NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Consultation summary report: joint replacement (primary): hip, knee and shoulder

Quality Standards Advisory Committee post-consultation meeting: 19 January 2022

1. Introduction

The draft quality standard for joint replacement (primary): hip, knee and shoulder was made available on the NICE website for a 4-week public consultation period between 15 November and 13 December 2021. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 9 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

1. Questions for consultation

Stakeholders were invited to respond to the following general 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 to 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.

Stakeholders were also invited to respond to the following statement-specific question in relation to statement 4:

4. For draft quality statement 4: Please comment on whether surgical protocols and checklists will enable the 2 ‘stop moments’ being carried out and their timing to be documented, to support the structure and process measures.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* General agreement with the areas for quality improvement.
* Patient Reported Outcome Measures (PROMs) for shoulder replacement should be mandatory. Including them in the [national (England) PROMs programme](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms) could help improve response rates.
* A metric for collecting PROMs data for shoulder replacement could be included.
* 100% rate of data submission by providers to the National Joint Registry was suggested as a measure.

### Consultation comments on data collection

* There was a mixed response.
* Smaller organisations may need to put resources and systems in place. It should be straightforward to collect the data even if resources and systems were not already in place. Conversely, concern was raised, that administrative support for extracting and using the data may not be readily available.
* National Joint Registry suggested it may be possible to capture compliance with the statements in their dataset.

### Consultation comments on resource impact

* Overall the statements can be met using existing resources.
* Staff time and education would be the primary investment.
* Electronic resources offer potential for supporting information delivery.
* Achieving statements 1 and 5 could be supported by creating cost-effective rehabilitation information resources nationally to minimise impact on existing resources.
* Some units may be unable to implement statement 5.
* Implementing statement 2 would be associated with increased costs and waiting times, for example for training of surgeons.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Adults having hip or knee replacement are given advice on preoperative rehabilitation when they are listed for surgery.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* General support for the statement; considerable variation in provision of preoperative rehabilitation was noted.
* Good quality information and advice should be available to ensure that patients are in optimum condition for surgery.
* Actively involving patients with arthritis who are waiting for surgery in preoperative rehabilitation would help to reduce the impact of prolonged pain and reduced quality of life.
* Recognise that many people with arthritis are waiting longer for their surgery, and lack care and support from local health systems due to disruption to communication caused by COVID-19.
* Include a reference to shared decision making having taken place before the final decision to have joint replacement.

**Measures**

* Feasible to add a requirement to record provision of, or referral for, preoperative rehabilitation within existing pathways.
* Data collection is feasible because it can be collected at the same point that other information is gathered when patients are listed for surgery (for example, when consent is documented).

**Definitions**

* Advice on preoperative rehabilitation: suggestion to specify the expected format of delivery, to enable provider performance to be measured.
* Listed for surgery: suggestion to amend the timeframe to provide a ‘maximum’ length of time, such as ‘within the 6 months prior to surgery’.

**Equality and diversity considerations**

* Clarify how accessible information and support should be delivered, to ensure that providers meet the requirements of people with additional needs and to support measurement.

**Resource impact**

* Alternatives to self-directed preoperative rehabilitation such as one-to-one sessions (potentially requiring an interpreter) not always feasible due to a range of restrictions and pressures, including those relating to COVID-19.
* A high-quality, evidence-based information video could meet accessibility requirements and potentially signpost patients to existing community exercise and health initiatives. This approach would also add value and minimise impact on local resources.

### Issues for consideration

**For discussion:**

* Is there any national information or advice to which we can signpost? There are no recommendations for a specific format of delivery.
* When should preoperative rehabilitation start?
* How significant are the resource impact issues raised by stakeholders?
  1. Draft statement 2

Adults with isolated medial compartmental osteoarthritis are given the choice of partial or total knee replacement.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* General support for this statement with partial knee replacements described as safe, effective and appropriate.
* Care may need to be transferred between consultants so that their operation is performed by the most appropriate surgeon: some units and surgeons do not offer partial knee replacements and surgeons need to perform a certain number annually to maintain the appropriate skills.
* Transfer of care may lead to increased waiting times, which could negatively affect uptake of partial knee replacement among both patients and surgeons.
* The statement risks simplifying this area of care; some adults with isolated medial compartmental osteoarthritis are unsuitable for partial knee replacement.

**Resource impact**

* Potential costs to upskill surgeons and associated with providing rehabilitation for day case surgery.

