NICE National Institute for Health and Care Excellence

# Guidance assessment consultation document for HTG10887 Digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery: early-use assessment

7 July 2026

## Guidance development process

NICE HealthTech guidance evaluates digital technologies, diagnostics and medical devices (including artificial intelligence). It provides evidence-based recommendations about how safe and effective these technologies are, and their cost effectiveness. The guidance supports healthcare professionals and commissioners to ensure that patients get the best possible treatments. NICE aims to promote innovations that meet the needs of patients and the healthcare system.

This guidance has been developed as early-use HealthTech guidance, for HealthTech products that could address an unmet need in the NHS and need more evidence to support routine use.

Find out more on the NICE webpage on HealthTech guidance.

NICE is producing this guidance on digital platforms to support rehabilitation before and after primary elective hip or knee replacement surgery in the NHS in England. The diagnostics advisory committee has considered the evidence and the views of clinical and patient experts.

**This document has been prepared for consultation with the stakeholders.** It summarises the evidence and views that have been considered, and sets out the recommendations made by the committee. NICE

invites comments from the stakeholders for this evaluation and the public. This document should be read along with the evidence.

The committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation?

After consultation:

- Based on the consultation comments received, the committee may meet again.
- If committee meets again it will consider the evidence, this evaluation consultation document and comments from stakeholders.
- The committee will then prepare the final draft guidance, which will go through a resolution process before the final guidance is agreed.

**Note that this document is not NICE's final guidance on digital platforms to support rehabilitation before and after primary elective hip or knee replacement surgery. The recommendations in section 1 may change after consultation.**

More details are available in NICE's HealthTech programme manual.

**Key dates:**

Closing date for comments: 27 July 2026

Second committee meeting: 12 August 2026

# 1 Recommendations

## Can be used during the evidence generation period

1.1 Four digital platforms can be used in the NHS during the evidence generation period as options to support preparation before and rehabilitation after primary elective hip or knee replacement surgery. The technologies are:

- for hip or knee replacement surgery:
  - mymobility
- for hip replacement surgery:
  - GoWellHealth
- for knee replacement surgery:
  - BPMpathway
  - Physitrack.

These technologies can only be used:

- if the evidence outlined in the evidence generation plan for digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery is being generated
- as long as they have appropriate regulatory approval including NHS England's Digital Technology Assessment Criteria (DTAC) approval.

1.2 The companies are responsible for ensuring that data collection and analysis takes place. They must confirm that agreements are in place to generate the evidence. NICE will contact the companies annually to confirm that evidence is being generated and analysed as planned. NICE may revise or withdraw the guidance if these conditions are not met.

1.3 At the end of the evidence generation period (3 years), the companies should submit the evidence to NICE in a format that can be used for decision making. NICE will review the evidence and assess if the technology can be routinely adopted in the NHS.

## More research is needed

1.4 More research is needed on 15 digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery before they can be funded by the NHS. The technologies are:

- for hip or knee replacement surgery:
  - ForPatientApp
  - getUBetter
  - Good Boost
  - Huma
  - Joint Academy
  - moveUP
  - myrecovery
  - Phio
  - PreActiv
  - QuestPrehab
  - Slider
  - Sword Thrive
- for hip replacement surgery:
  - BPMpathway
  - Physitrack
- for knee replacement surgery:
  - GoWellHealth.

## What this means in practice

**Can be used with evidence generation**

The digital platforms in recommendation 1.1 can be used as options in the NHS during the evidence generation period (3 years) and paid for using core NHS funding. During this time, more evidence will be collected to address any uncertainties. Companies are responsible for organising funding for evidence generation activities.

After this, NICE will review this guidance and the recommendations may change. Take this into account when negotiating the length of contracts and licence costs.

**Potential benefits of use in the NHS during the evidence generation period**

- **Access:** Digital platforms allow more consistent and timely access to preparation and rehabilitation programmes for hip or knee replacement surgery. Personalised programmes delivered through digital platforms could improve self-management and may reduce the frequency and duration of face-to-face physiotherapy appointments.
- **System benefit:** Improving self-management may free up access to face-to-face physiotherapy services for people who need them. Monitoring of progress and healthcare professional communication channels within digital platforms may help people escalate to face-to-face physiotherapy more efficiently if self-management does not meet their needs.
- **Clinical benefit:** Randomised controlled trial (RCT) evidence suggests that digital platforms may improve quality of life, joint-specific function, mobility and functional performance, and reduce pain and readmission rates.
- **Resources:** Digital platforms could reduce the number of face-to-face appointments needed and their duration. They may also reduce length of

hospital stay by providing more comprehensive support during preparation for surgery.

