Type	Stakeholder	Order No	Document	Page No	Section No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	ArjoHuntleigh	1					This organisation was approached but did not respond	
SH	Arrhythmia Alliance	2					This organisation was approached but did not respond	
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.00	Full	General	General		Given the lack of evidence available to review, the document gives a good commonsense baseline of guidelines. There is a structured rehabilitative model of practice with clearly identified points of intervention for assessment and evaluation. Whilst it would have been helpful for new services to have had some identified standardised assessments, as a means of measuring outcomes, hopefully this will be the case when the document goes under review in the future and more evidence becomes available.	Noted.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.01	Full	54	2.4.2	1334	It would be beneficial and important to include the study by Morris et al entitled Early intensive care unit mobility therapy in the treatment of acute respiratory failure CCM 2008 to help provide more substantial evidence to show that Physiotherapy / early rehab can decrease ITU LOS and hospital LOS?	The study has been included as indirect evidence. See section 2.2.2
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.02	Full	12	1.1.4	294	Would this be a national booklet like the Heart manual – cost implications	It is outside the remit of this guideline to provide recommendations on service delivery models or service

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								configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.03	Full	16	1.1.9	378	Would the primary care team know enough about the hospital stay if its meant to be a team approach, how can we ensure all the information is handed over	In recommendation 1.1.21 we deal with arrangements that should be put in place prior to discharge and stress the need to forward all discharge documents to primary care.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.04	Full	14	1.1.6	331	Much reference is made to follow up rehabilitation services in the community. Are the relevant parties aware of this, as the waiting lists for these services are long and very borough/PCT dependent. The feeling is that although this is a good idea, it may not be entirely feasible. These services are generally only	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this

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							available to more dependent patients, whereas we are looking to rehabilitate our critical care patients to there maximal functional level. Could we not therefore recommend physical rehabilitation similar to that offered to patients following cardiac surgery	particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.05	Full	6	1.1.1 and foreword	143 and 255	Coordination by suitably trained and experienced health care professionals' - Intensive Care Physiotherapists are ideally placed to provide coordination; - ITU physios commonly crossover to the wards, providing unique experience, expertise and continuity of care to patients.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.06	Full	7 and 33	Foreword and 2.2.3i	183 and 708	'…lack of detailed understanding of the pathophysiology of…. muscle wasting' I feel it is worth giving particular attention to Critical Illness Polyneuropathy and Myopathy (CIPNM) due to their high incidence and potentially profound clinical implications. Ref: Ricks E. Critical Illness polyneuropathy and myopathy: a review of evidence and the implications for weaning from mechanical ventilation and	The Foreword has been re-edited.

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							rehabilitation. Physiotherapy 2007;93:151-156 CIPNM risk factors (sepsis/SIRS and MODS) provide a useful indicator for stratifying likely risk of developing physical morbidity.	
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.07	Full	10	1.1.2 and 1.1.5 table 1	252	measures to prevent avoidable physical and non-physical morbidity. There must be provision within the NICE guideline ensure there is adequate funding for provision of service from other professions such as OT, dietetics, mental health. Without this, the recommendations made simply cannot be met effectively. Table 1 indicates a clear need for early intervention from OT's, which is commonly unavailable due to inadequate funding for provision of this service.	The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.08	Full	14	1.1.6	331	Most trusts do not have provision to provide ongoing rehabilitation in the community for this group of patients. Appropriate referrals are likely to be impossible within the constraints of current service provision.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up

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								services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.09	Full	15, 16 and 34	1.1.7 and 1.1.9 and 2.2.3v	339, 378 and 765	- 2-3 month follow-ups must be practicably accessible to all patients (with the acknowledgement that this can be a self-selecting group with selection bias). - It is likely that some patients will need to be visited at home, ideally by the professional coordinating the patient pathway since their admission to ICU. - It would not be ideal to hand over the 2-3 month follow-up to 'primary/community care' as this provides no continuity of care or availability of expertise to the patient at this time. In order to effectively implement the rehabilitation care pathway, primary and secondary care providers must be required to work cooperatively to ensure adequate provision of continuous service.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care	3.10	Full	57	2.4.3ii	1413	'the GDG envisaged a 'core team' with other members joining intermittently, for example therapists…'	It is outside the remit of this guideline to provide recommendations on service

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	(ACPRC)						I strongly feel that therapists input and/or leadership must be continuous, throughout the rehabilitation pathway, not intermittent.	delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.11	Full	76	3.1	1955	There's an incomplete reference on p.76. It should be Chiang L, Wang L, Wu C et al (2006) Effects of physical training on functional status in patients with prolonged mechanical ventilation. /Phys Ther/, 86, 1271-1281.	This has been corrected.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.12	Full	general	general		It is surprising that Physiotherapists are not specifically mentioned in this guideline as they play an important role in the rehabilitation of patients in critical care, I see this as a wasted opportunity to develop our role in the icu and in the	The GDG had 2 physiotherapist members and the importance of physiotherapy for this group of patients is made clear in the guideline.

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							follow up programmes. To lump us together with other health professionals shows a lack of understanding of our current role with these patients. Patients deserve Physiotherapists with their knowledge of anatomy/pathology and physical examination would be ideally place to deliver much of what is being recommended but I see our skills being largely ignored and a push for new clinical specialist nurses to be created at our professions and the patients expense	It is, however, outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.13	Full	general	general		Centrally generated document for every profession would ensure seamless transfer of care	Noted.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.14	Full	general	general		Is there enough emphasis on the physical side of rehabilitation?	The GDG considered that current recommendations appropriately cover the physical side of rehabilitation.
SH	Association for Chartered Physiotherapists in	3.15	Full	general	general		How is the issue of coordination going to be addressed?	It is outside the remit of this guideline to provide

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	Respiratory Care (ACPRC)							recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.16	Full	10	1.1.1.	247/8	Rather than locally defined assessment tools, centrally generated assessment tools so that they can be transferred between regions/hospitals.	Due to a lack of evidence of their test performance, the recommendation of the 'locally defined tools' has been taken out. Detailed discussion on screening and assessment please see section 2.1.3 (evidence statements) and section 2.1.4 (evidence to recommendations).
SH	Association for Chartered Physiotherapists in Respiratory Care	3.17	Full	15	1.1.7	343-7	Physiotherapists should be involved in the r/v clinics	It is outside the remit of this guideline to provide recommendations on service

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	(ACPRC)							delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.18	Full	66	2.6	1698 - 1701	What information is most important to collate in the diaries?	Due to a lack of evidence of effectiveness, the GDG considered that the guideline should not make specific recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.19	Full		2.5,2.6		All the studies used are looking at ICU to ward, or patient diaries, not ward/rehab discharge home	Please see section 2.3.3 (evidence statements) for clarification.
SH	Association for Chartered	3.20	Full	4 and	2 and 4	81 &	Re: post traumatic stress 'phenomena' –	Noted. We are clear about this

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	Physiotherapists in Respiratory Care (ACPRC)			24		559	this is not a diagnosis, whereas post-traumatic stress disorder is.	distinction in line 559.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.21	Full	12	1.1.4	287	Footnote 4 – I wonder if the healthcare professionals need to be defined, i.e. appropriately skilled clinical psychologist and physiotherapist.	We have emphasised that the individual needs to have the appropriate skills, but consider specifying particular health care professions is outside the remit of this guideline as this would constitute recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Association for Chartered Physiotherapists in Respiratory Care	3.22	Full	13	1.1.5	318	psycho-social problems' – if these are different from the list above, perhaps they should be defined.	We have provided examples of psycho-social problems in Table 2.

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	(ACPRC)							
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.23	Full	15	1.1.8	357	'Give reassurance...' – this tends to be over-used and inaccurately used in hospital. I would suggest that accurate information might be more suitable.	Changes have been made in recommendation 1.1.13 to address this point - , the term 'reassurance' has been taken out and replaced with 'support'.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.24	Full	16	1.1.10	388	With suitable safeguards in relation to confidentiality in the case of a competent patient.	Rational for this is explained in footnote 6.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.25	Full	34	2.2.3	740-742	If physiotherapists were not consulted, this would limit the usefulness of the document.	The GDG had physiotherapy and OT membership and these contributed. The text has been re-worded to address this.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.26	Full	General	General		Perhaps there could be more on prevention. As well as medication, other risk factors are being talked over, having things done without warning, etc etc. I have worked in ICU's with follow-up clinics but no awareness of preventive care.	Noted.
SH	Association for Chartered Physiotherapists in Respiratory Care (ACPRC)	3.27	Full	General	General		Physiotherapy does not seem to be mentioned specifically, which is slightly odd in a paper on rehabilitation. One contribution of physiotherapy would be the importance of rest and sleep, as this is often lacking in critical care and is essential to rehabilitation.	We have revised the text to address this point. Please section 1.3.3 (Using this guideline) for the definition of Rehabilitation.
SH	Association of Catholic Nurses of England and Wales	4					This organisation was approached but did not respond	
SH	Association of the British Pharmaceuticals Industry (ABPI)	5					This organisation was approached but did not respond	
SH	Atrial Fibrillation Association	6					This organisation was approached but did not respond	

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SH	Barnsley Hospital NHS Foundation Trust	7					This organisation was approached but did not respond	
SH	Barts and The London NHS Foundation Trust	8					This organisation was approached but did not respond	
SH	Birmingham & the Black Country Critical Care Network	9					This organisation was approached but did not respond	
SH	Boehringer Ingelheim Ltd	10					This organisation was approached but did not respond	
SH	Bournemouth and Poole PCT	11					This organisation was approached but did not respond	
SH	Bradford Teaching Hospitals NHS Foundation Trust	12					This organisation was approached but did not respond	
SH	British Association for Counselling and Psychotherapy	13					This organisation was approached but did not respond	
SH	British Association of Cardiac Rehabilitation	14					This organisation was approached but did not respond	
SH	British Association of Critical Care Nurses	15					This organisation was approached but did not respond	
SH	British Dietetic Association	16					This organisation was approached but did not respond	
SH	British Geriatrics Society	17					This organisation was approached but did not respond	
SH	British Heart Foundation	18					This organisation was approached but did not respond	
SH	British National Formulary (BNF)	19					This organisation was approached but did not respond	
SH	British Orthopaedic Association	20					This organisation was approached but did not respond	
SH	British Pain Society	21.00	Full	General	General		We appreciate the extensive scope of this guideline and are pleased that pain is recognised as a problem about which enquiries should be made before discharge from critical care or discharge	The prevention and early recognition of pain are outside the scope of this guideline. We have, however, flagged pain up as appropriate in the recommendations

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							home. However, we feel more emphasis should be placed on the prevention and early recognition of pain. Also the assessment and treatment of pain should be specifically included in recommendations for follow up consultations.	(e.g., 1.1.2 footnote 2).
SH	British Pain Society	21.01	Full	General	General		Enquiries with colleagues undertaking critical care follow up clinics suggest that pain is • A common symptom following critical care admission • Often of a chronic and possibly neuropathic nature • May be as a result of prolonged ITU stay (neuropathy) and/or as a result of the original trauma or surgery • Frequently needs referral to a specialist pain clinic • Associated with depression; pain may contribute depression or depression may be due to pain None of the above are reflected in the narrative of the guideline.	Please see footnote 2, where stated that pain is part of the physical morbidity.
SH	British Pain Society	21.02	Full	10	1.1	232	Poor analgesia in the early or acute phase is implicated in the development of central nervous system 'wind up' which may go on to produce related chronic pain syndromes [1]. Levels of analgesia may be inadequate in patients in whom non-analgesic sedation is also being used either alone or in combination with analgesic sedatives. Measures must be	Noted and thank you.

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							taken to ensure adequate analgesia including where appropriate the use of regional anaesthetic techniques even in sedated patients. Assessment methods for monitoring analgesia in sedated patients have been described [2]. 1] Macrae WA. Chronic pain after surgery. Br J Anaesth. 2001; 87: 88-98 2] Summer GJ, Puntillo KA. Management of surgical and procedural pain in a critical care setting. Crit Care Nurs Clin North Am. 2001; 13: 233-42	
SH	British Pain Society	21.03	Full	10	1.1	232	Input from the Acute Pain team should be welcomed and encouraged at all times in the critical care admission of a patient to facilitate • Better acute pain management during sedation and recovery. • Better management of pre-existing chronic pain problems. • Early recognition and treatment of neuropathic pain in association with surgery or trauma. • Seamless follow up of patients through the rest of their hospital stay, post critical care, on the ordinary wards • Early pain clinic follow up if indicated.	'Pain' has been included as part of the physical morbidity throughout all recommendations to address this point. Please see footnote 2.
SH	British Pain Society	21.04	Full	11	1.1.3	259	Opioid withdrawal is a common problem following critical care admission. Specific consideration, and a structured weaning programme if appropriate, should be in place prior to discharge to the wards.	The management of opioid withdrawal is outside the scope of the guideline.

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SH	British Pain Society	21.05	Full	23	2.1.1	535	Avoiding contractures, as well as joint pain, is important. Passive, and where possible active, limb and spine mobilisation should be routine practice with physiotherapy support.	The recommendations do not go into the specific details of which specific physiotherapy interventions should be offered. This is appropriate as the guideline does not address the detailed management of specific diseases or conditions.
SH	British Pain Society	21.06	Full	15	1.1.7	338	A Pain assessment including site, nature, duration, triggers and disability due to pain should be undertaken at all follow up consultations.	Noted. The need to consider pain is flagged up in the footnote to 1.1.2.
SH	British Pain Society	21.07	Full	15	1.1.7	338	Clinicians undertaking these clinics should be able to recognize pain with neuropathic components and should be prepared to initiate treatment on their own or on the basis of immediate advice from a pain colleague (which may be a nurse).	Assessment and treatment of neuropathic pain is outside the scope of this guideline and the pharmacological management of neuropathic pain is in development as a short clinical guideline.
SH	British Psychological Society, The	22.00	Full	General	General		The explicit and detailed consideration of psychological aspects of care in Critical Illness Rehabilitation is very welcome in this document .This is exemplified particularly by the recommendations relating to Communication/Information giving[1.1.10] and Continuity/Coordination of care [1.1.9] as well as by the specific recommendations concerning psychological assessment/screening issues and interventions/treatment approaches.	Noted.
SH	British Psychological Society, The	22.01	Full	General	General		The Guideline recognises and acknowledges the as yet limited and varied quality of evidence available on	Noted.

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							which to draw conclusions concerning the psychological aspects of care in this context. It takes an appropriately 'cautious' view where recommending how psychological assessments and measurements should be used. It could perhaps usefully further emphasize that in addition to data obtained at recommended times for clinical assessments of non-physical morbidity, trends /patterns of psychological functioning within the individual may be important to consider when planning future care.	
SH	British Psychological Society, The	22.02	Full	75	2.7	1903 …	Research recommendations appropriately emphasize the need to examine and either replicate or alter the optimal timing of assessments and rehabilitation interventions depending on outcome of future studies. They usefully draw attention to the need to evaluate interventions to manage PTSD and related psychological conditions [76 1927] Could they also identify the value of research to improve communication/information giving strategies? [see examples below].	All the research recommendations have been reviewed by the GDG and re-drafted. .
SH	British Psychological Society, The	22.03	Full	17		399	While there is research data to indicate that repetition of healthcare information may improve recall /comprehension the optimal timing of this, the optimal modality used for this repetition and the ways to assess success in the process do not appear to have been carefully researched in this context. Should this be included in the research goals?	The GDG did not consider this question as a priority for research.
SH	British Psychological	22.04	Full	9		213	Would the BPS documentation/guidelines	The Mental Capacity Act (2005) has

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	Society, The						relating to the psychological aspects of assessing Capacity be of any specific relevance/help as a cross reference in this section?	been referred in the 'Patient-centred care' section.
SH	British Psychological Society, The	22.05	Full	21		489	While it is clear from the Guideline that this is not intended to apply to adult patients receiving palliative care there will be some individuals for whom a critical illness rehabilitation programme is planned whose clinical condition subsequently changes such as to need palliative/end of life care. It will be essential that communication between the relevant services is established [and possibly maintained?]. This may be particularly important where issues of anticipated recovery of function and role have to be psychologically managed alongside loss/bereavement issues. Should the Guideline make more reference to this?	Palliative care is outside the remit of this guideline.
SH	British Psychological Society, The	22.06	Full	General	general		See: British Psychological Society (2006) Assessment of Capacity in Adults Interim Guidance for Psychologists. Leicester: Author British Psychological Society (2008)The Role of Psychology in End of Life Care. Leicester: Author	Thank you.
SH	British Society of Rehabilitation Medicine	23.00	Full			238-240	Agreeing rehabilitation goals is a specialist skill -particularly for medium-term goals - and a level of competence is required. This process requires a trained specialist rehabilitation professional such as a Rehabilitation Medicine consultant	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the

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							with an MDT.	process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	British Society of Rehabilitation Medicine	23.01	Full			238-240	Involving the family in goals is also a skill & the above comment applies again – there are ethical and legal dangers in indiscriminate negotiations with relatives.	The Mental Capacity Act (2005) has been referred in the 'Patient-centred care' section, and all recommendations are based on the assumption that the patient has the capacity to give consent. The GDG recognised that patients may not have the capacity to give consent when they were still in critical care, and this is clearly reflected in recommendation 1.1.2 and footnote 6.
SH	British Society of Rehabilitation Medicine	23.02	Full			244-245	Professionals 'in critical care' is too vague: this should read: 'professionals trained in rehabilitation medicine'	Changes have been made to recommendation 1.1.2 that address this point.
SH	British Society of	23.03	Full			265-	The psychological assessments required	Noted. It is important to note that

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	Rehabilitation Medicine					271	here cannot be carried out effectively by untrained personnel – consultants in Rehabilitation Medicine are trained to do these assessments	the guideline differentiates between two types of assessment – a short clinical assessment and a more comprehensive assessment. Practitioners should have the necessary competencies to undertake these assessments. It is noted that it is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	British Society of Rehabilitation Medicine	23.04	Full			272-275	Involving the family in goals is also a skill & the above comment applies again – there are ethical and legal dangers in indiscriminate negotiations with relatives.	The Mental Capacity Act (2005) has been referred in the 'Patient-centred care' section, and all recommendations are based on the assumption that the patient has the capacity to give consent. The GDG recognised that patients may not have the capacity to give consent when they were still in critical care, and this is clearly reflected in recommendation 1.1.2 and footnote 6.
SH	British Society of Rehabilitation Medicine	23.05	Full	12			Note 4 applies throughout section 1, not just to its current location	Noted. The footnote has been applied throughout.
SH	British Society of Rehabilitation Medicine	23.06	Full	12			Note 5: the team should include a specialist rehabilitation doctor	Noted. The composition of local MDTs in England and Wales vary widely, therefore a prescriptive definition of MDT could not be provided.
SH	British Society of Rehabilitation Medicine	23.07	Full		1.1.4		Rehabilitaton programmes require co-ordination. During ward-based programme there must be regular review by the lmulti-disciplinary team, including a rehabilitation physician	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration..
SH	British Society of	23.08	Full		1.1.6		A co-ordinator must be appointed prior to	Please see recommendation 1.1.1,

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	Rehabilitation Medicine						discharge and regular review must occur within the period prior to the 2-3 month point described in 1.1.7	which states: *Coordinate all the assessments and the rehabilitation programmes throughout the patient's rehabilitation care pathway to ensure continuity of care.*
SH	British Society of Rehabilitation Medicine	23.09	Full		1.1.8		There are hazards in waiting until 3 months before a programme of rehabilitation is deemed to have failed. The mechanisms for monitoring in the interim (see above) should include criteria for referral for review	Referral to appropriate services is recommended in recommendation 1.1.10 – before hospital discharge.
SH	British Society of Rehabilitation Medicine	23.10	Full	16			The implication in note 7 is that Intensive care personnel ipso facto have the necessary skills. This is not the case.	We would disagree. The recommendation note 7 refers to (1.1.1.) makes clear that the relevant HCP must have "the appropriate competencies".
SH	British Society of Rehabilitation Medicine	23.11	Full	19			Some adjustments would be required in line with our commens above	Noted. The recommendation note 7 refers to (1.1.1.) makes clear that the relevant HCP must have "the appropriate competencies".
SH	British Society of Rehabilitation Medicine	23.12	Full			294 297 incl footnote 5	This needs a specialist MDT in Rehabilitation Medicine. MDT by definition includes a specialist Rehabilitation Medicine physician. These teams provide holistic interdisciplinary treatment, not care	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	British Society of Rehabilitation Medicine	23.13	Full			671	Measurement tools. The reason many well known validated rehabilitation tools have not been used to evaluate these CI survivor populations is because the studies have not generally been designed by RM specialists and is not because the tools are no good. RM specialists have the knowledge and expertise to select the	Noted.

