Table 1: Final list of statements for consensus survey

Statement	Source
1. Patients with active rheumatoid arthritis should be offered the opportunity to commence conventional disease-modifying anti-rheumatic drug (DMARD) therapy (e.g., methotrexate, sulfasalazine, hydroxychloroquine), within six weeks of referral to a rheumatology service.	NICE[14]
2. Patients with active rheumatoid arthritis should be monitored 3-monthly, using a composite score such as DAS-28 CRP/ESR, until their treatment target is met.	NICE[14]
3. Patients with chronic rheumatic disease should have access to a rheumatology service to support coordinating their care (e.g., with a rheumatology nurse specialist or rheumatologist).	NICE[13]
4. Patients with chronic rheumatic disease and disease flares, or possible treatment-related side effects, should receive advice within one working day of contacting a rheumatology service.	NICE[14]
5. Patients with chronic rheumatic disease should have access to a nurse for education.	EULAR[22]
6. Patients with chronic rheumatic disease should have access to a nurse-led telephone service for ongoing support.	EULAR[22]
7. Specialist rheumatology nurses should participate in comprehensive disease management of chronic rheumatic disease.	EULAR[22]
8. Within an outpatient rheumatology clinic, a specialised rheumatology nurse should have their own consultations with chronic rheumatic disease patients.	Van Hulst[23]
9. Patients with chronic rheumatic disease, and difficulties with activities of daily living (ADLs), or hand function, should have access to specialist occupational therapy, and/or hand therapy.	NICE[13]
10. Patients with chronic rheumatic disease and active foot problems should have access to podiatry assessment and ongoing review.	NICE[13]
11. Patients with chronic rheumatic disease should have access to specialist physiotherapy, with periodic review.	NICE[13]
12. A rheumatology service should have timely access to musculoskeletal imaging, including ultrasound and magnetic resonance imaging (MRI), to aid in the diagnosis and management of inflammatory arthritis.	Researchers adapted from EULAR[24]
13. Patients with chronic rheumatic disease who suffer from pain issues, should have access to a qualified health professional who specialises in chronic pain management (e.g., specialist pain management physician or psychologist).	Researchers adapted from EULAR[25]
14. A rheumatology service should include an infusion unit for the delivery of specialist-prescribed intravenous medications (eg infliximab, tocilizumab, rituximab), which is supervised (directly, or at a distance) by a member of the rheumatology service.	Researcher generated
15. A rheumatology service should aim to involve other specialists in "combined clinics", where the management of chronic disease spans across different specialties (e.g., combined clinics with dermatology or ophthalmology).	Researcher generated
16. A public rheumatology service should involve at least one full time equivalent (FTE) rheumatologist per 80,000 people within the served population.	Researchers adapted from RCP[26]
17. A rheumatology service should provide outpatient assessment for patients with non-inflammatory musculoskeletal conditions, such as fibromyalgia and osteoarthritis, when specialist input is sought by primary care.	Researcher generated

Table 1 (continued): Final list of statements for consensus survey

Statement	Source
18. A rheumatology service should be supported in undertaking health equity assessments, using tools such as the Health Equity Assessment Tool, at appropriate time intervals.	Researcher generated
19. A rheumatology service should have a plan for implementing and evaluating processes that aim to achieve equitable health outcomes for Māori and other priority groups, as appropriate.	Researcher generated
20. Patients under the care of a rheumatology service should be offered telephone or video follow-up consultations, providing it is clinically appropriate to do so.	Rheumatologist generated
21. Healthcare professionals providing care to patients with chronic rheumatic disease, admitted to a public (DHB) hospital, should be able to access inpatient review by a member of the rheumatology service that the patient's care falls under, if requested and clinically appropriate.	Rheumatologist generated
22. Patients with chronic rheumatic disease who are clinically stable, and have a clear treatment plan, should be considered for discharge to primary care for ongoing follow-up without ongoing need for rheumatology service input (apart from administrative responsibilities, such as endorsement for methotrexate).	Rheumatologist generated

Abbreviations: EULAR = European Alliance of Associations for Rheumatology;
NICE = National Institute of Health and Care Excellence; RCP = Royal College of Physicians.

Table 2: Demographic characteristics of round one consensus survey participants

	Round 1 respondents (n=26)
Practice location in DHB population estimate	
<100,000 people	2 (7.7%)
100,000–250,000 people	5 (19.2%)
>250,000 people	16 (61.5%)
Not applicable (e.g., private practice/locum)	3 (11.5%)
Years' experience as a rheumatologist	
<10 years	6 (23.1%)
10–20 years	11 (42.3%)
>20 years	9 (34.6%)
Full time equivalent in rheumatology practice	
0–0.2	4 (15.4%)
0.3–0.4	10 (38.5%)
0.5–0.6	5 (19.2%)
0.7–0.8	5 (19.2%)
0.9–1.0	2 (7.7%)