- **Equality:** Digital platforms allow people to remotely engage with treatment, which can reduce the barriers relating to geographic variation in physiotherapist availability.

**Managing the risk of use in the NHS during the evidence generation period**

- **Costs:** Early results from the economic modelling show that some digital platforms could be cost effective.
- **Resources:** Implementing digital platforms to support preparation and rehabilitation for primary elective hip or knee replacement surgery could lead to an increase in the number of people needing physiotherapy. This is because it could identify more people who need face-to-face support.
- **Clinical assessment:** Healthcare professionals should check before and after surgery whether self-directed rehabilitation using digital platforms is suitable for the person having a hip or knee replacement. Digital platforms should not replace face-to-face physiotherapy for people who need it.
- **Safety:** Digital platforms have safety features to monitor progress, and to identify poor engagement or potential surgical complications. These can alert healthcare professionals to review the information or suggest to the user to contact their healthcare professional for advice.
- **Equality:** Some people may find it more difficult to use or engage with digital platforms and may need additional support. This includes:
  - people who are less familiar with using digital technologies or who have limited access to equipment or the internet
  - neurodivergent people
  - people with learning disabilities
  - people with visual, hearing or cognitive impairments
  - people who have problems with manual dexterity

- people who have difficulties reading, writing or understanding health-related information (including people who cannot read English).

**More research is needed**

There is not enough evidence to support funding the digital platforms in recommendation 1.4 in the NHS.

Access to these digital platforms should be through company, research or non-core NHS funding, and clinical or financial risks should be managed appropriately.

## What evidence generation is needed

Evidence generation is needed to compare the digital platforms in recommendation 1.1 with standard care in NHS settings. Digital platforms should be used both before and after surgery. More evidence needs to be generated on:

- health-related quality of life
- healthcare resource use, including length of hospital stay, physiotherapy contacts and readmissions
- adverse events
- patient engagement and adherence.

The evidence generation plan gives further information on the prioritised evidence gaps and outcomes, ongoing studies and potential real-world data sources. It includes how the evidence gaps could be resolved through real-world evidence studies.

## What research is needed

More research is needed on the digital platforms in recommendation 1.4 in NHS settings. Research should be comparative and should ideally be in the form of RCTs. The research should study digital platforms used both before and after surgery. The studies should report on:

- health-related quality of life
- length of hospital stay
- adverse events
- patient selection criteria
- escalation to face-to-face physiotherapy
- patient engagement and adherence
- physiotherapist time spent supporting patients.

## Why the committee made these recommendations

Standard care to help people mentally and physically prepare for hip or knee replacement surgery includes advice on exercises, lifestyle changes and self-directed rehabilitation. But the level of support varies. Digital platforms can support preparation for surgery and rehabilitation, and may help recovery from elective hip or knee replacement surgery.

Evidence on the clinical effectiveness of digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery varies and is limited for some platforms. RCT evidence available for some of the digital platforms suggests they could work as well as or better than standard care.

Early economic modelling suggests that the digital platforms may be cost effective. But there are uncertainties in the model, including the assumptions used to estimate health-related quality of life and length of hospital stay.

Assuming no health-related quality of life gain or reduction in length of hospital stay in the model, 4 out of 5 digital platforms with RCT evidence may

be cost effective for hip or knee replacement, or both. So, these digital platforms can be used during the evidence generation period.

For the remaining digital platforms, there is not enough evidence or the available evidence is not certain enough to recommend using these during an evidence generation period for hip or knee replacement, or both. So, more research is needed on these digital platforms.

# 2 Information about the technologies

2.1 This assessment considered 16 digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery. The technologies are designed to be used alongside routine NHS rehabilitation care. They provide support before and after surgery through exercise programmes, symptom check-ins, reminders and educational materials. An overview of the digital platform features is shown in table 1.