### Issues for consideration

**For discussion:**

* Should we highlight that not all adults with isolated medial compartmental osteoarthritis are suitable for the procedure?
* Could achievement be adversely affected by increased waiting times caused by the transfer of care?
* Is the statement achievable given the additional costs and resources identified?
  1. Draft statement 3

Adults having hip or knee replacement are given tranexamic acid during surgery.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* General support for this statement.
* It was suggested that considerable variation regarding the form and timing of administration exists, even within local units, and that some surgeons do not administer it.

**Statement and rationale**

* The wording ‘during surgery’ should be amended to improve clarity; it was highlighted that tranexamic acid is given immediately preoperatively in the anaesthetic room (if used) along with antibiotics, not ‘during surgery’.

**Measures**

* Local and national systems are not in place to support data collection.
* Would need to standardise data collection due to the variation in practice of mode and timing of administration.
* A formalised process (such as 2 ‘stop moments’) to enable the anaesthetist and surgeon to confirm the mode of administration could support measurement, as would introducing real-time documentation .
* Include overall blood loss as an outcome measure; this can be estimated intraoperatively. Wound drainage and haemoglobin (Hb) levels are routinely monitored and documented postoperatively.

### Issues for consideration

**For discussion:**

* Is ‘during surgery’ the best form of wording for this statement?
* Should overall blood loss be used as an overall outcome measure?
* Is it feasible to collect data for the measures?
  1. Draft statement 4

Adults having hip, knee or shoulder replacement have 2 ‘stop moments’ during surgery so that implant details and the compatibility of all components are checked.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* There was some support for this statement.
* Clarification needed as to whether the focus is on using electronic barcoding systems to match implant (and patient) data or a team ‘stop and review’ process.
* ‘Stop moments’ should be carried out before implantation. These checks would involve inspecting packaging to confirm that it is the correct implant and in date, and that the contents match.
* Implant checking process should be carried out whenever an implant is used, and not restricted to a 2-stage ‘stop moment’.
* 6 ‘stop moments’ suggested for modular hip implants.
* Evidence source queried and the lack of direct referencing to [National Safety Standards for Invasive Procedures (NatSSIPs).](https://www.england.nhs.uk/patient-safety/natssips/" \l ":~:text=The%20standards%20support%20NHS%20organisations,surgical%20never%20events%20can%20occur.)

**Rationale**

* The second ‘stop moment’ provides the opportunity to help correct the Never Event, but does not prevent them.

**Measures**

* Include more guidance on what information should be recorded; for example, whether signatures are required.
* A different team member should carry out the second ‘stop moment’ with the surgeon to support effective data collection.
* The [National Joint Registry’s Implant Scanning tools](https://www.njrcentre.org.uk/njrcentre/Healthcare-providers/NJR-Implant-Scanning-Interface) are freely available to UK hospitals and can be used to determine the compatibility of components.
* The list of [Never Events](https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/) is currently under review.
* Include the National Joint Registry as a data source (outcome measure).

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

*Please comment on whether surgical protocols and checklists will enable the 2 ‘stop moments’ being carried out and their timing to be documented, to support the structure and process measures.*

* Not standard practice but should be introduced. Training would be needed to embed practice.
* The first ‘stop moment’ could be added to the [World Health Organisation (WHO) surgical safety checklist](https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources) at the start of the operation; another document would be needed for completion part way through.
* Forms used by local units to record implants pre- and perioperatively could be adapted.

**Resource impact**

* The first ‘stop moment’ could be added to the World Health Organisation (WHO) surgical safety checklist at the start of the operation; another document would be needed for completion part way through.

### Issues for consideration

**For discussion:**

* We will keep the Never Events list under review and update the outcome measure and data source accordingly.
* Is there any more detail we could add regarding the quality and purpose of the ‘stop moments’?
* Do the 2 intraoperative ‘stop moments’ enable multi-component implants to be checked?
* Do we need to say any more about overlaps with existing checks? For example, the WHO surgical safety checklist, NatSSiPs?
* Should we amend text (for example, the rationale) to reflect that the second ‘stop moment’ enables implant selection errors to be fixed?
  1. Draft statement 5

Adults who have had hip, knee or shoulder replacement are given advice on postoperative rehabilitation before discharge.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* There was general support for this statement.
* The process of identifying the need for supervised group or individual rehabilitation is not standardised across the NHS, which can lead to suboptimal outcomes.
* Giving advice that reflects that some patients may have more specific rehabilitation needs is important.
* Good quality information and advice play a key role in ensuring that people are properly supported after surgery.

