NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Osteoarthritis

Date of Quality Standards Advisory Committee post-consultation meeting:
21 January 2015

2 Introduction

The draft quality standard for Osteoarthritis was made available on the NICE website for a 4-week public consultation period between 21 November and 19 December 2014. 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 18 registered stakeholders, 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.

3 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. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

4. For draft quality statement 5: Do you agree there should be an annual review for adults with osteoarthritis that meet the specific criteria?

4 General comments

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

- In general, stakeholders welcomed the quality standard and agreed that it reflects the key areas for quality improvement.
- It needs to be clearer who will be responsible for implementing the quality standard, and in particular that the main focus of activity will be in primary care.
- It was suggested that there should be more emphasis on the roles and contributions of allied health professionals and the voluntary sector. This was felt to be important given the time limitations in primary care.
- The prevention of osteoarthritis was highlighted as important given that incidence is likely to increase due to the prevalence of obesity.
- The needs of people with learning disabilities should be recognised specifically within the equality and diversity considerations.

Consultation comments on data collection

- Most stakeholders agreed the proposed data collection is realistic providing appropriate systems are in place.
- A stakeholder suggested there may be a need to consolidate the data measures to make it easier to collect as part of GP consultations.
- It was highlighted that there are currently a lack of national indicators for osteoarthritis and outcomes are not included in the QOF or CQUIN payment framework. It was suggested that the reliance on local data collection may reduce the impact of the quality standard.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults aged 45 years or over with activity-related joint pain and either no morning joint stiffness or morning joint stiffness that lasts no longer than 30 minutes are diagnosed with osteoarthritis clinically without investigations.

Consultation comments

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

- It was suggested that it may be more effective to re-word the statement to say that ‘X Ray investigation of a clinical diagnosis of osteoarthritis is only indicated if it will alter management’.
- A stakeholder was concerned that the diagnostic criterion of stiffness lasting less than 30 minutes fails to reflect the wide range of presentations of osteoarthritis.
- The terminology used in the patient audience descriptor was felt to be inaccurate as X- rays can be useful in diagnosing osteoarthritis, identifying complications and informing treatment and referral decisions.
- It was suggested that the wording of the statement is very long and it may therefore be better to use a definition for the relevant population instead.
- Several stakeholders emphasised that exclusions to ‘without investigations’ need to be clearer in the definition.
- It was suggested that ultrasound should also be included.
- It was felt that active people aged 45-55 years may find it difficult to accept a diagnosis of osteoarthritis without investigations and clinicians may find it challenging to make the diagnosis without first excluding other possibilities.

5.2 Draft statement 2

Adults have a holistic assessment when diagnosed with osteoarthritis.

Consultation comments

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

- As ‘holistic assessment’ is very generic it was suggested it may be more effective to include specific elements within the statement rather than just in the definition.
- It was suggested that the definition of the holistic assessment should be strengthened to include the detection of co-morbidities and their interaction with osteoarthritis.
- The rationale should be strengthened to emphasise why it is important for GP’s to spend their time carrying out a holistic assessment.
- It was felt that the measures could be improved by identifying how to measure the quality and performance of the holistic assessment rather than just what was included.

5.3 Draft statement 3

Adults with osteoarthritis have an agreed self-management plan that identifies which services will support them.

Consultation comments

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

- Stakeholders highlighted that not everyone will need services to support them and suggested that the statement wording should change to reflect that services should be seen as a tool to help people to identify what they need to do for themselves rather than just as a means of support.
- It was queried whether the statement wording could be more action-focussed and if it would be appropriate to focus on a specific element of the self-management plan.
- Stakeholders suggested it would be useful to strengthen the rationale to justify why it is important to develop a self-management plan, what it involves, and to emphasise the link to shared decision making and ‘no decision about me without me’.
- Several amendments were suggested to the definition of the self-management plan:
  - The plan should be provided in verbal and written format
  - The content of the plan should be mandatory rather than optional
  - It should specify that written information is provided at diagnosis
  - It should match the statement better by including information about services that will provide support.
  - ‘Using suitable footwear and assistive devices’ should be amended to ‘referral to local services that can provide advice regarding suitable footwear, orthotic devices (such as insoles and braces) and assistive devices (such as walking sticks)'.
- It was highlighted that the audience descriptor for commissioners should emphasise the role of the voluntary sector.
- Additional equality considerations were suggested:

  - availability of printed material on self-management for older people who do not access information online.
  - information in larger text format for people with visual impairments.
  - Easy read information for people with learning disabilities.
- It was questioned whether it would be more logical to re-order the statements so that this statement comes after current statement 4 (exercise and weight loss).

5.4 Draft statement 4

Adults with osteoarthritis are advised to exercise, and if they are overweight or obese are offered support to lose weight.

Consultation comments

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

- A suggestion was made to split this into two statements given the different populations.
- Wording changes were suggested:
  - 'Weight loss' should be replaced with 'weight management'
  - 'Exercise' should be replaced with 'physical activity'.
- It was felt to be important to highlight that the BMI ranges in the definition of overweight or obese may underestimate risk for some ethnic minority groups.
- A suggestion was made to add a measure of weight maintenance following weight loss.
- It was felt that the measure of receipt of advice on exercise is too simplistic.
- It was suggested that it is inappropriate to encourage everyone with advanced osteoarthritis to lose weight and exercise as some people are in too much pain and/or are severely disabled.

5.5 Draft statement 5

Adults with symptomatic osteoarthritis have an agreed date for a holistic review.