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							best measurement tools for the job to both monitor and audit the treatment process.	
SH	British Thoracic Society	24	Full	General			The guidelines seem well written and summarise the available evidence for critical care rehab. We particularly like their division into physical and non-physical side effects of critical illness and admission to critical care units. However after outlining (and even highlighting in the fornword) the paucity of good quality evidence the guidelines go on to list detailed recommendations for action. Clearly the panel brought together feel that there is merit in the field but given the weight of a NICE guideline, which will have profound organisational and financial costs for the NHS, we do wonder if it would have been netter to adopt a more circumspect position. In addition it is not clear where responsibility for the actions outlined would lie – would critical care departments have to deliver this, new departments or existing ones other than critical care?	Noted. Noted. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline. We agree that there is a limited evidence base in this area. But there remain many areas of healthcare where there is little or no evidence. Where there is no evidence, it is standard practice for the consensus opinion of the group developing the guideline as to what constitutes good practice to provide the basis for guideline recommendations. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools

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								• Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	BUPA	25					This organisation was approached but did not respond	
SH	Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's)	26					This organisation was approached but did not respond	
SH	Central Manchester and Manchester Children's University Hospitals	27.00	Full	General	General		We believe that adequate nutrition is vital to effective rehabilitation in this group. We have audit data that demonstrate strong correlation between weight & poor nutritional state with length of stay and time to meet rehabilitation goals following critical illness. NICE Guideline CG32 addresses the issue of providing adequate nutrition for at risk patients. We suggest that this cross reference is inserted in the section of the guideline covering the period preparing for and following transfer to the ward from critical care.	We agree. Please see recommendation 1.1.3 where the NICE nutrition guideline is cross-referred to.
SH	Central Manchester and Manchester Children's	27.01	Full	1.11 1.13	General		The terms 'short-term and medium-term rehabilitation goals ' are used frequently	Please see footnote 7 for definitions.

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	University Hospitals			1.15 and general			throughout the document to refer to different points along the rehabilitation pathway. These terms are not defined at any point in the document. The timeframes are therefore liable to interpretation. For example an Intensivist would probably regard 48-72 hours as a reasonable short-term timeframe whereas a psychologist in treating PTSD would regard 2-3 months as short term progress.	
SH	Central Manchester and Manchester Children's University Hospitals	27.02	Full	1.1.4	General		The term 'complex' could interpreted differently by different people, who is to make this decision and what stage of the patient's stay. Should the decision to start an individualized programme be based on the assessment made at Critical Care Discharge alone or are other factors to be included? Is the term referring to the complexity of the patients co-morbid state or the events that have led to the stay of the planned recovery?	We have revised the wording to address this point - please see recommendation 1.1.3 and 1.1.8.
SH	Central Manchester and Manchester Children's University Hospitals	27.03	Full	1.1.5	General	303	For the patients who are in Critical care for less than 48 hours, do these patients all require follow up assessments prior to discharge home this seems logistically challenging and unnecessary. If we are visiting all complex patients and assessing patients when they first return to the wards an informed and individual plan of care should be made.	Changes have been made. Please see the new care pathway for clarification.
SH	Central Manchester and Manchester Children's University Hospitals	27.04	Full	1.1.11		401	It is suggested that the information about the goals, sleep problems etc should be told prior to discharge to the ward. At this time the patient has a lot of information about the changes in level of care and transfer information. This information	Recommendation 1.1.6 has been changed to 'before or as soon as possible after being discharged'.

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							would not be withheld and should be given once the patient has returned to the ward.	
SH	Central Manchester and Manchester Children's University Hospitals	27.05	Full	1.1.3	General	260	Within Critical Care the assessment of the psychological state can be difficult to assess In our experience using HAD in Critical Care patient frequently demonstrate falsely high readings. Once the patients have been transferred to the ward a more realistic assessment can be made with reduced HAD scores, this will reduces unnecessary referrals to the psychiatric services and allows the patient to discuss any issues arising from the transfer can be addressed	There is no recommendation that recommends the specific use of HADS as a screening or assessment tool.
SH	Central Manchester and Manchester Children's University Hospitals	27.06	Full	1.1.3	General		Predicting the day of discharge is not always straightforward. Some people are deemed ready for discharge and then deteriorate. Some are discharged following an unanticipated improvement / prematurely. What provision is there for people who are discharged from ICU who did not have an assessment performed?	Recommendation 1.1.6 has been changed to 'before or as soon as possible after being discharged'.
SH	Chartered Society of Physiotherapy (CSP)	28					This organisation was approached but did not respond	
SH	Chelsea & Westminster Acute Trust	29					This organisation was approached but did not respond	
SH	Cheshire PCT	30					This organisation was approached but did not respond	
SH	College of Occupational Therapists	31					This organisation was approached but did not respond	
SH	Coloplast Limted	32					This organisation was approached but did not respond	
SH	Commission for Social Care Inspection	33					This organisation was approached but did not respond	
SH	Connecting for Health	34					This organisation was approached but did not respond	

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SH	Coventry and Warwickshire Cardiac Network	35					This organisation was approached but did not respond	
SH	Critical Care Network Northern Ireland	149.00	Full	General			Implementation of this document will be extremely demanding of resources at all stages.	Noted. The NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Critical Care Network Northern Ireland	149.01	Full	General			It is not clear who would be best placed to take overall ownership of the care pathway as some of the skills required may not be part of current training or practice in Intensive Care Medicine.	Noted. Recommendation 1.1.1 emphasises that Healthcare professional(s) with the appropriate competencies should coordinate all the assessments and the rehabilitation programmes throughout the patient's rehabilitation care pathway to ensure continuity of care.
SH	Critical Care Network Northern Ireland	149.02	Full	General			Infrastructure to deliver many aspects is currently not in place nor is it clear how to secure it.	Noted. The NICE Implementation Team is in the process of developing a specific

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								implementation plan for this particular guideline.
SH	Critical Care Network Northern Ireland	149.03	Full	General			Nevertheless there is considerable focus on good communication which should be part of our practice at present.	Thank you.
SH	Critical Care Network Northern Ireland	149.04	Full	General			The Research recommendations appear to acknowledge that these guidelines are not based on hard evidence e.g. early ICU versus later rehab. It may be appropriate to carry out trials before NICE issues specific recommendations on a foundation of what they admit is a "patchy evidence bas."	We agree that there is a limited evidence base in this area. But there remain many areas of healthcare where there is little or no evidence. Where there is no evidence, it is standard practice for the consensus opinion of the group developing the guideline as to what constitutes good practice to provide the basis for guideline recommendations.
SH	Critical Care Network Northern Ireland	149.05	Full	General			Review at 2-3 month post ICU is of very limited value in the absence of facilities/pathways to treat problems which are identified.	Noted. This is covered by revised recommendation 1.1.13
SH	Critical Care Network Northern Ireland	149.06	Full	General			How would this sit with other rehab facilities?	This guideline is for general adult critical care patients who do not fall into other specific rehabilitation facilities such as cardiac, stroke or neurological rehabilitation. Therefore, this guideline complements other specific rehabilitation facilities.
SH	Critical Care Network Northern Ireland	149.07	Full	General			Are these patients worse/different from/more deserving than those who were sick but did not get into ICU (and survived)?	The remit of the guideline is adult general critical care patients. For patients who were not admitted to critical care, please refer to the NICE clinical guideline 50 (Acutely ill patients in hospital).
SH	Department for	36					This organisation was approached but did	

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	Communities and Local Government						not respond	
SH	Department of Health	37					Organisation responded and said they had no comments to make	Noted.
SH	Department of Health, Social Security and Public Safety of Northern Ireland	38					This organisation was approached but did not respond	
SH	Derbyshire Mental Health Services NHS Trust	39					This organisation was approached but did not respond	
SH	East & North & West Hertfordshire PCTs	40					This organisation was approached but did not respond	
SH	East Kent Hospitals NHS Trust	41					This organisation was approached but did not respond	
SH	Faculty of Occupational Medicine	42					Organisation responded and said they had no comments to make	Noted.
SH	GlaxoSmithKline UK	43					This organisation was approached but did not respond	
SH	Gloucestershire Hospitals NHS Trust	44					This organisation was approached but did not respond	
SH	Guys and St Thomas NHS Trust	45					This organisation was approached but did not respond	
SH	Harrogate and District NHS Foundation Trust	46					This organisation was approached but did not respond	
SH	Healthcare Commission	47					This organisation was approached but did not respond	
SH	Hertfordshire Partnership NHS Trust	48					This organisation was approached but did not respond	
SH	Herts & Beds Critical Care Network	49					This organisation was approached but did not respond	
SH	Hill-Rom	50					This organisation was approached but did not respond	
SH	ICUsteps	51.00	Full	11	1.1.1	260	What additional steps are taken when patients are transferred between ICUs in different hospitals to ensure continuity of care?	This has been addressed in the revised recommendation: '*Ensure information, including documentation, is communicated*

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								between hospitals and to any other hospital-based or community rehabilitation services and primary care services', has been added in recommendation 1.1.1.
SH	ICUsteps	51.01	Full	12	1.1.4	285	How soon after ICU discharge does the rehabilitation programme begin, if it's only going to last for 6 weeks?	Footnote 18 from recommendation 1.1.8 explains that the optimal time for starting the structured and supported self-directed rehabilitation programme should be based on individual patients' physical and cognitive capacity at different stages of their illness and recovery. Therefore, it is not appropriate to recommend a fixed time for starting the rehabilitation.
SH	ICUsteps	51.02	Full			327	Flashbacks should be added to the list of symptoms under Anxiety and Depression in Table 1.	Changes have been made
SH	ICUsteps	51.03	Full	14	1.1.5	327	Physical Dimensions – Physical problems: suggest it should read 'inability/partial ability'.	Changes have been made
SH	ICUsteps	51.04	Full	15	1.1.7	337	By this stage in the patient's recovery, we believe their GP may well have value to add to the 2-3 month review and should be given the opportunity to contribute to this.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools

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								• Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	ICUsteps	51.05	Full	15	1.1.7	344	We understand the need to include the hospital as a possible venue on practical grounds but a change of emphasis to suggest the community setting as first alternative would be preferred.	Changes have been made to recommendation 1.1.12 to take account of this point.
SH	ICUsteps	51.06	Full	16	1.1.9	379	There is evidence that patient recovery from critical illness takes a minimum of 6 months and can take longer than 3 years (Ridley S & Plenderleith L; Survival After Intensive Care. Anaesthesia 1994: 49; 933-935). What is the patient's care pathway following the 2-3 month assessment? We believe that some issues with physical and psychological recovery may often not be apparent by this time and a route back into critical illness rehabilitation needs to be catered for to avoid these patients falling through the cracks.	In recommendation 1.1.13, it is clearly stated that: *Refer the patient to the appropriate rehabilitation or specialist services if:* *the patient appears to be recovering at a slower rate than anticipated according to the short-term and medium-term rehabilitation goals, or the patient has developed unanticipated physical and/or non-physical morbidity that was not previously identified.* Also recommendation 1.1.1 states that the *contact details of the healthcare professional(s) should be provided to all patients*, so that patients would know who to contact if problems occur after 2-3 months.
SH	ICUsteps	51.07	Full	17	1.1.10	394	In addition to providing information about	There is an absence of evidencve

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							equipment used during critical care, we would like patients to be offered the opportunity to revisit the unit to see and hear the equipment as part of this. The information itself is helpful but revisiting the unit can help normalisation, dispel anxiety and let patients come to terms with their experience.	here. The GDG considered that the practical problems of revisiting precluded it being recommended in the guideline. .
SH	ICUsteps	51.08	Full	66	1.1.10	1694	We believe it is important to ensure that the diary is presented to the patient with the support of an experienced professional as this can open up unnecessary anxiety and guilt without the appropriate back up. It's an excellent help in filling the gaps but needs careful monitoring.	Due to a lack of evidence of their effectiveness, the NICE technical team and the GDG agreed that the guideline is not in a position to make any specific recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	ICUsteps	51.09	Full	General			As an ICU support group consisting of patients, relatives and critical care nurses, we feel this is a very welcome guideline. The rehabilitation facilities are scant and we feel the guideline will be a landmark improvement in critical care.	Noted with thanks.
SH	Institute of biomedical Science	52					This organisation was approached but did not respond	
SH	Intensive Care Aftercare Network (i-canuk)	53					This organisation was approached but did not respond	
SH	Intensive Care National Audit & Research Centre (ICNARC)	54					This organisation was approached but did not respond	
SH	Intensive Care Society	55.00	Full	general			There is much to commend this document in particular the stages of care and the need to address rehab at all stages, especially early. A pathway containing assessment WITH intervention and review is paramount to this process and	Thank you.

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							this in principle is present. Well done and I would like to congratulate the guideline group. However I believe there is a failure to fully address the realities of the diverse population involved in ICU by age, severity and duration of illness (LOS) and the practical implications. Screening (which applies to all) and delivering Rehab (to some) is NOT the same as "follow-up" which for many people is observation or simple information provision. Follow-up can be far more inclusive since its goals and resource use are modest. Greater focus is what is needed for rehab along with a stepped care approach not to overload valued specialist resources which will not be available in abundance. It is clear many in the ICU community still consider a "follow-up" clinic alone as therapy fulfilling this role as reference in articles and within this guide as suggesting such a state is not a usual care, or a control condition. The principle of screening is not only to identify problems but also to exclude patients who do not need additional care beyond that which time alone provides. There needs to be more overt guidance on how to exclude patients who do not need elaborate rehab otherwise this guide will not bring the general intensive community along with it. Prolonged lengths of stay before or during ICU are strong indicators of need yet this seems to be forgotten.	After further GDG discussion, the recommendations have been substantively changed – a 'Short clinical assessment' has been added in the care pathway as the entry point for rehabilitation.

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SH	Intensive Care Society	55.01	Full	64			This must be miss-worded. Either this is 100,000 (see line 453) or it should say 70,000 LEAVE ICU?	This error has been corrected.
SH	Intensive Care Society	55.02	Full	65			The use of a generalisation that "majority" survive to go home (see above for presumed error) also miss informs. The reality is for those who have a longer ICU stay (e.g.10 days) and who are in reality those most in need of a full rehab programme have a mortality that is very high.	This statement is based on the ICNARC CMP Summary Statistics that approximately 70% patients survived to go home.
SH	Intensive Care Society	55.03	Full	285 & 289 & 1389	1.1.4		The Group have over interpreted a single study and have recommended that it should be applied to a very large number of patients; all those staying more than 48 hrs and even to be considered in those with less than 48 hrs stay. 48 hrs was used as an exclusion criterion and they recruited patients that were considered suitable for Rehab with a prolonged ICU stay (mean of 2 weeks) but also included some where the pre-ICU stay had been long. I have checked the original data and less than 23% stayed 5 or fewer days in ICU (less than 10% 3 days or fewer) but of these patients their pre-ICU hospital stay with illness was a median of 16 days. To assume this study has been tested suitable for ALL patients who have only stayed 48hrs is simplistic and does not reflect the study patient group nor the resources required. Patients were excluded from the study for other reasons as well and this has been ignored. It would have been more appropriate to use a stepped care assessment process	The relevant recommendations have been revised to address this point. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients.

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							within ICU and on discharge (as is being undertaken) to identify those selected patients (and provided suggested risk factors that match those studied) and offer this strategy to them. Busy general ICU s have a large population of short stay patients where there is no evidence to suggest elaborate Rehab is necessary for all. However there are some short stay patients where ICU is the last call in a long hospital stay and they need Rehab. Your screening would detect these.	
SH	Intensive Care Society	55.04	Full	326			There is no assessment, advice or therapy regarding nutritional problems & requirements. This is a major omission and misses the varied and important nutritional challenges these patients may encounter. Simple dietetic advice is insufficient. Nutrition should be an integral part of any rehab programme.	Noted. To address this point the guidance explicitly cross-refers to the NICE Nutrition guideline (NICE clinical guideline 32) has been added to recommendation 1.1.3.
SH	Intensive Care Society	55.05	Full	1145			It is very important that ICU rehab is NOT associated with "follow-up" clinics. Many such clinics were established only to observe the outcomes of patients and only later in a few have they incorporated some aspects of therapy. Genuine rehabilitation strategies require specific therapies at specific times so it is not correct to associate follow-up clinics with a multidisciplinary rehab strategy in this sentence. To do so implies that existing "follow-up" clinics provide a rehab service when they do not. The control group in the Jones 2003 study was a "follow-up" clinic, an observational activity that offers little real therapy other than information and underlines the difference between	The section has been further edited to address this point.

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							rehab and a follow-up clinic.	
SH	Intensive Care Society	55.06	Full	1472			The inclusion of a study that is not completed or published is unjustified. While we look forward to seeing this study we must be cautious since the study design is quite unlike the Rehab programme in this guide which has more ICU and hospital care delivered. It has a follow-up clinic focus predominantly and therefore it is not clear how it will provide economic data of value. The principle of Rehab as outlined is a process that starts within ICU, progresses within hospital and continues at home. Also the EQ-5D is a questionable measure in such a heterogeneous population (see later).	It should be noted that the guideline does not include this particular study (the PRACTICAL study) as evidence. The text only highlights the fact that there is a relevant ongoing trial which may provide useful evidence in the future.
SH	Intensive Care Society	55.07	Full	1916			While I understand the desire to use generic tools such as the EQ-5D they were developed in very different populations and have their strength in being simple. Sadly this means the information and their utility is also highly simplified. They are best suited for large populations of similar patients with the same diagnosis (e.g. elderly females with hip fractures) and have questionable use in multi-diverse populations where age, illness severity and diagnosis may be very different and the problems very diverse. To recommend their use where the utility of data in ICU has no veracity is questionable.	Thank you for your comment. Although the EQ-5D is the preferred measure of health related quality of life, data collected using condition-specific, preference-based measures may be presented in separate analyses. Alternative tools would have been considered had an economic evaluation been carried out.
SH	Intensive Care Society	55.08	Full		2.6.		Although providing information is all important there are few studies in any discipline where its provision alone has shown utility. Invariably those that need it	Noted.