**Definition**

* Refer to providing supervised group or individualised rehabilitation in a timely manner.

**Resource impact**

* Not all orthopaedic departments (units) can offer the same level of postoperative rehabilitation, especially in areas in which patients move out of the surgical ‘hub’ area immediately after surgery; their rehabilitation would have to be provided locally.
* This concern could be mitigated by the provision of, as a minimum, printed literature describing postoperative rehabilitation. It was suggested that this could be explored at national level, and material supported by organisations such as NICE.

### Issues for consideration

**For discussion:**

* Including timely delivery of postoperative supervised group or individual outpatient rehabilitation exceeds the scope of the recommendation.
* How can the statement be implemented if care is transferred to local units?
* Can the statement still be achieved if care is transferred to local units?

1. Suggestions for additional statements

Stakeholders suggested including a statement on collecting PROMs data, to support patient-centered care

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 1 | National Joint Registry | General comment | Quality improvement in arthroplasty in England, Wales, Northern Ireland, the Isle of Man and Guernsey is being driven by the NJR. Thus 100% compliance by a hospital could be used as a quality assurance metric itself. |
| 2 | National Joint Registry | General comment | Two of the measures rely on PROMs collection. Collection of this should be made mandatory across shoulders as well as hips and knees. Inclusion of shoulders in the National PROMs programme would help this and the targets for how many patients' pre-and post-op PROMs are returned could be ramped up further.  If the targets for completeness of collection of PROMs can't be increased then just making Shoulder PROMs subject to the same targets and making them a metric by which commissioners and/or providers are measured would still greatly improve the quality assurance feedback. |
| 3 | Arthroplasty Care Practitioners Association | Question 1 | We support the need for these statements to improve the pathways for arthroplasty patients. |
| 4 | British Orthopaedic Association | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Yes, we believe that the draft quality standard reflects areas for quality improvement. |
| 5 | Royal College of Nursing | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Yes |
| 6 | Arthroplasty Care Practitioners Association | Question 2 | Local systems may be available but there is often a need for local administrative support for orthopaedic professionals to extract and use the data. This support is not always readily available, particularly in the smaller orthopaedic units such as in district general hospitals. |
| 7 | National Joint Registry | Question 2 | NJR are happy to consider as part of our forthcoming dataset review whether there are opportunities to capture compliance with any of these statements at a national level |
| 8 | Royal College of Nursing | 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?  Yes, the resources/structures should be in place in large organisations, although if not already in place in smaller organisations should be straightforward to collect this data |
| 9 | Arthroplasty Care Practitioners Association | Question 3 | It would require staff time and education as the primary investment but potentially electronic resources to support information delivery would also be very useful. |
| 10 | British Orthopaedic Association | Question 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.  The draft quality statements should be achievable within resources with the following observations  1. No further comment  2. There may be resource implications in referring a patient requiring a partial knee to the most appropriate surgeon  3. No further comment  4. The 2 stop moments could be facilitated by additional checklists. One can be added to the WHO checklist process at the start of the operation and a further document will be required for completion part way through. Training will need to be given to ensure the practice is suitably embedded.  5. No further comment |
| 11 | Royal College of Nursing | Question 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?  Yes |
|  | **Statement 1** |  |  |
| 12 | British Orthopaedic Association | General comment | Good quality advice and information should be available for patient pre and post operatively to ensure patients are in the best condition possible for surgery and properly supported afterwards. It should be noted that post operatively some patients may have more specifically targeted rehabilitation needs and this should be reflected in the advice given. |