Consultation comments

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

- It was queried whether it is necessary to specify 'symptomatic' in the statement.
- There were suggestions to strengthen the rationale to state why a review is necessary and to specify the benefits of the specific components of the review.
- The use of the word 'treatments' in the definition was felt to be inaccurate as there is no treatment for osteoarthritis.
- It was suggested that measuring whether a review takes place is more useful than 'have an agreed date for a review'. It was also felt to be important to measure whether the review results in changes to the support provided.
- A stakeholder indicated that every patient should have a formal Care Plan and that reviews should be undertaken against the requirements of the Care Plan.
- It was suggested that a risk scoring matrix is needed to identify those who need an annual review.
- The importance of providing information to patients on when to seek a review was highlighted as important.
- It was queried whether it would be acceptable to suggest that a review of osteoarthritis is included within an annual health check.

Consultation question 4

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

- Some stakeholders felt it is appropriate to offer an annual review to patients with osteoarthritis that meet the specific criteria as with other chronic conditions.
- Some stakeholders felt annual reviews would have a large resource implication and put too much pressure on GP's and it is more appropriate to focus on self-management with people advised to seek help when necessary.
- The frequency of review should not be arbitrary but should be determined by symptom severity and response to treatment.

5.6 Draft statement 6

Adults with osteoarthritis whose symptoms have a substantial impact on their quality of life and have not responded to treatment discuss referral for joint surgery with their GP.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- It was suggested that ‘substantial impact on quality of life’ needs to be measurable.
- There was concern that the statement is not useful and simply creates measurement of multiple discussions.
- The wording of the statement should be revised to include ‘other healthcare professionals’ as they may also make referrals.
- A stakeholder suggested that a specific self-scoring tool/decision aid could be referenced in the quality standard.
- It was suggested that ‘aids and devices’ is replaced with 'suitable footwear, orthotic devices (such as insoles and braces) and assistive devices (such as walking sticks)’ in the definition of treatment for osteoarthritis.
- A stakeholder suggested that a definition of joint surgery is needed to specify which joints and which surgery are included.
- It was emphasised that people with learning disabilities should be included in the equality and diversity section to ensure they are not excluded from joint surgery.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Pain assessment and effectiveness of symptom control
- Regular review of effectiveness of pharmacological interventions
- Non-drug therapies
- Prevention of osteoarthritis
- Standardisation of specialist surgical services.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
1	Dietitians In Obesity Management	General	We support this quality standard on this important aspect of health.
2	Dietitians In Obesity Management	General	We agree that obesity and overweight are risk factors for the development of osteoarthritis, and their presence may make engagement in activity more difficult therefore weight management approaches are essential. Given the current prevalence of overweight and obesity in the UK, it is likely that incidence of osteoarthritis will increase, so prevention is key.
3	Dietitians In Obesity Management	General	We agree that the quality standards specified accurately reflect key areas for improvement in particular QS2-4.
4	Royal College of Chiropractors	General	Comment about quality statements 2-5: The RCC endorses statements 2 to 5 (holistic assessment, agreed self-management plan, exercise and weight management support, regular reviews) all of which are included in the RCC's Chiropractic Quality Standard on Supportive Self-Management in Chronic Care. The RCC also advocates the discussion of all treatment options (including surgery) with patients, but recognises the importance that the impact of symptoms is having on them, as well as ensuing that conservative management options are explored before considering more invasive interventions.
5	Oxford Health NHS Foundation Trust	General	"You may be offered treatment called 'manual therapy', which is provided by a physiotherapist or other healthcare professional and involves manipulation and stretching techniques. This is most likely to help if you have osteoarthritis of the hip." *(CG177, Information for the public)* My comments are: This is a perfectly acceptable statement but may create an expectation for patient they that will receive this by the physiotherapist
6	Oxford Health NHS Foundation Trust	General	There is no direct mention of any of the allied health professionals such as Physiotherapists and Occupational therapists, in the part where treatment (non-surgical) of osteoarthritis is discussed, and how their role is integral to treatment of osteoarthritis. I agree that there should be emphasis on self-management and tailoring treatment programmes to the individual.

[1]PLEASE 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.

ID	Stakeholder	Statement No	Comments[1]
7	Arthritis Care	General	Arthritis Care broadly welcomes the content of the draft quality standard on the management of osteoarthritis. However we believe the proposals in the standard on self management and conducting holistic assessments of people living with arthritis need to be strengthened. Commissioners also need to promote the role that the voluntary sector can play in enabling individuals to manage their own condition over a period of many years.
8	Arthritis Care	General	The quality standard includes a number of provisions that have the potential to greatly improve the delivery of health services for people living with osteoarthritis. Broadly Arthritis Care welcomes these recommendations. It is very important that the provisions relating to individual self-management, diet and exercise and information are included in the final quality standard. Arthritis Care has published and unpublished evidence that current clinical practice in England is substantially adrift of these standards. The quality standard could act as a spur for expanding the availability of best practice in patient care and support. However we propose that two amendments are made to the existing draft quality standard. These are as follows: - Stronger requirements introduced around the detection of co-morbidities amongst osteoarthritis patients - The self management plan proposed on page 17 of the standard should include a stipulation that written information is provided at the time of diagnosis Arthritis Care has gathered evidence that strongly indicates that the care of people with osteoarthritis in England falls below an acceptable standard. We have unpublished data gathered from 500 people living with arthritis in England from our Arthritis Watch project. Arthritis Watch is a survey that examines access to health services and includes information on their experiences of the quality of care. The survey found that only 38% of people reported that they had confidence in their GPs ability to manage their condition. Eighty two percent of respondents stated that they did not have a formal Care Plan. Only 57% of people living with arthritis reported that they had received information about their condition and how to manage it. Arthritis Care would highlight a particularly striking finding in relation to the quality standard. 71% of people in a sub-sample of people with osteoarthritis were not offered information to manage their condition. Only 20% of people were provided with information. Alongside this survey evidence there is a well established pattern of calls and inquiries to our telephone helpline where individuals have re-emphasised to us their dissatisfaction with the quality of care provided at general practice level. These ongoing concerns are particularly focused on the management of chronic pain in people with osteoarthritis. One area where evidence from Arthritis Watch is corroborated by the pattern of calls to our helpline is the finding that 66% of respondents with OA said that their treatment for pain was inadequate. This compares to 42% of respondents with rheumatoid arthritis holding the same opinion.
9	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
10	The Chartered Society of Physiotherapy	General	The Chartered Society of Physiotherapy (CSP) welcomes this quality standard and will support our members to use this quality standard to improve the quality of musculoskeletal services for people with OA.
11	NHS England	General	Thank you for the opportunity to comment on the above Draft Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.