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							the most do not read it. It is good to see the recognition of timing and the varied content needed. However it is also important in this guideline that a clear strategy is outlined to assist patient engagement to ensure information is actually delivered to the patient that needs it. Without such an approach the simple provision is costly and fruitless. A self-directed educational approach as used in the rehab study (Jones 2003) is one example to deliver patient specific information at the right time to the right patient as part of a rehab programme. Since the majority of ICU patients that will require rehab will be elderly there needs to be consideration regarding vision, hearing, reading and IT skills and access. The considerable cognitive problems of these patients appear not to have been considered. The reality is that family and carers MUST be engaged at all times.	
SH	Intensive Care Society	55.09	Full		2.7		Some of these research questions are very disappointing. The area of cognitive impairment and putative therapies is in much need of research and a similar question to that given in line 1927 for psychological conditions could be incorporated. It is not clear how these questions were derived after reading the guide. Were all members of the CDG involved? Was a true Delphi approach and critical analysis of the issues used to develop the questions?	All the research recommendations have been reviewed by the GDG and re-drafted.
SH	Intensive Care Society	55.10	Full	1904			Studies of screening tools in the first instance must be tested to confirm their	We agree. The GDG discussed this issue and have drafted a revised

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							ability to reliably enter a diagnostic pathway.	set of research recommendations that take account of these concerns.
SH	Intensive Care Society	55.11	Full	1907			Linking screening to outcome is not required, one needs to link specific diagnostic problems to therapies and then to outcomes.	We would argue that effectiveness studies of screening strategies should determine whether their use leads to clinically important outcomes.
SH	Intensive Care Society	55.12	Full	1913			This is a pointless study since it ignores the considerable scientific background on the problems of physical immobility. It would be practically and probably ethically impossible. One far more utilitarian question would be the nature and character of early and late physical mobilisation that is used to arrive at the "dose" required for particular patients. Different approaches to therapies could be assessed and patients randomised to arrive at different intensity of care. Timing is not the issue it is more one of degree of immobility & disability. Taken to its extreme one would leave "late" patients to develop secondary complications such as joint contractures!	Noted. The GDG discussed this issue and have drafted a revised set of research recommendations that take account of these concerns.
SH	Intensive Care Society	55.13	Full	1917			This is a generic question that covers all other questions. Perhaps this could be broken down into specific types of therapies to be more useful.	Noted. All research recommendations have been revised after further GDG discussion.
SH	Intensive Care Society	55.14	Full	1921			This seems to ignore the discussion contained in the guide and suggests there is a single specific time when patients could be screened? Perhaps the question could be rewarded to address specific screening for specific problems that are known to develop at different times during and after intensive care and hospital. How	The GDG discussed this issue and have drafted a revised set of research recommendations that take account of these concerns.

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							this differs from the first question is not clear.	
SH	Intensive Care Society	55.15	Full	1924			Again this seems to ignore all the discussion contained in the guide and again suggest there is a single optimal time and even perhaps that all patients are similar and have the same problems arising at the same time?	The GDG discussed this issue and have drafted a revised set of research recommendations that take account of these concerns.
SH	Intensive Care Society	55.16	Full		2.7		While we are aware of the problems there is an urgent need for service based research to define the acute community rehab needs in the first 3-4 months following hospital discharge. This will help define if service re-organisation is required to meet the demands of this pathway.	All the research recommendations have been reviewed by the GDG and re-drafted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.00	Full	General			The Intercollegiate Board are unanimous in their view that this document identifies an important area of need that should be developed and has the potential to have an immense impact on the patients welfare and that of their carers. There is clear recognition of the physical and non physical burden of ICU on patients and their families and carers is important for them, and acute care givers in general. We have tried to rationalise all the views given but some express individual opinion that will be of infinitely greater value in its original form. Hence there are many general points both at the start and in the concluding parts of this response.	Thank you Noted
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.01	Full	General			This guideline highlights the immediate need for significant professional rehabilitation input into this area that also overlaps with the needs of other patients	It is outside the remit of this guideline to provide specific recommendations on service delivery models or service

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							in other specialties that are also relatively lacking in rehabilitation facilities. This document should focus on the need for those resources, their complexity and the obvious fact that many do not exist currently and so demand cannot be easily met from within current facilities. The UK has woefully poor rehabilitation facilities for patients following Critical Care and it is difficult to avail the Units of professional help in many hospitals. That message is well hidden in this document.	configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.02	Full	General			One of the successful things to come out of Comprehensive Critical Care was the local development of CCDGs. One way forward would be a similar development of local groups charged with establishing and maintaining rehabilitation services. Such a group would comprise the ICM leadership (the purchaser) and the rehabilitation physicians and AHPs (the provider) with Trust Board/Management representation to ensure funding. Solutions need to be local to prevent disenfranchisement of the current local enthusiasts, but it would be useful to have nationally imposed mechanisms to	It is outside the remit of this guideline to provide specific recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning

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							oversee the delivery of such solutions.	statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.03	Full	General			At present there is no formalised rehabilitation program for critically ill patients except in a few hospitals where it is run by often unfunded enthusiasts. The Board considers that this may be our only opportunity to get the need for rehabilitation following critical illness acknowledged.	Noted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.04	Full	General			We do not know the extent of the problem, how ro assess or what interventions work therefore it is important/ essential to ensure that the right personnel are involved in this multidisciplinary approach. This reqquires more emphasis as a general point and in specific areas.	It is outside the remit of this guideline to provide specific recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools

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								• Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.05	Full	General			From the patients' and relatives' perspective there is a problem when patients are discharged from critical care to the wards and thence from hospital and there is no provision for help and support. It is important if, this group of patients are to have any chance of best recovery, that rehabilitation facilities are put in place with the capability of obtaining specialist advice without going back to the GP for a new referral. The GDG struggled with the lack of RCT evidence on what works and what doesn't following critical care but what is clear from the evidence given by the rehabilitation consultants on the GDG is that multidisciplinary biopsychosocial rehabilitation works in all other situations and we know, as patients and carers, that it certainly helps the recovery process for those discharged from critical care.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for

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							This issue seriously affects a large group of patients who have effectively been disenfranchised by the system because they are nobody's responsibility. The Guidelines seek to change this by recommending that patients deemed at risk following assessment will be offered multidisciplinary rehabilitation. Not by Intensivists, but by specialists in rehabilitation. This is the key and the guidelines need to be clear that Intensivists are not the appropriate people to carry this out. Local networks could be involved. The principles of the Guidelines reinforce that rehabilitation is a specialty in its own right (the College of Physicians has supported the British Society of Rehabilitation Medicine and this group supports the principle behind the Guidelines) and stress that quality research is needed.	follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.06	Full	General			This is an aspirational document addressing a pressing need. As such it needs to be very clear about what we have versus what we aspire to have so that deficiencies are clearly expressed. There has to be a clear indication of the gap between the document and reality if the document is to assist bridging the gap and if the document is not to be seen as disingenuous. The authors highlight the lack of information on assessment in this environment, the inadequacy of the	In section 1.3.1, it is stated that currently there is lack of rehabilitation pathway and services for general adult critical care patients. The guideline aims to address this important gap. Noted.

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							evidence of interventions that works and indeed at the timing of such interventions. They have suggested some common sense and some ideas such as information provision that seem self obvious. A strength of the paper is the commentary on research direction which is essentially a clean slate at the present time. It is therefore surprising that they have such didactic recommendations on assessment, on intervention and on follow up. There is a massive transition from a clear statement that there is no useful information in real terms to an aspirational statement of what should be done that is entirely opinion driven. The deficiency in rehabilitation but not rehabilitation services is highlighted. This document does not highlight what is available and what should be available. There is little or no actual substance in terms of instruction for those with no training in rehabilitation medicine which encompasses the vast majority of Intensive Care specialists in the UK. It needs clarification of who should be involved and occasional reference to appropriately trained people is easy to miss if you aren't the authors. At present it heavily implies that those making the initial assessments early in their care in ICU have an ongoing responsibility. That is clearly ICU consultants to the reader while I believe	It should be noted that there are many areas of healthcare where there is little or no research evidence. Where there is no research evidence, it is standard practice for the consensus opinion of the group developing the guideline as to what constitutes good practice to provide the basis for guideline recommendations. In the revised evidence to recommendation sections we clearly set out which recommendations are based on the presented evidence and which are the result of GDG consensus. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set

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							the document authors think they are implying establishing a rehabilitation driven assessment and programmed management system. If this is the case it is not clear from the document and should be addressed more obviously. Nowhere in this document is there discussion about sexual dysfunction or when it is safe to commence sexual activity. This is an area that can cause huge distress and it should be addressed somehow.	• Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues. We have now included in the guideline, recommendation 1.1.23 that, if appropriate, sexual dysfunction should be enquired about.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.07	Full	General			The responsible clinician in ICU is the ICU Consultant- the document implies this is also their remit and hence their responsibility and nothing in the first 10 pages dispels this intuitive notion.	As in recommendation 1.1.9, the guideline does not specifically recommend who should be or should not be the 'healthcare professional(s)'. This is down to local configurations. The NICE Implementation Team will develop implementation tools to assist this process.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.08	Full	6	L 139		This is good. But maybe should highlight recognition that acute clinicians/ nurses usually lack this expertise and hence the need for other resources.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the

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								process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.09	Full	8	L190		The document demonstrates lack of rehabilitation, lack of access to rehabilitation, lack of information generally and what needs to be done. Surely a fundamental part of the guideline is to plot a course between where we are and where we want to be. That requires defining where we are. At present it is only covered in a very general non specific manner. That in itself would be very useful.	The Foreword has been re-edited.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.10	Full	10	1.1.1	L235 -244	The recommendation to perform a clinical assessment etc which should be undertaken by different professional groups says essentially nothing that provides guidance or direction. 'Locally	Due to a lack of evidence of the test performance of such tools, the recommendation of the 'locally defined tools' has been taken out. Detailed discussion on screening

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							defined assessment tools' pre-supposes there are tools when the document then goes on to say there are effectively none. It is important to appreciate that this, as a coordinated exercise, will be new in most units. Therefore detail is important. The balance between prescriptive and vague is difficult and this document leans heavily to the latter at present, in that it appears to recommend doing anything rather than nothing - is that an intended impression and how do we decide what 'anything' is? The assessment will most likely need to be repeated as the patient's condition changes. I know this is alluded to in the next section but that refers to updating a plan that has already been set in place. The point is that a plan may not be deemed necessary early on but would need to be considered later if the expected rate of recovery slows; doing this at discharge may be too late.	and assessment please see section 2.1.3 (evidence statements) and section 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.11	Full	10	1.1.2	L257	Who and how - needs same rider as 1.1.1 L 244	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.12	Full	11	1.1.3	L279	Should be some recognition that these facilities may need to be derived from an MDT basis.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.13	Full	12	1.1.4	L301	New approach need coordinated and managed approach and will need thought as to how it is best developed. The document implies it is available and easy - neither is currently true.	Noted.

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SH	Intercollegiate Board for Training in Intensive Care Medicine	56.14	Full	13	1.1.5	L325	The interaction between `hospital' and primary care should be emphasised. The ideal GP would want involvement and Hospital based involvement disenfranchising the GP of involvement would be improper so this aspect needs highlighting. (especially as it is a probable source of problems). The interface between ICU and GP is tenuous, at best, in most units. This line, L325, does not cut it.	The GDG were of the clear opinion that good hospital / primary care interaction is crucial to the success of assessments pre-discharge and in the community. It is, however, outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.15	Full	14	Table 1		Good table.	Thank you
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.16	Full	15	1.1.6	L344	Emphasis on appropriately trained individual and the fact there probably isn't one at present- need highlighting. Who might be appropriate?	Given that it is outside the remit of this guideline to provide recommendations on service delivery models or service configuration the wording is appropriate. The NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education;

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								and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.17	Full	16	1.1.9	L369	7 This is very important and is a role that probably does not exist currently. This is something ICU could ask for. It is key to most of this document and is relegated to a footnote that may never be read.	The GDG agree that this is a very important role but as it is outside the remit of this guideline to provide recommendations on service delivery models or service configuration it is appropriate that the recommendation states that co-ordination should be delivered by HCPs with the appropriate competencies, with the footnote suggesting the likely professional groups involved.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.18	Full	20	1.3.1	L476 L477	Everyone knows there is very limited access to proper rehabilitation facilities after critical care. Even in disease-specific e.g. neuro- and burns the current available facilities are extremely poor. That is what this is about - why not state how poor it is -'varies widely' seems an understatement. "rehabilitation services"	Noted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.19	Full	22	1.3.4	L518	This is a statement of intent and it is therefore important it is adhered to both in terms of where evidence linkage exists but more importantly where it does not.	Section 1.3.4 'Developing the guideline recommendations' has been re-edited to make it clear the basis on which the recommendations have been made. We have also re-edited all the evidence to recommendation sections to improve clarity..

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SH	Intercollegiate Board for Training in Intensive Care Medicine	56.20	Full	27	2.2	L625	The recommendations 1.1. 1 presuppose the clinical assessment will be able to define objectives and goals - it is then disappointing to find no substance later. What are locally defined assessment tools? Given no assessment tools have been shown to be particularly useful this implies make them up yourself - is that helpful?	We agree that it is not helpful to imply that these tests should be developed ad hoc. Due to a lack of evidence as to their test performance, the recommendation of the 'locally defined tools' has been taken out. We have provided a detailed discussion on screening and assessment in section 2.1.3 (evidence statements) and section 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.21	Full	28	Rec 1.1.3		The rehabilitation goals will be based on the assessment which is ill defined and uses locally defined tools so we have a solid identifiable outcome despite no defined way of achieving it. Likewise 1.1.5.	Changes have been made and the recommendation on locally defined tools has been taken out.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.22	Full	32	2.2.3	L676	This section does not follow through appropriately. It states that the tools evaluated are not shown to be useful. None are validated and no one tool can be recommended. This means to a reader that no tools are yet shown to be of value although maybe some are but no one yet knows which. There then follows a leap of faith or enthusiasm to be able to say that all the assessments can still be carried out. This implies no tools are necessary or that there are none but more importantly tools as of yet unidentified described or tested can be used. If this is the case why look at the tools at all ? This is clearly just opinion and should be stated clearly that it is opinion - no problem with that but don't pretend this is evidence base.	The GDG agreed that the lack of validated tools for screening and assessment does not, and should not preclude clinical judgment by practitioners. Hence, recommendations on the need to conduct 'clinical assessments' were made. We have also re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation. – see section 2.1.4 (evidence to

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							If 1.3.4 L518 is to be followed, then the linkage here is opinion as the evidence does not exist.	recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.23	Full	32	2.2.3	L692	"these tools are not validated' and then says it should be done with 'locally defined assessment tools' (L 699)	Due to a lack of evidence of test performance, the recommendation of the 'locally defined tools' has been taken out. A detailed discussion on screening and assessment is provided in section 2.1.3 (evidence statements) and section 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.24	Full	33	2.2.3	L709	Explain linkage between no evidence and early identification being appropriate.	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation. – see section 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.25	Full	34	2.2.3	L736	'instead of using different assessment tools....functional assessment should focus on key dimensions'. Define how these key dimensions are to be assessed (see Table 1)- otherwise this paragraph following is at risk of moving from using defined objectives to ill defined jargon. Maybe reference Table 1 more obviously or put it closer so it is easier to follow. Even then it has moved from definition to description. These are vague descriptions on which to base supposedly objective	We have now re-ordered both tables (1&2) to address this point.

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							assessments (as yet undefined).	
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.26	Full	34	2.2.3	L756	Suitably qualified health care professionals - who are they, are they available or should they be made available?	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.27	Full	35	2.2.3	L767	Who defines who these people are? The Committee is better placed to make helpful suggestions given the composition of the committee and it seems highly likely that for many Trusts this coordinator may need to be a new role so guidance may help it happen.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will

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								include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.28	Full	42	2.2.7	L1018	'Lack of good quality evidence ...UK PTSS and HADS not appropriate but then leads to L1033 where same rationales and principles apply. if this is just opinion then it should be stated. The rationale and principle statement enjoys the same standing apparently as any evidence. Maybe it should but clarity is important.	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation. – see section 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.29	Full	44	2.2.7	L1049	'No one single screening tool' is misleading when what has been shown is that no clearly useful tests have been found. The conclusion once again is that locally defined assessment tools should be used - this panacea recurs and is inappropriate. 'There are not, therefore	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations.

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							there are' is not helpful. This needs a better form of words that does not imply that the established tests aren't right so local ones will be. Maybe it means anything will do so long as it is seen to be done.	We have also made it clear when GDG consensus is the basis for the recommendation. – see section 2.13 evidence statements and 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.30	Full	44	2.2.7	L1061	See above. 'No one single screening tool' is wrong. It should state that there are no clear useful tests found. Then stating that locally defined assessment tools should be used produces the same problem that the use of objective measures is implied despite none being found. Same problem.	We have revised the relevant sections to address this point - please section 2.13 (evidence statements) and section 2.1.4 (evidence to recommendations)
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.31	Full	45	2.2.7	L1088	Could a comment be made about what sort of person does these interviews that are presumably best done by someone trained in the area. Not for amateurs.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be

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								delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.32	Full	45	2.2.7	L1093	In L 1018 these test HADS and PTSS weren't very good- now they are - clarify. Again who can do these and where can clinicians find out who does these? Are they easily available in a DGH ? Are they available in Teaching Hospitals ? Could regional resources be pooled ?	We have revised the text to address this point - please section 2.13 (evidence statements) and section 2.1.4 (evidence to recommendations)
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.33	Full	46	2.2.7	L1104	'The same rationales and principles' underpins every conclusion. It is aspirational but has no linkage to evidence that has been described so far.	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation. – see section 2.13 evidence statements and 2.1.4 (evidence to recommendations).
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.34	Full	47	2.3.1	General comment	Rather upbeat about implied benefit given what follows.	Noted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.35	Full	49	2.4	L1202	Definite recommendation - where is the evidence - if opinion based surely it should say so.	We agree. We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation.

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SH	Intercollegiate Board for Training in Intensive Care Medicine	56.36	Full	49	2.4	Rec 1.1.4	Need far more emphasis than just a foot note on specialist input. A structured rehabilitation program needs professional planning (opinion)	Noted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.37	Full	50	2.4	L1226	This appropriate team - does it exist and can it exist currently in most centres or should it be developed. The latter is appropriate.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.38	Full	50	2.4	L1229	What are appropriate preventative strategies given what follows?	The information is provided in the NICE PTSD guideline. The recommendation cross-refers to it.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.39	Full	55	2.4.3	L1361	Consensus is based on a woeful lack of evidence but becomes a firm recommendation.	We have re-edited and restructured the evidence to recommendations section to make it clear how the

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								GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation.Please see section 2.2.4 (evidence to recommendations)
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.40	Full	56	2.4.3	L1374	Supporting evidence helpful and the consensus is firm as is the recommendation but the linkage should acknowledge that this is opinion based and is not in any way substantiated in the literature.	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations. We have also made it clear when GDG consensus is the basis for the recommendation.Please see section 2.2.4 (evidence to recommendations)
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.41	Full	56	2.4.3	L1385ff	On the basis of the Jones study is the UK going to embark on full blown structured rehabilitation programmes and if so what is that structure going to be? The self directed program will be 'based on the individual's physical and cognitive capacity'. The former is being identified already but this document already indicates the latter is hard to assess or to act upon. Is this helpful as a directive? This is aspiring towards a mirage.	We have revised the recommendation to address this point. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgement, it is not recommended for all patients
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.42	Full	57	2.4.3	L1411	The core team is a useful and constructive idea especially as it implies the formation of a team as a new concept rather than implying it is already in place.	Thank you.