| 13 | Versus Arthritis | General comment | This submission responds to Statement One only:  “Adults having hip or knee replacement are given advice on preoperative rehabilitation when they are listed for surgery”.  **Our response**  At Versus Arthritis we suggest people referred for potential surgery should have taken part in a structured shared-decision making processes, with the use of [relevant decision support tools](https://www.versusarthritis.org/about-arthritis/healthcare-professionals/musculoskeletal-decision-support-tools/), before the final decision is made to undertake joint replacement surgery. This is for the following reasons listed below.  **Pain has a substantial impact on the quality of life of people with severe osteoarthritis. As pain casts a shadow over all parts of life, people with severe OA may need support and information.**  The Covid-19 pandemic disrupted communication between local health systems and people waiting for joint replacement surgery and waiting times for orthopaedic surgery has grown exponentially throughout the pandemic. Many people waiting for their joint replacement surgeries have had to wait without clear communication, leaving many in agonising pain without care or support.  In June of this year Versus Arthritis developed a [support package](https://www.versusarthritis.org/media/23694/joint-replacement-support-package-june2021.pdf) for people waiting for their surgery.  The package recommends local health systems adopt a six-pronged approach to supporting people while they wait for surgery, including:  • **clear communication** to be provided to people about when they can expect to have their surgery and receive the care and services they need in the meantime  • **personalised** self-management and support to be provided to help people with arthritis manage their pain while they wait for surgery  • **physical activity programmes** designed to help people with arthritis stay active and prepare for surgery should be actively promoted  • **mental health support** to be offered to help every person with arthritis to manage their pain and any associated depression and anxiety  • **signposting to financial support and advice**, and  • **Covid-19 recover plans** should address the specific needs of people with arthritis.  The pain of waiting for surgery is exacerbated by poor communication and a lack of support from local health systems. It is essential that people waiting for their joint replacement surgery are supported to wait well and be actively involved in any preoperative rehabilitation.  **Decision-support tools are useful ways of people making informed choices about their treatments.**  Versus Arthritis has produced a suite of support tools to help people with shoulder, hip and knee pain. They were developed by Versus Arthritis with support from the Primary Care Centre Versus Arthritis at Keele University and with funding from NHS England. These tools have since been endorsed by NICE. Please view relevant information here: <https://www.versusarthritis.org/about-arthritis/healthcare-professionals/musculoskeletal-decision-support-tools/> These tools are used together with a healthcare professional to support a conversation, taking into account the context of people’s lives, and not assuming that there is a single ‘best’ option for everyone.  Whilst we recognise that adults on a waiting list for hip or knee replacements, may already have made key decisions about their treatment, we do believe that incorporating and ensuring that Decision Support Tools are part of the overall patient journey is important. |
| 14 | Arthroplasty Care Practitioners Association | Question 1 | We support the need for improvement in this area because the provision of preoperative rehabilitation is subject to considerable provider variation in contrast to compelling evidence supporting the benefits. Whilst some providers offer a comprehensive programme of supervised exercise and advice, it is more common to signpost patients towards some of the recommended elements of preoperative rehabilitation using booklets and websites. It appears that some providers do not provide any resource preoperatively that meets the description of preoperative rehabilitation. In addition, it is unlikely that self-directed preoperative rehabilitation (provision of booklet or web based resource) meets the needs of adults with cognitive impairment, language barriers, communication difficulties etc and alternative resources (such as 1 to 1 sessions with a therapist/specialist nurse plus interpreter) may not always be made available to meet that need due to staffing pressures, treatment space and coronavirus restrictions/pressures. |
| 15 | Arthroplasty Care Practitioners Association | Question 2 | The constitution of adequate preoperative rehabilitation needs further clarity particularly around the format of delivery, in order to enable trusts to determine if they meet the definition or not. This would aid data collection. Requirement to document provision or referral to pre-operative rehabilitation could be added to existing pathways at point of listing. This would sit alongside other documentation requirements at this time point including consent and collection of pre-operative PROMS and may not be too onerous. Issues around accessibility of information and support provided also need further clarification to ensure that providers are meeting the requirements of those with equality and diversity needs. It might be useful to add an outer timeframe to the preoperative rehabilitation definition (such as must be offered within the 6 months prior to surgery) to allow measures of improvement to be comparable between hospitals. |
| 16 | Arthroplasty Care Practitioners Association | Question 3 | A simpler option would be if NHS England could provide an information video (reviewed and updated based on emerging evidence) that providers could access. This relatively small investment would be more professional than local attempts to record content. Subtitles or sign interpreter could be added and other languages could be considered. This might be paired with signposting to existing community exercise and health initiatives, or a few sessions in a local exercise group, to offer a valuable service without hugely impacting on current resources. |
|  | **Statement 2** |  |  |