ID	Stakeholder	Statement No	Comments[1]
12	BOA PLG	General	"Quality statements on staff training and competency are not usually included in quality standards" This is very necessary as in my experience, standard vary tremendously from area to area. In physiotherapy, for instance, some physios can demand unduly harsh regimes of exercise for arthritis sufferers, not infrequently quoting the "no pain, no gain" myth. In addition, the fast recovery pathway appears for post-op patients appears to support this protocol also which is not only unhelpful but actually injurious to the patient's well being.
13	Royal College of Nursing	General	The RCN supports the development of this quality standard and is happy to provide comments to inform on its development. We feel it is prudent to state who is responsible for undertaking the quality statements. We would recommend that it is the responsibility of Primary care and not secondary care.
14	Royal College of Nursing	General	Table 2 (NHS Outcomes Frameworks section 2) The proportion of people feeling supported to manage their condition improving functional ability in people with long-term condition- In the case of elderly people – where you have an overarching standard a good aim should be maintaining functional ability.
15	Digital Assessment Service, NHS Choices	General	The Digital Assessment Service welcomes the QS and has no comments as part of the consultation
16	British Society for Rheumatology	General	We suggest that the quality standard needs to reflect that the condition should be managed almost entirely within primary care, with the exception of referrals to surgery. This is in line with existing clinical guidelines for osteoarthritis.
17	Arthritis Research UK	General	*All healthcare professionals involved in assessing, caring for and treating adults with osteoarthritis should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training will be considered during quality statement development.* Much of the care for people with osteoarthritis will be delivered by Practice Nurses, Nurse Practitioners and Healthcare Assistants. A report by Arthritis Research UK (The Absent Health Professional, 2013) highlighted the educational needs of these health professionals and the unmet information needs of patients. Broadly speaking these needs are centred around the three "e"s: providing basic advice on **Education, Exercise** and **Easing Pain**. Arthritis Research UK and Education for Health have developed a training programme for this group of healthcare professionals. The title of the programme is Assessing and managing patients with joint pain and introduces the concepts of care at a range of levels from basic to degree level. Even though each year around 20% of the registered population consult their GP with a musculoskeletal problem, most GPs complete their training with little or no formal training on how to manage these problems.[1] For the quality standard on Osteoarthritis to have impact on patients the GP workforce must have the skills to make a competent

ID	Stakeholder	Statement No	Comments[1]
			assessment of a patient. Additional skills in the care planning process will also be required. This is explored further in the 2014 Arthritis Research UK publication Care planning and musculoskeletal health. Arthritis Research UK have funded and jointly developed an educational programme for GPs and primary care health professionals with the Royal College of GPs. The Core skills in musculoskeletal care programme has a central focus on osteoarthritis in the context of long-term conditions management and support for self-care. Arthritis Research UK Primary Care Centre (2009), Musculoskeletal Matters.
18	Arthritis Research UK	General	Arthritis Research UK has published report describing a public health approach to musculoskeletal health.[2] Taking a life course approach, it reviews the determinants of musculoskeletal health, including the impacts of physical activity and diet, together with opportunities for health improvement and emerging research questions. http://www.arthritisresearchuk.org/policy-and-public-affairs/reports-and-resources/reports.aspx 1 Arthritis Research UK (2014), Musculoskeletal health: a public health approach.
19	Primary Care Rheumatology Society	Questions for consultation	The draft quality statement includes the key areas for quality improvement that is assessment, education and focus on core treatments with equitable access to surgery as required. This accurately reflects the key areas for quality improvement.
20	Primary Care Rheumatology Society	Questions for consultation	The proposed data collection is realistic; as most of this data collection would be in primary care, it is a simple set of codes that could be put into a template for ease of use, link with appropriate resources and ease of extraction
21	Primary Care Rheumatology Society	Questions for consultation	The main barrier identified for all the quality standards was time in primary care. Secondary barriers are knowledge of osteoarthritis in primary care; there would need to be support for education of clinicians and investment in time and resources, such as nurse led, physiotherapy led multidisciplinary teams to support these quality standards. There would also need to be IT support in templates, coding and links for ease of entry of data and ease of access of support tools.
22	The Chartered Society of Physiotherapy	Questions for consultation	The draft broadly addresses the key areas for quality improvement, but this could be enhanced by considering the comments above for each individual quality statement. In particular, quality statements 2, 3 & 4 form the framework for managing OA, but due to the constraints within the typical 10 minute primary care consultation, are rarely addressed as fully as they might be. It is therefore a desirable aim to improve this aspect of management. The GP role would ideally be to establish Osteoarthritis as the most likely diagnosis and then to refer the patient to another health professional for a more detailed assessment to include management options. This is generally what happens in primary care where, for example, patients are referred to a physiotherapy department for advice on further management.