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							That is helpful.	
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.43	Full	60	2.4.4	L1527	Are these numbers for real - £958 for a rehabilitation package, re-admissions outpatients, primary and secondary care and social services etc. Free at the point of care may have something to do with it but these numbers are meaningless to any economist. Is the difference the cost of the booklet (in which case it isexpensive) and there may be issues with reading 90 pages. Also L1536 the price is now £12041 and this is confusing. This section is disingenuous as are its conclusions.	Thank you for your comment. This is a review of an unpublished document and has been reviewed as such. There is a typo on line 1536. This should read £1204 (with a footnote that should be in superscript to show what the cost would be in today's prices using inflation indices). This will be altered for the final version of the guideline.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.44	Full	63	2.4.5	L1594	'the intervention arm was highly cost effective' - please justify this statement as most of a preceding page (60) seems to show nothing of the kind.	Thank you for your comment. Given the small incremental costs and low ICER reported by the study, at face value, the intervention would appear cost effective. The wording in the guideline has been altered to reflect this.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.45	Full	66	2.6	L1690	This section seems informative and useful. While very subjective and therefore to some extent expected results it seems easier to accept the recommendations. It would be hard to imagine not getting a positive response and probably falls into the category of good practice.	Noted.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.46	Full	75	2.7	L1904	Correctly and succinctly defines the shortfall in evidence base. If opinion based recommendations are to be put forward then addressing these research issues which might provide linkage is an important or mandatory requirement of this document.	Noted.
SH	Intercollegiate Board for	56.47	Full		3.1		References very comprehensive	Thank you

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	Training in Intensive Care Medicine							
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.48	Full	General			Main concern – resource implications. It is easier to set standards than to find the funding to make them happen.	It is outside the remit of this guideline to provide specific recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.49	Full	General			There has been more than one suggestion that mapping exercises of the extent (or lack thereof) of the practices to be recommended throughout hospitals and networks may be advisable in advising on benchmarking of a minimum standard of care if the recommendations	Service mapping exercises are outside the remit of this guideline.

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							are to go beyond the evidence available particularly in the area of interventions.	
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.50	Full	General			This document appears very prescriptive. There is a risk that if NICE recommendations are too prescriptive, there may be implementation of activities of unproven value, lacking robust evaluation of health benefit which when established by NICE may later preclude appropriate evaluation. At present with minimal evidence the document appears to provide firm evidence based recommendations. These then will no longer require 'proof' as they are in a NICE document. As they are rather prescriptive in nature this provides a mandate to try to institute these evidence based recommendations. Is this appropriate ?	We have reviewed the wording of the recommendations and have ensured that the need to use clinical judgement is flagged up as appropriate. In order to improve transparency section 1.3.4, section 2.1.4 and section 2.2.4 have documented explicitly which recommendations are evidence-based and which recommendations are based on GDG consensus.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.51	Full	General			At present there is a strong implication as the document is written that ICU should take on the role of a what is effectively chronic disease management. Clearly this is better dealt with by individual referring specialties or rehab medicine?	The guideline does not imply that ICU should take on the role. As stated in recommendation 1.1.1 Healthcare professional(s) with the appropriate competencies should coordinate all the assessments and the rehabilitation programmes throughout the patient's rehabilitation care pathway to

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								ensure continuity of care.
SH	Intercollegiate Board for Training in Intensive Care Medicine	56.52	Full	General			The consensus view is that this is an important document that could have very positive benefits to patients and their carers. It highlights a major problem and indicates the means of addressing it. It is very important that this is not seen as a DIY manual which patently lacks a Homebase. At present it is at risk of looking exactly that.	Noted.
SH	Ipswich Hospital NHS Trust	57					This organisation was approached but did not respond	
SH	Lancashire Teaching Hospitals Acute Trust	58					This organisation was approached but did not respond	
SH	Leeds PCT	59					This organisation was approached but did not respond	
SH	Long-term Conditions Alliance	60					This organisation was approached but did not respond	
SH	Luton & Dunstable Hospital NHS Foundation Trust	61					This organisation was approached but did not respond	
SH	Medicines and Healthcare Products Regulatory Agency (MHRA)	62					This organisation was approached but did not respond	
SH	Medway NHS Trust	63.00	Full	General	General		It is good to note that patients and their families are being considered	Noted
SH	Medway NHS Trust	63.01	Full	General	General		By using the term critical care is it being said that all patients who have been in a Level 2 facility (HDU) need to have all of these recommendations done Many patients in surgical HDU's are for routine elective surgery	Please see section 1.3.1 on groups that are not covered by this guideline
SH	Medway NHS Trust	63.02	Full	Genera	Genera		Look forward to seeing the	Noted

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				I	I		implementation tool as to how this guideline will be implemented across all of the areas that it needs to be	
SH	Medway NHS Trust	63.03	Full	Page 5	99-105	101	Not at all sure about the use of the term "non-physical". What is wrong with psychological domains?	The GDG considered that 'Psychological domains' does not cover cognitive dysfunction
SH	Medway NHS Trust	63.04	Full	Page 9		225	Not all patients will be in a position to "agree". This sentence may lead people to think that if patients do not agree then families and cares do not have to be given the opportunity to be involved.	The Mental Capacity Act (2005) has been referred in the 'Patient-centred care' section, and all recommendations are based on the assumption that the patient has the capacity to give consent. The GDG recognised that patients may not have the capacity to give consent when they were still in critical care, and this is clearly reflected in recommendation 1.1.2 and footnote 6.
SH	Medway NHS Trust	63.05	Full	Page 10 - 18	1.1		I agree in principle with all that is said but cannot see how in practice it will be done. As is known many hospitals have no critical care follow up at all.	Noted. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline. .
SH	Medway NHS Trust	63.06	Full	Page 10 - 11	1.1.1 – 1.1.3		I wonder how this can be achieved when many Level 3 ITU's run at very high occupancies rates and often patients are discharged out quickly to ensure space for a new admission.	Noted. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline.
SH	Medway NHS Trust	63.07	Full	Page 18	1.1.12	431	If copies of critical care discharge summaries are to be given to patients they must be written in a language that patients can understand. Are we	The GDG considered it was upto local teams to determine the discharge summary should be structured.

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							expecting to use the same discharge summary that would be used in section 1.1.3 line 276? Patients may not be ready psychologically to know what exactly what happened to them to take them to Level 3 critical care in the first place	
SH	Medway NHS Trust	63.08	Full	Page 15	1.1.8	357	We have concerns about the use of word "reassurance" as for some patients reassurance may not help	Changes have been made in recommendation 1.1.13 to address this point - , the term 'reassurance' has been taken out and replaced with 'support'.
SH	Medway NHS Trust	63.09	Full	Page 17	1.1.11		Not at all sure that all patients have capacity to "agree" , or that they are able to take in the information that is given to them at this stage	The Mental Capacity Act (2005) has been referred in the 'Patient-centred care' section, and all recommendations are based on the assumption that the patient has the capacity to give consent. The GDG recognised that patients may not have the capacity to give consent when they were still in critical care, and this is clearly reflected in recommendation 1.1.2 and footnote 6.
SH	Mid Trent Critical Care Network	64.00	Full			179	If this is regarded as a "major public health issue" we need to find some way of working more closely with our primary care colleagues to ensure a seamless service for our patients.	The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.
SH	Mid Trent Critical Care Network	64.01	Full			199-201	The challenge is in persuading our commissioning colleagues of the value of supporting this service requirement given all other service competing demand.	Noted
SH	Mid Trent Critical Care Network	64.02	Full			249 &	Health care professionals need to work together to ensure a joined up approach	Noted

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						278, 279	and best use of resources.	
SH	Mid Trent Critical Care Network	64.03	Full			331	This is key to ensure that the patient is appropriately supported both physically and mentally otherwise there is the potential to cause undue distress or confusion if a need is identified and then not supported.	Noted
SH	Mid Trent Critical Care Network	64.04	General				This is a refreshing approach particularly as it is centred on the patient pathway rather than one service. This is a challenging document in that many critical care units are likely not be compliant with all of the recommendations. One assumes that the rehabilitation programme developed by Christina Jones will be forwarded on and there will need to be instructions, workshops or briefings on how to use this. In terms of referral to specialists such as PTSD this will be challenging as few hospitals offer this service. We need to work with commissioners in terms of funding and it is helpful that no one model has been suggested. We would urge for there to be some sort of commissioning framework and standards to ensure this gets picked up and a good vehicle through which to ensure this happens is the critical care networks, where these are in place and functioning. We have developed such a framework in our Network (in conjunction with a neighbouring Network) and have included	Thank you. The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.

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							key performance indicators from your guideline. Alternatively this is included in HRG/PbR framework. Congratulations on producing a refreshing and inspiring guideline. We look forward to seeing the implementation plan.	
SH	Milton Keynes PCT	65					This organisation was approached but did not respond	
SH	MRSA Action UK	66					This organisation was approached but did not respond	
SH	National Outreach Forum	67					This organisation was approached but did not respond	
SH	National Patient Safety Agency (NPSA)	68					This organisation was approached but did not respond	
SH	National Public Health Service - Wales	69					This organisation was approached but did not respond	
SH	National Spinal Injuries Centre	70					This organisation was approached but did not respond	
SH	National Treatment Agency for Substance Misuse	71					This organisation was approached but did not respond	
SH	NCC for Acute Care	72					This organisation was approached but did not respond	
SH	NCC for Cancer	73					This organisation was approached but did not respond	
SH	NCC for Chronic Conditions	74					This organisation was approached but did not respond	
SH	NCC for Mental Health	75					This organisation was approached but did not respond	
SH	NCC for Nursing & Supportive Care	76					This organisation was approached but did not respond	
SH	NCC for Primary Care	77					This organisation was approached but did	

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							not respond	
SH	NCC for Women & Children	78					This organisation was approached but did not respond	
SH	NCCHTA (1)	79.00					Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline compared to its scope	
SH	NCCHTA (1)	79.01	Full	4-22			The summary and overview sections set the scene for the guideline, which in general adheres to the sentiment of the scope document The groups of interest are clearly defined, with the justification for the necessity of the guidelines clearly stated. Exclusions, including reasons are clearly made.	Noted Noted
SH	NCCHTA (1)	79.02	Full	General			Population is clear: Adults with rehabilitation needs following critical illness. Exclusions are clear: Adults receiving palliative care; clinical sub-groups that already have rehabilitation needs covered and areas where guidelines already exist. Scope: Physical and non-physical morbidity However I do not think the economic aspects are fully explored. I will explain more later.	Noted
SH	NCCHTA (1)	79.03	Full	23	2.1.1.	525	The clinical argument is clearly made for the guidelines. Presumably of the 100,000 people admitted to critical care in the UK each year, some will be covered by the existing guidelines, some with be covered by existing surgical management and others will proceed to palliative care.	Noted. In the development of the costing tools for this guideline the GDG and technical team will offer an estimate of the number of people who will require rehabilitation after a period of critical care, based on the available evidence from ICNARC**.**

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							Therefore, what is the actually number of patients that will directly benefit from these guidelines? This has important implications for the necessity of the guidelines and the cost of implementing them.	
SH	NCCHTA (1)	79.04	Full	19			Summary Table – Contains several error and missing information	This is not a summary table. This is a care pathway and therefore does not envisage to reproduce the exact wording of all recommendations. A new care pathway has been produced for clearer illustration.
SH	NCCHTA (1)	79.05					Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual)	
SH	NCCHTA (1)	79.06	Full	General			The authors performed a systematic review of the published literature, using a broad range of recognised sources. The quality of the studies was determined using the QUADAS checklist. Inclusion/exclusion criteria are clear, so the search can be repeated if necessary. The reasons for including and excluding identified studies are also explained. No meta-analysis was required, due to the limited evidence base.	Noted
SH	NCCHTA (1)	79.07	Full	38	2.2.4	864	Personally I do not like the phase 'a good quality study' I would prefer, 'a study based on good quality evidence'. A study can use good evidence but be poor quality. This is used throughout the report	Noted. The NICE technical team prefers to use terms that are consist with those used by GRADE methodology.
SH	NCCHTA (1)	79.08	Full	23-26			Screening and assessment tools: Poor evidence base, only seven cohort studies identified. None are randomised.	Noted. The generalisability of the included studies on screening and assessment were discussed in-

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							Evidence is taken from several countries with different health care settings (acknowledged by authors), therefore the generalisability may be questionable, although probably suitable for inclusion in the review. The only UK study dates back to 1991, therefore this may not be valid anymore, both in terms of setting or treatment options.	depth by the GDG and its deliberations are summarised in the 'Evidence to recommendations' section (section 2.1.4)
SH	NCCHTA (1)	79.09	Full	35			Non-physical morbidity: The evidence base is more compelling. The authors review the sensitivity and sensitivity of PTSS-10, PTSS-14, HADS, STAI-X1 and DASS.	Noted.
SH	NCCHTA (1)	79.10	Full	48		1187	Rehabilitation strategies: Based on only one study, I would have liked to see more information about the 23 studies that were excluded because they are low quality	These 23 studies are of low quality design and were therefore excluded..
SH	NCCHTA (1)	79.11	Full	53			Rehabilitation strategies: the critique of the Jones 2003 study highlights some interesting points that are not discussed in the text. 1) The sample is different at baseline, which may explain the differences at week 8 etc.. 2) Maximum number of patients are at 8 weeks, why not baseline? What happened to drop-outs?	We agree. The discussion of the limitations of the Jones et al (2003) study has now been documented in section 2.2.2 and section 2.2.4.
SH	NCCHTA (1)	79.12					Please comment on the health economics and/or statistical issues depending on your area of expertise	
SH	NCCHTA (1)	79.13	Full	46	2.2.8	1125	Sentence incomplete.	We have corrected this.
SH	NCCHTA (1)	79.14	Full	58-61	2.4.4		Health Economics: The authors present the findings of an unpublished trial-based utility study in Appendix 5. This study as a	Thank you for your comment. The limitations of this study are recognised by the authors and are

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							number of floors which may be why it hasn't been published yet! 1) The costs are not presented as unit costs, therefore it is difficult to follow what is included. 2) There is no statistical difference in EQ-5D scores between the groups at baseline or at 6 months, therefore why is the conclusion of the study that treatment leads to higher QALYs. 3) The QALYs are only calculated at the 6 month time period, rather than the cumulative QALY gain over this period (acknowledged by authors) 4) Incremental costs and benefits are not reported correctly (acknowledged)	presented in the review section..
SH	NCCHTA (1)	79.15	Full	61		1553	The authors highlight a common problem of running a economic evaluation along side a RCT, in that resource use is often over-estimated. This can be adjusted however.	Thank you for your comment.
SH	NCCHTA (1)	79.16	Full	62			I felt the health economic section would have been more useful if the authors had calculated the economic impact. For example, 1) estimated the number of patients that would receive the new rehabilitation service. 2) estimated the cost per patient of providing a) screening assessment/tools and b) patient manual, even if this meant examining the costs of similar interventions in different patient groups. With both these data, the authors could have provided an estimate of the total cost per year to the NHS.	Thank you for your comment. The costing team within NICE's implementation directorate will produce a report on the economic impact of the recommendations. Unless a comparative costing exercise could be carried out this would not be undertaken within the guideline.
SH	NCCHTA (1)	79.17	Full	75			Not discussed within the health economics section, is the cost of informal care. This could be measured as lost	Thank you for your comment. According to the guidelines manual (The Guidelines Manual 2009, p86-87), had an economic evaluation

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							utility caused by physical activity and the stress of looking after a family member. There are also the financial implications in terms of the opportunity cost of lost income etc….	been carried out, any information on the impact on carer utility would have been taken into consideration if the evidence allowed. Only direct costs to the NHS and PSS are considered. We do not take productivity losses into account.
SH	NCCHTA (1)	79.18					How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?	
SH	NCCHTA (1)	79.19	Full	31-32	2.2.3		Screening and assessment tools: The authors acknowledge the limitations of the evidence. However the recommendations appear to be based on the judgement of the GDG. I'm a little unsure why the authors recommend "all the clinical assessments of physical morbidity could be carried out at different stages of the patients rehab pathway", since they say most tools are not sensitivity to changes in this population	The GDG agreed that the lack of validated tools for screening and assessment does not, and should not, preclude the use of clinical judgment by practitioners. Hence, recommendations on the need to conduct 'clinical assessments' were made.
SH	NCCHTA (1)	79.20	Full	32 - 33			The four key stages of patient rehabilitation pathway are based on the opinion of the GDG rather than the published evidence.	Noted. This is made clearer in the revised evidence to recommendation sections.
SH	NCCHTA (1)	79.21	Full	General			Non-physical morbidity: The authors review several different assessment tools but do not recommend a superior instrument.	Noted. This discussion on why a specific assessment instrument was not recommended is set out in the 'Evidence statements' and 'Evidence to recommendations' sections. (section 2.1.3 and section 2.1.4)

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SH	NCCHTA (1)	79.22	Full	62-63			The authors acknowledge the limitation of the economic section	Thank you for your comment.
SH	NCCHTA (1)	79.23	Full	63		1603-5	The authors suggest that the introduction of a patient information booklet may be cost-effective. This is a strong statement based on no evidence.	Thank you for your comment. This statement is based on the review of an unpublished trial-based cost-utility analysis (Centre for Health Planning and Management 2001) and clinical evidence.
SH	NCCHTA (1)	79.24					Are any important limitations of the evidence clearly described and discussed?	
SH	NCCHTA (1)	79.25	Full	General throughout			The published evidence for these guidelines is very limited. In general the authors acknowledge these limitations.	Noted. We consider we have fully addressed the limitations of the current evidence base.
SH	NCCHTA (1)	79.26					Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.	
SH	NCCHTA (1)	79.27	Full	General			On the whole the report is well written and easy to follow	Thank you.
SH	NCCHTA (1)	79.28					Please comment on whether the research recommendations, if included, are clear and justified.	
SH	NCCHTA (1)	79.29	Full	General			As mentioned in the previous sections, the evidence base in lacking. Therefore most of the recommendations are based on the advice of the GDG rather than evidence of effectiveness or cost-effectiveness	Noted. This is made clearer in the revised evidence to recommendation sections.
SH	NCCHTA (2)	79.30					Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline	

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							compared to its scope	
SH	NCCHTA (2)	79.31	Full	General			It's very difficult to draw conclusions about the usefulness of this draft Guideline since the key outcome mortality is not addressed. This may reflect the lack of work in this area but it seems to me that RCTs are needed.	As this is a guideline regarding rehabilitation after critical illness (not the effectiveness of critical care treatments), physical and non-physical functions, and patient's quality of life are the key outcomes, not mortality.
SH	NCCHTA (2)	79.32					Please comment on the health economics and/or statistical issues depending on your area of expertise	
SH	NCCHTA (2)	79.33	Full			819. 794. 2304.	One of the issues (minor but a statistician would have picked this up) is simple presentation of data. Sensitivity (Se), Specificity (Sp), negative predictive value (NPV) and positive predictive value (PPV) are given as percentages (lines 819-816 and elsewhere). However, the areas under the curve (AUC) are given in decimals (line 794 and elsewhere). In addition, the definition of Se/Sp for the receiver operating characteristic (ROC) curve is given as a decimal (line 2304). This mismatch leads me to think that this team are not familiar with the interpretation of these (simple) indices.	This is an editorial issue – changes have been made to address this point.
SH	NCCHTA (2)	79.34	Full			2290 - 2292.	The definition of the RCT is poor. The reason why the RCT works as a design is the randomization to treatment but this is not picked up on by the team.	The definition is as stated in the guidelines technical manual 2009.
SH	NCCHTA (2)	79.35	Full			1302 - 1309.	Look at the table. What on earth I am supposed to make of this? This is the clearest indication to me that statistical input was required. ANOVA, headings, context etc not described for me to make	These called GRADE profiles. This is the approach to making the evidence to recommendations more transparent that NICE is now adopting in its guidelines programme. .Please see appendix

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							any sense of this information.	4 for the full version of the GRADE profiles and evidence table for detailed statistical analysis.
SH	NCCHTA (2)	79.36	Full			848-850. 852-855. 858-859.	Confusion over the terms validity and reliability. These have very little to do with Se, Sp, PPV and PPV. A valid instrument measures what it purports to measure; reliable instruments give the same results at different time-points, or for two or more different observers.	The technical team and the GDG understand that Se, Sp, PPV and PPV are measurements of accuracy, not validity. A test with high accuracy does not necessary mean it is valid when considering other issues, for example, generalisability. The technical team admits that the use of the terms 'validity and reliability' throughout the text as an overall subtitle may cause confusion. The text has been re-edited to reduce the risk of confusion.
SH	NCCHTA (2)	79.37	Full			785. 810.	Interpretation of Cronbach's alpha subjective. For example, a value of 0.89 is said to be 'reasonably good ' while a value of 0.93 is given as 'good'. Where is the evidence-base for these statements?	This is an editorial issue – changes have been made to address this point which are based on the Bland & Altman (1997) study published by the BMJ.
SH	NCCHTA (2)	79.38					How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?	
SH	NCCHTA (2)	79.39	Full			647-670.	Much of the evidence they cite is graded as low quality by the team. I would not have reviewed these types of papers in such fine detail. The low evidence in itself is an important conclusion to draw.	Noted.
SH	NCCHTA (2)	79.40	Full			1120.	The majority of studies reviewed are not RCTs so the evidence base is going to be weak (this is not their fault of course, and perhaps this is why a review was	Noted.