**Table 1 Overview of digital platform features**

| Digital platform (company) | Company physiotherapist provision | Healthcare professional communication | Additional features | Programme adjustment |
|---|---|---|---|---|
| BPMpathway (270 Vision) | No | 2-way | Motion sensor | Healthcare professional |
| ForPatientApp (B. Braun Medical Ltd) | No | 1-way | Optional motion sensor | Healthcare professional |
| getUBetter (getUBetter Ltd) | No | None | None | Healthcare professional and user |
| Good Boost (Good Boost Wellbeing Limited) | Yes | 2-way | None | Automatic and healthcare professional |
| GoWellHealth (SHI Global Ltd) | No | 1-way and 2-way | None | Healthcare professional and user |
| Huma (Huma Therapeutics Limited) | No | 1-way and 2-way | Motion tracking | None |

| | | | | |
|---|---|---|---|---|
| Joint Academy (Artho Therapeutics AB) | Optional | 2-way | None | Automatic and healthcare professional |
| moveUP (moveUP NV) | No | 2-way | None | Automatic |
| mymobility (Zimmer Biomet) | No | 2-way | Motion tracking | Automatic |
| myrecovery (HOPCo Ltd) | No | 2-way | Motion tracking | Healthcare professional |
| Phio (EQL Ltd) | Optional | 2-way | None | Healthcare professional and user |
| Physitrack (Physitrack PLC) | Unknown | 2-way | None | Healthcare professional |
| PreActiv (Snow Squared Ltd) | Yes | 2-way | None | Automatic and healthcare professional |
| QuestPrehab (C Digital Healthcare Ltd) | Optional | 2-way | None | Automatic and healthcare professional |
| Slider (AI Rehab Ltd) | Yes | 2-way | Exercise device | Healthcare professional |
| Sword Thrive (Sword Health) | Yes | 2-way | Motion-tracking tablet | Healthcare professional |

## Sustainability

2.2 For information, Carbon Reduction Plans for UK carbon emissions for 2 technologies are published here:

- 270 Vision, BPM Pathway Carbon Reduction Plan
- Snow Squared Ltd, PreActiv Carbon Reduction Plan.

The following companies did not disclose their Carbon Reduction Plan for UK carbon emissions:

- AI Rehab Ltd
- Artho Therapeutics AB
- B. Braun Medical Ltd
- C Digital Healthcare Ltd
- EQL Ltd

- getUBetter Ltd
- Good Boost Wellbeing Limited
- HOPCo Ltd
- Huma Therapeutics Limited
- moveUP NV
- Physitrack PLC
- SHI Global Ltd
- Sword Health
- Zimmer Biomet.

# 3 Committee discussion

The diagnostics advisory committee considered evidence on digital platforms to support preparation before and rehabilitation after primary elective hip or knee replacement surgery from several sources. This included evidence submitted by the companies, a review of clinical and cost evidence by the external assessment group (EAG), and responses from stakeholders. Full details are available in the project documents for this guidance.

## The condition

3.1 Hip and knee joint replacements are the most common orthopaedic operations done in the UK. In 2024, more than 250,000 primary hip and knee replacements were recorded in the National Joint Registry. This figure is expected to rise as the population ages and the prevalence of osteoarthritis rises. The demand for hip and knee replacements places a substantial burden on NHS services, including surgical capacity, inpatient beds, and physiotherapy and community support.

## Current practice

3.2 Before surgery, NICE's guideline on primary hip, knee and shoulder joint replacement recommends that people are given advice on:

- exercises to do before and after surgery that will aid recovery
- lifestyle, including weight management, diet and smoking cessation
- maximising functional independence and quality of life before and after surgery.

3.3 Before being discharged from hospital, the guideline recommends that a physiotherapist or occupational therapist should give advice on self-directed rehabilitation. It also recommends that people have a clear understanding of the importance of rehabilitation and that they have a point of contact for advice and support. Supervised outpatient rehabilitation is only recommended for people 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.

## Unmet need

3.4 Clinical experts said that, as seen in Getting It Right First Time's Orthopaedic Elective Surgery guide to delivering ambulatory perioperative care for joint replacement surgery (2023), access to pre-surgical in-person 'joint schools' has reduced since the COVID-19 pandemic. So, the level of support for people to mentally and physically prepare for surgery and rehabilitation is variable. After surgery, many people are discharged with written exercise instructions or links to exercise videos. But many do not receive routine in-person follow-up from physiotherapy services unless self-directed rehabilitation is not suitable or does not meet their rehabilitation goals. These exercise videos or paper-based instructions do not provide individualised support or track progress,

and they rely on patient-initiated follow up if they need more support or have concerns.