ID	Stakeholder	Statement No	Comments[1]
			Treatment planning should be based on shared decision making and be able to offer patients alternatives to achieve the stated aims. Most GP's and health professionals have access to exercise on prescription schemes and should aim to develop similar links to weight loss groups. Timely access to community dietetic services and occupational therapy is also important. The implications of this are that there would be considerable additional pressure put on already stretched resources.
23	The Chartered Society of Physiotherapy	Questions for consultation	If systems were in place, yes it would be possible, but the difficulty is more likely to lie within having appropriate systems in place.
24	The Chartered Society of Physiotherapy	Questions for consultation	Online educational tools for clinicians, as well as patients. Weight loss resources for patients that take into account OA and its functional/social limitations - particularly online reliable resources. Ensure timely access to other services such as weight-loss, and consider self referral to physiotherapy services given the variable course of OA in terms of the effects on QOL and disability.
25	Grünenthal Ltd	Questions for consultation	Whilst the draft quality standard broadly reflects the key areas for quality improvement, critically it does not include a measure of adequate symptom control. In setting out the need for this quality standard the introduction highlights that: pain is associated with changes in mood, sleep and coping abilities; core treatments and medication are concerned with managing symptoms such as pain and there is often a lack of adequate symptom control among people with osteoarthritis (OA). Thus failure to include a measure of adequate symptom control in this Quality Standard is a major oversight. Service providers, healthcare professionals and commissioners could quite feasibly attain achievement levels of 100% in all quality measures without any impact on the focus of the Quality Standard which is to improve symptom control. As Moore et al. concluded 'any patient-centred treatment programme that does not include the achievement of adequate pain relief as part of its goals is likely to fail to deliver on expected benefits' . The authors propose the target of 'not worse than mild pain' based on a clear demonstration of the associated health and economic benefits and a recognition that there is no one standard pain scoring system.
26	Grünenthal Ltd	Questions for consultation	It will prove difficult to collect data for the proposed quality measures for the following reasons; 1) There are a lack of national indicators in place that could be used to measure improvements in the structure, process and outcomes of care in people with OA. 18 of the 22 proposed quality measures rely on local data collection. None of the national indicators identified for 4 of the measures are specific to people with OA. Two of the indicators are contained within the proposed 'care.data', the national extraction of which has not yet been formally agreed. 2) Attainment of many of the quality measures is ill-defined and subjective. For example, whilst the components of a holistic assessment have been identified there is no recommendation on how the performance of a holistic assessment should be recorded in order to aid measurement. 3) None of the outcomes are incentivised in the QOF or CQUIN payment framework and so their measurement is unlikely to be a focus
27	Grünenthal Ltd	Questions for	To support improvement in the management of people with OA consideration should be given to defining a measure

ID	Stakeholder	Statement No	Comments[1]
		consultation	of symptom control, including this measure in the national indicator set and incentivising healthcare professions and service providers to achieve this outcome
28	BOA PLG	Questions for consultation	Q1 - Generally yes, with attention to the first comment above
29	Royal College of Nursing	Questions for consultation	We feel that this standard is good as far as it goes, however there is absolutely no discussion about pain or the assessment of pain – which we feel should be addressed. There should be an indicator that stipulates the Health Professional should ask about pain and when reviewing, to see if pain relief has improved.
30	Royal College of Nursing	Questions for consultation	Q2 - Superficially yes – but we feel measures should be put in place to ensure that a true holistic assessment has been undertaken by a competent practitioner
31	Royal College of Nursing	Questions for consultation	Q3 - More training of practice nurses, community nurses, care assistants in knowledge of OA and how to offer non pharmacological support and guidance to patients
32	British Society for Rheumatology	Questions for consultation	The BSR believes that most of the key areas are addressed in the standard, however one that has been omitted, is in relation to pharmacological interventions and in particular the need to review their effectiveness after 3 months and to cease any pharmacological intervention that is proving ineffective or producing adverse reactions.
33	British Society for Rheumatology	Questions for consultation	GPs may find it difficult to collect the data for some of the proposed quality measures because of their diverse and all-encompassing nature. For example quality statement 3 is looking to measure verbal advice and written information given about managing the condition, self-identifying goals and self-management plans and quality statement 4 will measure exercise and weight loss advice. There may be some merit to consolidating the measures for these two statements to make them easier to collect as, in practice, all of these will be discussed as part of patient/doctor consultation.
34	Arthritis Research UK	Questions for consultation	**Question 2** If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? • Data relating to musculoskeletal conditions, including osteoarthritis, were not included in the initial GPES dataset for the care.data programme and will not be captured during the pathfinder phase of the programme. This is a significant omission, as around 20% of the general population consult their GP about a musculoskeletal problem each year.[1] Data on musculoskeletal conditions should be included within the GPES dataset as soon as possible. • Arthritis Research UK is developing the musculoskeletal calculator to provide local estimates of the number of people with four major types of musculoskeletal conditions in England, for use in the planning of healthcare services and public health programmes for local populations. The calculator osteoarthritis includes data for total and severe osteoarthritis of the hip and knee http://www.arthritisresearchuk.org/mskcalculator 1 Arthritis Research UK Primary Care Centre (2009), Musculoskeletal Matters.
35	Dietitians In Obesity	Statement 1	We agree with this standard. We also agree that proposed quality measures should be possible using data sources

ID	Stakeholder	Statement No	Comments[1]
	Management		suggested. In order to support it we feel it will need widespread dissemination of the Quality Standards for example through the Royal Colleges and professional bodies of allied healthcare professionals.
36	The Royal College of Radiologists	Statement 1	"One stakeholder suggested that all patients presenting with persistent knee pain should have a baseline validated imaging study using an X-ray and MRI to identify disease progression". The RCR recommends knee radiographs for assessing osteoarthritis should be specified to be weight bearing radiographs. The RCR believes MR should be suggested in the document, particularly not as a “baseline” in osteoarthritis.
37	The Royal College of Radiologists	Statement 1	“X-rays are not useful for diagnosing osteoarthritis or deciding on treatment.” The RCR believes this is not correct. Radiographs are useful for diagnosing OA; they are not useful for assessing pain. They can diagnose complications of OA (femoral head collapse etc.). They do help decisions on treatment.
38	The Royal College of Radiologists	Statement 1	“However, if an alternative diagnosis is possible, it may be necessary to carry out imaging to confirm the diagnosis. [Expert opinion]”. Quite, GPs often want to exclude other pathology and use severity of X-ray findings to decide whether to refer to a surgeon. Sudden marked deterioration in symptoms should trigger review, possibly also imaging (e.g. sudden collapse of femoral head?). Other treatment options: joint injections (image guided) can buy years of time before joint replacement - specialist referral for unremitting symptoms may be appropriate.
39	Royal College of Chiropractors	Statement 1	General comment: The RCC supports efforts to reduce the over-reliance on imaging and therefore unnecessary patient exposure to radiation, assuming that there are no conflicting findings, red flags, or potential contraindications to any treatment options that would warrant further investigation.
40	The Chartered Society of Physiotherapy	Statement 1	Whilst we welcome the emphasis on symptoms rather than imaging for diagnosis, we would suggest expanding quality statement 1 to mention exclusions to "without investigations". This would help to support the sentence on page 10 “Adults aged 45 years or over who go to their GP with joint pain that is typical of osteoarthritis are usually