| 17 | British Orthopaedic Association | General comment | Partial knee replacements are safe, effective and appropriate for patients. This quality standard will support their use but it should be noted that not all surgeons perform them. BASK and GIRFT guidelines mandate that those performing the operation should perform a certain number annually to remain appropriately skilled. This might mean that patients are required to move between consultants to ensure the most appropriate surgeons performs the operation. |
| 18 | National Joint Registry | Statement | Not all isolated medial compartment OA cases are suitable for partial knee replacement. Therefore this statement is an oversimplification. |
| 19 | Arthroplasty care Practitioners Association | Question 3 | The main impact will be the need to transfer a patient's care if they present at a unit where partial knee replacement is not offered. There is no doubt that this will increase waiting times. As such, there may be reluctance on both the patient's and surgeon's part to go down this route. There will also be costs involved in upskilling of surgeons and potentially associated rehab costs in terms of day case arthroplasty. |
|  | **Statement 3** |  |  |
| 20 | British Orthopaedic Association | General comment | There is overwhelming evidence that giving tranexamic acid has benefits and we would support this recommendation. |
| 21 | National Joint Registry | Statement | We suggest that it is best to give tranexamic acid immediately pre op (anaesthetic room, if used, as with antibiotics) not “during operation”. Perhaps the precise wording could be clarified. |
| 22 | Arthroplasty care Practitioners Association | Question 2 | At present there are no local (or national) systems in place to collect and/or analyse data regarding this proposed quality measure. Certainly, while it could be argued that this intervention is evidenced-based to some degree, the variance, even in local practice, suggests that the evidence-base cannot account for the multiplicity (variance) of practice and there is a need to standardise the collection of the data. For instance, it is our experience that some surgeons request TxA at the commencement and end of surgery, some surgeons request TxA only at commencement of surgery, some knee surgeons request intracapsular injection of TxA on closing the knee surgical wound, some surgeons avoid TxA administration. |
| 23 | Arthroplasty care Practitioners Association | Question 4 | Certainly, the two ‘stop moments’ would be an ideal opportunity for the anaesthetist and surgeon to confirm the exact modality of TxA having been given and for the reporting of an accurate intra-operative blood loss figure (including the weighing of used swabs and blood suctioned), the aim being a best estimate of overall blood loss. The monitoring of post-operative wound drainage and post-operative Hb levels would normally be documented after the patient had returned to the ward (day one post-op). A formalised process and the introduction of real time documentation may help support this measure. |
|  | **Statement 4** |  |  |
| 24 | British Orthopaedic Association | General comment | We would fully support any action to eliminate never events and 2 stop moments in surgery would seem to be a suitable method. |
| 25 | National Joint Registry | General comment | It is worth noting that the second stop moment won’t stop never events. Once the wrong implant is implanted then a never event has occurred. It helps addressing the issue to fix it before the wound is closed but won’t prevent the never event occurring.  It would be better if for knees both stop moments occurred before implantation eg boxes of implants checked correct and in date, then once opened check actual implants are correct ie left femur for left knee. With modular hips, 6 stops are really required to confirm. Acetabulum, femur and then head. |
| 26 | NHS England & NHS Improvement: Patient Safety Team | General comment | Do you have an evidence-based source for this ‘two stop’ quality statement?  Does the stop moments also incorporate check/use of any electronic bar code scanning system, such as those to map the patient to the implant and also to map the implant to any components, to ensure compatibility; or is the intention more a ‘team’ stop and review process?  Additional guidance on prescription of what to record, should signatures be required, should the second stop moment be carried out with the surgeon and a different theatre team member to the first may be helpful. If there is to be a national audit of the quality statements from the onset to support good data collection.  The surgical checklist and NatSSIPs support the implant checking process at each stage that an implant is put in, but not sure this should be restricted to a ‘two stage’ stop moment. It should be whenever an implant is used. There doesn’t seem to be any referencing to NatSSIPs, and no mention of the Joint Registry as a data source.  In relation to ‘Outcome’, we are currently reviewing the list of Never Events so these types of implants could be excluded from the NE list as a result of this review. |
| 27 | National Joint Registry | Measures | We would draw attention to the NJR Implant Scanning tools. These are available free of charge to hospitals in the UK and can be used to determine the compatibility of components. Perhaps NICE may wish to reference these in the QS documentation. <https://www.njrcentre.org.uk/njrcentre/Healthcare-providers/NJR-Implant-Scanning-Interface> |
