee has not sought or obtained any external funding for this work. All the authors have declared and provided details of any conflicts of interest (see Appendix 4).

Appendix 1. The future

The management of rheumatoid arthritis is changing rapidly. It is expected that, through ongoing research, new approaches to the management of rheumatoid arthritis will change the course of the disease radically in the near future.

To achieve this improvement in the quality of life, it is expected that evidence will become available which will suggest that:

- the use of biological agents in patients with early disease is effective in those patients, who can be identified as likely to have severe destructive disease. It will therefore be necessary to see people with early rheumatoid arthritis within 6 weeks of presentation
- control of comorbid conditions, such as ischaemic heart disease, hyperlipidaemia and hypertension, will become increasingly important.

Appendix 2. Suggested audit topics

1. 12-week wait for first consultation.
2. Use of anti-TNF in patients fulfilling NICE guidance, to include registration and availability of drugs.

3. Annual review, including the following analyses:

- DMARD type vs HAQ/disease activity score (DAS) (include common combinations; e.g. MTX + SASP, MTX + hydroxychloroquine (OHHCQ), MTX + cyclosporin)
 - TNF pretreatment vs current vs HAQ/disease activity score 28 joints (DAS28)
 - NSAIDs/COX IIs vs age, gastroprotection
 - Steroids vs bone-protective agent by type (including combinations)
 - All patients vs clinical event
 - All patients vs examination finding of nodules, lung disease, vasculitis, Sjögren's syndrome, etc.
 - All patients vs work codes, benefits codes
 - rheumatoid arthritis vs drugs for comorbidities
4. Patient satisfaction and empowerment to include assessment of the quality of life.

Appendix 3. Bibliography

	Grade of recommendation [12]
1. Royal College of Physicians. Clinical standards – agreed by Joint Specialist Committee.	C
2. SIGN Guidance, No. 48. Management of early rheumatoid arthritis. SIGN, 2000.	B
3. NICE Technology Appraisal Guidance, No. 27, July 2001. Guidance on the use of cyclooxygenase (Cox) II selective inhibitors, celecoxib, rofecoxib, meloxicam and etodolac for osteoarthritis and rheumatoid arthritis. NICE, 2001.	A
4. NICE Technology Assessment No. 36, March 2002. Guidance on the use of etanercept and infliximab for the treatment of rheumatoid arthritis	A + C
5. Thea PM, Vleit Vlieland Multidisciplinary Team. Care and outcomes in rheumatoid arthritis. <i>Curr Opin Rheumatol</i> 2004;16:153–6.	A
6. Royal College of Physicians of London. Glucocorticoid induced osteoporosis – guidelines for treatment and management. RCP, 2002.	A
7. Guidelines in the Management of Rheumatoid Arthritis: update 2002. <i>Arthritis and Rheumatism</i> 2002;46:328–46.	A
8. British Society for Rheumatology Consensus Statement from the Standard of Care for Persons with Rheumatoid Arthritis Committee.	C
9. ARMA standard: www.arma.uk.net (website nearing completion).	C
10. Royal College of Physicians of London. Charter for disabled persons using hospitals. RCP, 2002.	C
11. Royal College of Physicians of London. Working for patients. RCP, 2002.	C
12. Royal College of Physicians of London. Clinical Effectiveness & Evaluation Unit: Concise Guidance to Good Practice. RCP, 2003.	C

Appendix 4. Details of committee members and declaration of interest

These Standards have been endorsed by:

- Arthritis Care
- ARMA
- BSR
- BSPAR
- NRAS
- Primary Care Rheumatology (PCR)
- Rheumatology Nurses Forum

Declaration of interest statement

The Working Party was set up independently of any input or funding from the manufacturers of treatments for rheumatoid arthritis.

Members of the Working Party were asked to clarify their relationships with the manufacturers' treatments for rheumatoid arthritis. Members were asked to declare if they, as individuals, had been sponsored to attend scientific or other meetings in the past 24 months or if they had a direct financial stake in the manufacturing companies. Organizations were asked to declare if

they had received sponsorship from manufacturers of treatments for rheumatoid arthritis (either educational or promotional) or for activities not related to the therapies.

The following replies were received:

- The units in which the following Working Party members work have received funding from one or more of the manufacturers of therapies or treatments for rheumatoid arthritis: G. Struthers, H. Sinclair, R. Hull, V. Abernethy, T. Kennedy, M. Shipley.
- The following Working Party members have received funding from pharmaceutical companies involved in producing biological therapies to attend scientific meetings in the past 24 months: H. Sinclair, R. Hull, V. Abernethy, T. Kennedy, M. Shipley, K. Chakravarty, D. Bax.
- BSR has established a register which is funded by the manufacturers of biological therapies; training for rheumatologists in data collection has also been funded by these manufacturers.
- The following Working Party members have received honoraria from the manufacturers of therapies or treatments for rheumatoid arthritis: V. Abernethy, R. Hull, H. Sinclair.
- No Working Party members declared a direct financial stake, such as personal shareholding, in companies manufacturing the new biological therapies.