ID	Stakeholder	Statement No	Comments[1]
			diagnosed with osteoarthritis without the need for an X-ray or a scan". Having exclusions to "without investigations" will help clinicians identify/support clinicians in requesting imaging when their patient does need further investigations. The diagnosis of OA should be symptom not age dependent. The inclusion of an age range starting at 45 is sensible to remind clinicians to consider OA at this relatively young age, but not withstanding the consideration of alternative diagnoses, we feel that it would be challenging for active patients in a 45-55 year age bracket to accept a diagnosis of OA without investigations. We also feel that it would be equally challenging for clinicians to confidently make the diagnosis as we believe that there is a perception that in this particular age group, knee pain is due to meniscal or ligament pathology. To address this, we would suggest making the final sentence on page 11 more prominent in this section; "However, if an alternative diagnosis is possible, it may be necessary to carry out imaging to confirm the diagnosis".
41	Royal College of General Practitioners	Statement 1	Are we really to believe that a person with joint stiffness lasting less than 30 minutes has osteoarthritis and one with it lasting 35 minutes does not? This sort of diagnostic criterion that fails to reflect the wide range of presentations does not help.
42	Royal College of General Practitioners	Statement 1	The abandonment of X Rays to help the diagnostic and management pathway will represent a challenge for both primary care and secondary care, far better to state that X Ray investigation of a clinical diagnosis of osteoarthritis is only indicated if it will alter management
43	Royal College of General Practitioners	Statement 1	"X-rays are not useful for diagnosing osteoarthritis or deciding on treatment". This is not so, X Rays do help in deciding if a patient should be referred for consideration of surgical intervention & can help avoid unnecessary referrals & better signpost patients towards non-surgical management.
44	BOA PLG	Statement 1	Would patients with such a low grade of symptoms ever present themselves for treatment? I wouldn't think so
45	BOA PLG	Statement 1	Excellent proposal! However, I do think that an Xray at first consultation should be deemed necessary as a baseline for judging future deterioration in joints. Xrays may not always be 'useful' but a preliminary Xray will provide a baseline for future degeneration and as such, should be deemed necessary in good history taking. It's also possible that such pain might be due to other causes such as AVN, neoplasms or stress fractures
46	The Society and College of Radiographers	Statement 1	What is very interesting to note (and applaud) is the very clear steer away from imaging (x-rays, MRI) to confirm clinical suspicion of OA. As the imaging appearances do not always correlate well with clinical symptoms. There is no mention of ultrasound. MSK ultrasound is being used for joint imaging, although this is more for RA rather than OA.
47	Dietitians In Obesity Management	Statement 2	We agree that a holistic approach which includes aspects of physical and psychological wellbeing is essential in order to tailor approaches to the individual. We suggest that holistic assessments will require good communication skills, so training of healthcare professionals to encourage a patient-centred way of working is essential in our view. The

ID	Stakeholder	Statement No	Comments[1]
			suggested measures for evaluation should also be possible using the data sources outlined. In terms of support we feel that this QS may be difficult to achieve because time may be seen as a barrier by healthcare practitioners. A truly tailored plan achieved as a result of a patient-centred holistic assessment will take time. However we feel that this is the basis for patient self-management and therefore may save time in the long run.
48	Arthritis Care	Statement 2	We welcome the fact that the quality standard includes a stipulation for there to be a holistic assessment of individuals with osteoarthritis. However the standard's references to co-morbidities are insufficient. The standard needs to reference the need for primary care clinicians to focus on the detection and early detection of co-morbidities amongst people with osteoarthritis. There is established evidence that people living with osteoarthritis are in many cases likely to have co-morbidities. Osteoarthritis and cardiovascular diseases commonly co-occur in the older population. The management of these conditions often does not take into account the interaction between these two conditions Osteoarthritis and cardiovascular disease are often associated with eech other. Explanations for this pathologic links, similar and shared risk factors or intermediary links, such as drugs (anti-inflammatories). GPs are already in possession of information like cardiovascular markers that equip them to do analysis and early detection of at risk patients, such as people with arthritis. They should be encouraged to utilise this information. Arthritis Care's 2014 pain survey found that 34% of people living with arthritis reported their pain as being 'just about bearable'. One in ten people reported their pain as being 'unbearable'. In this context, GPs should be specifically alerted to the risks of isolation and depression amongst people living with osteoarthritis. This could then guide their questioning of individuals during consultations. One of the areas that the Department of Health could investigate is whether arthritis related discussions are the main topic of a GP consultation or whether they are tacked onto the end of consultations. If the latter is the case then this will diminish the ability of GPs to gauge wider health risks like co-morbidities.
49	Royal College of General Practitioners	Statement 2	Where is the evidence that undertaking a "holistic assessment" makes any difference to the patient's wellbeing? It may be laudable but is it effective? What evidence is there that spending GP time undertaking such data gathering makes any difference & would their time be better spent elsewhere?
50	Royal College of Nursing	Statement 2	Under the equality and diversity considerations - in all the quality statements it mentions, 'cultural and communication needs' (see page 14 for example). We feel It could be more specific for people with learning/intellectual disabilities by including learning/intellectual disabilities as 'communication needs' may suggest English as a second language when linked with cultural and communication needs in the same sentence. We feel measures should be put in place to ensure that a true holistic assessment has been undertaken by a competent practitioner