3.5 Digital platforms can provide personalised rehabilitation support and education that may help preparation for, and recovery after, surgery. Platforms can track progress, give feedback, provide alerts to users if they need to seek additional clinical support, and provide a consistent route of communication between patients and healthcare professionals. They are used remotely and when convenient for the user, which can support people who may struggle to attend face-to-face services. These platforms may increase confidence in self-directed rehabilitation, maintain motivation to complete rehabilitation tasks, and improve recovery.

## Innovative aspects

3.6 The technologies include a range of features that can offer different benefits. Some platforms include or have an option for a company-provided physiotherapist who can monitor user progress and provide clinical input when needed. Many platforms include 1- or 2-way channels for communication with a healthcare professional. Most platforms have rehabilitation plans that can be adjusted to suit the needs of the user. Some of these are automated or artificial intelligence (AI)-supported based on user feedback. Many platforms include tools that may support progress tracking, such as dashboards, symptom-monitoring questionnaires, automated engagement prompts, and red-flag systems. Some technologies also integrate optional wearable sensors or motion trackers to provide range-of-motion measurements and feedback on exercise form.

## Clinical effectiveness

### Evidence base

3.7 Evidence relevant to the decision problem was identified for 13 out of 16 technologies, as summarised in table 2.

**Table 2 Highest quality evidence identified for each digital platform for total hip replacement, total or partial knee replacement, and mixed indications**

| Digital platform | THR | TKR or PKR | Mixed indications |
|---|---|---|---|
| BPMpathway | No evidence | RCT | No evidence |
| ForPatientApp | No evidence | Single-arm study | No evidence |
| getUBetter | No evidence | No evidence | No evidence |
| Good Boost | Single-arm study | Single-arm study | No evidence |
| GoWellHealth | RCT | Non-randomised comparative study | Single-arm study |
| Huma | No evidence | No evidence | No evidence |
| Joint Academy | No evidence | No evidence | Single-arm study |
| move UP | No evidence | No evidence | Single-arm study |
| mymobility | RCT | RCT | Single-arm study |
| myrecovery | No evidence | No evidence | Non-randomised comparative study |
| Phio | No evidence | No evidence | Single-arm study |
| Physitrack | No evidence | RCT | No evidence |
| PreActiv | No evidence | No evidence | Single-arm study |
| Quest Prehab | No evidence | No evidence | No evidence |
| Slider | No evidence | Non-randomised comparative study | No evidence |
| Sword Thrive | RCT | RCT | No evidence |

Abbreviations: PKR, partial knee replacement; RCT, randomised controlled trial, THR, total hip replacement; TKR, total knee replacement.

3.8 The primary outcomes were:

- health-related quality of life
- pain and joint-specific function
- meaningful function and participation in daily living

- confidence in recovery and self-management
- mobility
- functional performance
- face-to-face clinical review.

Evidence was identified for all primary outcomes except for escalation to face-to-face clinical review.

3.9 The committee acknowledged the range of study designs outlined in the evidence base and the conclusions of the EAG. The EAG's conclusions were that, while there was no clear and consistent benefit of digital platforms on any primary outcomes, the evidence indicated that some digital platforms may be equal or superior to current practice. It felt that RCT evidence provided the most methodologically robust findings and that other study designs did not provide enough good quality evidence to justify an evidence generation recommendation. In particular, the committee did not think that evidence from single-arm studies was useful for decision making. This is because it did not think that it was possible to determine if the changes in clinical outcomes were a result of the digital platform used. The committee agreed that digital platforms with RCT evidence for either total hip replacement or total knee replacement could be used for further evidence generation in the joint in which the RCT was done, provided they were cost effective under pessimistic assumptions. It stated that comparative studies, ideally RCTs for digital platforms without this evidence, with a comparator that reflects current practice in the NHS are a priority for further research.

## Evidence limitations

3.10 The committee noted that generalisability of the evidence to current NHS practice is a key limitation. This is because of the difficulty interpreting the comparative evidence because some studies had

comparators that were standard care in the NHS, or similar, but most were compared with in-person physiotherapy. Clinical experts confirmed that access to face-to-face physiotherapy after leaving hospital is variable. They estimated that around 50% of people with a total knee replacement and 90% of people with a total hip replacement receive information to self-manage their recovery with no face-to-face physiotherapist support. The committee acknowledged that the higher intensity of physiotherapy used in many comparator arms, compared with standard care in the NHS, meant that the effects of digital platforms have the potential to be replicated if used in the NHS. But it stated that well-conducted comparative studies done in an NHS setting should be prioritised for further evidence generation.