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							commissioned). On line 1120 they say that under ideal circumstances the RCT are required. Although study designs other than the RCT can provide an evidence-base, the RCT is the gold standard.	
SH	NCCHTA (2)	79.41					Are any important limitations of the evidence clearly described and discussed?	
SH	NCCHTA (2)	79.42	Full			2388 - 2415.	The literature search was carried out according to 'The Guidelines Manual 2007'. However, there is no recognition or attempt to access the so-called 'grey literature' (i.e., work ongoing but unpublished). I could not see a mention of publication bias and how this might affect their interpretation of the evidence. There's a large statistical literature in this area, and while I don't expect a formal analysis (actually difficult with the types of studies assessed) I would have expected a reference at the very minimum.	There is appropriate recognition of unpublished ongoing work. One relevant ongoing study (the PRACTICAL study) was indeed identified and highlighted in the health economics section.
SH	NCCHTA (2)	79.43	Full			587-602.	A flow chart would have been useful.	Please see appendix 4.
SH	NCCHTA (2)	79.44					Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.	
SH	NCCHTA (2)	79.45	Full			165.	Overall, the paper lacks clarity from an academic perspective. The English is poor and language non-scientific. It is clearly vital...'.	These comments relate to the foreword. This has been re-edited.
SH	NCCHTA (2)	79.46	Full			170.	'...modestly-sized studies of proportions of patients...' What on earth does this	These comments relate to the foreword. This has been re-edited.

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							statement actually mean?	
SH	NCCHTA (2)	79.47	Full			64. 525.	I'm not an expert in critical care but there seemed to be some confusing statements. On line 525 I am told that 100,000 people are admitted to critical care in the UK; but in the 'Forward' this figure is 70,000. I noticed that the 'Forward' referred to England and Wales, while the other figure was the UK (the 30,000 difference reflects the larger area of the UK I guess). I am aware, of course, that these two geographical areas are not the same but my preference would be to stick with one or the other. As a non-expert this serves to confuse.	Error has been corrected
SH	NCCHTA (2)	79.48					Additional comments	
SH	NCCHTA (2)	79.49	Full			135	I found it surprising that none of the group appeared to be a statistician. It is therefore not surprising that their interpretation of the evidence is not strong. A point made by them (line 135) is that this was seen as a strong team of reviewers that brought a 'wealth of experience'. I don't doubt their clinical expertise, but I remain to be convinced that all members have good academic backgrounds. I'm not being a snob here, but feel strongly that such reviews should be carried out with appropriate clinical, statistical and epidemiological expertise. Otherwise, we are back to eminence-based medicine rather than evidence-based medicine. I understand the importance of the condition and the work put in but overall I thought this was a disappointing result.	All members of the NICE Technical Team have appropriate qualifications and academic backgrounds in health services research. As well as all being clinical experts in the field, a number of the GDG members of this guideline are also academics in their own right with experience of primary research and extensive lists of journal publication.
SH	NCCHTA (2)	79.50	Full			848-	Their understanding of terms such as	The technical team and the GDG understand that Se, Sp, PPV and

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						850. 852-855. 858-859.	validity and reliability leaves a lot to be desired. These terms have very little to do with sensitivity and specificity as I pointed out earlier.	PPV are measurements of accuracy, not validity. A test with high accuracy does not necessary mean it is valid when considering other issues, for example, generalisability. The technical team admits that the use of the terms 'validity and reliability' throughout the text as an overall subtitle may cause confusion. The text has been re-edited to reduce the risk of confusion.
SH	NCCHTA (2)	79.51	Full				Tables of basic characteristics of the patients, sample size, power calculations (as you might report for CONSORT) would have been of value (to be reported per paper). I accept that there are very few RCTs in this area but this should have been a clue as to cut down the review. The DoH will see the RCT as the gold standard as do I.	Please refer to the guideline appendix 4. This sets out this information.
SH	NHS Bedfordshire	80					This organisation was approached but did not respond	
SH	NHS Clinical Knowledge Summaries Service (SCHIN)	81					This organisation was approached but did not respond	
SH	NHS Kirklees	82					This organisation was approached but did not respond	
SH	NHS Plus	83					This organisation was approached but did not respond	
SH	NHS Purchasing & Supply Agency	84					This organisation was approached but did not respond	
SH	NHS Quality Improvement Scotland	85					This organisation was approached but did not respond	
SH	NHS Sheffield	86					This organisation was approached but did not respond	
SH	Norfolk, Suffolk and	87					This organisation was approached but did	

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	Cambridgeshire Critical Care Network						not respond	
SH	North Bristol NHS Trust	88.00	Full	General			This guidance has been reviewed and discussed by our multidisciplinary ICU research team that includes intensivists, respiratory physicians, psychologists, physiotherapists. We have also discussed this with research collaborators at the University of West of England and Stanford University, USA. The recommendation to considering both physical and non physical rehabilitation from an early stage is welcome as is the early involvement of family members or others who are close to the patient.	Noted and thanks.
SH	North Bristol NHS Trust	88.01	Full	General			Introducing awareness of emotional/ cognitive issues from the beginning of a patient's critical illness will change the current status when non-physical issues are addressed at a later stage or not at all.	Noted.
SH	North Bristol NHS Trust	88.02	Full	General			Addressing psychological issues at a later stage of a patient's illness sometimes comes as a shock. Early consideration of psychological issues for patient and family may well reduce subsequent psychological difficulties.	Noted.
SH	North Bristol NHS Trust	88.03	Full	General			The guidance does not mention that some patients do not wish to take part in rehabilitation after discharge from hospital. This is especially the case for non-physical issues. Many patients drop out or do not wish to have this. Whether	The guideline aims to provide recommendations for adult general critical care patients who meet the inclusion criteria specified in the Scope (appendix 1). It is outside the Scope for this guideline to address

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							this is because they do not have any problems or do not wish to discuss them is difficult to say.	issues such as adherence with therapy..
SH	North Bristol NHS Trust	88.04	Full	47	2.3		The guidelines are not specific in terms of the content of a physical rehabilitation program. Apart from that it should be designed etc by a multidisciplinary team. The main justification for this is the lack of evidence to support a any particular intervention	Noted
SH	North Bristol NHS Trust	88.05	Full	75	2.7		The Research Recommendations are excellent - concise but comprehensive, and they really outline the major issues related to co-morbidity, assessment, and intervention.	Thank you
SH	North East & Cumbria Critical Care Network	89					This organisation was approached but did not respond	
SH	North Trent Critical Care Network	90					This organisation was approached but did not respond	
SH	North West London Critical Care Network	91					This organisation was approached but did not respond	
SH	North Yorkshire and York PCT	92					This organisation was approached but did not respond	
SH	Northampton General Hospital NHS Trust	93					This organisation was approached but did not respond	
SH	Northumbria Healthcare NHS Foundation Trust	94	General				Lots of good content but far too bulky document for most working clinicians and nurses to read. Simple summary tables would help, and page 19 is a good one.	The guideline has been re-edited to reduce repetition and to aid clarity.
SH	Nottingham University Hospitals NHS Trust	95					This organisation was approached but did not respond	
SH	Nutricia Clinical Care	96					This organisation was approached but did not respond	
SH	Oklahoma State University	97					This organisation was approached but did not respond	
SH	Oxford Radcliffe Hospitals NHS Trust	98.00	Full	10	1.1.1	235-257	This section clearly describes the current role of the intensive care physiotherapist	Noted. It is outside the remit of this

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							and does not do justice the professional capabilities of this group	guideline to provide recommendations on service delivery models or service configuration.
SH	Oxford Radcliffe Hospitals NHS Trust	98.01	Full	12	1.1.4	285-288	Welcome the recommendation but there is too much ambiguity in recommending a six week programme although acknowledge lack of specific evidence.	The recommendations have been changed. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients
SH	Oxford Radcliffe Hospitals NHS Trust	98.02	Full	14	1.1.6	331	In reality there are huge issues surrounding access and funding for follow up opportunities or rehab provided away from the acute hospital. Who funds ongoing care needs- especially relevant to tertiary centres. Clear guidance needed to remove these barriers and provide the service when and where needed. Waitin times to access outpatient and community physio/OT unacceptable to most patients.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation

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								Advisor will engage appropriate stakeholders to address the above issues.
SH	Oxford Radcliffe Hospitals NHS Trust	98.03	Full		1.1.7	338	Follow up at 2-3 weeks is necessary but specific inclusion of rehab professionals is patchy. Welcome recommendations that involve physiotherapy and other rehab professionals at follow up but concerned that access to services needed by patients are given low priority by PCTs. More specific recommendations needed to remove these barriers for patients.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Oxford Radcliffe Hospitals NHS Trust	98.04	Full	General			Emotional support and family support should be readily available for relatives especially those with dependents.	This is addressed: recommendation 1.1.11 recommends that general guidance and information on support services should be provided to family/carers as well as patients.
SH	Paediatric Intensive Care Society	99.00	General				The Guideline Group is to be congratulated on a very thorough piece of	Thank you

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							work on an area of practice that has yet to achieve full recognition. Such guidance as this is both much needed and very timely.	
SH	Paediatric Intensive Care Society	99.00	General				It is noted by our Society that the work has been conducted in reference to Adult patients.	The population the guidelines addresses (adult) is set by the remit from the Department of Health.
SH	Paediatric Intensive Care Society	99.01	General				The NICE Document states 70,000 people are looked after in intensive care per year (Is the number of admissions to adult intensive care 70 000 (Foreword) or 100 000 (Section 1.3)? We don't know if this includes children. We do know that more than 15,000 children passed through both adult and paediatric intensive care in 2007(1). Our registry does not double count as there is a mechanism for avoiding this.	Thank you. The error on our part has been corrected
SH	Paediatric Intensive Care Society	99.02	General				It is a shame that NICE did not choose to include a section on paediatric intensive care. There are now a number of DoH guidelines/reports relating to Critical Care which make no mention of paediatrics or the care of children and families in this situation. The fact that this is happening again with this guideline (and apparently with the proposed NICE guideline on Delirium) seems to represent a missed opportunity for people working in adult and paediatric settings to share knowledge in these areas.	Children are outside the remit of this guideline.
SH	Paediatric Intensive Care	99.03	Genera				If a separate "paediatric" guideline were to	Noted.

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	Society		l				be commissioned it is not likely to be read by adult intensivists/nurses/AHPs and so a lot of the paediatric literature on patients and relatives which may be relevant to adult units will not be seen.	
SH	Paediatric Intensive Care Society	99.04	General				If there is no time for paediatric relevant material to be included here, there would remain a case for the formation of a Guideline group to examine the rehabilitation of children and their parents and carers. There are added complexities: children present at different ages with varying degrees of dependency on their families and, consequently, the degree of impact on the family may vary accordingly. Added to this are the complexities of the dynamically changing nature of the child's development that will be affected by the intensive care experience, both from physical and psychological aspects.	Noted. NICE welcomes stakeholders suggesting topics for future guidelines through its Topic Selection process. See: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
SH	Paediatric Intensive Care Society	99.05	General				The evidence base is very limited regarding the natural history of psychological symptomatology in patients and carers following critical care treatment. As yet, we do not have agreed ways to screen for risk of PTSD, although there is evidence that screening instruments used at the time of discharge have some utility in detecting parents at risk in paediatric settings(2, 3); we do not have measures to assess delirium across the age range but there is evidence that children report similar delusional	Children are outside the remit of this guideline.

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							experiences to adults (4, 5) and the evidence for the value of early intervention with families is scant. However, experience with parents in PICU settings using the COPE Program (6) is encouraging.	
SH	Paediatric Intensive Care Society	99.06	General				The focus on psychological symptoms and on follow-up is welcome but the implications for resources are huge as regards the regular assessment and monitoring of patients' psychological symptoms. In particular, the manpower required to devise individual rehab programmes far outstrips the current capacity of adult units (and the same would be true for paediatric units).	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Paediatric Intensive Care Society	99.07	General				A seismic cultural shift will be required in order for these guidelines to be taken on by intensivists who are used to working acutely and who have traditionally always	It is outside the remit of this guideline to provide recommendations on service delivery models or service

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							passed on the clinical responsibility for their patients at the point of discharge. It will be important to clarify which clinicians are responsible for providing and overseeing the rehabilitation programmes as recommended here. Will there be a need for the development of new breed of intensive care rehab professional?	configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Paediatric Intensive Care Society	99.08	General				We welcome the idea of patients/families receiving a) copies of the ICU discharge summary and b) information on the differences between ICU and the general ward. Families report high levels of stress relating to transfer in paediatric settings (7) and provision of information on the what to expect on discharge from PICU has been associated with reduced anxiety in parents (8-10)	Noted
SH	Paediatric Intensive Care Society	99.09	General				Although patient diaries are reportedly well received, they take a great deal of	Due to a lack of evidence of effectiveness, the GDG and the

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							time to put together – this issue would need to be appreciated by any team wishing to incorporate them into regular practice. Also there is no published evaluation of the effect of the provision of diaries as an intervention, although I understand one is planned.	NICE technical team considered that the guideline is not in a position to make any specific recommendations regarding the use of diaries. As result, this particular recommendation has been removed.
SH	Paediatric Intensive Care Society	99.10	General				The lack of an effect of the self –help manual on longer term psychological symptoms may indicate that more individually tailored clinical input with the most distressed is required.	Noted.
SH	Paediatric Intensive Care Society	99.11	General				There is relatively little in the guideline on the assessment of cognitive problems, which affect paediatric patients as well as adult ones (11).	This issue has been discussed in the 'evidence statements' section and the 'evidence to recommendations section (section 2.1.3 and section 2.1.4)
SH	Paediatric Intensive Care Society	99.12	General				There is relatively little in the guideline on the assessment of psychological problems in relatives. This is an issue which is probably more central in paediatrics where patients are usually totally dependent on parents for their aftercare, but which is also acknowledged as important in relation to adult units.	Psychological assessment and interventions for relatives are outside the scope of this guideline.
SH	Paediatric Intensive Care Society	99.13	General				Only 1/15 people on the panel was a psychologist/psychiatrist. This seems a low proportion given the weight attached to the importance of psychological follow up.	Another member of the GDG (Consultant Nurse) is also a qualified psychotherapist.

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SH	Paediatric Intensive Care Society	99.14	General				References: 1 PICANet. Abridged National Report of the Paediatric Intensive Care Audit Network 2005-2007. 2008: http://www.picanet.org.uk/Documents/General/Annual_Report_2008/Abridged%2020PICANet%2020National%2020Report%202005%202020-%202007.pdf. 2 Colville G. Screening for post traumatic stress in parents after their child's admission to PICU. Pediatr Crit Care Med 2006; 7: 410. 3 Balluffi A, et al. Traumatic stress in parents of children admitted to the pediatric intensive care unit. Pediatr Crit Care Med 2004; 5: 547-553. 4 Colville G, Kerry S, Pierce C. Children's factual and delusional memories of intensive care. Am J Respir Crit Care Med 2008; 177: 976-982. 5 Colville G. Rats, cats and scorpions: children's hallucinations in paediatric intensive care. Br J Hosp Med (Lond) 2008; 69: 492-493. 6 Melnyk BM, et al. Creating opportunities for parent empowerment: program effects on the mental health/coping outcomes of critically ill young children and their mothers. Pediatrics 2004; 113: e597-607. 7 Colville G, et al. The impact on parents of a child's admission to intensive care: Integration of	Thank you.