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51	Grünenthal Ltd	Statement 2	Attainment of many of the quality measures is ill-defined and subjective. For example, whilst the components of a holistic assessment have been identified there is no recommendation on how the performance of a holistic assessment should be recorded in order to aid measurement.
52	British Association of Prosthetists & Orthotists (BAPO)	Statement 3	There is a point under Quality Statement 3 saying 'A self-management plan is jointly developed with the person with OA and may include... ...using suitable footwear and assistive devices such as walking sticks' BAPO suggest that this should be replaced with '…referral to local services that can provide advice regarding suitable footwear, orthotic devices (such as insoles and braces) and assistive devices (such as walking sticks)'. This alteration would better reflect the role of the orthotist in providing biomechanical interventions that are varied in nature. It would also highlight the importance of educating the patient to allow them to make sensible decisions about their footwear choices.
53	Dietitians In Obesity Management	Statement 3	We agree with this quality standard. Self-management in most patients is desirable. However plans must be specific and staff training in helping facilitate SMART goal-setting by patients may be required. Plans should be both verbal and in written format. We also agree that self-management plans should include advice and support on effective weight management approaches for those who are overweight or obese. The suggested measures for evaluation should also be possible using the data sources outlined. Like QS2, we feel that time may be seen as a barrier to achieving this QS by many healthcare professionals. However similarly to QS2, we feel that effective self-management will, in the long run, save practitioner time.
54	Arthritis Care	Statement 3	The self management plan proposed on page 17 of the standard should include a stipulation that written information is provided at the time of diagnosis. Arthritis Care published an opinion survey conducted by YouGov in May 2014. The survey's sample was over 2,000 people living with arthritis. The survey found that 78% of people with arthritis who had received self management reported that they had benefited from it. Unfortunately the survey found that only 20% had received this support. To quote a recent article in the British Medical Journal: Supporting self management is about helping patients to develop skills such as problem solving, setting goals, accepting change, finding coping strategies, managing relationships through communication and finding quality of life in difficult circumstances. The attributes listed for the self management plan on page 17 of the draft quality standard are all an essential part of people living with arthritis being given the support they need to reduce the impact of their symptoms. Therefore Arthritis Care believes that they should be mandatory elements for inclusion in a self management plan. The current wording indicates that NICE believes they should be discretionary. Page 17 also outlines proposed responsibilities for local commissioners. Arthritis Care believes that commissioners should investigate not only the statutory services that can assist peoples self management but also identify the contribution that the voluntary sector can play in this regard.

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55	Arthritis Care	Statement 3	Equality considerations - Large numbers of people in this client group are older people, many of whom will not be online. It is therefore of great importance that printed material on self management is made available to people as an option. Written information also needs to be available in larger text formats as some people with osteoarthritis will have visual impairments.
56	Royal College of General Practitioners	Statement 3	As above is there any evidence that time spent on self-management plans actually makes any difference to patient wellbeing outcome in osteoarthritis or that patients follow them?
57	Royal College of Nursing	Statement 3	We would prefer the wording of this quality standard title to be 'self-management'. We would like the rationale to incorporate shared decision making and self-management programmes to reflect the nature of 'no decision about me without me' and the NHS putting patients at the centre of their care. We also would prefer the wording to reflect the fact that the services need to be seen as a tool to help people to identify what they need to do for themselves to self-manage including when to ask for help rather than seeing services merely as a means of support.
58	Royal College of Nursing	Statement 3	Definition - Verbal and written information is stated; There is also the need for 'Easier to Read' written information to be included as this is a reasonable adjustment for people with a learning disability to aid comprehension.
59	British Society for Rheumatology	Statement 3	In relation to quality statement 3 on self management and support, patients need to have access to a wide range of information about osteoarthritis and self-management, for example e.g. leaflets, group education, online materials. All of these should reinforce the same message and easily accessible to general public. It should also be noted that not all patients will need services to support them.
60	Dietitians In Obesity Management	Statement 4	We would like the term 'weight management' used throughout, in place of 'weight loss', since maintenance of new lower weight is also required and is not captured by the term 'weight loss'.
61	Dietitians In Obesity Management	Statement 4	We agree with the essence of QS4. However we question the wording used and would suggest that 'physical activity' is used throughout in place of 'exercise'. 'Exercise' is sometimes seen as a barrier to participation by those who have had previous poor experiences eg with school sports, or those whose weight is a barrier (real or perceived) to participation. In our view the key messages to promote are increased day to day physical activity as well as a reduction in sedentary activities. Part of the advice around activity needs to include a realistic approach to the impact of increased activity on body weight; the benefits of activity have been shown in maintenance of a lower bodyweight rather than causing weight loss to occur.
62	Dietitians In Obesity Management	Statement 4	We agree with the proposed measures but would like to add weight maintenance among adults who are overweight or obese (since weight loss is more difficult to achieve in situations where mobility is lessened). We suggest the wording could be amended to 'weight loss followed by weight loss maintenance'.
63	Dietitians In Obesity Management	Statement 4	What this means for commissioners - We agree that weight management services should be available with sufficient capacity to meet the needs of those with osteoarthritis. This means that a range of services will need to be available. For example, lifestyle weight management approaches used for losing 5-10% of initial body weight if BMI<35kg/m2 and enhanced lifestyle weight management for those with BMI>35kg/m2 to enable 15-20% weight loss. This should