3.11 The committee noted that the same digital platform would be offered before and after surgery. It acknowledged that many studies used digital platforms either before or after surgery, but not both before and after. The committee was unable to determine how studies on digital platforms used only before or after surgery would translate into the NHS. It said that this was because the degree to which the before and after surgery elements of the platforms contributed to potential benefits was uncertain. It concluded that evidence generation needs to capture the use of digital platforms both before and after surgery to replicate how the platforms would most likely be used in the NHS.

3.12 The committee noted that most of the evidence was on total knee replacement, with limited evidence on partial knee replacement and total hip replacement. Most of the evidence came from studies including mixed indications, with no evidence on hip resurfacing. Clinical experts estimated that around 10% to 20% of knee replacement procedures are partial, and that around 1% to 2% of hip replacement procedures are resurfacing procedures. They

noted that the care pathways for all hip and knee replacement procedures are similar. But they said that the populations, recovery times and recovery expectations differ between each. The committee agreed that evidence for total knee replacement could be transferred to partial knee replacements and that evidence for total hip replacements could be transferred to hip resurfacing procedures. But it concluded that evidence for total knee replacement was not transferable to total hip replacement. So, the committee split the recommendations by hip and knee replacement, making recommendations for use with evidence generation based on the RCT evidence available per joint.

## Adverse events and patient safety

3.13 The committee discussed the risks of using digital platforms. It was concerned by the lack of adverse-event data because most studies did not report this outcome. Experts stated that the main types of complications after surgery are:

- acute surgical complications and medical complications, which happen in 1% to 2% of cases
- escalating rehabilitation needs after surgery, which is more common.

Although digital platforms have red-flag mechanisms to direct people to seek further clinical support, the committee was concerned that digital platforms could reduce contact with healthcare professionals, which could risk complications being missed. The committee agreed that data on adverse events was a priority for evidence generation.

## Ongoing studies

3.14 The committee acknowledged that there were 15 ongoing studies for 11 digital platforms, with the EAG considering 7 of them being

likely to address key evidence gaps. Of the ongoing studies, there are 7 RCTs. Four RCTs are investigating digital platforms that had no RCTs identified in the evidence review (Good Boost, Joint Academy, moveUP and Slider). Five RCTs are being done in the UK, or include UK sites (BPMpathway, Good Boost, Joint Academy, Slider and Sword Thrive). The committee considered this when making its recommendations and agreed that ongoing research could address its concerns regarding the clinical and cost effectiveness of some digital platforms.

## Patient perspectives

3.15 The results of a user survey, and 1 patient organisation submission, were presented to the committee alongside commentary from 2 people or carers of people who have had knee or hip replacements. Common themes across all sources were that digital platforms provide flexibility for users, may improve mental and physical preparation for surgery and can empower people to manage their rehabilitation. Concerns included the:

- widening of health inequalities for people unable to access or use digital platforms
- potential additional burden on carers supporting the use of digital platforms
- isolation from healthcare professionals.

All sources strongly stated that digital platforms should not replace face-to-face physiotherapy for people who need it. The committee agreed that while digital platforms may be beneficial for some people, they are not suitable for everyone. The committee said that NHS trusts using digital platforms should have mechanisms in place for users to access support when needed. Experts confirmed that in current practice people would be screened to check if self-directed rehabilitation is suitable

both before and after surgery and that this would be the same for the use of digital platforms. Overall, the committee concluded that patient selection criteria is a priority for further research.

## Cost effectiveness

### Early economic model

3.16 The EAG developed a decision-tree economic model for total hip and knee replacements with a 1-year time horizon. It compared digital platforms with standard care in the NHS for a 'generic' digital platform in the base case as well as the optimistic and pessimistic scenarios for each digital platform. The optimistic scenario used the claimed benefits of the technology for each input when available, or the base case values if there was no evidence. It assumed a reduction in length of hospital stay and a gain in quality-adjusted life years (QALYs). The pessimistic scenario assumed that no reduction in length of stay or QALY gains would occur with digital platforms. The committee acknowledged from the EAG assessment that all digital platforms were cost effective for both total hip and total knee replacement at a willingness to pay threshold of £20,000 per QALY gained in the optimistic scenario. Under pessimistic assumptions, BPMpathway, ForPatientApp, Good Boost, GoWellHealth, moveUP, mymobility, myrecovery and Physitrack remained cost effective for both total knee and total hip replacements. PreActiv remained cost effective for total knee replacement, but not total hip replacement.