| 28 | Arthroplasty Care Practitioners Association | Question 4 (question for consultation) | Our experience that this would be supportive and that local forms, currently used to record implants pre op or peri op, could be modified to facilitate this guideline (example at Sheffield Teaching Hospitals NHS Foundation Trust) |
| 29 | British Orthopaedic Association | Question 4  (question for consultation) | On Statement 4: Please comment on whether surgical protocols and checklists will enable the 2 ‘stop moments’ being carried out and their timing to be documented, to support the structure and process measures.  This is not standard practice but should be introduced.  The 2 stop moments could be facilitated by additional checklists. One can be added to the WHO checklist process at the start of the operation and a further document will be required for completion part way through. Training will need to be given to ensure the practice is suitably embedded. |
|  | **Statement 5** |  |  |
| 30 | British Orthopaedic Association | General comment | Good quality advice and information should be available for patient pre and post operatively to ensure patients are in the best condition possible for surgery and properly supported afterwards. It should be noted that post operatively some patients may have more specifically targeted rehabilitation needs and this should be reflected in the advice given. |
| 31 | Dynamic Metrics Ltd | Definition | The rehabilitation team should decide whether adults should be offered supervised group or individual outpatient rehabilitation based on their clinical and personal situation.  Advice on post operative rehabilitation will be provided to patients before they leave the hospital.  Hip and knee replacement patients will be given advice on self directed rehabilitation. However, Supervised group or individual outpatient rehabilitation is offered to adults who have had hip, knee or shoulder replacement surgery who:  • have difficulties managing activities of daily living or  • have ongoing functional impairment leading to specific rehabilitation needs or  • find that self-directed rehabilitation is not meeting their rehabilitation goals.  Discussions with physiotherapists show that this decision is not standardised across the NHS, which can lead to significant long term consequences to the patient and the NHS.  Those that should be provided with supervised group or individual rehabilitation should receive this in a timely manner and this should be identified in the guidance document.  Our current study on post operative rehabilitation at Norfolk and Norwich Hospital has shown that only a small percentage of those who require group or individual rehabilitation have received it. On our feedback forms one patient was very clear that they felt this was a huge shortfall with respect to the entire procedure. |
| 32 | Arthroplasty Care Practitioners Association | Question 3 | Not all orthopaedic departments may be able to offer the same level of post-op rehab. This is especially noted in areas where patients move out of the hub area immediately after surgery and rehab would have to be provided locally. A minimum of printed literature describing post-op rehab should be provided. This may be an area that could be explored at a national level and literature supported by organisations such as NICE |
|  | **Additional areas** |  |  |
| 33 | British Elbow & Shoulder Society |  | As we understand it Quality Standards can only be set from Nice Guideline Recommendations (June 2020) where an 'offer' recommendation was used not a 'consider'. I attach our quality improvement recommendations that BESS submitted in April 2020 **Analyst note: this response was resubmitted for the topic engagement carried out in 2021 and is available in Appendix 1 of the briefing paper.**  You will see that one of those recommendations was for PROMS to be a quality standard and this was strongly supported by the BOA and other specialist societies. Our opinion is that NICE have missed the best opportunity that will ever be presented to them to impact on quality standards in shoulder replacement surgery.  'Patient centred care' is supposed to be at the heart of all actions undertaken and recommendations made by healthcare professionals and Organisations involved in healthcare so it is really difficult to understand why Patient Reported Outcome Measures are not a QS. Whilst I am not surprised that this has been ignored it does sadden all of us at BESS that once again the rhetoric about patient centred care and reality are as far apart as ever. |
| 34 | British Orthopaedic Association |  | Following the Cumberlege report we believe that Patient Reported Outcome Measures (PROMS) should be a major part of any quality standard.  We would support the feedback from our colleagues in the British Elbow and Shoulder Society that 'Patient centred care' is supposed to be at the heart of all actions undertaken and recommendations made by healthcare professionals and Organisations involved in healthcare so it is really difficult to understand why Patient Reported Outcome Measures are not a QS. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Arthroplasty Care Practitioners Association
* British Elbow & Shoulder Society
* British Orthopaedic Association (draft response was circulated to the British Elbow and Shoulder Society, the British Society for Surgery of the Knee and the British Hip Society before submission to NICE)
* Dynamic Metrics Ltd
* NHS England & NHS Improvement: Patient Safety Team
* National Joint Registry
* Royal College of Nursing
* Versus Arthritis