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			include evidence based programmes such as using very low calorie diets in the initial weight loss stage, followed by structured food reintroduction and weight loss maintenance stages. Approaches such as meal replacements have also been shown to be useful approaches for some individuals.
64	Dietitians In Obesity Management	Statement 4	We would like added to the BMI statement, that the BMI ranges specified may underestimate risk in some ethnic groups who may have increased risk at lower BMI (eg south Asians).
65	Royal College of General Practitioners	Statement 4	Most patients with osteoarthritis state that it is pain that stops them exercising, yet there is nothing in these quality standards about evidence based holistic management of pain, and the provision of non-drug therapies. Weight reduction can really make a significant difference and perhaps it is time to look once again at the need to loose weight before surgical intervention is considered. Think about how that weight loss can be quantified and recorded.
66	Royal College of General Practitioners	Statement 4	Just measuring the number of patients who are “given advice on exercise” is far too simplistic, think about how it can be quantified
67	BOA PLG	Statement 4	Weight loss may be a worthy objective but it must be noted and allowed for that some patients’ pain will not permit exercising. Such a programme should not be imposed on people with advanced, disabling arthritis for humanitarian reasons. Also the quality of dietician training is key as patient’s seeking advice/support very often get somewhat rudimentary advice.
68	Arthritis Care	Statement 5	We also call for every patient with osteoarthritis to be given a formal annual Care Plan. The progress of individuals can then be reviewed against the requirements of the Care Plan.
69	Dietitians In Obesity Management	Statement 5	We agree with the principles of regular review and also agree with the specific criteria suggested for those who may require annual review. We do not support the need for annual review in all patients with OA.
70	Primary Care Rheumatology Society	Statement 5	PCRS agreed that there should be an annual review for adults with osteoarthritis. However, there was concern that there is not the capacity in the GP workforce to undertake this at the current moment and also concern that the level of education and knowledge about osteoarthritis would need to be improved.
71	The Chartered Society of Physiotherapy	Statement 5	We would suggest reviewing this quality statement. As it stands, it would generate potentially millions of extra appointments within general practice and due to the fluctuating natural history of OA may not be appropriate at the time. It should be more in line with current thinking for patients to be supported in self-management and to seek help when it is necessary. This aim could be supported by the provision of quality, evidenced-based material such as decision aids (sdm.rightcare.nhs.uk) and prompt access to health professionals for advice and treatment when necessary. To ensure that appropriate patients are offered an annual review, consider the use of a rick scoring matrix to assess for need for annual review. For example, scoring on severity, number of joints affected, level of analgesia, employment, levels of activity, mood etc. to determine how regularly they should be reviewed.
72	Royal College of General	Statement 5	Where is the evidence that bringing patients back for a review makes any difference?

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	Practitioners		"Adults with osteoarthritis that causes symptoms such as pain or stiffness are offered an appointment (usually with their GP) to review their condition. If their joint pain is causing problems, more than 1 joint is affected, they have other health problems or they are taking regular medication for their osteoarthritis they should be offered an appointment annually". Where is the evidence that this use of GP time will have any impact on outcome? The emphasis is on education and self management, exactly. So let adult patients self-manage their condition rather than impose arbitrary annual reviews.
73	Royal College of General Practitioners	Statement 5	Holistic review A holistic review for adults with osteoarthritis should include: • monitoring the person's symptoms and the ongoing impact of the condition on their everyday activities and quality of life • monitoring the long-term course of the condition • discussing the person's knowledge of the condition, any concerns they have, their personal preferences and their ability to access services • reviewing the effectiveness and tolerability of all treatments • support for self-management. Where is the evidence that any of this will alter outcome? Regarding treatments, do we actually have any true treatments? Lets not kid ourselves, we have a number of approaches that palliate but do not treat. Osteoarthritis.
74	Grünenthal Ltd	Statement 5	With regard to Quality Standard 5; in order to support improvement, rather than check that a date for a holistic review has been agreed, a better measure would be confirmation that a holistic review takes place regularly and that the support for the patient is modified based on the documented outcome of the review.
75	Grünenthal Ltd	Statement 5 – Question 4	An 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. Guidelines on the management of other long term conditions such as diabetes mellitus, cardiovascular disease and chronic obstructive pulmonary disease in the NHS already include the annual frequency of patient follow-up. The introduction to this Quality Standard highlights that currently osteoarthritis is managed as a recurrent acute condition and not in the same way as other chronic conditions. In order to be consistent and equitable, people with OA should also be offered the opportunity for an annual review.
76	BOA PLG	Statement 5 – Question 4	Q4 - I don't really see why. Some cases of arthritis can remain stable for years whilst others progress rapidly. I think it would be a gross waste of time and resources to review annually though patients should be advised clearly to re-attend if their symptoms get worse
77	Royal College of Nursing	Statement 5 – Question 4	Yes, we believe that an annual regular review is required.
78	British Society for	Statement 5	In relation to quality statement 5 on an annual holistic review, the BSR suggests that this should take place in primary