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							qualitative findings from a cross-sectional study. Intensive Crit Care Nurs 2008: doi 10.1016/j.iccn.2008.1010.1002. 8 Bouve LR, Rozmus CL, Giordano P. Preparing parents for their child's transfer from the PICU to the pediatric floor. Appl Nurs Res 1999; 12: 114-120. 9 Linton S, Grant C, Pellegrini J. Supporting families through discharge from PICU to the ward: The development and evaluation of a discharge information brochure for families. Intensive Crit Care Nurs 2008; 24: 329-337. 10 Van Waning NR, Kleiber C, Freyenberger B. Development and implementation of a protocol for transfers out of the pediatric intensive care unit. Crit Care Nurse 2005; 25: 50-55. 11 Elison S, et al. Neuropsychological function in children following admission to paediatric intensive care: a pilot investigation. Intensive Care Med 2008; 34: 1289-1293.	
SH	Patient Liaison Group - RCoA	147.00	Full	General			The PLG of the RCoA welcomes this NICE Guideline, which if implemented should provide patients and their families with the information they need to help manage their expectations of recovery. The equal emphasis on both physical and non-physical morbidity is particularly	Thank you

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							commended, as is the delineation of the 'during' and 'before discharge' phases for critical care and ward-based care, the tabular summary presentation and useful cross references to other pertinent NICE Guidelines. We have extremely few negative comments to offer, but would like to highlight the following points for consideration:	
SH	Patient Liaison Group - RCoA	147.01	Full	14,15,16	Summary	334,345,350,369	The term 'appropriate' is used repeatedly: 'appropriate discharge service' ' appropriately skilled healthcare professionals' 'appropriate rehabilitation services' ' communicated as appropriate' We feel that this word may well have different meanings depending upon the person who is interpreting the Guideline and/or the facilities which are available (depending upon where the patient lives). We think that there may be a risk of subjectivity creeping in, and wonder whether a way around this could be to include examples; the list would be non-exhaustive, but would go some way to alleviating our concern.	Editorial changes have been made
SH	Patient Liaison Group - RCoA	147.02	Full	30	Evidence Review and Recommendations	635 – 643	Linked to (2) above, we are not sure how, in practical terms, recommendation 1.1.7 will be achieved effectively if at the time of the 2 -3 month review the patient is receiving community/primary care in a rural setting. Unless the 'appropriately skilled health care professional (ashcp) is able to observe and talk to a patient over a period of time, at a superficial level they are unlikely to spot diminished cognitive	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include:

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							function in someone who is articulate and apparently capable of making competent decisions. We feel that it should be explicitly recommended that the 'ashcp' should liaise with the family/carer as part of this review, so that those who have day to day experience are able to raise any concerns. (An example of the 'ashcp' in this context might be the GP.) We note that the 2 – 3 month review is specified only for patients for whom continuing rehabilitation needs have been identified during ward-based care. Would it be prudent to require some limited review for all other patients, to ensure that no latent problems have arisen after discharge from hospital?	• Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Patient Liaison Group - RCoA	147.03	Full	72	Evidence Review and Recommendations	1828	This line raises the question of the inclusion of photographs of the patient in the ICU diaries. We are uneasy about consent for this being delegated to the family/carer if the patient lacks the capacity to do so; however well intentioned, when the patient is conscious they may feel that this was an intrusion of their privacy when they were at their most vulnerable.	Due to a lack of evidence of effectiveness, the GDG considered that the guideline should not make specific recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	Patient Liaison Group - RCoA	147.04	Full	General			Although we feel that the Guideline is to be applauded, some concern was expressed about its use in practice. If interpreted as tick box protocols which if complied with absolve the assorted hcps from any form of criticism, there is a danger that professional judgement could be eroded, with a consequent effect on real effectiveness and actual patient	Noted. We have revised the relevant recommendation. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients.

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							outcome. Line 288, which states 'at least six weeks' is one example which gave rise to this point.	The guideline also emphasises that examples from Table 1 and Table 2 should not preclude clinical judgment.
SH	Patient Liaison Group - RCoA	147.05	Full	General			Like most people who have not experienced the difficulties of transition from critical care to high dependency to ward to community care and finally discharge to home, some of us were naïve in thinking that when patients are discharged from critical care they 'bounce back'. One of us with recent experience of supporting a close relative wishes that these recommendations had been in place earlier, as the understanding that they would have brought to both patient and family would have eased their pathway considerably after a period of over six weeks in a critical care environment, and brought much more realism to the long road to recovery. This particular patient was helped by a visit from a friend who described how vulnerable and desolate he had felt in a similar situation some 20 years before, and how it had taken 5 months before he could lead a normal life and resume work. Although each patient is a unique individual, in cases of critical care marathons might it be worth considering providing other peoples' accounts of their feelings so that there is a realisation that they are not alone and that there are good outcomes? (This refers to non-physical morbidities in particular.)	The GDG considered that individual wishes should be taken into account regarding sharing experiences. Nevertheless, in recommendation 1.1.11, the guideline recommends that information on support services, such as support groups should be provided to patients, therefore patients know where to access those services if they wish to.
SH	Pennine Acute Hospitals	100					This organisation was approached but did	

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	NHS Trust						not respond	
SH	PERIGON Healthcare Ltd	101					This organisation was approached but did not respond	
SH	Pernicious Anaemia Society	102					This organisation was approached but did not respond	
SH	Plymouth Primary Care Trust	103					This organisation was approached but did not respond	
SH	Plymouth Teaching Primary Care Trust	104					This organisation was approached but did not respond	
SH	Renal Association	105.00	Full	General			There is very little evidence-base to support the proposed guidelines	Noted. This is made clearer in the revised evidence to recommendation sections.
SH	Renal Association	105.01					The proposed guidelines are very long and repetitive, considering there is very little evidence base	The final version of the guideline has been re-edited and the evidence to recommendations sections have been made more concise. This has resulted in a reduction in document length from 102 pages to 86 pages.
SH	Renal Association	105.02	Full	General			The guidelines do not stipulate, who performs the clinical assessments on the patients during their critical care stay or prior discharging the patient to home or community care. They need to be more specific.	Noted. In line with the remit of the guideline, we have flagged up that this should be delivered by appropriately trained health care professionals. It is outside the remit of this guideline to provide specific recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set

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								• Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Renal Association	105.03	Full	General			The guideline development group was very specialised but did not include general physicians, who will be accepting these patients onto their wards outside of the specialist rehab physicians.	The constituency of the GDG was approved by NICE. It is considered that the constituency of the GDG is appropriate as it includes medical and healthcare professionals who have experience in carrying out the screening and assessment and in delivering rehabilitation.
SH	Renal Association	105.04	Full	General			Overall, the guidelines lack clarity and are very generalised.	Noted. The final guideline has been revised and re-edited to improve clarity.
SH	Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust	106					This organisation was approached but did not respond	
SH	Royal Brompton & Harefield NHS Trust	107					This organisation was approached but did not respond	
SH	Royal College of General Practitioners	108					This organisation was approached but did not respond	
SH	Royal College of Nursing	109.00	Full	Genera	Genera		We would like to see a definition in terms	We agree. Please see section 1.3.4

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				l	l		of what 'rehabilitation' is in the document. For example, it could be argued that rehabilitation takes place as soon as the patient is admitted to ITU i.e. physiotherapy taking place, sedation hold, transferring out into bed even when ventilated. This would clarify any confusion.	for definition.
SH	Royal College of Nursing	109.01	Full	General	General		The whole ethos of rehabilitation would need to be changed within ICUs as ICU health professionals frequently focus upon the physiological priorities of life saving treatment and rehabilitation often comes second.	Noted.
SH	Royal College of Nursing	109.02	Full	General	General		If rehabilitation needs are to be assessed on admission there would need to be a strong change agent in place to change ethos amongst health care staff and ICU culture in achieving this. There was no real mention of education of ICU staff and ward staff on the importance of rehabilitation & ICU relocation stress following ICU.	The GDG is very aware of the importance of education and training, however specific recommendations on these areas are outside the scope of this guideline.
SH	Royal College of Nursing	109.03	Full	General	General		We support the recommendations made in this draft consultation which ultimately will enhance the care of patients following Intensive Care discharge. The recommendations are appropriate and are vital to enhancing the psychological and physiological care of patients post ITU discharge.	Noted
SH	Royal College of Nursing	109.04	Full	General	General		We welcome the care pathway, the recommendations and time frame that it	It is outside the remit of this guideline to provide

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							follows. Our main concerns are over the implementation of guidance and who undertakes such role.	recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.05	Full	6	Foreword	130	We like the GRADE appraisal of the evidence.	Thank you
SH	Royal College of Nursing	109.06	Full	General	General		In the rehabilitation pathway, we would like to see the mention of chronic/acute pain needs for referral.	Assessment for chronic/acute pain needs is outside the scope of this guideline. However, in footnote 2, it does state that pain is part of physical morbidity.
SH	Royal College of Nursing	109.07	Full	17-18	1.1.11-1.1.12	401-436	Information regarding patient rehabilitation given from ITU to ward and on discharge is vital and will help continuity of care for the patient. Involvement of the family will enhance the	Noted

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							quality of rehabilitation of the patient.	
SH	Royal College of Nursing	109.08	Full	17-18	1.1.11-1.1.12	401-436	We believe rehabilitation care pathway should be a single document with relevant assessment tool for relevant clinical areas, which could be used in ITU, ward and in the community.	Noted.
SH	Royal College of Nursing	109.09	Full	17-18	1.1.11-1.1.12	401-436	If we are to develop this care pathway we need to involve Multi-disciplinary Team (MDT) from hospital and community. This way there will be a greater understanding of the tools in all relevant clinical areas in the hospital and in the community, which will enhance quality of the patient's rehabilitation. It would be even better if we are able to develop a national rehabilitation pathway for this group of patients.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Royal College of Nursing	109.10	Full	56-57	2.4.3	1404 - 1416	Individualised programme should be provided to all patients not only for patients with more complex needs.	The recommendations have been revised. Please see the new care pathway.
SH	Royal College of Nursing	109.11	Full	56-57	2.4.3	1404 - 1416	We agree that a 'core team' in each setting would be useful. If we have a dedicated rehabilitation unit for this group of patients, with MDT including psychologist, rehabilitation nurse consultant, rehabilitation nurse specialist, GP, community nurses and social workers etc attached to the unit, will follow the patient from ITU to ward or the rehab unit (depending on the complexity of the patient's needs).	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support

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							When the patient is discharged he / she is followed up in the community and if the patient's condition deteriorates in the community, the GP or nurse consultant should be able to refer the patient to the consultant at the unit directly. This will enhance the patient's care as well as provide good communication links among hospital and community colleagues.	• Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.12	Full	97	4.2.12	2607	Already nurses are finding it hard to manage their workload that without assurances of extra funding and follow up services, this will prove extremely difficult to implement. Currently NHS Trusts have a number of clinical targets and Healthcare Commission (HCC) goals to achieve, unless NICE are explicit in what it recommends this will not take precedent. Some NHS Trusts may put the recommendations set down by NICE to the bottom of its priorities as it will not be compulsory compared to HCC targets for example related to infection control. We would recommend that the guideline is explicit to stating "Must do's".	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how

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								rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.13	Full	General	General		With regards to the implementation of the guidance, our major concern relates to who will do this role. This will be a significant increase in workload which is going to be difficult for already overstretched critical care nurses and outreach teams.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.14	Full	General	General		There needs to be some guidance regarding who will co-ordinate this, as to do this properly, it will require staff who are both experts in critical care, have good communication & interpersonal skills	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE

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							as well as skills in counselling. If these guideline recommendations are to fall onto already busy critical care nurses then this will be difficult to achieve. The document needs to recommend that a designated critical care follow-up nurse is employed by trusts that will co-ordinate the recommendations from NICE. With only 30% of ITUs providing a follow up clinic, often these are run with the good will and time of nurses and other healthcare professionals. We reiterate that it will be essential that trusts employ a specific nurse who will co-ordinate and formally lead the recommendations.	Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.15	Full	General	General		The standard bedside ICU nurse does not have the additional training in undertaking this specialist role of rehabilitation. Therefore this role cannot be just left to the standard bedside ICU nurse as the role will not be of value and maybe more harmful. Proper training of specialist practitioners would be required.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning

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								statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.16	Full	General	General		If a co-ordinator or after care clinic specialist is not employed it will fall on the already stretched nurses and other healthcare professionals who will have to undertake this pathway as well as everything else they currently do. Often due to limited critical care beds, patients are often discharged out to make room for an emergency or another patient and the process of discharge planning may be more superficial than one would like. Despite NICE recommending avoidance of out-of hours discharges from critical care, this does frequently occur due to bed problems. Also the opposite can happen where patients are frequently declared ward fit and due to shortages of ward beds patients remain in critical care but do not need to be there. This creates problems with patients' psychological rehabilitation as they witness other critically ill patients and see the stressors	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate

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							they go under. Due to staff workload, nurses are often discharging patients to make room for a new admission this would be difficult to achieve as doing a rehabilitation assessment formally is a significant change in practice.	stakeholders to address the above issues.
SH	Royal College of Nursing	109.17	Full	General	General		In the rehabilitation of this group of patients, all the MDT members who are able to provide rehabilitation should be involved. Our concern is that some ITU professionals may not be actively involved, as most of them are not trained in rehabilitation philosophy. If the MDT is not actively involved, the rehabilitation work with the patients will mainly fall on the nurses, as stated earlier, nurses work load may increase. Therefore at times patients' rehabilitation may suffer. It may be a good structure, but if the MDT including the ITU consultants do not participate actively to promote this group of patients' rehabilitation due to cost or other reasons, it may remain a good structure on paper without applying in practice.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.18	Full	General	General		We appreciate that the evidence for after care clinics may be debatable and that	It is outside the remit of this guideline to provide

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							NICE may not want to be explicit on what the method of delivering the rehabilitation programme may entail. However, healthcare professionals need as much support as possible for us to go to commissioners to state that we need this particular service to deliver the rehabilitation programme otherwise some commissioners and PCTs may see this as not essential and we will not be able to implement the recommendations into practice. Budgets are tight and healthcare professionals need as much clout or evidence to try to secure financial support for this development. If NICE are not explicit on how to provide the rehabilitation pathway in practice, the recommendations will not be financially supported and will be flawed in practice. Also if NICE are not going to state after care clinics as a recommendation, they need to explicitly state that after care or follow up clinics are used in a number of hospitals and this is a good practice model that could be used to deliver the rehabilitation pathway. The guidance needs to refer to successful aftercare clinics that have been set up and give examples of their successes.	recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Nursing	109.19	Full	General	General		In our view, NICE need to give examples of how these recommendations can be	It is outside the remit of this guideline to provide

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							achieved (for example by after care clinics) otherwise when taking these recommendations to commissioners they will be ignored as other priorities will take precedent and the guidelines will be meaningless or superficially undertaken by the already stretched bedside ICU nurse with little training or specialist skills in the role.	recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Paediatrics and Child Health	110					This organisation was approached but did not respond	
SH	Royal College of Pathologists	111					This organisation was approached but did not respond	
SH	Royal College of Physicians London	112					Please see comments made by BSRM (Order No 23)	Noted
SH	Royal College of Psychiatrists	113					This organisation was approached but did not respond	
SH	Royal College of Radiologists	114					This organisation was approached but did not respond	

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SH	Royal College of Speech and Language Therapists	115.00	Full version	13	1.1.5	310	The RCSLT welcomes the mention of communication problems	Noted
SH	Royal College of Speech and Language Therapists	115.01	Full version	10 & 13	1.15	307-318	There is a need to keep information in each section consistent. We are pleased to see communication and swallowing mentioned	Noted.
SH	Royal College of Speech and Language Therapists	115.02	Full version	14	1.1.8	327	We are pleased to note swallowing and communication difficulties documented	Noted
SH	Royal College of Speech and Language Therapists	115.03	Full	24	2.1.1	553	The last paragraph raises the issue of swallowing problems but not communication problems. As communication problems are discussed throughout the document we recommend the inclusion of communication as well as swallowing. It is important to ensure both communication and swallowing are viewed as important issues for these patients.	Changes have been made in section 2.1.1 to address this point.
SH	Royal College of Speech and Language Therapists	115.04	Full version	24	2.1.1	553	We would recommend the inclusion of the impact of the loss of communication due to tracheostomy	Changes have been made in section 2.1.1 to address this point.
SH	Royal College of Speech and Language Therapists	115.05	Full version	29	1.15		There is a need to keep information consistent in each section.	Noted.
SH	Royal College of Speech and Language Therapists	115.06	Full version	34	2.2.3	741	There is a lack of mention of input from AHPs and their role. We strongly that this is included.	The GDG had physiotherapy and OT membership and these contributed. The text has been re-worded to address this.
SH	Royal College of Speech and Language Therapists	115.07	Full version	34		741	There is a need to be more specific about the role of AHPs within the MDT	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE

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								Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Speech and Language Therapists	115.08	Full version	49	General	1206	Speech and language therapists are a key stakeholder. They will need to consider the impact of this guideline and look at commissioning of services for slt within critical care.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning

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								statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Royal College of Speech and Language Therapists	115.09	Full version	70	General		The guideline is very comprehensive regarding information needs of patients and carers. There is a need to reinforce the information to be given. Information must be available both written and verbally.	Noted.
SH	Royal Liverpool and Broadgreen NHS Trust	116					This organisation was approached but did not respond	
SH	Royal Society of Medicine	117					This organisation was approached but did not respond	
SH	SACAR	118					This organisation was approached but did not respond	
SH	Sandwell PCT	119					This organisation was approached but did not respond	
SH	Scottish Intercollegiate Guidelines Network (SIGN)	120					This organisation was approached but did not respond	
SH	Sheffield PCT	121					This organisation was approached but did not respond	
SH	Sheffield Teaching Hospitals NHS Foundation Trust	122					This organisation was approached but did not respond	

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SH	Sherwood Forest Hospitals NHS Foundation Trust	123.00	Full	General	General		With regards to the title " rehabilitation AFTER critical rehab" we feel that the emphasis is on rehab post ITU care, rather than during their ITU stay. Perhaps the word after needs to be considered changing within the title. We have experienced a lack of interest from our consultants, and a lack of responsibility because of the title "rehabilitation after…".	Noted.
SH	Sherwood Forest Hospitals NHS Foundation Trust	123.01	Full	12	1.1.4	285	Using the inclusion criteria of a >48hour stay with mechanical ventilation is likely to create a large increase in workload, with patients who may not have developed mobility/function problems. Perhaps 72hours may be a more suitable time scale to use to ensure guidelines are fully implemented.	These recommendations have been changed to address this point. Please refer to recommendation 1.1.8, which states that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients
SH	Sherwood Forest Hospitals NHS Foundation Trust	123.02	Full	General	General		In general we found this an easy document to read, and also not too scary!!! From recommendations made we have found that we do not have too many big changes to make; instead we have to tweak a few things here and there. It was good for us to see that we do already have things in place i.e. patient diary but the document has highlighted to us that we must make the most of these things and use them to their full potential.	Noted
SH	Sherwood Forest Hospitals NHS Foundation Trust	123.03	Full	General	General		We would be interested to know who you as authors see as taking these recommendations forward? I.e. Physiotherapists or Intensivists?	We see a range of health care professionals taking this work forward, including these two groups.
SH	Social Care Institute for Excellence (SCIE)	124					This organisation was approached but did not respond	
SH	Society of British Neurological Surgeons	125.00	Full	P5		Lines 106 -	The scope exclusion to recognise that a number of Neurosurgery units in UK use	Noted.

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						110	general adult critical care beds to manage acute brain conditions because a special neuroscience critical care facility is not available.	
SH	Society of British Neurological Surgeons	125.01	Full	general	general		The commencement of rehabilitation is often delayed due to lack of capacity in Neurological rehabilitation units. These patients can occupy ward beds for longer than desired. The commencement of rehabilitation and semi-acute supervision will be facilitated by the availability of Intermediate rehabilitation areas sited in proximity to the acute care areas.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	South East Wales Critical Care Network	126.00	Full	6			Really appreciate the recommendations taking an overall view of the patient's trajectory – not splitting their care into service or directorate specific chunks. Does this not open up to us literature on other rehabilitation pathways and	The population for this guideline is general critical care patients who do not fall under specific rehabilitation pathways such as cardiac, stroke or neurological rehabilitation.