# Appendix 2: Quality standard consultation comments table – NHS England & NHS Improvement (NHSEI) GIRFT and BestMSK improvement programmes (registered stakeholder)

**These comments are not summarised in the consultation summary report. They were circulated to the quality standards advisory committee and discussed during the post-consultation meeting.**

| ID | Section | Comments |
| --- | --- | --- |
| 1 | General | My main thought was there was nothing specific on shared decision making. I would have liked it to be - or even expected it to be - one of the quality standards here: participation in a structured, supported shared decision making process.  They did consider SDM in their discussions, so that means it wasn't out of scope. I think we need the NICE QS to say very clearly that people with OA should have taken part in a SDM process before surgery, and one which isn't only about the 'benefits and harms of surgery', but fully explores other options too that the person may not previously have explored that link to supported self management, not least mental health and physical activity options.  I'd welcome others' thoughts, but I'd hope that NHSEI will be going back to NICE very clearly and robustly on this. |
| 2 | General | Thanks for your swift feedback. I absolutely agree regarding SDM and this will be included in NHSE/I feedback both from the Best MSK Health Programme and from the Personalised Care Group. I will also advocate for including a standardised measure of SDM and ideally use of decision support tools where available.  In terms of the preoperative rehabilitation advice for hip and knee replacement – I would like to see reference to assessing and building health confidence, we know providing information and advice on its own is unlikely to be sufficient for someone with low health confidence (activation).  Keen to hear thoughts/comments from others especially in relation to embedding supported self-management within the standards. |
| 3 | Statements 1 and 5 | Couldn’t agree more regarding the SDM comments made already and in particular around whether patients have the skills, knowledge and confidence to the use the information being ‘given’. It’s the so what question- the quality improvement measure is not just that they have been given pre/post rehab advice, but have they been able to use it appropriately and also what about the quality of the advice being given.  Re the PROM measure for statement 1 & 5- there may be many other factors that influence whether the outcome is excellent or very good- not just whether they have been given pre/post rehab advice. Having access to the services being advised will greatly effect outcomes so just having the measure as ‘given advice’ may not be of great value if wanting to measure QI and outcomes  There is also no mention of the digital opportunities as an area of QI. |
| 4 | Statements 1 and 5 | Fully agree around the advice wording- it needs to be much more about support to make pre op changes and be able to follow through on post op rehab.  So something about pro active identification of patients with low confidence to engage in pre and post op physio/rehab and ensuring they are supported through structured self management education/health coaching |
| 5 | General | I completely agree with this. The need for more than advice and information. Especially when they are referring to things like weight loss and smoking cessation, but also exercise when you are in pain.  Do we want to talk about activity rather than exercise. How much of this is “exercises” and how much is keeping moving?  The points about low confidence are so important to equalities issues. I don’t know if they only want things that address protected characteristics. There are big issues about people in more deprived areas, lower levels of literacy or education, for instance, being able to engage. That’s not about cognitive impairments or directly related to protected characteristics.   I agree about the shared decision making too. Surprised it’s not there.  I guess there will be a question about how you measure this and if it is achievable within current resource |
| 6 | General | For knee OA it probably really is ‘exercise’/’exercises’, rather than activity/movement (which would be appropriate for fibromyalgia, and perhaps some types of back pain. Muscle strengthening is really key to improvement of OA knee symptoms, and arguably a person is unlikely to achieve that through e.g. walking more. |
| 7 | General | Agree completely with these comments – the SDM omission is a priority to reconsider I think, alongside consideration of the opportunity and ability of the patient to engage and use the information. This speaks not only to the information being shared/discussion taking place but also to health inequalities and consideration of how these impact on engagement and outcome. Agree re digital opportunities as a real potential for QI too |
| 8 | General | Also agree. |
| 9 | General | Shared decision Making – relevant throughout and specifically quality statement 2.  The quality standard mentions very little about Shared Decision Making. We would expect shared decision making to be one of the quality standards for hip, knee and shoulder replacement or explicitly reference throughout: including participation in a structured, supported shared decision-making process.  We would like this quality standard to clearly state that people with OA should have taken part in a SDM process before surgery. Be clear that this isn't only about the 'benefits and harms of surgery', but fully explores other options too that the person may not previously have explored that link to supported self-management, not least mental health and physical activity options (in line with NICE SDM implementation guidance, June 21)  Use of a validated measure of SDM should be included and referenced in the standard |