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	Rheumatology	– Question 4	care. It should be noted that not all patients will require an annual review, but certainly those receiving pharmacological intervention should be subject to an annual review. It is also important that patients be given information on when it is appropriate to seek review.
79	Arthritis Research UK	Statement 5 – Question 4	*For draft quality statement 5: Do you agree there should be an annual review for adults with osteoarthritis that meet the specific criteria?* We are supportive of the need for a review of patients with symptomatic osteoarthritis. This needs to be seen as part of any holistic review of patients with one or more long-term condition. Given the fluctuant nature of symptoms osteoarthritis, the frequency of the review should be determined more on symptom severity and response to treatment rather than arbitrary review timescales. This topic is explored further in the 2014 Arthritis Research UK publication Care planning and musculoskeletal health.
80	British Association of Prosthetists & Orthotists (BAPO)	Statement 6	There is a passage listing non-surgical treatments. Here 'aids and devices' is mentioned. BAPO suggest that this should be replaced like the above with 'suitable footwear, orthotic devices (such as insoles and braces) and assistive devices (such as walking sticks)' so as to provide greater clarity as to potential interventions.
81	Oxford Health NHS Foundation Trust	Statement 6	"You and your healthcare professional should discuss possible referral for joint surgery before your symptoms and pain becomes so bad that you find it hard to carry out your day-to-day activities." *(CG177, Information for the public)* My comments are Which healthcare professional are they referring to the GP/Surgeon? I would prefer this to read "You and your healthcare professional should discuss possible referral to surgeon/specialist to discuss joint surgery ----------"
82	The Chartered Society of Physiotherapy	Statement 6	Consider re-wording to include discussion with GPs or other appropriate healthcare professionals. Many people with OA are now managed in physiotherapy/other services so it may be more appropriate to include other healthcare professionals, as it is often interface services that make these onward referral decisions in line with shared decision making.
83	Royal College of General Practitioners	Statement 6	If I read this correctly you are suggesting that it would be a useful effort to measure how many times patients who are bad enough to consider joint surgery discuss joint surgery. Is this what primary care has come to?
84	Royal College of General Practitioners	Statement 6	What joints? What surgery? The availability of specialist surgical services varies across the country. Much better to look at standardisation of this in terms of commissioning.
85	BOA PLG	Statement 6	Some indication should be given that there is a point beyond which NO pharmaceuticals will control the pain. At this point, ever increasing amounts of narcotics is not the answer, only surgery is.
86	BOA PLG	Statement 6	"Ultimately it is the person with osteoarthritis who is best placed, with appropriate support and advice, to decide whether surgery is likely to be beneficial" often patients are so scared of the surgery they are unable to make this decision. I have created a scoring chart that has enabled many individuals to more accurately score their own quality of life and thereby make this decision. Bone Smart questionnaire created by Josephine Fox below

ID	Stakeholder	Statement No	Comments[1]

Score chart: how bad is my arthritic knee?

This chart is compiled using information from various official scoring tools such as can be found on www.orthopaedicscore.com It can be useful to hand the completed form to your surgeon when you are explaining the impact of your arthritic joint on your life style. If you have some months before you plan to seek medical advice, perhaps complete a new one every 4-6 weeks to track progress.

↓ Scoring in column 1 = **1** totally unimportant to **5** being extremely important		**1**	**2**	**3**	**4**
This is important		**Can do this with ease**	**Can do with some difficulty**	**Can do with much difficulty**	**Unable to do at all**
	Getting on and off the toilet				
	Washing 'difficult to reach' places				
	Getting in and out of bath / showering				
	Putting on socks and shoes				
	Crouching				
	Kneeling on the floor				
	Stairs; going up and down				
	Sleeping				
	Work: concentration, performance				
	Driving				
	Light cleaning: just a quick dust around				
	Heavy cleaning: house, cupboards, defrosting freezer				
	Changing bed linen				

ID	Stakeholder	Statement No	Comments[1]

	Family meal prep					
	Clearing up the kitchen					
	Laundry: collecting, putting in machine, getting out, hanging out and sorting					
	Putting out rubbish (trash) into wheelie bins					
	Putting out wheelie bins for collection					
	Looking after baby/children/grandchildren					
	Playing with baby/children/grandchildren					
	Sex					
	Cleaning windows					
	Cleaning car					
	Keeping garden tidy					
	Recreational gardening: weeding, digging, planting					
	Visiting friends					
	Going out for a meal					
	Recreational shopping					
	Holidays/vacations					
	Walks, short: short trip down the garden and back					
	Walks, long: half a mile or more					
	Hiking, Nordic walking, rock climbing					
	Cycling					
	Swimming					
	Skiing					
	Surfing, waterskiing					

Standing stamina	More than 20 mins	Between 10 and 20 mins	Less than 10 mins	Can't stand at all
What is the longest period you can stand in a queue for?				

<table>
<tr><th>ID</th><th>Stakeholder</th><th>Statement No</th><th>Comments[1]</th></tr>
<tr><td></td><td></td><td></td><td>SCORING
There are 38 activities on this list (excluding the standing score)

The higher your scores in columns 3 and 4, the greater is the impact of your knee on your preferred lifestyle

<table>
<tr><td>Totals</td><td colspan="2"></td></tr>
<tr><td>1</td><td>Can do with ease</td><td></td></tr>
<tr><td>2</td><td>Can do with some difficulty</td><td></td></tr>
<tr><td>3</td><td>Can do with great difficulty</td><td></td></tr>
<tr><td>4</td><td>Unable to do at all</td><td></td></tr>
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</td></tr>
<tr><td>87</td><td>Royal College of Nursing</td><td>Statement 6</td><td>Under equality and diversity considerations- it is stated that age, sex, obesity, smoking and co-morbidities should not be barriers to referral for consideration of joint surgery. People with learning disabilities (LD) are living longer and do suffer with osteoarthritis, therefore we feel LD should not be listed as being a barrier to referral for consideration for joint surgery. LD is not co-morbidity. Please see page 29.</td></tr>
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Stakeholders who submitted comments at consultation

- Arthritis Care
- Arthritis Research UK
- British Association of Prosthetists & Orthotists (BAPO)
- British Orthopaedic Association, Patient Liaison Group (BOA PLG)
- British Society for Rheumatology
- Department of Health
- Dietitians In Obesity Management UK (domUK)
- Digital Assessment Service, NHS Choices

- Grünenthal Ltd
- NHS England
- Oxford Health NHS Foundation Trust
- Primary Care Rheumatology Society
- Royal College of Chiropractors
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Radiologists
- The Chartered Society of Physiotherapy
- The Society and College of Radiographers