### Model uncertainties

3.17 The committee was cautious about the assumptions used to inform the model, specifically the:

- non-platform-specific use of clinical parameters
- weak evidence when platform-specific evidence was used in addition to the use of expert assumptions.

The committee was uncertain whether the inputs were robust enough to support decision making based on cost effectiveness. But the committee acknowledged that it is an early model and that evidence generation is needed to provide robust outcome measures for each technology to inform future modelling. Because the model inputs were highly uncertain, the committee used the most conservative scenario in its decision making. It concluded that digital platforms that had RCT evidence for the joint, and were cost effective under pessimistic assumptions, can be recommended for use while further evidence is generated.

3.18 The committee discussed the plausibility of the QALY input used in the model. The model incorporated a QALY gain of 0.035 with digital platforms based on a non-randomised comparative UK study of 1,160 people having total knee replacement. The committee noted that although the evidence was the most generalisable to the NHS, the non-randomised and retrospective study design and large amounts of missing data introduced uncertainty into the robustness of the QALY gain. The committee was also concerned that the health-related quality-of-life outcomes were variable between identified studies, with some non-UK randomised trials finding no health-related quality-of-life benefit with digital platforms. The committee acknowledged that non-UK evidence was limited by the generalisability of the comparator. It was not confident in the robustness of the QALY estimates and whether the digital platforms would result in any QALY gain. As a result, it preferred the pessimistic scenario which omitted QALY gains with digital platforms. It concluded that evidence generation is needed on health-related quality of life from comparative studies done in the NHS.

3.19 The committee discussed the plausibility of the 0.5-day reduction in length of stay used in the model base case and optimistic scenario. It heard that the estimate was based on several non-randomised studies, which generally reported small reductions in length of stay, and clinical expert opinion. The committee acknowledged that length of stay is a key driver in the model but that a sensitivity analysis showed that platforms could still be cost effective if there was no reduction in length of stay in the base case. The committee also noted the Getting It Right First Time Orthopaedic Elective Surgery guide to delivering ambulatory perioperative care for joint replacement surgery (2023) which states that 'a stay of 0- or 1-night is the default expected'. The committee agreed that this might affect the potential benefit of digital platforms on length of stay in the future. Overall, the committee was not confident that using digital platforms would result in any reduction in length of stay. So, it preferred the pessimistic scenario which omitted length of stay reductions with digital platforms.

3.20 The committee understood that patient engagement and adherence to digital platforms was not included in the model because of inadequate evidence. The committee was concerned that not modelling adherence could impact the cost effectiveness of the technologies, especially because the limited evidence available suggested low compliance with digital platforms. But, the committee acknowledged that this is an early model and that adherence is a concern across all digital technologies. The committee concluded that patient engagement and adherence is a priority for evidence generation.

## Equality considerations

3.21 The committee agreed that some people may struggle to use digital platforms, including people:

- who are less familiar with using digital technologies or who have limited access to digital hardware or the internet
- with lower levels of digital literacy
- with difficulties reading, writing or understanding health-related information (including people who cannot read English).

Patient experts highlighted that the burden of using digital platforms can fall to carers of people having hip or knee replacement, with additional support needed to access and engage with the platforms. The committee acknowledged that digital platforms could reduce regional inequalities in care provision by providing more consistent access to remote support, mitigating the effect of long waiting list times and limited access to in-person physiotherapy. But, digital platforms should not prevent access to face-to-face physiotherapy for those that need it.

# 4 Committee members and NICE project team

This topic was considered by NICE's diagnostics advisory committee, which is a standing advisory committee of NICE.

Committee members are asked to declare any interests in the technology to be evaluated. If it is considered there is a conflict of interest, the member is excluded from participating further in that evaluation.

The minutes of each committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

## Chair

**Tom Clutton-Brock**

Chair, diagnostics advisory committee

## NICE project team

Each evaluation is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the evaluation), a technical adviser, a project manager and an associate director.

**Toby Sands**

Technical lead

**Charlotte Pelekanou**

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