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							efficacious mechanisms/ interventions?	
SH	South East Wales Critical Care Network	126.01	Full			235-237	Appreciate this principle, although recognising that current evidence in respect of non-physical risk factors provides only limited variance for prediction (Brewin et al 2000). Local evidence (Vick TL. 2008 Doctoral Thesis) suggests that a prolonged critical care stay and those scoring highly for traumatic stress symptoms at two-weeks post ICU discharge were strongly predictive of later PTSD.	Noted.
SH	South East Wales Critical Care Network	126.02	Full			245-248	The use of standardised assessment tools would be more favourable and have been recommended (Tedstone & Tarrier 2003; Vick TL. 2008 Doctoral Thesis), as opposed to locally defined tools. The use of standardised tools would provide additional evidence and more comparable findings across the UK.	The recommendation on 'locally defined tool' has been taken out due to lack of evidence as to their test performance.
SH	South East Wales Critical Care Network	126.03	Full			254 - 257	Appreciate the concept of an "individualised" programme, although the recommendation for provision of a rehabilitation programme is based upon very limited evidence (x 1 RCT). There are concerns with regards to increase in IES and anxiety scores at six months, following the interventional rehabilitation programme and the standard care of "follow-up" at a dedicated clinic. Can we be certain that the interventions did not exacerbate symptoms of anxiety and early traumatic stress. Also, can we be certain that an intervention is suitable for all patients, noting the high mean trait anxiety scores of participants in Jones et al (2003) study and subsequent non-	The recommendations have been changed to address this point. Please refer to recommendation 1.1.8, which states that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients.

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							physical findings.	
SH	South East Wales Critical Care Network	126.04	Full			258 -	BEFORE DISCHARGE FROM CRITICAL CARE - Factors associated with PTSD Should include pre-traumatic, peri-traumatic and post traumatic factors that have been found to be associated with PTSD through meta-analysis (Ozer et al 2003, Brewin et al 2000) NB "flashbacks" are a fairly rare phenomenon and commonly misunderstood. Probably should also be alerted to - Withdrawn, apathetic individuals Irritable or angry individuals Disorientated or confused individuals	Noted. The GDG considered this proposal and did not consider that factors associated with PTSD should be flagged up.
SH	South East Wales Critical Care Network	126.05	Full			298 - 301	Rather vague recommendation - A care pathway would be more appropriate, particularly for those not familiar or who lack knowledge or experience of PTSD. This has been recently proposed (Vick TL Doctoral Thesis 2008) The key recommendations (NCCMH 2005) regarding the initial response provided to those who have experienced a traumatic event are for watchful waiting for mildly symptomatic individuals, with further contact arranged within one month. The provision of brief, single session interventions should not be routinely provided. For those with severe symptoms, provision of Trauma Focussed Cognitive Behavioural Therapy (TFCBT) is the only proven effective treatment in the first month, conducted on an	The care pathway for patients with PTSD is provided by the NICE PTSD guideline and is clearly cross-referred to in recommendation 1.1.8 and 1.1.13.

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							outpatient basis. Some forms of medication in the short term, such as hypnotics, for the management of sleep disturbances may be considered, but in the longer term, the use of suitable anti-depressants are more suited as an adjunct to psychological therapy. (Vick TL - Doctoral Thesis 2008)	
SH	South East Wales Critical Care Network	126.06	Full			302	Non -physical symptoms before discharge to home - Should include education of patients with regards to symptoms of PTSD. Evidence also suggests that educating those close to patients (e.g. relatives / carers) is the most optimal for recognition of problematic responses (Bisson 2007). Reference to non-physical problems - More attention is required to develop stepped care models of response, which includes immediate practical, social, and emotional support, offered by non-mental health professionals (Bisson 2007). Recovery of individuals in the aftermath can be facilitated by assessment and provision of identified needs of practical and social support of individuals and significant others, in addition to education of individuals in respect of the range of emotional responses that may develop, along with methods of alleviating them or accessing the relevant support (Vick TL Doctoral Thesis 2008) NB. Referral pathways need to be clarified on detection of symptoms, as a priority.	Education of lay carers/relatives is outside the scope of this guideline. The NICE PTSD, Depression, and Anxiety guidelines and stepped care model are clearly cross-referred to in recommendation 1.1.8 and 1.1.13.

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SH	South East Wales Critical Care Network	126.07	Full			From 329	Might it be helpful to expedite GP information at critical care discharge, or at least investigate this. Experience suggests GP's are often unaware of patient admission to ICU for some weeks after discharge, or until informed by the patient or a relative.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration..
SH	South East Wales Critical Care Network	126.08	Full			337	Delaying assessment of non-physical problems to 2-3 months where known problems exist, does not comply with NICE PTSD Guideline. Please note Point 5, with regards to Prevention and Treatment of PTSD. Delaying assessment misses a window of opportunity to identify, refer, treat and prevent later PTSD, patients may be disadvantaged by this delay. GP needs to be informed of all problems identified, so they may also monitor their patients. .	The recommendations do not delay non-physical assessment. The 2-3 months assessment is a re-assessment. Please see recommendation 1.1.5 and 1.1.9 (before discharge). These recommendations do cover assessment of traumatic stress related symptoms and appropriate referrals before completing the discharge.
SH	South East Wales Critical Care Network	126.09	Full			348 - 364	As per NICE Guideline -Non- physical problems (PTSD)- needs to be monitored from the earlier assessment through "watchful waiting" for mildly symptomatic individuals, with further contact arranged within one month. For those with severe symptoms, provision of Trauma Focussed Cognitive Behavioural Therapy (TFCBT) is the only proven effective treatment in the first month, conducted on an outpatient basis, so patients need to have been appropriately referred before 2-3 months. NB - An appropriate stepped care pathway is need.	Please see recommendation 1.1.5 and 1.1.9 (before discharge). These recommendations do cover assessment of traumatic stress related symptoms and appropriate referrals before completing the discharge (recommendation 1.1.10). In recommendation 1.1.13 (2-3 month assessment), the NICE PTSD guideline is clearly referred.

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							NB.- funding in Wales for non-physical problems is as yet, not in line with the rest of the UK. Welsh patients may be disadvantaged by long waiting lists for treatment.	
SH	South East Wales Critical Care Network	126.10	Full			390 - 400	Provision of information in diary form - The provision of brief, single session interventions should not be routinely provided. (NCCMH 2005) These may be considered a form of brief intervention, which could be potentially traumatic for some patients, needs to be subject to a RCT and should not be mandatory or forced on patients (personal communication - Dr J.Bisson) .	Due to a lack of evidence of their effectiveness, the NICE technical team and the GDG agreed that the guideline is not in a position to make any specific recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	South East Wales Critical Care Network	126.11	Full			473 - 478	Insufficient evidence. Some evidence to suggest physical benefit, but not for non-physical. NB. Increased PTSD and anxiety scores	Noted.
SH	South East Wales Critical Care Network	126.12	Full			479 - 482	Agree with regards to statement, however for non-physical morbidity, approved stepped care pathways provide guidance for this and could be developed for critical care survivors.	Noted.
SH	South East Wales Critical Care Network	126.13	Full	General 28 - 43			concerned about assessing patients and labelling them as 'anxious' or 'depressed' in systems that rarely have much psychological input to make send of this. Current screening tends to have happened in systems that have developed follow up service and multidisciplinary input. The CDG call for 'clinical assessment by suitably qualified professional for non – physical morbidity…at the five key stages'. Establishing this will have huge funding	We recognise that there is a need to implement all the recommendations. It is, however, outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include:

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							implications. There is a danger that implementation of the recommendation to screen may happen in absence of an established team and input. This may then lead to patients being pathologised for what often may be a normal psychological response to an extreme situation. We do not know enough about the natural history of the patient's recovery to make send of what scores mean at different times in their recovery again - we need more research into this.	• Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	South East Wales Critical Care Network	126.14	Full			630	Non - physical dimensions. Please refer to point 5 and 6 regarding stepped care pathway development, the recommended NICE guideline for prevention and treatment of PTSD and the use of educational strategies for optimal recognition of problematic responses. Raising awareness and sorting out proper referral systems should be the priority at present (personal communication - Dr J. Bisson)	Recommendation 1.1.8 and 1.1.13 make clear cross-reference to the NICE PTSD guideline.
SH	South East Wales Critical Care Network	126.15	Full			770 -	Post traumatic stress symptoms. PTSS 14 has not be validated to a recognised gold standard for PTSD. This should be correctly validated using either the CAPS (Blake et al 1995) or the SCID (First et al 1996) As it stands, sample size was too small,	Noted.

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							numbers in excess of 100 participants would normally be required to obtain a reasonable level of precision. (Mossman and Samoza 1989). There is no convincing evidence so far for a "suitable" screening measure for recommendation and such a tool would need to look more globally at psychological distress (personal communication - Dr Jonathan Bisson)	
SH	South East Wales Critical Care Network	126.16	Full			1227 - 1229	A stepped care pathway for PTSD has been proposed that complies with The NCCMH (2005) guideline for PTSD (Vick TL 2008 - Doctoral Thesis)	Noted.,
SH	South East Wales Critical Care Network	126.17	Full			1253 - 1258	A stepped care pathway for PTSD has been proposed that complies with The NCCMH (2005) guideline for PTSD (Vick TL 2008 - Doctoral Thesis) A stepped care pathway for critical care survivors with anxiety and depression needs to be developed, that also complies with NICE Guidelin	Noted. The guideline has explicitly referred to NICE PTSD, Depression, and Anxiety guidelines (recommendation 1.1.8 and 1.1.13).
SH	South East Wales Critical Care Network	126.18	Full			1301 -	Results of RCT - Repeated measures ANOVA shows significant improvement in physical functioning (PF) over time, this appears to have been between baseline and 8 weeks as at the six months assessment the mean PF score is the same as at baseline. Presume that this is based upon the intervention group? Re: depression, anxiety and PTSD - were there no baseline screenings? What were the mean PTSD scores at six-months?	Noted. These comments reflect the limitations of the Jones et al (2003) study.
SH	South East Wales Critical Care Network	126.19	Full	General 54			Surprised that guidelines are being drawn up based on so little research evidence – small number of studies that the authors	Noted. We have revised relevant recommendations and restructured the evidence to recommendation

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							conclude are of 'mixed quality'. Whilst supportive of the idea of developing follow up, consider that many of the conclusions of this document are not based on demonstrated efficacy. More research is needed. Is it appropriate to recommend an intervention based on one study that did not demonstrate efficacy in reducing non physical morbidity? On the basis of what the authors admit is 'probable'.	sections to make it clear as to which recommendations are based on the reviewed evidence and which are based on the consensus view of the GDG.. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients.
SH	South East Wales Critical Care Network	126.20	Full			1429 - 1434	Appreciate this point	Noted
SH	South East Wales Critical Care Network	126.21	Full			1440 - 1444	Patients with early and more severe traumatic stress symptoms need to have been already referred and not have to wait until 2-3 months for this and for treatment. As per NICE guideline recommendation for mildly symptomatic patients - further contact arranged within one month, for those with severe symptoms, provision of TFCBT is the only proven effective treatment in the first month. (NCCMH 2005)	Recommendation 1.1.5 and 1.1.9 includes clinical assessment of traumatic stress symptoms such as nightmares, delusions, flashback, avoidance behaviour, and in recommendation 1.1.10, it clearly states that: *"If continuing rehabilitation needs are identified before the patient is discharged, ensure that:* *arrangements are in place, including appropriate referrals for the necessary ongoing care before completing the discharge."*
SH	South East Wales Critical Care Network	126.22	Full			1472 -	The PRACTICAL Study (Cuthbertson et al 2007) - it is noted that results from this study are currently awaited and these will inform practice and therefore this guideline may be somewhat premature. Please note that the Davidson Trauma Scale used to detect PTSD in the	Noted. The lead author of this study is a member of the GDG.

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							PRACTICAL Study has been recently found to be unsuitable for use within a critical care population (Vick TL 2008 Doctoral Thesis	
SH	South East Wales Critical Care Network	126.23	Full			1636	Grave concerns regarding this recommendation and the reference made to "debriefing" patients, which does not comply with NCCMH guidelines for PTSD. Debriefing is not recommended and may be harmful (Rose et al 2005). The use of critical care diaries, has not been adequately tested within the critical care population. The use of patient diaries needs formal evaluation through randomised controlled studies; ensuring appropriate assessments for PTSD are conducted before recommendation of the use within a critical care rehabilitation guideline.	Due to a lack of evidence of effectiveness, the GDG and the NICE technical team considered that the guideline is not in a position to make any specific recommendations regarding the use of diaries. As result, this particular recommendation has been removed.
SH	South East Wales Critical Care Network	126.24	Full	66			Recommendation of patient diaries. This may mean different things to different people – there is no clarification of what a diary consists of. There is also no consideration of how the diary may result in retraumatisation of patients with little or no recall.	Due to a lack of evidence, the NICE technical team and the GDG agreed that the guideline should not make any recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	South East Wales Critical Care Network	126.25	Full			1827	Grave concerns regarding photographs as they can be potentially traumatising. (Clinical Experience of this). This needs to be appropriately investigated (RCT).	Due to a lack of evidence, the NICE technical team and the GDG agreed that the guideline is not in a position to make any recommendations regarding the use of diaries and photographs. As result, this particular section has been taken out.
SH	South East Wales Critical Care Network	126.26	Full			1846 - 1864	Information needs to be provided about commonly reported symptoms of PTSD to both patients and carers. Recovery of	Clinical assessments for PTS related symptoms have been covered in recommendation 1.1.5,

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							individuals in the aftermath can be facilitated by assessment and provision of identified needs of practical and social support of individuals and significant others, in addition to education of individuals in respect of the range of emotional responses that may develop, along with methods of alleviating them or accessing the relevant support (Vick TL Doctoral Thesis 2008)	1.1.9 and 1.1.12
SH	South East Wales Critical Care Network	126.27	Full	General			There is insufficient evidence at this stage to inform a guideline for the rehabilitation of critical care patients. There is a clear need for more research into patient outcomes. There is a lack of prospective longitudinal studies. Further investigations are recommended. The validation of PTSD questionnaires compared to a gold standard and conducted within the critical care population, is also recommended (Vick TL Doctoral Thesis 2008). Although this guideline makes several references to the NICE guideline for PTSD, several recommendations in this guideline do not comply with NICE guidelines for PTSD. These include - • Mention of debriefing of patients • Assessment of PTSD deferred to 2-3 months, thereby delaying treatment of more severely traumatised individuals. • A delay in referral of patients with PTSD	Noted. We have flagged up both the limited evidence available in this area, and the limitations of the available evidence. We disagree with these points: • There is no mention of 'debriefing' in the recommendations. • The recommendations do not defer the assessment of PTSD. The 2-3 month assessment is clearly stated as a 're-assessment' in order to pick up those patients at risk of PTSD who have not already been picked up and referred during the ward-based care

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							• The use of patient diaries and photographs could be potentially traumatising. (Provision of brief, single session interventions should not be routinely provided) • The lack of a clear pathway for survivors with PTSD symptoms	assessment (recommendation 1.1.4) • Referral to follow the NICE PTSD guideline was mentioned in recommendation 1.1.8 – During ward-based care. The GDG considered that this is not a delay as much non-physical morbidity would not become apparent before critical care discharge. • It should be noted that this recommendation has been removed from the final version of the guideline in response to this and other related SH comments.. • The recommendation 1.1.8 states that this subgroup of patients should be referred to the NICE PTSD clinical guideline).
SH	South East Wales Critical Care Network	126.28	Full	General			Considering the document in general it is seen as being the gold standard. It is what health care professionals in the 21st century would like to be able to provide for those who survive critical illness. However certainly in the Network region support services are not readily accessible and to open up wounds both physical and psychological without the necessary support could do more harm than good. We must therefore start small and expand the service as and when possible. It would be easier to do this if	The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.

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							everyone agreed upon a starting point and took small steps from there.	
SH	South East Wales Critical Care Network	126.29	Full	General			• Identification of the clinical and socio- economic risks associated with physical morbidity, post critical care admission is welcomed, in particular the recognition of the concept of "early rehabilitation." This is an area of clinical practice that has, in some critical care environments not formally been recognised. • Advances in the medical management of patients within Critical care have resulted in improved survival rates and increasing demands for rehabilitation. This guidance supports the need to develop services to this patient group. Without the recognition of the associated clinical risks and the lack of a robust evidence base, this has been a difficult area to resource. • We recognise the importance of developing the research to provide the evidence base and support the suggestions identified within the guidance. Recognition of the issues will offer the opportunity to develop research in this area. • The outlined standards of care for supporting the rehabilitation of this patient group with physical morbidity are comprehensive.	Thank you. Noted. Thank you. Thank you.

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SH	South East Wales Critical Care Network	126.30	Full				Need to be aware of different local provision. I suspect these guidelines have been written relying on the Increased Access to Psychological Therapies work in England enabling the stepped care model recommended in the Anxiety, PTSD and Depression guidelines. NICE needs to be aware no such extra provision has been made in Wales.	Noted. The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations. Although the implementation tools are not specifically produced for Wales they are placed on NICE website and can be downloaded by anything with access to the internet.
SH	South East Wales Critical Care Network	126.31	Full	General			Where there is acknowledged lack of evidence on ITU specific populations would it not be worth looking at similar populations- such as the work on cardiac surgery patients and later cognitive impairment.	As mentioned in section 1.3.4, all GDG consensus recommendations were based on both their own experience in the field and also from other related fields such as neuro-rehabilitation, cardiac rehabilitation and stroke rehabilitation.
SH	South East Wales Critical Care Network	126.32	Full	General			General PTSD literature would suggest watchful waiting for early PTS symptoms. Indeed some early interventions have been found to be unhelpful. Is it appropriate then to recommend non proven early interventions such as diaries?	Due to a lack of evidence, the NICE technical team and the GDG agreed that the guideline should not make any recommendations regarding the use of diaries. As result, this particular recommendation has been taken out.
SH	South East Wales Critical Care Network	126.33	Full	General			One recommendation is to identify patients who may be at risk of later non physical morbidity – but data on this is absent. There is a study (Rattray et al 2004) looking at risk factors to later psychological difficulties – that is not cited in the review.	The review of different prediction models of risk factors for psychological problems is outside the scope of this guideline
SH	South East Wales Critical Care Network	126.34	Full	General			Quality of Critical Care in Wales is driven by the Welsh Assembly Government Quality Requirements for Adult Critical Care (published 2006) which specifies the	Noted.

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							way in which the service should be organised and delivered. Critical Care Networks were established in Wales in 2007 and Wales has been proactive in developing and implementing a consistent approach to care management through a range of nationally agreed care bundles. All of the above demonstrate a commitment in Wales to providing a robust and patient centred approach to care	
SH	South East Wales Critical Care Network	126.35	Full	General			References: BISSON JI, BRAYNE M, OCHBERG FM, EVERLY GS. (2007) Early psychosocial Intervention following traumatic Events. American Journal of Psychiatry 164; 7 1016-1019 BLAKE DD, WEATHERS FW, NAGY LM, KALOUPEK DG, GUSMAN FD, CHARNAY DS, KEANE TM. (1995). The development of a Clinician-Administered PTSD Scale. Journal of Traumatic Stress 8, 1, 75-90. BREWIN C. R. (2005). Systematic review of screening instruments for adults at risk of PTSD. Journal of Traumatic Stress 18, 53–62. CUTHBERTSON BH, RATTRAY J, JOHNSTON M, WILDSMITH JA, WILSON E, HERNENDEZ R, RAMSEY C, HULL AM, NORRIE J, CAMPBELL M. (2007) A Pragmatic Randomised, Controlled Trial of Intensive Care follow up programmes in improving Longer-term	Thank you.