| 10 | Statement 1 - General | Behaviour change research is clear that information and advice on its own is not predictive of behaviour change (see COM-B model). This is especially so for people with low levels of health confidence and health literacy. We would like to see reference to the pro-active identification of patients with low confidence to engage in pre and post op physio/rehab and ensuring they are supported through structured self-management education/health coaching ([Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf (health.org.uk)](https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf) |
| 11 | Statements 1 and 5 | PROMS in pre and post operative phase  The incorporation and prioritisation of PROMs in the pre and post-operative phase is very welcome and will provide useful data to audit and enhance services in the future. Have the team considered making a recommendation about increasing the availability of pre and post operative rehabilitation. From primary care working across diverse areas in Birmingham it appears that rehab services are more available to those in wealthier areas / with a strong support network and less available to those in poorer areas / less of a support network of family and carers / non-english speakers.  It’s the so what question- the quality improvement measure is not just that they have been given pre/post rehab advice, but have they been able to use it appropriately and also what about the quality of the advice being given.  Re the PROM measure for statement 1 & 5- there may be many other factors that influence whether the outcome is excellent or very good- not just whether they have been given pre/post rehab advice. Having access to the services being advised will greatly effect outcomes so just having the measure as ‘given advice’ may not be of great value if wanting to measure QI and outcomes |
| 12 | General | Digital Opportunities  There is also no mention of the digital opportunities as an area of QI. |
| 13 | Statement 1 – Structure measure | Data source: Surprising no national data. Can necessary information be inferred from available data? |
| 14 | Statement 1 – audience descriptors | “Service providers” … And also begin to keep data on provision of preoperative rehab? |
| 15 | Statement 1 - definitions | “Advice on preoperative rehabilitation: maximising … ”: As a lay person not sure what this means as distinct from the 3 previous points of advice |
| 16 | Statement 1 – equality and diversity considerations | Should equality considerations include providing advice about accommodating the disruption of surgery into people's lives? Thinking in particular of those on low incomes or with challenging lives, who will struggle to organise their time and find the resources to be able to cope with surgery. I.e., childcare matters, loss of income, transport problems. |
| 17 | Statement 2 – rationale | Might it not be worth mentioning personalised care in this context? The patient is being consulted, they will jointly decide what is the most appropriate treatment based on various factors including what the patient wants (which presumably will include their future life plans/goals). The final decision is a joint one in the sense that options are provided by the healthcare professionals which the patient will choose from based on their advice (in part). So a personalised care plan, jointly agreed and itemised, would make sense. This may well happen but perhaps worth specifying here or where appropriate in the document. |
| 18 | Statement 2 – audience descriptors | “Healthcare professionals”: Is there some reference to multidisciplinary teams or cross specialisation coordination required here? The colleague that healthcare professionals need to work with will presumably not just be within their own teams. Worth emphasising that the patient's care needs to be coordinated across a range of HCP specialities? |
| 19 | Statement 2 – audience descriptors | Adults … “could have either …”: See previous comments on personalisation |
| 20 | Statement 4 – General | Is there a back story here, have their been incidents in the past where things went wrong which showed the need for the 2 stop moments? Seems somewhat arbitrary otherwise. Not sure whether or not a NICE document would routinely provide an explanation of why something is necessary but, from a lay point of view, this requirement does beg the question. |
| 21 | Statement 4 – audience descriptors | “Healthcare practitioners”: Could there be a recommendation for this procedure to be emphasised during training, including ongoing training? |
| 22 | Statement 5 – audience descriptors | “Healthcare practitioners”: Worth emphasising that it's not just advice but actual treatment offered? Presumably everybody who undergoes surgery of the type discussed will need post-operative rehabilitation. So it's not just advice about whether or not it's a good idea, it's advice about which type of rehabilitation is appropriate. This is relevant as I understand not everyone is getting the post-operative rehab that they need currently. |
| 23 | Statement 5 – definition | “Adults who have had hip or knee replacement are given advice on self-directed rehabilitation (para 2)”:  Really? I find this surprising. Given the importance of rehabilitation to a successful outcome, I'm surprised that people who have had hip or knee replacement surgery are not routinely provided with individual or group rehab with a physio. Is there robust evidence to show that such adults are able to manage rehab on their own? |
| 24 | Statement 5 – definition | “Supervised group or individual outpatient rehabilitation is offered … • find that self-directed rehabilitation is not meeting their rehabilitation goals”: this seems to suggest that only when things go have gone wrong will supervised outpatient rehab be offered to most adults. Very surprising. |
| 25 | Statement 5 – equality and diversity considerations | When considering whether or not people will need assistance/supervision with their rehab, it would make sense to include socio-economic factors such as whether people have the time, space and freedom from commitments such as childcare or work, which will allow them to undertake unsupervised rehabilitation. A person with a lot of domestic commitments, limited space, many family around et cetera may well struggle even though they do not have physical sensory disabilities or learning or cognitive impairment issues |