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							outcomes from critical illness. The PRACTICAL study. BMC Health Services Research 2007, 7:116 FIRST M, SPITZER R, GIBBON M, ET AL. (1998) Structured Clinical Interview for DSM-IV Axis I Disorders, Non-Patient Edition (SCID-I/NP, Version 2.0), New York State Psychiatric Institute. JONES C, SKIRROW P, GRIFFITHS RD, HUMPHRIS GH, INGLEBY S, EDDLESTON J, WALDMANN C, GAGER M. (2003) Rehabilitation after critical illness: a randomized, controlled trial. Critical Care Medicine.31:2456-2461 MOSSMAN, D., & SOMOZA. E. (1989). Maximizing diagnostic information from the dexamethasone suppression test. Archives of General Psychiatry, 46.653-660 NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH (2005). Clinical Guideline 26. Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. National Institute for Clinical Excellence. RATTRAY J, JOHNSTON M, WILDSMITH JAW. (2005) Predictors of emotional outcomes of intensive care. Anaesthesia, 60, 1085–1092 ROSE S, BISSON J, WESSELY S. (2005) Psychological debriefing for preventing	

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							post traumatic stress disorder (PTSD) (Cochrane review). In: Cochrane Library. Chichester: John Wiley TEDSTONE JE, TARRIER N. (2003) Posttraumatic stress disorder following medical illness and treatment. Clinical Psychology Review 2003; 23: 409–48 TWIGG E, HUMPHRIS G, JONES C, BRAMWELL R, GRIFFITHS RD. (2008). Use of a screening questionnaire for post-traumatic stress disorder (PTSD) on a sample of UK ICU patients Acta Anaesthesiol Scand 52: 202–208	
SH	South Manchester University Hospitals NHS Trust	127					This organisation was approached but did not respond	
SH	South Tees Hospitals NHS Trust	128					This organisation was approached but did not respond	
SH	South West London Cardiac & Stroke Network	129					This organisation was approached but did not respond	
SH	Southport & Ormskirk Hospital NHS Trust	130.00	Full	General			The document presents good vision for the client group however it seems too general and does not make concrete recommendations or present models for the programmes. This can not be done with out additional resources, I simply do not understand who will do the assessments, carry out the rehab etc Existing services can not just do this as an add on. The priority for acute Trusts is to discharge patients asap unless there are ring fenced resources staff etc as per	We recognise that there is a need to implement all the recommendations. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set

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							Stroke services.etc The guidelines are bound to fail unless the service is funded and supported appropriately with staffing levels and a remit set down, e.g the staffing levels and resources for stroke units are well known and audited against, or a model based upon Cardiac Rehab etc There is an obvious need for primary and secondary care to have a coordinated joined up plan for the management of transition of these patients in to primary Care from the acute setting. If patients are to be referred.	• Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.01	Full		1.1		Who will do this??	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. .
SH	Southport & Ormskirk Hospital NHS Trust	130.02	Full		1.1.2		Who will do this?	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration..
SH	Southport & Ormskirk Hospital NHS Trust	130.03	Full		1.1.3		Resources???	**The GDG were aware that the delivery of the guideline has resource implications. Members of the GDG have been working with the NICE Implementation team on this. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline.**

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SH	Southport & Ormskirk Hospital NHS Trust	130.04	Full		1.4	289	This really opens the flood gates and questions of resources available must be tackled	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.05	Full		1.1.5		Who will do this??	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include:

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								• Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.06	Full			326	Who will do this??	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Southport & Ormskirk Hospital NHS Trust	130.07	Full		1.6		Does this assume rehab is available in the community	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools

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								• Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.08	Full		1.7		Who will do this??	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation

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								Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.09	Full		1.1.8	350	Where are these services? they need to be set up they are not available	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.10	Full		1.9	373	Resources	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an

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								implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Southport & Ormskirk Hospital NHS Trust	130.11	Full			449	There have to be designated staff to carry out the care pathway	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Surrey Wide Critical Care Network	131.00	Full	Foreword (143) and 1.1.1 (255			'Coordination by suitably trained and experienced health care professionals' • Intensive Care Physiotherapists are ideally placed to provide coordination; • ITU physios commonly crossover to the wards, providing unique experience, expertise and continuity of care to patients.	We agree that this group are one example of "suitably trained and experienced health care professionals". However, it is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Surrey Wide Critical Care Network	131.01	Full	Foreword (183)			'…lack of detailed understanding of the pathophysiology of…. muscle wasting' • It is worth giving particular	The Foreword has been re-edited.

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				and 2.2.3i (708)			attention to Critical Illness Polyneuropathy and Myopathy (CIPNM) due to their high incidence and potentially profound clinical implications. • Ref: Ricks E. Critical Illness polyneuropathy and myopathy: a review of evidence and the implications for weaning from mechanical ventilation and rehabilitation. Physiotherapy 2007;93:151-156 CIPNM risk factors (sepsis/SIRS and MODS) provide a useful indicator for stratifying likely risk of developing physical morbidity.	
SH	Surrey Wide Critical Care Network	131.02	Full	Patient - centred care (213) and 1.1.1 (238)			'Agree short- and long-term rehabilitation goals with the patient…' • Problem-orientated medical records used by physiotherapists could be applied to provide an ideal framework for goal-setting for the multidisciplinary team	Noted. The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.
SH	Surrey Wide Critical Care Network	131.03	Full	1.3.1 (469)			'For general adult critical care patients….. no alternative rehabilitation pathway exists' • Although no formal, pre-defined pathway exists, physiotherapy problem-orientated medical records are routinely used to allow rehabilitation to be planned and carried out in a coordinated manner.	Noted. The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.
SH	Surrey Wide Critical Care Network	131.04	Full	1.1.2 (252) and			'measures to prevent avoidable physical and non-physical morbidity • There must be provision within	It is outside the remit of this guideline to provide recommendations on service

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				1.1.5 table 1			• the NICE guideline ensure there is adequate funding for provision of service from other professions such as OT, dietetics, mental health. Without this, the recommendations made simply cannot be met effectively. • Table 1 indicates a clear need for early intervention from OT's, which is commonly unavailable due to inadequate funding for provision of this service.	delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Surrey Wide Critical Care Network	131.05	Full	1.1.6 (331)			'appropriate referrals for the necessary ongoing care before completing the discharge' • Most trusts do not have provision to provide ongoing rehabilitation in the community for this group of patients. Appropriate referrals are likely to be impossible within the constraints of current service provision.	Noted. The NICE Implementation Team is in the process of developing implementation tools to assist the implementation of the recommendations.
SH	Surrey Wide Critical Care Network	131.06	Full	1.1.7 (339) and			• 2-3 month follow-ups must be practicably accessible to all patients (with the	Noted.

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				1.1.9 (378) and 2.2.3v (765)			acknowledgement that this can be a self-selecting group with selection bias). • It is likely that some patients will need to be visited at home, ideally by the professional coordinating the patient pathway since their admission to ICU.	This is highlighted by recommendation 1.1.12, stating that the 2-3 months re-assessment should be carried out on a face-to-face basis, and this could be in hospital or in community.
							• It would not be ideal to hand over the 2-3 month follow-up to 'primary/community care' as this provides no continuity of care or availability of expertise to the patient at this time. • In order to effectively implement the rehabilitation care pathway, primary and secondary care providers must be required to work cooperatively to ensure adequate provision of continuous service.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above

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								issues.
SH	Surrey Wide Critical Care Network	131.07	Full	2.4.3ii (1413)			'the GDG envisaged a 'core team' with other members joining intermittently, for example therapists…' • Strongly feel that therapists input and/or leadership must be continuous, throughout the rehabilitation pathway, not intermittent.	Noted. The guideline recommendations do not preclude such a service configuration. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration.
SH	Surrey Wide Critical Care Network	131.08	Full	2.4.5			There seems to be much emphasis on the use of a self-help manual. Whilst agree this should be included for the use of all patients (acknowledging the difficulty for patients unable to pick up a book and / or read whilst recovering from critical illness), it is not felt that this should substitute for any aspect of formal hands-on/ face-to-face time with rehabilitation professionals.	Noted. We have revised the relevant recommendation. Please refer to recommendation 1.1.8, which stated that the self-help manual in Jones et al (2003) study could be part of the individualised rehabilitation programme based on clinical judgment, it is not recommended for all patients.
SH	Tees Valley and South Durham Critical Care Network	133.00	Full		1.1.1 1.1.2	235 – 257	This would be achievable if the units formed a dedicated multi disciplinary team (physio, medical, dietician, nursing as minimum) to develop a team dedicated to this patient group to undertake the clinical and develop rehabilitation plans. There is currently varying involvement of AHPs in critical care.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template

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								The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South Durham Critical Care Network	133.01	Full		1.1.3	265 - 271	Assessment of psychological and or psychiatric distress should be by appropriately trained staff. Very few critical care units have clinical psychologist involvement.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.

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SH	Tees Valley and South Durham Critical Care Network	133.02	Full		1.1.4	285-297	The provision of a rehab programme for 6 weeks post discharge would involve a trust team to design initially and support implementation. This would have heavy workforce implications for ward staff, physios and occupational therapists. The level of involvement required is not available at this time within any of the trusts.	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South Durham Critical Care Network	133.03	Full		1.1.4	298	Would require clinical psychologist involvement that is generally unavailable	Noted. This recommendation cross refers to existing NICE guidelines (PTSD). It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this

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								particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South Durham Critical Care Network	133.04	Full		1.1.5	304-328	The pre home discharge assessment including the dimensions in table 1 would require input from the MDT including OT's, physios, medical and nursing as minimum. It may also require other support staff, including social workers and psychologists. This resource is generally not currently available with the trusts.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools

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								will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South Durham Critical Care Network	133.05	Full		1.1.6	329-336	Structured, formal communication channels and care pathways will have to be developed between acute and primary care teams.	Noted. It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South	133.06	Full		1.1.7	338 -	Review 2-3 months post critical care	It is outside the remit of this

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	Durham Critical Care Network					364	discharge would require the need to establish follow up clinics run by experienced multi disciplinary teams. The accommodation and resources are not currently available within the trusts. Many of our trusts do not have outreach services to support clinics.	guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Tees Valley and South Durham Critical Care Network	133.07	Full	General			Many recommendations are not achievable at this time. Some recommendations may not be appropriate for all patients. The recommendations will require considerable resources and time to develop. There are time constraints in the training of appropriate and additional staff.	Noted. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline.
SH	Tees Valley and South Durham Critical Care Network	133.08	Full	General			Minimum standards need to be set and enforced for the establishments of AHPs, especially dieticians, physios, OTs and	It is outside the remit of this guideline to provide recommendations on service

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							clinical psychologists to encourage organisations to employ appropriate teams to deliver the guidelines.	delivery models or service configuration.
SH	Tees Valley and South Durham Critical Care Network	133.09	Full	General			The principles of the guidelines are welcomed and the benefits of implementation acknowledged but current establishments will limit the extent of implementation.	Noted. The NICE Implementation Team is in the process of developing a specific implementation plan for this particular guideline.
SH	UK Clinical Pharmacy Association (UKCPA)	134.00	Full	15	1.1.8	348	Cognitive dysfunction is not included in the list, but probably should be.	Changes have been made to address this point: see Table 2.
SH	UK Clinical Pharmacy Association (UKCPA)	134.01	Full	25	2.1.2	596 to 602	Not at all clear why delirium is a reason to exclude these studies. "Not relevant" and "Inappropriate population" are understandable. Exclusion for reasons of delirium needs clarifying please.	There is a NICE standard guideline on delirium in development (which will cover the critical care population and which will address identification and assessment) to be published in 2010. Delirium is therefore outside of the scope of this guideline.
SH	UK Clinical Pharmacy Association (UKCPA)	134.02	Full	34	2.2.3	748 to 760	Does the 2-3 month review apply to all patients who have been through critical care or just the ones who are still in hospital? The intention is presumably all patients, but the wording is unclear.	No. Please see the revised care pathway.
SH	UK Clinical Pharmacy Association (UKCPA)	134.03	Full	43	2.2.7	1035 to 1041	There is concern that the NICE group looking at delirium may not be specifically including critical care patients (originally critical care patients were specifically excluded). We request that the chair of the rehabilitation Guideline Development Group should ensure that the delirium NICE guideline does in fact SPECIFICALLY INCLUDE CRITICAL CARE. If critical care patients are not covered by the delirium guidance, then the critical illness rehabilitation document should address the issue.	We can confirm that there will be a separate NICE standard guideline on delirium - which will cover the critical care population - to be published in 2010.
SH	UK Clinical Pharmacy	134.04	Full	57	2.4.3 ii	1405	It is appreciated that a definitive makeup	It is outside the remit of this

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	Association (UKCPA)					to 1416	of the MDT is difficult to give, bearing in mind the range of models currently in practice. However a set of core skills for the MDT would help ensure that the patients' needs are met consistently across the country.	guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	UK Clinical Pharmacy Association (UKCPA)	134.05	Full	General	General		Psycho-sexual dysfunction after critical illness has been reported (Continuing Education in Anaesthesia, Critical Care & Pain 2004 4(6):202-205 "Follow-up after intensive care") but does not appear to be mentioned in this document.	Please see recommendation 1.1.12.
SH	UK Clinical Pharmacy Association (UKCPA)	134.06	Full	General	General		There is a dearth of references to drugs and/or medication which form a significant part of any stay in critical care, and which can cause significant morbidity (eg delirium).	Pharmacological management of the critically ill patient is outside the remit of this guideline.

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							There are a number of areas where reference should be made: 1) Medicines reconciliation – NICE/NPSA – this is relevant not only for the admission to critical care, but for subsequent discharge to the ward and home care. At each stage medicines should be assessed for appropriateness, and drug treatment amended accordingly. This could include stopping of pre-admission medication due to adverse effects (and also notification to the GP), stopping critical care specific treatment on discharge (eg drugs for stress ulcer prophylaxis) (Chahal JK, Shulman R, Taylor K: The impact of drug-history clerking using computerised notes in the ICU on subsequent prescribing. Pharmacy in Practice 2007, 17: 14-18.), ensuring continuation of relevant chronic therapies, and notification to the community pharmacist if the patient requires medication aids 2) Provision of information on medication to patients and carers – including length of courses, review dates etc 3) Optimisation of medication – both during the critical care stay eg refining therapy to minimise the potential for delirium, but also on discharge – ensuring that the	

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							patient is able to take the medication (eg if they have swallowing problems has the most appropriate formulation been supplied)	
SH	UK Clinical Pharmacy Association (UKCPA)	134.07	Full	General	General		There is no mention of health prevention strategies – this is particularly apposite for patients whose admission was linked to lifestyle issues eg intravenous drug use, obesity.	This is outside the remit of the guideline.
SH	University College Hospital London	148.00	Full	General			This are general comments that from what I could see there was no mention of medicine related advice in this document, though there are several strands that are relevant. 1) Medicine reconciliation: NICE/NPSA has guidelines on the importance of this but chronic drugs therapy sometimes gets missed in the ICU admission and if the information is not passed onto the ward then chronically used drugs may fall off the patients prescription leading to confusion and morbidity. 2) It is important that ICU type drugs are reviewed and stopped or treatment follow-up is communicated with the receiving team and GP when patients are discharged from the ICU. ICU type drugs eg for delirium should be stopped. Drugs for stress ulcer prevention eg proton pump inhibitors or ranitidine should be stopped. Dangerous drugs such as amiodarone should be	This has been addressed: a recommendation on 'review of prior and current medication' during critical care stay has been added in recommendation 1.1.3.

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							reviewed and potentially stopped if the reason for the arrhythmias has been sorted eg sepsis related. It is easy for these drugs to be continued all the way to discharge and beyond as everyone in the line thinks someone else is dealing with it. We have began to research this area and have published one paper Chahal JK, Shulman R, Taylor K: The impact of drug-history clerking using computerised notes in the ICU on subsequent prescribing. Pharmacy in Practice 2007, 17: 14-18. and are conducting a research project at our critical care follow-up clinic.	
SH	University Hospital Birmingham NHS Foundation Trust	136					This organisation was approached but did not respond	
SH	Walsall Hospital NHS Trust	137					This organisation was approached but did not respond	
SH	Walton Centre for Neurology and Neurosurgery NHS Trust	138.00	Full	47	2.3.1	1137 - 1142	Evidence for these statements does not appear to exist	We have revised the section.
SH	Walton Centre for Neurology and Neurosurgery NHS Trust	138.01	Full	49	2.4	1218	Evidence for the 6 weeks is based on a small study and only may apply to physical and not psych problems, as well as limited population	Noted. This is discussed in section 2.2.3 (evidence statements)
SH	Walton Centre for Neurology and Neurosurgery NHS Trust	138.02	Full	General	General		A majority of the evidence base is at best moderate quality, and based on studies with small and in some cases very small numbers of patients. Thus mainly consensus based. As this report could have significant resource consequences for trusts should this not be made very	We have re-edited and restructured the evidence to recommendations section to make it clear how the GDG interpreted the presented evidence base and the considerations they brought to bear in drafting the recommendations.

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							clear in the summary and opening statements, so that PCTs and patients groups are under no illusions re the potential weakness of this guidance	We have also made it clear when GDG consensus is the basis for the recommendation Please see section 2.1.4, section 2.2.4 and section 2.3.4.
SH	Welsh Assembly Government	139					This organisation responded and said they have no comments to make	Noted.
SH	Welsh Scientific Advisory Committee (WSAC)	140					This organisation was approached but did not respond	
SH	Western Health and Social Care Trust	141					This organisation was approached but did not respond	
SH	Worcestershire Acute NHS Trust	145.00	Full	General	General		Repetitive	Noted.
SH	Worcestershire Acute NHS Trust	145.01	Full	General	General		Could be more specific regarding self guided rehabilitation programme to prevent each organisation rewriting the wheel	The reference for the self-help manual (the Jones et al study, 2003) is provided in the guideline.
SH	Worcestershire Acute NHS Trust	145.02	Full	General	General		Critical Care Outreach teams offer a bridge between Critical care and the ward areas and therefore perfectly placed to facilitate some of the recommendations	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools

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								will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate stakeholders to address the above issues.
SH	Worcestershire Acute NHS Trust	145.03	Full	General	General		Some Critical Care Outreach Teams also provide follow up services for post Critical care patients	Noted.
SH	Worcestershire Acute NHS Trust	145.04	Full	General	General		Critical Care Outreach not mentioned	It is outside the remit of this guideline to provide recommendations on service delivery models or service configuration. However, the NICE Implementation Team is in the process of developing an implementation plan for this particular guideline which will include: • Slide set • Audit support • Costing tools • Bespoke - joint positioning statement and/or discharge template The development of the above tools will consider the following key issues: commissioning for follow-up services; training and education; and the range of options for how rehabilitation services could be delivered. The Implementation Advisor will engage appropriate

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								stakeholders to address the above issues.
SH	York NHS Foundation Trust	142					This organisation was approached but did not respond	